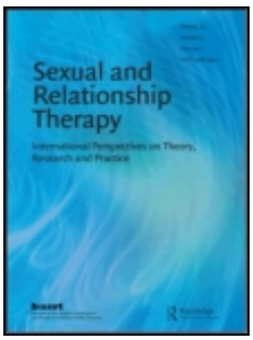

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Issues in the assessment and treatment of male sex offenders with mild learning disabilities

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ABSTRACT *The psychological assessment and treatment of male sex offenders has been of increasing interest in recent years, and a substantial literature, primarily cognitive–behavioural in orientation, now exists. However, there is little information about the application of this literature to men with mild learning disabilities (previously known as mild 'mental handicap'), who have impaired intellectual and social functioning and are at increased risk of additional difficulties. This paper uses the cognitive–behavioural approach as a framework for presenting preliminary guidance on the assessment and treatment of men with mild learning disabilities. It should be emphasized that, at present, almost nothing is known about the outcome of attempts to intervene in the sex offending of this population.*

Introduction

In recent years, there has been increasing interest in the psychological assessment and treatment of male sex offenders, that is, of men whose sexual behaviour is illegal—regardless of whether they have been convicted by a court. Initially, it was believed that the main problem presented by such persons was that of deviant sexual arousal, and a variety of specific behavioural techniques were designed to eliminate their sexual interest. Increasingly, however, it was recognized that such a narrow approach failed to address the clinical evidence that sex offenders often had many different problems in their lives. As a result, there was much greater emphasis on more comprehensive programmes, aimed at, for example, developing non-deviant arousal and social skills (Crawford, 1981). More recently, there have been two major developments: first, a more detailed examination of the impact of emotional experiences in childhood, such as lack of intimacy (Marshall, 1989) and sexual abuse (West, 1991), on adult offending. Secondly, there has been a focus on the role of cognitions in the aetiology and maintenance of offences. Recognition of the importance of cognitive factors has developed rapidly and a cognitive–behavioural approach is predominant in the psychological literature by clinicians and researchers

who specialize in the area of male sex offending (see, for example, Gudjonsson, 1986; Salter, 1988; Maletzky, 1991; Perkins, 1991).

Much of this specialist literature is derived from large clinical samples which probably include at least some men with mild learning disabilities. However, there is little specific mention of its application to such persons. At the same time, there have been few published attempts by workers of any theoretical orientation within the field of learning disabilities to address the problems of sex offending.

The present paper uses the available empirical evidence to draw attention to some of the special issues involved in the assessment and treatment of male sex offenders with learning disabilities.

Definition and characteristics of learning disabilities

Debate over the precise definition of 'learning disabilities' (previously known in the UK as 'mental handicap', and currently referred to in the USA, as 'mental retardation') continues (Zigler *et al.*, 1984; Baroff, 1991). At present, however, it is generally viewed (DSM-III, Revised; American Psychiatric Association, 1987); Police and Criminal Evidence Act, 1984 (Home Office, 1985); British Psychological Society, 1990) as a developmental difficulty associated with (i) impaired intellectual functioning—conventionally, this is regarded as a Full Scale IQ below 70 (taking into account the standard error of measurement) on a general test such as the Wechsler Adult Intelligence Scale, Revised (WAIS-R)—and (ii) impaired (whether delayed or abnormal) social functioning or its equivalent. There is no standard measure, equivalent to the WAIS-R, of social functioning, and its assessment remains problematic (Baroff, 1991; Gudjonsson, 1992). A comprehensive measure, such as the Vineland Scales of Adaptive Behavior (Sparrow *et al.*, 1984) which assesses a wide variety of skills in different areas, is frequently used. In the group of people with mild learning disabilities (that is, those with Full Scale IQ scores within the range 69–50), social functioning cannot be imputed directly from intellectual ability, and there can be great variation between the pattern of skills of individuals with the same level of intellectual ability.

In addition to their impaired intellectual and social functioning, people with mild learning disabilities are at increased risk, compared with their average ability counterparts, of additional difficulties. These include physical problems, such as sensory impairments (Ellis, 1986), epilepsy, and the specific impairments in social cognition which characterize autism (Hobson, 1986; Frith, 1989). In addition, psychiatric disorders and behavioural problems may be more prevalent than in the general population (Holland & Murphy, 1990). In some cases, such problems may be directly related to the cause of the learning disability. In others, the difficulties are likely, at least in part, to reflect the experiences of many people with mild learning disabilities which may result from, and exacerbate the effects of, their impaired intellectual and social functioning. These experiences often include limited opportunities for, and success in maintaining, friendships and relationships (see review by Murphy, 1992; Grant, 1993), resulting in feelings of loneliness and isolation. Some people with learning disabilities may also feel stigmatized (Jahoda *et*

al., 1988) by the very negative attitudes which are held towards them in the general population (MENCAP, 1992).

