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Treating Sexual Offenders With Learning Disabilities in the Community

A Critical Review

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This study offers a critical review of a treatment group for sexual offenders with learning disabilities. The participants were diverted from criminal proceedings due to their level of cognitive functioning and attended a 7-month treatment program comprising of four main components: sex education, cognitive distortions, offending cycle, and relapse prevention. A number of psychometric assessments were administered immediately before and after intervention. Although no significant differences were found in attitudes toward sexual offending following treatment, the trend was for improvements in sex knowledge and honesty of sexual interest. Improvements in socialization skills (leisure time and interpersonal skills) were significant. No further incidents of sexual offending have been reported during a 12-month follow-up. A number of explanations for the no significant improvement in attitudes are considered and recommendations for future treatment evaluation studies are made. The development of specific questionnaires and treatment programs for sexual offenders with learning disabilities is discussed.

Keywords: *Sexual offenders with learning disabilities; sex offender treatment programs*

Since Furby, Weinrott, and Blackshaw's (1989) negative review of the efficacy of treatment programs for sexual offenders, there have been a number of follow-up and meta-analytical studies demonstrating positive treatment effect of sex offender programs in reducing the risk of sexual recidivism (Alexander, 1999; Craig, Browne, & Stringer, 2003; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hall, 1995; Hanson et al., 2002). Although these results are encouraging, these reviews were based on mainstream non–learning-disabled sexual offenders, and there

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have been relatively few descriptions of community-based treatment programs available for sexual offenders with learning disabilities, most of which, are usually restricted to case studies (e.g., Lindsay, Olley, Braillie, & Smith, 1999; Murphy, 1997). Existing sex offending treatment programs within the UK have generally been restricted to offenders who do not have a learning disability and have an Intelligence Quotient (IQ) of 80 or more. This means that men with an IQ of 79 or less who have committed sexual offenses or engaged in sexually abusive behavior are often not offered such treatment (Williams, 2003) within criminal justice settings.

Well-controlled studies have found prevalence rates for individuals with learning disabilities to be slightly higher in offender populations than in the general population (Borthwick-Duffy, 1994; Lund, 1990; MacEachron, 1979). In a 10-month prospective study, Barron, Hassiotis, and Banes (2004) followed 61 learning-disabled offenders referred to specialist mental health and criminal justice services. Although not specific to sexual offenders, their study found that offenders with learning disabilities start offending at an early age and had a history of multiple offenses, sexual and arson offenses were overrepresented, and half reoffended at follow-up. In a sample of previous prison inmates with learning disabilities, Klimecki, Jenkinson, and Wilson (1994) reported a 34% recidivism rate for sexual offenders during 2 years, and an 84% of overall reoffending within the first 12 months. Indeed, learning disabilities might contribute to sexual-related or aggressive behavior in some individuals. It has been estimated that 6% of the learning-disability population have severe sexual aggression (Thompson & Brown, 1997) and that 41% engage in challenging behaviors defined as sex related, of which 17% had police contact and 4% were convicted of sexual offenses (McBrien, Hodgetts, & Gregory, 2002).

Cooper (1995) estimates the prevalence of learning disability in the general population is 9% but 10% to 15% of all sex offenses, although in reality, these differences are very small. Of offenders with learning disabilities, Gross (1985) estimates that between 21% and 50% had committed a sexual crime, whereas Walker and McCabe (1973) found that 28% of 33 men with an learning disability detained under hospital orders had committed a sexual offense. It is important to note that the higher prevalence rate may to some extent be accounted for by the misinterpretation of behaviors. The increased visibility of offenders with learning disabilities, where the commission of their offenses is often less sophisticated, increases the possibility of detection (see Craig & Hutchinson, in press). Furthermore, of the studies comparing rates of sexual offending in learning disabled and non–learning-disabled groups, it is not clear whether these groups were matched on educational level or other sociodemographic variables.

In trying to explain sexual offending in people with learning disabilities, a number of hypotheses have been postulated including counterfeit deviancy, tendencies toward sexual offending and lack of discrimination, sexual abuse, impulsivity, and mental illness (for a more detailed discussion, see Craig & Hutchinson, in press; Lindsay, 2004).

The counterfeit deviancy hypothesis assumes sexual deviance is a result of factors such as a lack of sexual knowledge, poor social and interpersonal skills, limited oppor-

tunities to establish appropriate sexual relationships, and sexual naivety. However, there is little research to support this hypothesis (Lindsay, 2004; Murphy, Coleman, & Haynes, 1983).

The tendencies toward sexual offending and lack of discrimination hypothesis assumes persistent sexual offending is a result of deviant sexual interests, mediated by distortions and selective cues. Sexual offenders with learning disabilities have been found to display deviant sexual arousal patterns and cognitive distortions (Murphy et al., 1983). Lindsay, Smith, et al., (2002) found that 62% of referrals had previous sexual offending. Although sex offenders with learning disabilities tend to have low specificity for age and sex of their victims (Gilby, Wolfe, & Goldberg, 1989; Griffiths et al., 1985), they have a greater tendency to offend against male children and younger children (Blanchard, Watson, & Choy, 1999; Brown & Stein, 1997).

The sexual abuse hypothesis assumes an association with sexual abuse in childhood and sexual offending (Lindsay, 2002). Lindsay, Law, Quinn, Smart, and Smith (2001) found that 38% of the sexual offenders with learning disabilities and 12.7% of the nonsexual learning disabled offenders had experienced sexual abuse. However, as Lindsay (2004) notes, a lack of standardization and appropriate controls in this area makes any conclusion speculative.

