DEVELOPMENT AND EVALUATION OF A TREATMENT PACKAGE FOR MEN WITH AN INTELLECTUAL DISABILITY WHO SEXUALLY OFFEND

NEIL R. SINCLAIR
PHD IN CLINICAL PSYCHOLOGY
UNIVERSITY OF KENT
2011

ACKNOWLEDGEMENTS

I first met with Professor Glyn Murphy in 1996 to discuss this project after its conception in Western Australia in 1994. It would not have been possible to complete it without the assistance and support of many people over the ensuing years.

Firstly, thanks are due to Professor Glynis Murphy for her guidance and advice, and perhaps most of all for her patience – I am not too sure if any of her previous PhD students have taken this long to submit.

My thanks to all the participants in groups who were willing to consent to address difficult issues in treatment, and allow information about them to be used for research. My thanks go to colleagues who have been a part of the Sex Offending Treatment Services Collaborative-Intellectual Disability (SOTSEC-ID), especially those who went out of their way to assist in data collection for both the main project and the reliability and validity study (Peter, Geetha, Liam, Andy, Guy, Rosemary & Frank amongst others).

Thanks are due to The Department of Health for the main research funding, Care Principles for gap funding for six months, and to the Baily Thomas Foundation for their grant to Professor Murphy and SOTSEC-ID.

Finally, to my family - Linda, who has been there unstintingly and uncomplainingly and who, as a colleague as well as a partner, understood every twist and turn, and to Nelson and Siobhan - here is your older sibling at last. To my mother and in memory of my father, who encouraged scholarship from the beginning, thank you for providing the vision and encouragement that nurtured a small boy's ambitions. To our family and friends, in both England and Australia - sorry it took so long.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

Sex offending in the general population has been a focus of interest for some time due to the damaging nature of the behaviour, and the need to reduce recidivism. Theoretical and clinical advances (Finkelhor, 1986; HM Prison Service, 1996; Marshall, Anderson, & Fernandez, 1999; Serran & Marshall, 2010) in treatment for sex offenders in the general population have been extended to men with an intellectual disability at risk of sexual offending (Lindsay, 2009). The purpose of this project is to develop and evaluate the SOTSEC-ID version of this model.

Participants are adult males from 15 different locations across England and Wales, with an intellectual disability or borderline cognitive functioning and who have committed sexual offences. A pilot study clarified assessments and procedures, and individual data over several years is presented. A qualitative study using Interpretive Phenomenological Analysis (IPA) illustrates the 'meaning making' of participants' treatment experience through six major themes. A reliability and validity study assesses the four main quantitative measures, QACSO, SAKA, SOSAS, and VESA, finding limited support for criterion validity for the SOSAS and SAKA, excellent inter-rater reliability for all four main measures, and good to excellent inter-rater reliability on all but the SAKA. Finally, a quantitative study, in collaboration with the wider SOTSEC-ID group, uses a repeated measures design to compare the QACSO, SOSAS and SAKA across pre-group, post-group and follow-up.

Significant main effects and post-hoc comparisons were in the predicted direction for all measures. A range of information on demographic, clinical and criminogenic factors including offending during treatment or follow-up are also presented. A recidivism rate of 12.3% over a year was calculated for the sample. The treatment model and collaborative framework is recommended for wider adoption.

CHAPTER ONE. SEXUAL OFFENDING IN THE GENERAL POPULATION

The Problem

Sexual offending by men with an intellectual disability is part of the much wider issue of sexual offending in the general population. Writing on our collective failure to stem one aspect of this wider problem, Mercy (1999) describes child sexual offending as a 'disease' in order to invoke the perspective of the public health model. He argues that our response to an analogous physical disease in which a pathogen affects one in five girls and one in seven boys prior to 18, resulting in emotional, behavioural and relationship problems both now and in the future, should be tackled with great vigor, coordination and the large scale funding of both research and treatment programmes. Sadly, Mercy's (1999) charge of complacency to our societal response is echoed nearly ten years later by Laws (2008) who argues that research is still poorly funded, our knowledge of aetiology is still limited, and scientific evaluation of treatment programmes is still producing ambiguous results.

Laws (2008) also supported the public health perspective for tackling the issue of sexual offending more broadly than just treating identified offenders, and describes the work of the "STOP IT NOW!" campaign in the USA (Stop It Now!, 2010), which has more recently been established in the UK under the auspices of the Lucy Faithful Foundation (Womensgrid, 2009). This mixture of academic, clinical and popular interest is also illustrated by a recent popular poll commissioned by the End Violence Against Women coalition, which describes itself as a coalition of activists, survivors, academics and service providers (End Violence Against Women, 2010). This poll was reported in The UK's Daily Mail, titled " 1 in 3 schoolgirls has been molested" ("1 in 3 schoolgirls has been molested," 2010) which reported the results of a YouGov online survey of 788 adults undertaken between 4th - 11th October 2010. The headline was based on the finding in the survey that 29% of girls and 14% of boys aged 16-18 self-reported that they had been sexually touched at school when they did not want to be (defined as groping, touching breasts or bottom or unwanted kissing). These figures are borne out by more formal research, as detailed below. Other authors, such as Campbell and Wasco (2005), have also called for greater effort to be directed at preventative rather than just ameliorative programmes.

Concerns about sexual offending have come to increasingly occupy academic, forensic and popular concerns since the initial discussions in 1996, which have led to the project reported here. This has been due to an increasing awareness of its relatively high frequency and its devastating impact on the victim and their family and friends. Sexual offending has been described as a serious social problem along with non-sexual crime, poverty, environmental damage and substance abuse (Barbaree, Hudson, & Seto, 1993; Marshall, Laws, & Barbaree, 1990, p. 1), and second only to murder in its destructive impact (Marshall et al., 1999). As a social problem, it is not confined to England or even western countries, but is a serious worldwide phenomenon (Beech, Craig, & Browne, 2009, p. 1; Mann & Marshall, 2009; van Dijk & Mayhew, 1993). Reports on the 1989 and 1992 International Crime Survey looked at sexual victimization across 18 countries and found quite similar rates of serious sexual offences at the level of rape, attempted rape and sexual assault in all 18 countries (van Dijk & Mayhew, 1993). Beech et al. (2009) report statistics from England and Wales which show that for the period 2006-2007 there were 43,755 serious sexual assaults (rape, sexual assault and sexual activity with children) reported to the Police. Figures from the British Crime Survey in 2000 generated annual incidence figures of actual rape of 0.4 percent for all women between 16 and 59 years, suggesting by extrapolation from these figures that the likelihood of rape between 16 and 59 years for these cohorts was around 18% (Myhill & Allen, 2002, though the extrapolation is by the present author and assumes no repeat offences against the same person). These figures do not include child sex offending figures, or those for older adults.

Prisoners convicted of sexual offences also seem to be an increasing proportion of the prison population, with the numbers increasing 68% between 1992 and 2002 from 3,146 to 5,283 (Beech et al., 2009, p. 1). These figures had further increased by 41% to 7428 by October 2007 (Beech et al., 2009; Ministry of Justice, 2007) and by a further 26.5% to 9,392 by August 2010 (Ministry of Justice, 2010). Brown (2005) points to a similar increase in reported sex crimes from 1986 to 1996 of 10% per year, although she also points out that this increase is likely to be due to

increased reporting to and recording by the police, rather than an increase in actual offence numbers. Nonetheless, the number of reported sexual offences in 2003-2004 was 52,000, which represented 5% of all recorded violent crime, and 0.9% of all recorded crime (Brown, 2005, p. 2).

Given the impact, size and scope of the problem, and its devastating impact on victims and their families, it is not surprising that sexual offending is a category of offence that arouses much indignation and hubris in the popular press, as the above YouGov poll and Daily Mail article illustrate. Such outrage often arises in relation to offences by perpetrators who were strangers to their victims. However, it is family members or others who are at least known to the victim that carry out most sexual offences against both women and children (Barbaree et al., 1993, p. 17; Brown, 2005; Myhill & Allen, 2002). For example, Finkelhor (1994) reported on 19 retrospective studies which examined adult recall of childhood abuse and found that only 20% -30% of reported abuse in childhood was perpetrated by strangers, and British Crime Survey figures point to as few as 8% of rapes being committed by strangers (Myhill & Allen, 2002).

Similarly, popular hysteria is often aroused against unknown serial rapists (Brown, 2005, pp. 7-8), but perpetrators known to their victims carry out most sexual assaults against adult females according to (Koss, 1992; Myhill & Allen, 2002). Sexual offending and the fear and indignation it arouses are often projected onto the "fearsome stranger", the "sexual pervert", the "dirty old man", but most sexual offending is actually conducted by fathers, brothers, husbands, partners, ex-partners, friends and acquaintances (Hudson & Ward, 1997). Hudson and Ward reviewed several population surveys of reported rape and found that the incidence of rape by complete strangers was low in all studies that examined this factor. Koss, for example, estimates from studies on rape in America that women are four times more likely to be raped by someone they know than a stranger (Koss, 1992). Gavey (1991) found that 82.5% of unwanted sexual incidents reported by his New Zealand sample were by men known to the victim. Randall and Haskell (1995) found that 83.3 % of the assaults committed against their random sample of 420 Canadian women were perpetrated by men who were known to the women.

It could be argued that the popular but erroneous argument that most sexual offences are perpetrated by unknown strangers, is the result of demonizing offenders (Marshall et al., 1999, p. 7) in order to distance ourselves as non-offenders from the behaviour of sex offenders. There is a reduced sense of risk because such offences are perceived to be carried out by 'monsters' at the edges of our society, not those who are known or are close to us (Brown, 2005, p. 8). Further, studies of attitudes towards sexual violence amongst the general male population, suggest this distancing of offenders has more to do with a reluctance to acknowledge the widespread misogynist attitudes and acceptance of violence towards women and children in the general population, which is much "closer to home" (Darke, 1990). Whatever the reason, Marshall argues (1999, pp. 7-8) that such distancing is unhelpful, as it diminishes our capacity to understand and treat sexual offending behaviour. Clinical psychology in general, and behavioural and cognitive-behavioural approaches in particular, have benefited from emphasizing the commonality of human psychology and explanatory constructs. Thus maladaptive behaviour and maladaptive cognitive schemas have been identified as common to all people, differing only in their severity, content and impact. The identification of perpetrators who are 'different', and who require different psychological explanations for their behaviour (Harris, 1994) may be more comfortable for researchers and therapists, but this process inadvertently renders such individuals less familiar and therefore perhaps less changeable and treatable (Marshall, 1999, pp. 7-8). Marshall and his colleagues have been eloquent advocates of this viewpoint as the following quotes from the same book attest:

> So long as we demonize sexual offenders, we will continue to struggle to understand them. Seeing them as more like us than different gives us a window into their world that would otherwise remain closed (p. 7).
> (and) ...the difference between sexual offenders and the rest of us is not in their habit of distorting, but rather, in the goals these distortions serve (p. 61).

Sexual offending is a problem that affects large numbers of people in many western societies as the figures earlier in this chapter and Brown's survey of treatment programmes demonstrate (Brown, 2005; Myhill & Allen, 2002; van Dijk & Mayhew, 1993). Although the most pervasive, intensive and long-lasting effects are borne by the immediate victim, and Post Traumatic Stress Disorder is a common consequence of both child abuse and of rape (Calhoun, 1993; Steenkamp, McClean, Arditte, & Litz, 2010), the impact of these crimes also has a substantial effect on the victim's family, future children and partners, as well as the family of the perpetrator (Marshall, 1999, p. 1). Browne and Finkelhor (cited in Barbaree, Marshall, & Hudson, 1993, p. 2) distinguish between initial and long-term effects of sexual victimization. Barbaree, Hudson and Seto go on to describe the initial effects of child sexual abuse as including emotional and physiological symptoms of anxiety and fear, anger and hostility, inappropriate sexual curiosity and behaviour, and social and behavioural problems. Long-term effects include mental health difficulties in the form of depression and anxiety, and ongoing difficulties in developing and maintaining social relationships. Unsurprisingly, difficulties are also reported by victims of child sexual abuse in establishing adult sexual relationships, and in fulfilling parental roles (Barbaree et al., 1993).

Definitions of Sexual Offending

Different terms and definitions abound in both the mainstream and intellectual disability literature on sex offending. Terms used include, 'sexual offending', 'sexual assault', 'sexual aggression', 'sexual abuse', 'sexually abusive behaviour' and 'inappropriate sexual behaviour' to name a few.

The lack of a widely accepted definition has hampered research and comparability of studies, and led to difficulties in comparing prevalence and incidence rates. A key reason for this range of definitions is that sexual offending is the result of definitions accepted by the various legislatures that enact the criminal legislation containing these definitions. There are significant differences from one jurisdiction to another in the terms that are used, the distinctions made between

different types of offences, and the age of consent for both males and females to engage in sexual intercourse, and these differences have predictable impact upon key statistics such as arrest rates, conviction rates etc. For example, in terms of age of consent, Seto comments on variations on the age of consent across countries and even different states within countries (e.g. USA), and current information on age of consent on the web indicates a range of ages from 12 years in Peru and Columbia to 20 years in Tunisia (Smith-Spark, 2004).

A number of definitions of sexual offending have been offered such as: "Sexual Aggression is any form of unwanted sexual contact between a perpetrator and a victim" (Hall, in Barbaree et al., 1993, p. 183); and "Sexual abuse occurs where sexual acts are performed on, or with, someone who is unwilling or unable to consent to such acts" (Brown, Stein, & Turk, 1995, p. 31; Brown & Turk, 1992). Sgroi (1989, p. 251) provides an exhaustive and detailed definition that in the end seems more confusing than clarifying because of its detail:

> "Sexual offence behaviour involves one person's looking at or touching certain parts of a second person's body (breasts, buttocks, inner aspect of the thighs, or genital and anal areas) for the purpose of gratifying or satisfying the needs of the first person, and when a barrier to consent is present for the second person. Sexual offence behaviour may also include exposing one's genital area to another person and/or compelling that person to look at or touch the above-mentioned parts of the first person's body when a barrier to consent is present for the second person (viewing or touching the breasts of a female but not a male is pertinent to this definition). Barriers to consent include age less than 16 years; the presence of a parental, custodial, or care-taking relationship between the persons involved; the use of a weapon, threat of injury, or use of force by the first person; the presence of a cognitive inability in the second person to understand the basic elements of sexual behaviours (as described earlier) or the presence of a power imbalance between which precludes consent by the weaker person". (Sgroi, 1989, p. 251).

Schilling and Schinke (1989) distinguish between sexually deviant behaviours and sexual offending behaviours, but their distinction between these two categories and their list of sexual offending behaviours is neither exhaustive nor clear, although they were not seeking to establish a definition for other researchers. Swanson and Garwick (1990), in one of the first published articles on group treatment for sex offenders with an intellectual disability, described sexual offending as the imposition of "....sexual content activity on someone else without the other person's prior consent." (Swanson & Garwick, 1990, p. 155), and in a recent article Fairbairn (2002) argues that:

> "...sexual abuse occurs no matter what the perpetrator does, provided he or she acts in order to gratify his or her sexual desires, using power to enable him or her to make use of another person" (Fairbairn, 2002, p. 21).

Although this definition makes an interesting shift to the notion of sexual gratification, this would not distinguish between legal sexual activity such as legally available pornography and illegal sexual activity such as the various sexual offences. The definition also does not acknowledge the increasing recognition that many sexual offences are only incidentally related to sexual desire and more often related to power assertion, aggression, revenge, etc.

An appropriate definition therefore needs to distinguish between abusive sexual contact and consenting sexual contact (Thompson, 2000, p. 35), to take account of the varieties of sexual offending from penetrative offences to obscene phone calls, and also to distinguish between inappropriate but not illegal sexual behaviour such as socially inappropriate conversation or inappropriate but not illegal brushing of bodies in residential services, and actual sexual offending. An additional complication for sex offenders with an intellectual disability is that, at least in the United Kingdom, diversion from the criminal justice system to the health system is likely at a number of points from detection through to investigation, and especially at

the Crown Prosecution Service stage and Court stage. This means that the criminal justice procedures cannot be relied upon to determine whether an offence actually occurred because of the high rate of diversion. As an aside, it is interesting that this is not the path taken in all countries, and in Australia at least there is an increasing recognition of the importance of proceeding with the criminal justice response as long as possible (O'Connor, 1996). In the UK, the relevant act which contains numerous legislative definitions is The Sexual Offences Act 2003, and a copy of the offences for which there is a definition in the Act is included in Appendix One.

The following definition is therefore offered as a working definition for the current study:

> Sexual offending refers to illegal sexual behaviour and sexual activity that is defined as illegal within the jurisdiction where the alleged offence occurred. Adjudication of whether such an offence has actually occurred is the remit of the criminal justice system. However, if the alleged perpetrator was diverted at any stage due to an intellectual disability or other mental health disorder, then corroborative eye-witness accounts of the offence should suffice to establish the reasonable probability that an offence has occurred for treatment purposes.

Problems of definition (White and Koss, cited in Barbaree, 1993, p. 183) make accurate estimation of incidence and prevalence of sexual assault difficult. Definitions of particular types of sexual assault vary from one jurisdiction to another, for example the age of consent differences discussed above, and even whether an act counts as a sexual offence or not. For example, under the UK Sexual Offences Act 2003 there is a category of offences called 'Abuse of Position of Trust' which is unlikely to exist under some other jurisdictions. Even the research and clinical literature is of little assistance in generating a commonly used definition. For example, although the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR) (American Psychiatric Association, 2000) deals with sexually deviant behaviour in the Paraphilias section (pp. 522-532), rape is not

included. Furthermore, the DSM-IV-TR definition of paedophilia (sexual activity with a pre-pubescent child) is highly controversial in that it includes a persistence requirement that can be difficult to establish. Marshall (Marshall, 1997a) and Laws & O'Donohue (1997, pp. 4-5) both provide devastating critiques of DSM-IV-TR in this area. Marshall states that he and his colleagues have responded by ignoring "...the diagnosis of pedophilia and... (describing)... all such clients as simply child molesters (Marshall, 1997a, p. 155), and a similar critique is made by Abel & Rouleau, (1990, pp. 18-20).

In addition to the definitional issue, there is also a problem of terminology. For mainstream offenders it is reasonably clear that what constitutes an offence is a conviction by a court. This is more difficult for people with an intellectual disability, however, because they are more likely to be diverted from the court system to the health system, and the situation could well arise (and often does) that technically they have not committed an offence because they have not been convicted of one, even if they have gone to court and been detained under the Mental Health Act. In addition to this diversion at the court stage, diversion by staff, services, the Police or Crown Prosecution is also possible, even when a definite illegal act has been committed. The terminology which will be adopted here, is that put forward by Brown (Brown, 2005, p. 3), that the term sex offender will be used to describe "those who engage in sexual behaviours that are illegal, whether or not they have been officially sanctioned", and by inference the term offence, re-offence, re-offender, etc. will be used to cover equivalent sexual behaviours that are illegal, whether or not the individual has been convicted. The above definition will be utilised in conjunction with this term so that there is some clarity on what constitutes an offence for the purpose of the current project.

Incidence and Prevalence

The terms incidence and prevalence derive originally from the public health model and can assist in identifying the nature of the problem faced. Incidence refers to the rate of new events in a population in a set period of time, for example, how many new cases of rape occurred over the last 12 months. Prevalence refers to the

total number of people in the population who have the problem or issue, for example life-time prevalence of rape to 30 years of age. Knowing prevalence rates tells us about the scope of the existing problem that needs to be addressed, and incidence tells us about how fast or slow the problem is growing- how many new cases are added each period.

However defined or estimated, it is clear that the gross underreporting of sexual offences in official statistics makes the definitional problems referred to previously less important than the difference between the official records and victim reports of offences (Brown, 2005; Darke, 1990; Hudson & Ward, 1997; Murrin & Laws, 1990). The American Federal Bureau of Investigation, for example, claims that its own data on the incidence of rape shows a greater underreporting than any other crime (Hudson & Ward, 1997). Marshall (1997a) estimates on the basis of The American Humane Association's 1988 national reporting study that there are over 300,000 cases of child sexual abuse per year in the USA. However, the number of actual convictions for child molestation in New York State during 1988, for example, which constitutes 15% of the USA population (US Census Bureau, 2010) and should therefore be 45,000 if all offences resulted in a conviction, is a mere 1,750. Brown (2005, p. 5) reports on a study by Percy and Mayhew, based on National Crime Survey results, that estimates that the number of unreported sex offenders is 15 times greater than the number of reported ones. Russell (cited in Darke, 1990) reports only a 10% conviction rate for reported sexual assaults, which as will be seen in the next paragraph, is a gross underestimate of the number of actual assaults.

In study after study, victim surveys of samples of the general population, which try to overcome the under-reporting in the official statistics, yield truly frightening trends. Darke (1990, p. 67) reports figures on male violence of over 90% from Russell's study (described below), sexual abuse rates of up to 50% for females under 18 years of age and sexual assault rates of adult female of 20% in Canada, based on 1984 figures, which are supported by comparative studies across western countries (Katz, in Marshall,1999, p. 2; Divasto et al in Darke,1990; and see Marshall et al., 1990, pp. 67, 74-77 &146-148 for other studies). Gavey (1991), in a

study of New Zealand university students, used the Koss and Oros Sexual Experiences Survey that had been used as a measure in the study reported by Darke above. Gavey (1991) found that over half the female students had experienced some form of sexual victimization and that just over a quarter (25.3%) had experienced rape or attempted rape. This figure is almost identical to a similar but much larger earlier study by Koss, Gidycz and Wisniewski (1987). They surveyed 3,187 women across 32 higher education institutions in the USA, and found that 27.5% of women reported a prevalence of sexual violence at the level of rape or attempted rape from the age of 14 years. Similar to Gavey (1991), Koss et al. also found that a little over half of the sample reported some level of sexual victimization, at the level of sexual contact for the same period. Koss argued that the figures now allowed for some indications as to the way in which rape and attempted rape is dealt with. She suggested that only a small proportion of rape victims actually report it to the police, perhaps as low as 5%, and that a significant number never acknowledge the rape to anyone, suggesting a figure of 42%. Interestingly, Koss also asked male students about their offending and tried to reconcile the victimization figures with the perpetration figures.

Despite significant acknowledgement of sexual violence, including rape reported by males who were interviewed, the number of incidents of sexual violence reported by victims was much greater than the number reported as being perpetrated by male interviewees. Russell's 1984 finding based on a large random sample of San Francisco women (reported in Darke, 1990, Gavey, 1991 and Koss et al.) also found a surprisingly high rate of rape or attempted rape. Russell interviewed 930 adult women in their own homes and found that 24% of women reported experiencing a completed rape, and 44% reported experiencing rape or attempted rape. While the higher rate in comparison to Koss's figures may reflect a greater willingness to acknowledge victimization experiences in the comfort of their own home, it may also reflect the cumulative effect of the year on year incidence of sexual violence risk, as they were older than the college sample. Randall and Haskell (1995) replicated Russell's study and interviewed a random sample of 420 women in Toronto, Canada, using face-to-face interviewers. They found that 42.4% of their sample reported child (prior to 16 years old) sexual abuse from touching to rape,

50.5% reported rape or attempted rape as adults (over 16 years old) and 55.7% of the sample reported rape or attempted rape at any time in their life up to the point of the interview[1]. Finkelhor undertook a survey of 530 female and 266 male college students at 7 different Colleges and Universities using self-administered questionnaires to whole classes, and found that 11% of females and 4% of males reported child sexual abuse having occurred prior to the age of 12. These figures are consistent with the findings reviewed above. Marshall (1997b) reported on the Canadian Committee on Sexual Offences against Children and Youths Survey carried out in 1984, which was a probability sample of Canadian adults reporting retrospectively on their sexual victimization, including as children. He found that up to the age of 12, respondents reported a sexual victimization rate of 31% of females and 23% of males; up to the age of 18, a rate of 40% and 25% for males and females respectively; and then as adults, reported rates were 50% for females and 32% for males. While these figures are slightly higher than Koss et al.'s figures, they are broadly consistent, and are certainly consistent with the figure of 44% reported for a more tightly defined category of 'rape or attempted rape' from Russel's 1984 study.

Finkelhor (1994) summarized 19 surveys which retrospectively asked adults about their abusive experiences when they were children, and concluded that a conservative estimate of childhood sexual abuse in the USA was at least 20% for women and 5-10% for men were sexually abused as children. Browne (2009, pp. 492-493) described a similar picture, including the results of similar retrospective studies which reported sexually abusive experiences in childhood in England of 12% for females and 8% for males in a 1985 study, and 20.4% and 16.2% for females and males respectively in a 2002 Irish study. Myhill and Allen(2002) looked at the British Crime Survey figures and compared these with reported incidents of rape to the police, finding that only 18% of rapes reported to the British Crime Survey were reported to the Police, and of those that were reported, only 8% lead to a conviction. It is clear that despite the variations which exist from study to study, the rate of sexual violence is, as Koss et al. (1987) comment, much higher than we had expected it to be.

---

[1] Although the article is not completely clear, the percentages suggest repeat victimization of many of the same women.

Impact of Sexual Offending

Sexual offending is therefore a widespread problem affecting very large numbers of people, particularly females, throughout the world. It is a problem that has far-reaching consequences for the victim and their family and friends, as well as the family of the perpetrator. These effects are often pervasive and long lasting – often devastating the victim's life for many years or even a life-time (Campbell & Wasco, 2005). The overall impact of sexual offending may be described using public health concepts, such as incidence and prevalence, and the public health model may be a useful paradigm within which to consider the broad range of treatment, ameliorative and preventative programmes designed to reduce the impact of the problem. Abel and colleagues (Abel, Osborn, Anthony, & Gardos, 1992) refer to the paraphilias as a public health problem, best addressed through prevention of the causative agents (Caplan, 1964) rather than by treatment of victims in isolation.

Caplan and Rappaport (Caplan, 1964; Rappaport, 1977) have shown how public health models for conceptualising our responses to physical diseases can be adapted and applied to social and mental health concerns. Indeed, Abel and Rouleau (Abel & Rouleau, 1990) argue that for sexual offences, investigation and treatment should focus on primary, secondary and tertiary prevention because, "There has never been a public health problem successfully reduced by treating individuals after they have developed the problem"(Abel & Rouleau, 1990, p. 20). After briefly reviewing the major findings from 20 years of research on rape, Campbell and Wasco 2005 comment that the incidence figures remain essentially unchanged by efforts to date, and that prevention programmes aimed at men are needed to address the problem more directly. Laws and O'Donohue (2008, p. 16) also call for a public health approach that incorporates primary, secondary and tertiary prevention approaches.

Caplan (1964) distinguishes between treatment of victims on the one hand, and prevention of future victims on the other. In the case of sexual assault, rape crisis centres and counselling for child abuse is part of the treatment response to the victims of sexual assault. Essential as these programmes are (and they are probably too few and too thinly resourced), their purpose is to treat the victims. They will not have any significant impact on ongoing incidence of sexual assaults or the number of victims being produced. The homily of saving drowning people after they have been pushed into a river without preventing the forces which are pushing others into the river, sums up the ideology of prevention which derives from the successful public health campaigns of the early part of the twentieth century (Rappaport, 1977, p. 62 for story on ideology of prevention).

Caplan argues that any significant social problem requires a comprehensive preventative approach, consisting of tertiary, secondary and primary strategies. Tertiary prevention consists of identifying the source of the problem and applying remedial strategies to minimize the likelihood of further damage, for example minimizing damage from already identified individuals. Secondary prevention consists of identifying and treating those individuals likely to develop the problem through early intervention programmes. Primary prevention seeks to tackle the underlying cause of the problem at a social level through identifying and changing the social factors that give rise to the problem in the first place. In the case of sexual assault, the incarceration and treatment of identified sexual offenders corresponds to tertiary prevention as it seeks to minimise the likelihood of further damage through isolating perpetrators from potential victims, and treating those who are to be released to reduce the probability of reoffending. Secondary prevention consists of early identification of "at-risk" individuals before they become sexual assault perpetrators, and provides early intervention programmes to reduce the probability of them becoming sexual offenders. Some of these risk indicators are now well known, such as physical or sexual abuse as a child, domestic violence within the home, and early exposure to pornographic material. Primary prevention seeks to address social factors that give rise to the high incidence of sexual assault in the general population, such as widespread misogynist attitudes, acceptance of violence towards women and

children in the popular media, and pornography which supports distorted beliefs about sexuality.

These targets can be addressed through whole population programmes aimed at the next generation of potential sex offenders, and would include those issues which the women's movement have repeatedly identified as contributing to sexual offending in our society. For example, Darke (1990, pp. 67-68) argues that, "Sexual violence against women presents as a logical and inevitable extension of attitudes and practices surrounding male-female relationships in a male-dominated culture." She goes on to support this with studies showing over 50% of a male college sample acknowledge that they may rape if they were confident that they would not be caught, and that a majority of a male high school sample claims that date rape is acceptable.

This comprehensive public health model, which considers both treatment and preventative strategies, and differentiates between primary, secondary and tertiary prevention, has been applied to a range of other areas including crisis intervention and the community mental health movement (Caplan, 1964; Rappaport, 1977). Table 1 shows one of the areas of previous application, smoking cessation, along with how this model could be applied to the social problem of sexual assault. Table 1 also provides an overview of the range of possible responses to the social problem of sexual assault, and therefore also provides a context for the present work. Treatment of victims of sexual assault, essential though this is, will only ameliorate the impact of such assaults on existing victims and will do nothing to prevent the occurrence or reduce the frequency of future assaults. The first steps at prevention are taken when identified offenders are treated, so that the severity and number of future offences by such identified offenders is reduced. This is tertiary or low level prevention, in that it seeks to minimize the number of future victims caused by perpetrators who have already been identified. Secondary prevention takes at-risk groups, in this case adolescent males in general, and in particular males whose social, demographic and criminogenic features correspond to known sexual offender characteristics, and seek to prevent the development of sexual offending behaviour through focused education, victim empathy training, and similar approaches.

Table 1. Application of Caplan's (1964) Prevention Model to Sexual Offending and Smoking Cessation

	Programme Type	Smoking cessation	Reducing Incidence of Sexual Assault
	Treatment	Medical treatment for health problems caused or contributed to by smoking.	Physical and psychological treatment programmes for victims of sexual assault.
Prevention	Tertiary	Quit and smoking reduction programmes in established smokers.	Incarceration and treatment/educational programmes for convicted offenders.
	Secondary	Advertising and education programmes aimed at high risk groups such as adolescent girls.	Identification and early intervention through treatment programmes of at-risk individuals, for example, hyper-masculine young boys and adolescents.
	Primary	General advertising and education programmes aimed at informing the general population about the addictive nature and long-term effects of smoking.	Educating the general population about the levels of sexual violence and likely contributory factors. Challenging these factors through education programmes, especially with children, which focus on misogynist attitudes, violence towards women and children, and myths and distortions about sexuality whether in the popular media or in pornography.

This model thus posits a wide programme of strategies and approaches aimed at the four different stages of the problem of sexual offending, namely the social and cultural features which may encourage its development (primary prevention), the early intervention with at-risk individuals (secondary prevention), the mitigation of risk through treatment of known offenders (tertiary prevention), and the amelioration of impact on victims (treatment). Applied to the context of men with intellectual disability, the establishment of a programme which at least identifies and provides treatment to identified offenders (the SOTSEC-ID model) is a crucial first step towards a preventative model by providing tertiary prevention strategies. A secondary prevention strategy would be to identify at-risk families and boys early on and provide appropriate family support, human relations support, and reduce the possibility of at risk children being abused sexually or in other ways. The establishment of an anonymous telephone line for men who are worried about attraction to children or offending, links with mainstream social action groups like STOP IT NOW, outreach services which visited residential and support services and Community Teams for Learning Disability (CTLD's) would all constitute the elements of a secondary prevention strategy. Finally, a primary prevention strategy might include child protection strategies for people with intellectual disability to minimize the likelihood of sexual or other abuse creating the conditions which may facilitate the development of future offenders, and teaching strategies aimed at challenging the development of misogynist attitudes within the family or other social groups, for example schools. It may also include broader human relations education, with both genders able to challenge and learn from each other in a safe environment, and restricting access to pornography both in the printed media and the internet as far as possible.

The Offenders

As indicated in the opening section, the term "sexual offender" conjures up an image in the popular imagination of an unknown and feared stranger, yet most offenders are known to their victim. This section focuses on additional characteristics of sexual offenders, such as what leads them to commit sexual

offences in the first instance, who they offend against, what is the risk of their reoffending, and how should they be treated to minimize this risk.

One of the difficulties in identifying characteristics of this population is that only a small percentage of sexual offences are reported and of those, only a small percentage results in a conviction. Abel & Rouleau (1990) suggest the identifiable figure is less than 15% of the total figure. It is possible that this group is different in important ways to the majority of sex offenders who are not known to the police or to treating professionals. This sample may be biased in unknown ways and therefore does not provide a representative sample of the overall population of sexual offenders, only of those sexual offenders who are convicted. While this issue remains a concern, separate research on identified offenders (Prentky & Knight, 1991) and unidentified offenders (Malamuth, Sockloskie, Koss, & Tanaka, 1991) has yielded similar characteristics as being related to sexual offending, and this provides some reassurance that identified characteristics may be generalizable. Malamuth et al. used Koss et al.'s (Koss et al., 1987) previously reported stratified random sample of male college students to investigate general attitudes to both sexual and non-sexual violence towards women using structural equation modeling. A set of factors were identified, namely delinquency, attitudes supporting violence in the childhood home, hostile masculinity (sometimes called hyper-masculinity), sexual promiscuity and social isolation, which all contributed towards sexual or non-sexual coerciveness against women. These findings are very similar to other studies that have examined factors for convicted sexual offenders.

Barbaree, Hudson & Seto (1993), summarizing a review of studies on characteristics of serious sex offenders, identified a number of common features including: (a) Frequently from a large family; (b) Come from a family environment with high rates of psychiatric, criminal and substance abuse histories; (c) Have been neglected, or physically or sexually abused; (d) Experienced sexual deviation in the family home, such as exposure to child pornography, sodomy, or witnessing unusual sexual practices.

Some of these factors have been identified and utilized in risk assessment tools, especially static approaches such as the Violence Risk Assessment Guide (VRAG) and the Sexual Offence Risk Assessment Guide (SORAG) (Quinsey, Harris, Rice, & Cormier, 2006) because the same factors that distinguish sexual offenders are also often predictive of future sexual offending. Hanson and colleagues (Hanson & Bussiere, 1998; Hanson et al., 2002) have shown that many of the features of sexual offenders are similar to offenders in general and include such factors as being young, single, having a history of lifestyle instability, violating rules, and/or being involved in violent crime, antisocial behaviour, or substance misuse (as also noted by Cortoni, 2009). More recent studies have also identified more psychological and dynamic factors that differentiate sex offenders summarized by Cortoni (2009) such as deviant sexual interest and problems with sexual self-regulation, having attitudes and cognitions consistent with sexual offending, anti-social or collusive associates or family members, problems with intimacy, and general problems with self-regulation and cooperation with supervision. Hanson (Hanson, 2006, p. 24) summarized this body of research in a similar way, and grouped factors that had a demonstrated empirical effect on recidivism into the four categories: Sexual Deviancy, Antisocial Orientation, Attitudes (consistent with sexual offending), and Intimacy Deficits.

Abel and Rouleau (1990) sought to address this problem in another way, by including as participants in their study voluntary assessment or treatment referrals to two treatment programmes for sex offending and sexual paraphilias. This resulted in a major survey of 561 participants described as "male sexual assaulters" (p. 9), although the sample included participants who had committed a number of non-contact offences such as voyeurism and exhibitionism, and paraphilias that were not offences, such as fetishism. The researchers went to extraordinary lengths to guarantee anonymity and immunity from prosecution by securing prior legal agreement, even keeping the participant list outside of the country to preserve anonymity. They found that ages ranged from 13 to 76 years with an average age of 31.5 years, moderate education levels with 40% attending at least one year of college, and the ethnic and socio-economic profile of the sample matching the city populations from which the samples were drawn (Memphis and New York). A

majority of the sample (53.6 %) developed deviant sexual interest in at least two paraphilias prior to the age of eighteen years, and this group had committed a staggering average of 380.2 offences per offender by the time they were eighteen years. These figures point to the importance of tertiary prevention strategies that aim to reduce the severity and frequency of future offending by known offenders.

In terms of the age of victims, Abel and Rouleau found that if age was used to categorise victims as children (under 14), adolescents (14 – 17), and adults (over 17), 49% of the sample of 561 offenders had targeted victims in only one category, 31% in two categories, and 11% in all three categories. The remainder had paraphilias such as fetishism and bestiality, where victim age was not relevant. In terms of gender, the authors reported that 67% of the sample targeted only females, 12% only males, and 20% targeted both genders. In looking at the extent to which offenders are specific in their paraphilic interest, including gender and age of victim, and the extent to which offenders restrict themselves to intra-familial or extra-familial offences, some surprising results were presented. Abel and Rouleau found that contrary to other well established views, offenders had specific paraphilias and only offended inside or outside the family, against victims of one gender and in a specific age range (Knight & Prentky, 1990; Prentky & Knight, 1991), that "many offenders assault(ed) against victims of various ages, various genders, with both assaultive and non-assaultive behaviour, and both outside and within their families" (p. 16). Abel and Rouleau (1990, pp. 16-17) further argue that such a pattern of offending is supportive of the idea that a general deficit exists which leads to different offences by the same person, rather than specific emotional conflicts leading to the development of specific offending patterns.

Overall, the clearest theme to emerge from the attempt to identify the key differences that distinguish sex offenders from non-offenders, is that there are relatively few differences, that research suggests such sexual violence is very common, and that as Brown says "... the image of sex offenders as identifiable 'abnormal' adults who offend against strangers in a particularly predatory and violent manner is flawed...sexually violent behaviour by men is endemic in our society, but only some get caught" (Brown, 2005, p. 12).

Turning from the differences between sexual offenders and non-offenders to the similarities and differences between sexual offenders, that might be broadly termed 'classification of sex offenders', there are three approaches that have persisted and will be reviewed here. The first of these is the demographic difference between types of victims, such as the difference long observed between offence type (child molesters and rapists, Marshall et al., 1999, p. 32), victim gender (i.e. male vs. female victims) and the relationship existing between victim and perpetrator (intra vs. interfamilial). The second is based on clinical description, for example, that found in the various versions of the Diagnostic and Statistical Manual of the American Psychiatric Association, and the third is the theory-driven approach developed initially by Knight and Prentky and colleagues. Bickley and Beech (2001) review methods of classifying child sex offenders and identify four approaches- the three identified above as well as one based on psychometric profiles such as those obtainable from the Minnesota Multiphasic Personality Inventory (MMPI) (Herkov, 1996) or the Multiphasic Sex Inventory (MSI) (Nichols & Molinder, 1984).

Considering the first approach, demographic differences are referred to by Bickley and Beech (2001, p. 52) as "...demographic clusters that involve the pragmatic combination of a number of variables of immediate interest..." For example, child molesters as a group can be distinguished from rapists in that they are typically older, less diverse in their non-sexual criminal offending, and usually start their criminal career later. Hudson and Ward (1997) also report that child molesters are also usually less likely to have gone to high school, more likely to be under assertive, less likely to have been married or living with a woman for at least a year, and more likely to have parents with an intact marriage than rapists. Many treatment programmes initially separated these two groups, although Marshall (1999, pp. 32-33) has recently argued that there are therapeutic advantages in mixing rapists with familial and non-familial child molesters as it helps to shift the focus from type of offence to victim distress. Barbaree & Seto (1997, p. 176) discuss the categorization of child molesters according to whether they are offending within the family (familial or incestuous) or outside the family (non-familial or non-incestuous), the

sex of the victim, and whether the offender is paedophilic or not. They also draw a distinction between incest victims who have a biological relationship with their perpetrator and those who have a legal relationship (e.g. step-father). While there are intuitively logical reasons for some of these categorizations, a majority of offenders do not restrict themselves to the one category of sexual offending, as was shown earlier in the Abel and Rouleau (1990) study.

With regard to the second approach, clinical descriptions aim to provide a description of an ideal type comprised of prototypical features (Bickley & Beech, 2001). The scheme adopted by the American Psychiatric Association in the latest version of its *Diagnostic and Statistical Manual for Mental Disorders-Text Revision* (American Psychiatric Association, 2000) has been the subject of much criticism, in particular for its failure to include rape as a paraphilia (Abel & Rouleau, 1990; Bickley & Beech, 2001; Hudson & Ward, 1997), and for the criteria it has adopted for paedophilia (Marshall, 1997a). Although it has been adopted as the organizational framework for a major work on sexual deviance, now in its second edition (Laws & O'Donohue, 1997; Laws & O'Donohue, 2008), the editors of this work also argue for clearer criteria to distinguish 'ordered' from 'disordered' sexual behaviour in order that the implication for no-treatment or treatment (whether mandated or voluntary) is clearer. Laws and O'Donohue in both editions also agree with the criticisms of Marshall and others that rape should be included as a paraphilia, and that the criteria for paedophilia should not exclude paedophiles who experience no distress or impairment as a result of their paedophilic behaviour (as it currently does). Bickley and Beech (2001) also describe the work of several researchers who developed early categorizations for paedophiles based on three subtypes, namely fixated, regressive and aggressive. Although these types come up in other work, notably the high and low fixation distinction within the child molester typology developed by Knight and Prentky (1990) to be described below, Bickley and Beech point to the lack of empirical support these distinctions have received, and therefore their lack of utility for clinical or theoretical purposes.

Finally, the third approach is exemplified by Raymond Knight and Robert Prentky, who in a series of publications (Knight & Prentky, 1990; Prentky & Knight,

1991), have outlined a taxonomic system derived from both theoretical and empirical methods for classifying child molesters (Knight, Carter, & Prentky, 1989) and rapists (Knight & Prentky, 1990) which seeks to identify the various sub-groups which make up this heterogeneous population. Knight and Prentky operationalized previously developed typologies gleaned from the literature, and cluster analyzed a group of known sex offenders on these variables (Bickley & Beech, 2001; Knight & Prentky, 1990). The first of these is named the Massachusetts Treatment Centre Child Molester Typology, Version 3 (MTC:CM3) (Knight et al., 1989), and consists of two separate axes, namely 'Degree of fixation', and 'Amount of contact', each of which is rated high or low and independently of the other for each child molester. The classification process is shown below in Figure 1. Twenty-four possible types would be obtained if these two dimensions were crossed, although Knight and Prentky (1990, p. 34) argue that there are interactions between elements of the two existing axes, and insufficient empirical evidence or theoretical reasons to use such a complex typology. They argue that child molesters should be allocated to separate types on each of the two axes, producing a type on each axis for each rated offender, so each offender would be categorized into one of the four types for the first axis, and to one of the six types for the second axis.

Fixation refers to the strength of paedophilic interest, or the extent to which the individual's fantasies and cognitions are focused on children, as measured by self-report or behaviour. Social competence refers to and is measured by success in employment, adult relationships and social responsibilities. As can be seen from Figure 1, this leads to four types. Types 0 and1 are both highly fixated on children and low and high respectively in social competence. Types 2 and 3 both have low fixation on children and are low and high respectively in social competence (Knight & Prentky, 1990, pp. 29-33).

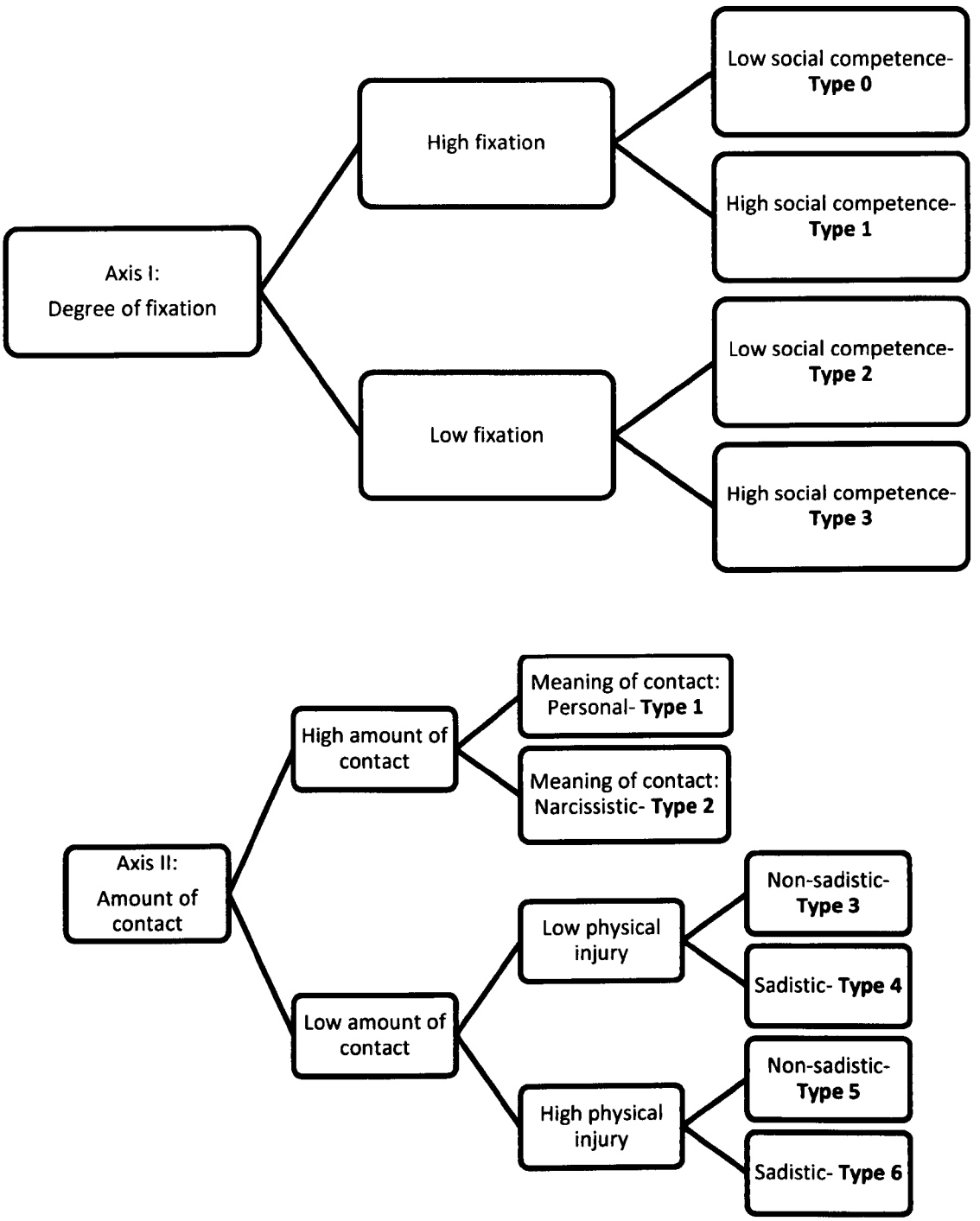


Figure 1. Knight and Prentky's (1990) Child Molester Classification Tree

Constructs for axis two are amount of contact with children, the meaning of such contact (for the high contact group), whether level of injury was high or low (for the low contact group), and then for the physical injury group whether the offence was sadistic or non-sadistic. Contact with children is measured by the amount of time an offender spends in close proximity with children, and the meaning of this contact is further divided into interpersonal or sexual contact, depending on whether an attempt has been made to establish an interpersonal and not just sexual relationship, and whether the offences have an orgasmic or non-orgasmic aim. The first two groups, Types 1 and 2, are thus made up of a group who have high contact with children and establish interpersonal relationships with their victims and whose offences have an interpersonal and non-orgasmic function (Type 1), and a group who also have high contact with children and whose offences are purely sexual or instrumental and focused on orgasm (Type 2). The next four groups, Types 3 –6, are derived from those offenders who have low contact with children. Types 3 and 4 describe offenders who commit low levels of physical injury of either a sadistic (Type 3) or non-sadistic (Type 4) nature. High physical injury refers to clear physical evidence of injury from the offence, while low physical injury does not have these features, and sadistic refers to the acting out of sadistic fantasies as assessed by self-report or from features of the offence. Types 5 and 6 describe offenders who offend with high levels of physical injury where the injury is instrumental (non-sadistic: Type 5) or where there is evidence that the aggression is eroticised (sadistic: Type 6). This framework has been described as " the most comprehensive typology of child molesters to date" (Bickley & Beech, 2001).

The taxonomic system for rapists also developed by Knight & Prentky (1990) is named the Massachusetts Treatment Centre Rapist Typology, Version 3 (MTC:R3), and produces nine different categories of rapists using three decision-levels. These are shown in Figure 2.

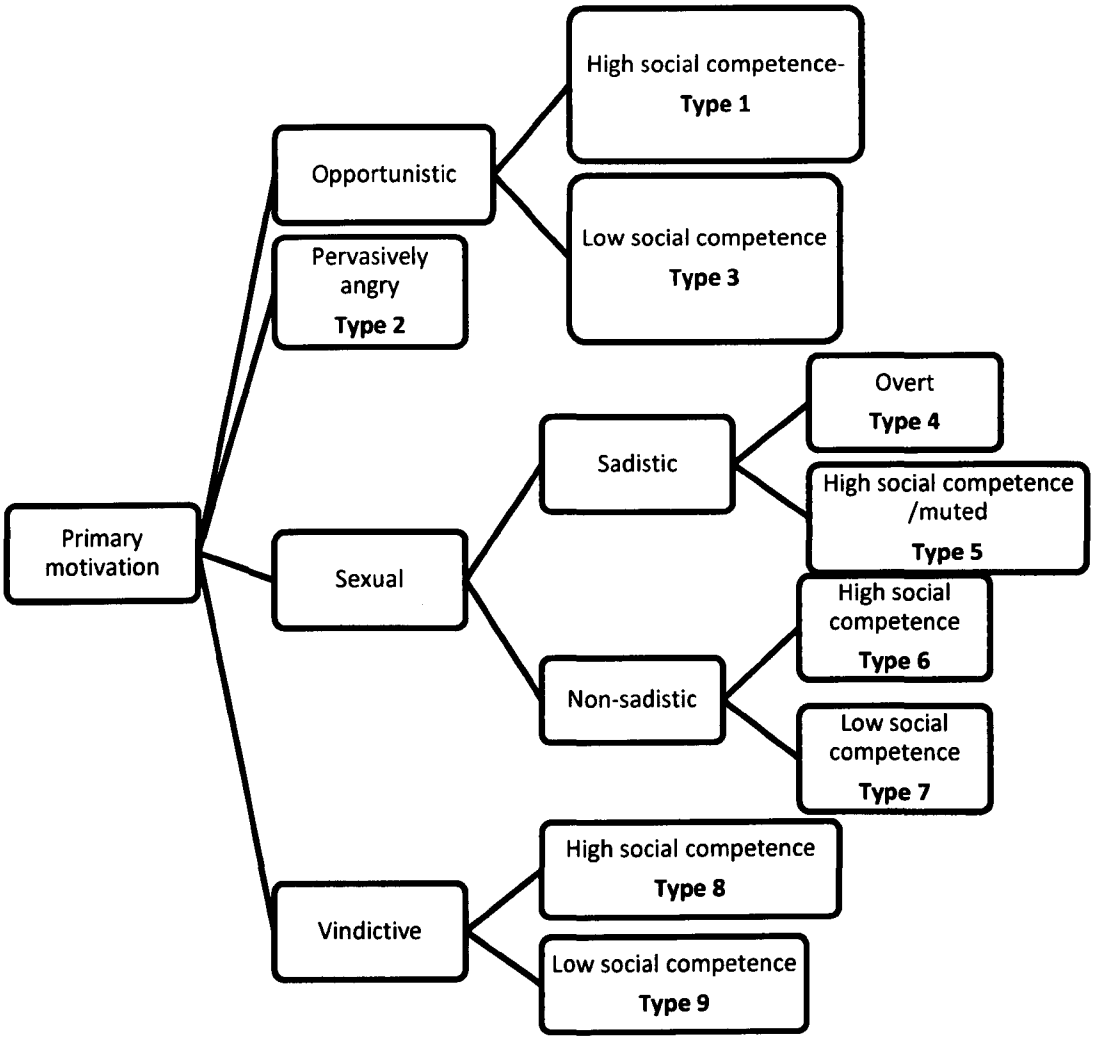


Figure 2. Knight and Prentky's (1990) Rapist Classification Tree

The taxonomic system for rapists is applied through a series of decisions, the first of which characterizes the primary motivation of the assaults as one of opportunistic, pervasively angry, sexual or vindictive. Offenders are described as opportunistically motivated if they are impulsive and influenced more by contextual and situational factors than by sexual fantasy or anger at women; as motivated by pervasive anger if they demonstrate global and undifferentiated anger in non-sexual situations as well; as sexually motivated if the offences are influenced and sustained by protracted sexual or sadistic fantasies; and vindictive if the motivation for offences is misogynistic anger. Opportunistic offenders are further divided into high and low social competence groups (Types 1 and 2), and pervasively angry offenders form Type 3. Sexually motivated offenders are divided into four types by dividing them firstly into sadistic (fusion of sexual and aggressive feelings) and non-sadistic groups (dominance needs and/or acute feelings of inadequacy), each of which is further divided into high and low social competency groups (Types 4, 5, 6 and 7 respectively), although the low social competency sadistic type is referred to as overt. The vindictively motivated group is separated into low and moderate social competence groups, yielding Types 8 and 9 respectively.

Although less relevant for the present work, a typology of female sex offenders has also been developed by Sandler and Freeman (2007), and Proulx and Beauregard (2009) have proposed and evaluated an emerging typology for rape and sexual murders with four categories, namely Sadistic, Angry, Opportunistic and Compensatory. They have provided empirical support in the form of crime script[1] evidence which supports at least the first three categories.

[1] Each type of crime involves specific information processing that leads to a sequence of choices and actions, known variously as the crime-commission process or the *crime script* (Proulx & Beauregard, 2009, p. 182).

Despite efforts that have been expended in developing classification systems, and the probable benefits in terms of understanding and describing the range of sexual offending and sexual offenders, such approaches have not translated into specific treatment programmes for specific types, and Marshall (1999, p. 32) argues that there are indeed advantages in treating different types of offenders together as described above. Bickley and Beech (2001, p. 65) conclude that this area of research has had "minimal impact on ...appropriate methods of intervention". The work of Abel and Rouleau (1990) described above also warns against categorizing different types of offenders into relatively small groups, especially given the apparent diversity of victims and offending within at least some individual offenders. Such work is still potentially fruitful, however, as it may shed light on differences between sub-groups of offenders in cognitive distortions, response to treatment, risk of recidivism and aetiology. Indeed, Proulx and Beauregard describe some of the particular cognitive-emotional states typical of the four categories they investigated as 'implicit theories' or views of the world (2009, p. 194), which illustrates the link between this area and that of theory building. This is addressed in the next section.

Theories of Sexual Offending

This chapter opened with the argument that sexual offending is a serious social problem, and as Ward, Polaschek and Beech (2006) opine in the opening to their excellent publication, Theories of Sexual Offending, to adequately address such a social problem as sexual offending requires theoretical guidance on many choices and issues. Some of these choices include which assessment tools, intervention targets and methods of intervention should be used. In addition, which personal factors should be considered, which approaches to treatment should be taken and which risk management strategy should be adopted. Some of the issues include addressing the conundrums implicit in many sexual offences, such as why some adult males are aroused by and want to have sex with pre-pubescent children; why some men seek to humiliate, degrade, torture, and even

murder their victims; who is most at risk in the community and how can the risk be reduced. All of these issues and choices are guided by explicit or implicit theories of the aetiology and maintenance of sexual offending.

Early attempts to explain sexual offending and guide assessment and treatment included single factor models such as biological, psychodynamic, sociological, and behavioural, all of which prove inadequate to the task (Fisher, 1994). More recent explanations of the etiology of sexual offending encompass a range of factors, such as biological, sociocultural, childhood attachment and interpersonal experiences, along with psychological factors such as emotions, cognitions and learning history. The need for this range of explanatory factors arises from the plethora of characteristics which have been found to partly differentiate sexual offenders from non-offenders (Williams & Finkelhor, 1990), but at the same time, this differentiation is not complete, with many characteristics overlapping the non-offending or at least non-convicted population. In an insightful comment in their 1990 article on incestuous fathers (itself focusing on only a section of sexual offending), Williams and Finkelhor (1990, p. 249) warned that such incest is likely to be the result of "multiple causes and multiple pathways... different men probably come to incestuous acts as a result of different needs, motives and impairments... and very likely this behaviour, even within one individual, is multicausal, requiring a combination of ingredients before a disposition becomes a real act."

Early theorists', such as Wolf (described in Fisher, 1994) and Finkelhor (Finkelhor, 1984), provided initial multi-factorial models that combined a number of factors to explain both the initiation of offending and repeated offending. Wolf proposed a model based on early abuse, which 'potentiates' the development of deviant sexuality, such as sexual attraction to children along with the development of obsessive, self-preoccupied personality and poor self-concept which the individual learns can be escaped from through deviant sexual fantasy and eventually acting out of these fantasies. The offending phase contributes to the maintenance of low self-esteem, and therefore to the perpetuation

of the cycle. This is often depicted in the sexual assault cycle developed by Wolf and shown below in Figure 3.

The cycle moves from a poor self–image,as described above where the person expects and receives rejection in some situations and then withdraws from that situation in an unassertive manner and engages in poor coping strategies consisting of compensatory deviant sexual fantasies probably associated with masturbation, followed by grooming and offending. Distorted thinking accompanies the inappropriate coping strategies, and grooming, offending and aftermath, until the reality of the offence asserts itself and the individual then engages in minimizing and resolves not to offend again, with the knowledge of the offence he has committed bringing him back to the start of the cycle again.

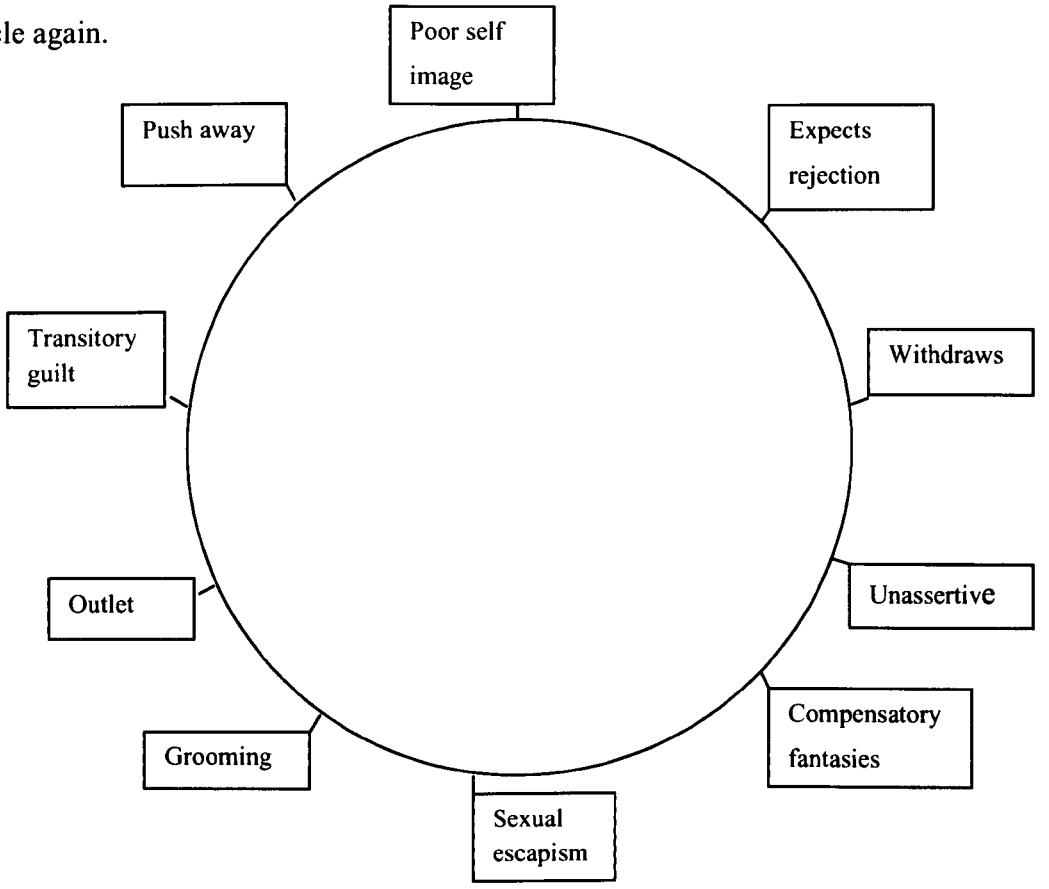


Figure 3. Wolf's Cycle of Offending (from Fisher, 1994)

David Finkelhor's model consists of four posited factors which are offered as the basis for the development of sexual offending against children, and a four stage or four preconditions model for explaining how an actual offence may occur. The four factors are regarded as overlapping and not all necessary for sexual offending against children to occur. The first factor is emotional congruence with children. The second factor is the development of deviant sexuality in which children become sexually arousing to the individual, possibly due to childhood sexual abuse, though this does not seem to explain all such deviant arousal, as some child offenders were not abused and many people who were abused are not attracted to children. The third factor is the blockage that occurs resulting in the individual being unable to meet his sexual and interpersonal needs from adults - either because the individual does not have the requisite skills to relate to adult females, or because his access to his sexual partner is blocked for some reason. The fourth factor seeks to explain why the individual is able to overcome normal feelings against having sexual contact with a child. These factors then work together with four preconditions, which are covered in detail in later chapters and will only be dealt with briefly here. The first precondition is to have or develop the motivation to offend, the second is to overcome internal inhibitions to offend, the third is to overcome external inhibitions to offend, and the final precondition is to overcome the resistance of the victim. Both these models have been extended widely beyond child sexual offending and have significantly influenced treatment models.

Marshall and Barbaree (1990) provide a more up to date and integrated theory, which they called an integrated theory of sexual offending. They describe the role of biological influences, such as aggression and sexual drive, and argue for common neurological systems and hormones involved in both drives, which make it a developmental task for males to learn appropriate management of both anger and aggression and sexual desire in the period around and following puberty. This maturational challenge is affected by childhood experiences that can increase or decrease the likelihood that the developing male will cope with this developmental task

appropriately or inappropriately, depending on childhood experiences of nurturance or neglect and abuse, and male models of aggression and sexuality to which he has been exposed. Poor childhood experiences, particularly abusive experiences and the presence of violence in the family home, provide poor modeling, and also negatively impact on the developing self-esteem of the young male so that they are less able to establish peer relationship skills or have the confidence to pursue their aims without the use of aggression. Masturbation plays a role at this time as well, with violent or child related sexual fantasies more likely if there is a failure to establish appropriate peer relationships.

The sociocultural context is also addressed in this theory by Marshall and Barbaree as a major conveyor of attitudes and distortions about women, sexuality and entitlement, within which context young men with a troubled family background who have poor self-esteem and poor peer relations are more likely to be vulnerable to accepting culturally transmitted distortions in these areas. The role of pornography in this context, with increasing availability on the internet, alongside the presence of interpersonal violence, male dominance and negative attitudes towards females in our society all contribute to continue the development of distorted ways of thinking and fantasizing in vulnerable young males. Finally, the theory posits that a variety of transitory situational factors such as intoxication, reduced probability of getting caught in some situations, the anonymity of large cities, the lack of familiarity or relationship with others and especially potential victims, the maintenance of sexual arousal (either deliberately through the active use of pornography or through accidental exposure to freely available sexual images in advertising or the press), the presence of anger, anxiety and other heightened emotions, can all make a sexual offence more likely, especially in those who are vulnerable to these influences.

Marshall cites the increased rate of rape during war as evidence that when circumstances are sufficiently extreme, the proportion of males who may engage in such offences is higher, quoting Malamuth et al.'s (1991) study, where 35% of his sample of college males acknowledged some likelihood of forcing a woman to have sex if they

could get away with it. Marshall and colleagues developed this model further in the 1999 publication (Marshall et al., 1999), illustrated in Figure 4.

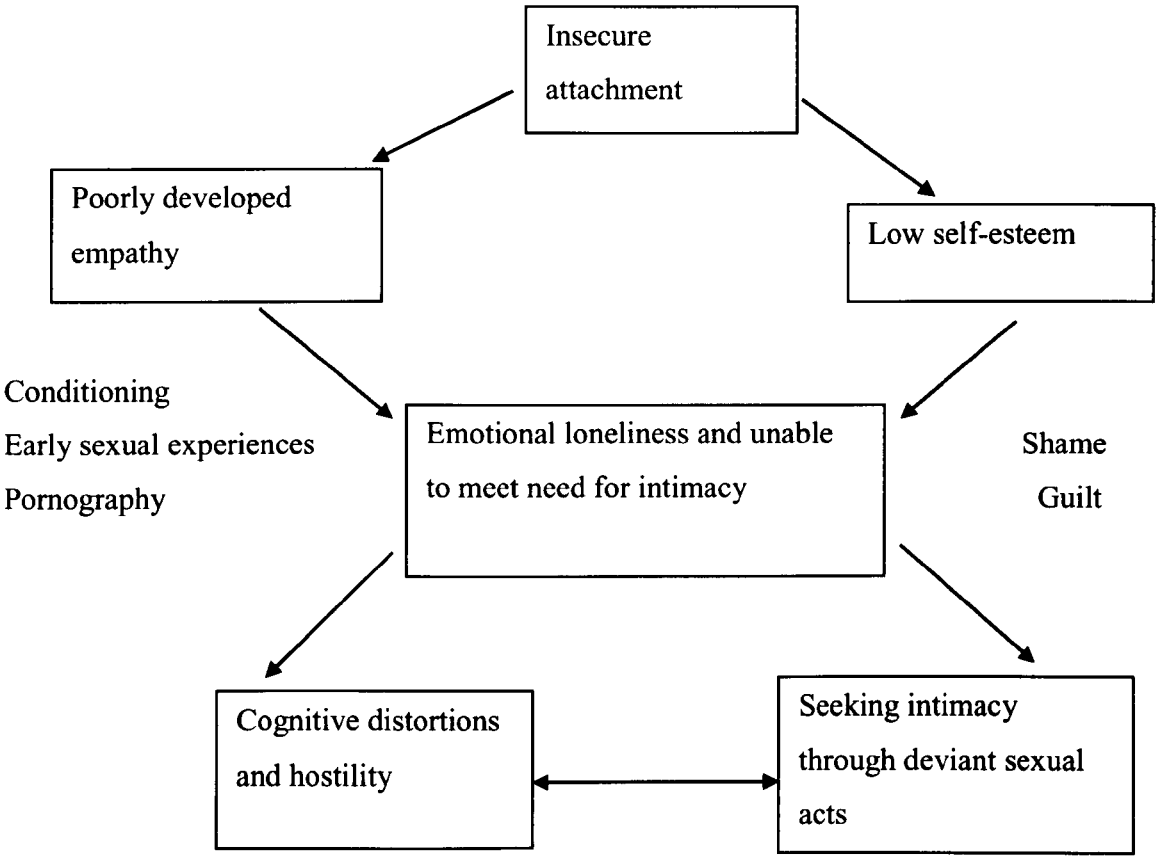


Figure 4. Depiction of Marshall et al.'s (1999) Integrated Theory of Etiology of Sexual Offending

(Taken from Marshall et al.'s [1999, pp.27-31] written description and from a model by Murphy (2004)

This shows the way in which poor attachment (see Craissati, 2009 for an excellent description of the way in which attachment and sexual offending may be related), which plays a larger role in this later formulation, together with poor family models of interpersonal relating, empathy and managing conflict, in combination with abuse and neglect, can contribute to the development of low resilience. This, in turn, leads to low self-esteem and poorly developed empathy and therefore poor social skills in combination with a range of possible distorting and shameful experiences, witnessed or experienced within the family, and the development of emotional loneliness, poor interpersonal skills and an inability as an adolescent, and then as a young man, to meet his own needs for relationships, intimacy and friendship. During this time, cognitive distortions have also developed and hardened, hostility has developed towards others who are more able, as well as females (or whoever he is sexually aroused by but unable to establish appropriate relationships with), and deviant fantasies and masturbation are well established and probable offending scenarios may have been regularly rehearsed imaginally.

Ward and Beech have taken the next step forward in theory development and proposed what they have termed 'An Integrated Theory of Sexual Offending' (ITSO) (Thakker, Ward, & Navathe, 2007; Ward & Beech, 2008; Ward, Polaschek, et al., 2006), which integrates most of the preceding material discussed above. There is insufficient room to give a full overview of the model here, but the model is presented below in Figure 5 and a brief description follows. Their 2006 book entitled *Theories of Sexual offending* (Ward, Polaschek, et al., 2006) provides a thorough description of theory development in sexual offending, a review of all published alternative theories, and proposes the ITSO as a general theory for sexual offending to guide future research and theory building, and through this process to guide treatment, risk assessment and management, and programme evaluation in the future. The model comprises three causal factors, namely Brain Development, Social Learning, and Neuropsychological Functioning, and a state factor, presenting clinical symptoms.

The Brain Development Factor includes biological inheritance; for example the preponderance of sexual aggression displayed by males rather than females, genetic inheritance and the role of evolution, including the role of sexual selection. This factor allows for the different ways in which brains develop given a different mix of genetic and cultural or environmental influences, and acknowledges the importance of both factors in the development of sexual offending behaviour. This trait also includes the distorting effects that high levels of certain neurotransmitters and hormones may have on neurobiological functioning by compromising decision making when subject to high levels of stress hormones or sex hormones.

The Social Learning Factor (or Ecological niche: Proximal and Distal Factors) addresses the range of cultural, familial, personal, and situational circumstances that will differentially affect individuals, and may provide adverse circumstances such as abuse, poor parenting, and sexual victimization as a child. This factor also includes proximal factors such as availability of victims, likelihood of being apprehended, intoxications and the like.

The third trait, Neuropsychological Functioning, refers to the way in which three neurological subsystems, namely the motivational/emotional system, the action selection and control system, and the perception and memory system can all have their optimal functioning compromised by some of the foregoing issues through brain development or social learning experiences, and so compound the actual ongoing functioning of the individual even after having left behind a dysfunctional childhood, early abuse, or other compromising features. For example the identification and management of emotions, or the capacity to meet personal needs for emotional and sexual intimacy, may both be compromised through previous experience, genetic contributors or brain development, which have an effect on the motivational/emotional system. Similarly, the action selection and control system may lack the balancing and weighing capacity, the ranking

of lower and higher order goals, etc., and problems with memory and perception being influenced by prior experiences are well established.

Problems in any or all of these three factors will therefore compromise the person's ability to function adaptively in their environment, for example mood management or resolving interpersonal conflict. These are likely to be observable in sex offenders within the domains already outlined separately by Hanson (Cortoni, 2009; Hanson, 2006), namely problems in the areas of self-management, socio-affective functioning, distorted attitudes and deviant sexual interest. The model, taken without change from Ward and Beech (2008), appears below in Figure 5.

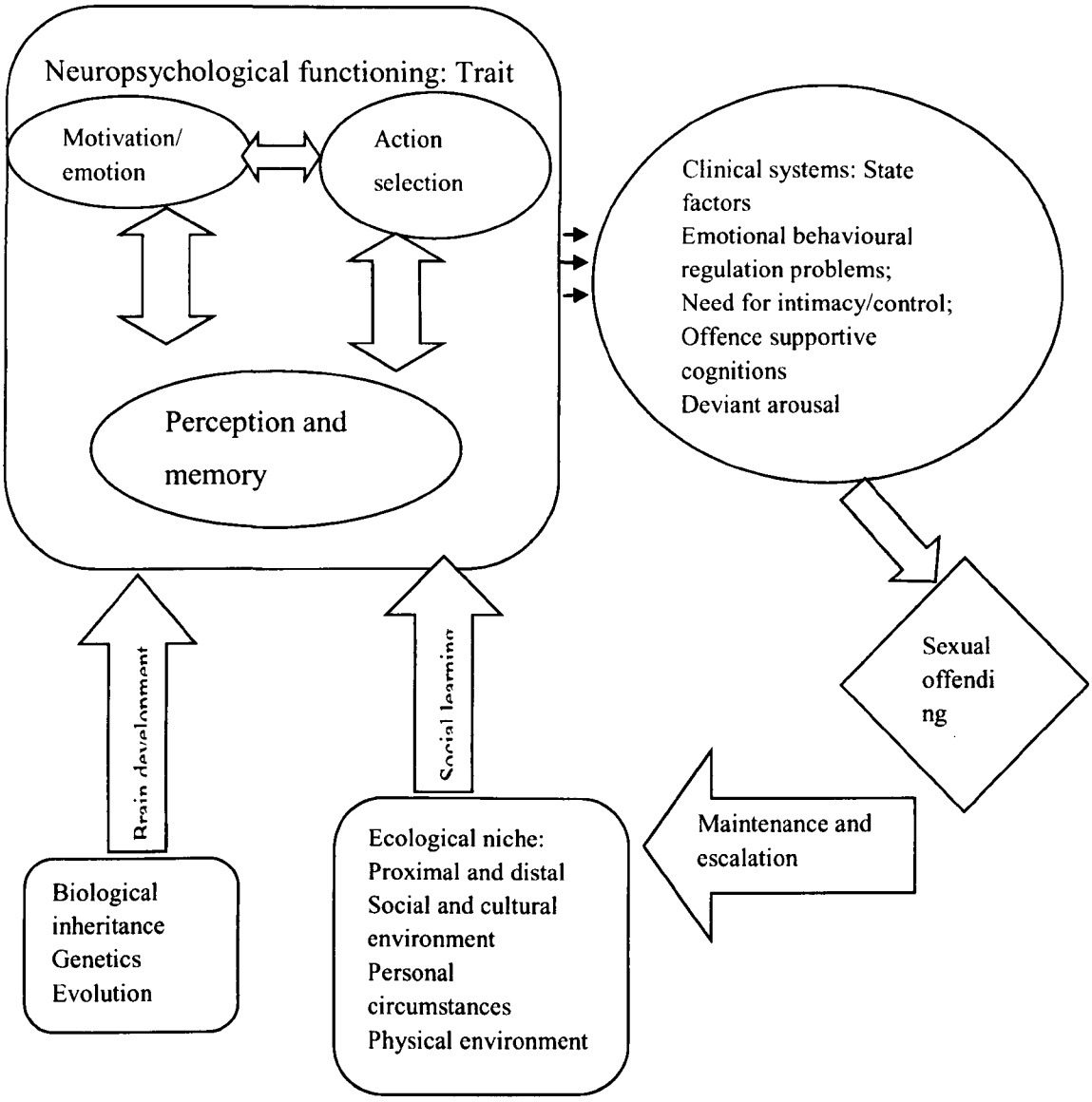


Figure 5. Ward and Beech, (2008, p. 23) Integrated Theory of Sexual Offending

Although Laws and O'Donohue (2008) claim that after a 50-year history of sex offender treatment we can still not make any unequivocal claims about treatment effectiveness, and point to the lack of progress since the first edition of their book in 1997, this last section shows a pleasing 'coming together' of many strands of research and theory, and augurs well for the future. There is at last a comprehensive and detailed theoretical framework which is empirically based, consistent with theoretical frameworks in adjacent areas, and able to generate testable hypotheses for research, as well as providing a beginning explanation for the complex clinical presentations that practitioners deal with on a day to day

basis. It is to be hoped that this framework will provide a clearer paradigm for research and treatment decisions over the next decade.