Current response to sex offenders with mild learning disabilities

Perhaps as a result of uncertainty as to the way in which their offending can best be understood, there has been little consistency in the response to sex offending by men with mild learning disabilities. If the behaviour is 'minor' or occurs within a specialist setting for people with learning disabilities, it appears that it is often overlooked by both care staff (Turk & Brown, in press) and the police (Swanson & Garwick, 1990). When action is taken, sex offenders, like offenders of any type with mild learning disabilities, often 'bounce' between mainstream and specialist treatment services and the criminal justice system (Department of Health, 1989). Recently, however, there have been initiatives in both the criminal justice system and in health and social services to change this situation (Home Office, 1990; Department of Health/Home Office, 1992). As a result, there is likely to be a much greater demand for, and commitment to, a co-ordinated, multi-agency approach to offenders with mild learning disabilities, including sex offenders. Specifically, it is intended that there will be a much greater emphasis on assessment and treatment for this population.

In view of these recent initiatives, the present paper focuses on sex offenders with mild learning disabilities. It should be emphasized, however, that, with the exception of an excellent paper by Murphy *et al.* (1983a), and a small number of individual case studies (Murphy *et al.*, 1983b; Foxx *et al.*, 1986; Holland & Murphy, 1990; Murphy & Clare, 1991) and descriptions of group treatments (Day, 1988; Swanson & Garwick, 1990), there are few published data on any aspect of the assessment and treatment of adult sex offenders within this population; controlled or comparison studies are virtually non-existent. Similarly, there is a dearth of adequate outcome data.

Given the lack of information applying specifically to men with mild learning disabilities, and the absence of any precise 'cut-off' between members of this, and the general, population, one approach is to draw on the cognitive–behavioural framework to assessment and treatment which dominates the specialist literature. The remainder of this article is a preliminary attempt to draw attention to some of the issues which may arise in the assessment and treatment of sex offenders with mild learning disabilities. These issues result from the impaired intellectual and social functioning, and vulnerability to additional difficulties, of this population.

Assessment

The aim of assessment is to clarify the factors contributing to the aetiology and, more importantly, to the maintenance of the individual's offending. From this, an initial formulation can be derived which will suggest points at which various forms of treatment and/or management might interrupt the behaviour. In practice,

assessment and treatment cannot be separated, since evaluation of the effectiveness of treatment may amend the formulation.

A cognitive-behavioural approach to assessment uses an expanded form of a 'functional analysis' (Owens & Ashcroft, 1982) of the individual's sex offending, that is, its antecedents and consequences and the context in which it occurs. In order to understand the sexual behaviour, three components are likely to be assessed: *sexual interests, social-sexual behaviour*, and *attitudes and thinking*. The first, *sexual interests*, includes physiological arousal to different stimuli (e.g. to children in the case of paedophiles, or to aggression for some rapists) and sexual fantasies. *Socio-sexual behaviour* includes sexual knowledge and social skills. Finally, *attitudes and thinking* draws attention to the contribution of the offender's beliefs about his victims and other people and his evaluation of the impact of his behaviour upon them.

Assessment of these three areas is normally carried out using one or more of four different methods: (i) *self-report*, which is most widely used in clinical practice, with data being obtained from interviews, questionnaires, card-sorting procedures and rating scales; (ii) *behavioural* observations of target behaviours; (iii) *physiological* measures, particularly penile plethysmography which has been established (Zuckerman, 1971) as the only valid indicator of male sexual arousal; and (iv) *archival* data, such as witness and victim statements, and previous reports. The general procedures involved in these methods are described in detail elsewhere (e.g. Murphy, 1987; Salter, 1988; Maletzky, 1991; Murphy *et al.*, 1991; Perkins, 1991).

Although assessment of the individual is a central tenet of a cognitive–behavioural approach, the disadvantages shared by people with mild learning disabilities are likely to have three important implications for the assessment of sex offenders within this population. These are outlined below:

1. Limited application of some assessment methods

The impaired intellectual functioning which forms part of the definition of learning disabilities is likely to be associated with one or more of the following:

(i) *Poor memory*. Even when people with learning disabilities are attempting to co-operate, memory problems may lead to difficulties in recalling past experiences.

(ii) *Acquiescent and suggestible responding*. Although people with learning disabilities do not find it easy to answer open-ended questions (Sigelman *et al.*, 1982), there is evidence that they are more likely than intellectually average persons to be acquiescent, that is to answer closed, 'yes/no' questions, affirmatively, regardless of their content (Sigelman *et al.*, 1981; Clare & Gudjonsson, 1993). In addition, they are more likely to be suggestible in interrogative situations, because they will be (mis)led by 'leading questions' (Clare & Gudjonsson, 1993).

(iii) *Reading difficulties*. Although reading difficulties can be overcome by administering written material verbally, this places a high demand on verbal memory ability, which is generally poorer in people with mild learning

disabilities than in their average ability counterparts (Clare & Gudjonsson, 1993).

