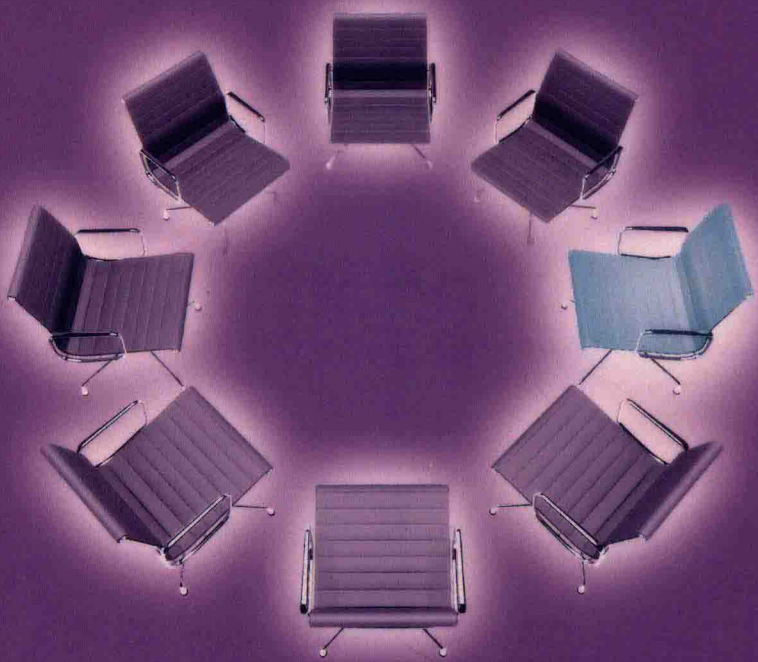
William R. Lindsay



The Treatment of Sex Offenders with Developmental Disabilities

A PRACTICE WORKBOOK

WILEY-BLACKWELL

The Treatment of Sex Offenders with Developmental Disabilities

A Practice Workbook

William R. Lindsay

WILEY-BLACKWELL

A John Wiley & Sons, Ltd, Publication

This edition first published 2009

Wiley-Blackwell is an imprint of John Wiley & Sons, formed by the merger of Wiley's global Scientific, Technical, and Medical business with Blackwell Publishing.

Registered Office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK
9600 Garsington Road, Oxford, OX4 2DQ, UK

350 Main Street, Malden, MA 02148-5020, USA

For details of our global editorial offices, for customer services, and for information about how to apply for permission to reuse the copyright material in this book please see our website at www.wiley.com/wiley-blackwell.

Library of Congress Cataloging-in-Publication Data

Lindsay, William R.
The treatment of sex offenders with developmental disabilities : a practice workbook / William Lindsay.
p. cm.
Includes bibliographical references and index.
ISBN 978-0-470-74160-3 – ISBN 978-0-470-06202-9
1. Offenders with mental disabilities. 2. Offenders with mental disabilities–Rehabilitation. 3. Sex offenders–Mental health serives. 4. People with mental disabilities and crime. 5. Criminal psychology. I. Title.
HV6133.L56 2009
365'.6672–dc22 2008052404

A catalogue record for this book is available from the British Library

Typeset in 10/13pt Galliard by Aptara Inc., New Delhi, India

1 2009

The Treatment of Sex Offenders with Developmental Disabilities

List of Figures

Participants gave their written consent for use of any material. All figures have been altered where required in order to change or remove any information that might enable identification of any participant.

Figure 7.1	Example of group rules	115
Figure 8.1	Two flipchart sheets from an exercise comparing prison and probation.	135
Figure 8.2	Example of group evaluation of each member.	139
Figure 8.3	Each group member placed on 'the ladder' allowing comparisons and discussion of progress.	140
Figure 10.1	The beginnings of a graded disclosure exercise.	154
Figure 10.2	Alfred's disclosure account.	159
Figure 10.3	Brian's disclosure account.	160
Figure 10.4	Commonalities drawn from disclosure accounts	162
Figure 11.1	'Good things' and 'bad things' drawn up by Fred	171
Figure 11.2	The avoidant/active pathway drawn up by Darren	173
Figure 12.1	Flipchart records from a session on dysfunctional associations between cognition, behaviour and physiology	183
Figure 13.1	Records from the problem solving scenario on responsibility for the offence	193
Figure 13.2	Flipchart record from the second exercise on responsibility for offences against women	197
Figure 13.3	Reviewing cognitive distortions of offenders against children	205
Figure 13.4	Flipchart record of the exercise on victim perspective and the disparity with offender's perspective	208
Figure 14.1	Reviewing types and consequences of child abuse	217
Figure 14.2	Flipchart records from an 'abused to abuser' session	219
Figure 15.1	Gary's offence cycle, about here	224
Figure 15.2	Albert's timeline used to understand the sequence of offending	228