Summary and Conclusion

This chapter has described the scope of the problem of sexual offending in our society, including under reporting of sexual offences, that most offences are committed by perpetrators known to their victims, and the need to bring preventative frameworks from public health to bear on the enormous scope of the task. A definition of sexual offending has been offered, which will be used in the research to be reported here. The public health model was considered, especially the relevance of preventative strategies to ameliorate the risk of future damage due to future sexual offending. The SOTSEC-ID model is offered as an initial step towards such a model, even though it is still only providing tertiary prevention strategies. Different approaches to describing and differentiating sex offenders from each other were considered, along with the link between such work and both theory development and risk assessment. Finally, a review of theories of sexual offending was undertaken, concluding with the Integrated Theory of Sexual Offending from Ward and Beech (2008) which offers considerable integration of existing theories and empirical knowledge.

There has been a long history of sex offender treatment for mainstream offenders (Laws & O'Donohue, 2008), and although it is clear that the question of effectiveness is still to be finally resolved, there is some developing clarity on why sex offending occurs and how it can best be addressed. In the same way that Stenfert Kroese (Stenfert-Kroese, Dagnan, & Loumidis, 1997) posed the challenge to psychology about the provision of cognitive behavioural treatment for people with an intellectual disability, the same question can be asked about treatment availability for men with an intellectual disability who commit sexual offences - not only for their sake, but more importantly for their future victims. This work is part of a response to that challenge, and chapters two and three will address intellectually disabled offenders and their treatment.

CHAPTER TWO. SEX OFFENDERS WITH AN INTELLECTUAL DISABILITY

Why Differentiate Offenders With an Intellectual Disability?

Chapter One provides an overview of sex offending in the general population, and provides a description of the range and frequency of sex offences committed by mainstream sex offenders. A description of these offenders was also presented, along with several attempts at classification and the links this helps us draw with aetiology. The most parsimonious assumption when we turn to sex offenders with an intellectual disability is that they are from the same population. This would mean that key features of sex offenders with an intellectual disability are not significantly different from their mainstream equivalents, and that the range and frequency of offences is also not significantly different. Puri (2000) undertook a study in which he compared the populations of two medium secure units, one whose patients had average intelligence and one whose patients had an intellectual disability. Patients were compared on socio-demographic, psychiatric, medical and medico-legal dimensions. The study found that the index offence for intellectually disabled patients was more likely to be a sexual offence, while for patients within the average range of intelligence, index offences were more likely to be physically violent offences such as homicide, attempted murder, manslaughter or grievous bodily harm. Patients with normal intelligence were also more likely to have been admitted from the penal system and to have a psychotic disorder such as schizophrenia or a mood disorder. Puri (2000) concluded that the two groups had separate psychiatric and behavioural requirements and should be served in separate programmes.

In a comprehensive review, Day (1993) argued that when intellectually disabled offenders as a group were compared to mainstream offenders, the following differences emerged: (a) Property and technical offences were most common, (b) there was a lower incidence of personal violence offences (similar to Puri, 2000, above), and (c) the frequency of sex and arson offences was elevated. Rice, Harris, Lang and Chaplin (2008) compared 69 sex offenders with intellectual disability (termed 'mental retardation' in the study due to differences in nomenclature) with 69 matched mainstream sex offenders and, in an unusual study, used phallometric measures to assess sexual preference and compared the two samples on this measure, as well as recidivism and victim choice. They found that intellectually disabled sex offenders had greater deviant preference for pre-pubertal, younger, and male

children than their non-intellectually disabled matched peers, that this preference was found in actual victim differences between the groups.

Barbaree, Hudson and Seto (1993) also argue for special consideration to be given to sex offenders with an intellectual disability in the planning of treatment and the assessment of dangerousness, as do Barbaree and Marshall (1988, 1989) and Marshall et al. (1986). In addition to these arguments, separate service systems have developed in a number of countries for offenders with a mental disorder and those who do not (Baker, 1993), and a further service distinction is beginning to develop for offenders with an intellectual disability (Ford & Rose, 2010; Sturmey, Taylor, & Lindsay, 2004). On these grounds, then, it seems reasonable to assume that while there may be significant similarities, the population of sex offenders with an intellectual disability is sufficiently distinct from mainstream sex offenders to require a separate description of the phenomenon amongst this population along with its aetiology and treatment.

Amongst practitioners working with people with an intellectually disability who have committed sexual offences, a similar point is repeatedly made. Beacock (2005, p. 13) has called for services to be designed for intellectually disabled sex offenders that are addressed to the specific needs they present, while Ford and Rose (2010, p. 360) have also called for specific service provision for treatment and risk management, including the provision of more local services. One significant difference with mainstream offenders is that most intellectually disabled sex offenders need support from services to meet their daily living needs, and as this can at times also include supervision and risk management for the minimization of risks to others, a careful balance needs to be achieved. Mosher (2010) addresses this issue for services and staff who work with intellectually disabled sex offenders, calling for specialist training, and Perini (2004) makes a similar recommendation for offending behaviour in intellectual disability services more generally. The sex offender treatment programme run by the National Offender Management Service within the Home Office in England and Wales is the largest programme of its type in the world (Craig, Browne, & Beech, 2008, p. 120), and offender treatment programmes have been run for mainstream offenders since 1991 (Williams & Mann, 2010). Despite some local variation within this overall programme (three programmes run with slight variations in different regions - West Midlands, Thames Valley and Northumbria), specific adapted programmes for

sex offenders who have IQ's below 80 have been offered in 13 prisons since 1997 (Williams & Mann, 2010, p. 294). Craig and Lindsay (2010) reviewed the characteristics of sex offenders with an intellectual disability in comparison to mainstream offenders and found considerable similarities, although with some differences such as greater difficulties with daily living, more impoverishment of relationships, higher rates of sexual abuse, lower rates of physical abuse, and some offending differences which will be revisited later in this chapter. Johnston (2005) also points to similarities with other sex offenders and offenders more generally, but further suggests other factors such as communication, understanding consequences of decisions, poor social skills and vulnerability to exploitation by others may be more prevalent, even if not unique, among intellectually disabled sex offenders, and Riding (2005, p. 45) points to the uneven availability of services from region to region.

Langdon and Murphy (2010) provide advice on assessment of treatment needs for intellectually disabled sex offenders. Although they suggest a framework which would probably be suitable for most offenders (clinical interview and mental state examination, functional analysis, assessment of dynamic risk factors and cautious use of actuarial risk tools), they point to the additional health risks for the intellectually disabled population and show how the above assessment process can provide an individual assessment and formulation-led treatment programme that is likely after such a process to be quite distinct from mainstream offenders. They also review possible assessment tools, most of which are intellectually disability specific, while often addressing similar areas to mainstream sex offender assessments. Adaption of assessments is a recurrent theme, with a number of researchers addressing the need for appropriate intellectual disability specific sex offending assessment tools (Keeling, Beech, & Rose, 2007; Keeling, Rose, & Beech, 2007; Lindsay, Carson, & Whitefield, 2000; Lindsay, Michie, et al., 2006; Lindsay & Taylor, 2009; Lindsay, Whitefield & Carson, 2007a; Talbot & Langdon, 2006; Williams & Mann, 2010) either by developing new tools (Lindsay, Whitefield, et al., 2007a) or adapting existing mainstream tools (Williams & Mann, 2010). At the same time a number of researchers have also been developing adaptations to existing tools, such as the HCR-20 (Boer, Frize, Pappas, Morrissey, & Lindsay, 2010a), the SVR-20 (Boer, Frize, Pappas, Morrissey, & Lindsay, 2010b) and the PCL-R (Morrissey, 2010), or considering their relevance to offenders with intellectual disability (Craig et al., 2010; Boer, Thakker, & Ward, 2009; Craig, 2010; Craig & Lindsay, 2010; Craig, Stringer, & Moss, 2006; Craissati, 2009; Ford & Rose, 2010; Garrett

& Thomas-Peter, 2009; Langdon & Murphy, 2010; Lindsay & Taylor, 2009; Lindsay & Taylor, 2010; Murphy & Sinclair, 2009; SOTSEC-ID et al., 2010; Williams & Mann, 2010). This conclusion is supported by the bourgeoning literature specific to sex offending amongst the intellectually disabled population, reviewed later in this chapter (Ayland & West, 2006; Barron, Hassiotis, & Banes, 2002; Boer, Tough, & Haaven, 2004; Bowden, 1994; Breen, 1989; Bremble & Rose, 1999; Brown & Thompson, 1997b; Brown & Turk, 1992; Brown, 2005; Broxholme & Lindsay, 2003; Caparulo, 1988; Churchill, Brown, Craft, & Horrocks, 1997; Clare, 1993; Clare, 1994; Cooper, 1995; Courtney & Rose, 2004; Courtney, Rose, & Mason, 2006; Craig, 2010; Craig et al., 2010; Craig et al., 2006; Day, 1999; Day, 1994; Dowrick & Ward, 1997; Furey, 1994; Griffiths, Hingsburger, & Christian, 1985; Haaven, Little, & Petre-Miller, 1990; Hays, Murphy, Langdon, Rose, & Reed, 2007; Hill, Hordell, Lawson, Wing, & Forshaw, 1995; Hingsburger, 1987; HM Prison Service, 1996; Keeling, Rose, & Beech, 2006; Keeling & Rose, 2006; Lindsay, 2004; Lindsay, Hastings, Griffiths, & Hayes, 2007; Lindsay, Law, Quinn, Smart, & Smith, 2001; Lindsay & Macleod, 2001; Murphy, 1997b, 2007; Murphy, Sinclair, Hays, & SOTSEC-ID members, 2007; O'Connor, 1996, 1997)

While approaches to sex offending by people with an intellectual disability have been significantly influenced by developments in treatment of mainstream sex offending, reviewed in Chapter One, there have also been contributions from the behavioural literature (Foxx, Bittle, Betchel, & Livesey, 1986; Mitchell, 1985; Polvinale & Lutzker, 1980), the extensive literature on teaching sex education and human relations (for example, Foxx, McMorrow, Storey, & Rodgers, 1984; Kempton, 1978; McCarthy & Thompson, 1998; Page, 1991) and the literature on challenging behaviour and general offending by people with an intellectual disability (Barron et al., 2002; Clare, 1993; Clare, Murphy, Cox, & Chaplin, 1992; Cockram, Jackson, & Underwood, 1992; Cullen, 1993; Day, 1988, 1993; Denkowski, Denkowski, & Mabil, 1983; Denkowski, Denkowski, & Mabli, 1994; Department of Health/Home Office, 1994; Hayes & Craddock, 1992; Holland, Clare, & Mukhopadhyay, 2002; Hurley & Sooner, 1995; Jackson, 1983; Johnston, 2002; Lindsay et al., 2001; Lindsay & Macleod, 2001; Lund, 1990; Lyall, Holland, & Collins, 1995; MacEachron, 1979; McNally, 1996; McNulty, 1995; Puri, 2000; Robertson, 1981; Taylor & Halstead, 2001; Thomas & Sting, 1995; Turner, 1998; Tutt, 1971). Before systematically reviewing this literature we will firstly look at some relevant definitions.

Definitions

Intellectual Disability

The term 'Learning Disability' or 'Learning Difficulty' is used widely in the United Kingdom to refer to what was formerly known as 'Mental Sub-normality', or 'Mental Handicap'. The term is not used widely elsewhere, except to refer to specific learning disabilities such as dyslexia. The most commonly used term in services in North America, Australia and New Zealand, and probably internationally is 'Intellectual Disability', although 'Mental Retardation' still has some currency in North America. Diagnostic schemes such as the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) still use the term 'Mental Retardation', and the International Classification of Diseases (World Health Organization, 1992) uses the term 'Intellectual Disability'. The term that will be adopted here is 'Intellectual Disability', due to currency of use internationally and in order to avoid the pejorative associations of the term 'Mental Retardation'.

Intellectual disability refers to "...a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities." (World Health Organization, 1996, p. 226) Such a condition is agreed to be present when three criteria are met, namely: (a) Significantly sub-average intellectual functioning, concurrent with (b) significant limitations in adaptive functioning in at least two adaptive functioning domains, both manifested (c) during the developmental period. These criteria are included in the diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), and the ICD-10 Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organization, 1992), as well as Luckasson et al.(2002), Jenkinson (1996), and Jacobson and Mulick (1997). According to these sources, the presence of significantly sub-average intellectual functioning must be determined using a valid, comprehensive measure of intelligence such as the Wechsler Adult Intelligence Scale (Wechsler, 1997), which is individually administered in a standardised format and interpreted

by a qualified practitioner. Sub-average is defined as two or more standard deviations below the population mean for the particular measure of intelligence. For example, taking the Wechsler Adult Intelligence Scale, Version 3 (Wechsler, 1997), this would mean a full-scale IQ score of 70 or less. Standard error of measurement should be taken into account, so that IQ scores above 70 may still lead to a diagnosis of intellectual disability, and IQ scores below 70 may lead to a diagnosis of no intellectual disability, depending on other clinical information, notably performance on measures of adaptive behaviour.

Determination of limitations in adaptive functioning may be assessed using a comprehensive individual measure of adaptive behaviour, such as the Vineland Scales of Adaptive Behaviour. DSM-IV-TR (American Psychiatric Association, 2000) specifies that there must be " ...significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety." (p. 41) Jacobson and Mulick (1997) provide a more general variation of this requirement. They suggest that where the adaptive behaviour measure provides a single score, this should be two or more deviations below the population mean for that measure, and where a range of factor or summary scores are provided, two or more of these scores must lie below the population mean for the relevant summary scores.

As well as both of the above criteria having to be met concurrently, both must manifest themselves during the developmental period. DSM-IV-TR specifies this to be before 18 years of age (American Psychiatric Association, 2000), ICD-10 Guide for Mental Retardation (World Health Organization, 1996) specifies before 19 years, while Jacobson and Mulick (1997) suggest 22 years of age due to the protracted adolescence that often occurs for this group . This specifically excludes neuro-degenerative conditions associated with cognitive impairment, such as Huntington's and the dementias, which normally become apparent later in life. Cognitive impairment following severe head injuries after the age of 18 years is also specifically excluded.

While this defines the category of intellectual disability, services usually include other clients who come under the wider rubric of developmental disabilities. This wider term includes specific disorders of speech and language, scholastic skills (sometimes referred to as

specific learning disabilities), and motor function, as well as pervasive developmental disorders such as Autism, Rett's syndrome and Asperger's syndrome (American Psychiatric Association, 2000; World Health Organization, 1992). Estimates of population prevalence for this overall population vary widely, but the majority is made up of those who meet the criteria for intellectual disability, and estimates for this group vary from 0.2% to 2.4%, (Hayes & Craddock, 1992 p. 31) with an estimate in DSM-IV-TR (American Psychiatric Association, 2000) of 1%. Craig and Lindsay (Craig & Lindsay, 2010) recently reviewed the definition along similar lines to those described above, and note the variation in use of the term intellectual disability among published studies.

Criminal Offence

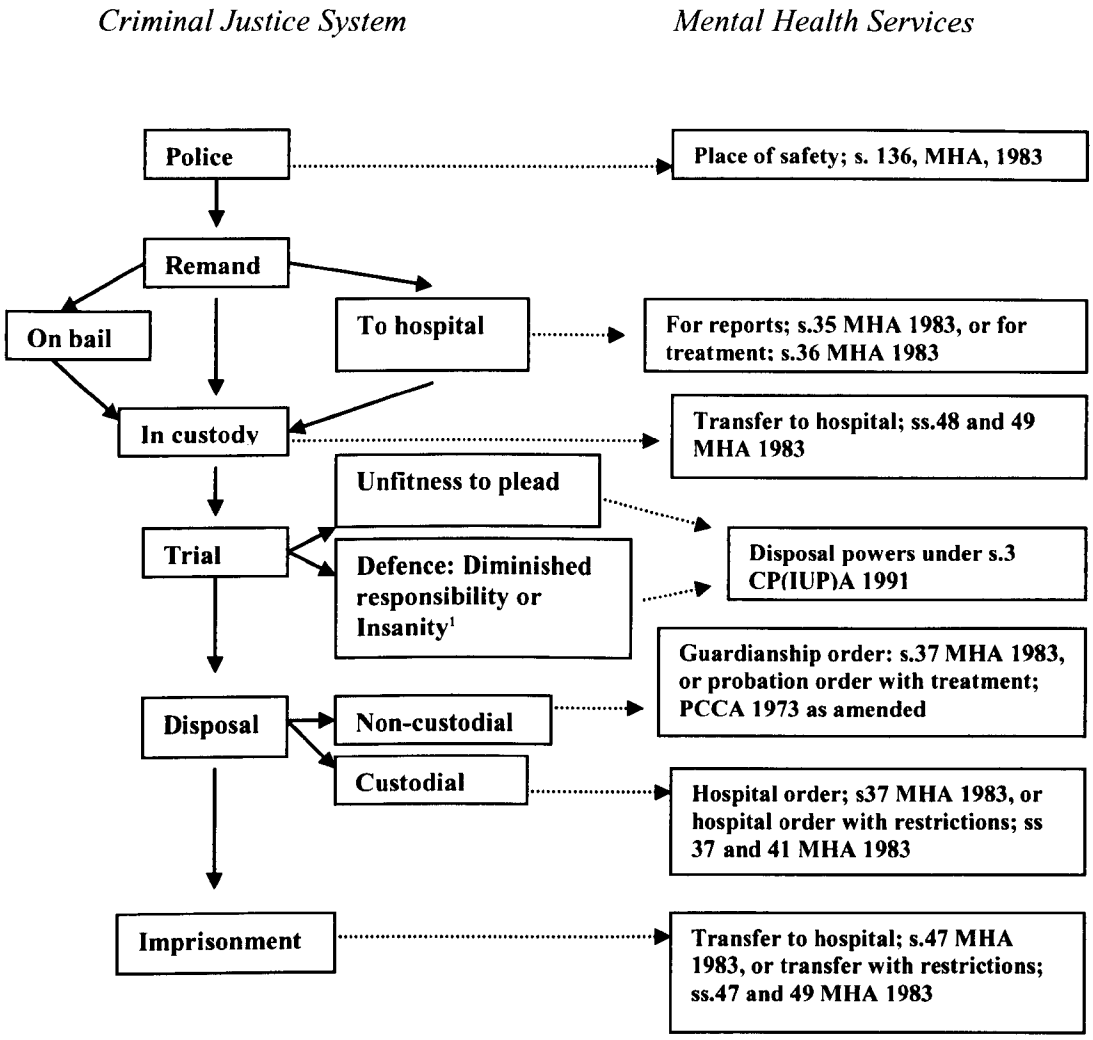
A behaviour or act can constitute a criminal offence when the person carrying out the behaviour commits a prohibited act ("actus rea"- guilty act), and also has a proscribed state of mind consistent with criminal responsibility, "mens rea" (guilty mind, Baker, 1993; Holland et al., 2002). Hayes and Craddock (1992) cite the Latin maxim *actus non facit reum nisi mens sit rea*, meaning, "there is no guilty act without a guilty mind" (p. 28). In addition, the person must have been able to understand the consequences (by having a sound mind to do so), and to be able to control their behaviour at the time of the offence (Baker, 1993, pp.10-11; Hayes & Craddock, 1992, p. 28). In addition to criminal responsibility, the issue of fitness to stand trial (Baker, 1993; Shah, 1993; Smith & Broughton, 1994) also complicates the situation still further as it allows significant diversion without necessarily clarifying whether an offence was committed in the first place (unless a 'trial of the facts' occurs).

When we consider how this may apply to defining criminal offending by people with intellectual disability, Holland, Clare, & Mukhopadhyay (2002) describe the problem of intent addressed in "mens rea" above, and also argue that the problem of under-reporting leads to an unknown number of 'offences' being dealt with in a discretionary rather than formal manner. They also comment on the various social and political factors involved in the "...transformation of behaviours into 'criminal offences' " (Holland et al., 2002). These difficulties, amongst others, make the distinction between behaviours that are classed as inconsequential, challenging, disturbed or criminal, much more arbitrary than is desirable for comparative purposes. The differences and apparent contradictions reported in various

prevalence studies to be looked at below are no doubt in part due to these vagaries. Baker (1993, p.23) provides a clear model for the key statutory connections at these discretionary points between the criminal justice system and the mental health system, and also provides an overview of the process of a 'behaviour' becoming a criminal offence. The model, which is produced on the following page in Figure 6, shows the numerous points at which individuals can be diverted from the criminal justice system to the mental health system in England and Wales.

This point is also addressed in an Australian context by Hayes and Craddock (1992), who describe in detail throughout their book the lengthy and complex process of a behaviour becoming a criminal offence. The key features that they identify are described in Figure 7, which is based on the content of Chapters Three to Seven in their book. A similar point is made by Johnston (2005, pp. 17-18 see figures 2.1 and 2.2), although she also includes the element of mental capacity assessment under the UK Mental Capacity Act (2005), which Hayes and Craddock writing for an Australian readership have not included. In Johnston's model, the capacity assessment occurs after the incident has been labeled an offence and a charge is made, but before a trial. Murphy and Sinclair (2009, p. 372, table 20.1) also describe the process, after an incident occurs, by which the person is: (a) reported to the police or not; (b) apprehended by police or not; (c) investigated by police or not investigated; (d) provided with legal representation or not; (e) charged with an offence or released; (f) prosecuted in court or not; (g) convicted, diverted under the Mental Health Act (1983 as amended) or found innocent.

Murphy and Sinclair (2009) also provide a description of the factors at each point that may sway the process one way (towards conviction) or the other (towards no formal action). For example, at the point when the police are deciding whether to investigate or not, there may be pressure for the matter not to proceed due to the presence of an intellectual disability (lower likelihood of securing a conviction, possibility of being found unfit to plead, etc.), and at the same point, there may be pressure for the matter not to proceed as the person who is alleged to have committed the offence may not be aware of his rights, may not tell the police he has an intellectual disability or may be naïve in dealing with the police.



Note: 1. Changed from original for clients with an intellectual disability rather than a mental illness.

Figure 6. Statutory connections between the Criminal Justice System and the Mental Health System (England and Wales)

(Adapted with minimal changes from Baker, 1993, p. 23)

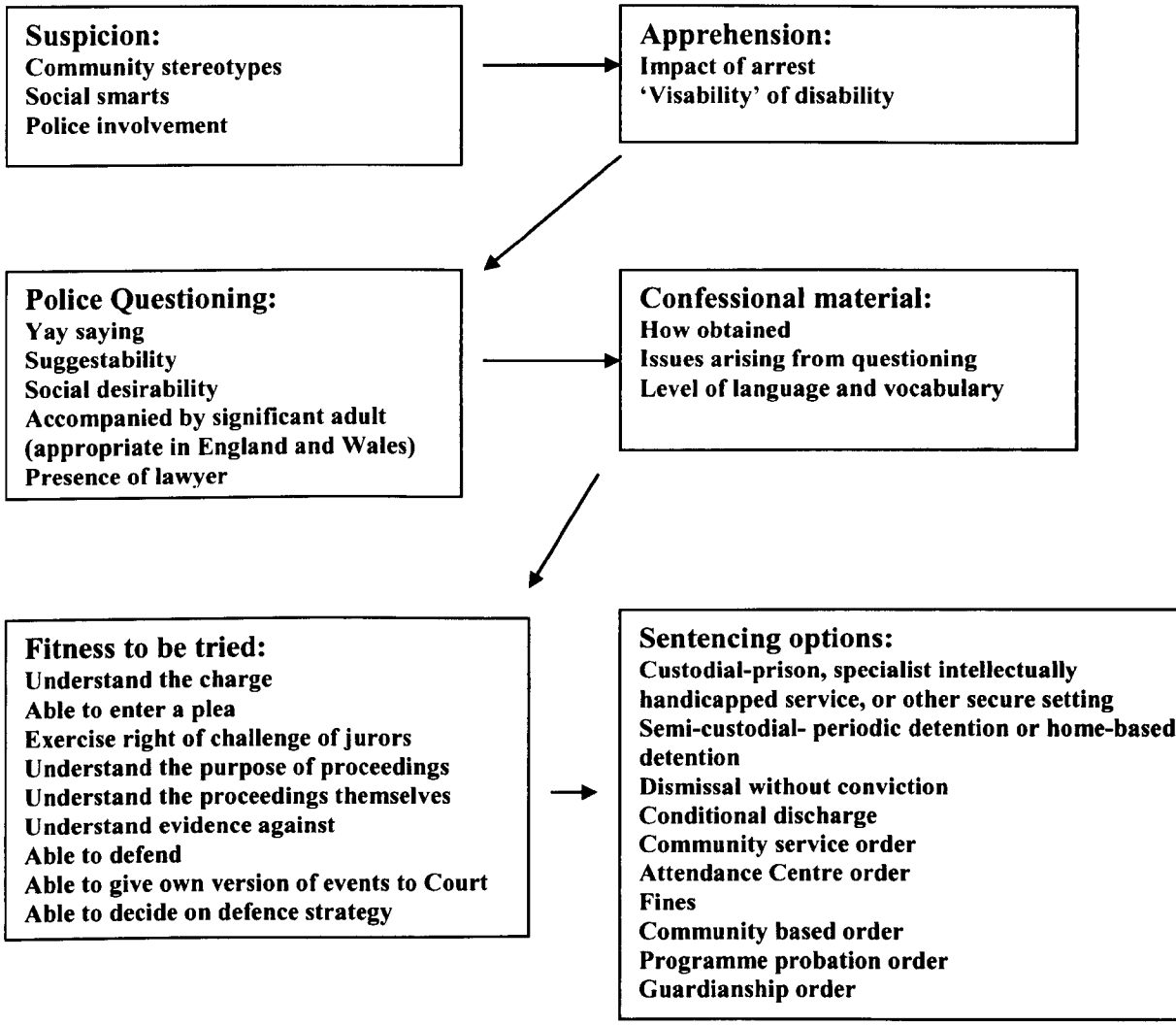


Figure 7. Discretionary points and factors affecting outcome in the processes leading from 'behaviour' to 'criminal offence'

(summary of chapters 3-7 from Hayes & Craddock, 1992)

Holland et al (2002) also present this process in diagrammatic form, which demonstrates how the level of discretion available to individuals in converting a challenging behaviour to an offence decreases as the 'processing' of the incident proceeds from the neighbourhood to carers to police to Crown Prosecution Service to the Courts and then to Post-Court options, as shown in Figure 8.

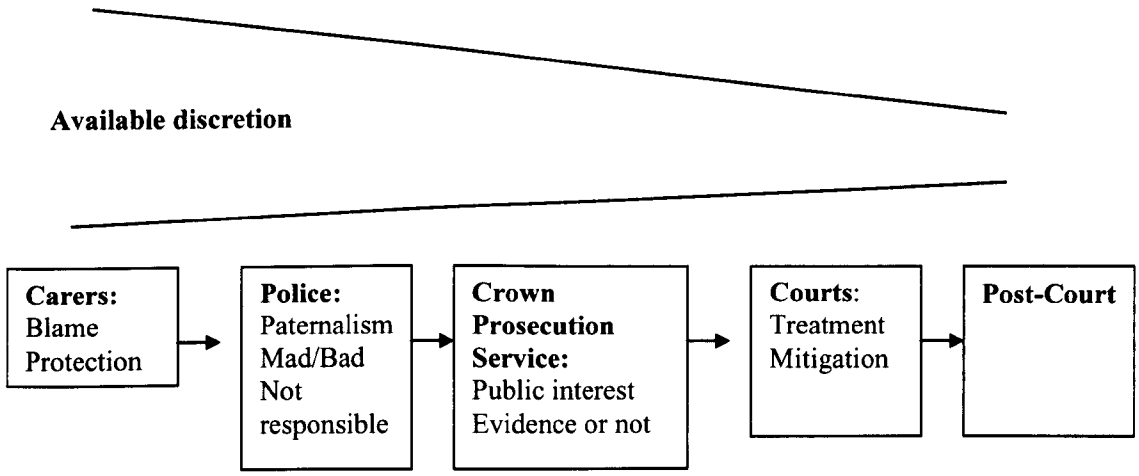


Figure 8. Model of Available Discretion and Factors Involved at Different Stages in the Transition to Criminal Offence
(taken from Holland et al., 2002, p. 9, with minimal changes)

It can be seen, therefore, that the definition of offending by people with an intellectual disability is not as simple as it may first appear. As described, there is the usual issue of under-reporting common to all crime definition and reporting, which as Holland et al. (2002) describe, becomes a steadily greater underestimate the further through the criminal justice process one looks. Holland et al. (2002) describe this by citing Grunhut, who speaks of the 'dark figure' of unreported crime, which becomes less and less indicative of the true level of crime as we move from criminal incidents through to convictions and imprisoned individuals (Holland et al., 2002). However, as Hayes and Craddock (1992) have shown, each of these discretionary points impacts upon people with an intellectual disability in a different and usually more dramatic manner than the rest of the population.

The consequence of this confusion becomes clear when the prevalence and incidence figures from various studies are considered. If we add to the discretionary confusion described above over how an incident may or may not result in a court appearance or conviction, the confusion over the definition of intellectual disability as it is applied both within the criminal justice system and within reported studies of prevalence and incidence, it is not surprising that we have seen confusing and often contradictory outcomes. This is made worse by the fact that different studies have taken their samples from different points along this discretionary continuum, rendering the results even less comparable. This point has been most clearly made by Holland et al. (2002), who used this framework to improve the comparability of previous studies by grouping studies that had been undertaken at similar discretionary points within the criminal justice/mental health service response continuum. Murphy and Sinclair (2009, p. 371) make the point that "the prevalence of sexual offending in men with intellectual disabilities is unknown", and Craig and Lindsay also conclude that sound estimates of prevalence are very unreliable given these difficulties. As can be seen from the above, it is difficult if not impossible to arrive at a clear definition of offence or offending given these vagaries, and given that these discretionary features of the process will continue, it is unlikely that many of the questions that researchers would like to address in terms of

prevalence and incidence, will ever be fully answered. The Sexual Offences Act 2003, which became law in May 2004, is the current legislation for determining whether a particular incident or behaviour constitutes a criminal offence in England and Wales. The Act proscribes a range of behaviours, with clear descriptions, such as 'assault by penetration' and 'causing a child to watch a sexual act'. A summary of the Act appears in Appendix One.

Challenging Behaviour and General Offending

Challenging Behaviour

The apparently arbitrary nature of what behaviours constitute an annoyance, challenging behaviour or a criminal offence is exemplified by the disorder formerly known as 'drapetomania', a disorder that impelled slaves to escape from slavery (Hollin & Howells, 1993). This process occurs in a socio-political context (Holland et al., 2002) that can have a dramatic impact on what behaviours actually become converted into criminal offences. This is not only true for intellectually disabled 'offenders', but also for the wider group of mentally disordered 'offenders' (Hollin & Howells, 1993) and for 'offenders' generally. When we add to the questions surrounding prevalence, questions of treatment and therefore aetiology, the possibility for conceptual confusion is magnified. As Hollin and Howells comment: "...is the propensity to commit a crime an individual failing, an act of free will, a product of environmental contingencies, or a socially constructed mechanism of control to preserve the power of the ruling class." (p.2)

Such processes will inevitably result in the same behaviour sometimes being ignored, and at other times and places and with other victims resulting in formal procedures and occasionally convictions of a criminal offence. There is some evidence, for example, that offences committed against other clients with an intellectual disability are reported less often than similar offences against members of the public, and that offences which occur within a closed or semi-closed service are reported less often than

similar offences that occur in the wider community. Such a discrepancy would be predictable from the above models that show the impact of repeated discretionary points on the conversion of a behavioural incident into a criminal offence. Given this continuum, it would seem sensible to begin our discussion of offending with challenging behaviour.

There are relatively few studies available that have examined the overall prevalence of serious challenging behaviour in the population. Emerson (Emerson, 1995) cites three studies, two in the north of England (Emerson, 1995; Kiernan & Qureshi, 1993) and one in California (Borthwick-Duffy, 1994). These surveys included self-injurious behaviour and property destruction as well as aggressive behaviour, and were conducted in 1987 and 1993.

Kiernan and Qureshi (1993) obtained figures of 1.91 per 10,000 in the general population presenting with serious challenging behaviour, and Emerson and Bromley (1995) figures of 3.33 per 10,000. Borthwick-Duffy (1994) obtained figures of 6.33 per 10,000 of the general population, although his definitions seemed less conservative than the north of England studies. Two further studies by Qureshi (1993) and Quershi and Alborz (1999) are cited by Murphy and Fernando (1999, p. 33) who conclude that both studies produce estimates of 6% of the intellectually disabled population. Murphy and Fernando (1999, p. 33) then apply this 6% figure to a Health Authority Area in the South of England comprising a general population of 415, 000, from which they extrapolate a figure of approximately 40, which represents the number of people with intellectual disability who will display severe challenging behaviour.

General Offending

When we turn to look at the literature that explicitly focuses on the description of offenders with an intellectual disability and their prevalence and incidence, it is probably helpful to separate this literature into theoretical and review articles (Barron et al., 2002; Cullen, 1993; Day, 1990, 1993; Holland et al., 2002; Lindsay & Macleod, 2001; Murphy

& Mason, 1999; Reed, 1997) and empirical studies on prevalence or incidence (Day, 1988, 1994; Denkowski et al., 1983; Hayes, 1994; Kat & Alexander, 1996; Klimecki, Jenkinson, & Wilson, 1994; Lund, 1990; MacEachron, 1979; Thomas & Sting, 1995). Before examining this literature in more detail, however, it is important to clarify the questions to which it has addressed itself, and our purpose in reviewing it here.

One of the key questions has been the comparison of rates of offending between people with an intellectual disability and the general community, and this issue in turn relates to the alleged connection between crime and low intelligence during the eugenics movement in the earlier part of last century (Holland et al., 2002). Some earlier studies (Bodna, 1987; Brown & Courtless, 1971; Cockram et al., 1992; Cullen, 1993; Day, 1993; Hayes, 1991; Klimecki et al., 1994) found that there were elevated rates of offending among the samples they studied, including suggestions that people with an intellectual disability were over-represented within the prison population (Cullen, 1993; Hayes, 1991; Walker, 2000). These included, in particular, elevated rates of offending for arson (Day, 1993; Klimecki et al., 1994) and sexual offences (Day, 1993; Hayes, 1991; Klimecki et al., 1994), with suggestions from some commentators (Bodna, 1987; Gross, 1985) that as many as 50% of offenders with an intellectual disability were convicted for sexual offences. Taken together with other reports of higher recidivism rates (Day, 1993; Klimecki et al., 1994), these studies begin to suggest a higher level of criminality among persons with an intellectually disability, uncomfortably albeit unintentionally echoing earlier discounted arguments from eugenics.

The fundamental question of comparative rates of offending between intellectually disabled and non-intellectually disabled populations seems unhelpful, because there are no obvious implications for either higher or lower rates among the intellectually disabled population, except back to the specter raised in the eugenics movement. Certainly from the point-of-view of a victim of crime, or a member of the general population, the key questions have to do with overall rates of crime, perhaps expressed as annual and lifetime probabilities of being a victim of particular crimes, and crime prevention and treatment for apprehended offenders. Population surveys of crime

victimization (e.g. Randall, 1995 and see studies reviewed in Chapter One)) address the first of these issues, and delivery of appropriate treatment programmes to identified or at risk offenders (Day, 1988; Denkowski et al., 1983; Denkowski et al., 1994) is the best way to address the second. The rate of offending by people with an intellectual disability, or for that matter sensory disability, physical disability or psychiatric disability, will not address either of these issues directly. What will help is to know the number of offenders with (in this case) an intellectual disability at the different stages and in the different sectors of the Criminal Justice and Health systems, in order to deliver the appropriate programmes for these populations in these settings. The numerous problems of definition of offending discussed above, the inconsistencies of defining intellectual disability, and regional and national variations in criminal law and health, and criminal justice system inter-relationships for this group mean that incidence and prevalence answers will at this stage be confusing at best and misleading at worst. For example, in contrast to some of the above findings, most studies of UK prison populations have reported low rates of intellectual disability (Birmingham, Mason, & Grubin, 1996; Coid, 1988; Murphy, Harnett, & Holland, 1995), sexual offence rates have been found to be similar to the general population (Lindsay, 2002), some studies have reported lower rates of fire-setting (e.g. Puri, 2000), and Day (1993) and Puri (2000) both report low rates of personal violence in contrast to Hayes (1996), who reports the opposite. Lund (1990) compared Swedish first offenders with an intellectual disability between 1984 and 1973, and found a significant increase in the 1984 figures for violence and sex offences, but a decrease in property related offences.

Summarizing much of this research, Lindsay and MacLeod (2001) declare that the data on prevalence on sex offending in the intellectually disabled population is confusing. Some studies seem to show elevated rates of offending in the intellectually disabled population, whilst others show similar or even lower rates to those in the general population. Much of this commentary, however, derives from poorly controlled studies as Lindsay and Macleod (2001) point out. This review and another by Holland et al. (2002) both conclude that we cannot be clear on the overall situation with regard to prevalence, type of offences or characteristics of offenders at this stage. Subsequent

reviewers draw similar conclusions, for example Holland (2004) points to the discretionary issues in the criminal justice system together with definitional problems of intellectual disability and points to the association between low IQ and offending, though not necessarily intellectual disability and offending, and Johnston (Johnston, 2005) is unable to draw any clear conclusions from the research she reviews for general offending prevalence for people with intellectual disability. Lindsay, Sturmey and Taylor (2004) also make the point that although there seems very strong evidence from a variety of different studies and methodologies (cross-sectional and longitudinal) linking low IQ to an increased rate of offending (or at least conviction), this only seems valid within a normal IQ range of two standard deviations above or below the mean, and does not seem to extend to people with an intellectual disability where their IQ is below 70 or less than two standard deviations below the mean.

Methodological issues, such as the above conceptual confusion about what constitutes an offence, are the reason for the conflicting and confusing results. In addition to definitional problems around intellectual disability and criminal offence, confusion between mental health and intellectual disability persists, especially in the criminal justice system, and several other factors have also been suggested: (1) Problems of poor detection rates for crime and the likely differential effect on people with an intellectual disability, as discussed above and argued by Hayes and Craddock (Hayes & Craddock, 1992). (2) Different populations from which samples have been drawn, such as community services, prisons, secure health services, court lists, police stations, etc., have led to widely divergent figures on prevalence being reported. Lindsay and Macleod (2001) comment on the difference in prevalence between samples drawn from the criminal justice system and samples drawn from Special Hospitals, with Special Hospitals providing much higher prevalence rates for offenders with an intellectual disability. (3) National and regional differences in the way such services develop and are used, mean that figures from different regions and countries cannot easily be compared. For example, there seems to be a greater reluctance to divert people with an intellectual disability from the criminal justice system in Australia (O'Connor, 1996; Hayes and Craddock, 1992) than in the United Kingdom (Holland et al., 2002; Lindsay & Macleod,

2001). (4) Changing social policy over the last 20 years (Wolfensberger, 1972) and the increased provision of community living (Jacobson & Mulick, 1997) has led inevitably to greater contact between people with an intellectual disability who were previously in institutional environments and the general community. This is likely to have increased the opportunities for involvement with crime, though more often as victims than as perpetrators (Wilson & Brewer, 1992; Wilson, Seaman, & Nettlebeck, 1996).

In terms of prevalence studies, the framework offered by Holland et al. (Holland et al., 2002) is the most helpful way so far presented in the literature of viewing the apparently conflicting results. They firstly divide studies between those that are based on surveys of individuals within intellectual disability services, and those that are based on surveys of individuals within the criminal justice system. This dual approach is necessary because offenders with an intellectual disability are distributed in both systems. Studies that focus on intellectual disability services look for evidence of involvement with the criminal justice system, while studies that focus on criminal justice services look for evidence of eligibility for intellectual disability, such as IQ below 70 and significant deficits in adaptive behaviour. Holland et al. (Holland et al., 2002) further group the criminal justice system studies into those that focus on people with intellectual disability on arrest or detention at police stations, appearing as defendants, or held within the prison system (including young offenders institutions). They also review both retrospective and prospective studies of offending by people with an intellectual disability. They draw four conclusions from this review as follows: (1) There is an over-representation of people who are "...significantly intellectually disadvantaged..." (p. 16) throughout the criminal justice system, although it is unclear how many of these would meet the formal criteria for intellectual disability. (2) The previously expressed view that people who offend by setting fires or by committing sexual offences are over-represented in these groups is not supported. (3) Maleness and youth are by far the best predictors of contact with the criminal justice system, although intellectual disadvantage (note not necessarily intellectual disability) in the context of social disadvantage increases the risk of criminal or anti-social behaviours. (4) Two relatively distinct groups emerge, the first and probably larger of which is not known to intellectual disability services, as their

intellectual disability would not be judged serious enough, but who do have both intellectual and social disadvantage; the second is well known to intellectual disability services, and the process of involvement in the criminal justice system often seems arbitrary.

Sexual Offending by people with an intellectual disability

Early Approaches

Initial approaches to sexual offending or inappropriate sexual behaviour amongst people with an intellectual disability were predominantly behavioural in orientation and single-subject in design. For example, Foxx, Bittle, Betchel and Livesey (1986) reviewed a series of thirteen such studies between 1960 and 1982, eleven of which had single subject designs. In keeping with the initial mainstream approaches to sexual offending (Quinsey & Marshall, 1983), seven of the eleven studies used an aversive conditioning approach as a key element of treatment, and only one included a therapy group. One of these studies, Polvinale and Lutzker (1980), successfully applied a combination of differential reinforcement of other behaviours (DRO), which involved verbal praise and a social restitution procedure that consisted of apologizing to affected individuals, to genital self-stimulation and inappropriate inter-personal sexual behaviour exhibited by a thirteen–year-old boy with an IQ of 36 in a school setting. Many of the studies reviewed by Foxx et al. (1986) similarly reported effective treatment outcomes. Studies included mild (8), severe (3), profound (1) and unspecified (1) levels of intellectual disability. The reviewers concluded amongst other things that there was evidence for the effectiveness of behavioural treatment approaches, that sex education should be expanded and improved, and that "deviant sexual behaviours" (p. 315) were present amongst people with an intellectual disability as they were amongst the general population. Mitchell (1985), in an early comprehensive treatment text for this area, outlines detailed behavioural interventions for what she terms sexual problems.

Sex Education, Human Relations and the Counterfeit Deviance Hypothesis

Approaches to sex education and human relationships have often been inspired by concerns regarding inappropriate sexual behaviour, either in responding to potential perpetrators by increasing their knowledge of legal sexual behaviour (Foxx et al., 1986) or to decrease vulnerability of potential victims by increasing their sexual knowledge (Turk & Brown, 1993). Some of the teaching packages (Foxx et al., 1984; Kempton, 1978; McCarthy & Thompson, 1998, 2010) and approaches (Page, 1991) that have been developed are often applied in a preventive or reactive manner to issues of inappropriate sexual behaviour. This approach to sex offending amongst people with an intellectual disability is often referred to as 'Counterfeit Deviance' because the sexual attraction is not based on deviant arousal so much as it is on ignorance or confusion about sexual and human relations. Originally coined by Hingsburger, Griffiths and Quinsey (Lindsay, Sturmey, et al., 2004, p. 164), it formed the initial hypothesis about why people with intellectual disability committed sexual offences (Lindsay, 2009), and understandably led to sex education and human relations training being the first response to incidents of sexual offending, especially non-contact offences such as exposure, public masturbation and stalking.

Lunsky, Fritjers, Griffiths, Watson and Williston (2007) provided a direct test of this hypothesis by utilizing existing data gathered in the development of the Socio-Sexual Knowledge Attitudes and Assessment Tool (SSKAAT-R). They compared two separate groups of intellectually disabled offenders, called Type I (27 participants) and Type II (16 participants), to an equal sized group of matched controls who had not committed sexual offences. The Type I offenders had committed serious, usually contact offences at the level of rape or forced sexual assault, whereas the Type II offenders had committed mainly non-contact offences such as public masturbation or exhibitionism, and inappropriate touching. Using t-tests to compare the means of the groups, they found that Type I offenders actually scored higher on the SSKAAT-R than their matched controls, and the Type I offenders scored the same. When they controlled for exposure to sex and human relations training these differences disappeared, although Type I offenders

retained more liberal views to (inappropriate) same-sex contact. Talbot and Langdon (2006) also compared two groups of intellectually disabled sex offenders, one treated and the other untreated, to a control group of intellectually disable men who were not offenders. They found no difference between the untreated group and the controls, suggesting that lack of knowledge was not the reason for their offending.

Lindsay has addressed this topic in some detail (Lindsay, 2009, pp. 68-73) and describes the counterfeit deviance hypothesis as relying on a lack of sexual knowledge, poor understanding of social conventions, a lack of opportunity for appropriate sexual expression, and as generating 11 separate sub-hypotheses, each of which could be regarded as a possible pathway into sexual offending for men with an intellectual disability. Despite limited empirical support to date, Lindsay argues that it may constitute a viable explanation for a section of intellectually disabled sex offenders.

Sex offending by people with an intellectual disability

Estimates of prevalence rates for people with an intellectual disability who sexually offend are subject to the same methodological difficulties as for all offending by people with an intellectual disability as described above. Prior to the review articles by Lindsay and MaCleod (2001), and Holland et al. (2002) the disparate results reported provided more confusion than clarity regarding the true picture of prevalence of sexual offending rates. Some claims for elevated rates of offending by people with an intellectual disability in comparison to general population rates (Bodna, 1987; Cullen, 1993; Day, 1993; Gross, 1985; Hayes, 1991) are offset by other studies that show an equivalent rate. For example, Hayes (Hayes, 1991) found that 3.7% of offenders with an intellectual disability had committed sexual offences in comparison to 4% of non-disabled offenders in maximum-security prisons. There is evidence, however, that people with an intellectual disability are responsible for the majority of sexual offending against intellectually disabled clients (Lindsay & Macleod, 2001; Thompson, 1997, 2000). In terms of actual prevalence rates, Lindsay makes a similar conclusion to earlier comments for general offending, that future studies will be hampered by the same inconsistencies

around discretionary elements in the criminal justice system and the definitional issues of intellectual disability, and that the questions are probably unanswerable. He also suggests that part of the fascination for whether the rates of offending are the same or different may relate to vestiges of the eugenics debate, and the field is better off spending effort on treatment development and evaluation (Lindsay, 2009, pp. 10-11).

In terms of the type of victim and type of offence, there is some evidence for less planning and more opportunism, greater heterogeneity in gender of victims, younger children and male children (Blanchard, 1998), and suggestions of lower levels of violence and penetrative abuse (Day, 1994). Despite the issues already rehearsed in regard to methodological problems, there are consistent suggestions along these lines initially suggested in earlier research and commentary. Following a recent review, Craig and Lindsay concluded that intellectually disabled sex offenders may be more likely to offend against males as well as females, to offend against a wider group, and to be more opportunistic in their offending. Lindsay also concluded that persistent suggestions of higher recidivism rates may be accurate, but suggests that this may be due to greater levels of scrutiny by staff due to support needs (Craig, 2010).

Lindsay et al. (2001) compared the abuse histories of 48 sex offenders and 50 non-sexual offenders and found that there were significantly higher rates of sexual abuse (38% compared to 12.7%) in the sex offender group, and significantly higher rates of physical abuse (36% compared to 14%) in the non-sex offender group. Although they point out that not all abuse victims become sex offenders, and not all sex offenders have been sexually abused. From the Lindsay et al. (2001) study, 62% of sexual abuse victims and 64% of physical abuse victims did not go on to become offenders, at least in their victim area.

Finally, aetiology for sex offenders with an intellectual disability is unlikely to be different from mainstream offenders, as people with an intellectual disability are more vulnerable to many of the risk factors associated with the development of offending

outlined earlier, for example, disturbed attachment, social isolation, and poor self-esteem (Craig et al., 2010).

Conclusion

Although there has been somewhat of a false start, with some early conclusions and generalizations not being supported by later research, the reasons for different results in research on general and sexual offending behaviour by people with an intellectual disability are becoming clearer. Some helpful frameworks have now been suggested (Holland et al., 2002; Lindsay, 2002, 2009), which have already clarified some of the confusion, and will provide clearer direction for future research. Questions about comparative rates of offending or reoffending between mainstream and intellectually disabled offenders are perhaps less important than the availability of theoretically sound assessment, formulation and treatment models subject to robust evaluation. Chapter Three will now address such treatment models.

CHAPTER THREE. TREATMENT OF INTELLECTUALLY DISABLED SEX OFFENDERS

Previous Treatment Programmes

Mainstream Treatment Programmes

Previous work summarized in Chapter One shows the presence of a well-established literature and research output in the area of sex offending in the general population. There have been some important developments in theory (Fisher & Beech, 2007; Gannon, 2009; Thakker et al., 2007; Ward, Keown, & Gannon, 2006; Ward, Polaschek, et al., 2006) and clear directions and guidelines for treatment (Barbaree, Langton, & Peacock, 2006; Fernandez, 2006; Fernandez, Shingler, & Marshall, 2006; Laws & Ward, 2006; Marshall & O'Brien, 2009; Marshall et al., 1999; Marshall, Fernandez, Marshall, & Serran, 2006; Marshall, Marshall, Serran, & Fernandez, 2006; Marshall, Marshall, Serran, & O'Brien, 2009; Serran & Marshall, 2010; Ward & Fisher, 2006; Ward & Marshall, 2004).

One landmark study also sets the stage for significant changes in the way risk assessment and management of sex offenders is approached. Hanson and Bussiere (1998) carried out the most significant meta-analysis in the area to that time, in which they reviewed 61 follow-up studies of identified sexual offenders comprising 23,393 participants, only half of whom had attended treatment programmes. They found an overall sexual re-offence rate of 13.4% (this was across both treatment and non-treatment participants), and a general re-offence rate of 36.9% over an average follow-up period of four to five years. The primary focus of the study was to identify factors that correlate with future reoffending. They examined criminal lifestyle, sexual deviance, and psychological maladjustment factors, and found that while general reoffending was related to being young, unmarried and having a history of antisocial behaviour, sexual reoffending was related to sexual deviance (which refers to sexual arousal in response to children or violence associated with sex), age and extent of prior sex offending, and sexually deviant victim choices such as boys and strangers. There was a clear and positive correlation between treatment refusal or drop-out and reoffending, although no correlation between negative clinical

factors such as low remorse, denial or low empathy, and reoffending. This research breathed new life into the sexual offending risk assessment and management literature, and many subsequent publications and new risk assessment tools and conceptualizations about risk factors emerged (Doren, 2006; Hanson, 2006; Hanson & Harris, 2001; Harris, Phenix, Hanson, & Thornton, 2003), including the identification of common factors between theoretical formulations of sex offending and risk assessment or recidivism prediction (Yates & Kingston, 2006).

In terms of treatment outcome, there has been increasing debate and controversy due to conflicting results and interpretation. Furby, Weinrott and Blackshaw (1989) reviewed 42 outcome studies on recidivism of treated and untreated mainstream sex offenders and concluded, largely due to methodological difficulties, that no positive conclusions could be drawn about treatment effectiveness, and they recommended a number of features to make evaluation of such programmes more effective. However, most of the programmes were 'first generation' behavioural treatment programmes, mainly operating prior to 1980, often with aversive behavioural components directed at changing deviant sexual arousal. Aytes, Olsen, Zakrajsek, Murray and Ireson (2001) took a novel approach to the methodological difficulties of undertaking research on sexual offender treatment outcome by retrospectively comparing sexual and non-sexual recidivism rates from two counties in the state of Oregon comprising 864 participants. They found that across both sexual and non-sexual offences the recidivism rates (defined as new felony convictions) at five year follow up were lowest for participants who had been in the programme for at least a year (8.8%) in comparison to those in another county who had not been offered treatment (15%) .

Hanson et al. (2002) undertook a meta-analysis which was based on selected studies that had used psychological treatment and compared treated sex offender participants to a control group of sex offenders for approximately the same period on the same criterion measure, with at least ten participants, five in each group (treatment and control). They found 43 studies that met these criteria as of May 2000 (it was an ongoing study with subsequent reports planned) with a total of 9,454 participants. They found that

across all treatment groups, the average sexual offence recidivism rate was 12.3% for treated participants in comparison to an average of 16.8% for untreated controls, a reduction in reoffending by the treatment group of 27% in comparison to untreated controls. They also found a stronger effect for 'second generation' multi-element programmes than earlier (mainly pre-1980) programmes, which showed no significant effect.

Losel and Schmucker (2005) also undertook a meta-analysis across studies reported in five languages (English, German, French, Dutch, or Swedish) using similar criteria to Hanson et al. They extended the range of treatment options to physical and medical (castration and medication) as well as psychological, and the date of publication to June 2003. They found 69 studies that met their criteria constituting 22,181 participants, and found an overall recidivism rate of 11.1% for treated participants in comparison to 17.5% for untreated participants. This represents an effect size of 0.29, and a reduction in reoffending for treated participants of 37% in comparison to untreated participants. This was a stronger difference than the 27% found in the Hanson et al. study, mainly due to the strong treatment effect of the castration and medication interventions. Interestingly, the Hanson et al finding that pre-1980 programmes were less effective than post-1980 was not replicated. There were some confounding factors on castration (only offered on a voluntary basis to highly motivated and well screened participants) and hormonal (confounded with CBT treatment) treatments which mitigated confidence in their generalizability, and meant that only the CBT treatment effect (based on 35 independent comparisons) remained when these other factors were controlled statistically.

In contrast to these positive findings of treatment effectiveness, a well-funded and controlled study by Marques, Wiederanders, Day, Nelson, & van Ommeren (2005) found that treatment was ineffective. This study, a long-awaited randomized control design, which was especially legislated for by the California legislature, was offered over a ten year period with substantial follow-up periods of five to ten years. The study found no significant difference between an intense year-long four to five hour per week relapse

prevention treatment group, and voluntary and non-voluntary control groups. While this study has been in contrast to a number of less controlled but positive treatment-effect studies, the rigor of the design and execution does suggest that the developing sense of confidence with group cognitive behavioural treatment for sexual offending may be misplaced. However, there were some serious problems with participant mortality, as well as significant differences about the milieu in which the treatment and control groups lived, both of which had an impact on equivalence of the treatment and control groups. There was also a positive treatment effect for those treatment participants whose measures on assessments indicated they were cooperating with the treatment goals, as they had significantly lower recidivism rates in comparison to the control groups. Nonetheless, the study stands as a sobering result that at the very least raises concerns about the relapse prevention model of sex offender treatment, if not other aspects of current cognitive behavioural treatment programmes in this area. Rice, Harris and Quinsey also provide a critical review of cognitive behavioural treatment programmes and conclude that "the effectiveness of sex offender treatment has yet to be demonstrated" (Rice, Harris, & Quinsey, 2001, p. 302).

Hall (1995; Rice et al., 2001) undertook a meta-analysis of 12 studies comprising 1,313 participants that appeared after the Furby et al. review (1989) and found a small treated versus untreated effect of $r = 0.12$, which resulted in reoffending rates of 19% and 27% respectively, and a clear and equally positive treatment effect for cognitive behavioural and hormonal treatments. Studies that included outpatients (presumably because of the greater opportunities for reoffending) had longer follow-up periods (at least five years), higher base rates of recidivism, and showed a stronger treatment effect. McGrath, Cumming, Livingston, & Hoke (2003) compared three groups of convenience rather than random allocation (56 completers, 49 non-completers and 90 refusers), who

nonetheless did not differ significantly pre-treatment on RRASOR[1] and Static-99[2] scores. They found over a six-year follow-up period that there was little difference between refusers and non-completers, with reoffending rates at 30.0% and 30.6% respectively, but that completer's reoffending rates were considerably lower at 5.4%. Aftercare and community supervision was also associated with lower reoffending.

Taken overall, there are a number of studies with small positive treatment effects but some methodological weaknesses such as lack of random allocation of participants and differential survival to the end of treatment of participants who seem more motivated and less anti-social, thus compromising reoffending comparisons. Against the conclusion from this set of studies is the methodologically robust Marques et al. (2005) study, the Furby et al. (Furby et al., 1989) meta-analysis, and critical commentary on a number of positive findings in Rice et al. (2001). Laws and O'Donohue (2008) summarize this situation by commenting that very little has been achieved in terms of knowing whether treatment is effective despite significant research efforts, Rice et al. (2001, p. 303) comment that "the question of the effectiveness of cognitive behavioural or behavioural treatment of sex offenders will go on in the absence of a scientifically definitive answer for a long time to come", and Lindsay (2009, p. 57) also concludes that "This debate will go on and on and on". Nonetheless, in terms of cognitive behavioural (and hormonal) treatment, the current positions range within limits from there being nil or very low reduction in reoffending to a moderate reduction in reoffending of 20% - 40%, depending on what is counted and how. There are virtually no commentators currently advising against treatment (unless it is exclusively humanistic or psychodynamic-see Quinsey et al., 2001, p. 302) because it has a negative effect, which was the previous situation for offenders with high psychopathy scores (see Barbaree et al., 2006, for a review of this issue).

---

[1] Rapid Risk Assessment for Sexual Offences Recidivism (RRASOR), a static risk assessment tool developed by Hanson (see R. K. Hanson & Thornton, 2000 for a comparison of the RRASOR, SACJ-Min and the Static-99).

[2] This is a Risk assessment of static factors developed by Hanson and Thornton (2000) from the SACJ-Min (Structured Anchored Clinical Judgement- Minnesota) and the RRASOR.

In the UK, this type of group cognitive behavioural therapy treatment programme was exemplified in the seven community-based programmes evaluated by Beckett, Beech, Fisher and Fordham (Beckett, Beech, Fisher, & Fordham, 1994). The treatment components described include: (a) Recognition of distorted thinking, (b) Heightening empathy towards victims, (c) Increasing awareness of short and long-term effects of sexually abusive behaviour, (d) Skills training, and (e) Relapse prevention training (R. Beckett et al., 1994, p. 4).

Such community-based programmes have also become part of the Probation Service, such as the Sex Offender Unit established by the West Midlands Probation Service described by Allam, Middleton, and Browne (1997). The core themes in the six modules of this programme were: (a) Cycles and cognitive distortions, (b) Self-esteem, social skills and assertiveness training, (c) Sexuality, (d) Role of fantasy in offending, (e) Victim empathy, and (f) Relapse prevention.

The Sex Offender Treatment Programme (SOTP) that has become a standard feature of treatment for convicted sex offenders in the English Prison Service (Grubin & Thornton, 1994) also adopts a group cognitive-behavioural approach for mainstream offenders. Treatment components of this programme are described by Beech, Fisher & Beckett (1998) in an evaluation report of the programme as follows: (a) Description of the offence, (b) Challenging distorted thinking, (c) Victim empathy, (d) Fantasy modification, (e) Social skills, assertiveness and anger control, and (f) Relapse prevention. This model also serves as the basis for an adapted programme for people with an IQ less that 80 which will be discussed further in the next section.

Intellectual Disability Treatment Programmes

Offenders with an intellectual disability, of whom sex offenders form a significant proportion (Day, 1993; Klimecki et al., 1994; Lindsay, 2009), pose a number of awkward issues for clinicians. These include the fact that such offenders are to be found in a range

of service settings including intellectual disability, forensic and mental health services. Factors affecting allocation seem to be the level of severity of offending, the presence of secondary features such as mental illness or substance use, and the vagaries of individual services and clinicians at key decision points as reviewed in Chapter Two (Brown & Thompson, 1997b; Holland et al., 2002; Johnston, 2005; Murphy & Sinclair, 2009). The majority of such offenders are usually to be found in intellectual disability services where there is considerable tension between the security and community protection requirements on the one hand (Lindsay & Taylor, 2010), and the requirements for community involvement and integration on the other (O'Brien, 1987; Wolfensberger, 1972; Wolfensberger & Thomas, 1982). For this reason maintaining known sex offenders within intellectual disability services has often resulted in additional offending within the intellectual handicapped population (Brown & Turk, 1992; Craft, Brown, Churchill, & Horrocks, 1997, pp. 13-14; Robertson, 1994), and treatment for this group is especially important because of the importance of protecting other vulnerable adults in these settings.

Recent research by Cambridge, Beadle-Brown, Milne, Mansell, & Whelton (In Press), which utilized existing official monitoring records for Adult Protection referrals in two local authorities in Kent, emphasizes this point. Using data predominantly from 2000 to 2005, they found that one fifth or 397 of all Adult Protection referrals for people with intellectual disability (total of 1857) related to alleged sexual abuse, that two thirds of these were for women, and that sexual abuse was confirmed in one quarter of cases, approximately 100. Many of these incidents would have occurred after the SOTSEC –ID treatment programme commenced, and almost a significant number of the perpetrators would have been male clients with a learning disability, who were fellow service users.

Mainstream programmes reviewed in the preceding section, at least in England and Wales, have generally been restricted to offenders who do not have an intellectual disability, but who have an IQ of 80 or over (Grubin & Thornton, 1994; Williams & Mann, 2010). This means that imprisoned offenders with an IQ below 80, as well as individuals with an intellectual disability resident in various mental health and

intellectual disability services who committed offences or engaged in 'sexually inappropriate behaviour', were not included in such programmes until 1997, (Williams & Mann, 2010) although a little earlier in parts of the National Health Service (Hill & Hordell, 1999; Hill et al., 1995). No doubt part of the reason for this initial exclusion was the generally held uncertainty over the relevance of these programmes for sex offenders with an intellectual disability, but perhaps it was also partially a symptom of the previous generalized 'therapeutic disdain' towards people with an intellectual disability referred to by Bender, which can be traced back to psychotherapy's roots to Freud (Stenfert-Kroese et al., 1997, p. 4).

The development of a treatment programme for prisoners with an intellectual disability who were ineligible for the mainstream programme as well as patients transferred into the health system was undertaken by HM Prison Psychology Service and The Janet Shaw Clinic in Birmingham (Allam et al., 1997; Hill & Hordell, 1999; Hill et al., 1995; Williams & Mann, 2010). This programme included similar components to the mainstream prison programme with less emphasis on fantasy modification, an increased focus on requisite social skills for group therapy, and the addition of human relations and sex education. There was also an understandable adjustment to the rate at which concepts were introduced, greater attention to repetition to accommodate the level of intellectual functioning and greater use of visual aids (Allam et al., 1997). Hill and Hordell implemented the health service model at the Janet Shaw Clinic using an intensive treatment model of two to three days treatment content per week. Hill and Hordell (1999) identify seven main components of this programme as follows: (a) Undermining current patterns of thought, (b) Increasing sexual knowledge, (c) Developing understanding of victim harm, (d) Developing relapse prevention skills, (e) Developing relevant social competence, (f) Developing impulse control, and (g) Increasing self-esteem and feelings of self-worth. Williams and Mann (2010) describe the HM Prison Service Programme, which was developed at the same time and called the Adapted Sex Offender Treatment Programme (ASOTP). It is comprised of four modules, namely (a) Becoming new me, (b) New me coping, (c) Healthy sex and relationships, and (d) Staying strong support group. Only one of these components is written at this stage according to Williams &

Finkelhor (1990), namely the main treatment component Becoming new me, which is comprised of 12 blocks and listed below in Table 2 along with a brief description of the content of each block.

The programme consists of 89 two to two-and-a-half hour sessions, offered at a minimum of twice weekly, and has a number of adapted process measures, although not the QACSO, the most widely used and best recognized measure in working with intellectually disabled sex offenders. The programme appears to be run to some extent as a scripted psycho-educational programme with paraprofessional trainers rather than trained therapists. Williams and Mann state, "The personal qualities of the facilitators, rather than their professional qualifications, are the important factors in the delivery of treatment to sexual offenders" and further cite Coleman and Haaven in support of their policy (Williams & Mann, 2010, p. 305). This raises two issues, firstly the issue and debate about manualized therapy versus manual-guided or principle-guided therapy (Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997; Iwamasa & Orsillo, 1997) and secondly, the relevance of training and skills of individuals leading the treatment groups.

Table 2. Outline of Adapted Sex Offender Treatment Programme

Block Number	Title	Description
1	Getting going	Group formation, establishing rules, etc.
2	New me	Life history maps to contextualize current predicament, use of diaries and other supports.
3	New me and sex	Sex education and human relations and labeling body parts.
4	My feelings	Awareness, identification and expression of feelings.
5	Making it OK	Cognitive distortions, called 'excuses' within the group.

Block Number	Title	Description
6	My risky things	Using the SARN[1] model to identify risk area for reoffending.
7	Old me versus new me and offending	Previous situations where an offence occurred or was desisted are analyzed using 'old me' as the offending me, and 'new me' as the desisting me.
8	Mid-treatment individual interview	Individual review session to assist with treatment motivation.
9	Other people's feelings	Prepares for victim work.
10	What my offending does to victims	Victim empathy enhancement.
11	New me coping	Positive coping strategies are introduced such as 'Stop and think', 'What happens to me', 'Sticking at it', 'Better life', 'Their shoes', 'Praise and reward'.
12	New me planning for the future	New me life line to plan positively for the future.

This marks a distinction with the current approach reported in the SOTSEC-ID project, which is based on manual-guided therapy rather than manualized therapy, and leadership of the treatment groups being led by qualified cognitive behaviour therapists (registered psychologists or graduate CBT qualified practitioners). The ASOTP programme is no doubt well structured, supervised and has a detailed supervision, quality control and auditing infrastructure including "specific implementation quality criteria" (p. 305).

[1] SARN is an acronym which refers to the *Structured Assessment of Risk and Need*, developed conceptually by Thornton (Thornton, 2002) and comprising four interrelated sets of dynamic factors for predicting reoffending. They are: 1. Sexual Interests – deviant arousal and preoccupation; 2. Distorted Attitudes- beliefs and attitudes which may be used to justify offending; 3. Social and Emotional Functioning- feelings of inadequacy, grievance thinking (hard done by), and lack of emotional intimacy; 4. Self Management- ability to problem-solve, regulate dysfunctional emotions and limit inappropriate impulsivity.

However, there are clear and important differences between ASOTP and SOTSEC-ID programmes that may have implications for delivery and bears further discussion.

Prior to these developments in the UK, from at least the early 1980's in America, there were some sex offender treatment programmes running and being described for men with intellectual disability (Griffiths et al., 1985; Haaven et al., 1990; Murphy, Coleman, & Haynes, 1983). A number of other clinicians and researchers in the field have recognized the relevance of such programmes, and have developed, described, and in some cases carried out evaluations (Allam et al., 1997; Bowden, 1994; Charman & Clare, 1992; Clare, 1993; Gardiner, 1996; Gilby, Wolf, & Goldberg, 1989; Griffiths et al., 1985; Griffiths, Quinsey, & Hingsburger, 1989; Haaven et al., 1990; Hickey & Jones, 1996; Murphy et al., 1983; Swanson & Garwick, 1990). Some of these evaluations are described below in conjunction with a brief review of relevant literature and are presented in Table 4.

Haaven et al. (1990) provided a group treatment programme to 62 men with an intellectual disability within a residential programme that included other elements such as medication, alcohol and drug misuse treatment, residential milieu-based social skills, and general habilitation training. Griffiths (Griffiths et al., 1985; Griffiths et al., 1989) and Haaven et al. emphasize the importance of recognizing early childhood neglect and abuse, impoverishment of opportunity, and lack of social and adaptive skills development, and suggest that sexual offending develops because of these difficulties rather than deviant sexual arousal. Lindsay also recognizes this argument (Lindsay, 2009, pp. 57-58), and notes that the field was drawn to attend to the social and life enhancing aspects of rehabilitation from the first programmes, as well as treating sexual offending. In some ways, anticipating the 'Good Lives Model' (Ward, Collie, & Bourke, 2009).

Swanson and Garwick (Swanson & Garwick, 1990) adopted an open-ended group format, similar to Lindsay, that provided ninety-minute weekly sessions to clients over an average treatment period of 14 months or 35 sessions. They used a goal-attainment scaling approach to evaluate effectiveness, and used an explicit treatment philosophy that

clients, services and family members agreed to in writing. This included a clear focus on reducing offending through components such as sex education, social skills, some focus on cognitive distortion (admitting and accepting personal responsibility for previous offences), and victim empathy (feelings of victims).

Lindsay and his colleagues in Scotland began presenting case study data on outcomes from their early innovative programme (Lindsay, Marshall, et al., 1998; Lindsay, Neilson, Morrison, & Smith, 1997; Lindsay, Olley, Jack, Morrison, & Smith, 1998), as well as looking at specific topics such as length of treatment (Lindsay & Smith, 1998) and the effects of early childhood abuse on offence patterns (Lindsay et al., 2001). They have also presented outcome data from their programme (Lindsay, Smith, et al., 2004; Lindsay et al., 2002; Lindsay, Steele, Smith, Quinn, & Alan, 2006), with an initial report in 2002 (Lindsay et al., 2002) showing reoffending rates of 4% to 21%, for one to four year follow-up periods respectively, for a group of 62 male sex offenders with intellectual disability. Lindsay and his colleagues reported significant levels of harm reduction in two other studies that reported outcome data for intellectually disabled sex offenders. They found significant harm reduction in a 2004 study (Lindsay, Smith, et al., 2004) comparing number of incidents two years prior to their index offence to two years or longer after treatment commenced for successive annual cohorts, and secondly found reoffending rates ranging from 10.5% to 25% over one to twelve years respectively for 12 separate annual cohorts with follow-up data of 12 years (Lindsay, Steele, et al., 2006). Lindsay's treatment group (Lindsay, 2009; Lindsay et al., 2000; Lindsay, Neilson, Morrison, et al., 1997) adopted an open group approach, with members joining and leaving at different stages, often corresponding to probation limits. This programme features components such as: (a) The focus (i.e., sex offending) of the group, (b) Confidentiality, (c) Changing cognitive distortions, (d) Victim empathy, (e) Behavioural patterns surrounding offences, and (f) Social skills development. It is described in great detail, with excellent examples and illustrations, in his 2009 publication.

Rose and his colleagues have also reported on development and treatment programmes. In an interesting report prior to the increase in awareness of need and

availability of sex offender treatment for intellectually disabled offenders, Bremble and Rose (1999) reported on an audit of 24 referrals for sexual offending to a psychology department. Using the Thompson and Brown (1997) definition of sexual offending behaviour, they selected 16 cases from 224 total referrals during 1997, which accounted for 7% of total referrals. The final set of participants also included eight additional cases that were open to the department. They collected information from files via file audit and the therapists by interview, reporting on referred client details, sexual behaviours reported, whether risk assessments were undertaken, and interventions and outcomes. Sexually abusive incidents consisted of 13 sexual advances, 4 masturbating, 5 exposure, 6 sexual comment(s) and 7 sexual assaults. Only one of the referrals was reported to have committed one incident, seven were reported to have committed between one and five offences, and ten referred clients were reported to have committed over ten incidents. Bremble and Rose reported that all referrals were male, most victims were known to the perpetrator, and different treatment (systemic, behavioural, cognitive-behavioural, analytic) and risk-assessment approaches were used with minimal formal structure or guidance as to which approach should be followed.

Rose, Jenkins, O'Connor, Jones, & Felce (2002) describe a short 16 week programme with six participants that showed no significant pre to post treatment changes in a range of measures, including the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO), apart from a measure of locus of control. In three related papers, Keeling and Rose reported on the adaptation of a programme for special needs participants in Australia from a mainstream sex offending treatment programme (2006), an evaluation of the same adapted programme with a group of special needs prisoners (Keeling et al., 2006), and then a comparison to mainstream sexual offenders on four matched measures (Keeling et al., 2007). They describe the separation of offence-related and offence-specific components, which are shown below in Table 3. All topics were the same as the equivalent mainstream treatment programme run at the time in New South Wales, with the addition of the sex education component. The programme used process groups to address fundamental treatment issues for sexual offenders (criminogenic needs), and issues groups to address broader social and other skill needs. The programme

ran for 12 months, for two and a half hours per day, for four days per week. The programme included an extensive battery of assessments, including the QACSO (Broxholme & Lindsay, 2003) and the Victim Empathy Scale (VES) (Beckett & Fisher, 1994).

Table 3. Treatment Components and order in Keeling and Rose (2006), and Keeling et al. (2006)

Issues groups Offence-related	Order of component in therapy	Process groups Offence-specific	Order of component in therapy
Communication, problem solving & decision making	2	Introduction to treatment	1
Victim awareness	4	Sex education & sexual abuse education	3
Emotions	7	Disclosure	5
Sexual self-regulation	8	Victim empathy	6
Attitudes & beliefs	10	Cognitive distortions	9
Relationships	12	Life time patterns	11
Goal setting	14	Offence cycle	13
New me	15	Relapse prevention	16

Craig, Stringer and Moss (Craig et al., 2006) reported on a single group project involving six participants, which ran for seven months. They used four measures, namely the Coping Response Inventory (Moos, 1993), The Multiphasic Sex Inventory (Nichols & Molinder, 1984), the Vineland Adaptive Behaviour Scale (Sparrow, Balla, & Cicchetti, 1984) and the Mini–PAS-ADD (Moss, Prosser, & Costello, 1998). They found no

significant differences on any of these measures, which they explained as being due to the short length of the group and the insensitivity of the measures, especially for intellectually disabled participants, for whom there were no specific norms. This finding is consistent with the lack of significant difference in pre- and post-test scores (apart from locus of control) found by Rose et al. (2002), which did use the QACSO, an intellectual disability-specific measure, and the finding in another study (Lindsay & Smith, 1998) where participants were found to offend at a lower rate after a two year treatment programme in comparison to a one year programme. The empirical evidence points to longer treatment periods being more effective.

In adapting a multi-element cognitive behavioural approach for intellectually disabled sex offenders, researchers and programme developers have been well supported by other therapeutic developments, as cognitive behavioural treatments have come to be more widely applied with positive outcomes for people with learning disabilities for a range of presenting problems. Following the publication in the UK of Stenfert-Kroese, Dagnan, and Loumidis' influential book *Cognitive-Behaviour Therapy for People with Learning Disabilities* (Stenfert-Kroese et al., 1997) in which there are chapters on applying cognitive behavioural principles with people with intellectual disability and anger control problems (Black, Cullen, & Novaco, 1997; Stenfert-Kroese et al., 1997), depression (Reed, 1997), regulation of emotion (Williams & Jones, 1997), and anxiety, (Lindsay, Neilson, & Lawrenson, 1997), there have been a number of other publications providing further models and guidance. Examples of these include a detailed anger treatment manual (Taylor & Novaco, 2005), an edited book on cognitive behavioural therapy with a range of types of offenders with intellectual disabilities (Lindsay, Taylor, & Sturmey, 2004), readiness for cognitive therapy (Joyce, Globe, & Moody, 2006) and obsessive compulsive disorder treatment (Willner & Goodey, 2006) to name a few. Very specific guidance has been forthcoming in the last two years with the publication of Lindsay's treatment manual for intellectually disabled sex offenders (Lindsay, 2009) and an edited handbook on assessment and treatment with intellectually disabled sex offenders (Craig et al., 2010).