(iv) *Problems in understanding complex language and concepts and discriminating responses.* There is anecdotal evidence (Murphy *et al.*, 1983a; Charman & Clare, 1992) that people with learning disabilities may have difficulty in understanding the material used in many standard self-report measures, such as questionnaires, and in making the fine discriminations required for responding.

These difficulties are most likely to affect self-report measures, such as interviews, and standard assessments (such as those which exist for the measurement of attitudes). How can they be alleviated? On the basis of research with children with learning disabilities (Dent, 1986), it appears that a balance between the accuracy and completeness of the information gained from interviews can best be obtained by using open questions which are general, rather than specific (e.g. as Gudjonsson, 1992, suggests, asking 'what happened next?' rather than 'what did you do next?'). Unfortunately, this approach can be difficult to maintain, particularly if the offender is unable or unwilling to be frank about his activities. Analysing audio-tapes of interviews can be used as a check on the extent to which the interviewee may have been 'led' inadvertently (Clare & Murphy, 1993).

It is possible to simplify some of the standard measures: for example, the situa-tions described can be presented visually, in the form of video-clips or pictures, rather than verbally (Murphy *et al.*, 1983a). Rating scales can also be presented visually (e.g. in the form of a 'thermometer') and the range of possible responses reduced.

Nevertheless, assessment of test–retest reliability over short periods suggests that, even when simplified, the majority of standard measures remain unsuitable for most people with mild learning disabilities. The information on sexual attitudes, interests, and preferences which such measures have been devised to provide, can sometimes be obtained in alternative ways: for example, from analysis of the thoughts the person has recorded onto a tape-recorder during masturbation, or self-monitoring of the frequency of sexual impulses. A useful method (devised by Beckett, 1992) for assessing attitudes employs vignettes based on the individual's offence, which 'invite' a mis-perception of the situation (for example, an adolescent girl on a bus responds politely to a man's question. When she gets off the bus, the man follows her and sexually assaults her). This is followed by a series of questions regarding the extent to which the man believes that the girl will be a partner and the degree of responsibility for the crime he attributes to the offender and the victim.

The impact of intellectual impairments on self-report data of people with learning disabilities means that it is particularly important to supplement such information with other methods of assessment. There are few descriptions of the use of penile plethysmography with sex offenders with learning disabilities, but two case studies (Murphy *et al.*, 1983a) draw attention to the problems which may be encountered. First, there is a tendency for men in this population to be prescribed major tranquilizers to control their behaviour. Such medication may interfere with

sexual arousal and should be withdrawn prior to assessment. Second, some offenders may not be able to identify sexual stimuli accurately (for example, they may not realise that a scene involves a rape, rather than consensual sexual intercourse). In such cases, specific training, involving asking the offender to identify deviant and acceptable acts, and giving him feedback on his responses, may need to be carried out before psychophysiological assessment begins.

Similarly, although behavioural observations are very frequently used for the assessment of problematic behaviours among people with a marked degree of learning disability, their use in assessing sexual offending by people with mild learning disabilities is rare. There are obvious practical and ethical problems in setting up situations in which there is a risk that others may be sexually victimized. Nevertheless, it is sometimes possible to set up such observations. For example, Holland & Murphy (1990) describe the use of systematic behavioural observations before, and during, withdrawal of psychotropic medication as part of the evaluation of the contribution of a putative mental illness to the sexual offending of a man with a mild learning disability.

2. Need for broad-based assessment of socio-sexual behaviour

There is anecdotal evidence (Murphy *et al.* (1983a) that sex offenders with mild learning disabilities in this population are particularly likely to experience the deficits in their socio-sexual knowledge and behaviour found in other populations of sex offenders (Perkins, 1991). From the limited empirical evidence available, it seems useful to assess at least the following areas:

(i) *Inter-personal social skills.* While there is a considerable literature on inter-personal social skills in people with learning disabilities, it is focused almost entirely on appropriate deficits in performance which have been identified as problematic during role-plays or behavioural observation (Robertson *et al.*, 1984). The other components which theoretical analyses, such as that of Dodge & Murphy (1984), have identified as crucial to successful social behaviour—motivation and goals in the encounter, analysis (decoding and interpretation of social information), and performance feedback (the person's perception of his/her performance and its evaluation by others)—have been largely ignored. There is some evidence (Hobson, 1986; Lindsay, 1986) to suggest that all four components are likely to be important in understanding the inter-personal skills of a person with mild learning disabilities. Unfortunately, at present, there is no methodology specifically for this population which would allow a systematic assessment of the four components and their interaction, although useful accounts of the main issues are available (Matson & DiLorenzo, 1986; Hollin & Trower, 1986). In addition, a recent pilot study (Charman & Clare, 1992) has described the use of pictorial materials (photographs, slides and video-tapes) for pin-pointing the difficulties in understanding sexually-related situations of male sex offenders with mild learning disabilities.