The impulsivity hypothesis assumes that sexual offenders with learning disabilities will be more impulsive than their non–learning-disabled counterparts. However, a comparison of levels of impulsivity between learning-disabled and non–learning-disabled sexual offenders revealed no significant differences (Lindsay & Parry, 2003). Similarly, no differences were found in terms of educational history, childhood disturbances, adolescent history, contact with psychiatric services, or the number of previous charges for sex crimes (Glaser & Deane, 1999).

The mental illness hypothesis assumes that sexual offenders with learning disabilities are more likely to have a dual diagnosis of mental illness acting as a disinhibitor to offending. Day (1994) and Lindsay, Smith, et al. (2002) both reported that 32% of sexual offenders with learning disabilities had suffered psychiatric illness in samples of sexual offenders with learning disabilities. However, Lund (1990) reported that 91.7% (87.5% categorized as behavior disorders) had a diagnosis of mental illness in a sample of 274 mixed offenders with learning disabilities. As Lindsay (2004) points out, variations in definitions of mental illness may account for this discrepancy as behavior disorders were reported separately in both the Day and Lindsay studies.

Sexual offenders with learning disabilities require specialist treatment intervention and are more likely to be diverted from criminal justice settings to local learning disability services (Green, Gray, & Willner, 2002). Although there are a number of evaluative research projects currently underway (see Murphy et al., 2004), there are few descriptions of community treatment programs for sex offenders with learning disabilities. Although some treatment studies adapted for sexual offenders with learning disabilities have been published (Charman & Clare, 1992; Swanson & Garrick, 1990), few have been empirically validated.

Cognitive-behavioral approaches to working with sexual offenders has been empirically supported (Craig, Browne, & Stringer, 2003; Hanson et al., 2002; Mar-

shal, Anderson, & Fernandez, 1999) and have also been successfully applied to offenders with learning disabilities (Lindsay, Allen, et al., 2003; Stenfert-Kroses, Dagnan, & Loumidis, 1997), including sexual offenders (Lindsay, Neilson, Morrison, & Smith, 1998; Rose, Jenkins, O'Conner, Jones, & Felce, 2002) as measured by reduced recidivism.

In a review of the extant risk assessment and treatment literature on sexual offenders with learning disabilities, Craig and Hutchinson (in press) found that most programs for sexual offenders with learning disabilities have been adapted from the mainstream programs compensating for cognitive deficits. However, in spite of a number of published treatment studies, few have been empirically validated, and as yet, it remains unclear as to which treatment components are most effective in reducing sexual recidivism in offenders with learning disabilities. Of the small number of published studies that describe treatment programs, most are based on small samples, and few have been empirically validated. However, of the various studies reviewed by Craig and Hutchinson, a few key components emerged as critical in treatment programs for sexual offenders with learning disabilities. Common among the majority of adapted programs (Hayes, 1991) for sexual offenders with learning disabilities are components including challenging denial and restructuring cognitive distortions, enhancing victim empathy, social skills, offending awareness, sex education, relationship skills, law and offending behavior, self-control and fostering self-reliance skills, developing relapse prevention skills, decreasing inappropriate arousal and increasing appropriate arousal, insight into the effects on victims, self-control procedures and methods of avoiding risk situations, and treating sexual dysfunction using multimodal interventions (Allam, Middelton, & Brown, 1997; Coleman & Haaven, 2001; Griffiths et al., 1985; Hill & Hordell, 1999; Lindsay, Neilson, et al., 1998; Lindsay, Olley, et al., 1999; Lindsay, Smith, et al., 2002; O'Connor & Rose, 1998; Rose et al., 2002). Given the poor levels of sexual knowledge in these offenders, specially designed sex education resources have also been developed (Lindsay, Bellshaw, Culross, Staines, & Michie, 1992; Kempton, 1993) with positive results.

The aim of this study is to critically evaluate a community-based treatment program for sexual offenders with learning disabilities. It was anticipated that following treatment intervention, there would be a reduction in the number of pro–sexual-assault attitudes evidence by psychometric measures and reduction reports of sexually inappropriate behavior.

Method

Defining Learning Disability

Difficulties in assessing adaptive and social functioning have contributed to a tendency among clinicians to concentrate on assessment of intellectual functioning (Professional Affairs Board, 2001). This assumes that provided significant impairment of intellectual functioning has been established, similar deficits in adaptive and social functioning are likely. The diagnosis of a learning disability is not solely related to low

intellect. It is a mistake to overemphasize the role of IQ as an indicator of appropriate treatment strategies because IQ alone does not adequately describe a person's ability (Coleman & Haaven, 2001). Indeed, the British Psychological Society recommends that a classification of learning disability should only be made on the basis of assessed impairments of both intellectual functioning and adaptive and social functioning that have been acquired before adulthood. The American Psychiatric Association diagnostic criteria for mental retardation as described in the *Diagnostic and Statistical Manual of Mental Disorders* has changed little in the recently revised version (American Psychiatric Association, 2000) and defines a learning disability as

(a) significant subaverage intellectual functioning (IQ of approximately 70 or below) on an individually administered IQ test,
(b) concurrent deficits or impairments in present adaptive functioning (i.e., the persons effectiveness in meetings the standards expected of his or her age and cultural group, in at least two of the following: communication, self-care, home living, social and interpersonal skills, use of community resources, self-direction, functional academic skills, work, health, and safety), and
(c) the onset before age 18 years.