There has been several qualitative publications on work with intellectually disabled sex offenders, reviewed in Chapter Six, and several articles arising from the SOTSEC-ID project (Goodman, Leggett, Weston, Phillips, & Steward, 2008; Hays et al., 2007; Langdon & Murphy, 2010; Murphy & Mason, 1999; Murphy & Sinclair, 2009; Murphy, Sinclair, Hays, & SOTSEC ID Members, 2007; SOTSEC-ID et al., 2010) as well as other demonstrations of group work programmes with this population (Courtney & Rose, 2004; Garrett, 2006; Keeling et al., 2007; Rose et al., 2002). There have also been guidance and discussion papers on specific topics relevant to intellectually disabled sex offenders including relapse prevention and the Ward and Hudson Pathways Model (Keeling & Rose, 2005), the relevance of Ward and Hudson's Pathways Model (Langdon, Maxted, Murphy, & SOTSEC-ID Group, 2007), the Good Way Model (Ayland & West, 2006, a reframing of the Old Me-New Me Model incoprorating good lives and user input), a test of the counterfeit deviance hypothesis (Michie, Lindsay, Martin, & Grieve, 2006), an evaluation of a six-session direct-care staff training workshop (Taylor, Keddie, & Lee, 2003) and the difficulties of men with intellectual disability accessing and progressing in prison sex offender treatment programmes (Henson, 2008; Talbot, 2007).

Given the confusion and conflict that remains over the meaning of research on treatment effectiveness for mainstream sexual offending, there is little surprise that there is even more confusion in regards to the effectiveness of treatment for intellectually disabled sex offenders. The smaller number of offenders, their geographic spread and their additional individual variation, such as levels of disability and additional developmental and physical health difficulties (Langdon & Murphy, 2010), make establishing treatment difficult and research trials, which typically need greater numbers for control conditions, almost impossible. The lack of published trials of treatment for intellectually disabled sex offenders where there is a robust and 'long enough' treatment programme, sufficient numbers and an intact and planned control group speaks of this difficulty. However, there is now very clear evidence of the historical levels of sexual abuse experienced by people

with intellectual disability within institutional services (Hayes, 1993)[1], evidence that this has continued into community services (Brown et al., 1995; Turk & Brown, 1993) is still current (Cambridge et al., In Press), and that many of the perpetrators are men with intellectual disability in the same service settings (Brown & Thompson, 1997b; Thompson, 1997, 2000). The problem has been clearly documented, and despite some appropriate hesitation about whether, and to what extent, treatment for sexual offending is effective, particularly among intellectually disabled sex offenders, it is imperative that such treatment programmes be established and delivered, and that they be done in a way that allows for evaluation in as rigorous a manner as possible. At the very least, such programmes seem to provide invaluable risk management information, so that the most risky individuals can be better managed. At best, such a programme could reduce reoffending and enable the question of effectiveness to be properly addressed. Table 4 below summarizes some of the previous treatment programmes in tabular form, before outlining the particular treatment model adopted by SOTSEC-ID and for the research to be presented here.

[1] Hingsburger commented in a 1987 article: "In our clinic, for example, all clients who had lived in institutions had been molested as children or coerced into sexual activity within those institutions, and many of them had later become perpetrators of similar acts" (Hingsburger, 1987).

Table 4. Summary of Previous Treatment Programmes and Guidance for Treating Intellectual Disabled Sex Offenders

Programme Author(s) Year	Treatment components	Comments
Outpatient treatment programme, Tennessee, USA. Murphy, et al.(1983)	Social skills training, sex education, covert sensitization, satiation, attitudes to women.	An early attempt to grapple with the treatment and risk issues. Described the dilemma of residential options where the individuals may be victims in one setting and victimizer in another.
York Behavior Management Programme, Ontario. (Griffiths et al., 1985; Griffiths et al., 1989)	Social competency skills, sex education, relationship training, (sub-divided into personal, interactive, social and moral areas of responsibility), coping skills training (consisting of relaxation, cognitive restructuring, assertiveness and problem-solving), and altering deviant behaviour (refers to altering deviant sexual arousal). Used Quinsey & Varney (1977) social skills game to teach social skills. Included four-level relapse prevention model.	Hingsburger (1987) identified seven problems to be addressed: Confused self concept; Isolation from peers; Lack of sexual knowledge; Sexuality as furtive behaviour; Negative sexual experiences; Inconsistent socio-sexual environment; Lack of personal power. Enhancing life opportunities and adaptive skills seen as an early and appropriate goal within intellectual disability services.
North of England outpatient Hames, (1987)	Individual sessions of offence analysis (offence, consequences and treatment programme) and clarification of feelings, family and other relationships; social skills group; sex education teaching; behavioural desensitization programme in which clients were taken amongst school children both escorted and unescorted while arousal was	Clients were believed by the author to be naïve, misinformed and confused rather than intent on offending.

Programme Author(s) Year	Treatment components	Comments
	monitored and then debriefed.	
Canadian programme Gilby et al. (1989)	Cognitive restructuring regarding denial, acceptance of responsibility and other pro-offending myths and attitudes, victim empathy, the offence chain, offenders own experiences of sexual victimization, sex education, interpersonal and social skills, elimination of deviant arousal through covert sensitisation and masturbatory re-conditioning	Suggest a combination of psychosocial and pharmacological treatments. In addition there was the provision of family therapy or other interventions to facilitate reintegration of the offender into a supportive social network.
Haaven et al. (1990) USA Secure inpatient setting	Analysis of offending behaviour; modification of deviant arousal; relationship skills; sex education, cognitive restructuring; anger management, and relapse prevention.	Included other elements such as medication, alcohol and substance use, residential milieu-based social skills, and general habilitation training.
Minnesota, USA. Swanson & Garwick (1990)	Sex education, social skills, cognitive distortions, and victim empathy. Eight point treatment philosophy. Goal-attainment scaling approach to evaluate effectiveness	Open-ended group format, ninety-minute weekly sessions, average treatment period of 14 months or 35 sessions.
Melbourne, Australia. O'Connor (1996)	Cognitive restructuring, covert sensitisation to address deviant arousal, a problem-solving model and interpersonal skills to assist with problems of daily living which contributed to offending, victim empathy, and relapse prevention.	Problem-solving intervention programme
Rampton Hospital	Social/relationship skills, sex education, basic moral reasoning, the law and community orientation, analysis of the offence, challenging	Conference presentation.

Programme Author(s) Year	Treatment components	Comments
(Hickey & Jones, 1996)	**cognitive distortions, modifying fantasies and relapse prevention.**	
Scotland (Lindsay et al., 2002; Lindsay, Steele, et al., 2006)	Cycles of offending, pathways to offending, cognitive therapy, motivational strategies, perspective taking and victim empathy, self-regulation and restraint, relapse prevention, good lives model and quality of life.	This programme has evolved over a substantial period (approximately 16 years).
West Midlands Allam et al. (1997)	Cycles and cognitive distortions; self esteem, social skills and assertiveness training; sexuality; role of fantasy in offending; victim empathy; and relapse prevention.	Adapted a mainstream programme by using more repetition, covering less material in each session, and using more visual aids.
West Midlands Community Group (Rose et al., 2002)	Sex education, self-control procedures, victim empathy, identifying emotions, assertiveness, avoiding risky situations.	16 week programme. No significant changes other than locus of control.
New South Wales, Australia (Keeling et al., 2006)	See topics listed in Table 3 above.	12 month programme, 4 days per week, 2.5 hour sessions.
West Midlands (Craig et al., 2006)	Sex education, cognitive distortions, offending cycle, and relapse prevention.	Programme was only 7 months long and resulted in minimal significant differences, but no convictions on 12 month follow-up
North of England community group (Garrett, 2006)	Emotional recognition, sex education, offending pathways, victim empathy, relapse prevention.	Provides a description of the infrastructure, funding and planning and preparation required to run a group treatment

Programme Author(s) Year	Treatment components	Comments
		programme
West of England community group (Goodman et al., 2008)	Group rules, purpose, initial social skills and establishment of a common language, human relations and sex education, identification and changes in distorted thinking, a four-stage model for explaining sexual offending adapted from Finkelhor, 1984, the development of general empathy and victim empathy, and relapse prevention.	Applied the SOTSEC-ID treatment model.

Recent Theoretical Developments

Recent theoretical developments include the development of the Good Lives Model as a rehabilitation model in contrast to both the Risk-Need-Responsivity Model (Ward et al., 2009) and the Relapse Prevention Model (Mann & Marshall, 2009, pp. 334-335; Ward, Mann, & Gannon, 2006). The Good Lives Model argues that approach goals (associated with the good life) rather than avoidance goals (avoiding sexual offending and its consequences) are more effective in motivating people generally, and therefore also sex offenders. This means that programmes should focus more on establishing for each individual what their 'good life' would consist of and what prerequisite skills, steps and strategies they need to pursue that good life, and how treatment can help them achieve that. Remaining offence-free then becomes a side benefit of aiming for this good life, as offending again would interfere with their own goal to lead the 'good life'.

At the same time, Hudson and Ward have proposed their Pathways Model (or Self-Regulation Model) (Ward, Hudson, & Keenan, 1998) which posits how offences are committed through four possible self-regulation paths (approach-explicit, approach-automatic, avoid-active, and avoid-passive) in combination with nine separate phases (life event, desire for offensive sex/activities, goals re sexual offending, planning strategy selected, high risk situation, lapse, sexual offence, evaluation, attitude to future offending). This theory provides a testable model that is consistent with much empirical knowledge on sexual offending, especially recidivism, and explains the maintenance of sexual offending (see Ward, Polaschek, et al., 2006, pp. 225-227 for a diagrammatic representation of the theory). Meanwhile, the integrated or unified theory of sexual offending, which was outlined in Chapter One, provides an explanation for the aetiology of sexual offending, explaining how for a particular individual, their genetic and environmental factors can affect the development, content and functioning of psychological systems of perception-memory, motivation-emotion, and action selection-control, so that the particular constellation of clinical symptoms develop that are likely to lead to sexual offending. These clinical symptoms, it should also be noted, partially overlap with Thornton's Four Risk Factor Model (Thornton, 2002).

Furthermore, there has also been significant theoretical clarification of the nature of cognitive distortions and a reframing of these as emanating from broader and more deeply held 'implicit theories' (Fisher & Beech, 2007; Ward, Keown, et al., 2006), which offers a further link between violent offending and sexual offending, and an understanding of how the notion of a limited number of 'implicit theories' can develop that are specific to individual combinations of offenders. For example, Thakker, et al. (2007, pp. 21-22) set out five implicit theories (which for the moment can be thought of as schemas, though they argue this terms is too vague) which they argue are the schema, implicit theory, or broadly based but subliminally held attitude, from which the specific cognitive distortions of child abusers develop. The five implicit theories are *Children as sexual beings*, *Entitlement*, *Dangerous world*, *Uncontrollable*, and *Nature of harm*. The thesis of their book *Aggressive Offender's Cognitions* (Gannon, Ward, Beech, & Fisher, 2007), is that a similar set of implicit theories can be identified for each category of sexual offender and indeed for each category of violent offender. In addition to the above developments, Thornton's (2002) Four Factor Risk Model (Sexual interests, Distorted attitudes, Social and emotional functioning, and Self regulation) not only sits well alongside the clinical presentation that emerges from the integrated or unified theory of sexual offending, it is also consistent with the notion of distal and proximate factors in the model that correspond with static, stable and acute risk factors, and the way in which these operate at the level of self-regulation or offending pathways.

Taken together, this flurry of research and theoretical development begins to help make the 'unexplainable' acts of sexual offending more understandable and perhaps in time, more predictable and treatable. The integrated or unified theory (Figure 5 in Chapter One) explains the genesis or aetiology of sexual offending through one or more genetic and biological influences, one or more ecological niche (social/cultural, physical and personal) factors such as early childhood abuse, poor attachment, poor social skills and family environment, emotional loneliness, the development of vulnerability (lack of efficacy or resilience) resentment and socialization and education into the development of psychological systems such as 'implicit theories', which are supported by a web of

pro-offending attitudes, memories, perceptual biases and emotional dysregulation, all leading to poor self-regulation, poor action selection and control and the development of clinical features that exacerbate the process even further. The self-regulation or pathways model can then potentially show how a particular individual with a particular emotional and cognitive style and clinical presentation according to the unified theory, develops and maintains a particular offending pattern, and both theories should point to how and where to intervene to break the cycle. The Good Lives Model as a rehabilitation theory then provides motivation and support to identify optimal life goals and goods that can become approach goals for the individual, and both the unified theory and the Pathways/Self Regulation Model should work with the Four Factor Risk Model to identify stable and acute risk factors for both treatment targets and risk indicators. Gannon, Ward, Beech and Fisher and their colleagues (Fisher & Beech, 2007; Gannon, 2009; Gannon et al., 2007; Thakker et al., 2007) have also shown how the notion of 'implicit theories' is a potential link between different types of violence, not only sexual violence. It is likely, given the significant overlap there is between general offenders and sexual offenders, that in time a similar model to the unified theory, with different content for the different domains and processes, may help to account for the development of other types of offending as well.

The SOTSEC-ID Treatment Programme

Introduction

The SOTSEC-ID Treatment Manual was developed collaboratively by the present author, along with Professor Glyn Murphy and Sarah-Jane Hays during 2000-2002, and reflects the treatment and research literature at the time. Since the program commenced, there has been significant developments in the areas of theory formulation, risk assessment and management, and treatment guidance for both mainstream and intellectually disabled sexual offenders, some of which has been briefly reviewed above.

The development of the Treatment Manual, like the SOTSEC-ID project overall, was a collaborative endeavour, and the individual contribution of the present author is

carefully described in Chapter Four. In terms of the Treatment Manual itself, first authorship of all treatment components other than (b) human relations and sex education, and (e) the development of general empathy and victim empathy was undertaken by the present author. All three authors contributed significantly to the final product, however. The treatment components described in the Treatment Manual comprise:

1. Treatment model and therapeutic approach,
2. Group rules, purpose, initial social skills and establishment of a common language,
3. Human relations and sex education,
4. The cognitive model-identification and changes in distorted thinking,
5. The sex offending model-a four-stage model for explaining sexual offending adapted from Finkelhor, 1984,
6. The development of general empathy and victim empathy, and
7. Relapse prevention.

Although the terms used may vary, most of the components described in the intellectually disabled sex offender treatment programmes reviewed above and listed in Table 4 are included in the SOTSEC-ID treatment programme. The two exceptions to this are risk assessment and management, and deviant sexual arousal. The topic of risk assessment and management is addressed within Chapter Four of the Treatment Manual (Sinclair, Hays, & Murphy, 2002), and is also addressed in detail in Appendix 17. Addressing deviant sexual arousal is problematic for this population because of reported difficulties in using covert sensitization and masturbatory reconditioning (Murphy et al., 1983; Clare, 1993), and ethical concerns over the use of pornography and penile plethysmography. Procedures are more developed for mainstream offenders (Fernandez, 2009; Marshall, O'Brien, & Marshall, 2009), and include the use of plethysmography as well as psychometric assessments. Following Thornton's (2002) elaboration of a Four Factor Model for risk of sexual reoffending, the concept of sexual deviancy has been broadened to include not only sexual preference (what was previously thought of as sexual deviancy), but also sexual preoccupation, both of which (sexual deviancy and sexual preoccupation) make up the first factor of Sexual Interests. This factor, along with

three other factors, Distorted Attitudes, Social and Emotional Functioning, and Self Management, all comprise the now broader concept of sexual deviancy (Craig & Lindsay, 2010). Craig and Lindsay have proposed a range of psychometric assessments that can be utilized to assess sexual deviance for intellectually disabled sex offenders. This work has only recently been published, so the programme to be presented here and which was used in the SOTSEC-ID treatment programme include only minimal elements that consciously addressed sexual deviance.

Because of the Treatment Manual's length (244 pages) and collaborative authorship, it is not included in total in the appendix. The full Treatment Manual is available from the present author, Professor Murphy or SOTSEC-ID, and a significant section comprising the treatment components has been included in Appendix Two. A brief summary of these sections is also presented here.

Treatment Components from the Treatment Manual

Therapist characteristics and therapeutic approach.

Providing a therapeutic experience, of course, is not just a matter of describing treatment or curriculum components. The way in which these components are delivered by the therapist(s) and the climate within which this occurs is a crucial feature of the programme. Indeed, some research supports the argument that these features are even more important than the content of the components (Duncan, Hubble, & Miller, 1997; Miller, Duncan, & Hubble, 1997). Marshall et al. (1999, p. 39) quote Mahoney and Norcross (1993) regarding this point, and it is worth repeating here: "Therapeutic techniques and therapeutic relationships are not (and cannot be) mutually exclusive: they are inherently interrelated and interdependent."

Concern about the characteristics of therapists and the therapeutic climate they create is especially important for sex offenders with an intellectual disability as therapists will have to manage not only the social stereotypes about intellectual disability, and the

difficulties this may bring to the therapeutic process, but also their repugnance to some of the offences committed by such clients.

Underlying attitudes and values which the therapist brings to the group.

Marshall et al. (1999) make a well argued case for the repudiation of the objectification or distancing of offenders in a therapeutic programme. They argue that sex offenders are best conceived as having a personal history that has deformed an aspect of their behaviour, but that like most people they are multi-faceted, with many if not most other aspects of their lives being unremarkable. Thus, the term sex offender uses a single feature of a person's life, albeit a feature that is important and dangerous to others, to label the entire person, in much the same way as 'mentally retarded' has been previously used. This is to argue, therefore, that therapists have a responsibility not only to avoid distancing or demonizing the individual, which would render therapy ineffective, but also to avoid labeling and stereotyping.

The underlying attitudes and values that the therapist brings to the group should therefore be a willingness to be accepting, tolerant and open towards clients in the group, a belief that all group members are capable of making positive changes in relation to their offending behaviour, and a belief that the same psychological processes and principles apply to both clients and therapists. These attitudes should co-exist with a clear refusal to accept, tolerate or be open in any way to offending behaviour, and to expect clients to make the effort involved to confront their offenses and make the appropriate changes required in their thinking, attitudes and behaviour.

Therapist qualities that make for good therapy.

There is little debate today that therapist qualities are an important and significant contributor to therapeutic outcome, through the therapeutic relationship and therapeutic culture they help to establish. All therapeutic models view empathy, warmth and acceptance as essential minimum features for effective therapy. Perhaps the most important therapist feature is whether the therapist adopts a confrontational or positive approach to treatment. The former assumes that clients have to be confronted, challenged

and almost bullied into acknowledging their offences and distortions, while the latter assumes that within the appropriate framework, most clients can be encouraged to look honestly at their previous offending, including related cognitive distortions. Marshall et al. (1999) argue that the confrontational approach is more likely to lead to treatment refusal, manipulation of the therapist (by the client talking in an appropriate manner but retaining different, un-stated beliefs), bullying and/or reductions in self-esteem. The positive treatment approach, on the other hand, supports and develops the client's self-esteem by providing enhancing rather than degrading feedback, and respecting the many positive features of the client unrelated to his offending behaviour (e.g. humour, persistence, interesting hobbies, having overcome or coped with handicaps and difficulties, vocational skills or progress in training, etc.). This approach helps develop empathy through modelling it in the first place. Part of this approach is to help clients think of themselves as "someone who has engaged in offending", rather than an offender.

Desired therapeutic climate within the group.

Underlying values and attitudes in conjunction with specific therapist features continue to make the major contribution to the particular therapeutic climate that exists within any given group. Previous studies in this area have used the Group Environment Scale (Moos, 1986) to assess the therapeutic climate (Marshall et al., 1999) or culture (Eldridge, 1998) that exists in a particular group, usually towards the end of the group treatment programme.

Beckett et al. (1994) report on the therapeutic climate for each of twelve different groups at seven different community programmes using the Group Environment Scale (GES). Comparing the two groups with the most divergent results on the GES, Beckett et al. (1994) found that the features of successful groups were: (a) High levels of group cohesiveness, where all clients felt involved in the group, (b) High levels of task orientation, placing emphasis on practical tasks and decision-making, (c) Clear structure and explicit rules, and (d) An atmosphere where members felt encouraged and respected as individuals and did not feel that they were viewed solely as sex offenders (R. Beckett et al., 1994, pp. 4-5).

Beech, Fisher and Beckett (Beech, Fisher, & Beckett, 1998), undertook a similar evaluation as part of a comprehensive evaluation of twelve treatment groups within the Sex Offender Treatment Programme that is a feature of the English Prison System. They found that the three key features of an effective therapeutic group for sex offending are that the group: (a) Encourages high levels of disclosure by participants, (b) Is perceived by the participants as supportive, and (c) Instills hope about the possibility of change about the future.

Marshall et al. (1999) argue that groups that are constructive, provide positive feedback to members and which have a balanced combination of support and constructive challenge will be most effective in developing self-esteem and self-efficacy (Bandura, 1977). Improvements in self-esteem and self-efficacy, in turn, facilitates positive engagement in offence-specific therapeutic elements such as self-disclosure of offence details and supporting cognitive distortions, development of victim empathy and relapse prevention plans. A necessary but not sufficient condition (Marshall et al., 1999) for therapeutic change within group treatment therefore, is the creation of an appropriate therapeutic climate, as Eldridge describes it: " ...a non-collusive but safe place for change."(Eldridge, 1998, p. 24) Such a climate includes several of the features measured by the GES (Moos, 1986) such as cohesion, facilitator supportiveness, task orientation and tolerance of negative feelings and disagreement, as well as encouraging in members and modeling by facilitators of an appropriate level of self-disclosure.

Group rules, purpose, initial social skills and establishment of a common language.

Group rules.

The first treatment component seeks to establish the social and therapeutic framework within which the group treatment will proceed. Although cognitive behavioural interventions are more known for their focus on tasks and techniques than their focus on process (Marshall et al. 1999), groups by their very nature demand that careful attention is paid to this social and therapeutic framework. Groups can create a

climate in which the focus of treatment is clear, responsibility for treatment progress is shared across the group to some extent, and a safe environment is created that reduces defensiveness whilst at the same time permitting appropriate confrontation (Beech & Fordham, 1997).

Group Purpose.

This element serves to ensure there is no doubt that the men are attending a group for men who are at risk of committing sexual offences and that all men in the group have committed such offences in the past. Lindsay (1997) has argued that "...it may take up to six months for the offender with an intellectual disability to accept that he is attending treatment because he has committed a sex offence." (p. 9).

Initial Social Skills.

Previous programmes for this client group have included social skills. Griffiths et al. (1985) taught social skills using a social skills game developed earlier by Quinsey and Varney (Quinsey & Varney, 1977), and Lindsay (1997; 1998), Swanson and Garwick (1990), and O'Connor (1996) have all included a social skills or interpersonal skills element in their programmes.

Establishment of a Common Language.

A common language for describing parts of the body is generated by the group for each relevant anatomical feature by generating all possible terms and writing them on flip sheets, and then selecting an agreed and appropriate term for each feature.

Human Relations and Sex Education.

This section of the Treatment Manual was initially written by Sarah-Jane Hays. As described in the manual and in the treatment component included in Appendix Two, the areas of general sex education and human relations, as well as topics related to sexual offending, such as consent and risky behaviour are covered.

The general material includes both male and female maturational changes from birth to old age with a focus on changes around the point of puberty, the range of commonly accepted sexual activities and sexual health. Resources such as Sex and the 3 Rs, Rights, Responsibilities and Risks: a Sex Education Package for Working with People with Learning Difficulties (McCarthy & Thompson, 1998, 2010) and numerous others are recommended in the Treatment Manual.

This section also addresses the issue of consent in some depth, ensuring the participants understand the legal issues around consent in general and age of consent, informed consent, and coercion in particular. More general issues, such as sex-role stereotypes and misogynistic attitudes, are raised and discussed and an attempt made to restructure these where appropriate.

Identification and Changes in Distorted Thinking.

Description of Cognitive Distortions.

Most mainstream treatment programmes have included for some time a substantial component that seeks to identify, challenge and then change distorted cognitions supportive of sexual offending (Murphy, 1990). However, what exactly is meant by cognitive distortions is not so clear. Marshall et al. (1999) ask whether there is any difference between a cognitive distortion and simply lying, arguing after a brief review that many clients may initially begin by lying, but after some time many become at least partly convinced of the distortion. They also argue, as does Murphy (Murphy, 1990), that the process of cognitive distortion is not pathological or unusual, but is a human response to incongruent or uncomfortable cognitions.

There has not been agreement in the mainstream sex offending literature on the different types or categories of cognitive distortions. Marshall et al. (1999) describe a typology of different cognitive distortions, Barbaree and Cortoni (1993) present a typology focusing on denial and minimization in which they argue denial and minimization are different degrees of the same process, and Murphy (1990) argues for three different types of cognitive factors. Although there is little agreement about the

exact structure and interrelationship of cognitive distortions related to sexual offending, there is clear agreement that cognitive distortions in the widest sense of the term are found amongst most sexual offenders, and that such distortions, while highly resistant to treatment, are an essential focus for successful treatment, and that some agreement on appropriate methods for assessing and changing them has been achieved.

Assessment of Cognitive Distortions.

There have been three scales developed within the United Kingdom, none of which has been published. There are no available data on reliability and validity for these scales, but two have been widely used in clinical practice. They are the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO) developed by Bill Lindsay and described in part in some published studies (Lindsay, Marshall, et al., 1998; Lindsay, Olley, et al., 1998; Lindsay & Smith, 1998), and the Sex Offenders Self-Appraisal Scale (SOSAS) developed by Dominic Bray (Bray & Forshaw, 1996). Bray has also developed the less widely used Sex Offenders Opinion Test (Bray & Forshaw, 1996). More recently, a version of the Abel and Becker scale referred to above for mainstream offenders has been developed within the USA for offenders with an intellectual disability, but this scale was not available in the UK at the time of writing (Kolton, Boer, & Boer, 2001).

Changing Cognitive Distortions.

Cognitive distortions are modified through a process known as cognitive restructuring (Jenkins-Hall, 1989a; Meichenbaum, 1977). The process is based on the cognitive model of behaviour change, in that by changing the way people think about their experiences, it is possible to change their emotions and also their behaviour (Beck, 1976; Ellis & Grieger, 1977). Cognitive restructuring endeavours to identify and challenge maladaptive cognitions, and replace them with more adaptive cognitions.

In undertaking cognitive restructuring with sexual offenders, Murphy (1990) argues that clinicians will need to know about the particular victim(s) for each client and

the impact of the offence on the victims, and understand in general the links between cognitive distortions supportive of particular types of sexual offending and the actual offending, as well as being aware of the broad range of cognitive distortions that offenders are likely to utilize. Murphy also warns that a defensive and even angry reaction should be expected when cognitive distortions are challenged.

A Four-Stage Model for Explaining Sexual Offending.

A model of sexual offending provides a framework within which facilitators and participants can discuss the offending behaviour and come to understand it better, especially the various stages or steps involved in the offending process. A derivative of David Finkelhor's model has been utilised. Finkelhor (1984) developed a model for men who offended against children, which described the four preconditions necessary for abusive behaviour to occur. These were: (a) Motivation to abuse, (b) Overcoming internal inhibitors, (c) Overcoming external inhibitors, and (d) Overcoming victim resistance. The model used here (after the Adapted Sex Offender Treatment Programme) consists of the following stages: (a) Thinking not OK sexy thoughts, (b) Making it OK, (c) Planning to offend, and (d) Offending.

The Development of General Empathy and Victim Empathy.

The victim empathy section was written by Professor Glynis Murphy. There are no clear definitions of empathy that are agreed or accepted, and there is some debate about whether it is emotional, cognitive or both. Sex offenders do not seem to lack empathy so much as lack victim empathy, and sometimes even victim empathy specific to their victims or their victim category. Marshall's (Marshall et al., 1999) chapter on victim empathy clarifies this further.

Exercises recommended to improve victim empathy include offence disclosure, recognizing emotions, role playing victim, discussing impact on victim, writing a letter to victim (as an exercise only - never sent).

Relapse Prevention.

Relapse prevention was originally developed by George Marlatt and others (e.g., Marlatt, 1982; Marlatt, 1985; Marlatt & Gordon, 1980) as a treatment approach to substance abuse and addiction, due to the problem in the addiction field of short-term successful responses to treatment followed by long-term failure. Relapse prevention provided an alternative conceptual framework to the prevailing medical model that viewed addictive behaviours as a poor adaptive response to life stressors rather than a disease, advocated an active role for clients in the treatment process rather than a passive one, and aimed at reduced probability of the addictive behaviour rather than a cure (George & Marlatt, 1989).

The first published application of the relapse prevention model to sexual offences was by Pithers, Marques, Gibat and Marlatt (1983). Application of the relapse prevention model to sex offending (e.g., Eldridge, 1998) can be argued either on the basis that repetitive sex offending has significant overlap with addictive behaviours such as smoking, gambling, or alcohol addiction, or that recidivism of sex offenders can be regarded as a problem of maintenance. Similarities identified by George and Marlatt (1989, p. 13) between sex offending and other addictions include: (a) A focus on short-term self-gratification and ignoring of long-term negative consequences, (b) A reliable positive mood-altering experience, (c) Presence of significant cognitive distortions that serve to deny the behaviour, minimise its effect, or diminish personal responsibility, and (d) Relapse is a common difficulty.

Because of the obvious differences in consequence between many addictive behaviours such as smoking, alcohol addiction and gambling, and sexual offences, George and Marlatt (1989) argue for a very conservative definition of lapse and relapse in the case of sexual offending. They define a lapse as any wilful movement towards the possibility of sexual offending including deliberate fantasizing or return to stimuli associated with the offence (p. 6), to which we could add planning, or entertaining offence-supportive cognitive distortions. They define relapse as any occurrence of a sexual offence.

The key features of the relapse prevention model as applied to sex offending, then, are that: (a) Sexual offences occur at the end of a chain of events or behaviours, (b) Most offenders will slip or lapse along this chain from complete abstinence, (c) There is an emphasis on impact of other life events and mood on "risky " behaviours, (d) These risky behaviours act to increase the problem of immediate gratification (PIG), (e) Engaging in risky behaviours can be followed by either a coping response and return to abstinence or a non-coping response and a lapse, (f) After a lapse there is an abstinence (rule) violation effect in which the person sees themselves as a failure and are therefore more likely to lapse further, (g) Relapse prevention plans consist of individualising the particular risky behaviours and situations in the form of an offence chain for each offender so that their occurrence can be minimised, and (h) There is a sharing of the "offence chain" with others so that early events serve as a signal to others to intervene.

Support for the extension of the full relapse prevention model to sex offending treatment is not universal, however. Marshall et al. (1999) claim there is no empirical evidence for the extension of the relapse prevention models from addiction treatment to sex offending treatment. These same authors also argue that the existing relapse prevention model is too complex to teach to clients, and argue for a simpler approach. This criticism is supported by Ward (cited in Marshall et al., 1999) who has proposed a nine-stage offence chain, which also serves as a relapse prevention model.

The model used here combines the adapted Finkelhor (1984) model of sexual offending (a simple offence-chain) with the decision matrix originally developed by Marlatt (1985, p. 58) and described for sexual offender treatment by Jenkins-Hall (1989b). This results in a relatively simple model that shows the four-stage offence chain in contrast to a four-stage non-offence chain. This model builds on the understanding of the offending model already developed, and includes within each cell specific tactics and strategies to assist in preventing relapse at that stage. These include the positive and negative, and short and long term consequences identified in the decision matrix described above, and are specific to each individual. The model allows inclusion of

relevant victim empathy information, restructuring of cognitive distortions, and strategies to avoid risky situations. These plans are very detailed and take several hours of group time to develop for each individual client. However, they also provide a convenient way to capture the particularities of each client's previous fantasies, distortions, planning and offending in such a way that they can be specifically counteracted in the non-offending column. The relapse prevention plan thus developed for each individual serves as a summary of the relevant points of the group treatment programme, as well as a portable relapse prevention plan that can be distributed to relevant parties such as the residential service and Care Manager, as well as the client. Marshall et al. (1999) similarly distribute their offence chain described above to the Parole Board and an external supervisor in addition to the client (p. 144).

Conclusion

When the treatment manual was prepared in 2000-2002, there was a general sense of confidence about treatment and recidivism for mainstream sex offenders due to the Hanson and Busiere (1998) findings, which at the time had not been vigorously challenged. With this in mind, adapting a 'successful' mainstream treatment model, which included relapse prevention, for men with an intellectual disability seemed an obvious step. Findings in mainstream recidivism projects since then, however, have given rise to some hesitation about the effectiveness of programmes in general and the Relapse Prevention component in particular (George & Marlatt, 1989; Marlatt, 1989; Marlatt & Gordon, 1980, 1985; Pithers, Marques, Gibat, & Marlatt, 1983). Arguments against Relapse Prevention, and perhaps more importantly the lack of evidence for its continuation, are mounting. This is somewhat surprising because as recently as 2006 Wheeler, George and Marlatt wrote that Relapse Prevention was a central component of 90% of sex offender treatment programmes in North America (Wheeler, George and Marlatt, 2006). However, Wheeler, George and Marlatt were themselves critiquing the lack of evidence supporting Relapse Prevention as a therapeutic component. In particular, they highlighted the lack of evidence of an Abstinence Violation Effect among sex offenders.

In addition to evidence from the Marques et al. study (Marques et al., 2005), Ward and Laws (Laws & Ward, 2006) (2006) among others have attempted to reformulate Relapse Prevention and develop a model that better matches the experience of sex offenders. The Self-Regulation Model, reviewed earlier, seems to show more flexibility to different presentations, or 'offending pathways', and offers a potential replacement to the Relapse Prevention Model.

It is important to recognize that there are some powerful biological and behavioural principles contained within the Relapse Prevention Model that should be retained, such as the powerful primary reinforcing value of sexual activity, the difficulty of long term maintenance of behaviour change, the power of situational determinants on behaviour, and the 'pull' of established behavioural chains whatever their goal.

A reconsideration of models underlying treatment for intellectually disabled sex offenders is also appropriate in the wake of recent empirical and theoretical developments. Fortunately, neither SOTSEC-ID nor other intellectual disability sex offender programmes seem to have invested too much time reconstructing offending patterns in order to fit the Abstinence Violation Effect or the Problem of Immediate Gratification. In the SOTSEC-ID programme, the Four Stage Finkelhor Model and a variation on James Haaven's "New Me Old Me" Model (Haaven et al., 1990) became the vehicle for reducing the probability of future offences, usually on sound behavioural and cognitive grounds such as cognitive distortions, behavioural chains, potential reinforcers etc., although this element was named Relapse Prevention (RP) and the training programme and manual reflected some RP concepts.

Hudson and Ward (2000), have also contributed to this debate by proposing the Good Life Model, which remind us of the value of approach goals, positive reinforcement, and goal setting in motivating clients for behaviour change (Ward and Fisher, 2006). Lindsay (2009) has also contributed to this debate by suggesting that intellectual disability programmes in this area have always had a different genesis and

focus. Griffiths and Haaven's programmes in the 1980's, Lindsay reminds us, were focused at the outset on developing opportunities, providing social and relationship skills, teaching sex and human relations, addressing institutional and social abandonment and abuse, and improving independence and competence. In short, there was already a focus on The Good Life Model and addressing factors that interfered with its attainment. This is not to suggest that a re-evaluation of current models and practice is not desirable, only that a strong foundation for adoption of the Good Lives Model already exists within intellectual disability services (O'Brien, 1987; Wolfensberger, 1972, 1983; Wolfensberger & Thomas, 1982).

Within intellectual disability services, Keeling and Rose (Keeling & Rose, 2005) have provided a conceptual critique in favour of the Pathways Model, and Langdon et al. (Langdon et al., 2007) have investigated the theoretical predictions with mixed results. A reconsideration of treatment content is also appropriate, particularly any which owes its place to Relapse Prevention ideology rather than sound behavioural and cognitive principles. The Good Lives Model has also provided a salutary reminder of the commonality of human needs and 'goods', and should also help focus programmes on these motivational and goal setting aspects. The SOTSEC-ID treatment manual is currently being revised and these issues will help guide the revision process and programme development.

CHAPTER FOUR. INTRODUCTION TO PART II AND METHODOLOGY

Background to Empirical Studies

Part I outlined the state of our understanding of sex offenders in general and those with an intellectual disability in particular, as well as current and previous approaches to treatment, risk assessment and management. Part II describes the studies which were undertaken to select appropriate measures and a treatment approach, understand the experience from the participant's point of view, test the adequacy of the selected measures, and evaluate the effectiveness of the treatment programme itself.

Although there have now been a number of randomised control trials of the effectiveness of general sex offender treatment, and several comprehensive meta-analyses (Hall, 1995; Hanson & Bussiere, 1998; Hanson et al., 2002; Losel & Schmucker, 2005; McGrath et al., 2003) which have arguably established group cognitive behavioural treatments as effective in reducing recidivism of sex offenders (though see Furby et al., 1989; Quinsey et al., 2006 for a different opinion; Rice et al., 2001), significant gaps remain in the knowledge base for understanding and treating general sex offenders. Theory development, despite a recent boost, is still at an early stage (Ward, Polaschek, et al., 2006) and therefore our understanding of which treatment approaches work for which types of offenders (Laws & Ward, 2006; McGuire, 1995), and which treatment components are most effective, is limited. For example the clinical wisdom for some time was to be cautious about treating sex offenders with high psychopathy scores lest they become more effective offenders, with better interpersonal and grooming skills, yet Barbaree, Langton and Peacock (2006) recently concluded that there was no evidence to support this long-held assertion. This example shows the importance of empirical evidence in matching treatments to individual offenders and in selecting treatment components, for example the behavioural element (Fernandez et al., 2006), relapse prevention (Laws & Ward, 2006), and maintaining positive therapeutic engagement (Fernandez, 2006).

In terms of research, Laws and O'Donohue (1997) pointed to the significant methodological gaps still remaining in mainstream sex-offending research. Principle amongst these is the lack of psychometrically sound measurement tools, and the plethora of difficulties associated with patchy funding and resourcing: small sample sizes, lack of appropriate matching, non-random assignment, lack of treatment fidelity measures and insufficient follow-up time. Laws and O'Donohue called for funding of multi-site studies to overcome some of these problems, and have reiterated these concerns in the second edition of their publication ten years later (Laws & O'Donohue, 2008). They lament that "...many of the deficiencies we noted in 1997 remain." (Laws & O'Donohue, 2008, p. 7), and point to the mismatch between public concern over sexual offending as a public health issue and the level of resources allocated to finding effective solutions through research.

Lindsay has made the same call in connection with the work on sex offenders with an intellectual disability (Lindsay & Macleod, 2001), where these methodological problems are compounded many times over. Research funding is more difficult to attract, perhaps because sex offending or sexually abusive behaviour by this population is less visible- partly due to the victims often also having an intellectual disability (Brown & Thompson, 1997b; Green, Gray, & Willner, 2002) and partly to being diverted from the criminal justice system to the health system (Barron et al., 2002). The numbers of people with an intellectual disability and a sex offending or sexually abusive behaviour history are smaller and therefore more geographically dispersed than the general population of sex offenders, so obtaining large enough numbers to generate sufficient power to statistically detect any treatment effects (Tabachnick & Fidell, 2007) presents special difficulties, even in a relatively densely populated country like the United Kingdom. The availability of reliable and valid process measures, such as for cognitive distortion and victim empathy for people with an intellectual disability, is extremely poor, and as Lindsay commented for this population "...work on assessment is at an early stage" (Sturmey et al., 2004, p. 172). Keeling, Rose and Beech (2007) agreed with Lindsay that few assessments exist for offenders with intellectual disability. They adapted and evaluated four assessments for offenders with special needs including one of the

measures used in the present study, although unfortunately the adaptations made to one of the measures in the Keeling et al. Study (Victim Empathy Scale) is slightly different to those in this one, making comparison difficult. The present study must work with some of these endemic difficulties, and has endeavoured to address these problems through adopting a collaborative approach involving multiple sites (Laws & O'Donohue, 1997; Lindsay & Macleod, 2001), a focus on treatment consistency through training and the development of a substantial treatment manual (Sinclair et al., 2002), and the selection and development of the best available process and outcome measures.

The history of the present work owes part of its origins to a group which met at the office of the Programmes Development section of HM Prison service in London during 1997-9 chaired by Dr Jeremy Tudway, then a Consultant Clinical Psychologist at Llanarth Court Hospital, and drawing on the expertise of the programmes office in HM Prison (Fiona Williams) which had pioneered sex offender treatment work in the UK for general sex offenders (Grubin & Thornton, 1994). This group, called the *Sex Offenders with Learning Difficulties Assessment Development Group*, met to agree on measures to be used for assessing sex offenders with an intellectual disability. A smaller and largely Kent-based group grew out of this, convened by Professor Glynis Murphy and Neil Sinclair, called the *Men's Group Assessment Group,* meeting from 1998 to 1999. This in turn led to the initiation of *The Sex Offender Treatment Services Collaborative-Intellectual Disability (SOTSEC-ID),* led again by Professor Glynis Murphy and Neil Sinclair with an invitation letter from Professor Murphy circulated in November 1999 and a first meeting on 1st March 2000. The development of assessment measures and a focus on developing and evaluating treatment programmes for this population has remained the focus of the SOTSEC-ID group since its inception, and it has met regularly in London (and occasionally in Birmingham) five to eight times per year since. Table 5 shows the web site entry for **SOTSEC-ID** (www.kent.ac.uk/tizard/sotsec/).

Table 5. SOTSEC-ID Website Description

Sex Offender Treatment Services Collaborative Intellectual Disability - SOTSEC-ID

SOTSEC-ID is a collaborative group of professionals engaged in providing group treatment to men with intellectual disabilities who are at risk of sexual offending. Initially this group mainly involved professionals from South-East England, but participants, treatment providers and researchers now come from further afield. The group exists in order to provide:

- A forum within which clinicians who are treating this client group may meet to discuss treatment issues and ethical issues which this type of work raises.
- Meetings of interested professionals are held every 8 weeks in London and Birmingham.
- Appropriate training and dissemination of cognitive behaviour treatment (CBT) approaches for this client group.
- SOTSEC-ID arranges seminars and conferences, on cognitive behaviour group treatment for sex offenders and related topics.
- A data set of sufficient size to allow a valuable test of the effectiveness of CBT for this client group.

A treatment manual has been developed to provide a common framework for treatment with this group of clients. The treatment manual provides some assurance of standardisation and model fidelity for comparative research purposes. A research grant from the Department of Health has been awarded to the convenors of SOTSEC-ID, Professor Glynis Murphy and Neil Sinclair, to evaluate this treatment for men with intellectual disabilities at risk of sexual offending. Kathryn Heaton[1] has been employed as a researcher on the project. It is anticipated that the data set will be added to over time (even at the conclusion of the Department of Health funding) and there is the potential for collaborative partners from other regions within the UK and from other countries.

[1] A series of research workers have been employed over the years (2000-2010) including Sarah Jane Hayes (nee Booth), Katherine Heaton, Nancy Hampton, Sylwia Florczyk and Charlotte Peck.

The current author has run nine year-long groups, three in the community and six in hospital settings, several of which have contributed data to the overall SOTSEC-ID research programme. The pilot study, qualitative study, and reliability and validity studies to be presented later in this report derive from the author's own data-collection efforts (Chapters Five, Six and Seven). The quantitative data which addresses cognitive distortions and sexual knowledge (Chapter Eight) derives from data contributed to the SOTSEC-ID project by a number of researchers including the author. The present author has made a substantial contribution to the SOTSEC-ID programme, being lead author on the Treatment Manual, a key presenter at all SOTSEC-ID treatment training programmes, both in the UK and overseas, and has remained Co-convenor with Professor Murphy since SOTSEC-ID's inception. The sections on reliability and validity, the qualitative study, and the case studies which combine quantitative and qualitative methods were undertaken primarily by the author. Table 6 in the method section sets this out more clearly.

Overview of Studies

These studies were conducted to shed more light on the population of men with an intellectual disability who have committed or are at risk of committing sexual offences[1], and to evaluate whether treatment approaches shown to be effective for the general population of sex offenders can be adapted to treating a population with an intellectual disability. Consistent with suggestions in the relevant literature reviewed in the preceding chapters and above, this was achieved by attracting sufficient funding and interest amongst clinical colleagues to support a geographically dispersed multi-site study with sufficient numbers of participants to provide statistical power, selecting and adapting

[1] As will be seen later, not all the participants have been convicted of such offences in court (due largely to issues regarding diversion). Officially, therefore, not all the men can be called offenders, though I will use the terms offender, offending, reoffending and recidivism at times to avoid clumsy expression as discussed under definition in chapter two and following Brown (2005).

appropriate process and outcome measures, and addressing treatment consistency through the provision of manual-guided therapy, training and support (Eifert et al., 1997). The study was part of a wider study undertaken by SOTSEC-ID under the leadership of Dr Glynis Murphy.

The aims of the study were:

1. Describe the participants accurately on a range of variable such as IQ, diagnosis, adaptive behaviour, social skills, offence history and degree of autism;

2. Report on the qualitative experience of being a participant in a sex offender treatment programme for men with an intellectual disability, utilising both qualitative and quantitative data and examining patterns over a longitudinal period where possible;

3. Describe the particular treatment approach as implemented in terms of curriculum, length of sessions, number of sessions and session format, to examine where possible the respective contributions of these features to treatment outcome;

4. Implement and evaluate the reliability, and in some cases validity, of recently developed measuring tools for this group intended to measure cognitive distortions relevant to sex offending, sexual knowledge and victim empathy;

5. Draw conclusions about the treatment effectiveness of group CBT with this population;

6. Examine the relationship of variables such as IQ, offence history, degree of autism, changes in sexual knowledge and changes in cognitive distortion;

7. Examine the relationship of the above variables to rates of sexually abusive behaviour and reoffending or sexually abusive behaviour during and after treatment.

These aims were addressed through four linked sub-studies, named:

Study 1: Pilot study;

Study 2: Qualitative study;

Study 3: Reliability and validity study;

Study 4: Quantitative study.

As these studies were all part of the same overall multi-site ethical approval process, utilised the same participants, or sub-sets of the same participants, and all were concerned with the treatment of men with intellectual disability at risk of sexual offending, the four studies had many common features.

Method

The rest of this chapter will provide an overview of the framework under which these four studies were conducted, including elements in common such as ethical issues, participants, and measures. A detailed description is provided of each study in the chapters that follow. Table 6 provides a brief description of each study along with its relevant details.

Table 6. Outline of the Four Studies

Study Title Chapter	Thesis date	Period of study	Study goal(s)	N	Data collection
Study 1 Pilot study Chapter Five	2003	1999 - 2003 [1]	1. Test a range of existing measures and adapt or use as appropriate. 2. Develop operational elements of the treatment into a Treatment Manual.	14	Author
Design, measures and procedures	A repeated measures pre-post-follow-up design was used with QACSO, SAK, SOSAS, VES, Men's Group Data Base and a range of other measures being undertaken. These measures were trialled and treatment programme procedures developed over two community groups and three secure groups each of a year's duration. Some participants repeated groups.				
Study 2 Qualitative study Chapter Six	2007	2008 - 2009	To describe the experience of participating in the treatment programme as a participant.	9	Author
Design, Measures and Procedures	The design adopted was a qualitative interview and Interpretive Phenomenological Analysis (IPA) approach. Nine programme and research 'graduates' were interviewed for a 30-40 minute period in a familiar setting by the author using a Guided Interview approach. IPA was used to extract the key themes raised by participants and develop into a coherent description.				

[1] This work was conducted as a clinical trial with data remaining in the programme until ethical approval had been granted and consent sought and obtained from participants.

Study / Title / Chapter	Effect date	Period of study	Study goal(s)	N	Data collection
Study 3 Validity and Reliability Chapter Seven	2007	2008 – 2010	1. To assess whether the SAKA compares favourably with the SKIS as a valid measure of sexual knowledge and attitudes, and the SOSAS with the QACSO as a valid measure of cognitive distortion. 2. To assess inter-rater and test-re-test reliabilities of the QACSO, SAKS, SOSAS and VES.	29	Author[1]
Design, Measures and Procedures	A repeated measures design utilising two raters at two times approximately 2-3 weeks apart, with each participant's data used for inter-rater and test- retest reliability. The Sexual Knowledge Interview Schedule was also administered to some participants to act as a criterion for the SAKA. Measures used were the QACSO, SAKA, SOSAS, VESA and SKIS. Five different research sites across the South East, South and South West of England served as locations.				
Study 4 Quantitative Study Chapter Eight	2003	2003 – 2010	1. Describe the participants briefly in terms of demographics and victimisation experience using data. 2. Using three of the four main process measures (QACSO, SAKA, SOSAS) assess the effectiveness of the treatment programme for this population. 3. Using MGDB data evaluate the efficacy of the treatment programme on recidivism.	123	SOTSEC-ID including author
Design, Measures and Procedures	The design was an uncontrolled repeated measures design using pre, post and follow-up measures on the QACSO, SAK, SOSAS, and the Men's Group Data Base, as well as mid-programme measures on the QACSO. This was a multi-site study with a large number of participants (123) across fifteen different sites in England and Wales. A range of other measures were taken such as IQ, adaptive behaviour, PCL-R, autism checklist, PASADD, and measures on weekly content in each treatment group. A Treatment Manual, annual training, and 6-8 weekly peer- supervision and support meetings were provided to each over a nine-year period. A contract was agreed with each group and minimum standards set on qualifications and suitability of the lead facilitator for each group.				

[1] With assistance from four several researchers at sites across the South-East, South and South-West of England.

Study 1: Pilot Study

During the initial phase of the study the first five groups were used to assess and select the measures, finalise the content and delivery style of the treatment programme, and to trial consent, assessment and data collection procedures.

These groups were run in both community (2) and secure (3) settings by the author. Experience from these groups and three pilot groups in South London run by Dr Glynis Murphy (see Hays et al., 2007) led to the documentation of the assessment, preparation, planning and actual treatment in a Treatment Manual (Sinclair et al., 2002). The pilot study had been envisaged to include only 1-2 groups, but the research was by necessity conducted in an applied clinical setting as participants in sufficient numbers were only accessible in such settings. Such settings contain considerable clinical pressure to provide treatment, undertake risk assessment and management and provide 'value for money' (especially where the participants were in private rather than NHS settings), and this clinical pressure sometimes over-rode the research requirements for timely data collection for these pilot groups. The data collection for these first few groups was therefore incomplete, and is presented in Chapter Five as a pilot study rather than being included in the main quantitative data set in Chapter Eight.

Study 2: Qualitative Study

The qualitative design included a qualitative interview with a purposive sample of nine participants, use of clinical material from the groups, and a recorded group interview at the last session of the first treatment group. This study was important to undertake because whilst the main part of the overall study has focused on variables that can be quantified, the importance and impact of the programme on individual participants is not completely captured with such data (Charmaz, 2003; Patton, 2002; Todd, Nerlich, & McKeown, 2004). As Albert Einstein stated some time ago: "Not everything that can be counted counts, and not everything that counts can be counted." (quoted in Patton, 2002, p. 12). The quantitative description of reductions in cognitive distortions and increases

in victim empathy and sexual knowledge do not paint a complete picture. An exclusively quantitative approach provides no opportunity for the participants at the heart of sexual offending treatment to contribute their experience and understanding of the treatment and its impact upon them, and their view of themselves and their future. Such an approach is especially important when working with participants who have a learning disability and are already disempowered and devalued by this condition, and have the additional stigma of a sex offender label. To date, we have seen data on participants' views from brief feedback interviews completed from three SOTSEC-ID treatment groups (Hays et al., 2007), and the present study broadens this to another group of participants. Recent articles critical of the risk paradigm as applied to sex offenders have argued for the inclusion of participants perspective and for a focus on strengths and "primary human goods" as a way of providing a more holistic and constructive approach to treatment of sex offenders (Ward & Marshall, 2004). Ward and Marshall's article introduces the "good lives" model and argues that a common and shared narrative needs to be developed in working with sex offenders generally, while Ayland and West (2006) extend this concept to those with a learning disability.

Patton (2002, p. 341) distinguishes qualitative interviewing from quantitative survey methods, by describing it as allowing us to "...enter into the other person's perspective." It assumes that there is a meaningful and knowable perspective to learn about, and that through qualitative interviewing, we gather the stories of participants and users of programmes in a way that quantitative measurements and traditional forced choice questions do not. He describes three types of qualitative open-ended interviews, namely informal conversational interview, general interview guide approach, and the standardized open-ended interview. We have opted for the general interview guide approach, in which topic areas and some textual guidance is provided, as well as a series of prompts for each of the areas the interview should address. The order in which topics are addressed, however, and the style of the interview is semi-structured, that is more conversational than interview, more relaxed than formal. This seemed appropriate to the type of information we were seeking from the participants in this study, since more formal and structured approaches may discourage open disclosure.

Initial attempts to obtain participant feedback consisted of interviews and group discussions with participants at the conclusion of the first groups. Some of these collected by Professor Murphy have already been reported in a number of presentations and in the Department of Health report (Hays et al., 2007; Murphy, Sinclair, Hays, & SOTSEC ID Members, 2007). A systematic attempt was made to develop a participant feedback tool for the end of each group by drawing together some participants from the first few groups and asking their advice on the type and wording of questions that would be helpful to ask participants at the completion of treatment (undertaken primarily by Professor Murphy, Guy Offord and the current author). Some of this information and written notes from early group treatment sessions and the review discussions with participants at the end of the first group were used to identify key themes which need to be explored in the qualitative interview proposed here.

Themes which emerged include:

1. Relevance of previous life experience and previous sexual offending or sexually abusive behaviour,
2. Balance between talking and doing activities in the groups,
3. Difficulty of disclosure within the groups,
4. Presentation of challenging behaviours within the groups,
5. What the men have learnt in the groups,
6. Likelihood of reoffending or sexually abusive behaviour,
7. Suggested changes to the groups.

Published reports of the experience of sex offender treatment by people with intellectual disability are rare, with only the above study by Hays et al. (2007) providing such an insight. There are studies which describe the life experience (Thompson & Brown, 1998) and the offending experience (Courtney et al., 2006) using qualitative approaches from the perspective of the men themselves, but these latter studies do not directly address the experience of actual treatment.

Case studies are well suited to providing the richness, context and user or participant perspective which is otherwise lacking from quantitative approaches. Indeed, given the motto of a number of advocacy groups in intellectual disability, "nothing about us without us" (Patton, 2002, p. 337) it may well be presumptuous to undertake a research project in this area without making a concerted effort to include participants views in a systematic way. Thus in addition to the qualitative interviews, case studies were prepared on two of the participants which combine this qualitative information with information from the quantitative measures and relevant clinical information about the men over a period of several years, and in one case a decade. These provide a richer picture of their personal circumstances in terms of their family, forensic, and clinical history as well as their participation in the treatment programme, their quantitative profile on the formal measures, and their responses to the treatment as captured by the qualitative interview. These are included in Appendix 14 due to limitations of space in the main thesis.

Study 3: Validity and Reliability Study

This study consists of undertaking assessment for the purpose of providing information on reliability and validity of the four core change measures used in the research, namely the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO), the Sexual Attitudes and Knowledge Assessment (SAK), the Sex Offenders Self Appraisal Scale (SOSAS), and the Victim Empathy Scale (VES).

When this research project commenced there were no agreed or accepted measures for evaluating effectiveness of treatment programmes for sex offenders with a learning disability. Indeed, as discussed at the start of this chapter, the lack of agreed and acceptable measures was the first key problem which drew researchers together and provided one of the reasons for SOTSEC-ID's commencement. While this problem has been somewhat addressed since then, primarily through the work of Bill Lindsay and others in regard to the QACSO (Broxholme & Lindsay, 2003; Lindsay, Michie, et al.,

2006; Lindsay, Whitefield, et al., 2007a), the only current agreement in the literature is that there is no agreement about a set of adequate or accepted measures for assessing treatment outcome in men with a learning disability at risk of sexual offending or sexually abusive behavior. Although the QACSO is beginning to emerge as the first measure with acceptable reliability parameters as well as becoming more widespread in use, there is limited information on reliability of other selected measures with this client group (except for Broxholme & Lindsay, 2003; Langdon et al., 2007). Keeling, Beech and Rose (2007) have considered this situation through the Risk, Needs and Responsivity Model (Andrews & Bontna, 2002) and proposed a framework using the four dynamic areas Thornton (2002) argues are potentially responsive to treatment, namely deviant sexual interest, pro-offending attitudes, socio-affective problems, and self-management issues. Their analysis re-affirms the utility of the QACSO and traditional assessments in the area such as intelligence and adaptive behaviour, but also concludes there is a lack of appropriate adapted measures, especially for assessing deviant arousal.

Validity.

Validity refers to whether the assessment measures what it is supposed to measure, that is, whether it is a true or valid measure of the construct in question. For example, the validity of the QACSO refers to whether it is a true or valid measure of cognitive distortions which are supportive of sexual offending.

The validity of three of the four main measures QACSO, SOSAS and VES) can be addressed using existing data from the four measures, or through research which has been recently published. Lindsay, Whitefield and Carson (2007) were able to demonstrate the ability of the QACSO to discriminate between sex offender, non-sex offenders and non-offenders –all with a learning disability- and normal men (non offenders and non learning disabled), thus demonstrating its criterion (predictive) validity (Clark-Carter, 2004). The criterion (concurrent) validity (Clark-Carter, 2004) of the SOSAS can be demonstrated through looking at its correlation with the QACSO as they both measure cognitive distortions supportive of sexual offending. The validity of

the Victim Empathy Scale has been addressed in a recent paper by Keeling, Rose and Beech (2007) which reported a preliminary evaluation of a number of adapted assessments for offenders with special needs including a similar but not identical version of the Victim Empathy Scale to that used in this study. The fourth change measure, The Sexual Attitudes and Knowledge Scale (SAK) does not have this support in the literature and will therefore need the collection of new data to assess. The Sexual Knowledge Interview Schedule (SKIS) was published by Forchuk, Martin, and Griffiths (1995) with good face validity and acceptable reliability estimates. This will be administered to up to thirty participants who will also complete the SAKA, and criterion (concurrent) validity with the SKIS assessed.

Reliability.

Reliability refers to whether the assessment consistently produces the same results on different occasions, for example, whether the SOSAS produces the same results with different raters and at different times. Another aspect of reliability is internal consistency, the extent to which the items go together as a consistent whole, usually measured by Cronbach's Alpha (Clark-Carter, 2004). Internal reliability or consistency (Clark-Carter, 2004) of all four measures can be assessed using existing data on the measures which have already been collected. In addition, recent publications have also provided evidence of internal consistency for the QACSO (Lindsay, Whitefield, et al., 2007a), the VES (Keeling et al., 2007), and the SOSAS and VES, but not the SAK (Langdon et al., 2007). Although there is evidence for inter-rater and test-retest reliability for the QACSO and VES respectively, there are slight instrument differences and sufficient possible variations in administration to warrant ascertaining both test-retest and inter-rater reliabilities of all four change measures used in the current study, and for re-examining the internal consistencies of the measures.

The validity and reliability study thus re-assessed participants who had been through the main research and treatment programme using all four main measures (QACSO, SAK, SOSAS and VES) plus the Sexual Knowledge Interview Scale (SKIS). Participants were

assessed by two raters at the same time for inter-rater reliability, and then again two weeks later for test-retest reliability.

Study 4: Quantitative Study

The quantitative design utilised a repeated measures (pre, during and post) group design, although the difficulties of identifying and not treating control participants while still carrying out assessments on them in busy applied clinical settings was anticipated as a very difficult task. This approach had been suggested by Hanson and Busiere when they recommended "matched longitudinal follow-up designs" (1998, p. 350) for research on mainstream sex offender treatment, and we were able to follow up to a limited extent (6 months), but the project will lay the groundwork for potential future follow-up of these participants. The independent variable was treatment or no treatment, and there were a range of dependent variables, principally the outcome variable of recidivism. There were also a set of process measures presumed to relate to recidivism, namely cognitive distortions, and sexual knowledge and awareness. These measures were designed to detect any changes as a result of the treatment. The SOTSEC-ID study also included a measure of victim empathy, but the victim empathy data is not a part of the current project and will be reported separately. File analysis and questioning of clinicians involved with the participants were used to assess offending or sexually abusive behaviour over the period of the study, as well as to track a wide range of historical, familial and clinical variables previously shown or believed to be associated with risk of sexual offending (for example, see Hanson & Bussiere, 1998). These data were filled in by local researchers using the Mens' Group Data Base I, II & III (see Appendix 3).

Ethics

Background.

Ethical issues regarding the provision of treatment and involvement in research of people with intellectual disabilities sit at the crossroads of three areas which themselves are replete with ethical problems and histories of questionable practice. As the title of

Brown and Thompson's article, *The ethics of research with men who have learning disabilities and abusive sex offenders: a minefield in a vacuum* (1997a) warned, there are many dilemmas, sensitivities, and ambiguities which need to be clarified in undertaking research and obtaining informed consent from participants in this area. Marshall, Anderson, & Fernandez (1999) remind us of psychology's troubled history in the area of changing sexual preference of mainly male homosexual men through aversive behavioural approaches in the 70's and 80's, while Sturmey, Taylor, & Lindsay (2004) point to the fact that offenders in secure settings have been subject to dangerous and even abusive research in the past when they have been involved in research without due process, and they describe the consent process for people with intellectual disabilities as a "difficult area" (p. 344). Arscott, Dagnan & Kroese (1998, 1999) point to the difficulties and possible approaches to obtaining consent for people with intellectual disability participating in treatment (Arscott et al., 1999) and research (Arscott et al., 1998), and more recently Murphy and colleagues have developed guidance for psychologists regarding consent to treatment (British Psychological Society, 2006). Well before the UK Mental Capacity Act (2005) was promulgated, Arscott and her colleagues undertook a study involving 40 participants and proposed an instrument, The Ability to Consent Questionnaire (ACQ) (Arscott et al., 1999), to assist in determining whether individuals had capacity to consent to treatment. Since these publications and the commencement of the current research programme, the Mental Capacity Act 2005 has been introduced. This Act requires the presumption of capacity and specifies four criteria which must be met before deciding a person lacks the capacity to make a decision, namely that they lack:

1. an understanding of the relevant information about the decision to be made,
2. the ability to retain that information in their mind,
3. the ability to use or weigh that information as part of the decision-making process,
4. the ability to communicate their decision (Jones, 2008).

The responsibility for determination of capacity to consent to participation in the current research project and participation in the treatment itself rested initially with the treating teams, and was re-assessed informally at the time of seeking consent from each participant. Those participants in the treatment programme who were deemed to have capacity to consent were asked to sign written consent forms for treatment, and were later approached to give their consent to participate in the research. Although this approach predated the Mental Capacity Act (2005) when the research first commenced, it complied with Common Law, which applied at the time, and as the Mental Capacity Act 2005 is largely a formalisation of existing Common Law in the area (Jones, 2008), it is still consistent with guidance in the Mental Capacity Act and its accompanying Code of Practice (Department for Constitutional Affairs, 2005). The process of obtaining ethical approval from the Multi-Site Research Ethics Committee (then referred to as MREC) and subsequent operational approval from each Local Research Ethics Committee (then referred to as LREC) for each research site was a difficult process, and the ethical approval stage has itself been the subject of discussion (S. Hays, Murphy, & Sinclair, 2003).

Formal Approval

University ethical approval was initially granted by the Tizard Ethics Committee on the 27 January 1999, following which four subsequent applications were made to various Multi-Research Ethics Committees (MREC's) including correspondence and debate with these committees about various aspects of the research proposal (see S. Hays et al., 2003 for further details). The first application to an MREC had been made on the 6 June 2000, and eventual ethical approval was granted after much debate and correspondence by Professor Murphy on 19 February 2003. The process for MREC approval, which was a requirement prior to approaching local research ethics committees and then local services, took over two and a half years or 32 months to finally obtain, and the project which eventually obtained approval was identical in all major respects to the one initially proposed in June 2000. This was clearly a major setback to the project, and nearly resulted in its premature conclusion. During this period, a new Research Governance Framework was also published and implemented by

the Department of Health in 2001, a second edition published electronically in 2005, and updates made to this edition in September 2008 (Department of Health, 2001a, 2005). The resulting changes in procedure and administration of the research governance framework in the midst of the project added to the difficulties of seeking local approval from local ethics committee at each research site, and operational approval (now referred to as research and development approval) from service providing organisations, whether NHS Trusts or private organisations. After MREC approval had been granted in February 2003, applications then needed to be made to the Local Research Ethics Committee (LREC) for local approval. Applications were made by all researchers affiliated with SOTSEC-ID, including the present author, to their LREC's for local approval, with a full repeat of all information, protocols etc, supplied to the approving MREC. In the present author's case, these were duly approved by the two relevant LREC's on 1 August and 28 November 2003. Once local approval had been given, application was made to the two providers- a National Health Service (NHS) Trust and the other a private organisation. This final stage took 8 months for one provider and 4 months for the other. Extensions of the approval and Honorary contract have been necessary at both organisations.

The ethical and operational approval process described above relates only to the collection of the quantitative data for studies one and four. The process of obtaining ethical approval, operational approval and honorary contracts just for studies two and three is shown in the time line below. It is worth noting that other researchers who are part of the SOTSEC ID group and who contributed to the larger SOTSEC ID data set, also went through similar local research ethics committee and operational approval procedures (though not MREC). Most did not have to go through honorary contract procedures as they carried out the research within their employing organisations. This process and the accompanying dates are shown in detail in Table 7 due to the delaying effect it had on the overall project. Arscott et al. (1998) also advocate the collection of data which address "...how ethical review committees function in relation to research with people with intellectual disabilities..." (p.81), and the following two tables are an

initial attempt to look at one aspect of this- time taken to obtain ethical approval through all the required stages.

Table 7. Ethical Approval Process for Studies One and Four

Purpose	Body	Date applied	Decision	Date	Approval time (days)
Multi-site ethical approval	MREC 1	20.07.00	Rejected	16.08.00	27
Multi-site ethical approval	MREC 2	18.02.02	Rejected	20.02.02	2
Multi-site ethical approval	MREC 3	01.05.02	Rejected	27.09.02	149
Multi-site ethical approval	MREC 4	03.12.02	Approved	19.02.03	78
Current author Area1 local approval	LREC Area 1	20.06.03	Approved	01.08.03	42
Current author Area 2 local approval	LREC Area 2	20.06.03	Approved	28.11.03	162
Current author Area 1 Operational Approval and Honorary Contract	Service Provider R & D Committee	05.09.03	Approved	20.02.04	168
Current author Area 2 Operational Approval	Service Provider R & D Committee	05.09.03	Approved	28.01.04	145

Table 8. Ethical Approval Process for Studies Two and Three

Purpose	Body	Date applied	Decision	Date	Approval time (days)
Amendment Ethical Approval	Original MREC	25.06.07	Approved	16.10.07	113
Operational approval and Honorary Contract	Service Provider 1	15.11.07	Approved	03.12.08	19
Operational approval and Honorary Contract	Service Provider 2	23.10.07	Approved	04.12.07	45
Operational approval and Honorary Contract	Service Provider 3	15.02.08	Approved	01.06.09	470
Operational approval and Honorary Contract	Service Provider 4	15.04.09	Approved	03.07.09	79
Operational approval and Honorary Contract	Service Provider 5	06.01.09	Approved	07.05.09	121
Operational approval and Honorary Contract	Service Provider 6	29.06.09	Approved	18.03.10	263

Subsequent to the major ethical and operational approvals required for the main SOTSEC-ID research project, it was decided to undertake two follow-up studies which gathered qualitative information from some of the participants (Study 2) and looked at the reliability and validity of the measures (Study 3). A notice of substantial amendment application seeking ethical approval for these additional studies was made to the MREC which had granted original ethical approval, and then to each of five service providing organisation for operational (or research and development) approval. As discussed above, research governance arrangements had recently been changed, and there was no requirement to obtain approval from LREC's. This process is shown in Table 8.

It can be seen from the above two tables that the three to four separate processes, namely multi-site Research Ethics Committee approval, Local Research Ethics Committee approval, Operational approval, and where necessary the issuing of an Honorary Contract represent a prohibitive level of delay for most researchers, and is likely to have a restrictive effect on conducting research such as this which raises particular ethical concerns, as previous authors have already identified (Brown & Thompson, 1997a; Hays et al., 2003). It can also be seen from the above tables that the introduction of a new Research Governance Framework (2001 and 2005) does not seem to have improved the situation at all. The process appears to have become overly bureaucratic and removed from the actual issue of whether the participant is supported in similar ways to those suggested by Arscott et al. (1998). Such support would provide a genuine opportunity for the individual to consider their participation in the research project, and so to consent or not as they wish.

Consent Procedures

For all participants the judgement about capacity to consent to participate in the treatment programme, and capacity to participate in the research programme as either a

treatment participant or a control participant in any of the four studies was made by local clinicians who knew the person. Once this judgement was made by local clinicians, participants were taken through the consent process by either a member of the local clinical team or a 'Key Worker' (a staff member specifically allocated by the service to work with the person on a medium to long term basis), or the local researcher, and often both together. In many cases, the local researchers were well known to the participants. Effort was taken to ensure that participants were aware they were not required to participate in the research project in order to continue in the treatment programme, and indeed, there were some who took this option and participated in the treatment programme but chose not to participate in the research programme.

Participants were also aware that they could withdraw their consent to participate from either the treatment or the research at any time. Completion of the consent to participate in the treatment process often occurred prior to consent to participate in the research so that the two issues were not confused by the men, and there was some familiarity with the issues being considered in the consent decision regarding participation in the research. We sometimes found it difficult to convey the issues around consent to treatment at the same time as consent to research, probably because consent to participate in research is more abstract than consent to participate in treatment, making it both more difficult to explain and to understand. Arscott et al. (1998) found that the most poorly answered out of the questions they put to participants to assess their understanding of consent to participate in research was the most abstract one, namely their right to withdraw consent. For participants who were detained under the Mental Health Act (1983 as amended) there may have been some level of compulsion from Tribunals or clinical teams in regard to their treatment, as discharge may have been contingent on attendance or progress in treatment. Slightly different treatment consent forms were provided to these participants that reflected this legal distinction.

There was a full set of separate information sheets and consent forms, written in an easy-read format, approved by the relevant ethics committees described above, to assist in explaining both the treatment and research for studies one and four, with copies for participants as well as their parents or carers if they wished them to be advised. The consent sheet made clear the right of access to treatment not being contingent on participation in the research, the right to withdraw from either just the research, or both the treatment and the research, and the right to withdraw their consent for the full length of both the treatment and the research. These items can be found in Appendices eight and nine. Likewise, there was a further complete set of information sheets and consent forms in easy read format for Studies two and three, again with copies for parents and carers if the participant wished them to be advised or involved. These set out the aims of both the validity and reliability study and the qualitative study. These items can be found in Appendices ten and eleven, and on the SOTSEC-ID website. In practice, the information sheet and consent forms were usually discussed with a potential participant by the researcher or a member of the participants' clinical team or a key worker.

The principles which were followed in these discussions were firstly to ensure that as far as possible conditions were created to enable the person to refuse consent if they wished (familiar staff advocacy and support), secondly that their right to refuse was clearly understood by the person and those around them, thirdly that the information about the research was accurately and clearly presented (the person presenting understood research in general and this particular project), and finally that account was able to be taken of the person's understanding of the information sheet and research in the way it was presented and that the person was 'led through' the consent process in a respectful and helpful manner.

Confidentiality Limits

The issue of confidentiality and its limits in both the treatment and the research were clarified during the consent procedure, and again over the first few weeks of the treatment programme or within the group whenever a breach or near-breach occurred. This issue was explicitly dealt with in the Treatment Manual. Following one of the qualitative interviews, there was a disclosure of a previously unreported (albeit very old) offence, and this was reported to the Police with the participant's knowledge. This provides a good example of the limits which were adhered to in both the treatment and the research, namely that confidential information shared within the treatment or the research would be kept confidential provided that there was no disclosure of new offences, or disclosure which led clinicians providing the treatment or researchers to believe that someone, including the person themselves, may be at risk of harm. In some settings such as secure hospitals, there are existing protocols regarding disclosure of clinical information between team members and these were also clarified with participants in the treatment programme. The expectation of confidentiality between the participants in the treatment programme was also created within the group by teaching the meaning of 'What is said here stays here', and having that as part of the rules set at the start of the treatment group, subject to the above limitations. The exceptions to this rule described above- new offence disclosures or risk of harm- were also reiterated. However, we were also clear that while we could reasonably guarantee confidentiality within the limits identified above by the facilitators, confidentiality of other group members can only be requested on a mutual basis and the only available sanction is group exclusion, which was counterproductive for all as it excluded the men from treatment. This was particularly important in the initial weeks when the group was settling in. One of the ways in which this dynamic was maintained as the group developed was by endeavouring to keep the level of disclosure equivalent across group members so that there was an equal level of 'vulnerability to disclosure' by all

participants. These broad limits of confidentiality are common to mainstream sex offender treatment groups, for example, Beckett et al. (1994). Guidance was provided to local researchers and facilitators in the Treatment Manual on the duty to report as this is not always entirely clear, and depends to some extent on the severity of the offence, length of time since the offence occurred, the likelihood that it has already been reported previously, and the potential difficulty of being specific about matters such as the victim identity, time, location etc.

Risk Assessment and Management

Given the risky nature of the men's behaviour and the reason for the treatment programmes it was clearly important to have the issue of risk assessment and risk management of the men's sexually risky behaviour addressed prior to their commencement in the treatment and research programme. The guidance given in the Treatment Manual and in the training was that risk assessment and management was the primary responsibility of the service in which the client is residing, in conjunction with the community team working with a client, and in particular, the professional making the referral of the client to the treatment programme. In common with other areas which this research project addresses there has been significant improvement and developments in the whole area of risk assessment and management in general and in the area of sexual offending in particular. Guidance given in the Treatment Manual included a listing of some of the key variables that were relevant for an adequate risk assessment, and suggestions made for how the participant can be managed in terms of the risks he poses to the community in general, and as a result of attendance at the treatment group. The impact the treatment programme had on participants' risk levels was discussed in the Treatment Manual and during SOTSEC-ID meetings, including its unpredictable variability during the programme. This area was addressed through maintaining communication between group facilitators and community teams and care

workers who had primary responsibility for the participants in residential and community settings. It was made clear that any judgments made by group facilitators that risk had increased should be communicated as a matter of urgency, similarly, a dialogue should be established with staff members of services as well as local CLDT so that any judgments about increased risk which are made by these individuals were passed on to facilitators. A risk assessment and management protocol (Knox & Sinclair, 2004) was also made available as an appendix to the Treatment Manual. Given the type and degree of risk the men posed in terms of sexual offending or sexually abusive behaviour, it was also important that the location of the treatment group and any concomitant risks such as co-located children's activities, vulnerable individuals on transport used by the participants, etc., were considered carefully by facilitators or the participants services before regular attendance at the treatment programme became established. Thus, consideration needed to be given to escorting arrangements, vulnerabilities within the group from one participant to another and, finally, that there was a sharing of risk management plans between facilitators, services and other professional staff involved in the participants' care programmes.