(ii) *Sexual knowledge.* Knowledge of the biological aspects of sex is poorer among people with mild learning disabilities than their average ability counterparts (Bender *et al.*, 1983). While it is oddly-worded, the Sexual Knowledge Questionnaire (Bender *et al.*, 1983) is one of the few measures of sexual knowledge which provides some relevant normative data which can be used as a background to the evaluation of an individual.

(iii) *Understanding of the laws relating to sexual behaviour.* Very little is known about understanding of this area among any population. However, the need for investigation has been highlighted recently (Charman & Clare, 1992): all but one of six sex offenders with mild learning disabilities thought that it was legal to have sex in at least one public place (such as a park or the changing rooms of a swimming pool).

3. Need for multi-disciplinary assessment

The evidence regarding the increased probability of additional difficulties in people with mild learning disabilities suggests that, at least in some cases, the constellation of factors underlying and maintaining their sex offending may be more complex than is normally envisaged by a purely psychological assessment.

Members of other disciplines within a multi-disciplinary team can contribute information, derived from their different perspectives, which may lead to a more complete understanding. As far as possible, the contribution of these data to the formulation should be evaluated by setting up and testing hypotheses.

Treatment

Having obtained at least a preliminary formulation of a particular individual's offending, and the context in which it occurs, the aim of treatment is to reduce the frequency and/or severity of the behaviour. Within a cognitive–behavioural framework, this is normally achieved in two ways: (i) reducing inappropriate thoughts, feelings and behaviours; and (ii) increasing alternative thoughts, feelings and behaviours. Various psychological techniques are described in the specialist literature on sex offending (Gudjonsson, 1986; Salter, 1988; Maletzky, 1991; Perkins, 1991); these are summarized in Table I (adapted from Gudjonsson, 1986 by adding cognitive restructuring to the list of techniques for increasing desirable behaviour, and deleting the non-psychological techniques of chemotherapy and castration).

With the exception of sex education (Lindsay *et al.*, 1992) and inter-personal social skills training (Foxx *et al.*, 1984; Robertson *et al.*, 1984; Matson & DiLorenzo, 1986), there is little empirical support for the use of these techniques with men with mild learning disabilities. However, there are few reasons to suppose that any of them are inherently unsuitable for this population: recent developments in cognitive therapy suggest that even this technique, which is often regarded as only suitable for the 'intellectual' client, can be used successfully with people with learning disabilities, providing they have some verbal language skills (Williams & Moorey, 1989). A detailed discussion of the psychological techniques is outside the scope of

TABLE 1. Classification of some psychological techniques used in treating sex offending

Subjective cognitions	Increasing desirable behaviour	Decreasing undesirable behaviour
Overt behaviours	Social skills training Sexual education	Aversion therapy Shame aversion Self-control techniques
Subjective cognitions/emotions	Systematic desensitization Aversion relief Positive conditioning Fading Attitude change Cognitive restructuring Empathy training Psychotherapy Group therapy	Covert sensitization
Physiological responses	Orgasmic reconditioning	Satiation therapy

this paper and the following simply draws attention to some key issues in the treatment for sex offenders with mild learning disabilities.

1. Need to simplify treatments

The intellectual limitations of men with mild learning disabilities mean that, as far as possible, concrete examples, constant repetition, and a limited amount of information, should be used in the presentation of treatments. People with mild learning disabilities who are trying very hard to appear 'ordinary' may have difficulty acknowledging their limitations (Clare & Gudjonsson, 1991): for this reason, it is particularly important to check that the person has understood what has been said (for example, by asking him to summarize the session in his own words).

With the exception of sex education, for which at least one package has been developed to meet the needs of adults with learning disabilities (Kempton, 1988), and social skills training (Murphy *et al.*, 1983a), there is little information regarding ways in which specific psychological treatments for sex offenders might be simplified. However, some guidance is available on covert sensitization (Cautela, 1967). In recent reports (Salter, 1988), the technique involves the person imagining scenes relevant to his offending, following which he imagines both some unpleasant consequences which would occur if he were to offend, and the positive cognitive and material consequences of avoiding such behaviour. A variation of this procedure is 'assisted' covert sensitization (Maletzky, 1974; 1980). This involves providing a concrete aid to increase the salience of the unpleasant consequences. Originally, (Maletzky, 1974; 1980), it was suggested that a noxious smell (such as valeric acid) be used. In my clinical experience, people with learning disabilities find a posed photograph, indicating the subjectively most unpleasant consequence, more relevant.

For example, a photograph of himself in a locked, virtually bare, room (such as a seclusion room) might be used with a sex offender who fears a loss of freedom if he repeats his offence. In addition, since it is often difficult for intellectually disadvantaged people to produce a hierarchy of scenes, I have found it more useful to concentrate on gaining information about the situation in which the person feels most tempted to offend.