The principle method for determining levels of intellectual functioning is via use of psychometric assessment. The most commonly used assessment is the Wechsler Adult Intelligence Scale—Third Edition (WAIS-III: Wechsler, 1997) from which IQs can be calculated. The mean IQ score is 100 with a standard deviation of 15. A score of one standard deviation below the mean would correspond to an IQ of 85 or below, and two standard deviations below the mean would correspond to IQ of 70 and or below. In addition to using the WAIS-III assessment to determine IQ estimates, the *Classification of Mental and Behavioral Disorders—Clinical Description and Diagnostic Guidelines* (World Health Organization, 1992) and the Professional Affairs Board recommends the use of the Vineland Adaptive Behavior scales (VABS: Sparrow, Balla, & Cicchetti, 1984) as an assessment tool to measure impairment of adaptive and social functioning. The VABS is a semistructured interview method designed to measure what the individual usually or habitually does and is divided into four domains: *communication*, *daily living skills*, *socialization*, and *motor skills*—the items of which are scored 0 = *no*, 1 = *sometimes or partially*, and 2 = *yes, usually*. Scores can be compared to a range of different populations for which normative samples are available. Significant impairment of adaptive and social functioning is usually identified if scores fall at or below the third percentile range.

Measures

Four core psychometric measures were completed at baseline and at the end of the treatment group: the Multiphasic Sex Inventory (MSI: Nichols & Molinder, 1984), the Coping Response Inventory (CRI: Moos, 1993), the Psychiatric Assessment for Adults With a Developmental Disability (mini–PAS-ADD; Prosser, Moss, Costello, Simpson, & Patel, 1997), and the VABS (Sparrow et al., 1984). These measures were

chosen to reflect the explicit goals of the treatment intervention. For example, challenging cognitive distortions and denial, enhancing levels of offense responsibility and accountability, enhancing victim empathy, monitoring sexual interests, and improving sexual knowledge was measured using the MSI. Developing coping and problem-solving skills was measured using the CRI. Assessment of changes in mood states was measured using the mini–PAS-ADD. Changes in adaptive and social functioning, communication, and socialization skills were measured using the VABS. The VABS also provides an estimate of the participant's developmental level. Because of the limited literacy skills of the group members, the questionnaires were read out to them individually.

The MSI (Nichols & Molinder, 1984)

The MSI is a 300-item self-report questionnaire that produces six scales.

1. Validity scales are made up of three measures: Social and sexual desirability, which measures normal sex drives and interests and identifies whether clients are responding in a socially desirable way; Sexual obsession, which measures an offender's obsession with sex and any tendency to exaggerate his problems; and Lie scale—which measures the extent of denial and minimization.
2. Accountability scales are made up of three measures: Cognitive distortions and immaturity, which addresses the extent to which an offender adopts a victim stance in relationship to his present offense and measures levels of accountability accepted for offending behavior; the Justification scale (use of) examines the various justifications sexual offender may use to explain offenses; and the Attitude to Treatment scale measures the offender's attitudes to treatment for his sexual offending.
3. Sexual Deviance scales (Child Molest—Gender, Rape, and Exhibitionism) is based on the concept that a sex offender goes through an identifiable cognitive and behavioral progression leading up to a sexual offense. The sex offender's cognitions follow a path beginning with the thought or fantasy of committing a sexual assault (antecedent thought), through a series of self-justifying positions, on to planning and executing the assault. This scale assesses the style, magnitude, and duration of sexually deviant behavior.
4. Paraphilias (atypical sexual outlet) scales comprises of five subtests—fetishes, voyeurism, obscene call, bondage and discipline, and sadomasochistic—and measures the uniqueness and individuality of the offenders sexuality and offending behavior.
5. Sexual Dysfunction scales comprises of four subtests: sexual inadequacies, premature ejaculation, physical disabilities, and impotence.
6. The Sex Knowledge and Beliefs scale measures the offender's knowledge of sexual anatomy and physiology but not reproductive systems. The protocol also considers sexual history of the offenders; sex deviance development, marriage development, gender-identity development, gender-orientation development, and sex assault behavior list.

The CRI (Moos, 1993)

The CRI is a 48-item self-report questionnaire designed to measure an individual's capacity to cope with distressing life events and their typical behavioral, cognitive,

and emotional response styles in problem situations. In particular, it assesses whether an individual approaches problems in a positive way or whether he or she uses avoidance strategies as a means of coping. The protocol comprises of four scales measuring approach coping styles (logical analysis, positive reappraisal, seek guidance and support, and problem solving) and four scales measuring avoidance coping styles (cognitive avoidance, acceptance, seek alternative rewards, and emotional discharge).

The mini–PAS-ADD (Prosser, Moss, Costello, Simpson, & Patel, 1997)

The mini–PAS-ADD interview is a protocol designed to provide a structured framework within which information on psychiatric symptoms in people with learning disabilities can be collected. The instrument has been designed to produce a reliable and valid record of the person's symptoms during the rating period. The schedule produces scores relating to the following areas: psychosis, expansive mood (hypomania), autism, depression, unspecified disorder, anxiety disorders, obsessive compulsive disorder. Scores in these areas, which exceed the scale thresholds, are assessed as being likely to present with an Axis 1 psychiatric disorder. Any score above the scale threshold indicates that the person should be referred for a comprehensive mental health assessment.