The risk of participants becoming distressed during the treatment process was addressed through the way in which the treatment programme developed a pro-social and positive therapeutic engagement with the men and a positive therapeutic culture within the group. Good communication also ensured that when necessary and with the participant's consent such information could be conveyed to services so that appropriate support was provided to the participants.

Participants

Participants used in this study are for some parts of the study coincident with and for other parts a subset of the SOTSEC-ID participants (this will be further explained for

each of the studies in Chapters Five, Six, Seven and Eight). In both cases the participants are drawn from a clinical population of individuals referred for or in receipt of services related to their sexual offending or sexually abusive behaviour. Participants living in the community with various levels of support were usually recruited to the study through a member of their local Community Learning Disability Teams (CLDT's), and patients in low and medium secure hospitals were usually recruited through a member of their clinical team. In both situations they were referred for treatment for sexual offending or sexually abusive behaviour by referral to the CLDT or admission to a low or medium secure hospital. Typically, the professional at either the hospital or the CLDT tasked with the responsibility of providing suitable treatment (often a Clinical Psychologist) would approach SOTSEC-ID and enquire about suitable treatment. The referral process often started with one or two referrals due to sexual offending incidents in their catchment area, and quickly grew as other referrals followed –often with concerns about risk management. Often sufficient numbers for a group would develop as plans for a service response developed. Sometimes a nearby group was available, but usually the clinician opted to set up a SOTSEC-ID group. Support was provided via membership of SOTSEC-ID, attendance at 6-8 weekly meetings with others who had provided treatment previously and/or were doing so currently, access to the Treatment Manual, and an annual two-day training event based on the manual, as well as email and telephone access and support from SOTSEC-ID members.

Participants were eligible for inclusion in the study if they met the criteria set out below. They were still eligible for the treatment (and the professional still eligible for membership of SOTSEC-ID) even if they did not consent to be a research participant. The treatment manual stated that participants should:

1. Be associated with intellectual disability services, whatever their IQ, and must have a Full Scale IQ between 55 and 80. Where there is a large

discrepancy between Verbal and Performance IQ scores, Verbal IQ should be taken as the main guide to suitability for inclusion in the group[1].

2. Be aged between 18 and 60 years, with each group having a maximum age range of 30 years.
3. Have a history of sexually abusive behaviour. Sexually abusive behaviour refers to any sexually related behaviour for which the other person was non-consenting and the behaviour would be defined as illegal within the jurisdiction in which it occurred, as per the definition in Chapter Two.
4. Be in a stable residential placement (i.e. not homeless).
5. Be suitable for cognitive therapy and for working in a group, as determined through communication proficiency in the assessment process, performance in any previous groups and formal assessment results, especially the WAIS III and BPVS[2].
6. Absence of behaviours that may be disruptive in the group setting. and

Referrals were not eligible for inclusion as participants if they were detained in conditions of maximum security, on the basis that the needs of such men were likely to be quite different to those in the community and/or those detained in low and medium security levels, or if they had active symptoms of severe mental illness (though mental illness alone –e.g. mild depression-was not a criteria for exclusion). Participants were excluded from treatment and the research if they missed more than 40% of the overall

---

[1] The upper limit of 80 for IQ was accepted as the upper cut-off, provided the men were already in receipt of intellectual disability services and would otherwise be excluded from the treatment, as most Prison and Probation treatment programmes have a minimum cut-off full scale IQ of 80.

[2] An age equivalent of 5-6 years had been adopted by SOTSEC-ID in 2002 based on Professor Murphy's recommendation. Subsequently, empirical support was found for an age-equivalent of 7 years or above (Joyce, Globe & Moody, 2006).

treatment content, experienced a significant deterioration in mental state, or presented with violent, intimidating or seriously disruptive behaviour in the group. A three-warning system was in place to manage disruptive behaviour, which is discussed in more detail in the treatment manual (Sinclair et al., 2002).

Participants were not excluded for:

- Incompatibility of offences. There are good grounds for mixing offence types within a group to minimise collusion and to increase the likelihood participants will challenge each other's cognitive distortions (Salter, 1988; Marshall 1999).
- Being legally restricted, for example under sections of the Mental Health Act, or on probation, or a Court Order; nor for the absence of legal compulsion (some sex offender treatment programmes require legal compulsion)
- A diagnosis of mental illness.

Participants will be described in detail in the following chapters, but some key features of participants in each study are described in Table 9 below.

Table 9 . Features of Participants in Each of the Four Studies

Study	N	Age	IQ	BPVS Age Equiv (months)
1. Pilot Study	14	31	60.4	102.7
2. Qualitative study	9	30.6	64.3	132.0
3. Validity and reliability study	29	36.8	65.2	127.2
4. Quantitative study	121	35.8 (18-67)	65.8 (52-83)	131.2

Measures

There were a range of measures which were used in the four studies and these are described here if they were used in more than one study. The procedure that was followed in each study, as well as any study-specific measures, will be described in the procedure and measures section of the relevant chapter.

Initial or Screening Variables and Measures.

Variables of interest across one or more of the studies and the measures used to assess them are described below in several groups. The first group in Table 10 are the initial or screening variables such as measures for Intelligence, Adaptive Behaviour, Receptive Language, Mental Health, Autism and Psychopathy. Intelligence was measured using the Wechsler Adult Intelligence Scale-Third Edition (WAIS III) (Wechsler, 1997), adaptive behaviour was measured using the Vineland Scales of Adaptive Behaviour (Vineland) (Sparrow et al., 1984), receptive language was assessed using the British Picture Vocabulary Scale-Second Edition (BPVS-II) (Dunn, Dunn, Whetton, & Burley, 1997), the presence of a mental illness diagnosis was assessed using the Psychiatric Assessment for Adults with a Developmental Disability (Mini PAS-ADD)(Moss et al., 1998), the presence of an Autistic Spectrum Disorder was assessed using the Autism Checklist (Howlin, 1997), and the presence of a Psychopathic Personality Disorder was assessed using the Psychopathy Check List- Revised (PCL-R) (Hare, 1990).

Table 10. Initial or Screening Variables and Measures

Variable	Measure
Intelligence	Wechsler Adult Intelligence Scale-Third Edition (WAIS-III) (Wechsler, 1997)
Adaptive Behaviour	Vineland Scales of Adaptive Behaviour (Vineland) (Sparrow, Balla & Cicchetti, 1984)
Receptive Language	British Picture Vocabulary Scale-II (BPVS-II) (Dunn, Dunn, Whetton & Burley, 1997)
Presence of a mental illness diagnosis	Psychiatric Assessment for Adults with a Developmental Disability (Mini PAS-ADD) (Prosser, Moss, Costello, Simpson & Patel, 1997)
Presence of an Autism Spectrum Disorder	Autism Check List (Operationalises DSM IV criteria for autism) (Howlin, 1997). (Resource constraints did not permit use of more rigorous assessments such as the DISCO, ADI-R, or ADOS-G (Filipek et al., 1999)
Psychopathy	Psychopathy Check List-Revised (PCL-R) ((Hare, 2003)

Most of these measures need no explanation or rationale for their utilization as a measure of their respective variable as in each case they are either the most widely used (WAIS III, BPVS-II, PCL-R) or one of the most widely used (e.g. Vineland, Mini PAS-ADD) measure of the relevant variable. They also have well established and acceptable estimates of their validity and reliability. The Autism Checklist is a notable exception to this claim, and this measure indeed posed difficulties in terms of its construct validity, and reliability. There is, however, no universally accepted diagnostic measure for Autistic Spectrum Disorder (Filipek et al., 1999; Lord & Corsello, 2005), nor indeed is

there a full consensus about the diagnosis of either Autism, Aspergers Syndrome, or Autistic Spectrum Disorder (DSM - IV – TR) (American Psychiatric Association, 2000) (Filipek et al., 1999), so the difficulty experienced in assessing this variable is partly a reflection of the wider state of development of definition and diagnosis in this area, as well as a resource issue as mentioned in Table 10.

As well as utilising these measures to confirm that inclusion criteria for the research were met for each participant referred to the programme, they served other purposes. The measures of intelligence and adaptive behaviour confirmed the level of intellectual disability, and allowed correlational comparisons to be made between IQ and adaptive behaviour on the one hand, and process measures such as sexual attitudes and knowledge, cognitive distortions and victim empathy, as well as the outcome measure of recidivism on the other. Receptive language as measured by the British Picture Vocabulary Scale provided an indicator for likely effectiveness of cognitive behavioural therapy (Joyce et al., 2006), and therefore the overall treatment programme, as do measures for mental illness and Autistic Spectrum Disorder. A measure of psychopathy was needed because there has been much debate about the issue of psychopathy and sex offender treatment, with some researchers arguing that offenders with high psychopathy scores should not be included in sexual offender treatment programmes as it makes them more effective offenders by enhancing their interpersonal and grooming skills (Seto & Barbaree, 1999). Although more recent research has cast doubt on this earlier finding (Barbaree et al., 2006), it is arguable that the term Psychopathic Personality Disorder or Antisocial Personality Disorder (DSM-IV-TR) is actually a term for a relatively heterogeneous group with different aetiologies and treatment needs (Blair, Mitchell, & Blair, 2005). Being able to examine levels of psychopathy in comparison to previous offending as well as process and outcome variables for a relatively new population seemed desirable in this context.

Dependent variables and measures.

The second group of variables are dependent variables and measures. Dependent variables are those that are hypothesised to be responsive to the independent variable, that is, the presence or absence of the treatment programme. These can be divided into two groups, namely outcome and process or proxy variables. The outcome of interest is the effect of the treatment programme on offending recidivism in general, and sexual offending (or sexually abusive behaviour) recidivism in particular, and this is therefore the key outcome variable. However, measuring recidivism should ideally be undertaken over a longer time span than in the current study (for which there was only a 6-month follow-up) given the relatively low rate of occurrence of offending behaviour. So while data on the outcome variable is collected, proxy or process measures are also utilised as they are believed to mediate between the treatment programme (independent variable) and offending recidivism (outcome variable). In the present case, the process variables utilised are sexual attitudes and knowledge, cognitive distortions related to sexual offending, and victim empathy. These are all presumed to mediate between treatment and the reduction of recidivism and are shown below in Table 11 along with their measures.

Table 11 . Outcome Variables and Measures

Variable	Measures
Recidivism: during treatment	Section 2 of the *Men's Group Background Information and Data Base Schedule, Phase 2* (MGDBS II) (Murphy, Booth, & Sinclair, 2003) has 1 question about non-sexual offending (number and type of convictions), and 17 questions about sexual offending or sexually abusive behaviour during the period of the treatment. The 17 questions about sexual offending or sexually abusive behaviour address number and type of sexual offending or sexually abusive behaviour, details of the victim, response by the Police and Court disposal, social outcome of the incident, and details about the perpetrator such as marital/partner status, residence and use of substances.
Recidivism: post-treatment	Section 2 of the *Men's Group Background Information and Data Base Schedule, Phase 3* (MGDBS III) (Murphy et al., 2003) has 1 question about non-sexual offending or sexually abusive behaviour (number and type of convictions), and 17 questions about sexual offending or sexually abusive behaviour during the period of the treatment. The 17 questions about sexual offending or sexually abusive behaviour address number and type of sexual offending or sexually abusive behaviour, details of the victim, response by the Police and Court disposal, social outcome of the incident and details about the perpetrator such as marital/partner status, residence and use of substances.

Table 12 . Process or Proxy Variables and Measures

Variable	Measures
Sexual Knowledge	Sexual Attitudes and Knowledge (SAK)(Heighway & Webster, 2007)
Distorted Cognitions	Questionnaire on Attitudes Consistent with Sex Offences (QASCO) (Lindsay, Michie, et al., 2006) Sexual Offenders Self Appraisal Scale (SOSAS) (Bray & Forshaw, 1996)
Victim Empathy	Victim Empathy Scale-Adapted Scale (Beckett & Fisher, 1994) (see footnote previous page)

Men's Group Background Information and Data Base Schedule.

The principle outcome variable of interest was repeat offending or sexually abusive behaviour during or after treatment. The measure used to collect this data was an instrument called the *Men's Group Background Information and Data Base Schedule* (see Appendix 3). This measure had three versions, one for the period prior to the treatment commencing (Phase One), one for the period of the treatment (Phase Two), and one for the follow-up period 6 months after the group was finished (Phase Three). These measures were developed by the SOTSEC-ID group, initially as a concept proposal by Samantha Jones and Neil Sinclair using the list of variables from Hanson and Busiere (1997), and then in detail principally by Professor Murphy and Sarah Jane Booth, in collaboration with Neil Sinclair. The measures were finalised after the first

Treatment Manual was distributed in 2002. The three phases of this measure collected a wide range of historical and background information on the participants including any reports of or convictions for repeated sexual offending or sexually abusive behaviour.

Phase One is the most detailed, with section one asking information about the participant's demographics and current situation including the presence and nature of concurrent therapy for sexual offending or sexually abusive behaviour, security and escort levels, and medication; sections two, three and four asking information about family, educational and medical background respectively; section five addressing sexual history; section six addressing history of sexual victimisation; section seven addressing the index sexually abusive incident; and section eight addressing the history of other sexually abusive incidents perpetrated by the participant. Questions were also included which asked for information on previous non-sexual convictions as either a child or an adult (section four). Phases Two and Three had only two sections. The first section repeated section one of Phase One for identifying information (identifier, date of birth, group etc.) and all questions where there may have been a change such as the presence and nature of concurrent therapy, security and escort levels, and medication. Section two asked for information on new sexually abusive incidents. This was the recidivism measure for the twelve month period of the treatment group for Phase Two, and the six month follow-up period after the conclusion of the group for Phase Three.

Information sources for all phases of the MGDBS, particularly phase one, were clinical files, reports, and sometimes the men themselves or a member of their clinical team via interview. The requirement for this measure was to obtain as accurate information as possible using a variety of sources, in a similar way to the requirement for the Psychopathy Check List- Revised (Hare, 2003). Clinical teams always remained in touch with the men in view of the risk they usually posed, but were busy, so it was often a matter of simple persistence in pursuing the relevant information.

The information was often difficult to obtain, and there was much missing information, especially in relation to childhood. This was no doubt sometimes a reflection on fragmented and incomplete record keeping. There were no reliability checks on the information provided, but respondents (often Clinical Psychologists in Community Learning Disability Teams or secure settings) were usually very familiar with the participant's background, had full access to their files, and were encouraged to leave questions blank if they were unsure of the information. A copy of all three phases of the *Men's Group Background Information and Data Base Schedule* can be found in Appendix 3, as although the measures were more a part of the wider SOTSEC-ID project than the present study, and were not primarily developed by the present author, they are not published elsewhere and are important to the present study as a measure.

Sexual Attitudes and Knowledge Assessment (SAKA).

Sexual attitudes and knowledge were measured using the *Sexual Attitudes and Knowledge Assessment* (SAKA), (Heighway & Webster, 2007). This is a nineteen item questionnaire which has a line drawing corresponding to each item. Participants were shown the line drawing and then asked a question about the situation depicted. Situations included masturbation, dating, domestic and work situations, and male and female bodies. They depict neutral, abusive and potentially abusive situations which were further clarified by the information provided in the questions. For example, question twelve shows the line drawing reproduced below in Figure 9, and asks the participant: *"John sees a new woman at his job. He wants to be friends with her. What could he do?"* The participant's answer is then rated for its social appropriateness as either '1' or '0' when '1' is socially appropriate, and '0' is not. Most questions are '1' or '0', with question three having a score out of three, and question nineteen (on body part names) having a score out of twenty-four. This assessment produces four subscale

scores, namely Understanding Relationships (four items), Social Interaction (three items), Sexual Awareness (seven items), and Assertiveness (eight items), as well as a total score. Psychometric properties are unknown, despite a second edition of the assessment being published (Heighway & Webster, 2007), and were addressed in study three on validity and reliability in Chapter Seven. A copy of the SAKA is in Appendix 5, and is available on the SOTSEC-ID website.

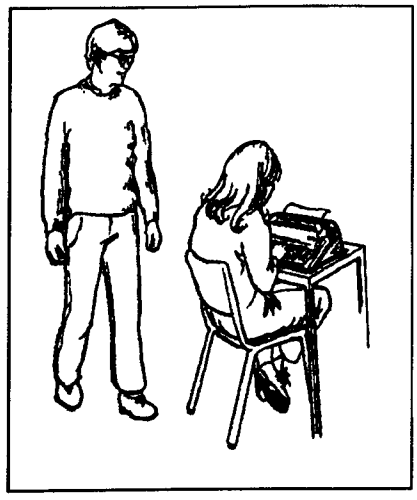


Figure 9. Line drawing from Q.12 of the SAKA

Questionnaire on Attitudes Consistent with Sexual Offending (QACSO).

The Questionnaire on Attitudes Consistent with Sexual Offending (QACSO) (Jan 2000 Version) , is a 106 item questionnaire with 79 'a' items and 29 'b' items, of which only the 79 'a' items were used in this study on the main author's advice to Professor Murphy (Lindsay, personal communication, May 2003). The scale was developed by Lindsay following a review of existing scales in mainstream sex offending, and after piloting early versions on men with an intellectual disability and a history of offending or sexually abusive behaviour. The scale was first published as a Conference abstract in

2000 (Lindsay et al., 2000). The scale's development was described along with data on its ability to successfully discriminate a group of men with intellectual disability and sexual offending behaviour (n = 17) from two groups of men, one with intellectual disability and no sexual offending behaviour (n = 19) and one group who had no intellectual disability and had not sexually offended (n = 36) (Broxholme & Lindsay, 2003). This publication also reported the exclusion of 29 of the original 92 items on the basis of either failure to discriminate between the three groups identified above (18 items) or for one of several other reasons (low item correlation, understandability, or scoring ambiguity) leading to a scale with 63 items over six subscales. Test retest reliability over a four week period ranged from 0.56 to 0.90 for the sex offenders with an intellectual disability group, and was lower for the other two groups. The revised 63-item scale had sub-scale Cronbach alphas of 0.70 to 0.87, and an overall Cronbach alpha of 0.95. Lindsay reports that he originally developed the items around three themes, namely intent, responsibility (with subthemes of personal and other responsibility) and victim awareness (Broxholme & Lindsay, 2003). As reported in this publication, the QACSO consisted of six subscales, and each of the subscales had a mix of what Lindsay called 'a' and 'b' items, although as reported above his advice was to use only the 'a' items, presumably because initial analysis of results suggested these were more robust.

Clarity over the overall number of items and subscales in the QACSO, and the purpose of the 'a' and 'b' items, does not seem clear, partly due to conflicting information in different publications. In the first major publication on the scale reviewed above (Broxholme & Lindsay, 2003), the QACSO is said to have been developed from an unpublished scale comprising 92 items divided into six subscales (the stalking subscale is missing), whereas a later publication (Lindsay, Whitefield, et al., 2007a) reports that the QACSO was originally 108 items and comprised seven different areas including stalking. In between these two publications there was a report of two studies in one publication which used a different form in each study (Lindsay, Michie, et al., 2006),

and a report of the overall number of items being 107 (p. 49). Against this background, the QACSO kindly supplied to SOTSEC-ID (and therefore this current research project) by Professor Lindsay comprised 79 'a' items over 7 scales (including stalking) and 29 'b' items, making a total of 108. The issue is somewhat confusing because there are now several versions of the QACSO in use, and the reliability and validity figures are of course specific to the form on which they were developed.

Table 13 attempts to clarify this situation by showing the presumed structure of the QACSO for each study including the SOTSEC ID study. It seems likely that the first version discussed in a publication (Broxholme & Lindsay, 2003) consisted of a total of 92 items over 6 subscales , and that following a thorough analysis and pruning of 29 of these items due to lack of discrimination or other item problems as discussed above, these 29 items became the 'b' items. In the 2006 publication (Lindsay, Michie, et al., 2006) the total number of items seems to have been mistakenly reported as 107 (when it should have been 108), and for some reason the old version of the scale including the 29 'b'items, which had been discarded in Broxholme and Lindsay, were used in the first study, and a new version (presumably the same as the reduced-item version from Broxholme and Lindsay but this is not clear) with a stalking subscale used in the second study. The 2007 publication (Lindsay, Whitefield, et al., 2007a) started again with the original 108 items (the original 92 which Broxholme and Lindsay started with, plus 16 items in the stalking subscale) and submitted this to further analysis including internal consistency of the subscales, inter-rater reliability, and the ability of individual items to discriminate between men with an intellectual disability who had sex offending, non sex offending, and non-offending backgrounds. This resulted in a further version of the QACSO which had 58 items over seven subscales. As can be seen from the table, the version used in this project and the SOTSEC-ID project contained 79 'a' items and 29

'b' items, although researchers were instructed to only complete the 'a' items, and only the 'a' items were included in the analysis.

There is some clarity about the process of 'winnowing' the items in the QACSO provided in Lindsay's latest substantial contribution to the field (Lindsay, 2009), and this addresses some of the concerns raised here. There is no doubt that the QACSO has been an enormous contribution to work in this area, and the QACSO is by far the most common assessment of cognitions related to sex offending for people with intellectual disability in current use in the UK, and probably elsewhere. Partly because of this importance, it would be helpful to be clearer about the different versions, the selection of items both initially and subsequently, and which versions of the instrument the different published reliability and validity parameters relate to. As this study remained with an older version of the QACSO, it is to be hoped that Lindsay's development of the QACSO has simply 'moved on', and that these questions are easily addressed with the latest version he is providing.

Table 13. Different Versions of the QACSO

Structure of Different Versions of the QACSO						
Broxholme and Lindsay, 2003 (items removed from each subscale because called 'b' items)				Lindsay, Michie, Whitefield, Grieve & Carson, 2006 (study 1/2)		
Subscales	'a' items	'b' items	Total	'a' items	'b' items	Total
Rape	16	10	26	16/16	10/10	26/26
Voyeurism	5	8	13	5/5	8/8	13/13
Exhibitionism	10	3	13	10/10	3/3	13/13
Dating abuse	8	2	10	8/8	2/2	10/10
Homosexual assault	9	3	12	9/9	3/3	12/12
Children	15	3	18	15/15	3/3	18/18
Stalking	-	-	-	-/16	Nil	-/16
Total	63	29	92	63/79	29/29	92/108
Lindsay, Whitefield & Carson, 2007. Further reduction of items. 'b' items dispensed with ?				Current study and SOTSEC-ID- called Lindsay, 2000. Only 'a' items used.		
Subscales	Initial items	Final items		'a' items	'b' items	Total
Rape	26	11		16	10	26
Voyeurism	13	8		5	8	13
Exhibitionism	13	5		10	3	13
Dating abuse	10	8		8	2	10
Homosexual assault	12	4		9	3	12
Children	18	12		15	3	18
Stalking	16	10		16	-	16
Total	108	58		79	29	108

For the current use of the QACSO in this project, each of the 77 'a' items were read out loud to participants, and they were asked to respond to each of the statements. Responses were scored as '0' for a socialised response, '1' for a response of "don't know", and 2 for any indication of an unsocialised response. Examples of the items are: *Is it only women who wear tight clothes that can be raped?* and *Do men rape women to gain power over them?* for the Rape and Attitudes to Women subscale; *Do women laugh about being flashed at?* and *Do men flash to scare women?* for the Exhibitionism subscale; *If a man does not try to fight his way out of a rape does he want to have sex?* and *Is it okay for men to have sex together*? for the Homosexual Assault subscale. Higher scores are indicative of higher levels of cognitive distortions and lower scores are indicative of low levels of cognitive distortions. Data on the psychometric properties of the QACSO has been presented in Broxholme and Lindsay (2003), Lindsay et al. (2006), and (Lindsay, Whitefield, et al., 2007a), although there are differences in the scales as discussed above, and scoring (scores were converted to 0 or 1 rather than 2,1 or 0 as described in the QACSO and as used here). A copy of the QACSO version used in this project can be found in Appendix 4, and is available on the SOTSEC-ID website.

Sex Offenders Self-Appraisal Scale (SOSAS).

Cognitive distortions supportive of sexual offending or sexually abusive behaviour were also assessed using the Sex Offenders Self-Appraisal Scale (SOSAS). This is a twenty item test in which each item is rated on a five-point scale, namely: disagree a lot, disagree a bit, in between, agree a bit, agree a lot. Each item consists of a statement in relation to the index offence or the victim. Four subscale scores are produced by the SOSAS. These are Denial, Victim Blame, Minimisation, and Realism (called Real by the original authors, but changed here for clarity). Each subscale has five items with the exception of Realism which only has four. The Denial subscale refers to distortions in relation to denial of the offence, the Victim Blame Subscale refers to distortions relating

to blaming the victim, the Minimisation Subscale refers to distortions which minimise the impact of the offence, and the Real Subscale assesses cognitive distortions related to the reality appraisal of the offender in terms of their likely risk, the nature of sexual offending, or sexually abusive behaviour and its legality.

In addition to reading out each of the twenty SOSAS statements, assessors were provided instructions to print out five cards with pictures of thumbs on them indicating two thumbs up for agree a lot, one thumb up for agree a bit, a horizontal thumb for in between, one thumb down for disagree a bit, and two thumbs down for disagree a lot. Clinicians administering the SOSAS were instructed to enlarge the font of the SOSAS to an appropriate size and cut and stick the statements onto a card, make up five boxes with the five pictures of thumbs on them (described below) to indicate their response to each item and then to work through the SOSAS question by question. The five boxes were for 'posting' the statements in, and consisted of pictures of: two thumbs for agree a lot, one thumb for agree a bit, a horizontal thumb for in between, one thumb down for disagree a bit, and two thumbs down for disagree a lot. There were four practice items which were used to ensure that the respondent understood the process and then the twenty statement cards were shuffled and respondents posted each card into a box depending on the degree of agreement or disagreement with the statement on it. In practice, however, this turned out to be a clumsy and difficult way to administer the SOSAS, not least because most participants were unable to read the statements and they had to be read by the clinician administering the assessment.

There are no published figures for reliability or validity on this instrument and there were problems in administering it and using the five-point scale as most respondents had difficulty making the distinction between agree a bit and agree a lot, and between disagree a bit and disagree a lot. A number of researchers did not use these aids as they found them unhelpful in the process of clarifying the scale to participants.

Some examples of the items include *Item 3:* I do not need help for my sexual behaviour, *Item 11:* He or she has got over it, and *Item 19:* I enjoyed having power over him or her. High scores on the SOSAS are consistent with high levels of cognitive distortion and lower levels are consistent with lower levels of cognitive distortion. A copy of the SOSAS is available in Appendix 6, and is available on the SOTSEC-ID website.

Conclusion

This chapter overviewed the four studies and their relationship to each other and the wider SOTSEC project, and described common elements of their methodology. The considerable difficulties and time delays obtaining ethical and operational approval experienced were described. These were largely due to problems with ethical approval governance and the administrative procedures and details surrounding them, and perhaps also due to the obviously sensitive nature of the research topic. Other aspects of ethics as they relate to the study were discussed, and common measures were discussed, in particular the QACSO and some issues relating to which versions the published reliability and validity parameters relate to. Chapter Five will present the pilot study from the first five groups, Chapter Six will describe the qualitative study using IPA, Chapter Seven will present the results of the reliability and validity study, and Chapter Eight will present the quantitative results from the overall SOTSEC-ID project. Case studies of two of the participants in the treatment programme, which illustrate both a qualitative and quantitative approach to addressing the question of treatment effectiveness, are to be found in Appendix 14 for space reasons. Each case study describes the participant's life leading up to the index offending, their involvement in the treatment, applies the IPA framework developed and described in Chapter Six to clinical notes from their treatment, presents each participant's relapse prevention plan, and summarizes the quantitative results of the assessments administered over the course of the treatment.

CHAPTER FIVE. STUDY1: PILOT STUDY

Introduction

Chapter four describes the 'Measures Group' which had by 1997 met for some time to reach agreement on appropriate measures, and also described how selection of appropriate measures became the early focus for the group convened by Dr Glynis Murphy and the present author which led to the formation of SOTSEC-ID. This reflected the state of development in the field at the time in 1999, that there was a lack of appropriate, agreed measures for assessing relevant variables in men with an intellectual disability at risk of sexual offending or sexually abusive behaviour, and a lack of published articles addressing this issue. This is still largely true, as discussed previously (Sturmey et al., 2004), although there is now a developing consensus and growing evidence for the QACSO as a measure of cognitive distortions (Lindsay, Michie, et al., 2006), and examination of psychometric properties (Keeling et al., 2007; Kolton et al., 2001) and clinical suitability (Craig et al., 2006; Keeling et al., 2007) of both mainstream and adapted instruments with this population.

The selection of appropriate measure from those that were available and the development of a written treatment protocol and guidance for both the research and treatment sides of the project were therefore the principal tasks of the pilot study. A related goal was to accrue practical experience in the task of recruiting referrals, setting up treatment groups, and developing a supportive infrastructure around such groups so that there was a source of practical and documentary guidance for future group facilitators in the project. Explicit hypotheses for this study were not really developed at the time, but the implicit null hypothesis was that no new measures, no new treatment approaches and no new practical experience or written guidance were necessary for this group, and that extant measures, treatment procedures and 'clinical wisdom' and practical guidance already readily available in the mainstream literature (Barbaree et al.,

1993; Greer & Stuart, 1983; Laws, 1989; Marshall et al., 1990) could be used without modification.

The mainstream sex offending literature, reviewed previously in chapter one, (e.g. Beckett et al., 1994; Beech et al., 1998; Marshall et al., 1990; Pithers, Marques, Gibat & Marlatt, 1983; Ward, 1997) was examined for possible measures and extant treatment approaches for sex offenders in the general population. Similarly, the limited published material on assessing and treating intellectually disabled sex offenders previously reviewed in chapter three (e.g. Clare, 1993; Day, 1988, 1994; Lindsay, Marshall, et al., 1998; Lindsay, Neilson, Morrison, et al., 1997; Lindsay, Olley, et al., 1998; Murphy et al., 1983; O'Connor, 1996, 1997) was also examined for measures and treatment approaches.

The pilot study reported here consisted of five treatment groups, conducted in community and secure settings in the South East between August 1999 and January 2004, a period of nearly four and a half years.
Table 14. Treatment Groups Comprising the Pilot Stud below shows each of the groups, the setting, the number of treatment and research participants, and the start and finish dates. Each treatment group consisted of a two-hour session, once per week for a year. Although it is not reported here in any detail, 'graduates' from the treatment groups in both community and secure settings who were thought not to need additional intensive treatment were offered fortnightly or monthly one-hour groups which sought to maintain treatment gains over time.

This chapter will review the ethics for this section of the research, describe the method followed (Participants, Measures, Procedure), present the results and discuss the implications.

Table 14. Treatment Groups Comprising the Pilot Study

Group Setting Number	Number of Treatment Participants	Number of Research Participants[1]	Start and Finish Dates
Community 1	8	7	Aug 99 to Aug 00
Community 2	5	5	Aug 01 to Aug 02
Secure 1	5	3	Oct 01 to Oct 02
Secure 2	5	3	Jan 03 to Jan 04
Secure 3	5	3	May 02 to Nov 03[2]

1. Not all treatment participants consented to being part of the research programme.

2. This group had a 4 month break as it was a combination of two separate groups which both had to be disbanded- see Participants section for further details.

Ethics

The first five treatment groups and the maintenance group were run as ordinary clinical programmes as ethical approval was being applied for concurrently. This provided an opportunity to trial a number of clinical measures, develop the treatment approach and infrastructure support as described above, and administer measures which may provide useful data for the research in future if ethical approval was granted. No data were removed from the clinical programme during this phase, nor were any participants asked to consent to being part of a research programme, although normal treatment consent protocols were followed. The treatment protocol being developed for the research coincided with 'best practice' in terms of assessment and treatment for this

group, so there was no compromise to the treatment being offered at the time. The patchy record of measures which emerged from these first five groups (see below) is evidence itself that clinical pressures and priorities dominated the treatment provision rather than research considerations. The first application for multi-site ethical approval was made on the 20th July 2000 (see Table 7) and was finally granted by the fourth ethical committee to consider the application on the 19th February 2003. At this point the information sheets and consent forms for research participation which had been endorsed by the ethics committee as part of their approval were used to seek the participant's consent to be part of the research study (see Appendix 9). Most men who completed the groups consented, with a higher proportion consenting from the community groups. The data which had been collected on a routine basis as part of treatment were then accessible for the research project. The data consisted of relevant measures administered prior to, at the end of, and as follow up to each treatment group, and records of treatment sessions and an audiotape of a discussion with the participants at the end of the first community group. The pre, post, and follow-up measures for these groups are presented in the results section of this chapter, and the record of treatment sessions and audio-taped discussion were used to inform the qualitative study reported in the next chapter.

Method

Participants

Selection criteria for participation in both the treatment programme and the research were identical and consisted of the conditions outlined previously in chapter four. Briefly, these consisted of having an intellectual disability (could have an IQ

between 70 and 80 provided the person had an association with intellectual disability services), being aged between 18 – 60 years of age, having a history of sexually abusive behaviour, having a home (i.e., not 'living rough'), and being suitable for cognitive therapy and group treatment. Participants were excluded if they were detained in conditions of maximum security or if they had active symptoms of mental illness. They were asked to leave the treatment programme (and therefore the research) if they were seriously disruptive during the programme, or missed more than 40% of the treatment content. This applied to one individual in the first community group (who subsequently was admitted to the secure service and came to be excluded from a further three groups in that setting for the same reason) and three individuals in the first secure group. There was one participant in the pilot study who was aged 65 years, and therefore was outside the criteria, but was included as he was physically healthy and had pressing clinical needs for treatment. As described previously in chapter four, community participants were referred by their Community Learning Disability Team (CLDT) and those in secure hospitals by their clinical teams within the hospital. Informing local teams and sources of referral about the treatment group, helping them identify appropriate individuals on their caseload, and answering questions about the treatment programme were all part of the 'tooling up' process for the treatment programme and ultimately the research as well.

Eighteen referrals were received for the initial community group (Community 1), and eight men were selected who met the criteria and were in need of the treatment. One was excluded after several weeks attendance due to disruptive behaviour, and the remaining seven all completed the programme. Six of these subsequently consented to participating in the research. Of the seven participants who completed the programme, two declined further involvement, one of whom lived alone and one of whom remained within services (and who offended again and joined a subsequent treatment group in an adjacent area), two joined a maintenance group which was offered at the same time as

the second community group (described further below), and three joined the second community treatment group. The second community group (Community 2) commenced after a gap of approximately a year, and two new referrals were added to the three participants from the first group who were deemed to be in need of further treatment. All five participants completed the second community group.

Fourteen referrals were considered for the first secure group (Secure 1), eight of whom were selected, although three of these either declined to consent to participate in treatment (2) or were asked to leave due to disruptive behaviour (1) after three to seven weeks of attendance. The remaining five participants all completed the programme. The second secure group (Secure 2) was made up of four of the five participants from the first group and an additional referral. All five participants completed this group. The third secure group (Secure 3) was a combination of two treatment groups comprising eleven participants in total which both became unviable within three to four months of commencing due to a range of reasons including discharges from the secure hospital (2), withdrawal of consent by participants to continue in treatment (3), and exclusion on the grounds of disruptive behaviour (1- the same participant who had previously been excluded from both community groups and a previous secure group) or concerns over cognitive capacity to participate in treatment (2). The remaining four participants completed treatment. Further information regarding participants in each of the groups, along with the results of the assessments on dependent measures is presented in the results section.

Measures

The pilot study began with a wide pool of possible measures from intellectual disability, sex offending treatment, and personality assessment. The purpose of utilising a wide group of potential measures was to assess their practical utility with this

population where that was not already known, their relevance to the variables of interest in this study, and guide selection of a smaller set for the major study to follow (in conjunction with others in SOTSEC-ID, notably Professor Glynis Murphy). The measures used in the pilot study are shown in Table 15 below, along with the variable they were intended to measure, its purpose in the study, and in which of the 5 treatment groups it was used. Bibliographic references for the measures is provided adjacent to the measure itself, and relevant clinical application of the measure with clients with an intellectual disability and/or sex offending treatment is provided in the 'Purpose of Assessment' column.

Table 15. Variables, Measures used and Purpose of Measure in Pilot Study

Variable	Measure	Purpose of Assessment and in which Groups Used	Groups Assessed
Intelligence	Wechsler Adult Intelligence Scale-Revised (WAIS-R; Wechsler, 1981)	Screen for level of intellectual disability (American Psychiatric Association, 2000)	1-5
	Wechsler Adult Intelligence Scale-Third Edition (Wechsler, 1997)	WAIS-R in Community 1 and 2; WAIS III across all groups	1-5
Adaptive behaviour	Vineland Scales of Adaptive Behaviour (Vineland; Sparrow et al, 1984)		1-5
Receptive language	British Picture Vocabulary Scale-II (BPVS-II; Dunn, et al, 1997) British Picture Vocabulary Scale (BPVS;(Dunn, Dunn, & Whetton, 1982)	Clarify suitability for cognitive therapy (Joyce et al., 2006). Used in all groups.	1-5
Personality	Psychopathy Check List-Revised (PCL-R; Hare, 1990)	Screen for presence of psychopathy (Barbaree et al., 2006). Used in all groups.	1-5
	Special Hospitals Assessment of Personality Scale	Screen for presence of personality disorders	1-2

Variable	Measure	Purpose of Assessment and in Which Groups Used	Groups Assessed
	(SHAPS; Blackburn, 1982)	(O'Shaughnessy, 2009). Used for Community 1.	
Mental illness	Psychiatric Assessment of Adults with a Developmental Disability (PAS-ADD 10; Prosser et al, 1997)	Screen for mental illness (Berlin, Saleh, & Malin, 2009; Garrett & Thomas-Peter, 2009). Used for all groups.	1-5
Anger	Benson Anger Inventory (Benson & Ivins, 1992; Benson, Rice, & Miranit, 1986)	Screen for anger control problems (Lindsay & Taylor, 2009, pp. 223-224). Used for community groups.	1-2
Cognitive distortions	Sex Offenders Opinion Test (SOOT; Bray & Forshaw 1996b)	Identify cognitive distortions as a proxy measure for recidivism (Ward, Keown, et al., 2006), and identify distorted cognitions as treatment targets. SOOT used for community groups, SOSAS used for all groups. Burt Rape Myth Scale and Children and Sex Scale used sparingly for Community 1. QACSO used across all groups.	1-2
	Sex Offenders Self Appraisal Scale (SOSAS, Bray & Forshaw 1996a		1-5
	Burt Rape Myth Scale (Burt, 1980), the and the		1-2
	Questionnaire on Attitudes Consistent with Sexual Offending (QACSO) (Lindsay et al. 2000)		1-5
	Children and Sex Scale (Wilson & Beckett, 1987)		1
Victim empathy	Victim Empathy Scale, Adapted (VESA) (adapted with	To assess for level of victim empathy (see chap 9 in	1-5

Variable	Measure	Purpose of Assessment and in which Groups Used	Groups Assessed
	permission from Beckett & Fisher, 1994)	Ward, Polaschek, et al., 2006). Used across all groups.	
Sexual attitudes, Knowledge and history	Sexual Knowledge Inventory Scale (SKIS) (Forchuk et al., 1995; Knox & Sinclair, 2004)	Assess for the 'counterfeit deviance' hypothesis of sexual offending (see Lindsay, 2009, pp. 24-25), and identify knowledge/ attitude gaps for treatment.	1-2
	Sexual Attitudes and Knowledge Assessment (SAKA) (Heighway & Webster, 2007)	SKIS and SONE used for community groups. SAKA used for all groups.	1-5
	Sone Sexual History (Sone, 1984)		1-2
Sexual fantasy	Wilson Sexual Fantasy Scale, (Wilson, 1978)	Assess level and content of sexual fantasy (though O'Connor, 1996, p. notes some difficulties) . Used for Community 1.	1-2
Social functioning (Keeling et al., 2007)	Fear of Negative Evaluation (FNE), Watson & Friend, 1969)	Assess social functioning as a covariate of offending. FNE and SAD both used for community groups.	1-2
	Social Avoidance and Distress Scale (SAD; Watson & Friend, 1969)		1-2
Demographic, forensic and clinical variables	Men's Group Database Schedules I, II, & III (MGDB I, II & III) (Murphy et al., 2003)	To be able to examine covariance between a range of demographic, forensic and clinical variables and treatment and recidivism.	1-5

Variable	Measure	Purpose of Assessment and in which Groups Used	Groups Assessed
including recidivism		Used for all groups.	
Risk of sexual offending	Risk Assessment and Management Protocol (RAMP) (Knox & Sinclair, 2004)	Assess risk and strategies to manage risk of sexual offending. Used for all groups.	1-5
Range of variables	Multiphasic Sex Inventory (Nichols & Molinder, 1984) Multiphasic Sex Inventory II (Nichols & Molinder, 2000)	Assesses sexual deviance, dysfunction, knowledge, paraphilias among others (Craig et al., 2006; Keeling et al., 2007). Used for community groups.	1-2

A number of the variables described above were primarily included for screening, identification and description of the participants, such as intelligence, adaptive behaviour and receptive language. Other variables were included for both screening and exploration of their relationship with treatment and offending/ recidivism variables as they had been used in previous offending or sex offending treatment (e.g. Anger, Personality, MSI). Other variables were the primary focus of interest as dependent measures such as cognitive distortion, sexual knowledge and attitudes and victim empathy, as well as the outcome variable of interest assessed in the Men's Group Data Base, recidivism. Some measures were discontinued quite quickly due to practical difficulties in administration or communication (e.g. level of reading or comprehension too high for participants in this study) such as the SONE, the Wilson Sexual Fantasy and the MSI, and these results are not presented here. Results from the remaining measures are shown in the results section.

Procedure

For the pilot study the treatment and research procedures were coincident, as the purpose of the pilot study was to assist in the development of a treatment protocol, choice of measures and treatment infrastructure for subsequent groups.

Community groups.

The first two groups could be described as community groups as all participants were living in the community and the group was held in the non-secure area of a local psychiatric hospital. Programme Structure for the first two groups was a year-long, 50 session programme, consisting of one 2-hour session per week. Groups were closed, meaning that new members could not join once the group had properly started (after the first few weeks). A range of facilitators were used, including a Clinical Psychologist, Cognitive Behaviour Therapist, Nurses and a Social Worker. There were a minimum of

two facilitators at each group, usually a male and a female, and one facilitator who had been at the previous week to ensure continuity. The current author, a Clinical Psychologist, attended all of the sessions for the first two community group programmes.

Supervised transport to and from the venue for community groups was provided for most of the participants by their residential service provider, with the exception of one participant who lived alone in the community and walked to and from the group each week. Other supervision precautions consisted of selecting a venue which did not have other vulnerable groups in close proximity, recording time of arrival and departure, signing men in and out of the group, and escorting participants to the toilet and outside (often for the purpose of smoking) during coffee break. These procedures were somewhat elaborate for unrestricted individuals living in the community, but one participant was subject to a Guardianship Order and another to detention under section 37, both under the Mental Health Act (1983), and there were some local concerns about the risk of running the group such as the risk it might pose to other users of the building, and whether the group would make the participants more likely to offend. A Forensic Clinical Psychologist from the local forensic service with extensive experience in debriefing and work with sexual offenders provided periodic debriefing to the facilitators. Three facilitator meetings were held during each of the year-long treatment groups, which had an organizational, mutual support and education function. These were in addition to the regular SOTSEC-ID group meetings described in Chapter Four.

Treatment guidance for the first group consisted of a 'Treatment Resource Pack', which was a forerunner of the later treatment manual and provided guidance on SOTSEC-ID, the research project, session content, resources such as Sex and The Three R's (McCarthy & Thompson, 1998), and advice on delivering and scheduling of components. Topics listed in the treatment manual for the first two groups were: group

rules, interpersonal skills (self disclosure, identifying and expressing emotions, turn-taking, the cognitive model of behaviour (general then offending), the Finkelhor Four-stage model of sexual offending, the participant's own victimization experiences, cognitive restructuring and development of victim empathy, and relapse prevention.

The typical structure of each weekly session was firstly a review of weekly events followed by recapitulation of material covered in last week's session, introduction of new material such as the cognitive model, the sex offending model, victim empathy or relapse prevention, with provision for a coffee break where social skills (e.g. turn-taking in conversations) and social conversation were modelled and taught *in situ*. The sessions usually concluded with a summary of what had been covered, setting of homework, and an opportunity provided for each participant to bring up any concerns before leaving.

The experience of running these first two groups, along with that of Dr Glynis Murphy who had by this time also run 2 groups in South London, allowed the development of a more lengthy (244 pages), structured and formalized treatment manual (Sinclair et al., 2002), which was able to be provided to those who subsequently ran treatment groups, and used as the basis for the two-day training programme for facilitators. This contained a description of SOTSEC-ID, a literature review about the area, an outline of the research programme, ethical issues, selection criteria, guidance on assessment and measures, operational and practical considerations to be borne in mind when setting up such a programme, the actual treatment programme itself, and a variety of resources such as films, videos, sex education packages etc. The overall content is based on an adaptation of mainstream sex offender programmes such as that described by Marshall, Anderson & Fernandez (1999).

The community maintenance group was a monthly session for three men who had completed at least a year of previous treatment. The purpose of the Group was to

support the maintenance and generalisation of treatment gains during the more intensive phase of treatment so that the effect did not diminish over time or as the participants encountered new situations. The maintenance group utilised the relapse prevention plan developed from the treatment programme, as well as the cognitive model and the sex offending model. As new situations were encountered in the men's lives, they were brought to the group and used to revise the cognitive model, the sex offending model, and the relapse prevention plan. Two of the three men in the maintenance group had come from the first community group and one came from another part of the country from a different treatment group. In the maintenance group such issues as social skills and developing romantic relationships were addressed. No measures were taken for this group.

Following the first community group, the number of assessments was reduced due to the amount of time involved in administering them and time restrictions in applied settings. The second community group started shortly after the first hospital group, a year after the conclusion of the first community treatment group (see Table 14 above) though they are described in a different sequence here for convenience.

Secure Groups.

Three groups were conducted in a secure hospital utilising the treatment model as described in the Treatment Resource Pack for the first group, and then the Treatment Manual for the second and third groups. All group procedures for these groups were similar to those described above. All three groups were run within the hospital by a clinical psychologist (present author) as the lead facilitator, with assistant psychologists, a psychiatrist and qualified nurses acting as co-facilitators. The present author attended all of the sessions for the first two groups, and all but 2-3 of the third group. Referrals, progress reporting, liaison with residential staff (who were all supervised by nursing staff) and security concerns were all managed within the hospital and within the one

clinical team. There were fewer concerns regarding transport, venue, etc. due to the external security of the setting (a low secure hospital).

Results

Community Groups

As described in Table 16 there were six research participants in the first group and five in the second, although three of the participants in the second group were repeat participants from the first group, thus making eight unique participants. As three of the participants attended both treatment groups the results for these participants are presented together in the tables below rather than separately for each group. Table 16 shows that five participants had index offences of child sexual offence, one had an index offence of sexual assault and rape, another had an index offence of stalking, and one of exposure and public masturbation. Most participants were not subject to a legal restriction, although one was subject to a Guardianship Order and another to Section 37, both under the Mental Health Act (1983). Psychopathy Check Lists (PCL-R) (Hare, 2003) were completed on five of the participants, none of whom scored highly on this measure. The MSI and the SHAPS were also completed on five participants and the PAS-ADD on only one.

Table 16. Index Offence, Legal Status, Personality and Mental Health Assessments for Community Groups

Participant	Index Offence	Legal status	PCL-R	MSI	SHAPS	PAS-ADD
P1	Child sexual offence	MHA s37		No	No	No
P2	Child sexual offence	No restriction	8	Yes	Yes	No
P3	Child sexual offence	No restriction	2	Yes	Yes	No
P4	Sexual assault and rape	MHA, Guardianship	9.5	Yes	Yes	No
P5	Child sexual offence	Probation	6.3	Yes	Yes	Yes
P6	Exposure, public masturbation	No restriction	10	Yes	Yes	No
P7	Stalking	No restriction		No	No	No
P8	Child sexual offence	No restriction		No	No	No

Table 17 shows that the mean age of participants in the two community groups was 31 years of age, and that they had a mean Full Scale IQ of 60.4, a mean Verbal IQ of 60.7, and a mean Performance IQ of 66.5. For all but one participant, Performance IQ was higher than Verbal IQ. The mean BPVS score was equivalent to 102.7 months, or 8 years, 6.7 months, and the mean Vineland score of 170.2 was consistent with expectations based on IQ scores, although the BPVS was only based on three, and the Vineland on four, participants. Mean scores for the Social Avoidance and Distress Scale was 13.7 and the Fear of Negative Evaluation was 13.7. The Benson Anger Scale score was 94.8.

Table 17. Demographic and Screening Measures on Participants for Community Groups

Part Num	Age SOG	IQ	VIQ	PIQ	BPVS	Vineland	SAD-pre	FNE-pre	Benson
P1	38	53	50	65			11	4	
P2	27					249	19	25	113
P3	27	65	66	70	89	156	20	15	108
P4	37	67	66	75			13	16	76
P5	36	59	59	63	123	160	12	10	92
P6	24	61	66	58	96	116	13	12	85
P7	40	60					12		
P8	19	58	57	68					
Mean (N)	31 (8)	60.4 (7)	60.7 (6)	66.5 (6)	102.7 (3)	170.2 (4)	14.3 (7)	13.7 (6)	94.8 (5)

Table 18. SAKA and QACSO Means for Community Groups

Month/Year[1]	Mean QACSO Score	Mean SAKA Score (N)
September 1999	59.4 (5)	47.2 (6)
September 2000	67.5 (2)	
September 2003	60.6 (5)	43 (5)

1. Within 3 months.

Table 18 shows mean scores for the eight research participants in the first two community groups on the Sexual Attitudes and Knowledge Assessment (SAKA) over two time periods. Mean scores on the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO) are also shown, again over three time periods. These results are graphed in Figure 10 below and show a small decrease in the SAKA score and an initial increase in the QACSO followed by a return to the initial level. Timing of the treatment groups in relation to assessment points is also shown in the graph with markers to show the beginning and end of each group. The N for the middle QACSO assessment was only 2.

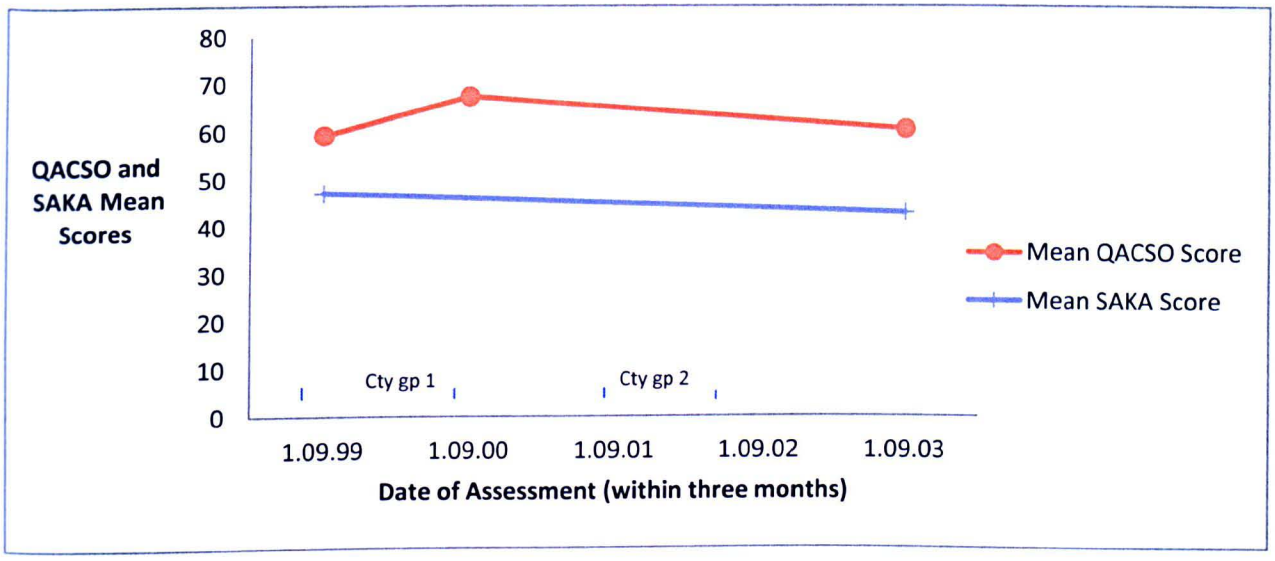


Figure 10. Graph of Mean SAKA and QACSO Scores for Community Groups

Table 19. SOOT, SOSAS and VESA Means for Community Groups

Month/Year[1]	Mean SOOT (N)	Mean SOSAS (N)	Mean VESA (N)
July 1999	64 (4)	56.4 (7)	
February 2000			35.6 (5)
October 2003	50 (2)	54.3 (6)	31 (4)

1. Within 3 months.

Table 19 above shows the mean scores for the Sexual Offenders Opinion Test (SOOT), the Sexual Offenders Self Appraisal Scale (SOSAS) and the Victim Empathy Scale Adapted (VESA) for the eight participants in the two community groups across time. This is also shown graphically in Figure 11 which again shows the timing of the two treatment groups in relation to assessment points. N's are low for SOOT and VESA, and particularly for the second VESA where N was only 2. Results show a decrease over time for the SOOT, a smaller decrease for the VESA, and virtually the same result for the SOSAS.

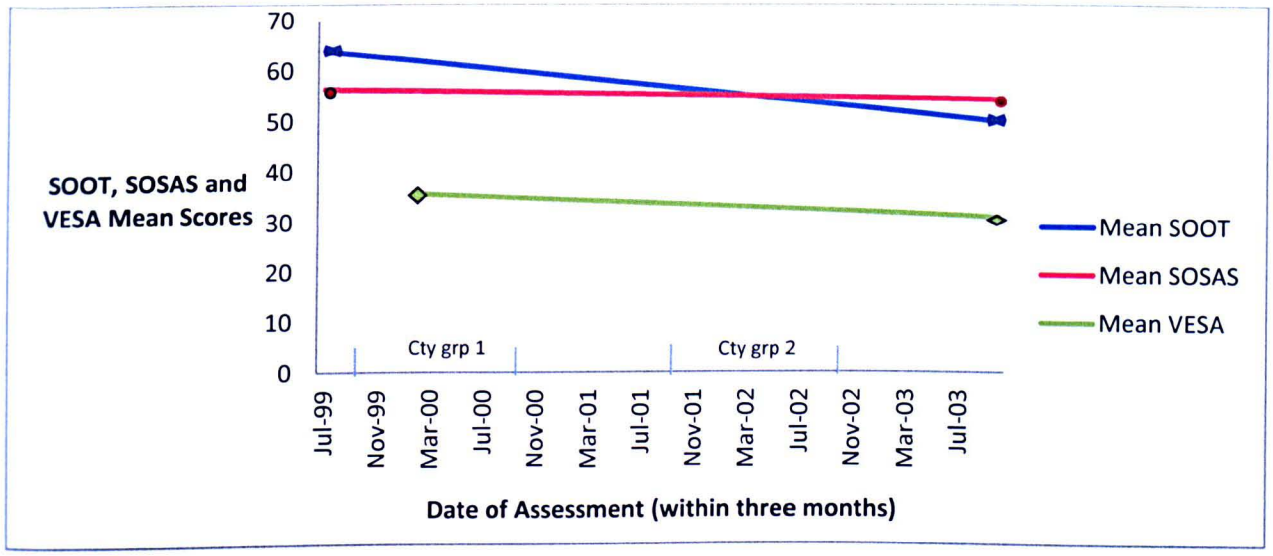


Figure 11. Graph of SOOT, SOSAS and VESA Means for Community Group

Table 20. Community Group Participant Total Scores on the QACSO

Month/Year	P1	P2	P3	P4	P5	P6	P7	P8
Oct-99			50	73	84	45		
Jun-00	81	40				54		
Oct-03	73		31	53	94			52
Jul-04					63			
Mar-06								37
Aug-09								47

Table 20 shows the total scores of each of the eight participants in the two community groups on the QACSO where an assessment was undertaken. These total QACSO scores are then shown graphically in Figure 12, again with the timing of the two treatment groups shown against the timing of the assessments. Most participants show a decrease over time, though P6 show an increase and P8 shows poor maintenance of earlier gains.

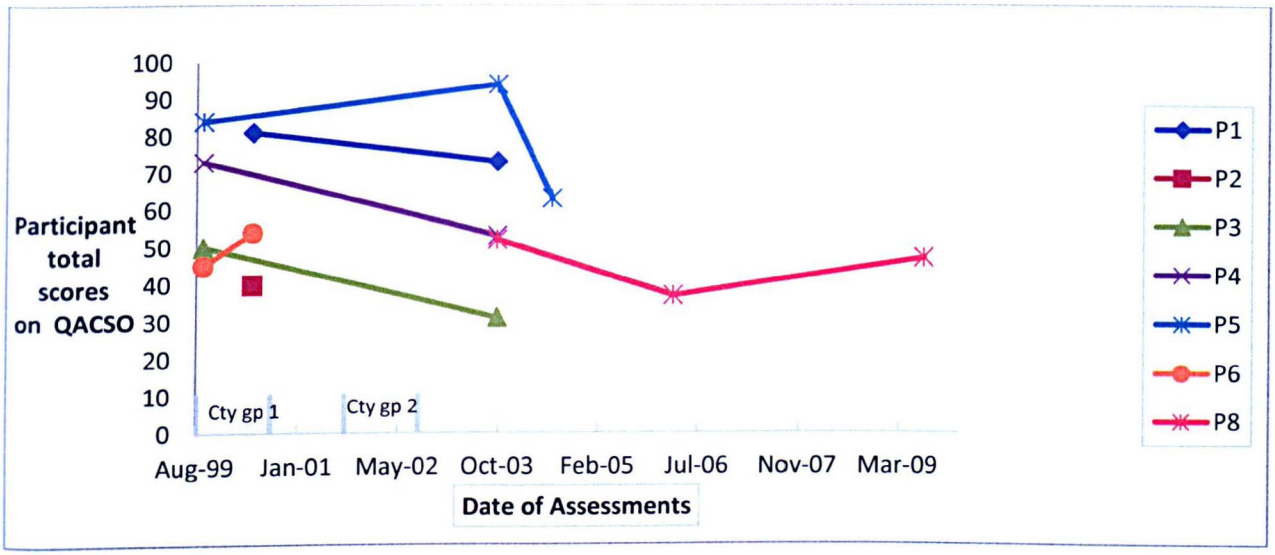


Figure 12. Graph of Community Group Participant Total Scores on the QACSO

Table 21. Table of Community Group Participant Total Scores on the SAKA

Month/Year	P1	P2	P3	P4	P5	P6	P7	P8
Oct-99		50	46	50	45	44	47	
Jun-00								
Oct-03	40		50	50	45			30
Jul-04					47			
Mar-06								34
Aug-09								47

Table 21 shows the total scores of each of the eight participants in the two community groups on the SAKA. These total SAKA scores are then shown graphically in Figure 13 below. Results show that all participants maintained or increased their SAKA scores over time.

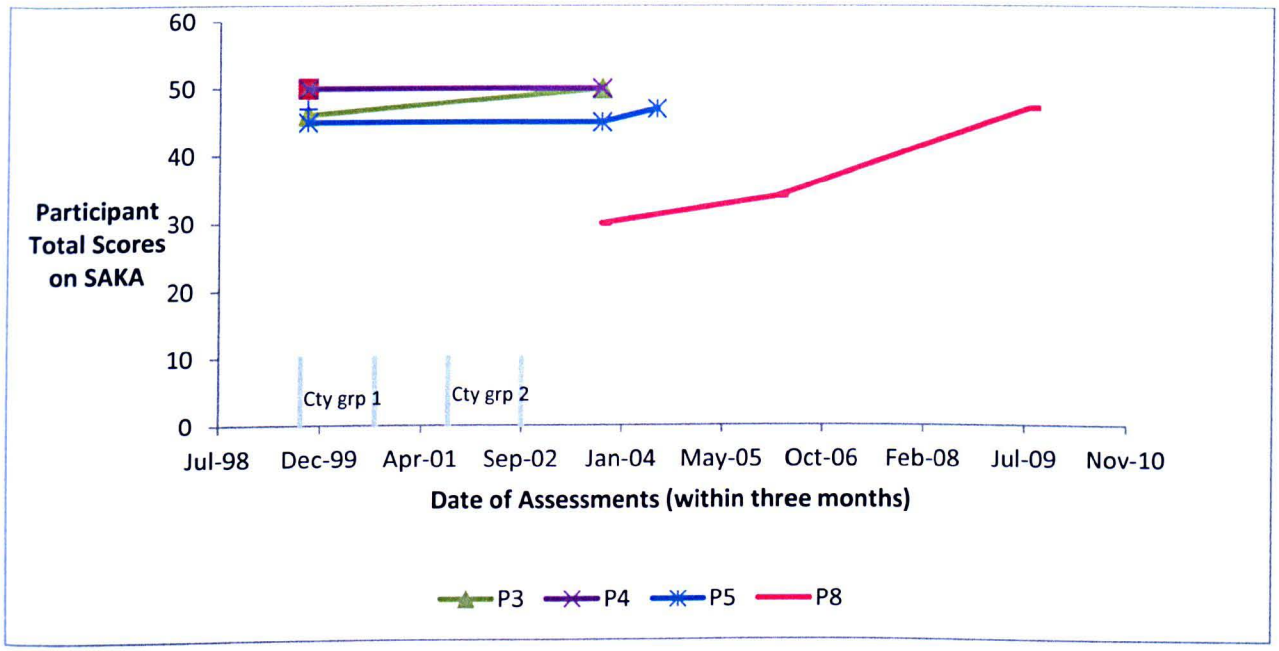


Figure 13. Graph of Community Group Participant Total Scores on the SAKA

Table 22. Table of Community Group Participant Total Scores on the SOOT

Month/Year	P1	P2	P3	P4	P5	P6	P7	P8
Oct-99		61		73	45	74		
Jun-00								
Oct-03		54				46		

Table 22 above shows the total scores for each of the participants in the two community groups on the SOOT where an assessment was undertaken. These total SOOT scores are then shown graphically in Figure 14 below. Results show that for the two participants on whom there are repeat assessments that participants decreased their SOOT scores over time.

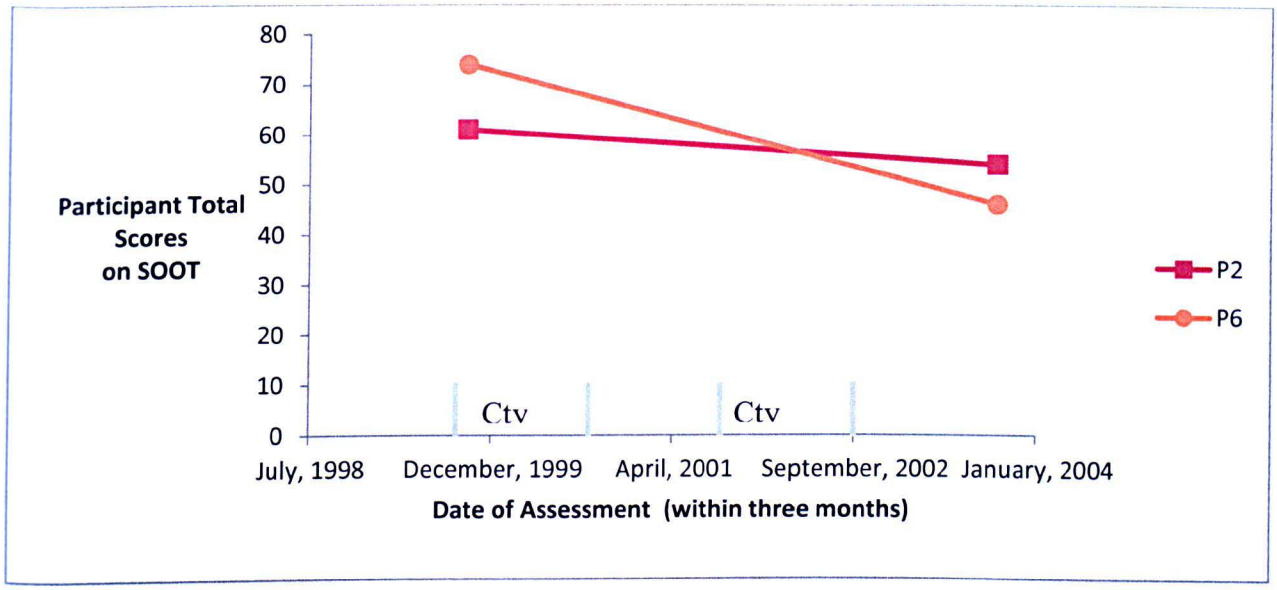


Figure 14. Graph of Community Group Participant Total Scores on the SOOT

Table 23. Table of Community Group Participant Total scores on the SOSAS

Month Year	P1	P2	P3	P4	P5	P6	P7	P8
Oct-99	65	50	63	57	50	54	56	
Oct-03	53	42	59	51	65	61		46
Aug-09								70

Table 23 above shows the total scores of each of the eight participants in the two community groups on the SOSAS. These total SOSAS scores are then shown graphically in Figure 15 below. Results show that the first four participants (P1, P2, P3 and P4) increased their SOSAS scores over time, but not participants five or six (P5, P6), whose scores decreased. Participant eight (P8) increased his score, although the time period for this participant was different.

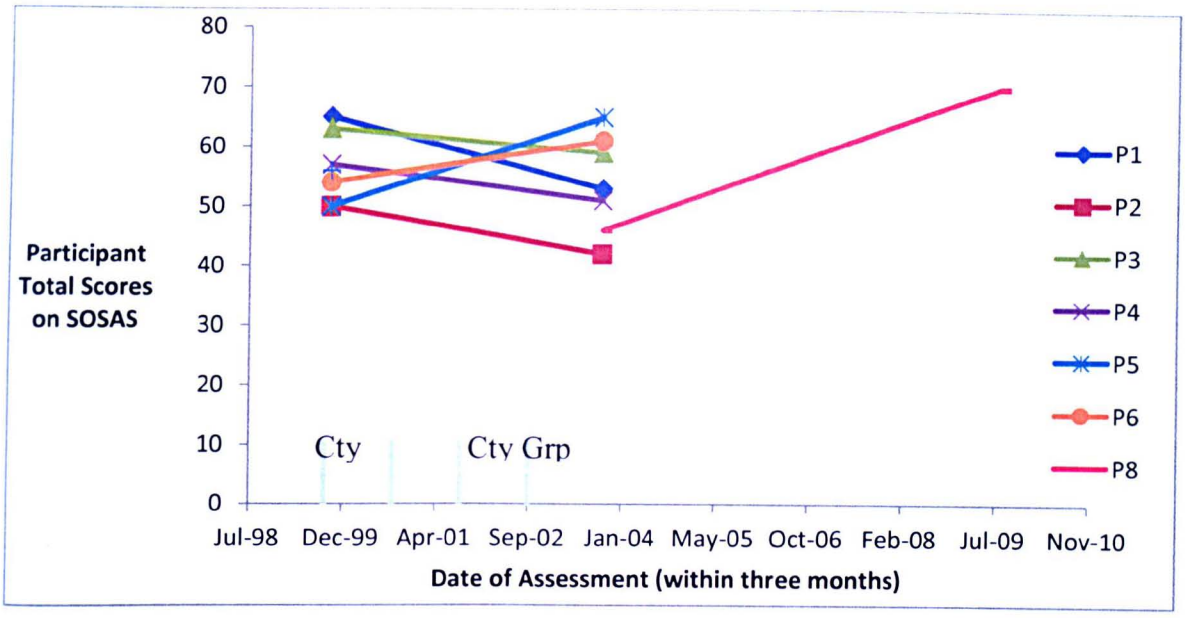


Figure 15. Graph of Participant Total Scores on the SOSAS

Table 24. Table of Community Group Participant Total Scores on the VESA

Month/Year	P1	P2	P3	P4	P5	P6	P7	P8
Oct-99			61	20	13		26	
Jun-00		58						
Oct-03			31	12	36			45
Jul-04					32			
Aug-09								44

Table 24 above shows the total scores of each of the eight participants in the two community groups on the VESA where an assessment was undertaken. These total VESA scores are then shown graphically I Figure 16. Results show that participants three and four (P3, P4) decreased their VESA scores over time, whereas participant five (P5) increased his over a similar time. Participant eight (P8) showed little change, though over a different time period.

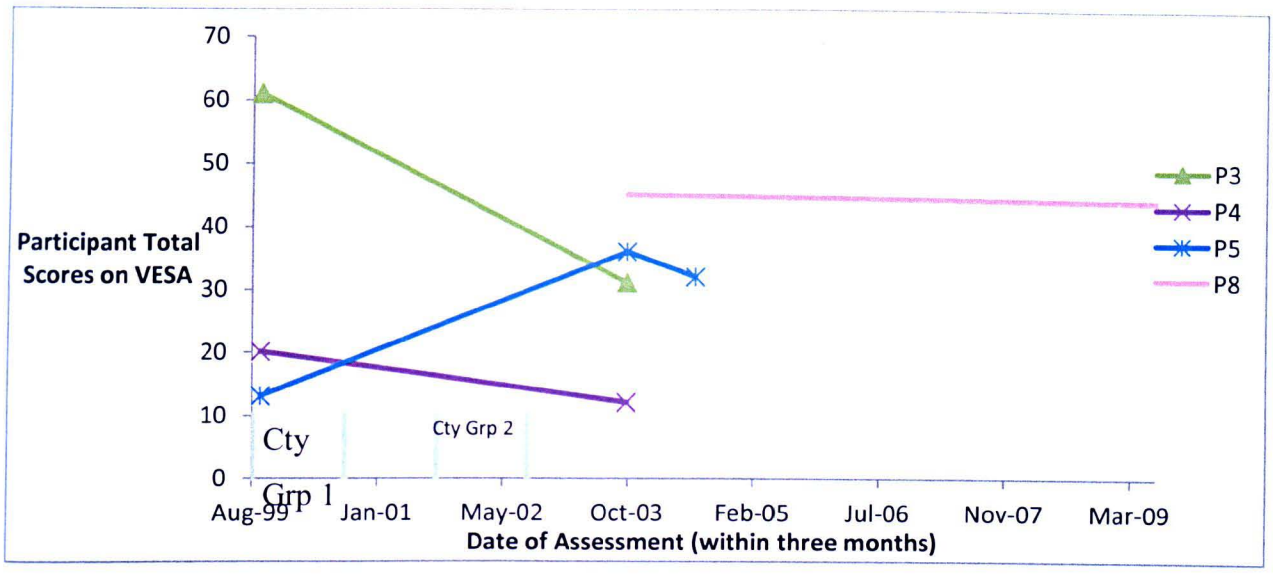


Figure 16. Graph of participant Total Scores on the VESA

Secure Groups

There were three research participants in the first two secure groups, and as these were repeat participants from the first to the second treatment groups, their results have been combined across the two treatment groups they attended. These were participants nine, ten and eleven (P9, P10 and P11). There were a further three participants in the third secure group who consented to participate in the research, namely participants twelve, thirteen and fourteen (P12, P13 and P14). Results for the first two secure groups (P9, P10 and P11) are presented first followed by the results for the third group (P12, P13, and P14).

Firstly, however, information on index offence, legal status, screening variables and demographic information is presented for all six participants in the three secure groups in Tables 25 and 26.

Table 25. Index Offence and Legal Status for Participants in Secure Groups

Part Num	Index Offence	Legal status
P9	Child sexual offence	MHA s3
P10	Child sexual offence	MHA s3
P11	Child sexual offence	MHA s3
P12	Child sexual offence	MHA s3
P13	Child sexual offence	MHA s37/41
P14	Sexual Assault	S37

Similar to the community participants, the most common index offence was a child sexual offence (5) with one participant having committed a sexual assault. As would be expected for a hospital setting all six participants were detained under the Mental Health Act, with four participants on a civil detention, section 3, and two being detained under a criminal proceedings detention, section 37, one of whom was also subject to a restriction order (section 41).

Table 26. Demographic and Screening Measures on Participants in Secure Groups

Participant Number	Age SOG	IQ	VIQ	PIQ	BPVS	Vineland	PCL-R
P9	37	60	57	66	84	111	
P10	22	66			78	137	23.3
P11	22	60	61	67		119	
Mean	27	62			81	122.3	
P12	45	54	51	68	101	158	
P13	65	68	67	74		160	
P14	22	77				226	
Mean	44	66.3	59	47.3		181.3	
Overall Mean (N)	35.5 (8)	63.9 (8)	59 (5)	68.8 (5)	87.7 (4)	151.8 (8)	

Table 26 above shows the mean age, mean Full Scale, Verbal and Performance IQ's, and mean BPVS and Vineland for each of the two sets of secure participants, and their overall means for these measures. The first set of secure participants (P9, P 10 and P11) were younger on average than the second set (27 years to 45 years), had a slightly lower Full Scale IQ score (62 to 66.3) on average, and performed less well on the Vineland Scales of Adaptive Behaviour (122.3 to 181.3) across all participants. Taking the overall group of six secure participants, their mean age of at the start of their first group was 35.5 years, their mean Full Scale IQ was 63.9, mean Verbal IQ was 59, and their mean Performance IQ was 68.8. Although only based on 4 scores, the BPVS mean score was an age-equivalent of 7 years and 4 months.

Secure Groups One and Two.

Results for the first two secure groups are presented in a similar format to the community groups, with means presented first, followed by individual scores for each participant on each of the measures.

Table 27. Table of QACSO and VESA Means for Secure Groups 1 and 2

Month/Year[1]	QACSO (N)	SOSAS (N)	VESA (N)
Dec-01	66.7 (3)		
Sep-02	54.7 (3)		
Nov-02	45.3 (3)		
Sep-03	40.3(3)		20 (2)
Feb-04	31.7(3)	44.3 (3)	14.3 (3)
Oct-04	30.5(2)	52 (2)	13.5 (2)

1.Within three months

The QACSO means for these two groups span nearly three years and include the two year-long treatment programmes. The means show a steady decline in QASCO mean scores at each successive assessment point. There were only three participants, but all participants were assessed on all but one of the assessment points depicted in the table and the following graph. The mean QACSO score drops from 66.7 at the first assessment close to the time of the first group in December 2001, to 30.5 nine months after the end of the second group in October 2004. The SOSAS means were both taken after the conclusion of the second treatment group, but show an increase rather than a decrease, while the VESA means, which were taken towards the end and after the second group, show a decline in scores. These trends, as well as the dates of the two treatment groups, can be seen in the graph in Figure 17. There were insufficient data from the SAKA and SOOT assessments to present as means.