2. Need to give clear messages

The literature on child development (Harris, 1989) suggests that, by about eight years of age, children have almost completed the transition from understanding the effects of their actions in terms of their personal consequences to making independent judgments of the extent to which their behaviour has fulfilled society's expectations. The very small amount that is known about the development of moral awareness in adults with mild learning disabilities (Flynn *et al.*, 1985) suggests that even persons who would be expected, on the basis of their intellectual ability, to make this transition, often do not do so. At least in part, this is likely to reflect their limited social experience. Difficulties in internalizing societal expectations are particularly likely to affect men with mild learning disabilities and behavioural problems, because their early lives are so frequently characterized by instability (such as parental conflict and periods in care) and subsequent inconsistency (Richardson *et al.*, 1985).

The apparent reliance of adults with learning disabilities upon external feedback suggests that this population need to receive very clear messages about the acceptability of their behaviour. This may be particularly necessary for men who have a history of receiving inconsistent responses to their sexual offending. In clinical practice, individual token economies (Ayllon & Azrin, 1968), in which the person receives tokens as reinforcers for acceptable behaviour in various clearly defined areas, often provide a good starting point for assistance in this area. There is evidence (Hall & Baker, 1986) that the key element for the success of such programmes is not the material reward represented by the token but the social interaction which takes place when staff give feedback and specific guidance about the person's behaviour at the time the tokens are given. This suggests that agreement about, and monitoring of, the manner in which feed-back is delivered by carers is at least as important as negotiating with the offender the precise behaviours to be targeted in the token economy.

Following the successful implementation of an externally-monitored system, such as an individual token economy, the aim is to assist the person to internalize standards of behaviour. This can be carried out using the methods associated with self-management procedures (Kanfer & Gaelick-Buys, 1990): self-monitoring (e.g. by written or audio-taped diaries or 'tick' charts of the frequency of events), self-evaluation and self-reinforcement (through self-instruction, as described by Meichenbaum & Goodman, 1971; Kendall & Wilcox, 1980).

3. Need for a multi-disciplinary approach

The plethora of psychological techniques available should not distract therapists from the possibility of implementing other types of treatments, associated with other disciplines. Some such treatments complement work directed primarily at the offending behaviour: for example, Occupational Therapy programmes in vocational, domestic and leisure skills assist the person to develop acceptable alternative sources of self-esteem. Other types of treatment are aimed directly at the offending behaviour. In both the specialist and the learning disabilities literatures on sex offenders, chemotherapy, aimed at reducing libido, is the most frequently mentioned. However, more positive alternatives are available: for example, if the offending is believed, primarily, to reflect a man's difficulties in meeting a partner because of his unusual facial appearance, cosmetic surgery may be considered.

4. Particular need to focus on motivation

The specialist literature draws attention to the difficulties which many sex offenders experience in acknowledging their behaviour and working to achieve therapeutic change. These motivational problems may be particularly salient for men with mild learning disabilities because: (a) offenders who have not received clear messages about their behaviour may be overwhelmed by feelings of resentment when they finally receive a negative response, (b) there are few opportunities for this population to form appropriate intimate relationships, even when they do not have a history of sex offending. It is unusual for men with learning disabilities to be accepted as partners by women or men of average intellectual ability unless there is some financial transaction involved. At the same time, there is, understandably, a reluctance by specialist services for people with learning disabilities to encourage potentially vulnerable women and men to form relationships with known sex offenders. As a result, the offender is often being required to practice life-long abstinence from sexual contact within the context of a relationship with another person—inevitably, a difficult task.

A number of strategies for facilitating motivation, including helping the offender understand the reason for the offences, reinforcing him for his co-operation (Bancroft, 1979), and persuasion and contingency management (Perkins, 1991), are described in the specialist literature, and are useful with men with mild learning disabilities. In addition, motivation for treatment of the offender's sexual problems can be enhanced if there is a perception that the therapist can assist him in achieving goals unrelated to his offence behaviour (for example, by arranging for individual education sessions to improve literacy and numeracy skills).

Nevertheless, motivation remains problematic, particularly when the person has not been convicted by a court. In my clinical practice, and consistent with Gunn's (1976) suggestion for sex offenders of average intellectual ability, motivation has been facilitated most successfully in cases in which, on conviction, the offender has accepted a Probation Order with a condition of treatment (and sometimes also of residence, to prevent him leaving a given placement on his own).

5. Need to consider consent to treatment

The psychological treatment strategies outlined in Table I all require the co-operation of the offender and would be ineffective without his full understanding and consent. However, in addition to problems of acquiescence, the imbalance of power between people with learning disabilities and professional staff means that, even if the person appears to understand fully what is planned, it is good practice, prior to any attempt to decrease undesirable behaviour, to seek the views of an ethics committee (such as that described by Murphy *et al.* (1991) for a specialist in-patient service). The membership of such a committee should include people who are likely to represent a range of views (e.g. a solicitor, a citizen advocate and members of groups such as MENCAP and MIND representing disadvantaged persons).