The VABS (Sparrow et al., 1984)

The VABS assess the developmental level of learning disabled populations and provides an estimate of the persons' developmental level in each of the three areas; communication, daily living skills and socialization, and a general estimate of developmental functioning based on the aggregate of these three scores. The communication domain assesses how able the person is to communicate with others within a variety of contexts (e.g., verbal, reading, and writing skills). The daily living skills domain focuses on the skills required by a person to look after themselves on a day-to-day basis (e.g., their ability to cook, clean, cross roads safely, use public transport, etc.). The socialization domain assesses the person's level of appropriate social interactions (e.g., turn taking in conversations, ending conversations appropriately). The VABS was administered when an individual was referred for an assessment of risk. This assessment tool became standard procedure in 1999. The VABS provides a maximum developmental age of 18, at which point the person is assessed as adult and therefore in possession of the necessary skills to function independently within a community setting. Administration takes place with the respondent most familiar with the behavior of the individual being assessed, in the form of a semistructured interview. The Expanded Form was used, which comprises 577 items, administration must take place with a psychologist or other professional with a graduate degree. It takes approximately 1 to 1 1/4 hours to administer and scoring takes approximately an additional 30 minutes.

Participants

The participants were known to the local National Health Service learning disability services and were assessed using the diagnostic criteria as described above. The treatment group consisted of six men with a mean age of 24.8 years (SD = 7.46 years, range of 18 to 39 years). All men had committed at least one previous sexual offense with two having committed two previous sexual offenses. Because of the small sample of the group, attention is paid to the individual descriptions of the participants and their treatment progress.

Participant 1

Participant 1 was a 20-year-old male living in private residential accommodation offering 24-hour support and supervision. He suffered a neglected and emotionally deprived infancy and was assessed as having developmental delay in a number of areas. His father abused alcohol and used excessive physical violence as a means of chastisement. He became known to social services at 12-months of age when his parents requested that he be taken into care because of his difficult and demanding behavior. He was reported to have set several fires from 4 years of age and, at the age of 10, came to attention of police for theft, burglary, and criminal damage. He was received into care at the age of 10. He has displayed self-injurious behavior for approximately 4 years and has used several illegal drugs including amphetamine, crack cocaine, and cannabis. He has a history of inappropriate sexual behavior at the family home and lack of boundaries and is suspected of being exposed to sexualized material (porn videos) at 12 years of age. He has expressed an interest in bestiality and has admitted two counts of rape (not charged) and engaging in inappropriate sexual behavior toward female staff. His primary sexual targets appeared to be adult females. In 1997, he was charged with two counts of indecent assault and one count of indecent exposure. In 1999, he was charged with two physical assaults. During the interview, he disclosed that he had also sexually abused his younger sister, for which he was not charged. He has also disclosed up to 40 other sexual offenses against adult females, again for which he has not been charged. The majority of these are indecent exposure. His Full Scale IQ was assessed using the Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999) and estimated at 66, with an estimated verbal and performance IQ of 70 and 67, respectively. Using the VABS, his communication domain falls within 6 years 11 months, his daily living skills domain falls within 17 years 3 months, and his socialization domain falls within 10 years 10 months.

Participant 2

This participant was a 25-year-old male living in private residential accommodation offering 24-hour support and supervision. He suffers from a chromosomal abnormality commonly associated with Klinefelters syndrome (47, XXY chromosomal disorder). There were unclear boundaries at home as a child, and he was reported to have engaged in inappropriate sexualized behavior toward his mother and sister. However,

he denies he was sexually abused as a child, and there was no contact with social services. There is no history of substance and alcohol abuse. His self-report of sexual interests varies; at times, he continues to report a sexual interest in children, although at other times, he has expressed heterosexual and homosexual interests. At the age of 10 years, he admitted to sexually assaulting a 5-year-old girl, and he was subsequently made the subject of a secure accommodation order. During a 15-year period, he disclosed having committed numerous offenses against children and often reported to staff his continued sexual interest in children. At the time of the group sessions, he was under no legal orders. The true level of sexual interest in children regarding this individual is difficult to measure. At a young age, he appeared to make links between the concepts of *offending* and *dangerousness*. Being perceived as dangerous from a relatively young age, he developed a perception that this had a certain amount of kudos, especially in a secure setting for adolescents. Consequently, his accounts of his offending history have varied to the extremes over time. His full scale IQ was assessed using the WAIS-III (Wechsler, 1997) was estimated at 73. Using the VABS, his communication domain falls within 15 years 9 months, his daily living skills domain falls within 16 years 6 months, and his socialization domain falls within 11 years 6 months.

Participant 3

Participant 3 was a 37-year-old male living in private residential accommodation. He has a history of sexually inappropriate behavior from the age of 19 years, exposure to children, sexual assault of a 4-year-old girl, although no action was taken. There is some suggestion that he engaged in mutual masturbation with his brother. He has no other criminal behavior or drugs or alcohol use. He was detained under a Home Office agreement, Mental Health Act of 1983, Section 37, 41 restrictions. He was supervised 24 hours a day. In 1993, he was charged with multiple counts of buggery against his 5-year-old niece and also charged with indecently assaulting a child. Allegations of a sexual nature were also made against him prior to 1993. Because of his length of time within the service, his level of intellectual functioning had not been formally assessed, but clinicians estimate that he fell within the *extremely low* range IQ < 70, possibly with a full scale IQ below 60. He was the most significantly impaired member of the group. Using the VABS, his communication domain falls within 16 years 6 months, his daily living skills domain falls within 18 years 9 months, and his socialization domain falls within 13 years 9 months.