Figure 15.3 Another piece of Albert's timeline to show the sequence of offending 229
Figure 18.1 Discussion on romantic and platonic relationships 260
Figure 18.2 Establishing relationships 262
Figure 19.1 Ian's timeline 270
Figure 19.2 Jason's timeline 272
Figure 19.3 Basic life map plan indicating sources of human goods leading to offending 273
Figure 19.4 Future projected pathways – an offence free, pro-social pathway and an offending pathway 275
Figure 19.5 Kenneth's future offence free and offending pathways 277
Figure 19.6 Ian's future offence free and offending pathways 278
Figure 19.7 An illustration of the use of the relapse prevention card 280
Figure 20.1 Personal and Sexual Dynamic Risk (PSDR) 285
Figure 20.2 An example of group ratings on 'the ladder' with staff ratings added to participant ratings 289

Foreword

The area of intellectually disabled sexual offenders is a particularly challenging one and up until relatively recently has been ignored by frontline researchers and program developers. Alongside innovators such as James Haaven in the United States, over the years Bill Lindsay has consistently argued for the need to develop specialized programs and assessment measures for intellectually disabled sex offenders. In this excellent book Professor Lindsay presents a comprehensive approach to the assessment and treatment of intellectually disabled sex offenders that is exhaustive in its approach and meticulous in its attention to research and theory. Professor Lindsay is an extremely able and incisive researcher whose suggestions for the treatment of sex offenders are thoroughly grounded in empirical data. Moreover, his rich experience as a clinical psychologist and therapist is evident in the book and he always makes sure he attends to the nuances and complexities of practical work with sex offenders. In fact, what sets this book apart from a number of recent texts on intellectually disabled sex offenders is that is written by a practicing scientist ***and*** therapist.

This is a large book containing twenty chapters and two appendices. Structurally the book is divided into three major sections, background theory and research, treatment considerations, and a treatment section where twelve chapters are devoted to a thorough description of how to treat clinical problems ranging from cognitive distortions to sexual fantasies. There are excellent chapters on the assessment section on risk assessment and the relevance of self-regulation offence pathways for intellectually disabled sex offenders. A valuable feature of the first section is that it provides a theoretical and research context for the subsequent more practical chapters and helps readers to understand the rationale and nature of the interventions outlined. For me the highlight of the theoretical section is the presentation of Professor Lindsay's own treatment model which is compromised of the skilful integration of several etiological and practice theories that emphasizes the importace of addressing sex offenders specific offence related problems and also facilitating their attachments and reentry to the community. It represents a supple framework for the assessment and treatment of intellectually disabled sex offenders and displays a fine sense of what is useful in current theory and relevant for this group of offenders. In the following two sections the

application of the treatment model to specific problems areas is well detailed and each chapter is full of useful practical suggestions and ideas. Therapists should come away from a close reading of the applied section with a clear idea of how to systematically assess and comprehensively treat intellectually disabled offenders. Researchers are also likely to have their appetites wetted by the numerous astute observations Professor Lindsay makes about offense related attitudes and factors.

I thoroughly recommend this book to specialists working with intellectually disabled sex offenders and those working with sex offenders of normal intellectual functioning. One of the great achievements of Professor Lindsay's book resides in its demonstration that it is possible to attend to and build strengths in offenders while also reducing risk for further sexual reoffending. In addition, an important thread running throughout the book is the thesis that if sex offenders are to successfully desist from further offending they need to re enter our community, regain their status as fellow citizens and have the opportunity to turn their lives around with the help of family, community members, and practitioners. A critical component of this process of redemption and reentry is the acquisition of the necessary personal and social resources to live better and less harmful lives. This book will be of immense help to those who are committed to such goals.

Professor Tony Ward
Victoria University of Wellington
New Zealand.

Preface

This book is the product of many years of working with men with intellectual disabilities who have perpetrated inappropriate sexual behaviour and sex offences. I began working with sex offender groups in 1987 and have continued with both intellectual disability and mainstream offenders. One of the exciting aspects of any clinical field is the possibility of combining research developments with clinical work and I hope that the reader will recognise the synthesis of both throughout the book. I have ha d the privilege to work closely with many talented colleagues; our clinical observations have informed our research and research has driven our clinical work.