Conclusions

The present paper has drawn attention to some of the issues involved in the assessment and treatment of male sex offenders with mild learning disabilities, using the framework of the cognitive–behavioural approach which dominates the specialist psychological literature. It has been argued that, if the special needs—arising from their impaired intellectual and social functioning, and the increased risk they face of additional difficulties—of the population are taken into account, there seems little inherent reason to believe that this approach will be inappropriate, at least for persons with verbal language.

At present, however, there is little empirical support for any type of intervention with male sex offenders with mild learning disabilities. Most of the studies describing interventions involve comprehensive packages of treatment, often based on assumed psychological need rather than careful analysis of the offenders' behaviour. It is a truism that the use of such packages leads to problems in identifying the components essential to success. Even when single treatments are used, the generalizability of the results to other people with learning disabilities may be difficult to assess because the population is so heterogeneous. This does not mean that evaluation cannot be carried out: at this very basic stage in our understanding, careful descriptions of single cases, based on clear relationships between assessment and treatment, would provide a useful basis for more refined experimental studies. Unless a serious research programme is undertaken, it is all too likely that recent initiatives aimed at providing assessment and treatment for sex offenders with mild learning disabilities, which are likely to prove expensive in both time and resources, will simply be discarded when criminological fashions change.

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References

AMERICAN PSYCHIATRIC ASSOCIATION (1987) *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn, revised (Washington, DC, American Psychiatric Association).

AYLLON, T. & AZRIN, N. (1968) *The Token Economy* (New York, Appleton Century Crofts).

BANCROFT, J. (1979) The nature of the patient–therapist relationship: its relevance to behaviour modification of offenders, *British Journal of Criminology*, 19, pp. 416–419.

BAROFF, G.S. (1991) Establishing mental retardation in capital cases: a potential matter of life and death, *Mental Retardation*, 29, pp. 343–349.

BECKETT, R. (1992) *A psychologist's contribution to the evaluation of community treatment programmes for sex offenders*, paper given at the Third European Conference of Law and Psychology, Oxford.

BENDER, M.P., AITMAN, J.B., BIGGS, S.J. & HAUG, U. (1983) Initial findings concerning a sexual knowledge questionnaire, *Mental Handicap*, 11, pp. 168–169.

BRITISH PSYCHOLOGICAL SOCIETY (1990) *Mental Impairment and Severe Mental Impairment: A Search for Definitions* (Leicester, British Psychological Society).

CAUTELA, J. (1967) Covert sensitisation, *Psychological Reports*, 20, pp. 459–468.

CHARMAN, T. & CLARE, I.C.H. (1992) Education about the laws and social rules relating to sexual behaviour, *Mental Handicap*, 20, pp. 74–80.

CLARE, I.C.H. & GUDJONSSON, G.H. (1991) Recall and understanding of the caution and rights in police detention among persons of average intellectual ability and persons with a mild mental handicap, in: M. MCMURRAN & C. MCDOUGALL (Eds) *Proceedings of the 1st DCLP Annual Conference*, 1, pp. 34–42 (Leicester, British Psychological Society).

CLARE, I.C.H. & GUDJONSSON, G.H. (1993) Interrogative suggestibility, confabulation, and acquiescence in people with mild learning disabilities (mental handicap): implications for reliability during police interrogation, *British Journal of Clinical Psychology*, 32 (in press).

CLARE, I.C.H. & MURPHY, G.H. (1993) MIETS: a service option for people with mild mental handicaps and challenging behaviour or psychiatric problems—3. Follow-up of the first six clients to be discharged: diverse measures of the effectiveness of the service, *Mental Handicap Research*, 6 (1), pp. 70–91.

CRAWFORD, D. (1981) Treatment approaches with pedophiles, in: M. COOK, & K. HOWELLS (Eds) *Adult Sexual Interest in Children*, pp. 181–217 (London, Academic Press).

DAY, K. (1988) A hospital-based treatment programme for male mentally handicapped offenders, *British Journal of Psychiatry*, 153, pp. 635–644.

DENT, H.R. (1986) An experimental study of the effectiveness of different techniques of questioning mentally handicapped witnesses, *British Journal of Clinical Psychology*, 25, pp. 13–17.

DEPARTMENT OF HEALTH (1989) *Needs and Responses: Services for Adults with Mental Handicap Who Are Mentally Ill, Who Have Behaviour Problems or Who Offend* (London, Department of Health).

DEPARTMENT OF HEALTH/HOME OFFICE (1992) *Review of Services For Mentally Disordered Offenders and Others Requiring Similar Services—Consultation Report of the Official Working Group on Services for People with Special Needs* (London, Department of Health/Home Office).

DODGE, K.A. & MURPHY, R.R. (1984) The assessment of social competence in adolescents, in: P. KAROLY & J.J. STEFFAN (Eds) *Adolescent Behavior Disorders: Foundations and Contemporary Concerns*, pp. 69–86 (Lexington, MA, Lexington Books).

ELLIS, D. (1986) *Sensory Impairments in Mentally Handicapped People* (London, Croom Helm).