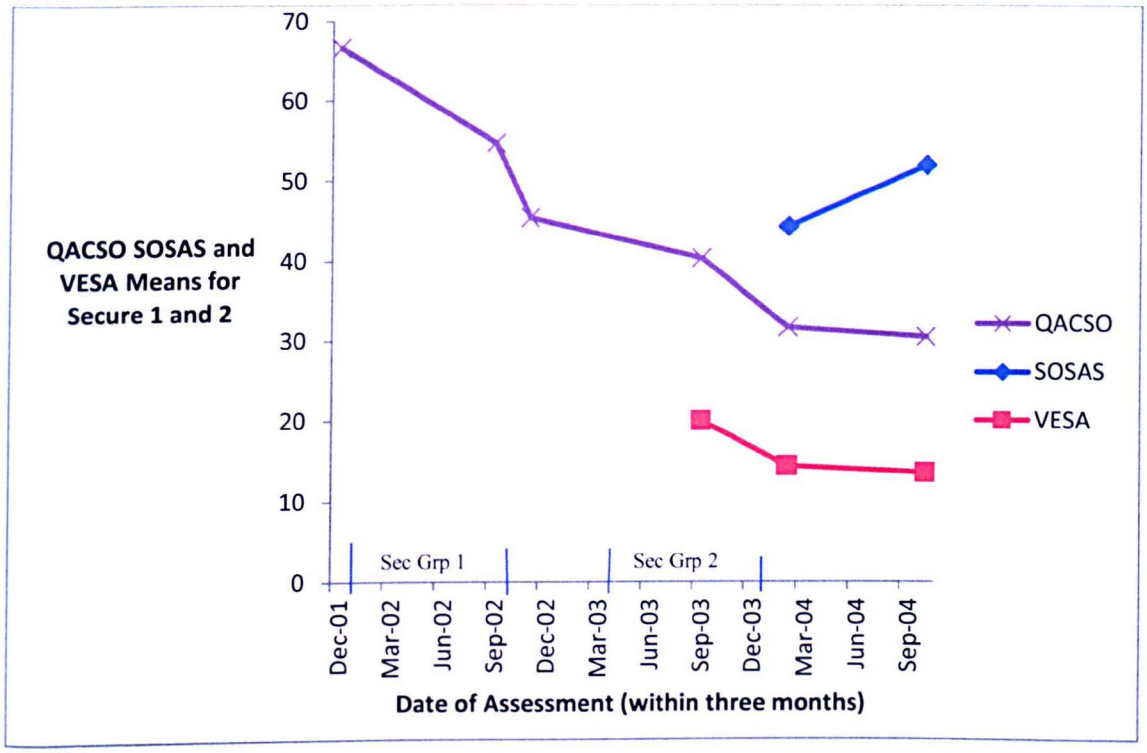


Figure 17. Graph showing QACSO SOSAS and VESA means for Secure Groups 1 and 2

The following tables and graphs show the participant total scores for the three participants in secure group 1 and secure group2 for each measure over the period of the pilot study. The first table, Table 28, shows the QACSO results for the three participants and shows a decrease in QASCO scores across all three participants, with the exception of the last score for P9. This is also shown graphically in Figure 18.

Table 28. Secure Groups 1 and 2 Participant Total Scores on the QACSO

Date/Month	Participants		
	P9	P10	P11
Dec-01	62	79	59
Jul-02	45	79	40
Nov-02	23	75	38
Sep-03	46	32	43
Feb-04	28	35	32
Nov-04	28	33	
Jun-05	21		
Dec-05	6	25	
Apr-06	28		

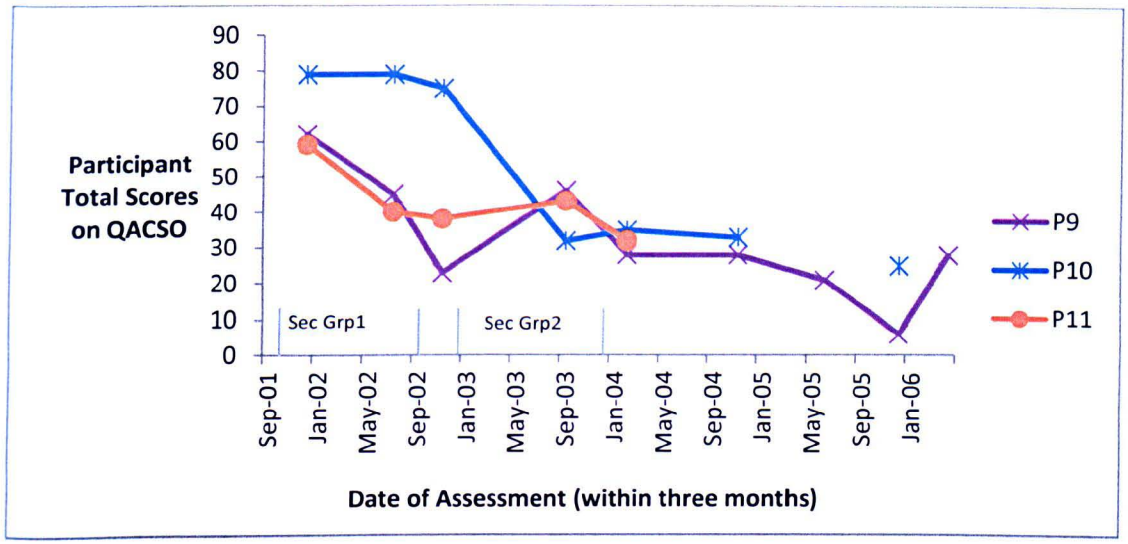


Figure 18. Graph of Secure Groups 1 and 2 Participant Total Scores on the QACSO

Table 29 below shows the participant total scores on the SAKA and the graph in Figure 19 shows that there was little change over five years on the SAKA scores for participants 9 and 10. Participant 11 showed a decrease, but this was a one-off effect. The timing of the two treatment groups is also shown on the graph.

Table 29. Secure Groups 1 and 2 Participant Total Scores on the SAKA

Date/Year	P9	P10	P11
Dec-01	45		
Jul-02		44	
Nov-02		47	
Sep-03	47	47	48
Feb-04	41	49	42
Nov-04	46		
Jun-05	45		
Dec-05			
Apr-06	48		

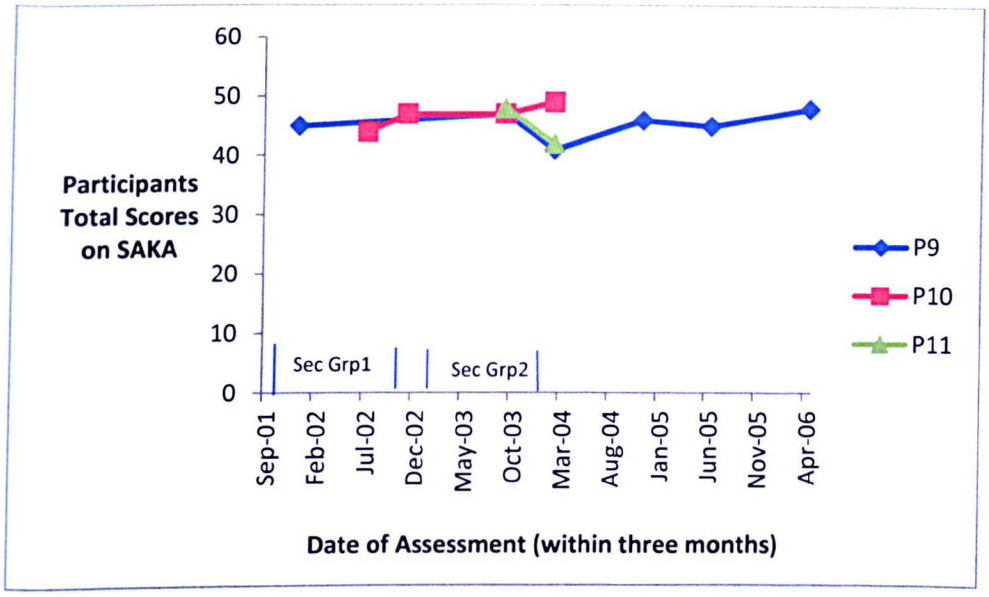


Figure 19. Graph of Secure Groups 1 and 2 Participant Total Scores on the SAKA

Scores on the SOSAS were only collected towards the end of the second secure group and are shown below in Table 30 and graphically in Figure 2 against the timing of the two treatment groups.

Table 30. Secure Groups 1 and 2 Participant Total Scores on the SOSAS

Date/Year	P9	P10	P11
Sep-03		32	
Feb-04	39	50	44
Nov-04	59	45	
Jun-05	55		
Dec-05			
Apr-06	56		

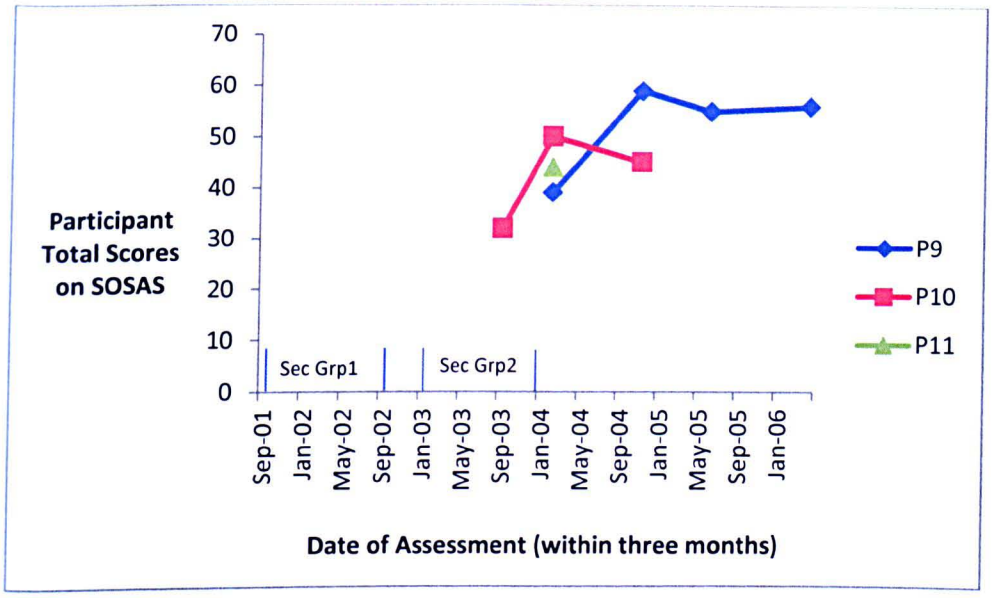


Figure 20. Graph of Secure Groups 1 and 2 Participant Total Scores on the SOSAS

The VESA assessments were not taken until towards the end of the second treatment group, although there is a large drop in VESA scores for P9, a modest drop for P11, and an increase followed by a return to first assessment level for P10. These results are shown in Table 31 and Figure 21 below.

Table 31. Table of Secure Groups 1 and 2 Participant Total Scores on the VESA

Month/Year	P9	P10	P11
Sep-03	38	13	9
Feb-04	14	21	8
Nov-04	14	13	
Jun-05	12		
Dec-05			
Apr-06	11		

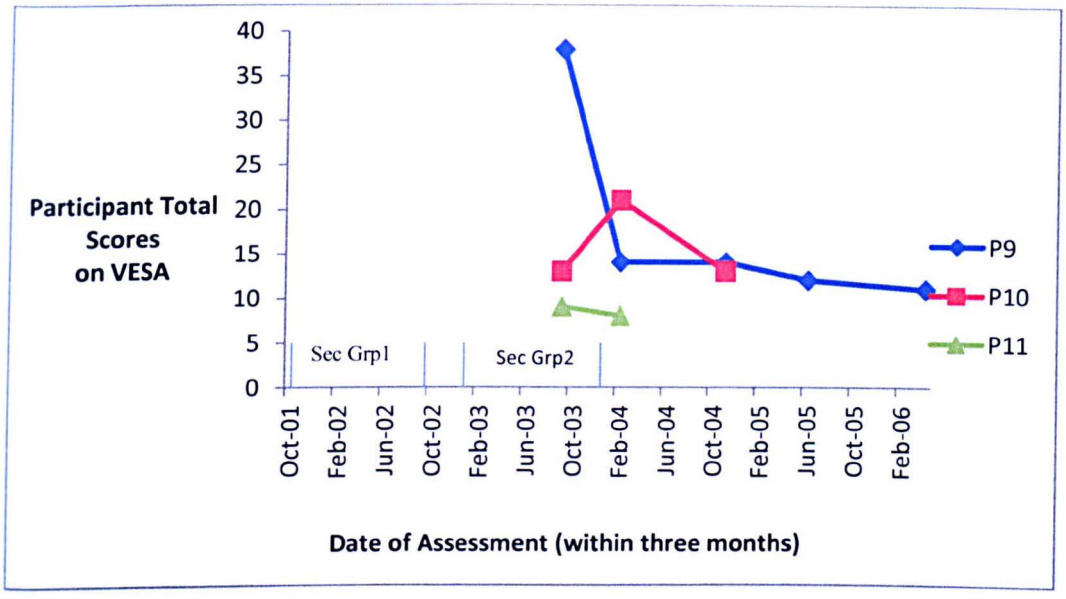


Figure 21. Graph of Secure Groups 1 and 2 Participant Total Scores on the VESA

Secure Group three

Results for the third secure group and the final pilot study group are presented in a similar format to those presented already, with means presented first, followed by individual scores for each participant on each of the measures. The means for these three participants (P12, P13 and P14) are shown below where there are means at four and five different points respectively for the QACSO and the SAKA, at three different points for the SOSAS, and only

one mean for the VESA. The results in the graph in Figure 22 show an increase over for the QACSO, largely similar scores across time for the SAKA, and a marginal increase in the SOSAS scores. The graph also shows the timing of the treatment groups.

Table 32. QACSO, SAKA, SOSAS and VESA Means for Secure Group 3 Participants.

Date	QACSO (N)	SAKA (N)	SOSAS (N)	VES (N)
Mar-02	68.3 (3)	42.5 (3)		
Jun-03	49.0 (2)	46.0 (2)		
Dec-03			47.3 (3)	44 (3)
Feb-04	73.5(2)	38.0 (2)		
Jun-04		46.0 (2)	48.5 (2)	
Nov-04	80 (2)	44 (2)	54.5 (2)	

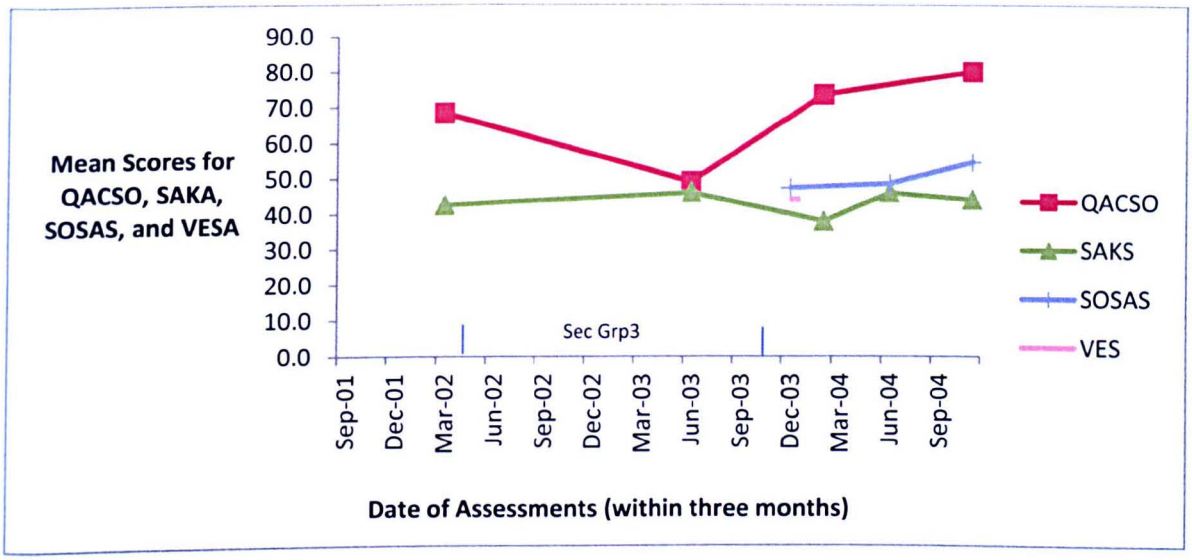


Figure 22. QACSO, SAKA, SOSAS and VESA Means for Secure Group

Individual participant scores on the QACSO over the period assessed are presented in Table 33 where there are four assessments for participants 12 and 13, and three for participant 14. This data is shown graphically below in Figure 23, where it can be seen that P12 increases and then returns to a similar level to the first assessment, while P13 and P14 both

show decreases in their QACSO scores over time. Dates of the treatment group are included in the graph.

Table 33. Secure Group 3 Participant Total Scores on the QACSO

Month/Year	P12	P13	P14
Date	P12	P13	P14
Mar-02	76	80	49
Jun-03		73	25
Dec-03			22
Feb-04	83		
Jul-04			
Nov-04	92	68	
Jun-05		66	
Jun-07	80		

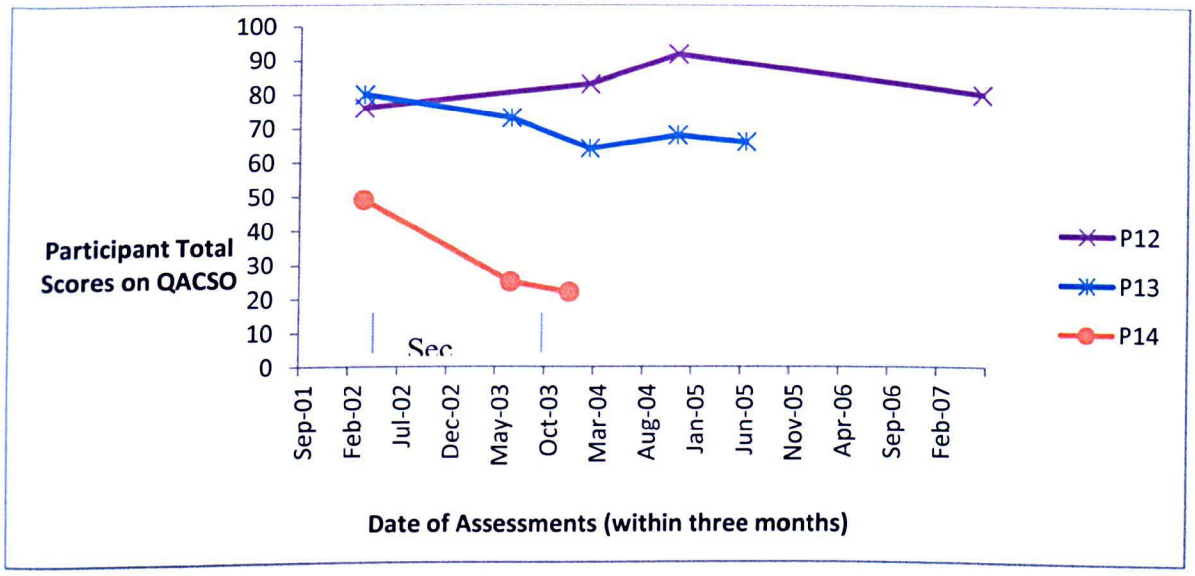


Figure 23. Secure Group 3 Participant Total Scores on the QACSO

There were four, six and three assessments on the SAKA for participants 12, 13 and 14 respectively, and these results are shown below in Table 34 and Figure 24. There was relatively little change in the SAKA scores over time.

Table 34. Secure Group 3 Participant Total Scores on the SAKA

Month/Year	P12	P13	P14
Mar-02	41.5	37	49
Jun-03		41	51
Feb-04	38	38	50
Jul-04		42	
Nov-04	46	42	
Jun-05		39	
Jun-07	40		

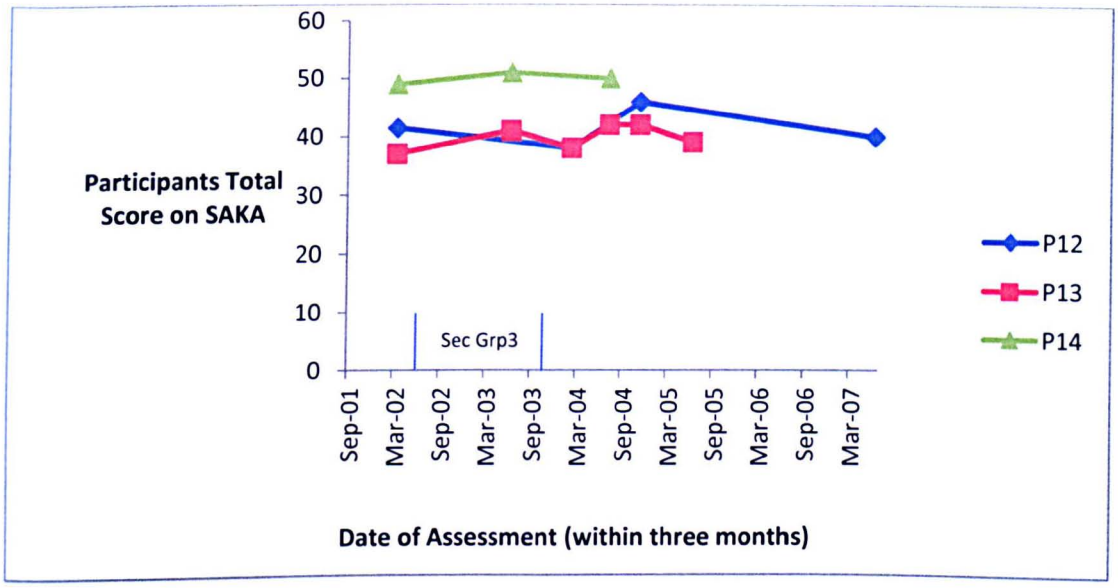


Figure 24. Secure Group 3 Participant Total Scores on the SAKA

The SOSAS assessment results were based on a small number of assessments, with three assessments for P12 and P13, and two assessments for P14. All assessments are at the end of

or after the treatment group. The results are presented in the table and graph below and show P12 had an initial decrease in his SOSAS score followed by an increase, P13 had a decrease over time, and P14 showed a rapid increase in SOSAS score over a quite short period of time.

Table 39. Secure Group 3 Participant Total Scores on the SOSAS

Month/Year	P12	P13	P14
Mar-02			
Jun-03			
Dec-03	61	67	14
Feb-04	46		51
Jul-04			
Nov-04	64	45	
Jun-05		43	
Jun-07			

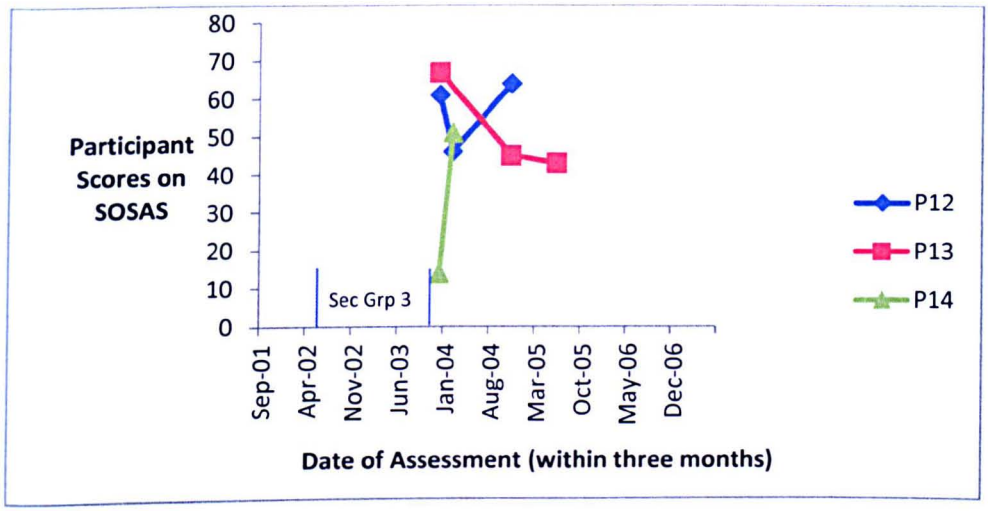


Figure 25. Graph of Secure Group 3 Participant Total Scores on the SOSAS

There were only sparse assessments on the VESA for Secure Group 3, and these are shown in

Table 35 and Figure 26 below, which shows an increase for P12's VESA score and a decrease for P13's VESA, and no conclusion can be drawn for P14 as there is only one assessment point.

Table 35.Table of Secure Group 3 Participant Total Scores on the VESA

Month/Year	P12	P13	P14
Dec-03	51	67	14
Jun-05		43	
Jun-07	64		

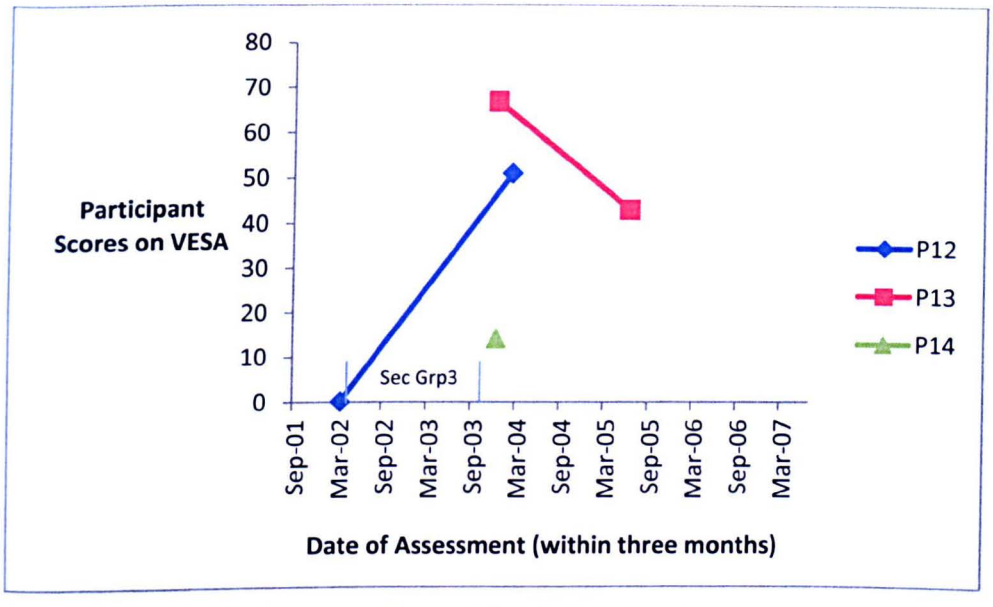


Figure 26. Graph of Secure Group 3 Participant Total Scores on the VESA

The following table compares the initial and final scores of the four main measures for all participants, and shows the mean for the group. Differences were in the predicted direction for all measures except the SOSAS. That is, the QACSO and the VESA mean scores reduced and the SAKA increased.

Table 36. Individual Pre Treatment and Post Treatment Scores (first and last) on QACSO, SAKA, SOSAS, and VESA

Participant	QACSO		SAKA		SOSAS		VESA	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
P1	81	73	40		65	53		
P2	40		50		60	42	58	
P3	50	31	46	50	53	59	61	31
P4	73	53	50	50	57	51	20	312
P5	84	62	46	47	50	58	13	32
P6	45	54	44		44	61	56	
P7								
P8		49	30	47	46	70	45	52
P9	62	28	41	48	39	56	38	11
P10	79	25	44	49	32	45	13	12
P11	59	32	48	42	44		9	8
P12	76	80	41.5	40				
P13	80	60	37	42				
P14	49	22	49	50				
Mean (N)	64.8 (12)	47.9 (12)	43.6 (13)	46.5 (10)	49 (10)	55 (9)	34.8 (9)	22.7 (7)
Sum	778	575	566.5	465	490	495	313	159

Discussion

The results present quite a mixed picture, perhaps not surprisingly for the pilot study phase of the project. The participants from the community and secure settings were similar on the measure examined, with similar mean ages (Community 31 years and Secure 36 years), similar mean IQ scores (Community 60 and Secure 64) and similar mean Vineland total scores (Community 170 and Secure 152). There were of course predictable differences in terms of the hospital participants being more legally restricted by the Mental Health Act (1983- as the pilot study preceded the recent changes to the Mental Health Act).

Looking at the different measures across the three groups for which results are presented above, QACSO results produced no obvious change between first and last QACSO assessment for the community group, a clear reduction of the first and second secure groups, and an increase for the third secure group. There seemed to be no change to the SAKA means between first and last administration for any groups, and this seemed to be at least in part due to a ceiling effect of the SAKA, as many participants scored quite highly on the SAKA at their first assessment, allowing little room to measure any subsequent improvement. Comparing first and last SOSAS scores resulted in no change for the community group, and an increase for the first and second secure group. VESA scores decreased for both the community group and the first and second secure group, with a more mixed picture for the third secure group.

When we examine the tables and graphs of individual participant results, the QACSO results for the community and first and second secure groups show clear positive results between first and last administrations, and the third secure group does for 2 participants but not for the third. SOSAS results were quite mixed, with increases or a mix of increases and decreases noted in all groups. This mixed result of some participants improving (VESA score decreasing) and some participants deteriorating (VESA score higher).

A comparison of the mean first and mean last assessment result for the two community groups taken together and the three secure groups taken together shows that the secure groups had a higher mean QACSO for the initial assessment, but a lower mean QASO at the last assessment. The community groups' initial mean on the SAKA was higher than the

secure group, although the community group had a lower mean score at the last SAKA administration whereas the secure groups taken together had a slightly higher though quite similar score at the end than at the beginning. In contract to the QACSO pattern, the community groups had a higher SOSAS initial mean than the secure groups, although final SOSAS results were very similar for both community and secure groups. Probably the most striking difference between the mean of the groups was on the VESA, where the community group scored much higher at the first and last assessment, but both groups dropped (i.e. improved) 5-6 percentage points between first and last mean score.

These conclusions and comparisons should be treated with caution, however, because there were many anomalies and inconsistencies in the timing and administration of these measures during the pilot study. The pilot study did serve its purpose, however, in identifying which measures were too difficult, such as the MSI, the SHAPS, the SONE, the Clarke Sexual history Interview, which were ambiguous such as the SOOT, the SAD and the FNE, and a smaller set of assessments were carried forward into the second phase of the project. The patchy nature of the timing and even the absence of many assessments during the pilot study, however, points strongly to the difficulties of carrying out applied research in clinical settings where the pressure to 'do something' with risky individuals who have offended sexually is a pressing and constant theme. This is particularly the case in private hospital settings where some of the pilot study research was carried out because continued admission and funding is often contingent on ongoing access to treatment programmes which often overwhelms research priorities.

CHAPTER SIX. STUDY TWO: QUALITATIVE STUDY

Introduction

As previously described in Chapter Four, the purpose of this study is to ensure that the views and experience of participants in sexual offender treatment programmes are elicited and considered alongside other sources of data. Such information can then be utilized to improve programmes and quite possibly treatment effectiveness in due course. Indeed, service user views are increasingly recognised as an important, if not the most important, indicator of service quality (Hays et al., 2007; Serran & Marshall, 2010). Nonetheless, much of the literature on sexual offending treatment in both mainstream and intellectual disability services has focused on either the descriptions, characteristics and typologies of offenders, or treatment content and effectiveness, and has almost ignored the perspective and experience of both mainstream and intellectually disabled men who are the participants in treatment programmes. The predominant paradigm of this research has been outcome focused and quantitative, yet it is likely to be the case that the focus of the participants' perspective using a qualitative approach will provide a more complete view of the issues, thus including both the experiential and the experimental (Charmaz, 2003; Smith, Flowers, & Larkin, 2009, p. 4), the subjective as well as the objective. This approach is consistent with the original arguments put forward by William James in *Stream of Consciousness* (James, 1890/2010) for the broad methodological approaches psychology should adopt, and echoed frequently in debates about idiographic verses nomothetic approaches (Nerlich, 2004, p. 27; Todd et al., 2004).

Some researchers have begun to address participants' treatment experience. Mann and Marshall (2009, p. 343) suggest that "...the investigation of sexual offenders' own experiences during treatment..." is a desirable direction for future research to improve treatment, and there have been several attempts to include this strand in mainstream offender treatment research. Marques and colleagues (cited in Garrett, Oliver, Wilcox, & Middleton, 2003, p. p.324) asked participants to fill out a feedback sheet at the conclusion of their programme, and Beckett, Beech, Fisher and Fordham (1994) included participants' views when they used the Group Environment Scale (GES) (Moos, 1986) to evaluate group performance within the community treatment programme they evaluated. This study in particular found evidence for a correlation between participant reports of positive experience and positive treatment outcomes. They found (as reviewed earlier in Chapter Three) that

several features experienced by the participants, such as group cohesion, group involvement and being treated positively and respectfully, were more common in the most effective groups. In an Australian study, Andrew Day (1999) surveyed participants in a group sexual offender treatment programme, and found that their views towards their treatment were similar to those expressed by recipients of mental health treatment services, implying they could play a legitimate role in service development. Garrett et al. (2003) surveyed participants who had committed a range of sexual offences in a series of probation-run and health-run treatment groups, and had 42 surveys returned from a total of 85. They found that the vast majority (94%) rated their treatment as "fairly or extremely positive", "thought they had retained most of the material from the group", and when asked about specific content, 25% said they "remembered the effects on the victim", 16% remembered relapse prevention strategies, 12% remembered group process, 9% remembered aetiology, and 9% remembered learning about their own capacity to distort/deny/make excuses. Only half the respondents offered suggestions for improvement, and these included feedback regarding the conduct of other group members, individual difficulties, process, organizational issues, and the behaviour of the facilitators. When asked which aspects of the programme they would like more time allocated to (more than one choice per respondent), "motivation to offend" was the most popular choice (60%), followed by victim empathy (50%), relapse prevention (47%), overcoming internal barriers (40%), denial (28%) and cycle of offending (25%). The results generally indicate a positive experience of group treatment and a willingness to engage in therapeutic elements, such as the motivation to offend.

Wakeling, Webster, and Mann (2005) report a mixed qualitative and quantitative study across nine prison settings in the UK, involving 46 adult males sexual offenders who had been through the HM Prison Service Sex Offender Treatment Programme (SOTP) (Grubin & Thornton, 1994). Part of the study used a semi-structured interview to ask participants about both general aspects and specific modules of the treatment they received. Results of the interviews were analysed using a grounded theory approach, which followed the Strauss and Corbin method (cited in Wakeling et al., 2005) in contrast to the original Glaser and Strauss approach (as discussed in Wakeling et al., 2005; Willig, 2008). The study also utilized quantitative methodology, using four sub-scales of the Sex Offence Attitude Questionnaire, and the 18-item Relapse Prevention Interview.

In general, grounded theory is an inductive process which takes information gathered from participants and develops analytic codes and categories from the data rather than imposing preconceived theoretical categories (Charmaz, 2003 even advocates analysis before the literature review) in order to allow more inclusive and eventually theoretical concepts to emerge from the data- a *grounded theory* (Willig, 2008). Grounded theory describes both a method, as 'categories of meaning' are developed from the data (Willig, 2008, p. 35), and theory development, as categories of meaning become progressively more abstract, and eventually as a theory explaining the original observations. The Strauss and Corbin approach is more prescriptive than the original formulation in that it encourages the specification of a research question prior to analysis and proposes a technique called 'axial coding', both of which are disputed by Glaser (Charmaz, 2003; Willig, 2008).

Wakeling et al. (2005) used axial coding as part of their analysis of the participants' responses to questions in their semi-structured interview, which asked a number of questions (the exact number is not specified, but it seems to be ten) about participants' involvement in the programme. Questions asked participants to describe their experience of the programme, whether it was positive or negative, any aspects of the programme that were particularly distressing or enlightening, and about specific components of the programme. The results of their analysis of question one is shown below in Figure 27. This form of grounded theory analysis begins with the allocation of one or more concept labels to each participants' answer on each question, which in this case resulted in 1203 concept labels for the 46 participants over the ten questions. Similar categories were developed for the other semi-structured interview questions, which overall indicated that participants found the programme to be positive and, more specifically, worthwhile in areas of *self development*, *positiveness for the future*, *understanding of the offence*, *victim empathy*, *coping strategies*, and *awareness of others*. Specific helpful aspects of the programme were identified, namely *good tutors*, *good group dynamics*, and *realising you are not alone*; and unhelpful aspects were *groups being too large*, *cultural difficulties*, *cancelled sessions*, and for a small number *poor support* and *poor group process*. The most distressing part of the programme was the "victim empathy role plays" which, interestingly, were also part of the most rewarding module, Victim Empathy.

The quantitative analysis showed that participants' ratings of most modules were positive, and these corresponded to staff progress ratings which were also positive. Comparisons between pre and post programme scores on the Sex Offence Attitude Questionnaire and the Relapse Prevention Interview showed significant improvements. However, therapist ratings of progress only correlated poorly (correlations between .01 and .25) with participants' ratings, raising the interesting issue of whether there are genuine differences between staff and participant ratings of progress in sex offender treatment.

Question 1: How would you describe your experience of the Core programme? What was it about the programme that makes you say that?

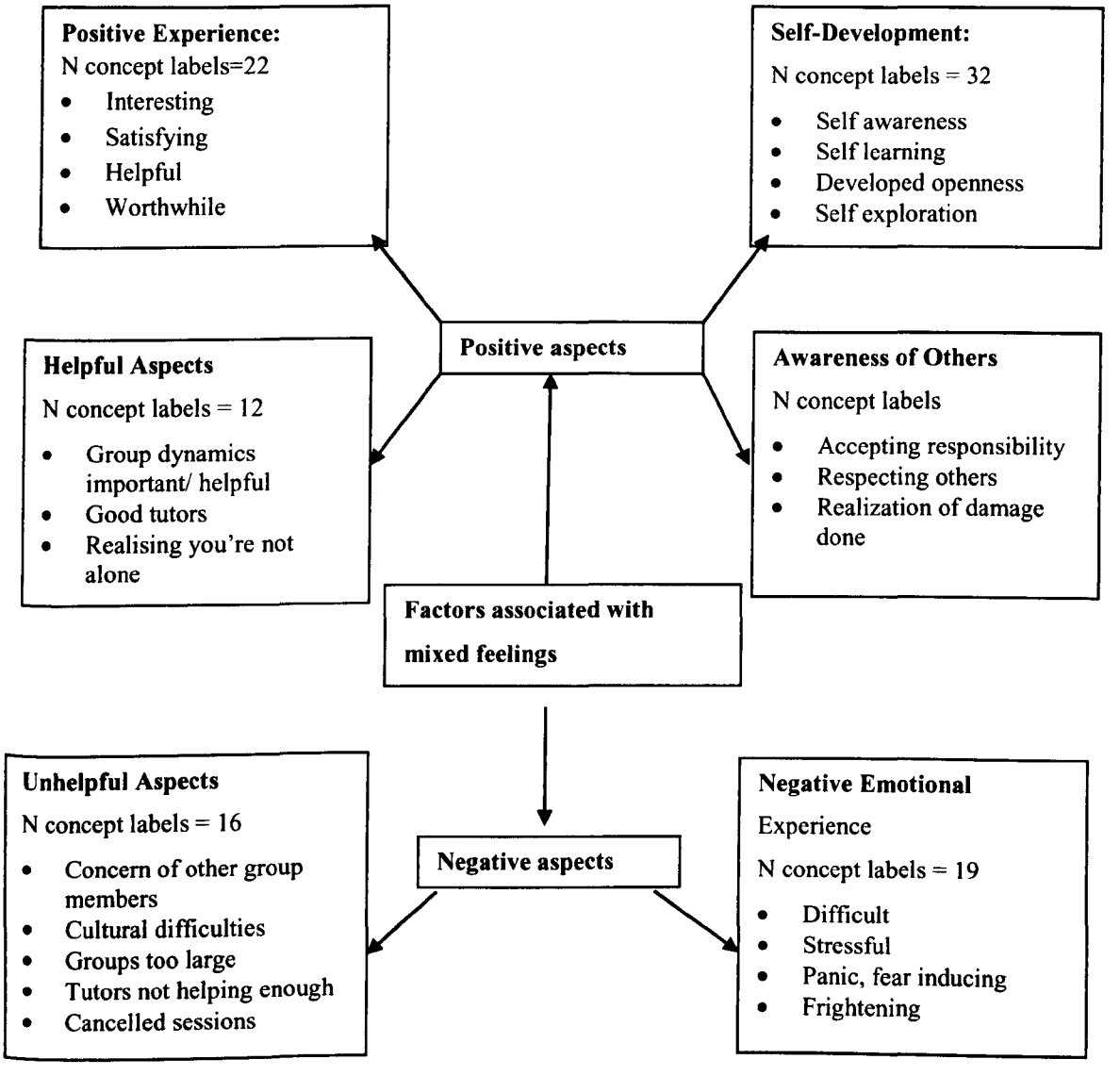


Figure 27. Grounded Theory Analysis of Question One from Wakeling et al. (2005, p. 177)

Three studies were identified which looked at views about treatment or offending[1] by men with intellectual disabilities and sexual offending. The first of these interviewed a group of nine people with intellectual disability attending psychodynamic psychotherapy groups in London, four of whom were men in a sexual offending group (MacDonald, Sinason, & Hollins, 2003). Adopting a qualitative approach and utilising Interpretive Phenomenological Analysis (Langdridge, 2007; Smith et al., 2009; Willig, 2008), MacDonald et al. aimed to elicit participants' positive and negative views on analytic group therapy (2003, p. 435). The participants from the two groups were combined, which for the purpose of examining sexual offending treatment, the results are only partially relevant.

Nevertheless, the study is well reported with a clear description of the interview guide and method, and clear articulation of how the raw data build into the major categories, although the interview guide is perhaps too detailed and prescriptive. In keeping with the way in which questions were framed into positive and negative features, the data divided into two divisions- positive and negative. Within each of these divisions three major themes emerged, with various numbers of categories within each major theme, totalling twenty eight in all. Specific answers from participants all fell within one of these 28 categories and are shown below in Table 37. Of these categories, clearly the most relevant is *helps resist urge to offend,* although *talking about difficult experiences*, *inclusion contrasting with exclusion elsewhere,* and *ability to help others* in the positive themes and *talking is distressing* and *therapists are too confrontational* in the negative themes may also have relevance to the present research.

The authors comment (MacDonald et al., 2003) that the participants seemed to understand therapy involves sharing painful experiences and have some ambivalence toward this aspect of therapy. They also suggest that while the warmth and acceptance of the group seemed as welcome as it is generally, the social exclusion experienced by people with an intellectual disability (Abbott & McConkey, 2006; Department of Health, 2001b, 2009) is likely to make this feature especially important for a group with intellectual disability. Where there is the additional stigma of offending and particularly sexual offending, such inclusion, warmth and acceptance is even more important.

---

[1] There have also been some publications, notably Thompson and Brown (Hingsburger, 1987; Thompson & Brown, 1998, 2007), who have developed training packages for care staff and have included the views and opinions of men who are sexually abusive in their material, but they are not examined here.

Table 37. MacDonald et al. (2003, p. 439) Major Themes and Categories from Interpretive Phenomenological Analysis of Group Participants

	Major themes	Categories
Positive	Non-specific positive comments	Non-specific positive comments about the therapists Non-specific positive comments about the group
	Communication	Talking characterizes therapy Feeling able to talk Talking about difficult experiences Ability to talk contrasting with other situations Being encouraged to talk Being listened to and being understood Helps resist urge to offend (men)
	Inclusion	Group is inclusive Therapists valuing Humour in way of speaking about therapists Inclusion contrasting with exclusion elsewhere Separating from mothers(women) Similar others in the group (women) Ability to help others Therapists are helpful
Negative	General avoidance	General negative comments, talking is distressing, other participants' distress is distressing, therapists are too confrontational, negative reminders
	Negative aspects of group members	negative patient behaviours, others in group dissimilar, group conflict (women), other group members absent (women)
	Other	concrete problems, other

In an interesting variation on seeking participants' views, Courtney, Rose, & Mason (2006) asked nine participants with an intellectual disability who had either been convicted of or engaged in sexually abusive behaviour about their offending process. They also used a

grounded theory approach, and triangulated the emerging 'grounded theory' by testing it against the views of six workers who worked with the men. Courtney et al. do not describe their measure, simply stating in their procedure section "All participants were interviewed using a flexible interview guide rather than a prescriptive structure" (Courtney et al., 2006, p. 173). This makes it harder to understand their departure point during the interviews, and how the interviews were guided or shaped by the interviewer. Nonetheless, this is one of the first published applications of a purely qualitative approach to intellectually disabled men at risk of sexual offending, and shifts focus to the offence process itself rather than response to or experience of treatment. Participants were typical of other published studies for this population, and the analysis produced a model in which eight major categories were described and the inter-relations between them shown diagrammatically.

Despite verbatim answers from participants being included under each major category, the process of going from raw data to major categories is not described in detail, and this undermines confidence about whether the derived categories reflect the raw material from the research, especially when taken together with the lack of information about the interview questions, prompts, etc. Indeed, the concepts do seem very reminiscent of different theoretical constructs in extant theories of sexual offending, such as Wolf's cycle of abuse (1984), but perhaps this reflects the accuracy of these theories or the language used in the treatment programmes. The eight major categories which emerged were *targeting the victim, offence planning, decision point, offence, attempts to stop, reactions to offence, consequences of being caught,* and *offender's attitudes and beliefs*. The authors present a model (Courtney et al., 2006, p. 179) linking these eight categories which has the category *offender's attitudes and beliefs* in the middle, with the other seven categories surrounding this central category, similar to Wolf's offending cycle model.

Hays, Murphy, Langdon, Rose, and Reed (2007) report on a study which interviewed men who had completed one of three SOTSEC-ID groups in London. Sixteen men who met the SOTSEC-ID criteria (identical to those described earlier for the overall SOTSEC-ID project) were interviewed using a semi-structured interview with fourteen questions called the Service User Interview. The interview had questions in three categories, namely factual/memory-related questions, content questions focusing on material covered in the groups, and questions designed to elicit views of treatment. How categories were derived was not made clear, but

the results were presented using categories which seem to have been derived mainly from options given to the participants within the interview (as some categories had zero responses), but possibly also using a content analysis approach in which additional categories are derived from the answers. Irrespective of how the categories were derived, frequencies were reported for all categories and show that a majority of the men recalled significant information for each question in the factual/ memory-related section; most did not refer to sexual offending or other direct terms when asked what the group was for, though their answers could be seen as indirect references to sexual offending ("something wrong"), and thus did recall parts of the programme, which compare favourably to the data presented by Garrett et al. (2003), especially when allowing for the intellectual disability of the Hays et al. (2007) group. The confidentiality rule was important to the men (85% recalling this rule), and having to trust others to keep this rule was difficult for some. Being part of a group and the accompanying social aspects of the programme was beneficial to many, as was the knowledge this brought of knowing they were not alone. Very few men recalled the victim empathy component; yet talking about their offence was the hardest part of the group for many, although many also found this a positive experience, perhaps because as Hays et al. commented "... talking about their secret was a relief" (2007, p. 114).

Some interesting comparisons can be made when looking across the above studies. Firstly, recall of detailed treatment content seems patchy but reassuring across both intellectually disabled (Hays et al., 2007) and mainstream (Garrett et al., 2003, if figures are adjusted for non-responders to this question) offenders, though unsurprisingly better for the latter group. Secondly, there is a consistent finding across several studies (Garrett et al., 2003; Hays et al., 2007; MacDonald et al., 2003; Wakeling et al., 2005) that there is ambiguity in regard to the offence disclosure and victim empathy components of the treatment in that the participants find this sections very difficult, but also seem to derive significant understanding and development from it. Hays et al. describe this in relation to the difficulty and relief which comes from disclosing a guilty secret; Wakeling et al. describe participants' experience of the victim empathy role plays and victim empathy module as being "multidimensional" (p. 184) in that they experienced both positive and negative affect; MacDonald et al. describe it as ambivalent as participants wished to avoid the emotional pain associated with disclosure but also describe it as positive, and relate this to defensive processes in mainstream clients in psychodynamic therapy. While Garrett, et al. (2003) did not report this feature, their survey

methodology may not have been sensitive enough to detect the mixed positive and negative nature of this element of participants' experience. These and other features of similarity and difference across these studies are shown in Table 38 below.

Table 38. Similarities and Differences in Participant Feedback Studies

Study Dimension	MacDonald et al., 2003.	Courtney et al., 2006	Hays et al., 2007	Garrett et al., 2003	Wakeling et al., 2005
Study type	Interpretive phenomenological analysis	Grounded theory	Semi-structured interview, with some open and follow-up questions	Survey	Grounded theory
Number of participants	9 (4 men in a SO group, 5 women in a female group); 2 refusals.	9 men with an intellectual disability	16 men with an intellectual disability who had completed a group treatment programme	42 surveys returned out of 83 sent out to completers of a mainstream sexual offenders group treatment programme	46 mainstream sexual offenders
Model	Psychodynamic	CBT	CBT	CBT	CBT
Mode	Group	Group	Group	Group	Group
Rated group positively	Yes	Focused on commission of offence rather than treatment, so these questions were not addressed.	Yes	Yes	Yes
Being valued, included in group	Yes, and warmth and acceptance of group important		Yes, but reluctant to be explicit about purpose of group	Yes	Not mentioned
Valuing social aspects of group	Yes		Yes	Yes	Not mentioned
Positive about rules/contract	Yes		Yes. Confidentiality rule very important	Yes	Not mentioned
Ambivalence about sharing painful/ illegal experiences	Yes		Yes	No, but survey method may not have detected this aspect.	Yes
Independent interviewer.	Independent, but still demand characteristics	Independent	Independent, but subsequent existing preferred	Survey mailed out or taken at end of group.	Programme staff

The information in the table suggests that:

1. different approaches have been used to seek participant views;
2. group sex offending treatment is generally positively viewed by participants;
3. being part of a group is important in terms of both inclusion and opportunities for socialisation and social skills;
4. the rules and contract framework for such treatment programmes are generally viewed positively;
5. there is considerable ambivalence about the difficulty of disclosing emotionally difficult or compromising material, but an acceptance this has postive effects.
6. when it comes to who should ask the participants for their views, there seems to be a preference by participants for existing staff presumably because
7. difficult disclosure and acknowledgement of offences or abusive behaviours has already occurred with such staff;
8. the demand characteristics this introduces into a study design may need to be controlled for in other ways, for example by having an independent interviewer repeat a random sample of interviews.

Having established the value of ascertaining participants' views and including them in a mixed study which includes qualitative and quantitative methodologies (Todd et al., 2004), we now turn to the aim of the qualitative study to be reported here and the method followed. In keeping with the broadly inductive approach of the qualitative paradigm, study aims have been developed rather than hypotheses (Smith et al., 2009, pp. 46-47 & 135). The study aims correspond to the two phases of the qualitative study, namely the qualitative interviews themselves and the resulting interpretive phenomenological analysis;

The research questions which this study addresses are:

1. To explore the phenomenon of group cognitive behavioural treatment (SOTSEC-ID model) for sexual offending as experienced by men with an intellectual disability who have completed at least one programme of a year's length using IPA to identify the core elements of the participant's experience.
2. To ascertain whether themes emerging from the IPA analysis can be applied to contemporaneous clinical notes from treatment sessions in two case studies.

3. To illustrate the broader context of two participant's lives through a case study analysis.

The first aim will be reported here and the second and third aims are illustrated through two case studies which have been included in Appendix 14 due to space considerations.

Method

Initial themes to guide the production of questions for the qualitative interviews were identified from treatment group records, a taped and transcribed group interview at the end of the second community men's group, and the participants' end of treatment brief interview (developed by Murphy and colleagues). The literature review, which some argue should follow the analysis rather than precede it (Charmaz, 2003), was also conducted beforehand, and the following framework and prompts were developed as guides for the interviews.

Such guidance, which was well-grounded in the participants' experience, was necessary as previous studies have pointed to the problems associated with interviewing people with intellectual disability about their treatment experiences (MacDonald et al., 2003), and it was thought that reflecting and articulating their feelings and thoughts was likely to be difficult for the participants. Some initial thematic development was thought necessary to help direct questions and probes to the most productive areas. Once topics had been identified through this process, interviews were conducted with participants who were well known to the present author over a six to eight year period as a result of being in one or more of the treatment groups and in receipt of associated individual clinical treatment. A Guided Interview (Patton, 2002) approach was used to encourage the participants to open up and talk as widely as possible. The guide areas and follow-up prompts were used to cue the participants into the focus area, and assist the participants to talk at as much length as possible on a relevant topic. Interpretative phenomenological analysis (Langdridge, 2007; Smith et al., 2009; Smith & Osborn, 2003) was used to analyse the transcripts from these interviews and develop answers to the research questions above. Finally in phase three, case studies were used to convey a sense of the treatment programme over time in the life of an individual participant, as well as combining both qualitative and quantitative methods in an

analysis. Case studies are well suited to providing the richness, context and user or participant perspective that is otherwise lacking from quantitative approaches (Yin, 2003).

Interpretive Phenomenological Analysis (IPA) has been selected as a tool for analyzing the material from the qualitative interviews, as it has been specifically developed for such purposes (Langdridge, 2007; Smith et al., 2009; Smith & Osborn, 2003; Willig, 2008). Willig (2008, pp. 72-73) compares grounded theory to IPA and concludes that while the abbreviated version of grounded theory (which starts with the transcript of an unstructured or semi-structured interview) has much in common with IPA, IPA was designed specifically to gain insight into participants' 'psychological worlds', and is therefore "...a specifically psychological research method" (p.73). Grounded theory on the other hand has been developed to address social research questions such as the social processes underlying phenomena, and there is debate and controversy about which grounded theory should be followed and why (Willig, 2008). Smith et al. (2009) acknowledge that grounded theory and IPA are both broadly inductive in their approach, and both proceed in a similar fashion, beginning with a line by line analysis of the original transcript and using increasingly inclusive categories. Grounded theory aims to build a theoretical account of a particular phenomenon with a comparatively larger number of cases, while IPA seeks to provide "... a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the convergence and divergence between participants" (J. A. Smith et al., 2009, p. 202).

Willig (2008) describes grounded theory and IPA in relation to three questions, the kind of knowledge aimed for (epistemological assumptions), assumptions about the world (ontological assumptions), and the role of the researcher. In terms of the kind of knowledge each aims to produce (epistemological assumptions), Willig claims that while grounded theory seeks to produce theories grounded in the data about "...contextualised social processes" (p. 47), IPA seeks to "...obtain an insight into another person's thoughts and beliefs in relation to the phenomenon under investigation" (p. 69). Both approaches assume a realist position in which knowledge of the world is believed to be discoverable and not influenced by the methods of study, although IPA also adopts a reflexive position, which acknowledges the researcher's own standpoint as influencing the sense that is made of the

participants' world view. However, they are similar in that both adopt a symbolic interactionist view of the world (meaning about the world is derived from interpretation of interaction with the world). Ontologically, grounded theory adopts a realist position which posits that the world is an external objective reality, separate to the researcher's attempt to study it, while IPA adopts a somewhat relativist position claiming that the important issue is people's experience of a situation or event. In terms of the third question posed by Willig (2008), the role of the researcher, grounded theory has the researcher as a witness, observing and describing the world and inducing theory from the particular, while IPA has the researcher in a reflexive position, using their own viewpoint to interpret the data. While grounded theory seeks to discover the theory contained within the object of study, IPA seeks to interpret (using the researcher's own viewpoint) the phenomena under study in a reflexive way, that is, in a way which moves between the researcher's and the participants' view. Willig specifically advises against using grounded theory as a methodology for exploring the meaning of a particular experience to individuals, favouring IPA and other phenomenological approaches instead (Willig, 2008, p. 47). IPA proceeds from immersion in the transcript to commenting on overall and section and line meanings, to noting emerging themes, and the development of a hierarchical table of themes and sub-themes, all linked to the original text.

This process is undertaken for one individual participant, and then repeated for others, testing and refining the emerging themes (Langdridge, 2007, pp. 110-111; Smith et al., 2009, pp. 82-106; Willig, 2008, pp. 58-63). This approach is well illustrated in a recent study which examined the changing sense of self from an 'offender' to a 'pro-social' identity of five ex-prisoners who had successfully made the transition to a desistant or non-offending lifestyle (Aresti, Eatough, & Brooks-Gordon, 2010). In this article, the authors also offer an excellent summary of the IPA approach.

The IPA approach has recently been applied in studies involving people with intellectual disability. Longo and Scior (2004) used IPA to examine the perspective held by service users with an intellectual disability and carers on the in-patient psychiatric care of the participants with an intellectual disability. Separate themes were indentified for service users and carers, and the service users themes were *lack of control, protection and nurture versus indifference and harm, negative aspects of the environment, and positive aspects of admission*. Specialist settings were described more favourably than generic settings by both

groups. Clarkson, Murphy, Coldwell & Dawson (2009) used IPA to explore the characteristics of staff which were valued by service users with an intellectual disability and described a number of superordinate and subordinate themes. These are shown in Table 39.

Table 39. IPA Superordinate and Subordinate Themes Described by Clarkson, et al., 2009

Superordinate Themes	Staff Relationship Factors	Staff Attributes
Subordinate themes	Trust	Positive attributes
	Sensitivity	Staff competence
	Helping	Negative attributes
	Mutual Protection	

In a recent article, Cookson and Dickson (2010) used IPA to examine the experience of people with an intellectual disability who had a diagnosis of schizophrenia and were detained in a medium secure unit, and found three superordinate themes, namely *reality of symptoms, making sense, a search for meaning,* and *perceptions of being labelled.* These studies point to the applicability of IPA for people with an intellectual disability, and the Cookson and Dickson (2010) study, in particular, shows that people with an intellectual disability and schizophrenia are able to "...explore and search for meaning in understanding their diagnosis of schizophrenia and psychotic phenomena that they experience" (p. 387).

The case study approach needs no explanation or justification for its inclusion in a psychology study, having a long and well established tradition in psychology and clinical psychology in particular. A number of the studies reviewed in earlier chapters have used this approach, including some on the topic of intellectually disabled sex offenders (Hays et al., 2007; Lindsay, 2009; Lindsay, Marshall, et al., 1998; Lindsay, Neilson, Morrison, et al., 1997; Lindsay, Olley, et al., 1998; Murphy, 1997a). According to Yin (2003), a case study approach allows exploration of contemporary phenomena where context /phenomena boundaries are unclear, where multiple sources of evidence are available, and where there are

more variables of interest than data points. Yin also identifies six sources of evidence for a case study (p.86), namely documentation, archival sources, interviews, direct observations, participant observation, and physical artifacts, the first five of which are available to this study.

Participants

There were nine participants in this study, all of whom had completed at least one, and sometimes two, cycles of the SOTSEC-ID treatment programme with the author, who also served as the interviewer. Thus each participant had a long-standing therapeutic relationship with the interviewer, in one case spanning over a decade and in several others over five years. Participants were selected to represent the different types of participants in the wider treatment programme, so that there was a range of offences, treatment responsiveness, age, legal constraint and residential arrangement (i.e. hospital vs community settings). Details of participants are shown below in Table 40.

Table 40. Description of Participants in the Qualitative Study

Partici-pant	Index Offence	Legal status at time of treatment	Legal status at time of interview	Residence at time of interview	Age[1] SOG	IQ	VIQ	PIQ	Vinelan d	Group Dates[1] (mm.yy-mm.yy)
P1	Stalking	No restriction	No restriction	Community	40	59	60	67		08.06-08.07
P2	Child abduction	s37/41 MHA	s37/41 MHA	Hospital	40	68			168	08.10-08.11 and 02.12-02.13
P3	Sexual assault	s38 MHA	s38 MHA	Hospital	26	64	75	57	156	08.10-08.11 and 02.12-02.13
P4	Sexual assault	s37 MHA	s37 MHA	Hospital	21	77			226	05.07-11.08
P5	Child sexual assault	s3 MHA	s3 MHA	Hospital	20	62	64	67	148	02.12-02.13
P6	Indecent assault	s37 MHA	No restriction	Community	32	67	62	79	203	06.09-06.10 and 09.10-08.11
P7	Rape	s3MHA	No restriction	Community	27	56	62	57	123	06.09-06.10 and 08.10-08.11
P8	Child sexual offence	s3 MHA	s3 MHA	Community	22	60	61	67	119	10.06-10.07 and 01.08-01.09
P9	Manslaughter (child)	S37/41 MHA	S37/41 MHA	Hospital	47	66	71 65		129	08.10-08.11 and02.12-02-13

[1] Age and dates changed systematically to protect anonymity.

Measures

Patton (2002) distinguishes qualitative interviewing from quantitative survey methods, by describing it as allowing us to "...enter into the other person's perspective" (p. 341). It assumes that there is a meaningful and knowable perspective to learn about, and that through qualitative interviewing, we gather the stories of participants and users of programmes in a way that quantitative measurements and traditional forced choice questions do not. Patton describes three types of qualitative open-ended interviews, namely informal conversational interview, general interview guide approach, and the standardized open-ended interview. The measure adopted here is the general interview guide approach, in which topic areas and some textual guidance is provided, as well as a series of prompts for each of the areas the interview should address. The order in which topics are addressed, however, and the style of the interview is more conversational than interview, more relaxed than formal. This seemed appropriate to the type of information we were seeking from the participants in this study.

In order to begin the process of entering into the participant's perspective for the IPA analysis, a set of topics or issues were developed from several data sources on the treatment programme, namely:

1. an audio tape and transcript of a group interview/discussion held at the end of the second SOTSEC-ID treatment group run by the present author;
2. clinical material from treatment groups[1] for these nine participants;
3. Men's Group Data Bases (see Chapter Four for further details) for these nine participants;
4. Participants' end of treatment interview (based on the feedback form developed by Professor Murphy and colleagues)

---

[1] This 'clinical material' was notes taken during treatment groups, and participants understood that,

> "We will get to know lots of detailed information about you personally and your thoughts and feelings about the Men's Groups, and sexual offending.
> We will write what is called a case study which brings all this information together along with the results of your assessments in the Men's Groups. The case study will not include your name or anything that will identify you."

Taken from Information sheet to participants (see Appendix 11).

Analyses of these areas resulted in the following themes emerging:

1. the relevance of previous life experience and sexual offending;
2. the need for balance between 'talking activities' and 'doing activities' in the groups;
3. the difficulty of disclosure within groups;
4. the upsetting nature of challenging behaviours within groups;
5. that the men considered the groups a 'learning' activity;
6. they were concerned about reoffending;
7. the men liked being asked about changing the group;
8. interviews should be conducted by people who had run the group.

These topics were in turn utilised to develop the questions for the Guided Interview, guidance for which was taken from Patton (2002), and in particular his guidance on the structuring and framing of questions (pp. 348-379). Patton argues for the utilization of a two dimensional matrix which incorporates six different questions types (*experience and behaviour, opinion and values, feelings, knowledge, sensory, and background demographics*) over three different timeframes (*past, present and future*) to ensure all required areas are addressed and sequenced appropriately in the interview guide. Patton suggests that initial questions should focus on the present and easily answerable areas, such as superficial aspects of an experience, and be based on description of events rather than disclosure of feelings. He further advises that future oriented and deeper questions about feelings and deeply held beliefs should come after the participant is "warmed up" and talking as freely as possible. Thus the questions in the Qualitative Interview Guide developed for this study began with questions about the practical details of the treatment, then to knowledge of what was learnt in treatment and then to opinions and feeling about treatment. All of these topics were either in the past (e.g. practical details of the group) or the present (e.g. what knowledge do you still retain about the topics covered), and started with easier practical issues and moved to more sensitive topics (opinions and feelings about the group). The questions then moved to earlier life experiences prior to offending before asking sensitive questions about

previous offending and the participants' understanding of the risk they posed and how this should best be managed. Finally, the questions moved to the participants' view of their future and recommendations for change in the treatment itself. A draft interview guide was thus produced and administered on a trial basis to one participant and modified slightly for subsequent interviews as a result. The final form of the interview guide appears in Appendix 16.

Procedure

Overall ethical approval[1] for this part of the research has been discussed previously in Chapter Four and will not be reviewed here. The participants were taken through the approved ethical procedure to obtain consent in which the information sheet about the research was read out and explained. In one case, the information sheet was partly read by the participant himself and assistance provided for meaning of some sections and phrases. In all cases, the research project was discussed with the men on at least two occasions so that they fully understood the procedure they were consenting to. Following the concerns raised by Arscott et al. (1998), particularly those in regard to acquiescence, care was taken to have a key worker, named nurse or other member of staff present who could advocate on behalf of the client, and these individuals were encouraged by the researcher to fulfil this advocacy role. An information sheet was left with the participant if they were willing to retain it (some were not), and copies were offered to staff members including the staff member in attendance during the consent procedure. Each of the participants, once they consented, attended an interview which ranged in time from thirty minutes to an hour and was audio recorded on a digital dictaphone and later transcribed. The interview proceeded through a series of ten topic areas in which the topic area, textual guidance, and prompts within each area were supplied by the interviewer, and the interviewer used unscripted follow-on questions where appropriate. Interpretive phenomenological analysis was used to analyse the transcribed interviews.

The analysis followed the standard IPA procedure ((Langdridge, 2007) in which the following steps occurred.

1. Transcripts (with wide left and right margins) were read and re-read, and then comments made in the left hand margin about the meaning of the section. Interpretive comments were kept to a minimum.
2. Emerging themes from the comments made in step one were listed in the right margin, on the basis of the left hand margin comments, but also referring back to the taped interview itself and the transcript. These themes were broader than the initial comments in step one.
3. All of the comments in step one and the emerging themes in step two were listed on a separate sheet of paper in their original order of appearance, and then combined and re-combined with reference to the text.
4. A final table of superordinate themes and sub-themes was produced, which included reference to the particular participant comments from which it is derived or which exemplifies the theme.
5. These themes are then described in some detail with reference to direct quotes from the participants.

IPA, like grounded theory, asks researchers to immerse themselves in the words and concepts and descriptions provided by participants of their experience, and to develop a conceptual framework without pre-conceptions or constructs imposed on the data. Transcriptions of the interview were read and re-read and then initial comments and possible themes were noted prior to a line by line consideration of the transcript for possible themes. The four stages described above were carried out for the first three participants, and a further separate analysis carried out several months later on a further participant. These two analyses were then combined and refined on the five further participants.

Results

The combined IPA analysis was based on two separate IPA analyses carried out several months apart, in both cases by the author. The combination of these two analyses produced a set of six themes to describe the experience of participating in the SOTSEC-ID treatment programme (the previous set is shown in Appendix 15) which is summarized below in Table 41.

Table 41. Combined IPA Superordinate and Subordinate Themes

Superordinate Theme	Subordinate Theme
Background to Offending	Family history, dynamics and dysfunction Personal history and victim experiences Index offending
Memory of Treatment	Incidental operational details Psycho-educational content
Experience of Group Processes	Confidentiality and disclosure Help and comfort of group Disruptions Adjustment to treatment Change from Start to finish Seriousness of group
Impact of Treatment	Responsibility for offence Overall effects Likelihood of getting caught Risk/restriction balance
Future	Self Group
Fear of Reoffending	Urge to reoffend still present Resentment of freedom and 'hold' of group to whom attracted Dread of desire and its consequences

Background to Offending

This theme of the IPA attempts to understand the person's perception of key aspects of the family structure within which the person was raised, especially any potentially dysfunctional features such as absence of either parent for significant periods, any physical, sexual or emotional abuse which occurred during their personal history, and the manner of their index offending and any connections which can be drawn between these elements. The three subthemes are thus Family history, dynamics and dysfunction; Personal history and victim experiences; and Index offending. An observation on the basis of clinical experience in running the groups is that there is often a similarity between the way in which the participants were abused, especially sexually, and the nature of their subsequent offending or sexually abusive behaviour.

Family history, dynamics and dysfunction.

All participants spoke of some significant family disruption, disintegration or experience of abuse. P3 spoke of his parents separating, using wry humour to cover his hurt over the incident some years previously *...they split in* (gives year) *and it was on (*gives date) *and guess what, it was on my birthday too*[1]. Some had very disruptive home lives with multiple male partners in the home, as P2 describes it, *I don't know who my real dad was; some stayed for a little while some stayed for a bit longer; it must have been about twenty, thirty people.* In some cases the sexual boundaries seem very relaxed and inappropriately discussed across generations, *I believe that now she's got more than one partner because* (while on holiday with one partner the same P3's mother told him) *I found myself (another) boyfriend.* When asked about his father, of whom he had no memory, P4 said *I've got, I've got... you know I've got pictures of him.* The same

[1] All participants' comments will be in italics.

participant described being intimidated at the hands of a foster dad, *No um... one was a foster parent (who) threatened me with a... I dunno... think a screwdriver or something...*

For P1, his dysfunctional family history and abusive history overlapped. He reported that his father had sexually and physically abused him, and said of his dad that *He s... scarred me, he s...* referring to emotional scarring. When asked about his dad, P5 said *He left about over a dozen times*, and when asked about the present said *He's left full time*. When this participant was asked about sexual abuse, he said *Um...apart from my brother, that's it...sexually abused me.* He also reported being bullied *...loads of times when I was at school, loads of times...* P6 reported a history of domestic violence which had included witnessing his father attempting to strangle his mother and being hit by his father. He had also been bullied at eight-nine years of age and assaulted by a group of boys, as well as being sexually assaulted at age 17. P8 reported multiple father figures and two mother figures (neither of whom was his biological mother), as well as cross-generational couples within the extended family. He said, *My real mum walked out when I was younger..er, must have been about six* (question about this being upsetting) *Well it weren't really upsetting because I was ready to kill them* (aged six).

Personal history and victim experiences.

There was reference to bullying or abusive incidents during childhood amongst all participants, such as P9, who although having both parents at home for most of his childhood, described an abusive incident involving a van driver who showed him pornography. He reported, *er...he used to show me porno pictures from Sweden...he was allowed to have them in his bedroom* (my older brothers were) *calling him a queer, a pervert...he (*P9's brother*) did hit him as well*; and P2, *Well I was badly hurt um... many years ago and abused at the back of a school bus*. P3 describes an abusive incident when two older youths sexually assaulted him and were arrested and went to gaol, *both, both of those got arrested;* and prior to their arrest their threat to P3 about disclosing the incident, *They said that if I told the police they were going to smash my head against a gravestone. So actually I was frightened, I was scared. I was worried and came running back in tears.* P4 described a sexually abusive incident when he was fifteen years old, *I was*

talking to this bloke you know... yeah... so we went upstairs and had a beer and that... all I know is that I woke up in the bed.

Index offending.

This is based on a noted similarity between the personal abusive histories of some of the group participants and the form of their sexual offending. P2 suggests a possible link between emotional distress and offending when he says that he cannot watch violence and abuse on television *because it brings back to me sad memories...and it makes me feel very anxious and very agitated...and sometimes I might take it out on other people.* P8, who had a very fractured and disintegrated family life, offended by befriending families through church and then offering to babysit or child-mind. During a treatment group (not a qualitative interview) he said he wanted to *rip the families apart.*

Memory of Treatment

This theme includes two subthemes, namely recall of incidental operational details of the treatment and recall of the psycho-educational content of the treatment. While not a vital issue, especially incidental operational details, it does demonstrate the treatment as a significant event worth remembering, and the lack of any reactions to such questions suggests little trauma associated with the treatment.

Incidental operational details.

The first subtheme refers to participants' recall of the practical details of the programme such as how many groups they had attended, where the groups were, how long they were, how frequently they occurred each week, as well as who facilitated the group. All participants were able to recall broad details such as length of treatment, facilitators names, time and day of the treatment, and other practical details, for example, *I attended two of them in two years (P9);* (when questioned about the number of groups) *I've done two (P3).*

Psycho-educational content.

his included elements of the programme such as sexual knowledge and attitudes; the cognitive model of behaviour including the identification of thoughts, feeling and actions; the four stage sexual offending model adapted for the programme from David Finkelhor's original model; victim empathy or their understanding of the range and level of impact of their offence on their victim(s); and finally relapse prevention or the way in which risk control strategies were brought together in a package which with their agreement and cooperation could be used to minimise future offending or sexually abusive behaviour. Participants all recalled at least some of the above elements, and when asked what they recalled responded with comments such as, *Victim empathy...er...putting myself in their shoes (P2). We did the four stage model...not OK sexy thoughts...making it OK, planning; I've got the four stage model, I've got the um oh the four stage model relapse prevention plan (P3). What it was like for the victim of our offence ... now that means putting myself in the victim's shoes (P3);* (touching) *Young children- it's against the law, and there's all kinds of laws nowadays protecting children from people like me (P9); age of consent; we did the four stage model (P3). Thoughts... feelings... thoughts, feelings and er actions and offending (P2). Yeah we done... we done the four stage model..., feelings... actions...And thoughts. I have learned how it feels for the victim...* (P4). P1 said that he learnt *...not to stare.* P1 also reported that more than five years after the conclusion of his second treatment group he had watched reporting of sexual crimes on Crimewatch (BBC TV programme) and realised that it makes the victim feel ... *lot bad, lot bad,* illustrating some generalisation of the victim empathy component.

Experience of Group Processes

This theme captures the psychological and emotional response to the different therapeutic elements in the treatment programme, including the difficulty of attending, participating and engaging with the group at an interpersonal and psychological level.

There are a number of subthemes, namely Confidentiality and disclosure, Help and comfort of group, Seriousness of group, Adjustment to treatment, Disruptions, and Change from start to finish.

Confidentiality and disclosure.

There were high levels of concern around confidentiality. For example, *Because one or two of the other patients have said 'are you here for children'* (in a way that implied threat) ... *it was very difficult for me to disclose any confidential information* (P2.) There were also concerns about the actual disclosure process itself, for example in response to a question about disclosing feelings, P3 said, *Hard...they were hard (to disclose), difficult, especially if...your mum and dad had a marital breakdown and split up, and... if you've had racist problems... like I had at school... it, it does upset you a lot, it's hard to talk about* (P3). P2 was clear that confidentiality was important to him, *...it was very difficult for me to disclose any confidential information. That's (confidentiality) the number one key issue.* There were many concerns expressed about disclosure of general information about themselves including their feelings and especially concern about attitudes towards them by members of the public, *They... if they saw people like me they would literally beat you up.* Although disclosure was difficult, once this occurred most reported it as a positive experience. P3 said ... It was very hard, it was quite emotional and upsetting, but I've managed to get through that. P7 found discussing previous offending very difficult, *...what we talk about I did find it really upsetting* (question- which bits?) *...in the past...I mean what you've done to your victim in the past.*

Help and comfort of group.

This included issues such as acceptance within the group, for example one participant when asked why he thought other group members had not rejected him when he disclosed his offence (his previous fear), replied (referring to offenses of other people in the group) *similar offences themselves;...one big you know... family in the group and we all got to live together (P2).* There was comment about the comfort or support provided by the group, with P1 saying about the group that he had *liked all of it.* In terms

of the preference for group therapy over individual therapy, P2 said...*personally myself I'd like to be in a group;* P1 said *group* in response to a question as to which he would prefer. P4 remarked, *Doing it individual yeah, you're... gets a bit boring and it's... you help each other out.* P3 said... *and when I leave um, I think everybody's gonna miss me because I'm a really kind guy, a funny man, good sense of humour...* One participant (P9) stated he had learnt to *take turns* (in conversations), and *I've learnt other people have problems with children as well;* and *...the people around me was helping me.* When asked which aspects of the group he had liked P1 replied *all of it.* P5 rated the group and the whole treatment as *good.*

Seriousness of group.