In developing my work I have drawn on many influences including mainstream writing on sex offenders, the voluminous research on intellectual disabilities, extensive treatment reports and clinical trials in behavioural and cognitive therapy, psychometric assessment research and risk assessment research. The chapters reflect these various research and treatment strands with practical methods for proceeding with work in these various tasks. Like all practising clinicians, I have also assessed and treated hundreds of patients who have influenced all my approaches and methods.

One purpose in writing this book is to help professionals working with offenders with intellectual disabilities to feel they can develop competence in important areas of working with these clients. I have been very aware over the years that colleagues are keen to engage with clients but are unsure of how and where to start. There is always the frustration of reading about important clinical innovations and at the same time being unsure of their application in one's own clinical setting. I have tried to outline the theoretical and research developments with an emphasis on how they can be applied to sex offenders with intellectual disabilities.

In 2004 John Taylor, Peter Sturmey and myself edited a book for Wiley entitled "Offenders with Developmental Disabilities" and we observed that research and practice developments had been growing considerably. Since that time, the pace has quickened with many authorities and services now recognising the nature of the clinical and social problems to be addressed and turning to the increasing volume of research work for some guidance on assessment, treatment and organisation of services. The requirements are such that, now, developments will occur to address the service need

with or without sound writing and research to underpin their validity. It is my hope that publications such as this and those of others will indeed provide parameters for new practices.

I do not think that this book is a finished article on the topic of treatment for sex offenders with intellectual disability. I have no doubt that the next ten years will bring important, clinically effective innovations to the field. It is essential to conduct treatment with an understanding of its derivation and an open mind to validated, reliable changes emerging from the work of others. In this way treatment will not atrophy in a set of tired familiar techniques. I have witnessed treatment groups where the facilitator goes through the motions of presentation with no real understanding of the reasons for application or the specific requirements of the individuals in treatment. That is not to say that we should be swayed by every fad and fashion to arrive – there are and will be plenty of them. It is just to make a plea for continued awareness of clinical progress in the field.

One issue of terminology requires to be addressed in any book on intellectual disabilities. I have preferred "intellectual disability" and "developmental disability" as internationally recognised terms to refer to this client group. However until very recently the American Association of Intellectual and Developmental Disabilities has endorsed the term "mental retardation" and this is still widely recognised in North America. In Canada these is widespread use of "developmental disabilities " to refer to the client group. One has to be careful in interpreting this latter term since developmental disabilities can include disorders which, although highly prevalent in populations of individuals with intellectual disability, also include a number of people who function, intellectually, at a higher level. Here I am thinking of disorders on the Autistic spectrum. Closer to home, in the U.K. we have for some time used the term "learning difficulty" to describe the population. The reader should realise that all these references to the population are synonymous (apart from the exceptions mentioned in relation to developmental disability) and all relate to people who fulfil three diagnostic criteria. The person should have an intelligence quotient below 70 IQ points as measured by a reputable and well standardised assessment such as the Wechsler Adult intelligence scale – third edition. The IQ should take into account the standard errors of the test. The second criterion is that the individual should have significant deficits in adaptive behaviour, again as measured by a recognised standardised assessment. Different classification systems recommend slightly different criteria in adaptive behaviour but they all use it as a requirement of classification. The third criterion is that any such deficits should have a childhood onset, generally prior to age 18.

Over the years, i have noticed that professionals are apprehensive about working with sex offenders and even about accepting sex offenders into their services. This is understandable given the valence afforded to this group in the public consciousness. That is one reason why this type of treatment and service intervention should always be conducted within the auspices of a clinical team. To have one's colleagues to balance judgement and support intervention is immensely valuable. I would like to acknowledge the help of several people in the development of my work which has culminated in this book. So many colleagues have fashioned my thinking over the

years. I have also been fortunate to have strong work partners to help in what is clearly a contentious clinical area. Anne Smith, the consultant psychiatrist with whom I worked for two decades has been a constant support and latterly Fabian Haut, Steve Young and Fergus Douds have been influential. More recently Peter Oakes and Farooq Ahmad have challenged my thinking on service delivery. Many nursing staff have spent years of their professional lives helping to keep groups running constantly including Ronnie Allan, Steve Scott, Evelyn Kelly, Paul Winters, Lesley Murphy, Danny Murphy, Lorna Cox, John Whitelaw, Tom Morgan and others. I am in huge debt to Charlotte Quinn and Pamela Reid for their administrative support. I am also indebted to various staff at Wiley for their patience and perseverance, especially at a time when so many staff and editorial changes were afoot.