FLYNN, M.C., WHELAN, E. & SPEAKE, B. (1985) Assessing and facilitating the moral awareness of mentally handicapped adults, *British Journal of Mental Subnormality*, XXXI (1), pp. 19–23.

FOXX, R.M., MCMORROW, M.J., STOREY, K. & ROGERS, B.M. (1984) Teaching social/sexual skills to mentally retarded adults, *American Journal of Mental Deficiency*, 89 (1), pp. 9–15.

FOXX, R.M, BITTLE, R.G., BECHTEL, D.R. & LIVESAY, J.R. (1986) Behavioral treatment of the sexually deviant behavior of mentally retarded individuals, in: N.R. ELLIS & N.W. BRAY (Eds) *International Review of Research in Mental Retardation*, 14, pp. 291–318 (Orlando, FL, Academic Press).

FRITH, U. (1989) *Autism: Explaining the Enigma* (Oxford, Blackwell).

GRANT, G. (1993) Support networks and transitions over two years among adults with a mental handicap, *Mental Handicap Research*, 6 (1), pp. 36–55.

GUDJONSSON, G.H. (1986) Sexual variations: assessment and treatment in clinical practice, *Sexual and Marital Therapy*, 1 (2), pp. 191–214.

GUDJONSSON, G.H. (1992) *The Psychology of Interrogations, Confessions and Testimony* (Chichester, John Wiley).

GUNN, J. (1976) Sexual offenders, *British Journal of Hospital Medicine*, 15, pp. 57–65.

HARRIS, P.L. (1989) *Children and Emotion* (Oxford, Blackwell).

HALL, J.N. & BAKER, R.D. (1986) Token economies and schizophrenia: a review , in: A. KERR & R.P. SNAITH (Eds) *Contemporary Issues in Schizophrenia*, pp. 410–419 (London, Gaskell).

HOBSON, R.P. (1986) The autistic child's appraisal of expressions of emotion, *Journal of Child Psychology and Psychiatry*, 27, pp. 321–342.

HOLLAND, A.J. & MURPHY, G.H. (1990) Behavioural and psychiatric disorders in adults with mild learning difficulties, *International Review of Psychiatry*, 2, pp. 117–136.

HOLLIN, C.R. & TROWER, P. (1986) Social skills training: critique and future development, in: C.R. HOLLIN & P. TROWER (Eds) *Handbook of Social Skills Training*, Vol. 2, pp. 237–258 (Oxford, Pergamon).

HOME OFFICE (1985) *Police and Criminal Evidence Act*, 1984 (London, HMSO).

HOME OFFICE (1990) *Circular No. 66/90* (London, Home Office).

JAHODA, A., MARKOVA, I. & CATTERMOLE, M. (1988) Stigma and the self-concept of people with a mild mental handicap, *Journal of Mental Deficiency Research*, 32, pp. 103–115.

KANFER, F.H. & GAELICK-BUYS, L. (1990) Self-management methods, in: F.H. KANFER & A.P. GOLDSTEIN (Eds) *Helping People Change: A Textbook of Methods*, 4th edn, pp. 305–360 (New York, Pergamon).

KEMPTON, W. (1988) *Life Horizons—Sex Education for Persons with Special Needs* (Santa Monica, CA, J. Stanfield).

KENDALL, P.C. & WILCOX, L.E. (1980) Cognitive behaviour therapy for impulsivity: concrete versus conceptual training in non-self controlled problem children, *Journal of Consulting and Clinical Psychology*, 48, pp. 80–91.

LINDSAY, W.R. (1986) Cognitive changes after social skills training with young mildly mentally handicapped adults, *Journal of Mental Deficiency Research*, 30, pp. 81–88.

LINDSAY, W.R., BELLSHAW, E., CULROSS, G., STAINES, G. & MICHIE, A. (1992) Increases in knowledge following a course of sex education for people with intellectual disabilities, *Journal of Intellectual Disability Research*, 36, pp. 531–539.

MALETZKY, B.M. (1974) 'Assisted' covert sensitisation in the treatment of exhibitionism, *Journal of Consulting and Clinical Psychology*, 42, pp. 34–40.

MALETZKY, B.M. (1980) Self-referred versus court-referred sexually deviant patients: success with assisted covert sensitization, *Behavior Therapy*, 11, pp. 306–314.

MALETZKY, B.M. (1991) *Treating the Sexual Offender* (Newbury Park, CA, Sage Publications).

MARSHALL, W.L. (1989) Intimacy, loneliness and sexual offenders, *Behaviour Research and Therapy*, 27 (5), pp. 491–503.

MATSON, J.L. & DILORENZO, T.M. (1986) Social skills training and mental handicap and organic impairment, in: HOLLIN & TROWER, op.cit., pp. 67–90.

MEICHENBAUM, D. & GOODMAN, J. (1971) Training impulsive children to talk to themselves: a means of developing self-control, *Journal of Abnormal Psychology*, 77, pp. 115–126.