The final subtheme is the serious nature of the group which came through repeatedly, despite attempts by some participants to trivialise, joke, or even to capture the agenda and move it to one supportive of sexual offending. For example, *...doing my little practical joking about... I've been told to, you know, knock it on the head...because the group is more serious than that you know, than the joking about thing, because people might take an offence to that (P2).*

Disruptions.

P1 was a major source of volatile verbal incidents during one of the groups. When P1 was asked how this had been dealt with he replied that *we had a chat*, and agreed that as a way of dealing with this disruptive behaviour *it was okay, yeah*. P6 described how *when others talked about child offending it upset me* (interestingly this probably reflected his worry about being labelled as a paedophile, as his victims were underage, though not children).

Adjustment to treatment.

This refers to the adjustment the men made during the group to accepting the need for treatment. P1 indicated that while it was hard to talk about things that were private initially, this became *easier* as the group went on, which was a similar sentiment to P5,

who said it was a *bit hard at first*, but as the group went on he *just got used to it*, and had *been more open*. P6 reported that initially he was *confused, nervous, anxious and agitated, and didn't know what to do*, but he adjusted to the programme and *felt OK and relaxed*, and was able to *get everything out* although he was also *glad it is over*. This process is conveyed most clearly in P7's comments, *First day... I was nervous I was a bit scared... I was ... (*wondering*) what we would talk about, it would be um... not good to talk about.* (Question: And as the group went on... did it get harder or easier?) *It gets... it got a bit harder... but then it got easier. Because... I just thought it just got a bit easier after I think I felt more comfy with people.*

Change from start to finish.

When asked about the start of the group one participant (P9) said, *At first I thought it was negative, always thinking the worst...and always had my suspicions that you* (talking directly to the interviewer who had also been the therapist) *was up to something;* then when questioned how he feels now about the group replied (I) *want to do another one.* P4 said, *First time we met it was hard...* (implying it became easier as the treatment went on). P4, commenting on how he felt in the early stages also said, *Yeah, it's like I said before... you don't know what they're thinking* (talking about other members of the group*)*... and then agreed it became easier as the treatment proceeded, *Took us like, took us like a couple of months and that.* P5 said, when questioned about how he felt at the beginning, *I was nervous...I didn't want to do it... um... at the end I felt... I need to do it again.*

Impact of treatment

This theme refers to the impact treatment has had on the men's future likelihood of sexual offending. Subthemes include the level of responsibility accepted for the index offence and other offending, overall effect of the treatment, the role of other restrictions in conjunction with treatment, the likelihood of getting caught for future offending, the balance between risk and restriction, and self-esteem.

Responsibility for offence.

The first subtheme was acceptance of responsibility for the offence, which includes key cognitive distortions around blaming the victim or other circumstances for offending, and accepting both the actual commission of the offence as well as its aftermath and consequences for the victim and their family. P9 said in relation to how much percentage responsibility was his or his victim's for his index offence of killing a child (trying to test whether he would attribute even a small percentage to the victim), *one hundred...* and then in relation to an assault on a girl, s*he was only five...* (to a question on how much of the fault was his) *...hundred percent.* P2 replied to a similar question, *Me. Not them. It's me. It was me* and *No, no, hundred percent my fault.* P2 also stated more clearly and eloquently, *...it's not the person's fault that they wear trendy clothes...it's my fault if I've got sexual orientations towards young fourteen year old ...boys...I've got to deal with it, I have to deal with the sexual offending and I have to deal with that, so that I don't reoffend.* When asked whose responsibility his index offence had been, replied, *Ninety-nine point nine per cent.* To the question: who is to blame, he replied, *Me.*

Overall effects.

The second subtheme was the overall change the participants perceived had occurred as a result of the group, including the amount of this change. Most participants viewed the treatment programme in a very positive light and described the impact on their outlook and likelihood of future reoffending as significant. P9 said, *It was a great help.* P2, who was still finishing his second group, said, *I think it's going very well... and if it does come to an end, which it is very soon, I'm hoping that I can go in to another group or a maintenance group. Yes I believe the group* (speaking of the first group) *has helped, yes.* Some participants described this change as a *massive change;* others described it as *wonderful, perfect, a hundred percent (P3).* When P4 was asked what specific way the group had helped him after saying that it had helped a lot, he stated, *when I go out in the community and I know like... right from wrong* and, *I learnt not to offend in the future.* P1 said in response to a question about the overall treatment, *...it*

went well, it went well, and asked what changes it had made to him, said he had learnt about *not touching people, not touching people.* P6 said that the programme helped him to stop offending.

Likelihood of getting caught.

Most participants thought they had a higher likelihood of their apprehension in future should they re-offend, partly because they had already been 'caught' at least once previously, partly because they had become labelled as a result of this process, and partly because this particular distortion about 'getting away with it' had been changed during the treatment programme. Comments related to this subtheme include, *too much to gain too much to lose; ...I would end up in prison* (P3). P1 conveyed in a long and repetitive dialogue how he fooled himself that *...it's okay to do it* (an offence), thinking that he won't get caught, but now realises ... *you get caught*, and later in the interview when asked why he had said *No!* (quite firmly) to the possibility of reoffending, said *get caught* again.

Risk/restriction balance.

This related to the balance between risk reduction strategies contained within the relapse prevention programme and the impositions these imposed on the men's lifestyle, free movement and liberty. This subtheme identifies the men's understanding of this balance between risk and supervision and the way that the relapse prevention plan operates on a day to day basis leading the participants away from high risk activities and strategies towards lower risk activities and strategies. This is exemplified in the following comments, *one day I might be ... not risky to children...which is like a dream... stay with staff all the time... I'm not to be trusted... not to be trusted by myself* (P9). Yet despite this insight about needing supervision, later in the interview P9 also said, *and... er... I want to ask the Home Office about this, if they could move the restriction order, and make me, er, I would volunteer to stay in hospital.* P3 said, *and not going to parks and that, yea, I do understand that, yeah. So you've got to weigh up the balance between...the risks that I pose to the public...So you have to weigh up the options.* P2 said,

Like, if you see a young kid playing in the park don't go there... you know... (staying on the) *right side of the law, giving people space, not hanging around risky places- swimming pools, adventure playgrounds, school gates, very risky for me. Distracting yourself... we went to XYZ church and there was a group of schoolchildren and I said to staff, Mary (not actual name), Can we go* (i.e., leave), *Mary, you know? And she goes Yes, You can. I said I feel a bit uncomfortable. But that was honest so that's good. Like the good force and the bad force (P2).* P4 talked of the restrictions in the following way, *Er... not take all of them away no... But relax them a bit don't it?* (Question: Relax them completely or just relax them a little bit?)... *No just a... relax them slowly init. I dunno it's like... keep an eye on me...* P4 also provided a sense of what it is like to live under such restrictions by pretending they are not there whilst still abiding by them, *Act as if they're not there and you are on your own... so you try to act within your restrictions but pretend they're not there. They're okay. Sometimes they're just don't... they're acceptable, to me a bit, sometimes I just like er... I know they're there but... I think they're not... So you pretend they're not there* (Question: Is that because you feel a little bit embarrassed about them when you are out in the community?) *Yes.*

The Future

Subthemes which are part of the future include the men's view of their own likely future in terms of reduced detention such as... *moving on. I'd like it to be a very slow progress.* Paraphrasing their comments, they wanted steady decreases in restrictions for those in secure settings, and for most participants more generally, an increased freedom of movements and opportunities for social outings and engagement. This also includes the men's comments about what changes should be made to the treatment programme for other participants similar to themselves who may need treatment in the future. In all cases the participants were usually very positive about the programme continuing to be available for others in the future and were relatively unable to make any suggestions for improvements.

Self.

Some participants, such as P4, had not thought much about their future, *Er... I... I don't know really 'cos I haven't thought about it.* Although, despite this comment he also said... *It's made my like... future better now* Others were quite positive, and hoped their progress would help them move on, for example, *I see my future hopefully in the Summer leaving here.*

The group.

P4 suggested more sex education and role play, and P1 suggested the facilitator should be gentler on participants in terms of pressing them less to disclose difficult material, though when asked if we should keep running the men's group, most participants were quite clear, *yes, yes, yes* (P1); *Keep it as it is* (P5).

Fear of Reoffending

This theme refers to a developing awareness that seems to emerge towards the end of treatment that despite their best intentions, the urge to offend again is still present within many if not most of the participants. While this may be in part a natural consequence of the appetitive and primary biological system involved in sexually abusive behaviour, this realisation seems to weigh heavily on some participants. There was also a sense of dread in some of the participants about both this attraction and its possible consequences. One or two expressed this as fear of being put away in gaol, or in a deep dark hole. The specific subthemes were the urge to offend still being present, a resentment of the 'hold' that the group they were attracted to seemed to have over them, and a sense of dread some had about the future.

Urge to reoffend still present.

Examples of this include comments such as, *You know... you can... you can use a scrubbing brush and scrub the carpet as much as, you know, as much as you can, but its*

still, it's still not as good as having it like from stage one... because I want to be less risky to children (P2). *Like to be a lower risk but maybe you never stop it, but nice to have the hope of reducing risk (P3). You can't really say...you've done enough work, you know, we think, we're going to give you a chance and...you know...leave hospital... without supervision...feelings still not umm..I do think it's reduced my risk a little bit... I wouldn't say much, but a little bit, which is about enough for me, you know.*

Resentment of freedom and 'hold' of group to whom attracted.

The second subtheme which seems part of this fear of reoffending is a resentment towards the group (e.g. male children, female children) to whom the participant is attracted, which seems to relate both to their relative freedom in comparison to the participants (especially those detained under the Mental Health Act (1983 as amended) and also to the 'hold' which these objects of desire have over the men. For example, *Kids nowadays, they can go where they want, they can dress how they want... You know... kids can walk around with a label on them saying...you know...I'm under age, you can't do nothing to me, they can walk around as freely and easily as they like.*

Dread of desire and consequences.

The fear of reoffending is also expressed in the fear for themselves of the consequences of reoffending. Despite the victim empathy element within the programme, this fear of the consequences is largely about the personal consequences for the men, namely stigma, repudiation, and further incarceration. One of the participants referred to this as being put into a... *deep dark hole.* Another said, *Now someone like me who has got learning difficulties... went to prison... wouldn't cope because people in prison would not take kindly, to people like me... You know, what I've done. They... if they saw people like me they would literally beat you up... Because they don't take kindly to... people like that, and the public don't like people like that, because you know... because*

the perception of the public is...you know... some of them... all of them, all of the public people wouldn't like that, and they say it's disgusting and horrible.

DISCUSSION

The purpose of the IPA was to explore the experience of attending and participating in a sex offender treatment group for men with an intellectual disability. For most of the participants, treatment was a two year programme, and many difficult issues were raised in regard to family and previous trauma, as well as their offending. Due to the length of treatment and the issues which treatment raised, this also meant that issues to do with early family dysfunction, previous trauma and especially sexual abuse were raised. The men also clearly remembered aspects of the treatment content, the psychological processes and emotional effect within the treatment, and its longer term impact on them. They also expressed some sanguine views about the persistence of their preoccupation with an illegal act and its risks for them and others in the future. Five themes and twenty subthemes emerged which have been summarized previously in Table 39, and are considered again now from a wider perspective. The five themes were Memory of treatment, Background to offending, Experience of group process, Impact of treatment, Fear of reoffending, and Future.

The first major theme, *Background to Offending*, raised the difficult issue for most participants of childhood and early family life, which is captured in the sub-theme *Family history, dynamics and dysfunction*. Only one of the nine participants in the IPA had any substantial positive contact with his father during his formative years. *Physical history and victim experiences* reflects the fact that sexual abuse was a common occurrence in most of the participants' pre-adult lives. There was some support for links between early patterns of victimization and subsequent offending, though this was not common to all, and is somewhat conjectural. It was clear from the way in which these issues were discussed within treatment, that these issues were still a potent force within the men's lives. While there is previous reference to family dysfunction and early abuse factors

being prevalent in the backgrounds of sexual offenders in general (Barbaree et al., 1993), and sexual offenders with an intellectual disability (Lindsay et al., 2001), there have been few qualitative studies, at least in intellectually disabled offenders, which have looked at these issues from the participants' viewpoint. *Index offending* reflects the participants' experience of their index offence as a 'hinge event' in their lives, a point around which many things changed.

The second major theme to emerge from the IPA is *Memory of Treatment.* The participants' experience and comments suggest, as do previous studies reviewed in Chapter Three as well as Hays et al. (2007), that men with an intellectual disability do retain relevant memory of the treatment including psycho-educational content.

The third major theme, *Experience of Group Processes*, examines the participants' experience of therapeutic processes in some detail. It seems clear from the subtheme *Confidentiality and disclosure,* that there are very strong concerns around confidentiality, and that unsurprisingly this is closely connected to the willingness of the participants to disclose relevant material. There is also some evidence for the same finding of previous studies (MacDonald et al., 2005; Hays et al., 2007; Garrett et al., 2003) that there is an ambivalence about disclosure, which changes once the 'secret' is revealed and is therefore cathartic and positive for the participants. The subtheme *Help and comfort of the group*, shows the importance of these therapeutic elements in the group treatment programme, and is consistent with earlier work by Beech and Fordham (1997), and a more recent summary of research related to therapeutic processes by Serran and Marshall (2010). Both of these publications point to the importance of participant experience of treatment being a positive one in order for treatment to be effective. The subtheme *Seriousness of group,* points to how the participants understood and appreciated the serious content of the group and the importance of maintaining a therapeutic focus. The subtheme *Disruptions*, was a particular example of this in that maintaining a peaceful and positive atmosphere and minimising disruptions was important to the men, at least in part because they wished to maintain a therapeutic focus.

The subtheme *Adjustment to treatment*, describes the adjustment which participants seem to make from anxious anticipation and avoidance, to enjoying the positive aspects of the group and engaging with the group processes to make therapeutic progress. The subtheme *Change from start to finish*, identifies the contrast between participants' attitudes to treatment at the beginning and end of treatment, a trend which usually continued into the second treatment programme, with even further improvements. These changes in their experience of the programme were evident in both their comments during the qualitative interviews, but also in their comments, engagement and expressed emotion during the treatment programme itself (although not formally part of the IPA).

The fourth major theme, *Impact of Treatment*, tries to summarise the participants' experience of change when looking back at the way in which the treatment affected them. For nearly all participants, the subtheme of *Responsibility for offending* reflected their own perception of their responsibility for offending. After, or at some point during treatment, it had changed from their initial attitudes in which there was minimal acceptance, to "...one hundred percent" over the course of treatment, as more than one participant said. Most participants also expressed strong positive views about the *Overall effect* of the group on their offending intentions and attitudes, the second theme. A similar positive change was reflected in both an increased understanding of the likelihood of being apprehended if they offended again (*Likelihood of being caught*), and a more realistic appraisal of the risks and restrictions which services must manage and which participants experience daily (*Risk/restriction balance*).

The fifth major theme, *Future*, considered the participants' perceptions of what lay in their future and how they felt about it. The two subthemes which emerged were about their own personal future (*Self*), and their thoughts about the future of the treatment (*Group*). With the present author having a long term knowledge and experience of each of the men and their views through the treatment programmes and other clinical work, their comments in this area had echoes of some of the comments participants had made in the treatment groups or during individual sessions. There was also an interesting age

split, in which the younger participants tended to be more optimistic and hopeful- perhaps naively-and the older participants tended to be more fearful of the future. Their positive experience of the treatment, especially towards the end, seemed to be reflected in their positive views of the programme and their recommendations that others in their situation should also experience the group.

The sixth and final major theme, *Fear of Reoffending*, was not common to all participants, but contained interesting subthemes. The subtheme *Urge to reoffend still present*, captures the frustration and even slight sense of despair that some participants had when they began to see their sexual attraction to children as a long-standing problem for which there was no 'easy fix' and one that required constant vigilance on their part to manage. The subtheme *Resentment of freedom and 'hold' of group to whom attracted,* was also not apparent in all participants, but was quite clear in some, namely a resentment of the 'hold' that participants attributed to the individuals and group to whom they were attracted. This resentment seemed more acute for those who were detained as the contrast was more obvious. There are some interesting parallels between this finding and some crimes involving sexual violence especially when it is gratuitous rather than instrumental (Proulx & Beauregard, 2009). The final subtheme *Dread of desire and its consequences*, is the dread felt by some participants of the consequences of their sexual attraction to children, both in terms of potential loss of liberty, but also in regard to the despair referred to in the first subtheme., *Urge to reoffend still present.*

While several studies were reviewed earlier in this chapter which have considered the perspective of participants in either mainstream sex offender treatment programmes (Wakeling et al, 2005; Garrett et al., 2003) or programmes for men with an intellectual disability (MacDonald et al, 2003; Courtney et al., 2006; Hays et al., 2007), and three IPA studies were also discussed which looked at the experience of people with an intellectual disability with schizophrenia (Cookson & Dickson, 2010), or in hospital settings (Longo & Scior, 2004; Clarkson et al, 2009) very few were discovered which applied either an IPA or a Grounded Theory approach to the experience of men with an

intellectual disability who had completed a sex offender treatment programme. While MacDonald et al. (2003) used IPA to look at a group of four men with an intellectual disability and sexual offending; they had completed a psychodynamic rather than cognitive-behavioural treatment group, and had combined the results with another group of five women who did not have sexual offending histories. Hays et al. (2007) looked at the same population as this analysis, who had also completed the same SOTSEC-TD cognitive behavioural treatment programme, but they used a content-analysis approach, and the study by Courtney et al. (2006) examined the offending process itself rather than treatment using a grounded theory approach.

The above analysis represented an IPA of a small group of men who had experienced sexual offending treatment for up to two years and were interviewed by a therapist with whom they had worked intensively for this time and in some cases many years longer. The therapist in question was also the researcher and the present author, so there are clear issues about the objectivity of the interviewing and analysis process. On the one hand this led to a greater familiarity and ease of conversation which facilitated discussion of occasionally difficult and sensitive topics, but on the other hand ran the risk of simply 'discovering' from the interviews the very categories and issues which the researcher expected- both from his previous exposure to the participants as a therapist, and from his own preconceptions as a researcher. There was in all cases an apparently good 'therapeutic rapport' during the interviews and as expected this will have created an opportunity to bring both insight and depth to the material and the analysis from both sides, as well as a risk of imposing on the data through the questions, the interviews and the IPA itself a set of pre-existing categories of meaning that are more about the researcher and therapist's experience than that of the participants. However, there is a resonance between the IPA analysis and the major themes and subthemes which emerge, the comments and recounting of their experience by the participants, and this author's experience of the participants' therapeutic journey. The quality and objectivity of the interview data, and the IPA itself, would be improved by separate analysis of the audio recordings by another researcher who had no involvement with the participants as a

therapist. Similarly, interviews of participants by a researcher who had not also been a therapist would offer the opportunity to either challenge or confirm the categories and sub-categories emerging from the above analysis.

CHAPTER SEVEN. STUDY THREE: VALIDITY OF THE MEASURES

Introduction

Validity is not a new concept in psychology. Writing in 1955, Cronbach and Meehl's classic paper on construct validity (Cronbach & Meehl, 1955) changed the way in which validation of psychological tests are viewed. They argued that there are four forms of validity, namely predictive validity, concurrent validity, content validity, and construct validity (p. 281). As both predictive validity and concurrent validity can together be described as criterion validity - as in each case a comparison to a criterion is required- one at the same time (concurrent) and another in the future (predictive) – Cronbach and Meehl argue there are only really three, namely criterion validity, content validity, and construct validity. They argue that the most important form of validity is construct validity, which they somewhat clumsily describe in the form of a question to a construct validity investigator as: "What constructs account for variance in test performance" (p. 282). Another way of saying this is that construct validity is the extent to which the test measures what it purports to measure and what else it is also measuring.

Whether a test measures what it purports to measure is no small matter, however, and as Cronbach and Meehl show, construct validity exists as part of a 'nomological net' (p.291) which is the system of ideas, concepts and laws about their relationship which makes up the theory of which the particular construct is a part. If the theory of which the construct is a part is deficient, then this will affect the construct validity of the test. In this sense, the whole of this research is about the validity of the constructs underlying the measures that have been used. In the case of the proxy measures - two measures of cognitive distortion (QACSO and SOSAS) and one measure of victim empathy (VESA) - the constructs have an indirect relationship to the variables of interest, and are presumed to mediate between treatment and sexual offending. In other words, the nomological net holding these constructs purports theoretical links between the specific treatment proposed here and sexual offending, namely that the treatment programme will reduce the future frequency of sexual offending or sexually abusive behaviour, and that changes

in cognitive distortions and victim empathy are a proxy or indicator of this later change in offending or sexually abusive behaviour reduction. Of relevance to these links, then, are other ongoing research and theoretical explanations which attempt to further clarify the theory which links treatment elements to offending reduction such as the emergence of implicit theories of sexual offending reviewed in Chapter one (e.g., Fisher & Beech, 2007; Thakker et al., 2007; Ward, Keown, et al., 2006; Ward, Polaschek, et al., 2006). These recent empirical and theoretical developments have strengthened the nomological net within which the construct of cognitive distortions consistent with sexual offending are found, and so has increased the construct validity of such measures.

Such research has not provided similar support for victim empathy measure (VESA), and there has been a consistent lack of support for a correlation between scores on victim empathy assessments either pre or post-treatment and recidivism (Hanson & Busier, 1996; Marshall et al., 2009, Ward et al., 2006). Thus the construct validity of the VESA, in this particular application at least, has been weakened by the same research. It is not clear whether this lack of relationship between schools on victim empathy and recidivism is due to victim empathy measures not measuring victim empathy properly or whether victim empathy as a construct (or victim empathy measures) are simply a form of cognitive distortion, but either way there is an urgent need for greater clarity of the construct of victim empathy, and then for measures which validly and reliably assess it. This is true for mainstream offenders, where much research and discussion has occurred. It is reasonable to state that this construct and the measure we currently have available (VESA) in intellectual disability are even less understood, and are further complicated by problems in emotion recognition and cognitive functioning in this population. Of interest are recent suggestions of a role of 'Theory of Mind' as an explanatory concept for the development of cognitive distortions and possibly also victim empathy. Implications for possible research with people with autism, where theory of mind is a particular issue, have yet to be explored. Results to be reported in Chapter Eight which have been recently published by the wider SOTSEC-ID group (SOTSEC-ID et al., In press) point to

the higher recidivism and lower response to treatment of people who have been diagnosed with autism, thus providing tangential support for this view.

Similarly, in the case of the measures of sexual knowledge and attitudes (SAKA), whilst the measure itself is direct, it is also part of a theoretical explanation which links sexual knowledge to reoffending. However in the case of sexual knowledge and attitudes, research and theorizing over the last ten years has undermined the role of sexual knowledge and attitudes in sexual offending by men with an intellectual disability (Lindsay, 2009) and therefore diminished its construct validity as an indicator of progress in a treatment group aimed at reducing reoffending or further sexually abusive behaviour by men with an intellectual disability. As Kerlinger points out, the construct validity of a test is not specific to the test, but to the use to which it is put in a specific situation (Kerlinger, 1964, p. 457), so the SAKA may well retain good construct validity in other situations, even as its construct validity in this one has diminished.

In the case of measures of reoffending (Mens' Group Database Schedules) and participant's experience of the treatment (qualitative interviews), the constructs measured by the assessments are more direct and less reliant on theoretical links, though difficulties remain as to whether each of these measures assesses what it purports to measure. In the case of reoffending or repeated sexually abusive behaviour, the issue is whether all instances are captured accurately and there is no under or over counting, and in the case of the qualitative interview, the issue is whether the method of assessment adequately captures the richness of the sense-making experience of the participants in the treatment programme. The former is not dealt with here, and the latter was addressed in the previous chapter.

In addition to construct validity, Cronbach and Meehl (1955) also identified criterion and content validity, as does Clark-Carter (2004, pp. 29-32), and Clark-Carter also discusses face validity, the extent to which the test appears to measure what it

measures. More recent descriptions of validity, however, are less compartmentalized and describe validity in a quite different way, viz:

> Evolving conceptualizations of the concept of validity no longer speak of different types of validity but speak instead of different lines of validity evidence, all in the service of providing information relevant to a specific intended interpretation of test scores. Thus, many lines of evidence can contribute to an understanding of the construct meaning of test score (1999 Standards for educational and psychological testing, quoted in McCallin, 2006, p. 626).

This broader meaning of validity is actually quite close to Cronbach and Meehl's original articulation of construct validity briefly described above. Rather than considering each form of validity for each measure, then, the above descriptions and previous commentary in earlier chapters will serve as a summary of the different lines of validity evidence for each measure, and results to be presented later in this chapter will address criterion validity for the SAKA and the SOSAS. In terms of the QACSO, The introduction to study 3 in Chapter Four summarized the situation as being one in which there were virtually no accepted standardized measures of criminogenic issues for people with intellectual disability, other than developing evidence and agreement concerning the QACSO. The purpose of this study, therefore, is to investigate the adequacy of the other current measures as far as possible. The study will focus on the four main quantitative measures, and will not address the men's group database (or the measure of recidivism) or the qualitative interviews further. The study will consider validity and especially reliability of these measures. The focus of the study is summarized in Table 42.

Table 42. Focus of the Reliability and Validity Study

Assessment	QACSO	SAKA	SOSAS	VESA
Validity	Reasonable predictive validity now established (see Lindsay, Whitefield, & Carson, 2007b). Theoretical support growing.	This study- SKIS used as a criterion measure. Pilot study and R & V participants	This study- QACSO used as a criterion measure. Quantitative study and R & V participants	Not addressed here. See Keeling et al., 2007. Further SOTSEC-ID results to be reported
Reliability	Inter-rater	This study- Pearson r or Spearman rho and Intraclass correlation coefficients reported for all four measures. R & V participants.		
	Test/Retest	This study- Pearson r and Inter class correlation coefficients reported for all four measures. R & V participants.		
	Internal Consistency	This study- Cronbach's Alpha reported for all four measures. R & V participants.		

The study aim is therefore that adequate criterion validity will be demonstrated for the SAKA and the SOSAS, and that adequate reliability in the form of test-retest, inter-rater, and internal consistency will be obtained for the QACSO, SAKA, SOSAS and

VESA. Taking each measure in turn, starting with the QACSO, Lindsay, Whitefield and Carson (2007) were able to demonstrate the ability of the QACSO to discriminate between sex offenders, non-sex offenders and non-offenders – all with an intellectual disability - and normal men (non offenders and non learning disabled), thus demonstrating criterion (predictive) validity (Clark-Carter, 2004) of this measure. Sexual attitudes and knowledge assessment (SAKA) does not have any support in the literature, despite being republished recently (Heighway & Webster, 2007) and will therefore need to be addressed here. The criterion (concurrent) validity (Clark-Carter, 2004) of the SOSAS also needs addressing, and will be investigated through looking at its correlation with the QACSO, as they both measure cognitive distortions supportive of sexual offending or sexually abusive behaviour. The validity of the Victim Empathy Scale has been addressed in a recent paper by Keeling, Rose, and Beech (2007) which reported a preliminary evaluation of a number of adapted assessments for offenders with special needs including a very similar adaptation to the Victim Empathy Scale used in this study.

The Sexual Knowledge Interview Schedule (SKIS) was published by Forchuk, Martin, and Griffiths in 1995 with good face validity and acceptable reliability estimates (detailed below under reliability). This was administered to up to 15 participants who were also administered the SAK, and criterion (concurrent) validity established with the SKIS.

Reliability refers to whether the assessment consistently produces the same results on different occasions, for example, whether the SOSAS produces the same results with different raters and at different times. Another aspect of reliability is internal consistency, the extent to which the items go together as a consistent whole (Clark-Carter, 2004).

Internal reliability or consistency (Clark-Carter, 2004) of all four measures was assessed using existing data on the measures which have already been collected. In addition, recent publications have also addressed internal consistency of the QACSO (Lindsay, Whitfield, and Carson 2007) and the VES (Keeling, Rose, and Beech 2007).

Although these articles have also addressed inter-rater and test-retest reliability for the QACSO and VES respectively, there are slight instrument differences and sufficient possibly variation in administration to warrant ascertaining both test-retest and inter-rater reliabilities of all four change measures used in the current study.

Ethics

As will be detailed further below, there were three groups of participants used in this study, those in the quantitative study, those in the pilot study, and an additional set of 29 new participants. Overall ethical approval for the project has been discussed at length previously in Chapter Four, and specific ethical issues concerning the quantitative study or the pilot study are discussed in Chapters Eight and Five respectively. Additional ethical approval for the 29 new participants for this study was sought and obtained from the original NHS ethical approval committee under an amendment to the main study approval, which included the qualitative study and the present reliability and validity study. Subsequent research and development approval was successfully obtained from the five NHS organizations and one private organization which ran the clinical programmes at the six sites where participants were, or had been, a part of a SOTSEC-ID programme. Although ethical approval of the amendment took less than four months (113 days), obtaining research and development approval from all six service providing organizations took a further 28 months (874 days), making a total period for ethical approval for this study from the date of submission to the NHS ethical approval committee to final research and development approval of the last service providing organization of 33 months (997 days).

Information forms and consent forms approved by the relevant NHS Ethics Committee and the local Research and Development Committee were presented to potential participants after they had already provided verbal consent to the local researcher. Participants were approached in conjunction with the local researcher, who

usually knew the participants well as they had run the treatment group. Participants were explained the purpose of the study and risks and benefits using the information sheet, which had been prepared and approved by the ethics committee. The participants were then taken through the consent form and had any questions answered. Following this, they signed to indicate consent if that was their wish, and we proceeded with the assessments. Copies of all information sheets and consent forms for this study are shown in Appendix 10. Consent was given in all cases, but one participant withdrew his consent during assessment, and several participants did not present themselves for the follow-up test-retest assessments two weeks later.

Method

The design was a repeated measures inter-rater and test-retest design with a two-week gap between the testing sessions and with multiple raters where possible at each testing to gather inter-rater data. Participants were asked to complete the assessments with a second assessor present, and an additional set of the assessments two weeks later. On some occasions, instead of a second rater present in the room, an audio recording was undertaken to allow inter-rater reliability checks. These measures were undertaken at a convenient break in the treatment programme where possible, when there was a week without treatment or when pre or post measures were being collected. There was also a single administration of the SKIS at one of the sessions for some participants. Data from previous assessments undertaken as part of the pilot study or the quantitative study to be reported in Chapter Eight also contributed data to this part of the project. Data collection was difficult due to repeated delays over research and development approval from the six different sites involved, problems with participants attending on two separate occasions, or in some cases even completing the assessments, and problems with availability of the same assessors on both assessment sessions. Despite these difficulties, 374 assessments on one of the QACSO, SAKA, SOSAS, VESA or SKIS instruments were carried out on 29 separate participants at six separate sites over a two and a half year period.

Participants

Participants comprised existing participants in the pilot and the quantitative studies, as well as an additional 29 participants (called new participants here) who had previously completed at least one SOTSEC-ID treatment programme. In this sense they were not 'new' at all as most had also consented previously to being part of the main SOTSEC-ID research programme, but they were a newly configured subset of this group and undertook additional assessments. These new participants were all part of clinical programmes in six sites in different parts of the country from the South West to East Anglia. Different combinations of these three groups of participants were composed for the different analyses to be reported in this study. Participants were not able to be randomly selected from the wider set of SOTSEC-ID participants due to time and resource constraints on the study. The participants ranged in age from 22 to 57 years of age and had an average age of 36.8 years. The mean IQ was 65.2 and ranged from 56 to 71.

Measures

Although the actual assessments administered to participants were the four main measures discussed extensively in Chapter Four, namely the QACSO, SAKA, SOSAS and VESA, as well as the SKIS, the measures used to assess criterion validity of the SOSAS and the SAKA, and to assess reliability of the four measures themselves are statistical tests applied to the scores resulting from these assessments.

Criterion validity.

Pearson Product Moment Correlations (r) were calculated as a measure of association between the SOSAS and its criterion the QACSO, and both Pearson's r, Kendall's tau (τ) and Spearman's rho (r_s) served as a measure of association between the SAKA and its criterion the SKIS. Kendall's τ and Spearman's r_s were used for the SAKA

as some of the assumptions for Pearson's *r* were violated for the SAKA distribution, such as normality (this is discussed further under inter-rater reliability). The Sexual Knowledge Interview Schedule (SKIS) is a 47 item scale of sexual knowledge and attitudes (Forchuk et al., 1995). The SKIS includes an abuse scale, items on feelings, identification of body parts and their function, as well as general sexual knowledge. Forchuk et al. (1995) report inter-rater reliability of 95.3%, test-retest reliability of 70.1%, and internal consistency for scales/subscales of 0.78 to 0.96. In the administration of the SKIS reported here, we found several of the questions from 30 to 47 inconsistently understood and responded to, so for the analysis only answers to questions 1 to 29 were included. The measures used to assess criterion validity were therefore the Pearson *r*, Kendall's τ, and Spearman's r_s.

Inter-rater Reliability.

Inter-rater reliability can be measured using correlation as a measure of covariance between raters, such as Pearson Product Moment Correlation (Pearson *r*), although this measure fails to detect absolute differences in rating between raters because Pearson *r* only measures the extent to which scores vary together, not whether they are the same or similar in absolute value (Clark-Carter, 2004). In our case, however, the issue at stake for the quantitative study was whether there was a reliably assessed difference between pre, post and follow-up scores rather than a reliably assessed absolute value. Indeed, apart from the QACSO (Broxholme & Lindsay, 2003), there are no indications in the literature as to what the absolute values on the measures represent in terms of the underlying construct being measured, so a measure of inter-rater reliability which assesses covariance of the measures rather than the absolute value still provides helpful information on the reliability of the measures used in the quantitative study, as Pearson *r* does detect relative changes in measures. On this basis, then, the first measure of inter-rater reliability presented for each of the four measures will be the Pearson *r*, or an

equivalent rank-order coefficient where the data require it (see discussion below on the SAKA).

Intraclass Correlation Coefficient.

The problem of not detecting absolute differences with the Pearson r, or even more so with the rank-order correlations to be presented, is that the correlation coefficients do not address differences of absolute value between raters, just their variation relative to each other. The measure recommended for addressing this problem is to use intraclass correlation coefficients (Clark-Carter, 2004; Howell, 2007; Tabachnick & Fidell, 2007). However, the authors are not so forthcoming about the range of intraclass correlation coefficients available (ten according to McGraw & Wong, 1996) nor on how to choose between them.

McGraw and Wong (1996) describe differences between *inter*class correlation coefficients such as the Pearson *r*, and *intra*class correlation coefficients in the following terms. Intraclass correlation coefficients have the same metric and the same variance, while interclass correlation coefficients have a different metric and variance. The term metric is *not* used here to refer to the level of data, as in *nominal*, *ordinal*, *interval* or *ratio*, but to the meaning of measuring units, for example distance and time have a different metric because the numbers have a different value in each measuring system- inches or centimeters in one, and seconds in another. Variance refers not just to the total amount of variance being equivalent, but to the range and variability as well as the formally measured variance (i.e. sum of the squared deviation scores divided by one less than the number in the sample). Inter-rater reliability ratings are comparing identical measuring systems with the same metric and at least similar variance because they compare raters on the same measuring scale to see if the measuring scale varies between raters. Hence, intraclass correlation coefficients are uniquely suited to measuring inter-rater reliabilities. The arguments presented earlier in this section to support the suitability of the Pearson *r* for the data to be presented in Chapter Eight from the main quantitative

study are still valid for that data because it is the relative movement of scores between pre, mid, post and follow-up, that is of interest. Intraclass correlation coefficeints will still be presented here, however, both to contrast the values of the two measures for the quantitative study data, and as well for the general use of these scales as there seem to be no published studies providing intraclass correlation coefficients for these measures.

Guidance on the choice of which of the ten known variants of intraclass correlation coefficient to use is provided by a number of authors, most of whom bemoan the lack of address of the topic in mainstream psychology statistics (McGraw & Wong, 1996; Shrout & Fleiss, 1979; Yaffee, 1998). The first choice is whether the data is best represented by a one-way or two-way analysis of variance model, then if a two-way model is chosen, whether the column variable (raters or judges) is fixed or random, and for each of these variants further choices must be made about whether a single or average measure is of interest (which refers to the reliability coefficient for a single measurement or average measurements using the scale in question), and whether consistency (equivalent to varying together without agreeing in absolute terms) or absolute agreement (varying together as well as absolute values on the scale agreeing). In the data to be analyzed here, a one-way model was selected because the participants (rows in the ANOVA model) are chosen (not exactly randomly as the model requires, but still as an approximation of a random sample) from a wider group and are the main source of systematic variation. The raters are two sets of 'dummy raters' made up from a compilation of other raters. There is no further specification of the one-way model required.

In order to prepare an appropriate data set for analysis, the first data set comprised participants by raters, with rows representing 26 participants (actually 18 separate participants, but 26 because a number were assessed on two separate occasions) and each column in the table representing an individual rater. However, as there were actually 14 different raters (with a total of only 66 ratings between them across the 26 participants) there were too many cells with insufficient observations and the analysis could not be

carried out. In order to overcome this problem and still be able to generate an intraclass correlation coefficient, two 'dummy' rater variables were created in which the first 'dummy' rater was made up of several of the experienced raters, and the second of several of the less experienced raters. This was done, not in an attempt to systematically vary the rater variable (and therefore a two-way analysis of variance model would be more appropriate), but to underestimate the reliability on the basis that comparing experienced raters to inexperienced rater was a more difficult test than experienced with experienced or inexperienced with inexperienced raters. In addition to this comparison, the data sets used for calculating Pearson or other correlations were also used to calculate intraclass correlation coefficients. In the same way as the comparison described above, these were also 'dummy' raters in the same sense as there were a mix of raters on each of the two rater's columns which were being compared.

SAKA.

For one of the measures, the SAKA, the variability of scores was restricted as many participants scored in the top range of the scale on their pre-test, thus allowing little room to demonstrate improvement on subsequent post-test and follow-up assessments. Improvements were nonetheless observed, though at the cost of reducing variability as many scores, especially at post-test and follow-up test, became 'squeezed' at the top of the range. This 'ceiling effect' (Cohen, Swerdlik, & Smith, 1992) resulted in an underestimation of the correlation because it restricted the variability in the data (Clark-Carter, 2004; Tabachnick & Fidell, 2007). If the population standard deviation is known for a measure, then Tabachnick and Fidell (2007) provide a formula for estimating the true (larger) correlation, but there are no published data on the SAKA from which to estimate such figures. In addition to these problems with the overall SAKA scores, one of the SAKA subscales had limited score variability due to comprising only three items as well as also having a ceiling effect within the subscale scores. Due to these difficulties with the SAKA data, results for the SAKA will show Pearson r, as well as the ordinal level correlation measures, Kendall's tau (τ) and Spearman's rho (r_s), which compare the

rank order between two sets of scores. Kendall's τ is recommended (Clark-Carter, 2004; Howell, 2007) over Spearman's r_s, but both are presented here along with the Pearson r.

Test-retest reliability.

Test-retest reliability can be measured by a correlation coefficient and by ensuring there has been no systematic change in the mean, because the correlation coefficient will not detect such a change. The intraclass correlation coefficient is a better indicator if the sample is small, but this is not the case here, so again Pearson r will be the primary measure of test-retest reliability, along with Kendall's τ and Spearman's r_s for the SAKA.

Internal consistency.

Internal consistency is a measure of the extent to which all the items are consistent with each other, assessed by correlating one half of the items in the assessment with the other half. The best measure of this is Cronbach's coefficient alpha (Clark-Carter, 2004), which is the equivalent of undertaking all the possible split-half comparisons. Clark-Carter (2004, p. 314) cites Kline in recommending that Cronbach alpha should be 0.9 and never below 0.7, although Schmitt (1996) warns against such simple 'rules of thumb' arguing for a more detailed examination of the scale, especially if it is a multidimensional scale (as it might be argued the SAKA is). Cronbach's alpha also provides a line of validity information about the measure as the internal consistency of the data as measured by Cronbach's alpha is an indicator of the internal consistency of the underlying construct being measured, though according to Schmitt (1996), internal consistency is a necessary but not sufficient condition for homogeneity, which is a more inclusive concept referring to the unidimensionality of the measure.

There were 88 separate assessments during the reliability and validity study for each of the QACSO, SAKA, SOSAS and VESA, resulting in a data set of 12,496 potential item scores across the four measures, minus missing data for incomplete items

or whole assessments. These data were used for the analysis and Cronbach's alpha scores produced as a measure of internal consistency for each of the four measures.

Procedure

Where possible, the assessments were conducted at the same time as pre-group or post-group assessments to minimize inconvenience to the participants. In some cases this was not possible as treatment groups were not being provided at the time. All four assessments were usually administered during one assessment session, and the process was repeated two to three weeks later. Usually the assessment was also completed by a second rater, and on a few occasions, the assessment was audio taped and rated by the second rater at a different time. The SKIS was administered on either the first or second assessment session, depending on the individual, time, availability etc.

The data from the reliability and validity assessments were entered item by item for each assessment into SPSS (PASW Statistics 18 and IBM SPSS Statistics 19) and subject to the analyses described above and reported below. Data from the pilot study and the quantitative study were also utilized and combined where appropriate. This is detailed in the relevant section in the results. The difference between the study N and the N reported in the analyses in the results is due to the missing measures owing to the difficulties of obtaining both measures (either inter-rater or test-retest) in an applied setting with a clinical population. If either one of the measures was not fully completed, both measures were excluded from the analysis by the SPSS pair-wise deletion procedure.

Results

The criterion validity results are presented for the SOSAS first, followed by the SAKA. The inter-rater, test-retest and internal consistency results are then presented for the QACSO, The SAKA, the SOSAS, and the VESA, in that order. Preliminary

discussion of the results occurs immediately following the relevant tables for ease of reference, with summary and overall comment provided in the discussion section to follow.

Criterion validity of the SOSAS

Repeated measures of the QACSO and SOSAS on the same participants was a necessary part of the design for the reliability and validity study to obtain inter-rater and test-retest reliabilities, and in the quantitative study there were repeated measures at pre, post and follow-up assessments using the QACSO and the SOSAS. This meant that the 29 participants in the reliability and validity study and the 108 participants in the quantitative study (N for the quantitative study was 121, but this included 13 participants who did repeat treatment) resulted in 137 different participants producing 451 measurement points for both QACSO and SOSAS assessments. However, some of these measuring points involved repeated measures with the attendant problem of order and carry-over effects (Clark-Carter, 2004). Particularly in assessing criterion validity, if there is repeated assessment of the same participants on the measure being assessed and the criterion, this may lead to inflation of the correlation between them as the measures are not independent. Repeated measures was a desirable feature of the quantitative study, however, as it sought to assess the effect of the treatment over the course of the repeated measures. This means that for the assessment of criterion validity of the SOSAS, utilization of the same pre, post and follow-up model was appropriate as this provided a comparable test between the criterion validity data and the quantitative study data.
The question of the criterion validity of the SOSAS was thus addressed by looking at the Pearson Product Moment Correlations between QACSO and SOSAS scores for four different sets of the potential participants described above. In the first case, presented below in Table 43, the correlations between the QACSO and its subscales with the SOSAS and its subscales is presented for participants in the quantitative study who either did not repeat treatment, or for whom the scores used are the set of scores corresponding to their first treatment. The repeated measures at pre, post and follow-up scores were all

utilized as it was precisely the variation and covariation of the assessments over the course of treatment that was of interest. This sample produced a set of 324 measurement points.

Table 43. QACSO Total and SOSAS Total and SOSAS Subscale Correlations for N = 324 Quantitative Study Repeat Measures, no repeat treatments no Reliability and Validity Participants

		SOSAS Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
QACSO Total	Pearson *r*	.493**	.205**	.286**	.582**	.123
	Sig. (2-tailed)	.000	.001	.000	.000	.057
	N	237	238	239	238	239
	Variance (R^2)[a]	.243	a	a	.339	a
QACSO Rape	Pearson *r*	.450**	.277**	.242**	.484**	.116
	Sig. (2-tailed)	.000	.000	.000	.000	.073
	N	237	238	239	238	239
	Variance (R^2)	.202	a	a	.234	a
QACSO Voyeurism	Pearson *r*	.290**	.156*	.156*	.361**	.044
	Sig. (2-tailed)	.000	.016	.016	.000	.501
	N	238	239	240	239	240
	Variance (R^2)	a	a	a	a	a
QACSO Exhibitionism	Pearson *r*	.429**	.164*	.198**	.485**	.212*
	Sig. (2-tailed)	.000	.011	.002	.000	.001

		SOSAS Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
	N	238	239	240	239	240
	Variance (R^2)	.184	a	a	.235	a
QACSO Dating Abuse	Pearson *r*	.333**	.117	.206**	.419**	.051
	Sig. (2-tailed)	.000	.071	.001	.000	.434
	N	238	239	240	239	240
	Variance (R^2)	a	a	a	.176	a
QACSO Homosexual Assault	Pearson *r*	.408**	.166*	.292**	.447**	.077
	Sig. (2-tailed)	.000	.010	.000	.000	.237
	N	237	238	239	238	239
	Variance (R^2)	.166	a	a	.200	a
QACSO Offences with Children	Pearson *r*	.456**	.155*	.306**	.548**	.071
	Sig. (2-tailed)	.000	.017	.000	.000	.274

		SOSAS Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
	N	237	238	239	238	239
	Variance (R^2)	.208	a	a	.300	a
QACSO Stalking and	Pearson *r*	.366**	.122	.195**	.482**	.100
Sexual Harassment	Sig. (2-tailed)	.000	.061	.002	.000	.122
	N	238	239	240	239	240
	Variance (R^2)	a	a	a	.232	a

Variance explained (R^2) is provided where $r \geq 0.4$.

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 43 shows that the overall correlation between the QACSO Total and the SOSAS Total is significant ($r = 0.493$, $p=0.000$), as is the correlation between the QACSO Total and the subscales of Denial, Blame and Minimization, but not the Subscale Real. This was true also for most of the QACSO Subscales, namely that the correlation was significant with the SOSAS Total for all seven subscales of the QACSO, and also for the Blame and Minimizations Subscales, and all but two of the QACSO Subscales for Denial. The Real Subscale did not correlate significantly with any QACSO subscales except Exhibitionism. However, these statistically significant results simply reassure us that the results are unlikely to have occurred by chance, and that the two scales (QACSO and SOSAS) are sampling a similar domain, it does not reassure us that the SOSAS overlaps sufficiently with the QACSO to be a good a measure of this area in comparison to the QACSO.

By squaring the correlation values, we can obtain a measure of the effect size or the amount of variance in common between the two measures being compared. This has also been provided in Table 3 for all results where Pearson r is greater than or equal to 0.4. When this is undertaken, it is clear that the QACSO variance explained by the SOSAS scores is insufficient to establish a reasonable level of criterion validity. Only the SOSAS Total and the SOSAS Minimization Subscale have shared variance with the QACSO or its subscales that even approach reasonable levels for some comparisons. The SOSAS Total accounts for only 24% of the QACSO Total, and not much more than this for all QACSO subscales except for Voyeurism and Exhibitionism, which are both low, and Stalking and Sexual harassment of which nearly 30% is accounted for. It is interesting that the five item subscale Minimization accounts for an equivalent or greater amount of variance of the QACSO Total and all its subscales than the full nineteen item SOSAS total. On the basis of the QACSO as a criterion, the Miminization Subscale would be better used on its own than the full SOSAS especially as it would be so quick to administer.

The analysis was repeated on larger samples successively adding the 13 participants who undertook repeated treatment (N = 363), the reliability and validity sample without any repeated measures (N = 392), and the reliability and validity sample with repeated measures (N = 451). The results of these four analyses are shown inTable 44 with only the correlation between the QACSO Total and the SOSAS Total and subscales shown for each sample, not the QACSO Subscales.

A similar pattern emerges from these analyses, with correlations that are statistically significant but still lower than the level required to establish criterion validity for the SOSAS against the QACSO. The variance accounted for on the QACSO by the overall SOSAS does increase as the repeat treatment participants are added in from 24.3% to 28.4%, but the addition of the participants from the reliability and validity sample does not increase the variance of the QACSO accounted for by the SOSAS. The Minimization Subscale follows the same pattern, increasing for the addition of the repeat treatment participants, but then the reliability and validity participants not adding any additional explained variance. Again, the Minimization Subscale is a better predictor of the QACSO Total for every sample than the SOSAS Total, with the Minimization Subscale predicting 33.9% against 24.3% for the first sample, and 38.3% against 28.4% for the second sample which includes repeat treatment participants.

Table 44 . QACSO Total and SOSAS Total and SOSAS Subscale Correlations for Various possible samples

Sample Description	SOSAS Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
	Pearson r Sig (2-tail) N $R^{2\,a}$	Pearson r Sig (2-tail) N R^2	Pearson r Sig (2-tail) N R^2	Pearson r Sig (2-tail) N R^2	Pearson r Sig (2-tail) N R^2
Quantitative study sample (108) with repeated measures (pre, post and follow-up). No repeated treatments. No R & V participants. N = 324 (3 x x108)	.493** .000 237 .243	.205** .001 238 a	.286** .000 239 a	.582** .000 238 .339	.123 .057 239 a
Quantitative study sample (108) with repeated measures (pre, post and follow-up) plus repeated treatments (108 +13 =121). No R & V participants. N = 363 (3 x 121)	.533** .000 265 .284	.269** .000 266 a	.285** .000 267 a	.619** .000 266 .383	.143* .019 267 a

Sample Description	SOSAS Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
Quantitative study sample with repeated measures and repeated treatments (363). R & V participants no repeated measures (29). N= 392 (363 + 29)	.521**	.227**	.288**	.598**	.156**
	.000	.000	.000	.000	.007
	291	292	293	292	293
	.271	a	a	.358	a
Quantitative study sample with repeated measures and repeated treatments (363). R & V participants repeated measures (88). N = 451 (363 + 88)	.532**	.201**	.294**	.591**	.187**
	.000	.000	.000	.000	.000
	347	348	349	348	349
	.283	a	a	.349	a

a.Variance explained (R^2) is provided where $r \geq 0.4$.

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Criterion Validity of the SAKA

The Pearson *r* correlation between the SKIS and the SAKA is shown in Table 45 below. The means of the SKIS and SAKA were 21.3 and 47.4, and the standard deviations 3.8 and 4.1, both respectively. The sample size for both measures was 17. This analysis is based on the sample of seventeen SKIS and SAKA results obtained from the pilot participants and the reliability and validity study participants. The correlation of 0.42 is not significant for this N, and is not statistically significant. The variance accounted for (R^2) is 17.6%, so the SAKA is a poor predictor of the SKIS. Examination of the data by means of univariate frequency distributions for both measures and a bivariate scatterplot showed a negatively skewed distribution for the SAKA, and revealed an extreme score which distorted the result due to the low number in the sample. By removing this participant's score, the correlations reached significance, but were still low in terms of criterion validity requirements.

Due to the skew of the SAKA distribution and the consequent violation of the normality assumption, Kendall's τ and Spearman's r_s were also calculated for the N = 17 sample, and all three coefficients were calculated for the N = 16 sample with the outlier removed. These are all shown in Table 45 below.

Table 45 . SKIS and SAKA correlations

Correlation coefficient	N = 17	N = 16 (with outlier removed)
Pearson *r*	$r = 0.42, p = .093$	$r = 0.56^*, p = .02$
Kendall's τ	$\tau = 0.29, p = 0.13$	$\tau = 0.4^*, p = .047$
Spearman's r_s	$r_s = 0.41, p = .102$	$r_s = 0.54^*, p = .03$

*Correlation is significant at the 0.05 level (2-tailed)

QACSO inter-rater, test-retest and internal consistency

There were 29 unique participants who completed the four assessments- QACSO, SAKA, SOSAS and VESA. Most of the participants had multiple assessments as the inter-rater and test-retest reliabilities required the same person to be assessed by a second rater at the same time and then again two weeks later. Due to potential concerns regarding repeated measures, the data are presented here for the different samples so that any confounding effect of the repeated measures can be seen. The results are presented firstly without any repeated measures, then with repeated measures across participants, and finally with repeated measures across both participants and raters. Both Pearson *r* and intraclass correlation results are presented together. The Pearson *r* results show high inter-rater reliability for the QACSO Total, with minimal variation across samples. Likewise, the Pearson *r* results for each of the QACSO subscales are well over 0.9 except for Stalking and Sexual Harassment. While there is some variation across samples, this is not a systematic increase as repeated measures are added, and all samples indicate a good inter-rater reliability for both the QACSO Total and for all subscales. The intraclass correlation results are very similar, with very high intraclass correlations for all comparisons, ranging up to 0.99, with the exception of Stalking and Sexual Harassment again.

Table 46 . Inter-Rater Pearson and Intraclass correlations, across samples for the QACSO Total

Sample description	Pearson Correlation	Intraclass Correlation
Inter-rater sample with no repeated measures. N =18.	$r = .988^{**}$ $N = 16$ $p = .000$	$ICC_{single} = 0.99^{**}$ $ICC_{average} = 0.99^{**}$ $F_{16, 17} = 174.6, p = .000$ N = 17
Inter-rater sample with repeated measures across participants. N = 31.	$r = .991^{**}$ $N = 30$ $p = .000$	$ICC_{single} = 0.99^{**}$ $ICC_{average} = 0.99^{**}$ $F_{29, 30} = 218.5, p = .000$ N = 30
Inter-rater sample with repeated measures across participants and raters. N = 45.	$r = .991^{**}$ $N = 3$ $p = .000$	$ICC_{single} = 0.99^{**}$ $ICC_{average} = 0.99^{**}$ $F_{43, 44} = 218.6, p = .000$ N = 44

**Correlation is significant at the 0.01 level (2-tailed).

Table 47. Inter-Rater Pearson r and Intraclass Correlation (ICC) across samples for the QACSO Subscales

Sample description	Statistic	QACSO Rape	QACSO Voyeurism	QACSO Exhibitionism	QACSO Dating Abuse	QACSO Homosexual Assault	QACSO Offences with Children	QACSO Stalking
Inter-rater sample with no repeated measures. N = 18.	Pearson r	.992**	.934**	.978**	.987**	.974**	.918**	.806**
	Sig. (2-tail)	.000	.000	.000	.000	.000	.000	.000
	N	16	16	16	16	16	16	16
	ICC	Only the lower ICC_{single} will be given. df is 16, 17 and p = .000 in all cases.						
		ICC= 0.99 F = 213.03	ICC= 0.93 F = 26.53	ICC= 0.98 F = 96.8	ICC= 0.99 F = 155.8	ICC= 0.97 F = 61.8	ICC= 0.91 F = 21.24	ICC= 0.83 F = 10.43
Inter-rater sample with repeated measures across participants. N = 31.	Pearson r	.993**	.952**	.968**	.992**	.971**	.952**	.854**
	Sig. (2-tail)	.000	.000	.000	.000	.000	.000	.000
	N	30	30	30	30	30	30	30
		Only the lower ICC_{single} will be given, df is 29, 30 and p = .000 in all cases.						
	ICC	ICC= 0.99 F = 229.34	ICC= 0.95 F = 40.78	ICC= 0.97 F = 62.78	ICC= 0.99 F = 236.17	ICC= 0.97 F = 64.4	ICC= 0.94 F = 34.4	ICC= 0.85 F = 12.8
Inter-rater	Pearson r	.991**	.965**	.970**	.989**	.961**	.944**	.883**

Sample description	Statistic	QACSO Rape	QACSO Voyeurism	QACSO Exhibitionism	QACSO Dating Abuse	QACSO Homosexual Assault	QACSO Offences with Children	QACSO Stalking
sample with repeated measures across participants and raters. N = 45.	Sig. (2-tail)	.000	.000	.000	.000	.000	.000	.000
	N	36	36	36	36	36	36	36
	ICC	Only the lower ICC_{single} will be given, df is 29, 30 and p = .000 in all cases.						
		ICC= 0.99	ICC= 0.97	ICC= 0.97	ICC= 0.99	ICC= 0.94	ICC= 0.95	ICC= 0.84
		F = 151.04	F = 65.10	F = 61.7	F = 152.29	F = 30.55	F = 37.25	F = 11.76
**Correlation is significant at the 0.01 level (2-tailed)								

Table 48 .Test-retest Pearson r across samples for the QACSO Total and Subscales

Sample description	Total	Rape	Voyeur	Exhibit	Dating Abuse	Homosex Assault	Offences with Children	Stalking
Test-retest sample with no repeated measures. N = 23.	r = .96	r = .80	r = .84	r = .91	r = .80	r = .84	r = .86	r = .89
	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000
Test-retest sample with repeated measures across participants. N = 29.	r = .96	r = .74	r = .83	r = .84	r = .73	r = .86	r = .90	r = .88
	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000
Test-retest sample with repeated measures across participants and raters. N = =70	r = .96	r = .69	r = .83	r = .83	r = .67	r = .85	r =.090	r = .80
	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000	p =.000

Internal consistency of the QACSO was assessed by calculating Cronbach's Alpha for the 86 separate QACSO assessments which were completed for the reliability and validity study. Each of the 79 item scores was entered for each of the 86 completed QACSO assessments and Cronbach's alpha calculated. The number of separate QACSO assessments is larger than either the inter-rater or test-retest number because two QACSO assessments were needed in a particular arrangement for each inter-rater and test-retest comparison. The results were based on 83 of the 87 assessments due to missing data where some of the 79 items had not been completed properly. Cronbach's alpha was 0.94.

SAKA inter-rater, test-retest and internal consistency

The SAKA results are presented in the same format as the QACSO results, with inter-rater correlation using Pearson *r* and Intraclass Correlation across the three same samples. There are some restrictions on the SAKA data, as discussed above in the measures section, so Kendall's τ and Spearman's r_s will also be presented for the SAKA Total and its subscales.

Table 49 . Inter-Rater Correlation, Interclass correlation, Significance and N across samples for the SAKA Total

Sample description		Pearson *r*	Intraclass correlation
Inter-rater sample with no repeated measures. N = 18.		$r = .932^{**}$ $N = 16$ $p = .000$	$ICC_{single} = 0.93$ $ICC_{average} = 0.96$ $F_{16,17} = 28.4, p = .000$ N = 17
Inter-rater sample with repeated measures across participants. N = 31.		$r = .924^{**}$ $N = 30$ $p = .000$	$ICC_{single} = 0.92$ $ICC_{average} = 0.96$ $F_{27,28} = 25.5, p = .000$ N = 28
Inter-rater sample with repeated measures across participants and raters. N = 45.	Pearson *r*	0.893^{**} $N = 40$ $p = .000$	$ICC_{single} = 0.89$ $ICC_{average} = 0.94$ $F_{39,40} = 17.7, p = .000$ N = 40
	Kendall's T	$\tau = .934^{**}$ $N = 40$ $p = .000$	
	Spearman's r_s	$r_s = .882^{**}$ $N = 40$ $p = .000$	

Table 50. Inter-Rater Pearson Correlation, Significance and N across samples for the SAKA Subscales

Sample description	Statistic	SAKS understanding relationships	SAKS social interaction	SAKS sexual awareness	SAKS Assert
Inter-rater sample with no repeated measures	Pearson *r*	.929**	.683**	.922**	.903**
		$p = .000$, $N = 16$	$p = .004$, $N = 16$	$p = .000$, $N = 16$	$p = .000$, $N = 16$
	ICC	$ICC_{single} = 0.92$	$ICC_{single} = 0.70$	$ICC_{single} = 0.92$	$ICC_{single} = 0.91$
		$ICC_{average} = 0.96$	$ICC_{average} = 0.82$	$ICC_{average} = 0.96$	$ICC_{average} = 0.95$
		$F_{16,17} = 22.6$,**	$F_{16,17} = 5.6$**,	$F_{16,17} = 24.1$**,	$F_{16,17} = 20.4$**,
		$p = .000$, $N = 17$	$p = .001$, $N = 17$	$p = .000$, $N = 17$	$p = .000$, $N = 17$
Inter-rater sample with repeated measures across participants	Pearson *r*	.824**	.416*	.744**	.680**
		$p = .000$, N = 33	$p = .016$, N = 33	$p = .000$, N = 33	$p = .000$, N = 33
	ICC	$ICC_{single} = 0.88$	$ICC_{single} = 0.44$	$ICC_{single} = 0.70$	$ICC_{single} = 0.73$
		$ICC_{average} = 0.94$	$ICC_{average} = 0.62$	$ICC_{average} = 0.82$	$ICC_{average} = 0.85$
		$F_{27,28} = 15.4$**,	$F_{27,28} = 2.6$**,	$F_{27,28} = 5.7$**,	$F_{27,28} = 6.48$**,
		$p = .000$, $N = 28$	$p = .000$, $N = 28$	$p = .000$, $N = 28$	$p = .000$, $N = 28$

Inter-rater sample with repeated measures across participants and raters	Pearson *r*	.833** $p = .000, N = 40$	.425** $p = .000, N = 40$	.789** $p = .000, N = 40$	.665** $p = .000, N = 40$
	Kendall's τ	.555** $p = .000, N = 40$	.331* $p = .037, N = 40$	.742** $p = .000, N = 40$	.395** $p = .003, N = 40$
	Spearman's r_s	.564** $p = .000, N = 40$	.334* $p = .0035, N = 40$	.824** $p = .000, N = 40$	.449** $p = .004, N = 40$
	ICC	$ICC_{single} = 0.82$ $ICC_{average} = 0.90$ $F_{39,40} = 10.13^{**}$, $p = .000$, N = 40	$ICC_{single} = 0.38$ $ICC_{average} = 0.55$ $F_{39,40} = 2.22^{**}$, $p = .007$, N = 40	$ICC_{single} = 0.77$ $ICC_{average} = 0.87$ $F_{39,40} = 7.58^{**}$, $p = .000$, N = 40	$ICC_{single} = 0.77$ $ICC_{average} = 0.87$ $F_{39,40} = 7.57^{**}$, $p = .000$, N = 40

Table 51. Test-retest Pearson r, Kendall's τ and Spearman's r_s across samples for the SAKA Total and Subscales

Sample description	SAKA total	SAKA understanding	SAKA social interaction	SAKA sexual awareness	SAKA Assert
Test-retest sample with no repeated measures. N = 23.	$r = .86^{**}$ $p = .000$	$r = .85^{**}$ $p = .000$	$r = .283^{**}$ $p = .000$	$r = .930^{**}$ $p = .000$	$r = .819^{**}$ $p = .000$
	$\tau = .334^{*}$ $p = .042$	$\tau = .351$ $p = 092$	$\tau = .272$ $p = .275$	$\tau = .566^{**}$ $p = .001$	$\tau = .315$ $p = .090$
	$r_s = .419$ $p = .052$	$r_s = .364$ $p = .096$	$r_s = .286$ $p = .238$	$r_s = .687^{**}$ $p = .000$	$r_s = .344$ $p = .117$
	N = 22 for all above correlations.				
Test-retest sample with repeated measures across participants. N = 29.	$r = .830^{**}$ $p = .000$	$r = .808^{**}$ $p = .000$	$r = .280$ $p = .157$	$r = .872^{**}$ $p = .000$	$r = .785^{**}$ $p = .000$
	$\tau = .377^{*}$ $p = .011$	$\tau = .173$ $p = .352$	$\tau = .280$ $p = .153$	$\tau = .462^{**}$ $p .002$	$\tau = .280$ $p = .096$
	$r_s = .463^{*}$ $p = .015$	$r_s = .183$ $p = .362$	$r_s = .280$ $p = .157$	$r_s = .567^{*}$ $p = .002$	$r_s = .318$ $p = .106$

Sample description	SAKA total	SAKA understanding	SAKA social interaction	SAKA sexual awareness	SAKA Assert
	N = 27 for all above correlations.				
Test-retest sample with repeated measures across participants and raters. N = =70	$r = .620^{**}$ $p = .000$	$r = .543^{**}$ $p = .000$	$r = .149$ $p = .241$	$r = .721^{**}$ $p = .000$	$r = .647^{**}$ $p = .000$
	$\tau = .352$ $p = .689$	$\tau = -.047$ $p = .689$	$\tau = .111$ $p = .373$	$\tau = .42^{**}$ $p = .000$	$\tau = .320^{*}$ $p = .002$
	$r_s = .456^{*}$ $p = .015$	$r_s = -.048$ $p = .702$	$r_s = .112$ $p = .377$	$r_s = .538^{**}$ $p = .000$	$r_s = .371^{**}$ $p = .003$
	N = 66 for all above correlations.		N = 64 for all above correlations.		

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Internal consistency of the SAKA was assessed by calculating Cronbach's Alpha for the 85 separate SAKA assessments which were completed for the reliability and validity study. All item scores were entered for all assessments and analyzed using SPSS. Because item 19 on the SAKA is quite a different item to the preceding 18 items, Cronbach's Alpha was calculated both with and without question 19 included. The results were based on 83 of the 85 assessments due to missing data where some of the items had not been completed or entered properly. Cronbach's alpha was 0.70 when question 19 was excluded and 0.59 when it was included.

SOSAS inter-rater, test-retest and internal consistency

The SOSAS results are presented in a similar format to the QACSO and SAKA results, with inter-rater correlation using Pearson *r* and Intraclass Correlation across the three same samples, as well as test-retest correlation and internal consistency as assessed by Cronbach's alpha. The first table, Table 52, presents the inter-rater correlation and the interclass correlation for the SOSAS Total across the three different samples used for the analysis, while the following table, Table 53, presents the same information for the SOSAS subscales.

Table 52. Inter-Rater Correlation, Intra-class Correlation, Significance and N across samples for the SOSAS Total

Sample description	Pearson *r*	Intraclass correlation
Inter-rater sample with no repeated measures. N = 18.	$r = .986^{**}$ $N = 17$ $p = .000$	$ICC_{single} = 0.98$ $ICC_{average} = 0.99$ $F_{17,18}=84.85^{**}, p = .000$ N = 18
Inter-rater sample with repeated measures across participants. N = 31.	$r = .985^{**}$ $N = 29$ $p = .000$	$ICC_{single} = 0.98$ $ICC_{average} = 0.99$ $F_{28,29}=118.53^{**}, p = .000$ N = 29
Inter-rater sample with repeated measures across participants and raters. N = 45.	$r = .970^{**}$ $N = 33$ $p = .000$	$ICC_{single} = 0.92$ $ICC_{average} = 0.96$ $F_{38,39}=24.76^{**}, p = .000$ N = 39

** Correlation is significant at the 0.01 level (2-tailed).

Table 53. Inter-Rater Pearson Correlation, Intraclass Correlation, Significance and N across samples for the SOSAS Subscales

Sample description	Statistic	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
Inter-rater sample with no repeated measures. N=18.	Pearson *r*	.939** $p = .000$, $N = 17$	.996** $p = .004$, $N = 17$	.934** $p = .000$, $N = 17$	.816** $p = .000$, $N = 17$
	ICC	$ICC_{single} = 0.94$ $ICC_{average} = 0.97$ $F_{17,18} = 30.24$,** $p = .000$, $N = 18$	$ICC_{single} = 0.99$ $ICC_{average} = 0.98$ $F_{17,18} = 384.1$**, $p = .001$, $N = 18$	$ICC_{single} = 0.94$ $ICC_{average} = 0.97$ $F_{17,18} = 33.9$**, $p = .000$, $N = 18$	$ICC_{single} = 0.79$ $ICC_{average} = 0.88$ $F_{17,18} = 8.46$**, $p = .000$, $N = 18$

Inter-rater sample with repeated measures across participants. N= 31.	Pearson *r*	.938** p = .000, N = 29	.997* p = .016, N = 33	.960** p = .000, N = 33	.881** p = .000, N = 33
	ICC	ICC_{single} = 0.94 $ICC_{average}$ = 0.97 $F_{28,29}$=30.33**, p = .000, N = 29	ICC_{single} = 0.996 $ICC_{average}$ = 0.998 $F_{28,29}$= 564.6**, p = .000, N = 29	ICC_{single} = 0.96 $ICC_{average}$ = 0.98 $F_{28,29}$=49.1**, p = .000, N = 29	ICC_{single} = 0.87 $ICC_{average}$ = 0.93 $F_{28,29}$=14.15**, p = .000, N = 29
Inter-rater sample with repeated measures across participants and raters. N = 45.	Pearson *r*	.934** p = .000, N = 33	.979** p = .000, N = 33	.958** p = .000, N = 33	.879** p = .000, N = 33
	ICC	ICC_{single} = 0.91 $ICC_{average}$ = 0.95 $F_{38,39}$=20.62**, p = .000, N = 39	ICC_{single} = 0.94 $ICC_{average}$ = 0.97 $F_{38,39}$=34.4**, p = .000, N = 39	ICC_{single} = 0.96 $ICC_{average}$ = 0.98 $F_{38,39}$=51.39**, p = .000, N = 39	ICC_{single} = 0.73 $ICC_{average}$ = 0.84 $F_{38,39}$=7.57**, p = .000, N = 39

** Correlation is significant at the 0.01 level (2-tailed)

Table 54 . Test-retest Pearson r across samples for the SOSAS Total and Subscales

Sample description	Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
Test-retest sample with no repeated measures. N = 23.	$r = .738^{**}$	$r = .528^{*}$	$r = .560^{**}$	$r = .745^{**}$	$r = .651^{**}$
	$p = .000$	$p = .011$	$p = .007$	$p = .000$	$p = .001$
	$N = 22$	$N = 22$	$N = 22$	$N = 22$	$N = 22$
Test-retest sample with repeated measures across participants. N = 30.	$r = .791^{**}$	$r = .723^{**}$	$r = .651^{**}$	$r = .778^{**}$	$r = .890^{**}$
	$p = .000$	$p = .000$	$p = .000$	$p = .000$	$p = .000$
	$N = 26$	$N = 27$	$N = 27$	$N = 27$	$N = 27$
Test-retest sample with repeated measures across participants and raters. N =70	$r = .772^{**}$	$r = .663^{**}$	$r = .604^{**}$	$r = .759^{**}$	$r = .735^{**}$
	$p = .000$	$p = .000$	$p = .000$	$p = .000$	$p = .000$
	$N = 59$	$N = 59$	$N = 59$	$N = 59$	$N = 59$

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Internal consistency of the SOSAS was assessed by calculating Cronbach's Alpha for the 87 separate SOSAS assessments which were completed for the reliability and validity study. Each of the scores for the 19 items (item 16 is not scored) was entered for each of the completed SOSAS assessments and Cronbach alpha calculated using SPSS. The results were based on 83 of the 87 assessments due to missing data where some of the items had not been completed. Cronbach's alpha was 0.59, and 0.61 for standardized scores (a procedure in which the analysis converts all the scores into standard -z- scores). This is a relatively low value for Cronbach's alpha as it is recommended that it should not generally be below 0.7, and so the internal consistency of the SOSAS is modest. The correlation matrix below shows the inter-correlations between the SOSAS Total and SOSAS subscales to illustrate where such lack of consistency may lie. The largest sample has been selected to minimize the influence of individual scores. It can be seen from the table that while there is reasonable correlation between the SOSAS Total and all subscales, and the Minimization and Denial Subscales have reasonable correlations on the Total Scale and Real and Blame, both Real and Blame Scales correlate poorly with the Total Scale and other scales, especially the Blame Scale which seems to correlate poorly with other sections of the SOSAS.

Table 55. Intercorrelations between subscales of the SOSAS on the largest sample (N= 451)

Subscale	SOSAS Total	SOSAS Denial	SOSAS Blame	SOSAS Minimization	SOSAS Real
SOSAS Total	1 N = 361	$r = .710^{**}$ $p = .000$ N = 361	$r = .395^{**}$ $p = .000$ N = 361	$r = .803^{**}$ $p = .000$ N = 361	$r = .540^{**}$ $p = .000$ N = 361
SOSAS Denial	$r = .710^{**}$ $p = .000$ N = 361	1 N = 362	$r = -.055^{**}$ $p = .000$ N = 362	$r = .426^{**}$ $p = .000$ N = 361	$r = .468^{**}$ $p = .000$ N = 362
SOSAS Blame	$r = .395^{**}$ $p = .000$ N = 361	$r = -.055^{**}$ $p = .000$ N = 362	1 N = 363	$r = .162^{**}$ $p = .000$ N = 362	$r = -.290^{**}$ $p = .000$ N = 363
SOSAS Minimization	$r = .803^{**}$ $p = .000$ N = 361	$r = .426^{**}$ $p = .000$ N = 361	$r = .162^{**}$ $p = .000$ N = 362	1 N = 362	$r = .334^{**}$ $p = .000$ N = 362
SOSAS Real	$r = .540^{**}$ $p = .000$ N = 361	$r = .468^{**}$ $p = .000$ N = 362	$r = -.290^{**}$ $p = .000$ N = 363	$r = .334^{**}$ $p = .000$ N = 362	1 N = 363

** Correlation is significant at the 0.01 level (2-tailed).

VESA inter-rater, test-retest and internal consistency

Unlike the preceding three assessments, the VESA does not have subscales and has a simpler one-scale feature with its 28 scored items (two items are not scored) being represented by a single percentage score. Inter- rater correlation, intraclass correlation and test-retest correlation are all presented for the VESA in Table 56 below. The measure of internal consistency, Cronbach's alpha, yielded a score of 0.84 when the individual item scores on the 67 completed VESA's were analyzed.

Table 56. Inter-Rater Correlation, Intra-class Correlation, and Test-retest correlation for VESA

Inter-rater Sample description	Inter-rater Pearson *r*	Intraclass correlation for inter-rater samples	Test-retest sample description	Test-retest Pearson *r*
Inter-rater sample with no repeated measures. N = 18.	$r = .992^{**}$ $N = 17$ $p = .000$	$ICC_{single} = 0.99$ $ICC_{average} = 0.996$ $F_{17,18}=228.5^{**}$ $p = .000$, N = 18	Test-retest sample with no repeated measures. N = 23.	$r = .897$ $N = 22$ $p = .000$
Inter-rater sample with repeated measures across participants. N = 31.	$r = .991^{**}$ $N = 29$ $p = .000$	$ICC_{single} = 0.99$ $ICC_{average} = 0.996$ $F_{28,29}=222.46^{**}$ $p = .000$, N = 29	Test-retest sample with repeated measures across participants. N = 30.	$r = .914^{**}$ $N = 24$ $p = .000$
Inter-rater sample with repeated measures across participants and raters. N = 45.	$r = .992^{**}$ $N = 32$ $p = .000$	$ICC_{single} = 0.99$ $ICC_{average} = 0.996$ $F_{34,35}=238.0^{**}$ $p = .000$, N = 35	Test-retest sample with repeated measures across participants and raters. N =70	$r = .903^{**}$ $N = 57$ $p = .000$

** Correlation is significant at the 0.01 level (2-tailed

Discussion

The purpose of this chapter has been to summarize and further evaluate the four measurement tools which formed a central part of this research, and which have in at least three cases (QACSO, SOSAS and VESA) seen wider application in other research directed at developing or assessing treatment packages for people with intellectual disability who have committed sexual offences (Broxholme & Lindsay, 2003; J.A. Keeling et al., 2007; J. A. Keeling et al., 2007). The specific focus has been to consider the criterion validity of the SOSAS and the SAKA, and to evaluate the inter-rater and test-retest reliabilities and internal consistency of the QACSO, SAKA, SOSAS and VESA.