Participant 4

Participant 4 was a 19-year-old male who had recently become known to the learning disability services. He lived in private residential accommodation and was subject to 24-hour support and supervision. He was referred to learning disability services on the grounds that he was statemented with special educational needs while at school. His mother suffered from learning disabilities, and he was adopted at an early age. Allegations were made by him of physical abuse by his adoptive father, after which social services become involved. He also was reported that he was sexually abused by

his adoptive brother who was 1 year older, where he was tied up and made to perform various sexual acts. He has reported experiencing suicidal thoughts and has attempted to run out in front of cars as a child. He also expresses an interest in death and guns. He has few friends and was the victim of bullies. He has developed various personas, dressing up as an Army solider, Lara Croft (at the time, he said he wanted a sex change—he wore fake boobs and shaved his legs), Woody (cowboy from the film Toy Story—he went to court dressed as Woody), a lion, (he refused to eat and said he preferred to lap water from a bowl on the floor). He dressed up as a character for a period of time, often a few weeks, and appears to enjoy shocking the staff with his attire. He will then switch to another character, often initiated by a program he views on TV. He has engaged in autoerotic asphyxiation and expresses an interest in bestiality. There is no history of criminal convictions or substance abuse. In 1999, he was cautioned for possession of indecent pictures of children. His full scale IQ was assessed using WAIS-III and was estimated at 80. His verbal and performance IQ's were estimated 81 and 83. Using the VABS, his communication domain falls within 5 years 11 months, his daily living skills domain falls within 9 years 2 months, and his socialization domain falls within 5 years 7 months.

Participant 5

This participant was a 22-year-old male living in private residential accommodation. His family was previously known to social services, and he was placed into foster care at 7 years of age because of his mother being unable to cope with children. In 1996, he was accused of exposing himself to children although he denied it, and no further action was taken. Members of his family have been convicted of sexual offenses, and he may have been sexually abused or exposed to sexually abusive behavior as a child. He was first referred to learning disabilities services in 1998 following an incident of self-harm. Here, he disclosed having sexual fantasies involving children and also disclosed committing illegal sexual acts. No other criminal, aggressive, or substance-use behavior has been reported. He has an interest in disasters (e.g., Dunblaine shooting in the UK and 9/11 terrorist attacks in New York) and hoards newspapers and has made proterrorist comments. In 1999, he was convicted of the sexual assault of a 5-year-old, and in 2000, he was made the subject of a sex offender order. The sex offender order imposes a number of restrictions on the behavior of the individual and can also dictate where he lives. This is usually put in place for a minimum of 5 years and can be extended. His full scale IQ was assessed using the WASI and estimated at 71. His verbal IQ and performance IQ's were 72 and 69, respectively. Using the VABS, his communication domain falls within 8 years 8 months, his daily living skills domain falls within 13 years 9 months, and his socialization domain falls within 8 years 0 months.

Participant 6

This participant was a 17-year-old male living with his grandparents who were also his foster caretakers. As a child, he was diagnosed with attention deficit hyperactivity

disorder and was prescribed Ritalin. His father was convicted of sexual abuse of a child, and it is therefore possible that he was also abused by his father. His mother and father separated, and there were some indications that his mother was involved in making pornographic videos and that he was exposed to sexualized material from a young age. He was taken into care at the age of 5 because of concerns of abuse and neglect. He admitted sexually abusing a 3-year-old boy, and five other allegations have been made against him by both male and female victims with learning disabilities. He has displayed aggressive behavior toward peers and was arrested for burglary in 2000, although he denied any involvement. In 1999, he was cautioned for the indecent assault of a 3-year-old boy, and his name was placed on the sex offenders register. His full scale IQ was assessed using the WASI and estimated at 75. His verbal IQ and performance IQ were 73 and 79, respectively. He lived within a residential community setting and was not under any agreed levels of supervision. Using the VABS, his communication domain falls within 7 years 7 months, his daily living skills domain falls within 7 years 11 months, and his socialization domain falls within 6 years 1 months.

Intervention

In general terms, individuals who fall within the mild or borderline learning-disability range of intellectual functioning (IQ < 80) are likely to experience a range of important cognitive deficits. These may include reduced capacity for and reduced speed of processing information, difficulties in learning new information, difficulties in solving problems, concrete thinking styles with difficulties in dealing with more abstract information, difficulties with language, and limited education based knowledge and skills. These individuals often experience difficulties with time orientation, poor working memory, and limited effective short-term memory (Mackinnon, Bailey, & Pink, 2004)

Therapeutic intervention took the form of cognitive behavioral therapy in group sessions running for 2 hours once a week for 7 months. The content of the group work as identified by Craig and Hutchinson (in press) included sex education and the law, identifying and reconstructing cognitive distortions, developing victim and relapse prevention skills. Group sessions also looked at the cycle of offending (Finkelhor, 1984) and thoughts related to sexual fantasy and masturbation. Information was presented using a number of different methods including pictures, drawings, interactive exercises, videos, quizzes, and structured group discussions. The focus of the framework is one of frequent repetition of simple, pictorially presented information until assimilated by the individual and the principles applied to a variety of contexts. Key to providing effective interventions with sex offenders with learning disabilities is in the presentation of information. Although following a structured-treatment model, therapeutic sessions are deliberately flexible and delivered at the group members own pace. Complex language was kept to a minimum, and key concepts explained pictorially and via role-plays. Each group session was supported by two main facilitators (one male, one female), a consultant clinical forensic psychologist, and a trainee forensic psychologist.