MENCAP (Royal Society for Mentally Handicapped Adults and Children) (1992) *A survey of attitudes towards people with a mental handicap* (personal communication).

MURPHY, G.H. (1987) Direct observation as an assessment tool in functional analysis and treatment, in: J. HOGG & N.V. RAYNES (Eds) *Assessment in Mental Handicap: A Guide to Assessment Practices, Tests and Checklists*, pp. 190–238 (London, Croom Helm).

MURPHY, G.H. (1992) Community adjustment, social integration, work and social competence for people with intellectual disabilities or mental retardation, *Current Opinion in Psychiatry*, 5, pp. 831–835.

MURPHY, G.H. & CLARE, I.C.H. (1991) MIETS: a service option for people with mild mental handicaps and challenging behaviour or psychiatric problems—2. Assessment, treatment, and outcome for service users and service effectiveness, *Mental Handicap Research*, 4 (2), pp. 180–206.

MURPHY, W.D., COLEMAN, E.M. & HAYNES, M.R. (1983a) Treatment and evaluation issues with the mentally retarded sex offender, in: J.G. GREER & I.R. STUART (Eds) *The Sexual Aggressor—Current Perspectives on Treatment*, pp. 22–41 (New York, Van Nostrand Reinhold).

MURPHY, W.D., COLEMAN, E.M. & ABEL, G.G. (1983b) Human sexuality in the mentally retarded, in: J.L. MATSON & F. ANDRASIK (Eds) *Treatment Issues and Innovations in Mental Retardation*, pp. 581–643 (New York, Plenum)

MURPHY, W.D., HAYNES, M.R. & WORLEY, P.J. (1991) Assessment of adult sexual interest, in: C.R. HOLLIN & K. HOWELLS (Eds) *Clinical Approaches to Sex Offenders and Their Victims*, pp. 77–92 (Chichester, John Wiley).

MURPHY, G.H., HOLLAND, A., FOWLER, P. & REEP, J. (1991) MIETS: a service option for people with mild mental handicaps and challenging behaviour or psychiatric problems—1. Philosophy, service, and service users, *Mental Handicap Research*, 4 (1), pp. 41–67.

OWENS, R.G. & ASHCROFT, J.B. (1982) Functional analysis in applied psychology, *British Journal of Clinical Psychology*, 21, pp. 181–189.

PERKINS, D. (1991) Clinical work with sex offenders in secure settings, in: Hollin & Howells, op.cit., pp. 151–178.

RICHARDSON, S.A., KOLLER, H. KATZ, M. (1985) Relationship of upbringing to later behavior disturbance of mildly mentally retarded young people, *American Journal of Mental Deficiency*, 90 (1), pp. 1–8.

ROBERTSON, I., RICHARDSON, A.M. & YOUNGSON, S.C. (1984) Social skills training with mentally handicapped people: a review, *British Journal of Clinical Psychology*, 23, pp. 241–264.

SALTER, A.C. (1988) *Treating Child Sex Offenders and Victims* (Newbury Park, CA, Sage Publications).

SIGELMAN, C.K., BUDD, E.D., SPANHEL, C.L. & SCHOENROCK, C.J. (1981) When in doubt, say yes: acquiescence in interviews with mentally retarded persons, *Mental Retardation*, 19, pp. 53–58.

SIGELMAN, C.K., BUDD, E.C., WINER, J.L., SCHOENROCK, C.J. & MARTIN, W. (1982) Evaluating alternative techniques of questioning mentally retarded persons, *American Journal of Mental Deficiency*, 86 (5), pp. 511–518.

SPARROW, S.S., BALLA, D.A. & CICCHETTI, D.V. (1984) *Vineland Adaptive Behavior Scales* (Interview Edition—Survey Form) (Circle Pines, MN, American Guidance Association).

SWANSON, C.K. & GARWICK, G.B. (1990) Treatment for low-functioning sex offenders: group therapy and interagency co-ordination, *Mental Retardation*, 28, pp. 155–161.

TURK, V. & BROWN, H. (in press) The sexual abuse of adults with learning disabilities, *Mental Handicap Research*.

WEST, D.J. (1991) The effects of sex offences, in: HOLLIN & HOWELLS, op.cit., pp. 55–76.

WILLIAMS, J.M.G. & MOOREY, S. (1989) The wider application of cognitive therapy: the end of the beginning, in: J. SCOTT, J.M.G. WILLIAMS & A.T. BECK (Eds) *Cognitive Therapy in Clinical Practice*, pp. 227–250 (London, Routledge).

ZIGLER, E., BALLA, D. & HODAPP, H.R. (1984) On the definition and classification of mental retardation, *American Journal of Mental Deficiency*, 89, pp. 215–230.

ZUCKERMAN, M. (1971) Physiological measures of sexual arousal in the human, *Psychological Bulletin*, 75, pp. 297–329.

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