The SOSAS and the QACSO both purport to be measures of cognitive distortion and as already reviewed, the QACSO has gone some way to demonstrating its suitability in this regard (Broxholme & Lindsay, 2003). The SOSAS Total score correlates with the QACSO total score 0.493 using the Pearson *r*, or to put it another way, approximately 25% of the variance in the QACSO scores is accounted for by the SOSAS scores. The SOSAS Total also correlates with most of the QACSO subscales, ranging from 10% to 25%, implying that the same variance explained in the QACSO Total is common to these subscales of the QACSO. Interestingly, the Minimization Subscale of the SOSAS has a higher correlation with the QACSO Total than does the SOSAS Total, of which it is a component. This suggests that some other items or subscales in the SOSAS actually detract from its value as a predictor of the QACSO. It is likely that some of these items actually correlate negatively, although this is not at the subscale level as none of these correlations with any of the QACSO subscales are negative. The Minimization Subscale actually correlates more highly with the QACSO Total and all of the QACSO Subscales than either the SOSAS Total or any of the SOSAS subscales. The five-item SOSAS Minimization Scale would seem to be a better measure on its own than the nineteen-item SOSAS. Two correlations- between Minimization and QACSO Total and Minimization

and QACSO Offences with Children both accounted for 30% or more of the relevant QACSO variance.

When the Pearson correlation between the SOSAS subscales and the QACSO Total is analyzed for three other samples with larger numbers and the addition of repeated measures, little changes in that the SOSAS Total continues to have a low correlation of just above 0.5, and the SOSAS Minimization continues to have a stronger correlation, though still only rising to a maximum of 0.619 with the sample in which treatment repeats are included. While there is clearly significant overlap between the scales, the SOSAS cannot be said to have adequate criterion validity on the basis of these results. Yet it is interesting that the five-item Minimization Subscale can account for nearly 40% of the 79-item QACSO, and as will be seen in Chapter Eight, the SOSAS changes in response to the treatment programme and in accord with the QACSO. There were clear problems in administering the SOSAS with the participants not always understanding the questions, reported frequently by most researchers, and there could still be benefit in further refinement of the SOSAS. In particular, the five items in the Minimization Scale are worthy of further investigation, and some parts of the SOSAS, notably the Real Subscale, could be removed with minimal loss to its current value, at least so far as the QACSO is a measure of this value.

The SAKA always presented difficulties as there was a clear ceiling effect, with the scores quite compressed at the top of the SAKA's range. The correlation between the SKIS and the SAKA of $r = 0.42$ does not provide any encouragement for the criterion validity of the SAKA, although it is also true that there was a relatively small number in the sample (N = 17), and the compression of scores at the top of the range is likely to have depressed the correlation. It is possible the SAKA may provide a useful pool of items for a quick assessment of sexual knowledge and attitudes, though the scale needs to be extended to eliminate the ceiling effect with this group of participants. The role of sexual knowledge and attitudes in the commission of offences seems less important than

previously thought following some criticism of the 'counterfeit deviance' argument (for example, Lindsay, 2009), though an assessment in this area still has much intuitive appeal. The SAKA still serves as a quick and convenient assessment of some areas related to sexual knowledge and attitudes, and scores on the SAKA have changed in the expected direction as participants have completed the treatment programme. There is still the same lack of quick and convenient-to-administer paper and pencil assessments addressing this area as there was at the time the SAKA was selected by SOTSEC-ID in 1998. The poor performance of the SAKA as a predictor of the SKIS, and in some of the reliability assessments as we will see later, suggests an urgent need for its restructuring and development more than its abandonment given the lack of a suitable alternative.

When we examine the reliabilities of the four assessments, a much clearer and more positive picture emerges. Intraclass correlation coefficients are sometimes argued for as measures of inter-rater reliability as they take better account of any differences in the absolute ratings of the raters rather than just whether they move up or down together (as detected by Pearson correlation coefficient) (Clark-Carter, 2004; Hollin & Howells, 1993; Howell, 2007). There is some debate about precisely which of the several forms of intraclass correlation should be used in a particular instance (Shrout & Fleiss, 1979), but they are more commonly used than Pearson correlations when differences in absolute levels are important. For our purposes in assessing reliabilities, Pearson correlation is an appropriate measure for reasons outlined previously in the measurement section of this chapter, namely we are less interested in whether the judges are differing in absolute amounts, and there is relatively little guidance in the literature as to what would constitute appropriate levels for pre-treatment or post-treatment.

When the actual Pearson inter-rater correlations for the QACSO are examined, they are extremely high, and point to good inter-rater reliability, at least to the extent that raters move up and down in the same direction when rating. Pearson r values are at 0.9 level and above for all samples, with the samples having minimal effect on magnitude of the correlation. Similarly, all subscales of the QACSO had high inter-rater correlations of

0.9 or above, with the exception of the Stalking Subscale, which was still above 0.8 for all samples. The intraclass correlations for the QACSO continued in this theme, with intraclass correlations of 0.99 and above common for the QACSO Total, the Rape and Dating Subscales, and values in the high 0.9 range for Exhibitionism and Homosexual Assault, and values in the low to mid 0.9 range for the remainder, with the exception of the Exhibitionism Subscale which has values in the 0.8 range. This was the most recent scale added to the QACSO (see detailed discussion on the development of the QACSO, and in Broxholme & Lindsay, 2003; Lindsay, Michie, et al., 2006; Lindsay, Whitefield, et al., 2007a) so perhaps it will improve as the items are further refined. Test-retest reliability was assessed using Pearson correlation, and the Pearson correlation for the QACSO suggests clearly that this facet of test performance is strongly addressed. The QACSO Total as would be expected is strongest at about 0.96, and all other subscales are above 0.8 for most of the samples on which they were evaluated. The final measure utilized to assess the adequacy of the QACSO was a measure of internal consistency, Cronbach's alpha. The obtained alpha of 0.94 suggests a high level of internal consistency or homogeneity, which supports both its reliability and its construct validity because the internal consistency measured by Cronbach's alpha supports the homogeneity of the measure and the construct being assessed (Cohen et al., 1992; Schmitt, 1996).

The SAKA distribution was negatively skewed due to a ceiling effect, and some of the SAKA scales had very few items- Understanding relationships had four items and could only vary in score from 0-6, and Social Interaction had three items and could only vary from 0-3. These features of the scale produced some generally disappointing and sometimes anomalous results. The SAKA Total, based on 16 items and a possible range of 51 points, was reasonably robust, obtaining Pearson correlations and Intraclass correlations in the high 0.8 to 0.9 plus range, although obtaining some rank-order correlations which were very low, even in the face of acceptable and even high Pearson or intraclass correlations. For example, a Pearson correlation of over 0.5 became a small

negative correlation for both the ordinal level measures (Kendall's tau and Spearman's rho) on Understanding Relationships with the largest sample considered. This problem was especially true for both the Understanding Relationships and Social Interaction subscales. If these two scales are removed, the majority of the remaining correlations are either acceptable or good, and most are above 0.7. These weaknesses also show up when the SAKA is subjected to test-retest correlation, with Pearson correlation values being acceptable for the Total Scale, and generally acceptable for Sexual Awareness and Assertiveness (scales which include seven and eight items, and ranges of 0-32 and 0-10 respectively), but being unacceptable to very low for the scales of Understanding Relationships and Social Interaction. The initial measure of internal consistency for all items was 0.59, but a careful look at the assessment in light of the alpha score, as suggested by Schmitt (1996), in particular item 19 which is quite different to the other items, suggests that a different dimension might be being assessed and that a low alpha is not necessarily problematic. Indeed, when this item is removed from the analysis, the alpha value increases to an acceptable 0.7.

Despite the difficulties in being able to establish criterion validity of the SOSAS with the QACSO, the inter-rater reliabilities for both the Total SOSAS and the subscales were nearly all around 0.9 on both Pearson correlations and on interclass correlations. This was true for all the subscales. The test-retest correlation was not so reassuring, as although the correlations obtained were generally in the acceptable range (above 0.7), one or two were low (0.53), and correlations changed considerably from one sample to another. Cronbach's alpha was low at 0.59, although this was slightly improved to 0.61 when the formula was applied to standardized scores.

All measures on the VESA were very positive. These were no doubt helped by the fact that it is a 28 item (2 items not scored) single scale item with considerable variability possible, participants being able to score from zero to 84. Inter-rater measures in the form of Pearson correlations or interclass correlations were all high – usually above 0.9, and often at 0.98 or 0.99, as were test-retest correlations. Cronbach's alpha was also good

being 0.84. The VESA is clearly a reliable instrument as it currently stands, and given it has been adapted for this project is in need of some criterion comparisons to help establish its validity in this form.

This chapter has provided further demonstration of the excellent qualities of the QACSO, and provides good support for the VESA. The SOSAS and the SAKA were generally disappointing. The SOSAS did not correlate sufficiently with the QACSO questioning its validity as a measure and rendering the good inter-rater reliabilities and less impressive test-retest reliabilities of little value. The SAKA had severe problems due to a ceiling effect and lack of variability within subscales, and again correlated very poorly with its criterion measure, the SKIS, also questioning its validity as a measure. Both assessments are of dubious value in their present form. The SOSAS Minimization Subscale bears further scrutiny and possible development due to the amount of QACSO variance this 5-item scale accounts for, and improvements to the SAKA, especially to two of its subscales and by increasing the range of possible scores may result in the development of a suitable quick assessment.

CHAPTER EIGHT. STUDY FOUR: QUANTITATIVE STUDY

Introduction

In 1998, Chambless and Hollon provided a framework for authors reviewing empirically supported psychological therapies for a range of populations and problems. They distinguish research that establishes whether an observed clinical change is attributable to the specific treatment intervention (treatment efficacy) from research that addresses whether the treatment can be shown to work in actual clinical practice (treatment effectiveness) (Chambless & Hollon, 1998, p. 14). Chambless and Hollon go on to propose a separate framework for both treatment efficacy research and treatment effectiveness research. For treatment efficacy research, their framework describes a number of factors including overall research design, sample description, outcome assessment, treatment implementation, data analysis and the contribution of single case experiments. The framework for treatment effectiveness includes generalizability (across populations and therapists / settings), treatment feasibility (patient acceptance and compliance, and ease of dissemination), and cost effectiveness. The authors are clear that while random controlled designs or their single-case equivalent are particularly powerful in demonstrating efficacy, which is whether a treatment effect is specifically due to the treatment offered, such a design is not necessarily essential for treatment effectiveness, which addresses whether the treatment is effective in actual clinical practice. Chambless and Hollon (1998) concur with previous suggestions that treatment effectiveness can be undertaken using quasi-experimental and non-experimental designs in order to "... address questions of clinical utility." (p. 14).

Despite such recommendations, there are still calls for random control trials to be used in establishing the effectiveness of sex offender treatment in applied settings (Rice and Harris cited in Marshall et al., 2009). Marshall (Marshall et al., 2009; Marshall et al., 2006) and others (Laws and O'Donohue 1997; Hanson and Bousiere, 1998) have suggested that waiting list control design research is the best approach in this area in order to take account of practical and ethical difficulties associated with random control

designs such as releasing known offenders without treatment, problems of comparability of different offenders and (in)sufficient numbers. As the present study is one of treatment effectiveness rather than treatment efficacy, a waiting list design would therefore have been appropriate, despite the objections raised and the calls for random control trials by ethics committees that reviewed it (S. Hays et al., 2003).

This study, more than the preceding three, is coincident with and a part of the wider SOTSEC-ID project, and there has been significant collaboration and joint planning to the extent that the SOTSEC-ID data base has been developed as a collaborative data set, accessible by those researchers, including the present author, who have contributed research effort and data to it. The research design from the beginning of both SOTSEC-ID and the current project had been intended as a waiting list control, due to the difficulty of keeping untreated offenders with an intellectual disability in a no-treatment control group and the difficulty of attracting both funding and ethical approval for this type of work. In practice, a waiting-list control design was not possible as insufficient control participants were included. The aims of the wider SOTSEC-ID Project and the present research also overlap in regard to study aims, and it is not the intent of the present study to exhaust all possible consideration of the data that has been collected as part of the wider project. Indeed, there have been some publications already that have drawn on the database (Murphy, Sinclair, Hays, & SOTSEC ID Members, 2007; SOTSEC-ID et al., 2010), and additional work is planned to utilize the significant amount of data collated for further analysis and reporting. The present study has therefore been contained within somewhat narrow boundaries in terms of what is possible given the array of data collected, especially through the Men's Group Data Bases I, II and III (MGDB). Only a small portion of the available data will be presented here, and the Victim Empathy Scale Adapted (VESA) is deliberately excluded from this study by prior agreement with SOTSEC-ID.

The aims of the present study are therefore to:

1. Assess programme effectiveness in an applied setting using proxy measures of cognitive distortion (QACSO and SOSAS) and a measure of sexual knowledge and attitudes (SAKA). The null hypothesis to be tested is that there is no difference between pre-treatment, post-treatment and follow-up means on the SOSAS or the SAKA, and no difference between pre-treatment, mid-treatment, post-treatment and follow-up means on the QACSO.
2. Describe demographic features of the participants, making a comparison to mainstream sexual offenders.
3. Describe recidivism rates among the sample during treatment and follow-up.

Method

Design

The design adopted in the present study was essentially an uncontrolled design as there were insufficient control participants. The independent or manipulated variable was treatment or no treatment, and the dependent variables were measures of sexual knowledge and attitudes, cognitive distortion, and recidivism or repeated sexually abusive behaviour. As discussed previously, a number of factors relating to the participant's personal, psychiatric, forensic, and treatment history were also collected using the MGDB, as well as relevant clinical factors such as IQ, receptive language and adaptive behaviour. Some of this data will be used to explore possible relationships with treatment effectiveness. The research design is shown in Table 57.

Table 57 . Quantitative Study Research Design Showing Measures over Time

Measures Time	Initial Measures	QACSO	SAKA	SOSAS	MGDB
Pre	Measure	Measure 1	Measure 1	Measure 1	MGDB I
Mid	-	Measure 2	-	-	-
Post	-	Measure 3	Measure 2	Measure 2	MGDB II
Follow-up	-	Measure 4	Measure 3	Measure 3	MGDB III

Participants

There were 123 participants overall who were drawn from a clinical population of individuals referred for services related to their sexually offending or sexually abusive behaviour. The criteria for selection have been described in Chapter Four. Of the 123 participants who completed a SOTSEC-ID group, 13 of these were repeating groups, and two were controls, leaving 108 participants who completed the programme once, or for the first time, and the results reported relate to these participants.

The mean age of the participants was 35.64 years (N = 94, SD = 11.7), their full scale IQ was 65.9 (N = 87, SD = 6.7), Verbal IQ was 67 (N = 85, SD = 6.9) and Performance IQ was 70 (N = 85, SD = 8.2). Their age equivalent score on the British Picture Vocabulary Test was 131 months or 10 years 11 months (N = 61, SD = 36.4 months), and their age equivalent on the Adaptive Behaviour Scale of the Vineland Adaptive Behaviour Scale was 120 months or ten years (N = 69, SD = 40.5 months). In terms of ethnicity, 76 were white British, 6 were white Irish or other white, 2 were Caribbean and 1 had Indian ethnicity. Further details are provided in the Results.

Measures

The measures used in this study have been extensively discussed in Chapter Four. They consisted of the initial or screening measures, and a range of variables collected through the Men's Group Background Information and Data Base Schedule, Phases One, Two, and Three (MGDB - I, II & III) (Murphy et al., 2003). These included both descriptive and diagnostic information on the participants, as well as criminogenic variables and recidivism. There was also a set of process measures that consisted of cognitive distortions consistent with sexual offending as measured by the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO) (Broxholme & Lindsay, 2003), the Sexual Offenders Self Appraisal Scale (SOSAS) (D. Bray & N. . Forshaw, 1996), and the Sexual Attitudes and Knowledge Assessment (SAKA) (Heighway & Webster, 2007). Please refer to Chapter Four for further information.

Procedure

Ethics.

The overall ethics of the research project was considered in Chapter Four, where the formal ethics approval process, the general consent procedures, confidentiality limits, and risk assessment and management procedures were all reviewed in some detail. Study Four received ethical approval from the multi-research ethics committee on the 19th February 2003, and local research ethics committee approval for the data collected by the current author in August and November 2003 (as two local research ethics committees were involved). Please see Chapter Four for further details.

Treatment.

Treatment was provided according to the SOTSEC-ID treatment manual (Sinclair et al., 2002) and as described in Chapter Three and Appendix 2. A summary of the treatment procedure can also be accessed on the SOTSEC-ID website (www.sotsec.org).

Research.

The research procedures were enmeshed within the treatment procedures, because features such as the treatment manual, annual training programme, six-eight weekly peer supervision and support groups, website, email and collegial network all worked to support and encourage both the treatment and research. Potential local researchers became interested initially in SOTSEC-ID as a means of helping them to provide relevant treatment to individuals on their caseloads or referral lists, and then became interested in the SOTSEC-ID research programme as well. The six to eight weekly SOTSEC-ID meetings, which served a peer supervision and support function for people working in the area, also served a research purpose as there were updates and information disseminated in each meeting about the research protocol as it was being developed. Issues regarding ethical approval, treatment or research procedures and other topics that crossed the research and clinical divide were frequently discussed and debated in this forum. In addition to those who actually attended the meetings, minutes were taken and disseminated to a wide group of people through a large email address list of up to eighty clinicians in the UK. Once a local clinician decided to join the treatment and research programme, they usually started by attending SOTSEC-ID meetings before attending the next annual training programme, often with several other local team members who would eventually become co-facilitators with them in the treatment programme. During this process the local clinician would apply to the local research ethics committee for local ethical approval. They also applied to their own organization's research and development committee for operational or research and development approval for the project within their organization. After obtaining participant's consent to participate in both the research and treatment programmes, clinical measures were collected and utilized from that point on for both clinical purposes locally, as well as being forwarded in an anonymous form to the SOTSEC-ID research team (Professor Murphy, Neil Sinclair and several research assistants, as described earlier). In selecting research measures, clinical and research best-practice procedures were followed so that clinican's efforts would serve both clinical needs and research requirements equally well. In this way, local clinicians were able to develop a best-practice treatment programme and at the

same time produce data that was potentially suitable for the research programme, provided participants consented to its use in this way. A collaboration agreement was signed between the local researcher and SOTSEC-ID that stipulated adherence to the treatment model as described in the treatment manual, specified data collection arrangements, and agreed to collect control data where possible. Separate collaborative agreements existed for treatment and control sites and these can be seen in Appendices 12 and 13. Local clinicians and researchers were requested to deal with late referrals to their group by taking an initial set of measures so that these individuals could serve as control participants in the research programme.

Due to the geographical spread of the programmes across the UK, the relatively small number of men with an intellectual disability at risk of engaging in sexually abusive behaviour, and the initially slow take-up of the treatment programme, the research programme had to extend over a number of years to build-up a reasonable number of research participants. There were also considerable difficulties in encouraging busy clinicians with heavy caseloads to complete all measures at the correct time according to the research framework, to send them in to the SOTSEC-ID research team and particularly, to fill out the MGDB I, II, and III

Results

Research and treatment locations

Results have been collated from 108 different participants who participated in 27 different year-long treatment groups at 15 different locations across England. These were predominantly National Health Service organizations, and included both community and secure settings. Some participants came from low or medium secure services run by the independent sector. Participants were spread unevenly across locations, with a mean number of participants per site of 7.2, ranging between 2 and 20 participants per site as some sites ran several groups over a number of years. The mean number of participants in

each group was 4.3, ranging from one[1] to eight. Community locations were used for groups attended by 59 of the participants, and low or medium secure for another 30 participants. Location is unknown for the remaining 19. Treatment groups were conducted over a nine year period from June 1998 to August 2007, and data collection for the results to be reported here occurred from June 1998 to November 2009.

Participants

Demographic, clinical and criminogenic features of participants.

Most information obtained is derived from the three versions of the Men's Group Data Base (MGDB I, II & III)) described earlier, which had a return rate for the main research data set of 82.4% or 89 of 108 research participants. The MGDB's were quite lengthy, especially MGDB I which had 102 questions, some of which were quite detailed. This may have contributed to a relatively low response rate to some of the items as indicated in the tables below. A previous description of a smaller sample (N = 52) has been presented from this same SOTSEC-ID project in Murphy, Sinclair, Hays and SOTSEC Members (2007) and (SOTSEC-ID et al., 2010).

Background information on the participant's family and childhood circumstances are presented in the following tables. Table 58 shows that for the 89 participants for whom this information was provided, 82% lived with at least one biological parent or close relative and 18% lived in substitute care or a residential facility; while Table 59 suggests that for 87 participants for whom there was information, 65.4% came from a family of four or more children. In terms of occupation, Table 60 shows that for 47 of the participants, 60% of their primary care givers had either routine or semi-routine work, or were unemployed, while Table 61 reports that of the 85 participants for whom

[1] This group initially commenced with three participants, but due to various circumstances only one participant was left at the end contributing data to the research project.

information was obtained, 26% experienced the death of a parent while living with that parent, although only 73% of 81 were reported to have experienced changes in main partners due to divorce, separation, or new partners. For 30 participants who experienced displacement for their family home to residential services as children, Table 62 shows that 50% did so for more than five years.

Table 58. Participant's primary residence as a child

Childhood Residence	Frequency	Percent
with at least one biological parent	65	73.0
with close relatives	7	7.9
adopted/fostered	4	4.5
residential facility	5	5.6
Multiple	8	7.9
Total	89	100.0

Table 59. Participant's siblings or step siblings

Number of siblings/step siblings	Frequency	Percent
None	5	5.7
1 sibling	25	28.7
2 - 3 siblings	33	37.9
4 - 5 siblings	15	17.2
greater than 5 siblings	9	10.3
Total	87	100.0

Table 60. Occupation of Participant's Primary Care Giver

Caregiver's primary occupation	Frequency	Percent
Higher managerial/professional	1	2.1
lower managerial and professional occupations	7	14.9
intermediate occupations	4	8.5
small employers and own account workers	6	12.8
lower supervisory and technical occupations	1	2.1
semi-routine occupations	7	14.9
routine occupations	12	25.5
never worked and long-term unemployed	9	19.1
Total	47	100.0

Table 61. Questions Regarding Participant's Parents

Changes in main parents during childhood	Frequency (%)	Death of participant's parent? (while participant at home)	Frequency (%)
rarely/never (once or twice over duration of childhood)	73 (90.1%)	Yes	22 (25.9%)
occasionally (every 2 - 5 years)	8(9.9%)	No	63 (74.1%)
Total	81(100%)	Total	85(100%)

Table 62 . Years in Residential Services as a Child

If lived in a hospital or residential facility as a child, how many years?	Frequency	Percent
less than 1 year	2	6.7
greater than or equal to 1 year - less than 5 years	13	43.3
greater than or equal to 5 years - less than 10 years	9	30.0
greater than or equal to 10 years	6	20
Total	30	100.0

Table 63 reports that for a sample of 80 participants (78 for one question), 67% went to a special primary school, 85% went to a special secondary school, and 62% had left school by the age of 16 years.

Table 63 . Schooling

Age left school	Frequency	Percent	Attended special school?	Frequency	Percent
5	1	1.3	yes secondary	68	85.0
12	1	1.3	no secondary	12	15.0
13	1	1.3	Total	80	100.0
14	5	6.3			
15	10	12.5	yes primary	52	66.7
16	39	48.8	no primary	26	33.3
17	7	8.8	Total	78	100.0
18	9	11.3			
19	7	8.8			
Total	80	100.0			

During their childhood, 80% (48) of 60 participants were reported as having contact with psychiatric, psychological or learning disability services, and for 62 participants this included intellectual disability, for 6 it included Autistic Disorder , for 9 it included Attention Deficit or Conduct Disorder, and for 5 participants it included encopresis or enuresis (higher number representing a higher response rate to this question and to some participants having multiple developmental disabilities). There were 18 (22%) of 81 participants who were reported to have childhood convictions, as seen in the top line of Table 64, which also shows the number of each type of category of offences for which there were convictions. Notably, there were 46 childhood convictions for different offences by these 18 participants as children. Notable also is the small number of drug offences.

Table 64. Childhood Convictions of Participants

Offence Type		Yes	No		Number Responding		
Any childhood convictions?		18	63		81		
How many were convicted of:	1	2	3	4	5	≥6	Total
Non-sexual offences	4	4	-	2	1	1	12
Sexual offences	5	4	1	1	-	-	11
Violence against the person	3	-	-	-	1	1	5
Burglary/ theft/stolen goods	4	3	2	-	2	-	11
Criminal damage (e.g. arson)	4	-	1	-	-	-	5
Drug offences	2	-	-	-	-	-	2

Table 65 shows the participant's living arrangement at the start of the treatment for 89 participants, with 68% living in formal residential services. Table 66 shows that over 56% of 87 participants were under some form of legal framework at the time of attending the treatment, with most of these (36%) under the Mental Health Act, and 16% under a Community Rehabilitation Order. Table 67 reports that 56% of 87 participants were designated as requiring an escort when out in the community.

Table 65. Participant's Residential Status at Start of Group

Living arrangement at start of group	Frequency	Percent
own home supported	11	12.4
own home unsupported	5	5.6
family or close relative	12	13.5
group residential home	24	27.0
secure environment - low secure	12	13.5
secure environment - medium secure	22	24.7
with support person in support person's home	1	1.1
Unknown	2	2.2
Total	89	100.0

Table 66. Legal Status at Start of Group

Legal status category	Frequency	Percent
informal	38	43.7
under mental health act	31	35.6
community rehabilitation order (probation order)	14	16.1
guardianship order	1	1.1
on bail	1	1.1
on licence	2	2.3
Total	87	100.0

Table 67. Level of Security/Escort Required by Participant when in Community

Escort level	Frequency	Percent
no escort required	37	42.5
1:1 escort required	42	48.3
2:1 escort required	6	6.9
3:1 escort required	2	2.3
Total	87	100.0

When asked whether the participants were receiving other concurrent (psychological) therapy at the commencement of the treatment, only 8 participants of 80 were reported as doing so, and for most of these (7) it was for sexually abusive behaviour and in most cases was described as CBT therapy. Information was provided on medication for 84 participant's, and most (54) were not on any psychotropic medication, 12 were on neuroleptics, 7 were on antidepressants, 5 each were on anticonvulsants and minor tranquilizers and 1 was on lithium. Only 1 was on anti-libidinal medication.

Over 90% of the participants had been in contact with psychiatric or psychological or learning disability services as an adult, and over 70% had been in contact for over four years, so most were 'known' to services. Most services also reported in the MGDB I that the participants were predominantly diagnosed with intellectual disability (over 90%). There were a range of other mental health difficulties reported for the 85 participants for whom this information was supplied, including Personality Disorder (19%), Sexual and Gender Identity Disorder (9.5%), Anxiety (7.1%), Mood (7.4%), Schizophrenia (7.4%) and Communication (5%). Perhaps surprisingly, given this set of difficulties in addition to an intellectual disability, only 37% said they had received therapy for these issues, and nearly 70% were described as not having had any psychological treatment. Of the 25 participants who did have psychological treatment, only 7 reported having psychological treatment as an adult, and as the preceding paragraph made clear, this was mostly for

sexual issues so was probably directed at sexual offending behaviour rather than addressing long-term mental health or adjustment issues of the men.

There was a range of other information about the participants which is not the focus of this project as it will be reported elsewhere. It is worth noting, however, that 37 (54%) of the 68 participants for whom information was provided had been the victim of sexual abuse as a child.

Assessment of Programme Effectiveness

At the beginning of this chapter reference was made to Chambless and Hollon's (1984) distinction between treatment effectiveness and treatment efficacy, and the intent of this research declared as being one of evaluating treatment effectiveness, that is, research that addresses whether treatment can be shown to work in actual clinical practice. Three proxy measures are used here to evaluate treatment effectiveness, the QACSO and the SOSAS as measures of cognitive distortion, and the SAKA for sexual knowledge and attitudes. Positive changes in the cognitive distortion measures are indicated by a reduction in score, and on the SAKA by an increase. These measures were used as a proxy for the primary outcome measure, recidivism, which will be considered separately. The null hypothesis being tested in all cases is that the population means are identical, in terms of the sample means, this would imply:

$\bar{X}_{pre} = \bar{X}_{mid} = \bar{X}_{post} = \bar{X}$ follow-up for the QACSO.

$\bar{X}_{pre} = \bar{X}_{post} = \bar{X}$ follow-up for the SOSAS.

$\bar{X}_{pre} = \bar{X}_{post} = \bar{X}$ follow-up for the SAKA.

A formal assessment of treatment effectiveness was conducted using a One-way Repeated Measures Analysis of Variance (ANOVA) design (Tabachnick & Fidell, 2007) for the QACSO and SOSAS scores, and the equivalent non-parametric test for the SAKA, the Friedman Test for Ordinal Data (Kinnear & Gray, 2006). The means and standard deviations for the QACSO, including subscales, are shown in Table 68, and for the SOSAS and SAKA and subscales in Table 69, both below. The means for all three assessments and their subscales are shown in Figures 28 to 34 following the tables. The graphs appear to show a clear treatment effect in the predicted direction, with QACSO and SOSAS decreasing across assessments, and SAKA increasing.

Table 68 . Means and Standard Deviations for the QACSO and Subscales for Pre-group, Mid-group, Post-group and Follow-up.

Measure	Pre-group			Mid-group			Post-group			Follow-up		
	N	Mean	SD	N	Mean	SD	N	Mean	SD	N	Mean	SD
QACSO total	100	50.66	22.66	74	38.09	23.24	96	33.47	22.88	56	31.34	25.77
Rape	100	9.40	4.89	75	7.92	5.07	96	7.14	5.58	56	6.07	5.55
Voyeurism	100	4.89	2.71	74	3.51	2.64	97	3.26	2.90	56	2.68	2.71
Exhibitionism	100	6.80	4.02	74	5.57	4.02	97	4.47	3.92	55	4.40	4.36
Dating abuse	100	5.39	3.91	74	4.28	3.59	97	3.46	3.34	55	3.71	3.70
Homosexual assault	100	5.76	3.08	74	4.07	3.13	96	4.08	3.39	55	3.65	2.93
Offences against children	100	7.94	5.24	74	5.22	5.14	96	4.35	4.46	55	4.64	5.53
Stalking	100	10.50	6.24	74	7.70	5.87	97	7.08	5.15	55	6.73	5.86

Table 69. Means and Standard Deviations for the SOSAS, SAKA and Subscales for Pre-group, Post-group and Follow-up.

Measure	Pre-group			Post-group			Follow-up		
	N	Mean	SD	N	Mean	SD	N	Mean	SD
SOSAS total	98	54.55	9.701	101	50.16	11.751	50	47.96	12.211
Denial	99	14.31	4.535	101	13.75	4.433	50	12.36	3.953
Blame	100	14.77	4.930	101	14.64	4.372	50	13.36	5.360
Mimimization	99	14.38	4.886	101	12.23	4.982	50	12.00	5.421
Real	100	11.23	3.657	101	9.63	4.014	50	10.24	3.589
SAKA total	101	42.455	6.4537	99	45.960	5.4270	53	47.915	3.7207
Understanding relationships	103	4.612	1.2871	100	5.105	1.0855	54	5.380	.9056
Social interactions	103	2.277	.7027	100	2.500	.8439	54	3.139	4.0404
Sexual awareness	101	27.629	4.0458	100	29.460	3.1348	54	30.361	3.3610
Assertiveness	103	8.063	1.7708	100	8.915	1.4513	54	9.926	5.8118

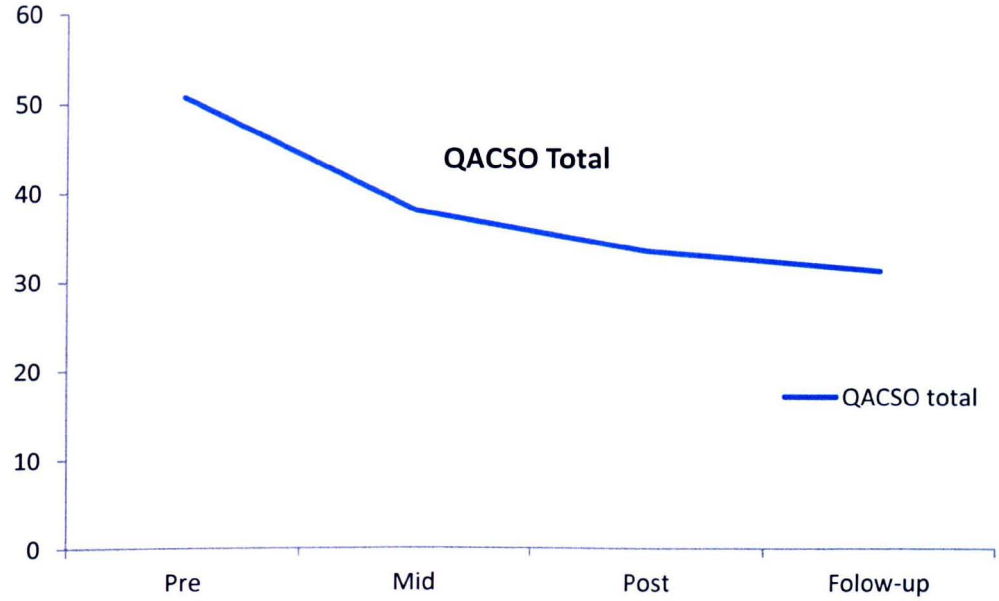


Figure 28. QACSO Total Means across Pre-group, mid-group, post-group, and follow-up assessments

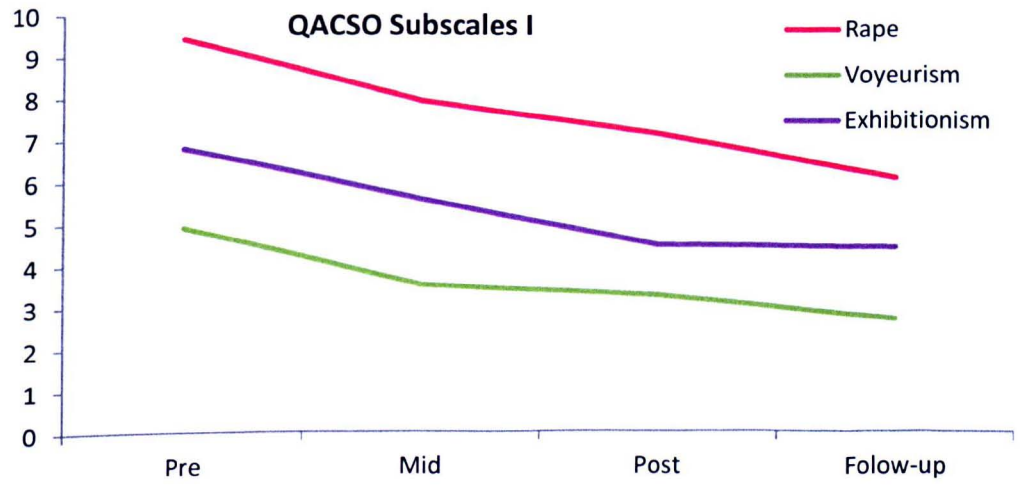


Figure 29. QACSO Subscales Rape, Voyeurism and Exhibitionism Means across Pre-group, mid-group, post-group, and follow-up assessments

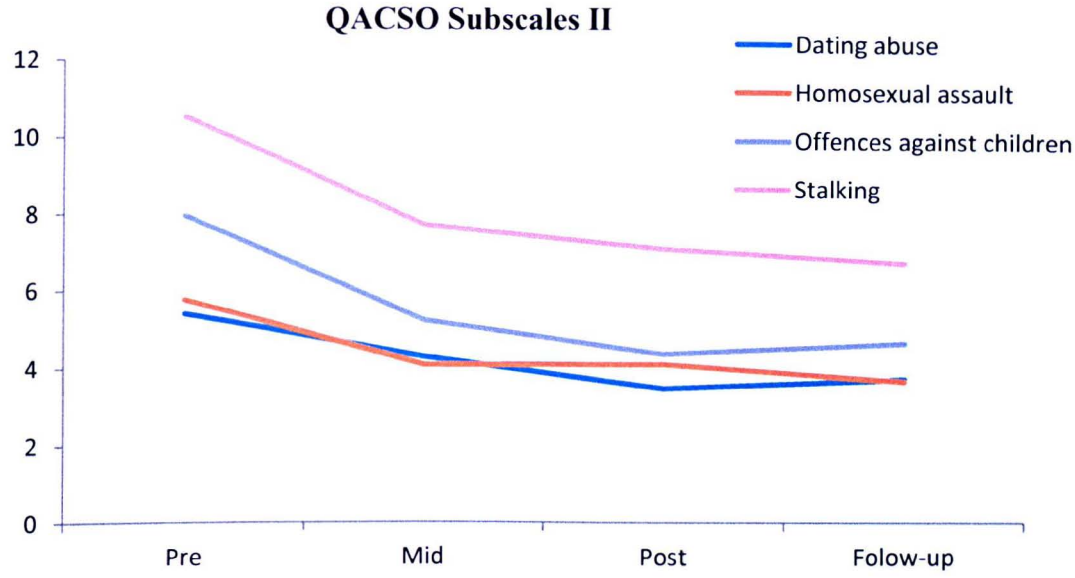


Figure 30. Dating Abuse, Homosexual Assault, Offences Against Children, and Stalking Means across Pre-group, post-group, and follow-up assessments

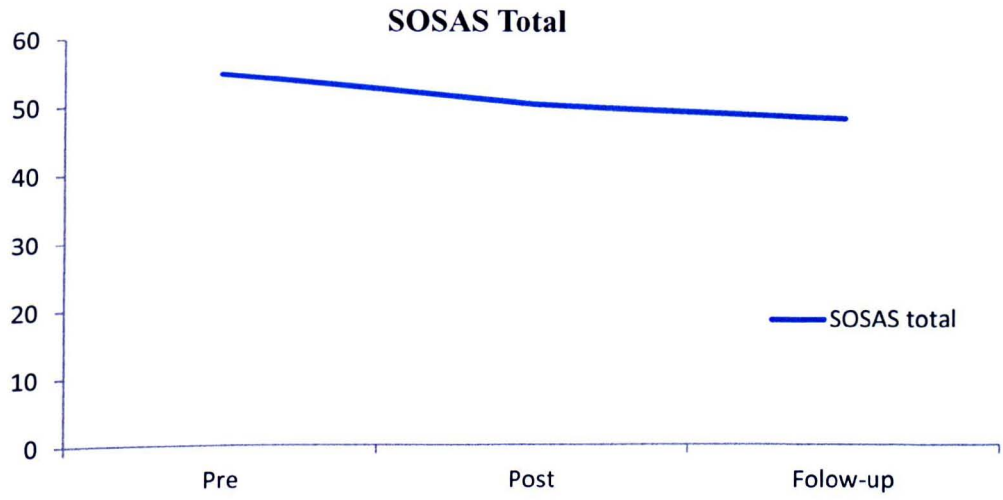


Figure 31. SOSAS Total Means across Pre-group, , post-group, and follow-up assessments

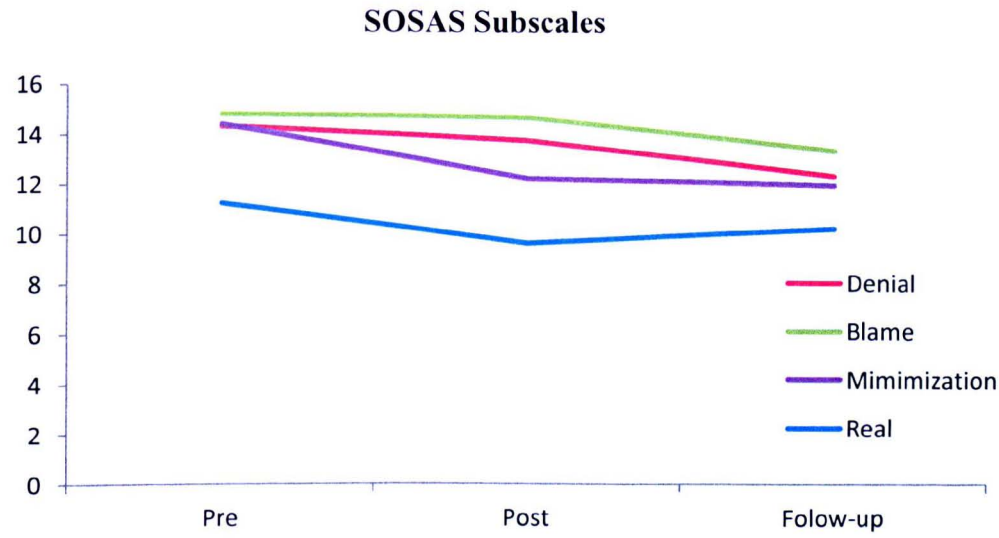


Figure 32 . Denial, Blame, Minimization and Real Means across Pre-group, post-group, and follow-up assessments

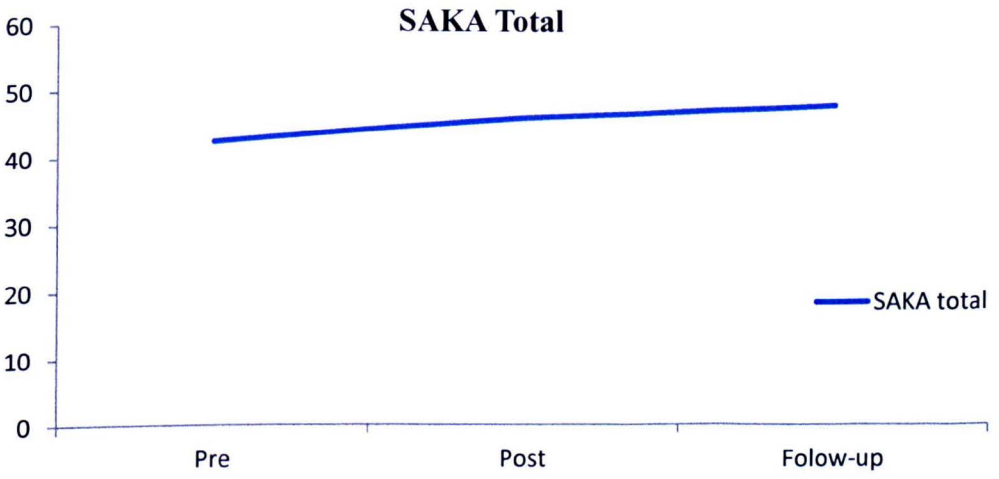


Figure 33. SAKA Total Means across Pre-group, post-group, and follow-up assessments

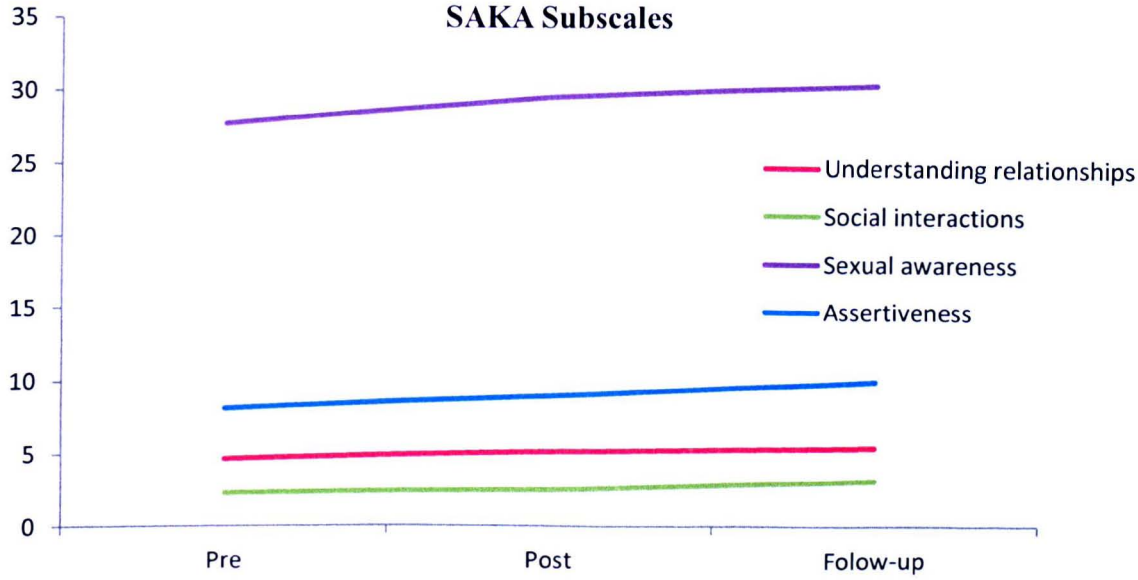


Figure 34 . Understanding, Social Interactions, Awareness and Assertiveness across Pre-group, post-group, and follow-up assessments

The data for the total scores on all three measures were subject to an exploratory data analysis (Howell, 2007) by visual inspection of their distributions using Box and Whisker, Stem and Leaf, Q-Q plots, and Histograms, and by formal tests of skew and kurtosis (Howell, 2007; Murdoch University, 2009). This revealed that the SOSAS distributions were normal for pre-group, post-group and follow-up; the QACSO distribution was normal for pre-group, slightly positively skewed and tending towards bimodality for mid-group and post-group, and there was a positive skew due to a 'floor-effect' for the follow-up, although these latter three QACSO distributions were all still reasonable approximations of a normal distribution. The SAKA distributions were strongly negatively skewed across the three distributions, with the skew increasing as the participants' scores approached the ceiling in the post-group and follow-up distributions. The value of the Skewness Statistic for the QACSO was approximately three times the Standard Error for mid-group, post-group, and follow-up, which is insufficient to violate the normality assumption for an ANOVA, but the value of the Skewness Statistic for all three distributions of the SAKA was highly significant, with the pre-group distribution five times the value of the standard error, the post-group distribution nine times standard error and the follow-up distribution seven times standard error, all of which seriously

violate the assumption of normality, even for ANOVA. As a result, the Friedman Test for Ordinal Data was selected for the analysis of the SAKA data, and the ANOVA with tests of normality and homoscedacity selected for the analysis of QACSO and SOSAS data.

The omnibus ANOVA on the SOSAS results was significant ($F_{2,84} = 6.647$, p=.002), and as would be expected from the exploratory data analysis, the homoscedacity assumption was not violated according to Mauchly's Test of Sphericity. Partial Eta Squared, a measure of effect interpretable in a similar way to r^2 as a measure of the variance predicted, was 0.137, a low effect. Post-hoc comparsions between the three means were carried out after adjustment for repeated testing by the Bonferroni adjustment to alpha levels. This resulted in significant differences between the means of the pre-group and both post-group (p = .028) and follow-up means (p = .008), but not between post-group and follow-up means. Examination of the relevant graph in Figure 31 visually confirms these results.

Mauchley's Test of Sphericity was significant for the QACSO distribution, so the omnibus ANOVA on the QACSO would normally be corrected by adjusting or correcting the degrees of freedom using one of the available corrections such as Greenhouse-Geisser, or Huynh-Feldt (see Howell, 2007, pp. 454-460), but the values of the F Statistic for either of these corrections is identical with the unadjusted F value, and so no adjustment is necessary for this analysis. The omnibus ANOVA result was significant, with $F_{3,114} = 41.052$, p = .000. The measure of effect, Partial Eta Squared, was 0.519, a moderate effect. Post-hoc comparisons between the four means were carried out with adjustment as above for repeated testing by the Bonferroni adjustment. Examination of the graph in Figure 28 is consistent with the results of the post-hoc comparisons, namely that there are significant differences between the means of the pre-group and all other assessments (p = .000 in all cases), the mid-group mean is significantly different to both the post-group mean (p = .000) and follow-up mean (p = .002), but the post-group mean is not significantly different to the follow-up mean.

The SAKA scores were subjected to the Friedman Test, a nonparametric statistic, and the result was significant, $\chi^2_2 = 45.590$ for N = 43. In order to conduct post-hoc comparisons to find out where the difference was, a Wilcoxon Signed-Rank Test was conducted on all

possible combinations with the type one error rate set at a lower level (.017) to allow for the additive effect of multiple comparisons. This analysis resulted in a significant difference ($p = .001$) for the comparison between the pre-group SAKA and both the post-group and follow-up groups, but was not significant for the post-group to follow-up comparison.

Any missing data for all analyses resulted in pair-wise deletion, meaning that the analysis was only conducted on the number of intact pairs, triplets or quadruplets (for the QACSO ANOVA), and replacement of missing data with the mean did not occur. Detailed analyses of any subscale scores has not been undertaken at this stage.

In summary, the above analyses allow us to reject the null hypothesis of there being no difference between the population means on the QACSO, the SOSAS and the SAKA. Specifically, there were significant differences between the pre-group and mid-group means for the QACSO, pre-group and post-group and pre-group and follow-up means for QACSO, SOSAS and SAKA, with only the post-group to follow-up means not being significantly different for all three measures.

Reoffending

Reoffending by participants was noted through the Men's Group Data Bases II and III, which both had 17 questions relating to reoffending. The MGDB II was administered at the end of the group, and the MGDB III was administered six months after treatment concluded.

Twelve men engaged in sexually abusive behaviour during the year of the treatment and seven offended in the six months post-treatment; although only two of these were new offenders, as this figure included five men who had already re-offended in the first twelve months. As some of the men re-offended quite frequently, this actually amounted to 36 'sets' of sexually abusive behaviours and approximately 41 different sexual abusive acts during the treatment or follow-up period. Taking each of these incidents as an 'offence' (following S. Brown, 2005, pp., p. 3) and each of the participants as a 'reoffender', a recidivism rate can be calculated. Although there were 108 participants in the data base,

only 78 had a completed MGDB III, which is the reporting mechanism for a further offence at the end of the follow-up period, so only this reduced group of 78 can be considered. Discounting multiple offences and not considering differential seriousness, there are 14 unique reoffenders out of a pool of 78 over an 18 month period. This represents a recidivism rate of a little over 12% per year (14 unique offenders divided by 78 total participants multiplied by 0.67 to convert 18 months to 12 months), although the threshold is much lower than for normal recidivism measures as it was not based on actual convictions. As only 5 participants had a court-mandated outcome (allowing this to count as a 'conviction'), this resulted in an annual recidivism rate of 4.3% using the same method. While this is not a generalizable figure because it includes an actual treatment period, the participant numbers are small and the follow-up period is too short, it is an index for this particular group of participants during the period in question.

The offences in the two periods will be dealt with together. In the first twelve month period, nine participants reoffended once, one participant reoffended twice, another five time, and another six times. In the six months post-group, six participants reoffended once, and one reoffended eight times. There were a range of types of offending, with the following all occurring only once: four participants engaging in stalking; two participants engaging in touching through clothes; two participants engaging in verbal sexual harassment; two engaging in public masturbation; a participant masturbating a victim; making their victim masturbate them; having their victim perform oral sex on them; and touching underneath clothing. There was also one participant who publicly masturbated five times, and another who verbally sexually harassed a victim four times. Another participant engaged in public masturbation on seven occasions, and there were individual offences by participants including another participant masturbating in public, one touching through clothing, two engaging in verbal sexual harassment, and a stalking incident. There were also two incidents that were not defined.

These offences occurred against 5 males and 14 females. The victims were other service users on seven occasions, acquaintances and strangers on ten occasions, a staff member on three occasions, and a close friend of the participant's family on one occasion, as well as three times against undefined others. The victims included eighteen adults, one 5-12

year old child, one 12 -18 year old youth, and a victim over 60, as well as fifteen incidents involving members of the public of unknown age and gender.

Turning to consequences, the participants who reoffended were interviewed by or came to the notice of the police due to their offending on nine occasions, and went to court on four occasions. The court outcomes included two Community Rehabilitation Orders, a Hospital Order under the Mental Health Act (1983 as amended), a fine or damages payment and a suspended sentence. One case was dropped and one was awaiting a court outcome. There were three convictions for indecent assault and one for sexual harassment. Service mediated changes as a result of these offences included twelve verbal reprimands, increased supervision on seven occasions, specialist referral on four occasions, two changes of residential placement, loss of 'privileges' on three occasions, a change of job or work placement on one occasion, nine outcomes which were not defined, and eleven occasions when there were no service mediated changes.

Most of the incidents happened while participants were single, though one participant offended on four occasions when in a non-cohabiting relationship. Participants were usually living in their own home on a supported basis when they offended (21 occasions), in their own home without support (4 occasions), or with family or a close relative (3 occasions). Participants offended on three occasions from a group or residential services, twice from a low secure service, once from a medium secure service, and once in the support person's home. No illicit substances or alcohol were used in the commission of the offences, and the offences consisted of five predominantly contact offences, twenty predominantly non-contact offences and one equally contact and non-contact. A more detailed and individualized account of the participants who reoffended in the first data set has been undertaken by Professor Murphy and presented elsewhere (Murphy, Sinclair, Hays, & SOTSEC-ID members, 2007).

With only a small number of participants reoffending and relatively little variability in the data that could be used (for example, a computed variable which combined the reoffending data from the post-group MGDB II and the follow-up MGDB III), it is difficult to imagine a statistical test that could be used to test a posited relationship, for example between initial QACSO score and recidivism, or a technique to explore their

correlation. Multiple Regression is an obvious choice to ascertain the best predictor of offending, but the data is insufficient at this stage. Likewise, a Discriminant Function Analysis may be helpful to develop a discriminant function made up of several predictor variables such as QACSO, Age, and SOSAS, amongst others, but again there is insufficient data to undertake such an analysis at this stage. In her earlier analyses, Professor Murphy had noted the preponderance of autism diagnoses (by psychiatrists rather than the diagnostic criteria checklist assessment we used) and concurrent psychological intervention (Murphy, Sinclair, Hays, & SOTSEC-ID members, 2007). She had noted that the concurrent intervention was probably due to a heightened sense of risk, whereas the autism diagnosis may be related to re-offfending through features known to be more prevalent amongst this group such as low empathy.

Discussion

In undertaking research with this population, clinical risk management and the risk of reoffending and the consequent pressure to 'do something' is a constant clinical imperative. At the same time, managing this imperative for such individuals in an environment in which there are also increasing demands for accountability and value for money in services also means that it is difficult to undertake methodologically robust treatment evaluations. It was for this reason that a waiting-list control design was used. Unfortunately, none of the research sites were able to collect adequate data on control participants to allow for a meaningful comparison. This means that any conclusions from the data must be tempered with the flaw that competing explanations for the changes observed cannot be excluded.

The men's group data base reported earlier in the chapter proved a rich source of information on the participants, only some of which have been reported here. Overall, the picture which emerges from these 'snapshots' (bearing in mind that information was not available for all participants) into the participant's lives prior to sexual offending treatment, is that they generally came from larger families with poor to moderate income (based on parent occupation), and that while a number seemed to stay within reasonably intact families, a significant number (30) spent more than five years out of their family home as a child. Over half were reported as being sexually abused under sixteen years,

with most occurring under twelve, and criminal convictions as a child were reported for 29%, though drug problems were rarely reported (as noted some years ago anecdotally by Haaven, (Haaven et al., 1990). Despite this troubled background for many, only 7 were in receipt of any psychological help for other than their sexual offending, despite being 'known' to services for a number of years. Most (68%) now lived in formal services, 56% were subject to a formal legal framework and only went into the community with an escort. This compares reasonably well with comparisons made in the first few chapters regarding profiles of mainstream sexual offenders, though there seems to be a lower rate of substance use, an earlier and greater involvement with services from childhood, and a greater level of intrusion through the level of community escorting which occurs.

The empirical analyses allows the null hypotheses to be rejected and for the conclusion that there is a significant difference between means in the predicted direction. The lack of a significant difference between post-treatment to follow-up means for all three measures also shows that the changes measured by the QACSO, SOSAS and SAKA last at least 6 months and do not simply revert back to pre-treatment functioning levels. Visual inspection of the graphs would suggest that the effect continued well after the treatment for all measures, at a slower rate, although this was not significant. The effect size measured by the QACSO was moderate while the SOSAS was small, and although it was not specifically assessed, the slope of the SAKA trend-line in Figure 33 suggests a low effect.

These results do not allow for a conclusion that the changes in the measures were due to the SOTSEC-ID treatment because of the lack of a comparison or control group. The original design had been for a matching waiting-list control group comparison, but virtually no control participants were recruited for various reasons as previously discussed. Plausible alternative explanations for this effect could be the socialization and reflection afforded through the groups and the additional attention and discussion from staff about sexual offending as a result of the men participating in the programme. Probably the most plausible and difficult to repudiate alternative explanation is that the men have simply learnt to 'talk the talk' but have not changed their pro-offending cognitions. Continued follow-up on reoffending for these participants (subject to appropriate ethical applications) will help clarify this issue in the long term.

The recidivism rate of 12.3% for reporting of an offense and 4.3% for conviction of an offense initially compares well with Lindsay's rate of 23.9% (Lindsay, 2006, 2009). However, Lindsay's rate was obtained over a much longer period (up to twelve years) and the issue of what constitutes an offense for the purpose of recidivism bears closer scrutiny.

Nonetheless, the framework of the treatment manual, regular SOTSEC-ID meetings, SOTSEC-ID website, annual provision of the SOTSEC-ID training, and the network of interested clinicians in a cognate area managed to continue for a number of years and is still operating as a framework, although this particular research project is drawing to a conclusion and is closed to new research participants.

CHAPTER NINE. GENERAL DISCUSSION

The Literature

The opening chapters of this dissertation reviewed mainstream sex offending theory and treatment literature, clarified terminology, argued for a public health perspective, and reviewed the problems and developments encountered when mainstream programmes were adapted for and applied to men with an intellectual disability who committed sexual offences. Although risk assessment and management of such men is a crucial aspect of the service response, space prohibited a detailed discussion within the main body of the dissertation. However, a discussion of the topic is provided in Appendix 17, including description of a four-factor model and frameworks for clinical practice. This thesis has sought to describe and evaluate a viable model for providing treatment for individuals with intellectual disability who engage in sexual offending behaviour.

The reason why such individuals need treatment is because sexual offending hurts others, whether perpetrated by individuals with or without intellectual disability. Victims are often vulnerable people, and offenses often have a deleterious impact on their current and future well being negatively affecting possible trajectories of their life. The desirability of reducing the severity, frequency and impact of sexual offending therefore, can be compared to other public health goals such as improving sanitation, reducing smoking and reducing spousal assault. A major contributor to the sex offending literature, Richard Laws, recently made exactly this point in an impassioned plea to view sexual abuse as a public health issue, to challenge the lack of public funding and support for its prevention and treatment, and to encourage greater efforts amongst his colleagues to develop, research and refine treatment programmes for identified offenders. He argued that primary and secondary prevention strategies can be developed and implemented in addition to the traditional individual and small group bastions of psychiatry and psychology - what might be described, at best, as tertiary prevention (Laws, 2008; Laws & O'Donohue, 2008). He advocates that treatment professionals should combine with community based public health organizations, such as 'STOP IT NOW', to develop approaches that combine the best of scientific research and clinical practice with the sociological

and epidemiological models from public health adopted by preventative psychiatry (Caplan, 1964) and community psychology (Rappaport, 1977).

That people with intellectual disability are vulnerable to sexual abuse is well understood, but a series of research and discussion articles (Breen & Turk, 1992; Brown et al., 1995; Brown & Turk, 1992; Turk & Brown, 1993) in the early to mid-1990's made it clear that this is not just a theoretical risk, but that perpetrators are often other people with intellectual disabilities - primarily men (Bremble & Rose, 1999; Churchill et al., 1997; Thompson, 2000; Thompson & Brown, 1998). Furthermore, it was argued that the absence of a suitable service response to such situations allows intellectually disabled service users – vulnerable adults - to bear the burden of our collective failure to properly acknowledge and respond to offending and treatment issues (Brown & Thompson, 1997b; Churchill, Craft, Holding, & Horrocks, 1996) and address the real risk (Murphy, 1997a).

The current project commenced in 1996-1997withmeetings on assessment and research, and SOTSEC-ID developed soon after, as described in Chapter Four. The purpose of the project continues to be the same, namely to reduce the risk of sexual predation and assault by some men with an intellectual disability, predominantly against other people with intellectual disability with whom they share services, but also members of the wider community. The best way this risk can be reduced in the long run appears to be to address individual needs for a 'Good Life' (Ward, Mann, et al., 2006), while at the same time protecting potential victims. This remains an essentially positive solution to an otherwise bleak picture.

A wider literature exists on the treatment of mainstream sexual offenders, which prior to the mid-1990's had not been fully explored and applied to the treatment of men with an intellectual disability (Barbaree et al., 1993; Greer & Stuart, 1983; Laws, 1989; Marshall et al., 1990; Marshall, Mulloy, & Serran, 1998). Lindsay and his colleagues adapted this largely cognitive behavioural approach for men with an intellectual disability in Scotland and disseminated a treatment model (Lindsay, Marshall, et al., 1998; Lindsay, Marshall, Quinn, & Smith, 1997; Lindsay, Neilson,

Morrison, et al., 1997; Lindsay, Olley, et al., 1998; Lindsay & Smith, 1998). Others at HM Prison Service and the Janet Shaw Clinic (Hill & Hordell, 1999; Hill et al., 1995; HM Prison Service, 1996) adapted the model in England. The SOTSEC-ID project as a whole, and the present project as a part thereof, has been guided and supported by these previous initiatives, and has added to the momentum of research in this area. This project has sought to develop and describe a viable, evidence-based psychological treatment response to the issue of sexual offending by men with an intellectual disability, to contribute to the development and testing of appropriate assessments, to improve treatment programmes by understanding how participants experience them and to evaluate, as rigorously as circumstances and resources allow, the effectiveness of the programme in an applied clinical setting.

The literature review noted the rapid developments that have occurred over the last ten years with both mainstream and intellectually disabled sex offenders. An ambiguous empirical picture on treatment effectiveness has added to the existing controversy within the field about treatment, which probably reflects a schism in wider society about our collective response to these crimes and the men who perpetrate them. That one of the most widely respected and methodologically rigorous studies of effectiveness suggests that the Relapse Prevention Model is wanting as an intervention strategy came as a shock, even though this was foretold for some time (Marques, 1999; Marques et al., 2005). It is likely that the results of this study will add momentum to the development and adoption of the Pathways Model, based on Self Regulation Theory, which Ward and others, including some in intellectual disability, have been developing for several years (Keeling & Rose, 2005; Langdon et al., 2007; Ward et al., 2009; Ward et al., 1998; Yates & Kingston, 2006). Work on the development of an overall theory that explains existing results and knowledge about the aetiology and maintenance of sex offending has also developed rapidly, with the Integrated Theory of Sexual Offending (Beech & Ward, 2004; Ward & Beech, 2008) being offered as a framework to guide assessment and treatment, and within which to develop testable hypotheses for future research. Work on offender cognitions has also developed rapidly, and there is now a clearer description of what is meant by a 'cognitive distortion' (Fisher & Beech, 2007; Gannon, 2009; Gannon et al., 2007; Thakker.et al., 2007; Ward, Keown, et al., 2006)

and the 'Implicit Theories' from which they come (Thakker et al., 2007). Such work may lead to the development of sets of implicit theories for different groups of offenders, and then to the development of assessment tools and intervention strategies for changing these implicit theories rather than just the cognitive distortions that they generate. This will include guidance on how such distortions develop and are maintained within the individual's cognitive world, and how and under what circumstances they become manifest in violent, including sexual, offences. Despite Laws pessimistic summary of the state of the field and his exhortation to "do better" (Laws & O'Donohue, 2008, p. 13), there are some clear directions provided in findings and theorizing to date. Although Relapse Prevention is likely to be removed from most treatment programmes, this will hopefully be done without also taking out the positive behavioural and cognitive elements it adopted (George & Marlatt, 1989). The Good Lives and Pathways/ Self Regulation Models are both providing direction and guidance for the immediate assessment and treatment of sex offenders, including those with an intellectual disability, and there is still room for cautious optimism regarding our capacity to develop effective treatment strategies.

Overview of Studies One to Four

The second half of the dissertation described how the aims of the project were addressed. As part of the SOTSEC-ID project, this included considering a range of assessments, developing a best-practice treatment manual and training package, and disseminating and supporting the implementation of the treatment package within a research framework.

The pilot study helped to focus the research project's efforts onto a smaller number of assessments and to underline the difficulty of collecting research information from busy clinical settings. The data collected and presented from the pilot study did not allow any clear conclusions, but participants more often scored in the predicted directions on the QACSO and VESA than on the SAKA, with the SOSAS appearing quite difficult to interpret. Overall group means between earliest and latest assessment on each of the four measures reflected this, with a clear difference

between means (not tested statistically) for the QACSO and VESA, a small difference in the predicted direction for the SAKA (an increase), and a difference against predictions for the SOSAS (that is, participants' scores got higher, indicating more cognitive distortions).

The qualitative study sought to show the experience of the treatment group from the 'inside out' in terms of the participant's experience; and of the major themes that emerged from the Interpretive Phenomenological Analysis (IPA), notable ones included recollections of childhood trauma and loss, an engagement with the serious material of the group and its implications for them personally, and a reflective acknowledgement of the impact that the group had made. A more sobering theme was the sense of foreboding and even fearful anticipation with which some participants regarded the course of their sexual desire (which we might describe as deviant sexual arousal) and its impact on their own life chances and liberty. Potential confounding effects of the author being the therapist, interviewer and conductor of the IPA were highlighted.

The third study examined reliability and validity of the measures used in this study, some of which have been used elsewhere, especially the QACSO. Further data collection was undertaken involving an additional 29 participants whose data were used in conjunction with the main SOTSEC-ID data set where appropriate. The results showed that the criterion validity of the SOSAS was poor, using the QACSO as a criterion, with overall correlation between the total SOSAS and the total QACSO being 0.49, although the 5-item Minimization Subscale achieved a correlation of 0.58 with the overall QACSO, and higher correlations with every other QACSO Subscale than the SOSAS overall. Although the SOSAS has always been poorly regarded in comparison to the QACSO, given their respective lengths (20 items for the SOSAS and 70 plus for the QACSO) and these results, there seems to be some interesting items in the Minimization Subscale that bear further examination. Given some of the suggestions regarding implicit theories of offending, it may be possible that there are one or two items in this scale that overlap with an implicit theory relevant to the participant's offending cognitions. Although the sample was small, the data suggested that the SAKA correlated poorly with the

SKIS, with correlations ranging from 0.29 to 0.56. The SAKA is a poor measure, but the analysis pointed to areas within the SAKA that could be developed further.

The inter-rater and test–retest reliabilities of the QACSO, both between total QACSO scores and all QACSO Sub-tests using both normal correlations and interclass correlations, were high, almost all above 0.9, as was the Cronbach alpha for internal consistency. The inter-rater correlations were higher than test-retest over a two to three week period. The SAKA also performed moderately well, better than anticipated, with good inter-rater correlations (inter-class and conventional) for the total scale and for the subscales, except for Social Interaction. Test-retest results for the SAKA were not as positive, and these are discussed in terms of where the test might be developed, namely the subscales of Social Interaction and Understanding Relationships, which are both particularly weak on this analysis. In terms of the SOSAS, inter-rater reliabilities for both the Total SOSAS and all SOSAS Subscales were nearly all around 0.9 on both Pearson correlations and on Interclass correlations, though test-retest correlations were lower - usually 0.7 or above, though some were as low as 0.53. Internal Consistency as measured by Cronbach's Alpha was low at 0.59, though improved slightly to 0.61 when scores were standardized to correct for non-normal distributions. This is consistent with the mixed correlation results obtained between SOSAS Sub-scales and QACSO Total and subscales in the criterion validity comparison. Given Lindsay's (Lindsay, Michie, et al., 2006) reported high Cronbach Alpha, which is replicated in these results, this is likely to be due to variability in the SOSAS rather than the QACSO. The VESA also performed very well on assessments of its inter-rater reliability and on test –retest, with Pearson correlations for both comparisons, and interclass correlations for the inter-rater mainly ranging from 0.9 to 0.99. Internal consistency was 0.84 on Cronbach's Alpha.

In summary, the results confirm the QACSO and the VESA as sound assessment tools in this area, and found poor validity for the SOSAS and SAKA, as well as poor stability over time for these latter two assessments. The results suggest that the Minimization Subscale in the SOSAS may have potential as a quick assessment tool, or may provide the foundation for one to be developed; it is also possible that the

SAKA could be improved as a quick assessment by adding items and attending to its sub-scale structure.

The fourth and final study in this dissertation analyzed some of the results from the MGDBI, II, and III, as well as the results of the main study scores on three of the four measures (QACSO, SAKA, and SOSAS). The profile of the men is not dissimilar to some reports of mainstream sexual offenders discussed earlier in Chapter One, though a detailed comparison was not made. Certainly the participants seemed to experience significant disadvantage. In addition to an intellectual disability, more than half had experienced sexual abuse as a child, a substantial portion had experienced significant dislocation from their family home as a child, but received minimal treatment other than for sexual offending. The quantitative analysis allowed the null hypotheses to be rejected, implying that there had been significant changes in the predicted direction for all three measures. Although alternative explanations cannot be entirely discounted, the SOTSEC-ID Treatment Programme is a strong contender as an explanation for the measured changes in cognitive distortion and sexual knowledge observed. Effect sizes were moderate for the QACSO and small for the SOSAS. The SAKA effect size was not measured. A recidivism rate of 12.3% was calculated for all known offences, and 4.3% for a Court disposal, though it is too early to feel confident with these figures. The issue that Lindsay raised of monitoring of offenders and its impact on recidivism rates (Lindsay, 2009) is not included in these figures, although there is some provision to do this in the future through questions on social outcome of an offence and questions on the level of escort in the community in the MGDB.

Criticisms of the Research

There were, inevitably, a number of weaknesses in the research reported here and therefore limitations on the conclusions that can be drawn from it. It is clear that opportunities for collecting data by the current author in the early years of the project were not maximized, largely due to clinical pressures already discussed. That this was a common problem for other researchers does not lessen the error or the effect it has had on extending the overall length of the project. One strategy to

encourage return of data on time would be to fund payment for duly completed assessments by qualified and trained assessors sent in on time. This was the strategy adopted in the recent UK standardization for the WAIS IV (the present author was part of the project).

The lack of a comparison group is a serious weakness, and it is a major challenge to develop viable robust methodologies that provide a suitable control group. Withholding treatment, as would be required for a random allocation control design, is difficult at any time, but may be nearly impossible without high-level support in an age of value for money within health services. Holding the purity of a random allocation design was one of the weaknesses identified in the recent major Relapse Prevention study discussed earlier (Marques et al., 2005), and that was despite backing by the state legislature and being located in a prison setting. Perhaps a waiting-list control design is still the best model, or research centres could be randomly allocated to treatment or control conditions. One strategy to encourage return of data would be to fund payment for duly completed assessments by qualified and trained assessors sent in on time. This was the model adopted in the recent UK standardization for the WAIS IV (the present author was part of the project).

There was a minor problem with repeat participants, but this was dealt with by excluding them from the analysis. As treatment programmes become more widespread, it is hoped that finding 'clean' participants who have not already completed some form of sex offender treatment may become more difficult. Perhaps the focus of measurement in the future will shift to improvements in mediating variables linked to offending, regardless of previous treatment.

Whether the IPA analysis reflected the author's own framework or a genuine transmission of the 'lived experience' of participants with an intellectual disability in sex offending treatment groups will not be resolved until subsequent analyses are reported. The confounding effect of the author being therapist, interviewer and IPA analyst was noted.

Detailed examination of the four measures used in this study, provided more data than has been presented within the limitations of this dissertation. Further analysis and exploration of the data produced is called for, along with item analysis and possible restructuring of the SOSAS and the SAKA. There may also be sufficient data to allow exploration of the factor structure of all measures through exploratory factor analysis. No data are presented about the equivalence of the reliability and validity sample to the main study group, and this is suggested for future analysis. The MGDB I, II, & III have yielded some very interesting and detailed data and much is still to be reported from these assessments. Reliability of the data is difficult to ascertain because of the way in which they were collected and the difficult of checking the details. A random reliability check on 10% of returns may address this weakness as part of future research if funding permits.

A final problem with the research was not with the design or its execution but the interminable delays and bureaucracy in obtaining all the different layers of ethical and operational approval prior to being able to collect data. While ethical approval is of course absolutely necessary, and prompts good practice in terms of examining ethical features of the research design, participant involvement and fulfilling all the ethical responsibilities of the researcher, the effect of the ethical approval process on this study was nearly sufficient to make the project unviable.. The tables on length of time taken to obtain ethical approval in Chapter Four speak for themselves, and this will be used to add to those voices already calling for the situation to change (McDonach, Barbour, & Williams, 2009).

Conclusion

There is no doubt that there is an urgent need to develop and implement effective treatment programmes for intellectually disabled sex offenders. Although this is the lowest level of preventative services, to do otherwise is to blithely accept the inevitability of reoffending. Although only a tertiary prevention response (Caplan, 1964; Rappaport, 1977), it may lay the ground work for developing secondary prevention programmes that identify and respond to potential offenders in the early stages of their offending career, and primary prevention programmes that address

misogynistic attitudes and behaviours in families and service settings where boys who may develop into offenders can be found. Due to the existing level of service contact with the families and lives of children with an intellectual disability, there may be a greater possibility of early identification and remediation than in mainstream settings. It is to be hoped that the current project will assist SOTSEC-ID in continuing to develop a viable and accountable treatment programme.

Significant further research is needed to continue to address the issue of treatment effectiveness and to manage the conflicting pressures that make it difficult to undertake methodologically rigorous research, such as (a) demand for any type of service for identified offenders, (b) difficulty in obtaining ethical approval for sensitive topics from an already cumbersome ethical approval process; (c) likely increased difficulty in obtaining funding in difficult economic times (Holland, 2004); (d) determining recidivism rates when escorting arrangements are unknown; and (e)increasing return rates from applied clinician/researchers.

In setting standards for future treatment programmes and research, Lindsay (2009) comments that our programmes should not necessarily be measured by whether they *stop* future offending but whether they reduce the harm such behaviour evokes. In seeking to set fairer standards for evaluating sex offender treatment programmes, Lindsay makes the point that treatment programmes for depression are judged by whether the severity and frequency of depressive episodes reduces post therapy. Similarly, the success of coronary heart surgery is not measured by whether the patient eventually dies of heart disease but the number of years they survive post operatively. Lindsay's research on harm reduction (Lindsay, Steele, et al., 2006) is a better way of conceptualizing treatment effectiveness, and while recidivism is still an absolute standard, harm reduction may be a more appropriate outcome measure in sex offending, as it has been in other areas of treatment, such as self-harm.

Research into other suitable assessments and indicators needs to continue, and there is further work required on the data collected in Study Three as discussed above. There are some interesting directions for possible development of the SOSAS and the SAKA suggested here, and there are existing data on the Sex Offenders Opinion

Test (SOOT) from the adapted program in HM Prison service (F. Williams & Mann, 2010). The first edition of the Multiphasic Sex Inventory (MSI I) was used in Study One, and email correspondence with one of the authors, Mollinder, recommends its suitability for people with an intellectual disability. The recently published MSI II has had all double negatives removed to increase understandability, has a reading level of grade seven and comes with an audio recording of the questions for those who cannot read (Nichols & Molinder, 2000). There is also an adolescent male version with norms which may be more suitable than the ordinary male version.To date, there has been at least one published report of the MSI being used with intellectually disabled sex offenders (Craig et al., 2006).