Group members were given individual responsibilities at each session for making sure adequate refreshments (i.e., coffee, tea, biscuits) were available for all members of the group. It was felt these responsibilities encouraged group members to develop social interpersonal and responsibility awareness skills that formed one of a number of implicit treatments aims of the group. These include the development of social, assertiveness, empathy, and listening skills as well as personal responsibilities (such as arrival promoting). The more explicit aims of the intervention relate to the goals of the treatment such as challenging cognitive distortions and developing victim empathy.

Debriefing sessions was held at the end of each group session between facilitators who discussed the progress of members of the group and planned future sessions. Notes were kept and the content of the following session planned. Information was also shared with principle caretakers of the men attending the group that informed risk and management strategies. The previous session was recapped at the start of each new session and new material was summarized at the end of the session. Sessions were held at the learning disabilities services headquarters, a place familiar to all group members.

Results

As there are only a small number of participants in this study, results are presented in the form of a brief description of individual progress during the sessions. All men were followed up for approximately 12 months after attending the group. This methodology and follow-up period is consistent with Rose et al. (2002). Unfortunately, because of changes in National Health Learning Disabilities Services funding, it was not possible to extend this period of follow-up. It was reported by facilitators of the group that the group members viewed the sessions as much as a social event as a requirement of their care plan. It was felt this acted as a positive reinforcer to maintain group attendance and cohesion.

Participant 1

He had previously attended an adapted sexual-offender treatment program and therefore differed to the other participants in this respect. Consequently, his benefits from attending this group were more difficult to gauge. It was unclear as to whether he was making progress or repeating what he had learned from previous interventions. He was often prompted to contribute to group discussions and would respond with useful and insightful contributions. To date, he continues to be monitored 24 hours a day, and under these conditions, no further offending behavior has been reported.

Participant 2

During the group, he recounted disturbing fantasies to professionals involving the sexual abuse and murder of a child. He has at other times disregarded his interest in children, reporting both heterosexual and homosexual interests in an age-appropriate

peer group. His was a keen and active participant in the group. Although there have been no reported incidents of new coercive sexual behaviors, to date, he remains under 24-hour supervision, although plans are being considered to move him into a more independent setting.

Participant 3

In addition to being the most significantly intellectually impaired member of the group, he was also the participant who was the most reluctant to engage in a group setting. It is thought that this was due to embarrassment. He was anxious and became distressed during appointments where the contact may relate to sexual matters. His anxiety was thought to be exacerbated in a group setting. He provided little voluntary contribution to the group, and when prompted, he often remained unable to engage. He provided limited often monosyllabic answers. To date, he remains under Home Office regulations and continues to be monitored 24 hours a day. There have been no reported new coercive sexual behaviors. He has not engaged in any further offending behavior, although a sexual interest in children remains evident.

Participant 4

Participant 4 refused to attend the groups, and he refused to comply generally with professionals. He continues to display behaviors that are indicative of sexual interest in children, both male and female. He has also reported a sexual interest in another male resident where he resides. He has a sadomasochistic interest and engages in autoerotic asphyxiation. There is some dispute as to whether he presents with a personality disorder.

Participant 5

He was a keen participant in the group, although his contributions often provided adverse reactions from other group member. He often made pro-offending and proterrorist comments (The group was running at the time of the 9/11 terrorist attack in New York). His verbal contributions to the group indicated little progress as he believes that sexual offending against children should not be considered as illegal. However, he reported continued interest in children provided evidence for the need to continue to provide high supervision levels under which he continues to be monitored. Under these conditions, no reports of further inappropriate sexual behavior have been reported.

Participant 6

As the youngest group member, he was at times reluctant to contribute to discussions. However, when prompted, he would often provide useful and insightful contributions. Since completing the group, he has reportedly developed some interest in age appropriate females. No further offenses have been reported.

Table 1
Multiphasic Sex Inventory Scale Scores
Preintervention and Postintervention

	Pregroup		Postgroup	
Multiphasic Sex Inventory Scales	*M*	*SD*	*M*	*SD*
Sexual and social desirability	18.4	4.66	16.4	5.89
Sexual obsession	4.4	4.03	5.0	4.79
Lie scale	11.0	1.22	8.6	2.96
Cognitive distortions and immaturity	7.6	1.81	9.6	5.50
Justifications	3.8	3.89	7.8	6.22
Treatment attitude	2.6	1.67	3.2	1.92
Child molest	9.6	6.54	10.6	6.02
Rape	4.2	2.86	3.0	3.31
Exhibitionism	3.2	3.11	2.8	2.49
Paraphilia (atypical sexual outlet)	2.8	2.68	4.0	2.23
Sexual dysfunction	5.2	2.58	6.8	5.26
Sexual knowledge and beliefs	8.0	5.56	13.4	1.51

Table 2
Coping Response Inventory Scale Scores
Preintervention and Postintervention

	Pregroup		Postgroup	
Coping Response Inventory Scales	*M*	*SD*	*M*	*SD*
Logical analysis	38.67	12.58	41.50	12.37
Positive appraisal	43.50	10.71	46.50	10.87
Seeking guidance	44.33	7.28	42.50	10.09
Problem solving	42.00	9.67	44.83	8.56
Cognitive avoidance	57.67	11.48	58.50	11.39
Acceptance and resignation	54.33	10.36	54.83	8.54
Alternative rewards	53.50	5.89	57.33	13.00
Emotional discharge	61.17	11.32	61.83	16.44