Finally, having worked on this project for nearly 14 years, and having had considerable clinical and research contact with some of the men who are the subject of this research, it has been reassuring to see that the results of the qualitative study confirm existing clinical impressions about the men and their motivation to engage in treatment. While there may be exceptions, most seem to be genuinely committed to becoming offence-free, even if the motivation for this has to do with their own liberty and independence rather than their desire to avoid harming others. Research reviewed in Chapter One (Malamuth, Sockloskie, Koss, & Tanaka, 1991) about American male college student views on sexual violence, and Rees documentation of the sexual violence that occurred in Germany in the aftermath of World War Two (Rees, 2008), should make us hesitate about condemning such motivation, because like sexual violence, it is more common than we would like to believe.

REFERENCES

1 in 3 schoolgirls has been molested. (2010, 2010, October 13). *Daily Mail.*

Abbott, S., & McConkey, R. (2006). The barriers to social inclusion as perceived by people with intellectual disabilities. *Journal of Intellectual Disabilities, 10*(3), 275-287.

Abel, G. G., Osborn, C. A., Anthony, D., & Gardos, P. (1992). Current treatments of paraphiliacs. *Annual Review of Sex Research, 3.*

Abel, G. G., & Rouleau, J. L. (1990). The nature and extent of sexual assault. In W. L. Marshall, R. D. Laws & H. E. Barbaree (Eds.), *Handbook of Sexual Assault.* New York: Plenum Press.

Allam, J., Middleton, D., & Browne, K. (1997). Different clients, different needs? Practice issues in community-based treatment for sex offenders. *Criminal Behaviour and Mental Health, 7*, 69-84.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition, Text Revision ed.). Washington, DC: American Psychiatric Association.

Andrews, D. A., & Bontna, J. (2002). *The Psychology of Criminal Conduct* (3rd ed.). Cincinati, Ohio: Anderson.

Anonymous. (2002). Sexual assault in adults. *Drug & Therapeutics Bulletin, 40*(1), 1-4.

Aresti, A., Eatough, V., & Brooks-Gordon, B. (2010). Doing time after time: an Interpretative Phenomenological Analysis of reformed ex-prisoners' experiences of self-change, identity and career opportunities. *Psychology, Crime and Law, 16*(3), 169-190.

Arscott, K., Dagnan, D., & Stenfert Kroese, B. (1998). Consent to psychological research by people with an intellectual disability. *Journal of Applied Research in Intellectual Disability, 11*, 77-83.

Arscott, K., Dagnan, D., & Stenfert Kroese, B. (1999). Assessing the ability of people with a learning disability to give informed consent to treatment. *Psychological Medicine, 29*, 1367-1375.

Ayland, L., & West, B. (2006). The good way model: a strengths based approach for working with young people, especially those with intellectual disabilities, who have sexually abusive behaviour. *Journal of Sexual Aggression, 12, 189-201.*

Aytes, K. E. (2001). Cognitive/behavioral treatment for sexual offenders: an examination of recidivism. *Sexual Abuse: Journal of Research & Treatment, 13*(4), 223-231.

Baker, E. (1993). The social and legal framework. In K. Howells & C. R. Hollin (Eds.), *Clinical approaches to the Mentally Disordered Offender.* Chichester Wiley.

Bandura, A. (1977). *Social Learning Theory.* Englewood Cliff, NJ: Prentice Hall.

Barbaree, H. E., & Cortoni, F. A. (1993). Treatment of the juvenile sex offender within the criminal justice and mental health systems. In H. E. Barbaree, W. L. Marshall & S. M. Hudson (Eds.), *The Juvenile Sex Offender.* New York: Guilford.

Barbaree, H. E., Hudson, S. M., & Seto, M. S. (1993). Sexual assault in society: The role of the juvenile offender. In H. E. Barbaree, Marshall, W. L., and Hudson, S. M. (Ed.), *The Juvenile Sex Offender* (pp. 1-24). New York: Guilford Press.

Barbaree, H. E., Langton, C., & Peacock, E. (2006). Sexual offender teatment for psychopaths: Is it harmful? In W. L. Marshall, Y. M. Fernandez, L. E. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 159-171). Chichester, West Sussex: Wiley.

Barbaree, H. E., & Marshall, W. L. (1988). Deviant sexual arousal, offence history and demographic variables as predictors of reoffence among child molesters. *Behavioural Sciences and the Law, 6*, 267-280.

Barbaree, H. E., & Marshall, W. L. (1989). Erectile responses among heterosexual child molesters, father-daughter incest offenders, and matched non-offenders: Five distinct age-preference profiles. *Canadian Journal of Behavioural Science, 21*, 70-82.

Barbaree, H. E., Marshall, W. L., & Hudson, S. M. (Eds.). (1993). *The Juvenile Sex Offender.* New York: Guilford Press.

Barbaree, H. E., & Seto, M. E. (1997). Assessment and treatment. In R. D. Laws & W. O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment and Research.* New York: Guilford.

Barron, P., Hassiotis, A., & Banes, J. (2002). Offenders with intellectual disability: The size of the problem and therapeutic outcomes. *Journal of Intellectual Disability Research, 46*(6), 454-463.

Beacock, C. (2005). The policy context. In T. Riding, C. Swann & B. Swann (Eds.), *The Handbook of Forensic Learning Disability* (pp. 1-14). Abingdon, Oxford: Radcliffe.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* NY: International Universities Press.

Beckett, R., Beech, A., Fisher, D., & Fordham, A. S. (1994). *Community-based treatment for sex offenders: An evaluation of seven treatment programmes.* London: HMSO.

Beckett, R., & Fisher, D. (1994). Victim Empathy Measure. In R. Beckett, A. Beech, D. Fisher & A. S. Fordham (Eds.), *Community -Based Treatment for Sex Offenders: An Evaluation of Seven Treatment Programmes*. London: Home Office.

Beech, A., Craig, L. A., & Browne, K. D. (2009). Overview. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 1-12). Chichester: Wiley.

Beech, A., Fisher, D., & Beckett, R. (1998). STEP 3: An Evaluation of the Prison Sex Offender Treatment Programme. London: Home Office.

Beech, A., & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: Journal of Research & Treatment, 9*(3).

Beech, A., & Ward, T. (2004). The integration of etiology and risk in sexual offenders: A theoretical framework. *Aggression and Violent Behavior, 10*(1), 31-63.

Benson, B. A., & Ivins, J. (1992). Anger, depression and self-concept. *Journal of Intellectual Disability Research, 36*, 169-175.

Benson, B. A., Rice, C. J., & Miranit, S. V. (1986). Effects of anger management training with mentally retarded adults in group treatment. *Journal of Consulting and Clinical Psychology, 54*(5), 728-729.

Berlin, F. S., Saleh, F. M., & Malin, H. M. (2009). Mental illness and sexual offenidng. In F. B. Saleh, A. J. Grudzinskas, J. M. Bradford & D. J. Brodsky (Eds.), *Sex Offenders: Identificantion, Risk Assessment, Treatment and Legal Issues* (pp. 119-129Keown). New Yourk: Offord University Press.

Bickley, J., & Beech, A. R. (2001). Classifying child abusers: its relevance to theory and clinical practice. *International Journal of Offender Therapy and Comparative Criminology, 45*(1), 51-69. doi: 10.1177/0306624x01451004

Birmingham, L., Mason, D., & Grubin, D. (1996). Prevalence of mental disorder in remand prisoners: Consecutive case study. *British Medical Journal, 313*, 1521-1524.

Black, L., Cullen, C., & Novaco, R. W. (1997). Anger assessment for people with mild learning disabilities in secure settings. In B. S. Kroese, D. Dagnan & K. Loumidis (Eds.), *Cognitive Behaviour Therapy for People with Learning Disabilities* (pp. 33-52). London: Routledge.

Blair, J., Mitchell, D., & Blair, K. (2005). *The Psychopath: Emotion and the Brain.* Malden, MA: Blackwell.

Blanchard, R. (1998). Birth order in homosexual versus heterosexual sex offenders against children, pubescents, and adults. *Archives of Sexual Behavior, 27*(6), 595-603.

Bodna, B. (1987). *Finding the Way: The Criminal Justice System and the Person with Intellectual Disabilities.* Melbourne: Office of the Public Advocate, Victoria, Australia.

Boer, D. P., Frize, M., Pappas, R., Morrissey, C., & Lindsay, W. R. (2010a). Suggested adaptations to the HCR-20 for offenders with intellectual disabilities. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 177-192). Chichester: Wiley-Blackwell.

Boer, D. P., Frize, M., Pappas, R., Morrissey, C., & Lindsay, W. R. (2010b). Suggested adaptations to the SVR-20 for offenders with intellectual disabilities. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 193-209). Chichester: Wiley-Blackwell.

Boer, D. P., Thakker, J., & Ward, T. (2009). Sex offender risk-based case formulation. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 77-88). Chichester: Wiley.

Boer, D. P., Tough, S., & Haaven, J. (2004). Assessment of risk manageability of intellectually disabled sex offenders. *Journal of Applied Research in Intellectual Disabilities, 17*, 275-283.

Borthwick-Duffy, S. A. (1994). Prevalence of destructive behaviours. In T. Thompson & D. B. Gray (Eds.), *Destructive Behaviours in Developmental Disabilities: Diagnosis and Treatment.* Thousand Oaks: Sage.

Bowden, K. (1994). 'No control of penis or brain'? Key questions in the assessment of sex offenders with a learning disability. *The Journal of Sexual Aggression, 1*(1), 57-63.

Bray, D., & Forshaw, N. (1996). *Sex Offender's Opinion Test* Lancashire Care NHS Trust North Warwickshire NHS Trust.

Bray, D., & Forshaw, N. (1996). *Sex Offender's Self Appraisal Scale. Version 1.1.* Lancashire Care NHS Trust; North Warwickshire NHS Trust.

Breen, T. (1989). Mentally handicapped sex offenders. Resources for Psychologists Working with Sex Offenders. Aukland: Psychological services, Department of Justice, New Zealand.

Breen, T., & Turk, V. (1992, Jun). *Sexual offending by people with learning disabilities.* Unpublished manuscript.

Bremble, A., & Rose, J. (1999). Psychological intervention for adults with learning disability accused of sexual offending. *Clinical Psychology Forum, 131*, 25-30.

British Psychological Society. (2006). *Assessment of Capacity in Adults: Interim Guidance for Psychologists.* London: British Psychological Society.

Brown, B. S., & Courtless, T. F. (1971). *The Mentally Retarded Offender.* Washington, DC: Department of Health, Education and Welfare.

Brown, H., Stein, J., & Turk, V. (1995). Report of a second Two Year Incidence Survey on the Reported Abuse of Adults with Learning Disabilities. *Mental Handicap Research, 9*(1), 1-22.

Brown, H., & Thompson, D. (1997a). The ethics of research with men who have learning disabilities and abusive sexual behaviour: a minefield in a vacuum. *Disability and Society, 12*(5), 695-708.

Brown, H., & Thompson, D. (1997b). Service responses to men with intellectual disabilities who have unacceptable or abusive sexual behaviours: The case against inaction. *Journal of Applied Research in Intellectual Disabilities, 10*(2), 176-197.

Brown, H., & Turk, V. (1992). Defining sexual abuse as it affects adults with learning disabilities. *Mental Handicap, 20*(2), 44-45.

Brown, S. (2005). *Treating Sex ffenders: An Introduction to Sex Offender Treatment Programmes.* Cullompton, Devon, UK: Willan.

Browne, K. D. (2009). Working to prevent sexual abuse in the family. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 491-514). Chichester: Wilwy-Blackwell.

Broxholme, S. L., & Lindsay, W. R. (2003). Development and preliminary evaluation of a questionnaire on cognitions related to sex offending for use with individuals who have mild intellectual disabilities. *Journal of Intellectual Disability Research, 47*(6), 472-482.

Calhoun, K. S., & Resick, P. A. (1993). Post-traumatic stress disorder *Clinical Handbook of Psychological Disorders.* New York: Guilford Press.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., & Whelton, B. (In Press). Patterns of Risk in Adult Protection Referrals for Sexual Abuse and People with Intellectual

Disability. *Journal of Applied Research in Intellectual Disabilities*, no-no. doi: 10.1111/j.1468-3148.2010.00574.x

Campbell, R., & Wasco, S. M. (2005). Understanding rape and sexual assault: 20 years of progress and future directions. *Journal of Interpersonal Violence, 20*(1), 127-131.

Caparulo, F. (1988). *A Comprehensive Evaluation of an Intellectually Disabled Sex Offender.* Reprinted manuscript. Orwell, Vermont.

Caplan, G. (1964). *Principles of Preventative Psychiatry.* New York: Basic Books.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*(1), 7-18.

Charman, T., & Clare, I. C. H. (1992). Education about the laws and social rules relating to sexual behaviour; a group for male sexual offenders with mild mental handicaps. *Mental Handicap, 20*(2), 74-80.

Charmaz, K. (2003). Grounded theory. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 81-110). London: Sage.

Churchill, J., Brown, H., Craft, A., & Horrocks, C. E. (1997). *There are no Easy Answers: The Provision of continuing Care and Treatment to Adults with Learning Disabilities who Sexually Abuse Others.* Chesterfield: ARC and NAPSAC.

Churchill, J., Craft, A., Holding, A., & Horrocks, C. (Eds.). (1996). *It Could Never happen Here! The Prevention and Treatment of Sexual Abuse of Adults with Learning Disabilities in Residential Settings* Chesterfield: ARC and NAPAC.

Clare, I. C. H. (1993). issues in the assessment and treatment of male sex offenders with mild learning disabilities. *Sexual and Marital Therapy, 8*(2), 167-180.

Clare, I. C. H. (1994). Treatment of men with mild learning disabilities who are perpetrators of sexual abuse: Motivational difficulties and effects on practitioners. *Bulletin of the National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (NAPSAC), 8*, 3-6.

Clare, I. C. H., Murphy, G. H., Cox, D., & Chaplin, E. H. (1992). Assessment and treatment of fire-setting: A single-case investigation using a cognitive-behavioural model. *Criminal Behaviour and Mental Health, 2*, 253-268.

Clark-Carter, D. (2004). *Quantitative Psychological Research: A Student's Handbook.* Hove, East Sussex: Psychology Press.

Clarkson, R., Murphy, G. H., Coldwell, J. B., & Dawson, D. L. (2009). What characteristics do service users with intellectual disability value in direct support staff within

residential forensic services. *Journal of Intellectual & Developmental Disability, 34*(4), 283-289.

Cockram, J., Jackson, R., & Underwood, R. (1992). Perceptions of the judiciary and intellectual disability. *Australia & New Zealand Journal of Developmental Disabilities, 18*, 189-200.

Cohen, R. J., Swerdlik, M. E., & Smith, D. K. (1992). *Psychological Testing and Assessment: An Introduction to Tests and Measurement* (2nd ed.). Mountain View, CA: Mayfield.

Coid, J. (1988). Mentally abnormal prisoners on remand-rejected or accepted by the NHS? *British Medical Journal, 296*, 1779-1782.

Cookson, A., & Dickson, J. M. (2010). The Subjective Experiences of People with an Intellectual Disability and Diagnosis of Schizophrenia Who are Detained in a Medium Secure Unit. *Journal of Applied Research in Intellectual Disabilities, 23*(4), 379-389. doi: 10.1111/j.1468-3148.2010.00554.x

Cooper, A. J. (1995). "Review of the role of two antilibidinal drugs in the treatment of sex offenders with mental retardation": Response. *Mental Retardation, 33*(5).

Cortoni, F. (2009). Factors associated with sexual recidivism. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 39-52). Chichester: Wiley.

Courtney, J., & Rose, J. (2004). The efffectiveness of treatment for male sex offenders. *Journal of Sexual Aggression, 10*, 215-236.

Courtney, J., Rose, J., & Mason, O. (2006). The offence process of sex offenders with intellectual disabilities: a qualitative study. *Sexual Abuse: A Journal of Research & Treatment, 18*(2), 169-191.

Craft, A., Brown, H., Churchill, J., & Horrocks, C. (1997). Framework chapter *There are no Easy Answers: The provision of Continuing Care and Treatment to Adults with Learning Disabilities who Sexually Abuse Others.* Chesterfield: ARC and NAPSAC.

Craig, L. (2010). Controversies in assessing risk and deviancy in sex offenders with intellectual disabilities. *Psychology, Crime and Law, 16*(1), 75-101.

Craig, L., Browne, K. D., & Beech, A. R. (2008). *Assessing Risk in Sex Offenders: A Practitioner's Guide.* Chichester: Wiley.

Craig, L., & Lindsay, W. R. (2010). Sexual offenders with intellectual disabilities: characteristics and prevalence. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.),

Assessment and Treatment of Sexual Offenders with Intellectual Disabilities (pp. 13-36). Chichester: Wiley-Blackwell.

Craig, L., Lindsay, W. R., & Browne, K. D. (2010). *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities*. Chichester: Wiley.

Craig, L., Stringer, I., & Moss, T. (2006). Treating sexual offenders with learning disabilities in the community. *International Journal of Offender Therapy & Comparative Criminology, 50*(4), 369-390.

Craissati, J. (2009). Attachment problems and sex offending. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 1-12). Chichester: Wiley-Blackwell.

Cronbach, L. J., & Meehl, P. E. (1955). Construct validity in psychological tests. *Psychological Bulletin, 52*(4), 281-302.

Cullen, C. (1993). The treatment of people with learning disabilities who offend. In K. Howells & C. R. Hollin (Eds.), *Clinical Approaches to the Mentally Disordered Offender* (pp. 145-164). Chichester: Wylie.

Darke, J. L. (1990). Sexual aggression: Achieving power through humiliation. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender*. New York: Plenum Press.

Day, A. (1999). Sexual offender views about treatment: a client survey. *Journal of Child Sexual Abuse, 8*(2), 93-103.

Day, K. (1988). A hospital-based treatment programme for male mentally handicapped offenders. *British Journal of Psychiatry, 153*, 635-644.

Day, K. (1990). Mental retardation: Clinical aspects and management. In R. Bluglass & P. Bowde (Eds.), *Principles and Practice of Forensic Psychiatry* (pp. 399-418). Edinborough: Churchill-Livingstone.

Day, K. (1993). Crime and mental retardation: A review. In K. Howells & C. Hollin (Eds.), *Clinical Approaches to the Mentally Disordered Offender* (pp. 111-144). Chichester: Wiley.

Day, K. (1994). Male mentally handicapped sex offenders. *British Journal of Psychiatry, 165*(5), 630-639.

Denkowski, G. C., Denkowski, K. M., & Mabil, J. (1983). A 50-State survey of the current status of residential treatment programs for mentally retarded offenders. *Mental Retardation, 21*(5), 197-203.

Denkowski, G. C., Denkowski, K. M., & Mabli, J. (1994). A residential treatment model for MR adolescent offenders. *Hospital and Community Psychiatry, 35*(3), 279-281.

Department for Constitutional Affairs. (2005). *Mental Capacity Act 2007, Code of Practice.* London: Department of Constitutional Affairs.

Department of Health. (2001a). *Research Governance Framework for Health and Social Services.* London: Department of Health.

Department of Health. (2001b). *Valuing People: A New Strategy for Learning Disability for the 21st Century.* London: The Stationery Office.

Department of Health. (2005). Research Governance Framework for Health and Social Services: Second Edition Retrieved from http//**www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digital** asset/dh_4122427.pdf

Department of Health. (2009). *Valuing People Now: a New Three Year Strategy for Learning Disabilities.* London: DH Publications.

Department of Health/Home Office. (1994). Review of health and social services for mentally disordered offenders. Vol. 7: People with learning disabilities (mental handicap) or with autism. London: HMSO.

Doren, D. M. (2006). Recidivism risk assessments: making sense of controversies. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 3-16). Chichester: Wiley.

Dowrick, P. W., & Ward, K. M. (1997). Journal of Intellectual and Developmental Disability.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with "Impossible Cases": The Efficient Treatment of Therapy Veterans.* New York: Norton.

Dunn, L. M., Dunn, L. M., & Whetton, C. (1982). *British Picture Vocabulary Scale.* London: nfer Nelson.

Dunn, L. M., Dunn, L. M., Whetton, C., & Burley, J. (1997). *The British Picture Vocabulary Scale,* (2nd ed.). London: GL Assessment.

Eifert, G. H., Schulte, D., Zvolensky, M. J., Lejuez, C. W., & Lau, A. W. (1997). Manualized behaviour therapy:merits and challenges. *Behaviour Therapy, 28,* 499-509.

Eldridge, H. (1998). *Maintaining Change: Relapse Prevention for Adult Male Perpetrators of Child Sexual Abuse. Therapist Guide.* Thousand Oaks: Sage Publications, Inc.

Ellis, A., & Grieger, R. (1977). *Handbook of rational-emotive therapy.* NY: Springer.

Emerson, E. (1995). *Challenging Behaviour: Analysis and intervention in people with learning disabilities*. Cambridge: Cambridge University Press.

Emerson, E., & Bromley, J. (1995). The form and function of challenging behaviours. *Journal of Intellectual Disability Research.*

End Violence Against Women. (2010). End Violence Against Women downloaded on 14.12.2010 from: http://www.endviolenceagainstwomen.org.uk/.

Fairbairn, G. (2002). Sex matters. *Learning Disability Practice, 5*, 20-23.

Fernandez, Y. M. (2006). Focusing on the positive and avoiding negativity in sexual offender treatment. In W. L. Marshall, Y. M. Fernandez, L. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 187-198). Chichester: Wiley.

Fernandez, Y. M. (2009). The standardisation of phallometry. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 129-144). Chichester: Wiley

Fernandez, Y. M., Shingler, J., & Marshall, W. L. (2006). Putting the"behaviour" back into the cognitive behavioural treatment of sexual offenders. In W. L. Marshall, Y. M. Fernandez, L. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 211-225). Chichester: Wiley.

Filipek, P. A., Accardo, P. J., Baranek, G. T., Cook, E. H., Dawson, G., Gordon, B., . . . Kallen, R. J. (1999). The Screening and Diagnosis of Autistic Spectrum Disorders. *Journal of Autism and Developmental Disorders, 29*(6), 439-483.

Finkelhor, D. (1986). *A Source Book on child Sexual Abuse*. London: Sage.

Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *The Future of Children, 4*(2), 31-53.

Finkelhor, D. (Ed.). (1984). *Child Sexual Abuse: New Theory and Research*. New York: Free Press.

Fisher, D. (1994). Adult sex offenders: Who are they? Why and how do they do it? *Sexual Offending Against Children: Assessment and Treatment of Male Abusers* (pp. 1-24). London: Routledge.

Fisher, D., & Beech, A. R. (2007). The implicit theories of rapists and sexual murderers. In T. A. Gannon, T. Ward, A.R.Beech & D.Fisher (Eds.), *Aggressive Offenders' Cognition* (pp. 31-52). Chichester, West Sussex: Wiley.

Forchuk, C., Martin, M. L., & Griffiths, M. (1995). Sexual knowledge and interview schedule: Reliability. *Journal of Intellectual Disability Research, 39*(1), 35-39.

Ford, H., & Rose, J. (2010). Improving service provision for intellectually disabled sexual offenders. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 343-364). Chichester: Wiley-Blackwell.

Foxx, R. M., Bittle, R. G., Betchel, D. R., & Livesey, J. R. (1986). Behavioural treatment of the sexually deviant behaviour of mentally retarded individuals. *International Review of Research in Mental Retardation, 14*, 291-317.

Foxx, R. M., McMorrow, M. J., Storey, K., & Rodgers, B. M. (1984). Teaching social/sexual skills to mentally handicapped adults. *American Journal of Mental Deficiency, 89*(1), 9-15.

Furby, L., Weinrott, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105*(1), 3-30.

Furey, E. M. (1994). Sexual abuse of adults with mental retardation: who and where. *Mental Retardation, 32*(3), 173-180.

Gannon, T. A. (2009). Social cognition in violent and sexual offending: an overview. *Psychology, Crime and Law, 15*(2), 97-118.

Gannon, T. A., Ward, T., Beech, A. R., & Fisher, D. (Eds.). (2007). *Aggressive Offenders' Cognition*. Chichester, West Sussex: Wiley.

Gardiner, M. (1996). Group for male sex offenders with learning disabilities. *NAPSAC Bulletin, 15*, 3-6.

Garrett, H. (2006). Development of a community-based treatment programme for adult male clients with a learning disability. *Journal of Sexual Aggression, 12*(1), 63-70.

Garrett, T., Oliver, C., Wilcox, D., & Middleton, D. (2003). Who cares? the views of sexual offenders about the group treatment they receive. *Sexual Abuse: A Journal of Research & Treatment, 14*(4), 323-338.

Garrett, T., & Thomas-Peter, B. (2009). Inteventions with sex offenders with mental illness. In A. R. Beech & L. A. Craig (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 392-408). Chichester, UK: Wiley-Blackwell.

Gavey, N. (1991). Sexual victimization prevalence among New Zealand university students. *Journal of Consulting and Clinical Psychology, 59*, 464-466.

George, W. H., & Marlatt, G. A. (1989). Introduction. In D. R. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 1-34). New York: Guilford Press.

Gilby, R., Wolf, L., & Goldberg, B. (1989). Mentally retarded adolescent sex offenders: Survey and pilot study. *Canadian Journal of Psychiatry, 34*(6), 542-549.

Goodman, W., Leggett, J., Weston, C., Phillips, S., & Steward, J. (2008). Group treatment for men with learning disabilities who are at risk of sexually offending: themes arising from the four-stage model to offending. *British Journal of Learning Disabilities, 36*(4), 249-255.

Grann, M., Belfrage, H., & Tengstreom, A. (2000). Actuarial assessment of risk for violence: Predictive validity of the VRAG and the historical part of the HCR-20. *Criminal Justice & Behavior, 27*(1).

Green, G., Gray, N. S., & Willner, P. (2002). Factors associated with criminal conviction for sexually inappropriate behaviour in men with learning disabilities. *Journal of Forensic Psychiatry, 13*, 578-607.

Greer, J. G., & Stuart, I.R., & Stuart, I. R. (Eds.). (1983). *The Sexual Aggressor: Current Perspectives on Treatment.* New York: Van Nostrand Reinhold.

Griffiths, D. M., Hingsburger, D., & Christian, K. (1985). Treating developmentally handicapped sexual offenders: The York behaviour management services treatment program. *Psychiatric Aspects of Mental Retardation Reviews, 4*(12), 49-52.

Griffiths, D. M., Quinsey, V. L., & Hingsburger, D. (1989). *Changing Inappropriate Sexual Behaviour: A community-Based Approach for Persons with Developmental Disabilities.* Baltimore: Brookes.

Gross, G. (1985). *Activities of a Developmental Disabilities Adult Offender Project.* Olympia, WA.

Grossman, L. S., Martis, B., & Fichtner, C. G. (1999). Are sex offenders treatable? A research overview. *Psychiatric Services, 50*(3).

Grubin, D., & Thornton, D. (1994). A national programme for the assessment and treatment of sex offenders in the English prison system. *Criminal Justice and Behaviour, 21*(1), 55-71.

Haaven, J., Little, R., & Petre-Miller, D. (1990). *Treating Intellectually Disabled Sex Offenders.* Orwell, VT: Safer Society Press.

Hall, G. C. N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology, 63*(5), 802-809.

Hames, A. (1987). Sexual offences involving children: a suggested treatment for adolescents with mild mental handicaps. *Mental Handicap, 15*, 19-21.

Hanson, R. K. (2006). Stability and change: dynamic risk factors for sexual ofenders. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 17-32). Chichester: Wiley.

Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-ananlysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*(2), 348-362.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W. D., Quinsey, V. L., & et al. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research & Treatment, 14*, 169-194.

Hanson, R. K., & Harris, A. J. R. (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: Journal of Research & Treatment, 13*(2).

Hanson, R. K., & Thornton, D. (2000). Improving Risk Assessments for Sex Offenders: A Comparison of Three Actuarial Scales. *Law and Human Behavior, 24*(1), 119-136. doi: 10.1023/a:1005482921333

Hare, R. D. (2003). *Hare Psychopathy Checklist- Revised (PCL-R)* (Second ed.). New York: Mulit-Health Systems.

Harris, A., Phenix, A., Hanson, K. R., & Thornton, D. (2003). Coding Rules for Static-2002 Retrieved on 20.11.2010 from **http://www.static99.org/**

Harris, P. M. (1994). Client management classification and prediction of probation outcome. *Crime & Delinquency, 40*(2).

Hayes, S. (1993). Sexual violence against intellectually disabled victims. In P. W. Easteal (Ed.), *Without Consent: Confronting Adult Sexual Violence.* Canberra: Australian Institute of Criminology.

Hayes, S. (1994). The Criminal Law and the Person with Intellectual Disability. . *Australia & New Zealand Journal of Developmental Disabilities 19*(4), 287-292.

Hayes, S. (1996). Recent research on offenders with learning disabilities *Tizard Learning Disability Review, 1*, 7-15.

Hayes, S., & Craddock, G. (1992). *Simply Criminal* (2nd ed.). Leichhardt: Federation Press.

Hays, S., Murphy, G. H., & Sinclair, N. (2003). Gaining ethical approval for research into sensitive topics: "two strikes and you're out". *British Journal of Learning Disabilities, 31*, 181-189.

Hays, S. J., Murphy, G. H., Langdon, P. E., Rose, D., & Reed, T. (2007). Group treatment for men with intellectual disabilities and sexually abusive behaviour: Service user views. *Journal of Intellectual and Developmental Disability, 32*, 106-116.

Heighway, S. M., & Webster, S. K. (2007). *STARS: Skills training for assertiveness, relationship-building and sexual awareness*. Arlington, Texas: Future Horizons, Inc.

Henson, T. (2008). Do sexual offenders with learning disabilities benefit from treatment programmes. *British journal of Learning Disabilities, 37*, 98-102.

Herkov, M. J. (1996). MMPI differences among adolescent inpatients, rapists, sodomists, and sexual abusers. *Journal of Personality Assessment, 66*(1), 81-90.

Hickey, N., & Jones, J. (1996). *The Challenge of Working with Learning Disabled Sexual Abusers*. Paper presented at the Division of Legal and Criminlogical Psychology Conference. Copy of manuscript held by Neil Sinclair retrieved from

Hill, J., & Hordell, A. (1999). The Brooklands sex-offender treatment programme. *Learning Disability Practice, 1*(1), 16-21.

Hill, J., Hordell, A., Lawson, A., Wing, S., & Forshaw, N. (1995). Learning disabilities or low IQ. offenders. Adapting the S.O.T.P. approach. *SOTP Newsletter, 1*(3).

Hingsburger, D. (1987). Sex counseling with the developmentally handicapped. *Psychiatric Aspects of Mental Retardation News, 6*(9), 41-45.

HM Prison Service. (1996). *Sex Offender Treatment Programme: Core Programme Manual.* London.

Holland, A. J. (2004). Criminal behaviour and developmental disability: an epidemiological analysis. In W. R. Lindsay, J. L. Taylor & P. Sturmey (Eds.), *Offenders with Developmental Disabilities* (pp. 23-34). Chichester, Uk: Wiley.

Holland, A. J., Clare, I. C. H., & Mukhopadhyay, T. (2002). Prevalence of 'criminal offending' by men and women with intellectual disability and the characteristics of 'offenders': implications for research and service development. *Journal of Intellectual Disability Research, 46*(Supplement 1), 6-20.

Hollin, C., & Howells, K. (1993). The mentally disordered offender. In K. Howells & C. Holin (Eds.), *The Mentally Disordered Offender: A Clinical Approach* (pp. 1-6). Chichester: John Wiley and Sons.

Howell, D. C. (2007). *Statistical Methods for Psychology* (Sixth ed.). Belmont, CA: Thomson Wadsworth.

Howlin, P. (1997). *The Diagnostic Criteria Checklist.* . St George's Hospital Medical School.

Hudson, S. M., & Ward, T. (1997). Rape: Psychopathology and theory. In R. D. Laws & W. O'Donohue (Eds.), *Sexual Deviance:Theory, Assessment and Research* (pp. 332-355). New York Guilford.

Hurley, R. D., & Sooner, R. (1995). Six cases of patients with mental retardation who have antisocial personality disorder. *Psychiatric Services, 46*(8), 828-831.

Iwamasa, G. Y., & Orsillo, S. M. (1997). Individualizing treatment manuals as a challenge for the next generation: Commentary on "manualized behavior therapy: Merits and challenges". *Behavior Therapy, 28*(4), 511-515.

Jackson, R. (1983). Mental retardation and criminal justice: some issues and problems. *Mental Subnormality, 29*, 7-12.

Jacobson, J. W., & Mulick, J. A. (1997). Definition of mental retardation. In J. W. J. J. A. Mulick (Ed.), *Manual of Diagnosis and Professional Practice in Mental Retardation.* Washington, D.C. : American Psychological Association.

James, W. (1890/2010). The Principles of Psychology Volume 1 C. D. Green (Ed.) Retrieved from Classics in the History of Psychology database Retrieved from **http://psychclassics.yorku.ca/James/Principles**

Jenkins-Hall, K. D. (1989a). Cognitive restructuring. In R. D. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 207-215). New York: Guilford.

Jenkins-Hall, K. D. (1989b). The decision matrix. In R. D. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 159-166). New York: Guilford Press.

Jenkinson, J. C. (1996). Identifying intellectual disability: Some problems in the measurement of intelligence and adaptive behaviour. *Australian Psychologist, 31*, 97-102.

Johnston, S. J. (2002). Risk assessment in offenders with intellectual disability:The evidence base. *Journal of Intellectual Disability Research, 46*(May), 47-56.

Johnston, S. J. (2005). Epidemiology of offending in learning disability. In T. Riding, C. Swann & B. Swann (Eds.), *The Handbook of Forensic Learning Disability* (pp. 15-30). Abingdon, Oxford: Radcliffe.

Jones, R. (2008). *Mental Capacity Act Manual* (3rd ed.). London: Sweet & Maxwell.

Joyce, T., Globe, A., & Moody, C. (2006). Assessment of the component skills for cognitive therapy in adults with intellectual disability. *Journal of Applied Research in Intellectual Disabilities, 19*, 17-23.

Kat, B., & Alexander, J. (1996). Mentally disordered offenders: Outcome of an audit. *Clinical Psychology Forum, 97.*

Keeling, J. A., Beech, A. R., & Rose, J. L. (2007). Assessment of intellectually disabled sex offenders: the current position. *Aggression and Violent Behaviour, 12*, 229-241.

Keeling, J. A., Rose, J., & Beech, A. (2006). An investigation into the effectiveness of a custody-based cognitive-behavioural treatment for special needs sexual offenders. *Journal of Forensic Psychiatry and Psychology, 17*(3), 372-392.

Keeling, J. A., & Rose, J. L. (2005). Relapse prevention with intellectually disabled sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 17*(407-423).

Keeling, J. A., Rose, J. L., & Beech, A. R. (2007). A preliminary evaluation of the adaptation of four assessments for offenders with special needs. *Journal of Intellectual and Developmental Disability, 1*, 52-59.

Kempton, W. (1978). *Sexuality and the Mentally Handicapped.* . Beckenham: Edward Patterson Associates.

Kerlinger, F. N. (1964). *Foundations of Behavioural Research*. New York: Holt, Rinehart and Winston.

Kiernan, C., & Qureshi, H. (1993). Challenging Behaviour. In C. Kiernan (Ed.), *Research to Practice? Implications of research on the Challenging Behaviour of People with Learning Disability* (pp. 53-87). Kidderminster: British Institute of Learning Disabilities.

Kinnear, P. R., & Gray, C. D. (2006). *SPSS 14 Made Simple.* Hove, UK: Psychology Press.

Klimecki, M. R., Jenkinson, J., & Wilson, L. (1994). A study of recidivism among offenders with an intellectual disability *Australia and New Zealand Journal of Developmental Disabilities, 19*, 209-219.

Knight, R. A., Carter, D., & Prentky, R. (1989). A System for the Classification of Child Molesters. *Journal of Interpersonal Violence, 4*(1), 3-23.

Knight, R. A., & Prentky, R. A. (1990). Classifying sexual offenders: The development and corroboration of taxonomic models. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender.* New York: Plenum Press.

Knox, M., & Sinclair, N. R. (2004). *Risk Assessment and Management Protocol: RAMP.*

Kolton, D. J., Boer, A., & Boer, D. P. (2001). A revision of the Abel & Becker Cognitions Scale for intellectually disabled sexual offenders. *Sexual Abuse: Journal of research and Treatment, 13*(3), 217-219.

Koss, M. P. (1992). The underdetection of rape: Methodological choices influence incidence estimates. *Journal of social Issues, 48*, 61-75.

Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55*(2), 162-170.

Langdon, P. E., Maxted, H., Murphy, G. H., & SOTSEC-ID Group. (2007). An exploratory evaluation of the Ward and Hudson Offending Pathways model with sex offenders who have intellectual disability. *Journal of Intellectual and Developmental Disability, 32*(2), 94-105.

Langdon, P. E., & Murphy, G. H. (2010). Assessing treatment need in sexual offenders with intellectual disabilities. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 233-252). Chichester: Wiley-Blackwell.

Langdridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method.* Edinburgh Gate, Harlow, Essex: Pearson/Prentice Hall.

Laws, D. R. (2008). The public health approach: a way forward? In D. R.Laws & W.T.O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment andTreatment* (pp. 611-628). New York: Guilford.

Laws, D. R. (Ed.). (1989). *Relapse Prevention with Sex Offenders.* New York: Guilford Press.

Laws, D. R., & O'Donohue, W. (1997). Introduction: fundamental issues in sexual deviance In D. R. Laws & W. O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment , and Research* (pp. 1-22). New York: Guilford.

Laws, D. R., & O'Donohue, W. T. (2008). Introduction. In D. R. Laws & W. T. O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment and Treatment* (2nd ed ed., pp. 1-20). New York: Guilford.

Laws, D. R., & Ward, T. (2006). When one size doesn't fit all: the reformulation of relapse prevention. In W. L. Marshall, Y. M. Fernandez, L. Marshall & G. A. Serran (Eds.), *Sexual offender Treatment: Controversial Issues* (pp. 241-254). Chichester: Wiley.

Lindsay, W. R. (2002). Research and literature on sex offenders with intellectual and developmental disabilities. *Journal of Intellectual Disability Research, 46*(Supplement 1), 74-85.

Lindsay, W. R. (2004). Sex offenders: conceptualization of the issues, services, treatment and management. In W. R. Lindsay, J. L. Taylor & P. Sturmey (Eds.), *Offenders with Developmental Disabilities* (pp. 163-186). Chichester, UK: Wiley.

Lindsay, W. R. (2009). *The Treatment of Sex Offenders with Developmental Disabilities: A Practice Workbook.* Chichester: Wiley-Blackwell.

Lindsay, W. R., Carson, D., & Whitefield, E. (2000). Development of a questionnaire on attitudes consistent with sex offending for men with intellectual disabilities. *Journal of Intellectual Disability Research, 44*, 368.

Lindsay, W. R., Hastings, R. P., Griffiths, D. M., & Hayes, S. C. (2007). Trends and challenges in forensic research on offenders with intellectual disability. *Journal of Intellectual & Developmental Disability, 32*(2), 55-61.

Lindsay, W. R., Law, J., Quinn, K., Smart, N., & Smith, A. H. (2001). A comparison of physical and sexual abuse: histories of sexual and non-sexual offenders with intellectual disability. *Child Abuse & Neglect., 25*((7)), 989-995.

Lindsay, W. R., & Macleod, F. (2001). A review of forensic learning disability research. *The British Journal of Forensic Practice, 3*(1), 4-10.

Lindsay, W. R., Marshall, I., & Neilson, C. Q. (1998). The treatment of men with a learning disability convicted of exhibitionism. *Research on Developmental Disabilities, 19*, 295-316.

Lindsay, W. R., Marshall, I., Quinn, K., & Smith, A. H. (1997, 16th May, 1997). *The treatment of men with a learning disability convicted of exhibitionism.* Paper presented at the Workshop on Learning Disabled Sex Offenders, Birmingham.

Lindsay, W. R., Michie, A. M., Whitefield, E., Martin, V., Grieve, A., & Carson, D. (2006). Response patterns on the questionnaire on attitudes consistent with sexual offending in groups of sex offenders with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 19*, 47-53.

Lindsay, W. R., Neilson, C. Q., & Lawrenson, H. (1997). Cognitive behaviour therapy for anxiety in people with learning disabilities. In B. Stenfert Kroese, D. Dagnan & K. Loumidis (Eds.), *Cognitive Behaviour Therapy for People with Learning Disabilities* (pp. 124-140). London: Routledge.

Lindsay, W. R., Neilson, C. Q., Morrison, F., & Smith, A. H. (1997, 16th May, 1997). *The treatment of six men with a learning disability convicted of sex offences with children.* Paper presented at the Workshop on Learning Disabled Sex Offenders, Birmingham.

Lindsay, W. R., Olley, S., Jack, C., Morrison, F., & Smith, A. H. W. (1998). The treatment of two stalkers with intellectual disabilities using a cognitive approach. *Journal of Applied Research in Intellectual Disabilities, 11*(4), 1998.

Lindsay, W. R., & Smith, A. H. W. (1998). Responses to treatment for sex offenders with intellectual disability: A comparison of men with 1- and 2-year probation sentences. *Journal of Intellectual Disability Research, 42*(5).

Lindsay, W. R., Smith, A. H. W., Law, J., Quinn, K., Anderson, A., Smith, A., & Allan, R. (2004). Sexual and Nonsexual Offenders With Intellectual and Learning Disabilities: A Comparison of Characteristics, Referral Patterns, and Outcome. *Journal of Interpersonal Violence, 19*(8), 875-890.

Lindsay, W. R., Smith, A. H. W., Law, J., Quinn, K., Anderson, A., Smith, A., . . . Allan, R. (2002). A Treatment Service for Sex Offenders and Abusers with Intellectual Disability: Characteristics of Referrals and Evaluation. *Journal of Applied Research in Intellectual Disabilities, 15*(2), 166-174. doi: 10.1046/j.1468-3148.2002.00111.x

Lindsay, W. R., Steele, L., Smith, A. H. W., Quinn, K., & Alan, R. (2006). A community forensic intellectual disability service: Twelve year follow up of referrals, analysis of referral patterns and assessment of harm reduction. *Legal and Criminological Psychology, 11*, 113-130.

Lindsay, W. R., Sturmey, P., & Taylor, J. (2004). Natural history and theories of offending in people with developmental disabilities. In W. R. Lindsay, J. L. Taylor & P. Sturmey (Eds.), *Offenders with Developmental Disabilities* (pp. 3-22). Chichester, UK: Wiley.

Lindsay, W. R., & Taylor, J. L. (2009). The assessment of treatment-related issues and risk in sex offenders and abusers with intellectual disability. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 217-236). Chichester Wiley

Lindsay, W. R., & Taylor, J. L. (2010). Assessing recidivism risk in sex offenders with intellectual disabilities. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 139-152). Chichester: Wiley-Blackwell.

Lindsay, W. R., Taylor, J. L., & Sturmey, P. (Eds.). (2004). *Offenders with Developmental Disabilities*. Chichester: Wiley.

Lindsay, W. R., Whitefield, E., & Carson, D. (2007a). An assessment for attitudes consistent with sexual offending for use with offenders with intellectual disabilities. *Legal and Criminological Psychology, 12*, 55-68.

Lindsay, W. R., Whitefield, E., & Carson, D. (2007b). An assessment for use with offenders with intellectual disabilities. *Legal and Criminological Psychology, 12*, 55-58.

Longo, S., & Scior, K. (2004). In-patient psychiatric care for individuals with intellectual disabilities: the service users and carers perspectives. *Journal of Mental Health, 13*, 211-221.

Lord, C., & Corsello, C. (2005). Diagnostic Instruments In Autistic Spectrum Disorder. In F. R. Volkmar, R. Paul, A. Klin & D. J. Cohen (Eds.), *Handbook of Autism and Pervasive Developmental Disorders, Volume 1, Diagnosis, Development, Neurobiology, and Behavior,* (3rd ed., pp. 730-771). New York: Wiley.

Losel, F., & Schmucker, M. (2005). The effectiveness of treamtent for sexual offenders: a comprehensive meta-analysis. *Journal of Experimental Criminology, 1*, 117-146.

Luckasson, R., Borthwick-Duffy, S., Buntinx, W.G.E., Coulter, D.L., Craig, E.M., Reeve, A., Schalock, R.L., Snell, M.E. Spitalnik, D.M., Spreat, S., & Tassé. M.J. (2002). Mental retardation: Definition, classification, and system of supports (10th Ed). Washington,D.C.: American Association on Mental Retardation.

Lund, J. (1990). Mentally retarded criminal offenders in Denmark. *British Journal of Psychiatry, 156*, 726-751.

Lunsky, Y., Frijters, J., Griffiths, D. M., Watson, S. L., & Williston, S. (2007). Sexual knowledge and attitudes of men with intellectual disability who sexually offend. *Journal of Intellectual and Developmental Disability, 32*(2), 74-81.

Lyall, I., Holland, A. J., & Collins, S. (1995). Offending by adults with learning disabilities and the attitudes of staff to offending behaviour: implications for service development. *Journal of Intellectual Disability Research, 39*(6), 501-508.

MacDonald, J., Sinason, V., & Hollins, S. (2003). An interview study of people with learning disabilities' experience of, and satisfaction with, group analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 76*(4), 433-453.

MacEachron, A. E. (1979). Mentally retarded offenders: Prevalence and characteristics. *American Journal of Mental Deficiency, 84*, 165-176.

Mahoney, M. J., & Norcross, J. C. (1993). Relationship styles and therapeutic choices: A commentary. *Psychotherapy, 30*, 423-426.

Malamuth, N. M., Sockloskie, R. J., Koss, M. P., & Tanaka, J. S. (1991). Characteristics of aggressors against women: Testing a model using a national sample of college students. *Journal of Consulting and Clinical Psychology, 59*(5), 670-681.

Mann, R. E., & Marshall, L. E. (2009). Advances in the treatment of adult incarcerated sex offenders. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 329-348). Chichester, UK: Wiley-Blackwell.

Marlatt, G. A. (1982). Relapse prevention:A self-control program for the treatment of addictive behaviours. In R. B. Stuart (Ed.), *Adherence, compliance, and generalisation in behavioral medicine* (pp. 329-378). New York: Brunner/Mazel.

Marlatt, G. A. (1985). Theoretical rationale and overview of the model. In G. A. Marlatt, & Gordon, J. R. (Ed.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Marlatt, G. A. (1989). Feeding the PIG: The problem of immediate gratification. In D. R. Laws (Ed.), *Relapse Prevention with Sex Offenders* (pp. 56-62). New York: Guilford Press.

Marlatt, G. A., & Gordon, J. (1980). *Determinants of relapse: Implications for the maintenance of change*. New York: Bruner/Mazel.

Marlatt, G. A., & Gordon, J. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Marques, J. K. (1999). How to answer the question "Does sexual offender treatment work?". *`Journal of Interpersonal Violence, 14*(4).

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005). Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results From California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment, 17*(1), 79-107.

Marshall, L. E., & O'Brien, M. D. (2009). Assessment of sexual addiction. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 163-180). Chichester: Wiley.

Marshall, W. L. (1997a). Pedophilia: psychopathology and theory. In D. R. Laws & W. O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment and Treatment* (pp. 152-174). New York: Guilford Press.

Marshall, W. L. (1997b). The relationship between self-esteem and deviant sexual arousal in nonfamilial child molesters. *Behavior Modification, 21*(1), 86-96.

Marshall, W. L., Anderson, D., & Fernandez, Y. (1999). *Cognitive Behavioural Treatment of Sexual Offenders*. Chichester: Wiley.

Marshall, W. L., & Barbaree, H. E. (1990). An integrated theory of the etiology of sexual offending. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (pp. 257-275). NY: Plenum.

Marshall, W. L., Barbaree, H. E., & Christophe, D. (1986). Sexual offenders against female children: Sexual preferences for age of victims and type of behaviour. *Canadian Journal of Behavioural Science, 18*, 424-439.

Marshall, W. L., Fernandez, Y. M., Marshall, L. E., & Serran, G. A. (2006). Conclusions and future directions. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 275-278). Chichester: Wiley.

Marshall, W. L., Laws, D. R., & Barbaree, H. E. (1990). *Handbook of sexual assault : issues, theories, and treatment of the offender*. New York: Plenum Press.

Marshall, W. L., Marshall, L. E., Serran, G. A., & Fernandez, Y. M. (2006). *Treating Sexual Offenders: an Integrated approach*. NY: Routledge.

Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2009). Psychological treatment of sexual offenders. In F. M. Saleh, A. H. Grudzinskas, J. M. Bradford & D. J. Brodsky (Eds.), *Sex Offenders: Identification, Risk Assessment, Treatment and Legal Issues* (pp. 159-170). New York: Oxford University Press.

Marshall, W. L., Mulloy, R., & Serran, G. (1998). *The identification of treatment-facilitative behaviours enacted by sexual offender therapists.* Unpublished manuscript, cited in Marshall, W. L., Anderson, D., & Fernandez, Y. (1999) (eds) Cognitive Behavioural Treatment of Sexual Offenders. Chichester: Wiley.

Marshall, W. L., O'Brien, M. D., & Marshall, L. E. (2009). Modifying sexual preferences. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 311-328). Chichester: Wiley.

McCallin, R. C. (2006). Test administration. In S. M. Downing & T. M. Haladyna (Eds.), *Handbook of Test Development* (pp. 625-652). New York: Routledge.

McCarthy, M., & Thompson, D. (1998). *Sex and the 3 Rs, Rights, Responsibilities and Risks: a Sex Education Package for Working with People with Learning Difficulties* (Second ed.). Brighton: Pavilion.

McCarthy, M., & Thompson, D. (2010). *Sex and the 3 R's-Rights, Risks and Responsibilities: A Sex Education pack for People with Learning Disabilities*. Brighton: Pavilion.

McDonach, E., Barbour, R. S., & Williams, B. (2009). Reflections on applying for NHS ethical approval and governance in a climate of rapid change: prioritising process over principles. *International Journal of Social Research Methodology, 12*(3), 227-241.

McGrath, R. J., Cumming, G., Livingston, J. A., & Hoke, S. E. (2003). Outcome of a Treatment Program for Adult Sex Offenders. *Journal of Interpersonal Violence, 18*(1), 3-17. doi: 10.1177/0886260502238537

McGraw, K. O., & Wong, S. P. (1996). Forming inferences about some intraclass correlation coefficients. *Psychological Methods, 1*(1), 30-46.

McGuire, J. (Ed.). (1995). *What Works: Reducing Offending*. Chichester: Wiley.

McNally, S. (1996). Offenders who have a learning disability. *British Journal of Nursing, 5*(13), 805-808.

McNulty, C. (1995). Police involvement with clients having intellectual disabilities: A pilot study in South London. *Mental Handicap Research, 8*(2), 129-136.

Meichenbaum, D. (1977). *Cognitive behavior modification: An integrated approach*. NY: Plenum.

Mercy, J. A. (1999). Having New Eyes: Viewing Child Sexual Abuse as a Public Health Problem. *Sexual Abuse: A Journal of Research and Treatment, 11*(4), 317-321. doi: 10.1023/a:1021319131875

Michie, A. M., Lindsay, W. R., Martin, V., & Grieve, A. (2006). A test of counterfeit deviance: a comparison of sexual knowledge in groups of sex offenders with intellectual isability and controls. *Sexual Abuse: A Journal of Research and Treatment, 18*, 271-278.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Towards a Unifying Language for Psychotherapy Practice*. New York: Norton.

Ministry of Justice. (2007). Population in Custody Monthly Tables October 2007 England and Wales. *Ministry of Justice Statistics Bulletin* Retrieved October 26, 2010, 2010

Ministry of Justice. (2010). Population in Custody Monthly Tables August 2010 England and Wales. *Ministry of Justice Statistics Bulletin*

Mitchell, L. K. (1985). *Behavioural Intervention in the Sexual Problems of Mentally Handicapped Individuals in Residential and Home Settings.* Illinois: Charles C. Thomas.

Moos, R. H. (1986). *Group Environment Scale Manual* (2nd Edition ed.). Palo Alto, CA: Consulting Psychologists' Press.

Moos, R. H. (1993). *Coping response inventory-youth form: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Morrissey, C. (2010). Psychopathy and other personality disorders in sexual offenders with intellectual disabilities. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 153-176). Chichester: Wiley-Blackwell.

Mosher, S. (2010). Staff support and development when working with sexual offenders with intellectual disabilities. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 255-270). Chichester: Wiley-Blackwell.

Moss, S., Prosser, H., & Costello, H. (1998). Reliability and validity of the PAS-ADD Checklist for detecting psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research 42*, 173-183.

Murdoch University. (2009). Notes on Q-Q Plots Retrieved 15/12/2010, 2010, from **http://www.cms.murdoch.edu.au/areas/maths/statsnotes/samplestats/qqplot.html**

Murphy, G. (1997a). Assessing risk. In J. Churchill, H. Brown, A. Craft & C. Horrocks (Eds.), *There are no Easy Answers:The Provision of Continuing Care and Treatment to Adults with Learning disabilities who Sexually Abuse Others* (pp. 103-108). Chesterfield, UK: ARC & NAPSAC.

Murphy, G. (1997b). Treatment and risk management. In J. Churchill, H. Brown, A. Craft & C. Horrocks (Eds.), *There are no Easy Answers: The Provision of Continuing Care and Treatment to Adults with Learning disabilities who Sexually Abuse Others* (pp. 109-124). Chesterfield, UK: ARC & NAPSAC.

Murphy, G. (2004). SOTSEC-ID Training Presentation. London: Not published.

Murphy, G. (2007). Intellectual disabilities, sexual abuse and sexual offending. In A. Carr, G. O'Reilly, P. N. Walsh & J. McEvoy (Eds.), *Handbook of intellectual disability and clinical psychology practice* (pp. 831-866). London: Routledge.

Murphy, G., Booth, S. J., & Sinclair, N. R. (2003). *Mens Group Data Base Schedule I, II, & III.* Tizard Centre, University of Kent.

Murphy, G., & Fernando, S. (1999). Services for people with chalenging behaviour and mental health needs at risk of offending. *Tizard Learning Disability Review, 4*(3), 31-39.

Murphy, G., Harnett, H., & Holland, A. (1995). A survey of intellectual disabilities amongst men on remand in prison. *Mental Handicap Research, 8*(2), 81-98.

Murphy, G., & Mason, J. (1999). People with developmental disabilities who offend. In N. Bouras (Ed.), *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation* (pp. 226-245). Cambridge: Cambridge University Press.

Murphy, G., & Sinclair, N. (2009). Treatment for men with intellectual disabilities and sexually abusive behaviour. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 369-392). Chichester: Wiley.

Murphy, G., Sinclair, N., Hays, S., & SOTSEC-ID members. (2007). Effectiveness of Group Cognitive Behavioural Treatment for Men with Learning Disabilities at Risk of Sexual Offending. Final Report to the Department of Health (pp. 58 plus Appendices). Canterbury: Tizard Centre, University of Kent.

Murphy, W. D. (1990). Assessment and modification of cognitive distortions in sex offenders. In W. L. Marshall, H. E. Barbaree & D. R. Laws (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 331-342). New York: Plenum Press.

Murphy, W. D., Coleman, E. M., & Haynes, M. R. (1983). Treatment and evaluation issues with the mentally retarded sex offender. In J. D. Greer & I. R. Stuart (Eds.), *The Sexual Aggressor: Current Perspectives on Treatment* (pp. 22-41). New York: Van Nostrand, Reinholt Company.

Murrin, M. R., & Laws, D. R. (1990). The influence of pornography on sexual crimes. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender.* New York: Plenum Press.

Myhill, A., & Allen, J. (2002). *Rape and Sexual Assault of Women: Findings from the British Crime Survey.* London: Home Office.

Nerlich, B. (2004). Coming full (hermeneutic) circle: the controversy about psychological methods. In Z. Todd, B. Nerlich, S. McKeown & D. C. Clarke (Eds.), *Mixing Methods in Psychology: The Integration of Qualitative and Quantitative Methods in Theory and Practice* (pp. 17-36). Hove, East Sussex, UK: Psychology Press.

Nichols, H. R., & Molinder, I. (1984). *Multiphasic Sex Inventory Manual.* Tacoma, WA: Authors.

Nichols, H. R., & Molinder, I. (2000). *Multiphasic Sex Inventory Manual II* (2nd ed.). Tacoma, WA: Nichols and Molinder Assessments Inc., 437 Bowes Drive, Tacoma, WA, 98466 - 70747 USA.

O'Brien, G. (1987). A guide to life-style planning: Using the Activities Catalogue to Integrate Services and Natural Support Systems. In G. T. Bellamy & B. Wilcox (Eds.), *A comprehensive Guide to the Activities Catalogue: An Alternative Curriculum for Youth and Adults with Severe Disabilities* (pp. 175-189). Baltimore: Paul H. Brookes.

O'Connor, W. (1996). A problem-solving intervention for sex offenders with an intellectual disability. *Journal of Intellectual & Developmental Disability, 21*(3).

O'Connor, W. (1997). Towards an environmental perspective on intervention for problem sexual behaviour in people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities, 10*(2), 159-175.

O'Shaughnessy, R. J. (2009). The role of personality disorder in sexual offending. In F. M. Saleh, A. J. Grudzinskas, J. M. Bradford & D. J. Brodsky (Eds.), *Sex Offenders: Identification, Risk Assessment, Treatmetn, and Legal Issues* (pp. 144-155). New York: Oxford University Press.

Page, A. C. (1991). Teaching developmentally disabled people self-regulationin in sexual behaviour. *Australia and New Zealand Journal of Developmental Disabilities, 17*(1), 81-88.

Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pithers, W. D., Marques, J. K., Gibat, C. C., & Marlatt, G. A. (1983). Relapse prevention with sexual aggressives: A self control model of treatment and maintenance of change. In J. G. S. Greer, I. R. (Ed.), *The sexual aggressor* (pp. 214-239). New York: VanNostrand/Reinhold.

Pithers, W. D., Marques, J. K., Gibat, C.C., & Marlatt, G.A. (1983). Relapse prevention with sexual offenders. In J. G. Greer, & Stuart, I.R. (Ed.), *The sexual aggressor* (pp. 214-239). New York: Van Nostrand Reinhold.

Polvinale, R. A., & Lutzker, J. R. (1980). Elimination of assaultive and inappropriate behaviour by reinforcement and social-restitution. *Mental Retardation, 18*, 27-30.

Prentky, R. A., & Knight, R. A. (1991). Identifying critical dimensions for discriminating among rapists. *Journal of Consulting and Clinical Psychology, 59*, 643-661.

Proulx, J., & Beauregard, E. (2009). Decision making during the offending process: an assessment among subtypes of sexual aggressors of women. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 181-198). Chichester: Wiley.

Puri, B. K. (2000). A comparison of patients admitted to two medium secure units, one for those of normal intelligence and one for those with learning disability. *International Journal of Clinical Practice, 54*(5), 300-305.

Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (2006). *Violent Offenders: Appraising and Managing Risk.* Washington: merican Psychological Association.

Quinsey, V. L., & Marshall, W. L. (1983). Procedures for reducing inappropriate sexual arousal: An evaluation review. In J. G. Greer & I. R. Stuart (Eds.), *The Sexual Aggressor: Current Perspectives on Treatment* (pp. 267-289). New York: Van Nostrand Reinhold.

Quinsey, V. L., & Varney, G. (1977). Social skills game: A general method for modeling and practice of adaptive behaviours. *Behavior Therapy, 8*, 279-281.

Randall, M. H., L. (1995). Sexual violence in women's lives: Findings from the women's safety project, a community-based survey. *Violence Against Women, 1*(1), 6-31.

Rappaport, J. (1977). *Communtiy Psychology: Values, Research and Action.* New York Holt, Rinehart and Winston.

Reed, J. (1997). Risk assessment and clinical risk management: The lessons from recent inquiries. *British Journal of Psychiatry, 170*(Suppl 32).

Rees, L. (2008). *World War Two: Behind Closed Doors : Stalin, the Nazis and the West.* Bristol: BBC Books.

Rice, M. E., Harris, G. T., Lang, C., & Chaplin, T. C. (2008). Sexual preferences and recidivism of sex offenders with mental retardation. *Sexual Abuse: A Journal of Research and Treatment, 20*(4), 409-425.

Rice, M. E., Harris, G. T., & Quinsey, V. L. (2001). Research on the treatment of adult sex offenders. In J. B. Ashford, B. D. Sales & W. H. Reid (Eds.), *Treating Adult and Juvenile Offenders with Special Needs* (pp. 291-312). Washington: American Psychological Association.

Riding, T. (2005). Sexual offending in people with learing disability. In T. Riding, C. Swann & B. Swann (Eds.), *The Handbook of Forensic Learning Disability* (pp. 31-50). Abingdon, Oxford: Radcliffe.

Robertson, G. (1981). The extent and pattern of crime amongst mentally handicapped offenders. *Journal of the British Institute of Mental Handicap, 9*, 100-103.

Robertson, J. (1994). Risk management for men who have learning disabilities and have sexually abused others. *NAPSAC Bulletin, 8*, 8-11.

Rose, J., Jenkins, R., O'Connor, C., Jones, C., & Felce, D. (2002). A Group Treatment for Men with Intellectual Disabilities who Sexually Offend or Abuse. *Journal of Applied Research in Intellectual Disabilities, 15*(2), 138-150. doi: 10.1046/j.1468-3148.2002.00110.x

Sandler, J., & Freeman, N. (2007). Typology of Female Sex Offenders: A Test of Vandiver and Kercher. *Sexual Abuse: A Journal of Research and Treatment, 19*(2), 73-89. doi: 10.1007/s11194-007-9037-4

Schilling, R. F., & Schinke, S. P. (1989). Mentally retarded sex offenders: fact, fiction, and treatment. *Journal of Social Work and Human Sexuality, 7*, 33-48.

Schmitt, N. (1996). Uses and abuses of coefficient alpha. *Psychological Assessment, 8*(4), 350-353.

Serran, G. A., & Marshall, W. L. (2010). Therapeutic process in the treatmetn of sexual offenders: a review article. *British Journal of Forensic Practice, 12*(3), 4-16.

Seto, M. C., & Barbaree, H. E. (1999). Psychopathy, treatment behavior, and sex offender recidivism. *Journal of Interpersonal Violence, 14*(12).

Sgroi, S. M. (1989). Evaluation and treatment of sexual offence behaviour in persons with mental retardation. In S. M. Sgroi (Ed.), *Vulnerable Populations* (pp. 245-283). Toronto: Lexington Books.

Shah, S. A. (1993). A clinical approach to the mentally disordered offender: An overview and some major issues. In K. Howells & C. R. Hollin (Eds.), *Clinical Approaches to the Mentally Disordered Offender* (pp. 211-236). Chichester: Wiley.

Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: uses in assessing rater reliability. *Psychological Bulletin, 86*(2), 420-428.

Sinclair, N., Hays, S. J., & Murphy, G. (2002). *Cognitive Behavioural Treatment for Men with Intellectual Disabilities who are at Risk of Sexual Offending*. Treatment Manual. Tizard Centre, University of Kent. Canterbury.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Los Angeles: Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 51-80). Thousand Oaks: Sage.

Smith, S. A., & Broughton, S. F. (1994). Competency to stand trial and criminal responsibility: An analysis in South Carolina. *Mental Retardation, 32*(4), 281-287.

Smith-Spark, L. (2004). BBC News. Live BBC News Channel. What is a 'right' age of consent. Article downloaded **on 22.12. 2010** from: **http://news.bbc.co.uk/1/hi/uk/3699814.stm.**

Sone, L. (1984). *The Sone Sexual History Background Form.* Alternatives to Sexual Abuse, P.O Box 25537,Portland, Oregon, 97225. Portland, Oregon.

SOTSEC-ID, Murphy, G. H., Sinclair, N., Hays, S.J., Heaton, K., Powell, S., Langdon, P., Stagg, J., Williams, J., Scott, J., Mercer. K., Lippold, T., Tufnell, J., Langheit, G., Goodman, W., Leggett, J., & Craig, L. (2010). Effectiveness of Group Cognitive-Behavioural Treatment for Men with Intellectual Disabilities at Risk of Sexual Offending. *Journal of Applied Research in Intellectual Disability.*

Sparrow, S., Balla, D., & Cicchetti, D. (1984). *Vineland Adaptive Behaviour Scales.* Minnesota: American Guidance Association.

Steenkamp, M., McClean, C. P., Arditte, K. A., & Litz, B. T. (2010). Exposure toTrauma in Adults. In M. M. Antony & D. H. Barlow (Eds.), *Handbook of Assessment and Treatment Planning for Psychological Disorders* (pp. 301-343). NY: Guilford.

Stenfert-Kroese, B., Dagnan, D., & Loumidis, K. (Eds.). (1997). *Cognitive-Behaviour Therapy for People with Learning Disabilities*. London: Routledge.

Stop It Now! (2010). Stop It Now: Together we can Prevent the Sexual Abuse of Children. Downloaded 20.12.2010 from: http://www.stopitnow.org.uk/.

Sturmey, P., Taylor, J. L., & Lindsay, W. L. (2004). Research and development. In W. L. Lindsay, J. L. Taylor & P. Sturmey (Eds.), *Offenders with Developmental Disabilities* (pp. 327-350). Chichester: Wiley.

Swanson, C. K., & Garwick, G. B. (1990). Treatment for low-functioning sex offenders: Group therapy and interagency coordination. *Mental Retardation, 28*(3), 155-161.

Tabachnick, B. G., & Fidell, L. S. (2007). Using Multivariate Statistics (5th ed., pp. 980). Boston: Pearson.

Talbot, J. (2007). No One Knows: Identifying and Supporting Prisoners with Learning Difficuties:The Views of Prison Staff: Prison Reform Trust.

Talbot, J., & Langdon, P. E. (2006). A revised sexual knowledge assessment tool for people with intellectual disabilities: Is sexual knowledge related to sexual offending behaviour? . *Journal of Intellectual Disability Research, 50*, 523-531

Taylor, J. L., & Halstead, S. (2001). Clinical risk assessment for people with learning disabilities who offend. *The British Jurnal of Forensic Practice, 3*(1), 22-32.

Taylor, J. L., Keddie, T., & Lee, S. (2003). Working with sex offenders with intellectual disability: evaluation of an introductory workshop for direct care staff. *Journal of Intellectual Disability Research, 47*(3), 203-209.

Taylor, J. L., & Novaco, R. (2005). *Anger Treatment for People with Developmental Disabilities- aTheory, Evidence and manual based approach* Chichester: Wiley.

Taylor, J. L., Novaco, R. W., Gillmer, B. T., & Robertson, A. (2004). Treatment of anger and aggression. In W. R. Lindsay, J. L. Taylor & P. Sturmey (Eds.), *Offenders with Developmental Disabilities*. Chichester, UK: Wiley.

Thakker, J., Ward, T., & Navathe, S. (2007). The cognitive distortions and implicit theories of child sexual abusers. In T. A. Gannon, Ward, Tony, Beech, A.R., & Fisher, D. (Ed.), *Agressive Offfenders' Cognition: Theory, Research and Practice* (pp. 11-30). Cichester: Wiley.

Thomas, D. H., & Sting, T. H. (1995). Offenders referred to a learning disability service: A retrospective study from one county. *British Journal of Learning Disabilities, 23*(1), 24-27.

Thompson, D. (1997). Profiling the sexually abusive behaviour of men with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 10*(2), 125-139.

Thompson, D. (2000). Vulnerability, dangerousness and risk: the case of men with learning disabilities who sexually abuse. *Health, Risk & Society, 2*(1), 33-46.

Thompson, D., & Brown, H. (1998). *Response-ability: Working with men with learning disabilities who have difficult of abusive sexual behaviours.* Brighton, UK: Pavilion.

Thompson, D., & Brown, H. (2007). *Men with Learning Disabilities who Sexually Abuse: Working Together to develop Response-Ability.* Brighton: Pavilion.

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research & Treatment, 14*, 137-151.

Todd, Z., Nerlich, B., & McKeown, S. (2004). Introduction. In Z. Todd, B. Nerlich, S. McKeown & D. D. Clarke (Eds.), *Mixing methods in psychology: The integration of qualitative and quantitative methods in theory and practice* (pp. 3-16). Hove, UK: Psychology Press.

Turk, V., & Brown, H. (1993). The sexual abuse of adults with learning disabilies: Results of a two year incidence survey. *Mental Handicap Research,, 6*(3), 193-216.

Turner, S. (1998). *The assessment of risk and dangerousness as applied to people with learning disabilities considered at risk of offending. Part 1: Literature Review, Part 2: Developing good practice.* Manchester: Hester Adrian Research Centre, University of Manchester.

Tutt, N. S. (1971). The Subnormal offender. *British Journal of Subnormality, 17*, 42-47.

US Census Bureau (2010). Population figures downloaded 22.12.2010 from: http://quickfacts.census.gov/qfd/states/36000.html.

van Dijk, J. J., & Mayhew, P. (1993). Criminal victimisation in the Industrialised World: Key Findings of the 1989 and 1992 International Crime Surveys Retrieved 21.12.10, 2010, from:**http://www.unicri.it/documentation_centre/publications/series/understanding/04_industr_countries.pdf**

Wakeling, H. C., Webster, S. D., & Mann, R. E. (2005). Sexual offenders' treatment experience: a qualitative and quantitative investigation. *Journal of Sexual Aggression, 11*(2), 171-186.

Walker, D. W. (2000). The treatment of adult male child molesters through group family intervention. *Journal of Psychology & Human Sexuality, 11*(3).

Ward, T. (1997). Cognitive distortions in sex offenders: an integrative review. *Clinical Psychology Review, 17*(5), 479-507.

Ward, T., & Beech, A. R. (2008). An integrated theory of sexual offending. In D. R. Laws & W. T. O'Donohue (Eds.), *Sexual Deviance: Theory, Assessment and Treatment* (pp. 21-36). NY: Guilford.

Ward, T., Collie, R. M., & Bourke, P. (2009). Models of offender rehabilitation: The good lives model and the risk-need-responsivity model. In A. R. Beech, L. A. Craig & K. D. Browne (Eds.), *Assessment and Treatment of Sex Offenders: A Handbook* (pp. 293-310). Chichester: Wiley.

Ward, T., & Fisher, D. (2006). New ideas in the treatment of sexual offenders. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall & G. A. Serran (Eds.), *Sexual Offender Treatment: Controversial Issues* (pp. 143-158). Chichester: Wiley.

Ward, T., Hudson, S. M., & Keenan, T. (1998). A Self-Regulation Model of the Sexual Offense Process. *Sexual Abuse: A Journal of Research and Treatment, 10*(2), 141-157. doi: 10.1023/a:1022071516644

Ward, T., Keown, K., & Gannon, T. A. (2006). Cognitive distortons as belief, value and action judgements. In T. A. Gannon, T. Ward, A. R. Beech & D. Fisher (Eds.), *Aggressive Offender's Cognition: Theory, Research and Practice* (pp. 53-70). Chichestere: Wiley.

Ward, T., Mann, R. E., & Gannon, T. A. (2006). The good lives model of offender rehabilitation. *Aggression and Violent Behaviour, 12*, 87-107.

Ward, T., & Marshall, W. L. (2004). Good lives: aetiology and the rehabilitation of sex offenders: a bridging theory. *Journal of Sexual Aggression, 10, 153-169.*

Ward, T., Polaschek, D. L. L., & Beech, A. R. (2006). *Theories of Sexual Offending.* Chichester: Wiley.

Wechsler, D. (1997). *Wechsler Adult Intelligence Scale* (3rd ed.). San Antonio, TX: The Psychological Corporation.

Williams, F., & Mann, R. E. (2010). The treatment of intellectually disabled sex offenders in the National Offender Management Service: the adapted sex offender treatment programmes. In L. A. Craig, W. R. Lindsay & K. D. Browne (Eds.), *Assessment and*

Treatment of Sexual Offenders with Intellectual Disabilities (pp. 293-316). Chichester: Wiley-Blackwell.

Williams, H., & Jones, R. S. P. (1997). Teaching cognitive self-regulation of independence and emotion control skills. In B. S. Kroese, D. Dagnan & K. Loumidis (Eds.), *Cognitive Behaviour Therapy for People with Learning Disabilities* (pp. 67-85). London: Routledge.

Williams, L. M., & Finkelhor, D. (1990). The characteristics of incestuous fathers. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender* (pp. 231-252). NY: Plenum Press.

Willig, C. (2008). *Introducing Qualitative Research in Psychology.* Maidenhead, Berkshire: Ope University Press.

Willner, P., & Goodey, R. (2006). Interaction of Cognitive Distortions and Cognitive Deficits in the Formulation and Treatment of Obsessive–Compulsive Behaviours in a Woman with an Intellectual Disability. *Journal of Applied Research in Intellectual Disabilities, 19*(1), 67-73. doi: 10.1111/j.1468-3148.2005.00279.x

Wilson, C., & Brewer, N. (1992). The incidence of criminal victimisation of individuals with an intellectual disability. *Australian Psychologist, 27*, 114-117.

Wilson, C., Seaman, L., & Nettlebeck, T. (1996). Vulnerability to criminal exploitation:influence of interpersonal competence differences among people with mental retardation. *Journal of Intellectual Disability Research, 40*(1), 8-16.

Wolf, S. C. (1984). *A multi-factor model of deviant sexuality.* Paper presented at the Third International Conference on Victimology, Lisbon.

Wolfensberger, W. (1972). *Normalization: The Principle of Normalization in Human Services.* Toronto: National Institute on Mental Retardation.

Wolfensberger, W. (1983). Social role valorization: A proposed new term for the principle of normalization. *Mental Retardation, 21*(6), 234-239.

Wolfensberger, W., & Thomas, S. (1982). *PASSING: Program Analysis of Service Systems Implementation of Normalization Goals.* Toronto: National Institute on Mental Reatrdation.

Womensgrid. (2009). The Stop it Now! Campaign to Tackle Chilld Sexual Abuse. Retrieved 20.12.2010 from http://www.stopitnow.org.uk/

World Health Organization. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders* Geneva: Author.

World Health Organization. (1996). *ICD-10 guide for mental retardation.* Geneva: Author.

Yaffee, R. A. (1998). Enhancement of Reliability Analysis: Aplication of Intraclass Correlations with SPSS/Windows v.8 Retrieved 07.12.2010, from **http://www.nyu.edu/its/statistics/Docs/intracls.html**

Yates, P., & Kingston, D. (2006). The Self-Regulation Model of Sexual Offending: The Relationship Between Offence Pathways and Static and Dynamic Sexual Offence Risk. *Sexual Abuse: A Journal of Research and Treatment, 18*(3), 259-270. doi: 10.1007/s11194-006-9018-z

Yin, R. K. (2003). *Case Study Research: Design and Methods.* Thousand Oaks: Sage.