Psychometric Measures

Means and standard deviations of the four scales pregroup and postgroup intervention are reported in Tables 1 through 4. The psychometric data were examined to observe trends in the group data. A Wilcoxon nonparametric test was used to see if there was any indication of overall change in the data between the pregroup and immediate postgroup scores. The only significant difference was found between the scores on the VABS. The Socialization Domain ($z = –2.201$, $p < 0.05$) and Play and Leisure Time scale of the VABS ($z = –2.201$, $p < 0.05$) were significantly different

Table 3
Mini–Psychiatric Assessment for Adults With a Developmental Disability Scale Scores Preintervention and Postintervention

	Pregroup		Postgroup	
Mini–Psychiatric Assessment for Adults With a Developmental Disability Scales	*M*	*SD*	*M*	*SD*
Depression	6.83	3.43	10.50	5.61
Anxiety	2.50	2.07	4.50	4.93
Expansive mood (hypomania)	4.50	3.01	5.67	4.08
Obsessive compulsive	0.50	0.54	0.50	0.83
Psychosis	0.33	0.81	0.67	1.03
Unspecified disorder	0.83	1.16	1.30	0.81

Table 4
Vineland Adaptive Behavior Scales Scale Scores Preintervention and Postintervention

	Pregroup		Postgroup	
Vineland Adaptive Behavior Scales Scale Scores	Months	*SD*	Months	*SD*
Communication domain	122.67	55.98	111.33	30.68
Receptive	73.50	22.88	76.50	27.26
Expressive	110.00	42.84	94.33	25.19
Written	145.33	55.32	119.17	28.06
Daily living skills domain	166.67	53.59	160.67	38.75
Personal	123.17	51.92	102.00	23.00
Domestic	171.33	55.61	181.50	47.95
Community	178.33	50.80	180.67	38.40
Socialization domain	111.50	39.01	144.00	42.58
Interpersonal	117.17	52.65	153.83	30.16
Play and leisure time	103.83	13.09	141.17	37.48
Coping	100.50	33.44	145.67	67.31

postintervention. Although not significant, the trend was for improvements in admitting sexual interests (MSI Lie Scale: $z = -1.857$, $p = 0.6$) and sex knowledge (MSI Sex Knowledge Scale: $z = -1.753$, $p = 0.8$).

Sexual Reconviction

All men were followed up for approximately 12 months after attending the group. During this period, official records revealed none of the men were charged or reconvicted for a new sexual offense.

Discussion

The aim of this study was to critically evaluate a community-based treatment program for sexual offenders with learning disabilities. Psychometric assessments were used to measure cognitive changes in attitudes toward sexual offending, coping, problem-solving, interpersonal, and socialization skills following the treatment intervention. Although significant differences in socialization skills were found postintervention, the trend was for some improvement in sex knowledge and disclosing sexual interests. Clinically, improvements in implicit treatment goals such as listening skills and social responsibility were also evident.

Although the results of this treatment review are mixed, none of the group members have been reconvicted for a new sexual offence, albeit for only 12-month follow-up. However, it is not clear whether this is a result of the sex offender specific treatment intervention, implicit socialization skills acquired during the intervention or a result of continued 24-hour supervision. Therefore, based on the current studies results, it is not possible to conclude that sex offender specific intervention for offenders with learning disabilities (as described here) was effective in reducing sexual recidivism.

Although no further sexual reconvictions have been reported, given the concern over the potential to cause harm, most of the group members received 24-hour care and supervision during the following up period. However, in some circumstances, group members had previously engaged in sexually inappropriate even while under supervision. Although none of the men were reconvicted of a sexual offense, official reconviction rates must be viewed with caution. Official sources are known to underreport recidivism (Marshall & Barbaree, 1988, Falshaw, Bastes, Patel, Corbett, & Friendship, 2003). A further source of error when using official sources is that some serious sexual offenses are often bargained down to violent offenses to secure convictions (Bagley & Pritchard, 2000), to the point where 12% of violent reconvictions are sexually motivated (Corbett, Patel, Erikson, & Friendship, 2003). Indeed, in 10 out of 19 rape cases reported in the UK, the sexual element of the crime was removed and downgraded to a violent offense (Lees, 1996). It is possible that some of the men in the present study may have engaged in sexually inappropriate behavior that did not attract attention of the police. Indeed, Green, Gray, and Willner (2002) compared 16 convicted and 30 nonconvicted offenders with learning disabilities and revealed few differences on factors associated with sexual recidivism. However, convicted men were more likely to have targeted children and males as victims and had perpetrated more serious sexual offenses. Further analysis revealed that predictors of convicted status were child victimization and, less reliably, emotional loneliness. They argue the decision to prosecute a man with learning disabilities who displays sexually inappropriate behavior is based more on the identity of the victim than on the nature of the offence. This suggests in some circumstances (e.g., where the victim is an adult female), the offender would more likely be diverted to the mental health system than be dealt with by the criminal justice system. Similarly, Lyall, Holland, and Collins (1995) found that tolerance levels of care staff were extremely high to the extent that theft and criminal damage offences were hardly ever reported. The sexual recidivism rate for sexual

offenders with learning disabilities was reported to be 34%, with 84% reoffending in the first 12 months (Klimecki et al., 1994). In a review of follow-up studies for sexual offenders with learning disabilities, Craig and Hutchinson (in press) suggest the sexual recidivism rate of offenders with learning disabilities is 6.8 times and 3.5 times that of non–learning-disabled sexual offenders at 2 years and 4 years follow-up, respectively. Gibbens and Roberston (1983) reported a reconviction rate of 68% in 250 male patients with learning disabilities detained under hospital orders. It is therefore possible that offense related behaviors were not pursued criminally.

The aim of the present study was to critically evaluate a community-based treatment intervention for sexual offenders with learning disabilities. Although no significant changes in attitudes relating to sexual offending were demonstrated statistical significance, a number of cognitive improvements have been found. The trend was for an improvement in sexual knowledge and anatomy following intervention. In line with some of the implicit aims of the intervention, preanalysis and postanalysis of the VABS revealed that members of group developed socialization skills, including coping skills, play and leisure time, and interpersonal relationship skills. Improvements in making friendships, thoughtfulness, group interaction, sharing and co-operation, manners, following rules, apologizing, controlling impulses and responsibility, are all desirable treatment outcomes.

Methodological Limitations

Although statistical analysis failed to demonstrate cognitive shift following the group intervention, there may be a number of explanations. The first relates to the psychometric measures used in the current study. A number of the core measures (i.e., CRI and MSI) were standardized on non–learning-disabled populations, and it is not clear to what extent these can translate to learning-disability groups. It is therefore possible that these measures are not sensitive to subtle changes in cognitive shift in clients with learning disabilities. Indeed, only one of the measures used has been specifically designed to assess psychosexual characteristics in sexual offenders (e.g., MSI). At the time of the group, specialist psychometric assessments adapted for sexual offenders with learning disabilities—such as the questionnaire on Attitudes Consistent with Sex Offenses (Lindsay, Carson, & Whitefield, 2000), the Sex Offenders Self Appraisal Scale (Bray & Forshaw, 1996), and the Victim Empathy scale–adapted (Beckett & Fisher, 1994)—were not available to the facilitators. Had these measures been available, it is possible that changes in cognitive shift would have been evident.

A second explanation may relate to the length of the treatment group itself. Although some studies have run from 11 (Friedman, Festinger, Nezu, McGuffin, & Nezu, 1999) to 16 weeks (Rose et al., 2002), most treatment groups run for a minimum of 1 year (Lindsay, Neilson, Morrison, & Smith, 1998; Murphy et al., 2004; Sinclair, Booth, & Murphy, 2002; Swanson & Garwick, 1990), although significantly better outcomes for sex offenders treated for 2 years have been reported (Day, 1994; Lindsay & Smith, 1998). As to the frequency of the group session, Lindsay (2004) argues that groups should be held weekly, and there is little benefit of running multiple group ses-

sions in the same week. As the present treatment group lasted only 7 months, it is possible that this was not a long enough period of intervention to effect significant change.

Although none of the group members were reconvicted for sexually assaultive behavior in the 12 months following the group, it is important to note that all of the six members of the group have been subject to high levels of supervision and 24-hour care. It is perhaps not supervising then given the lack of unescorted community time available that none of the group members have been reconvicted for a new sexual offense.

Conclusions

Clinical observations suggest sexual offenders with learning disabilities generally make little progress on mainstream programs regarding their sexual interests and attitudes to offending. Indeed, Barron et al. (2004) found little evidence for efficacy of therapeutic interventions that were nonspecific to people with learning disabilities.

Intervention aimed at increasing knowledge base and skill acquisition must recognize and take account of learning functioning. Any program of intervention based on programs delivered to adults who function within the normal range of intelligence will need to be modified to compensate for these deficiencies. Indeed, Ashman and Duggan (2003) argue that clinicians will have to continue to base practice on clinical experience and evidence from non–learning-disabled populations. For example, more use should be made of pictorial or visual materials rather than, or as well as, verbally presented information; the breaking down of complex information into simple, clear-cut components; and use of simple messages that are frequently repeated and followed by a request for feedback to ensure that the information has been fully processed (Allam et al., 1997). Similarly, news skills to be learned should be practice based and with the use of demonstrations by competent role models rather than theory-based work. In addition, there needs to be recognition that the time scale for achieving goals may be longer than that expected of an individual falling within the normal range of learning functioning (Lindsay & Smith, 1998).

There are more similarities than differences between sexual offenders with learning disabilities and their non–learning-disabled counterparts. However, given the methodological differences between studies, these conclusions must be viewed with caution. Part of the difficulty in establishing treatment efficacy for sexual offenders lies in the standardization and methodological limitations of treatment studies (Craig et al., 2003). This is especially true for offenders with learning disabilities (Courtney & Rose, 2004). Indeed, in contrast to mainstream sex offender treatment programs (Friendship, Mann, & Beech, 2003; Hanson et al., 2002), an evaluation into the effectiveness of pharmacological (including antilibidinal and psychotropic medication) and psychological treatments in reducing the target sexual acts, urges, and thoughts of sexual offenders with learning disabilities found there is no randomized controlled trial-based evidence for the effectiveness, or ineffectiveness, of any intervention (Ashman & Duggan, 2003). It is expected that treatment programs for sexual offenders with learning disabilities should run for at least 12 months using adapted

psychometric measures that have been developed and standardized on the client group. Nevertheless, until such time as randomized controlled trial evidence demonstrates the effectiveness of treatment interventions for sexual offenders with learning disabilities, clinicians will have to continue to base practice on clinical experience and evidence from non–learning-disabled populations.

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