Bill Lindsay
November 2008.

About the Author

Bill Lindsay, PhD, is Consultant Clinical Psychologist, Lead Clinician in Scotland and Head of Research for Castlebeck Care, Darlington, U.K. He is also Chair of Learning Disabilities and Forensic Psychology at the University of Abertay, Dundee. He holds a visiting chair at Northumbria University, Newcastle. An author of over 200 scientific articles and book chapters his research interests include the fields of cognitive behavioural therapy for people with intellectual disabilities and forensic psychology. He is a fellow of both the British Psychological Society and the International Association for the Scientific Study of Intellectual Disabilities. Previously he was a consultant psychologist in the State Hospital, Scotland with responsibilities for intellectual disabilities and mainstream sex offender treatment. He was also head of Clinical Psychology Learning Disability services in Tayside, UK. He has been a member of various advisory groups to both the Scottish and U.K. governments and chaired the Scottish Forensic Network working group on forensic intellectual disability services. He is currently associate editor for the Journal of Applied Research in Intellectual Disabilities and the Journal of Intellectual and Developmental Disabilities while also on the editorial board for the British Journal of Clinical Psychology and Psychiatry, Psychology and Law.

Contents

List of Figures vii

Foreword ix

Preface xi

About the Author xv

Part One Background Research and Theory 1

Chapter 1 Introduction to Offenders, Sex Offenders and Abusers with Intellectual Disability 3

Chapter 2 Assessment of Offence-Related Issues 13

Chapter 3 Risk Assessmen 35

Chapter 4 Treatment of Inappropriate Sexual Behaviour 51

Chapter 5 Theories of Sexual Offending and Intellectual Disability 67

Chapter 6 A Theory for the Sex Offence Process and a Model for Treatment in Offenders with Intellectual Disabilities 93

Part Two Treatment Considerations 109

Chapter 7 Introduction to the Treatment Programme 111

Chapter 8 Promoting Motivation 131

Part Three Treatment Manual 145

Chapter 9 Induction, Setting the Rules, Explaining the Modules 147

Chapter 10 Offence Disclosure and Accounts 151

Chapter 11	Allocating Offenders to Pathways	165
Chapter 12	Cognitive Distortions and Attitudes	179
Chapter 13	Problem Solving Scenarios and Exercises Which Challenge Cognitive Distortions	187
Chapter 14	Personal Physical and Sexual Abuse	213
Chapter 15	The Cycle of Offending	221
Chapter 16	Victim Awareness and Empathy	235
Chapter 17	Use of Pornography and Dealing with Sexual Fantasy	245
Chapter 18	Attachments and Relationships	255
Chapter 19	Lifestyle Change and Preventing Relapse	267
Chapter 20	Evaluation of Progress	283
References		299
Appendix 1	Vignettes and Scenarios for Problem Solving Exercises	317
Appendix 2	Examples of Quiz Questions	333
Index		337

Part One
Background Research and Theory

Chapter 1

Introduction to Offenders, Sex Offenders and Abusers with Intellectual Disability

The relationship between intellectual disability and crime seems to have fascinated writers and researchers in the field for well over a century. Both Scheerenberger (1983) and Trent (1994) have described in detail the historical association between low intelligence and crime in the late nineteenth and early twentieth centuries. Up until that time, people with intellectual disability (ID) were generally considered a burden on, rather than a menace to, society. Scheerenberger (1983) writes that during the eighteenth and nineteenth centuries, living conditions were harsh for people with ID especially in urban areas with growing industrialisation. In rural areas, they tended to work long hours in poverty but in industrial settings they were unable to be in employment or be accepted into apprentice programmes. The impetus for change was undoubtedly Darwin's theory of evolution, which Galton (1883) employed to argue for the role of genetics in individual greatness in his book *Hereditary Genius*. Others, notably Goddard (1912), employed the same methods for ID to devastating effects.

In fact, these authors were part of a general movement which increasingly regarded ID as a menace. Scheerenberger (1983) notes, 'By the 1880s, mentally retarded persons were no longer viewed as unfortunates or innocents who, with proper training, could fill a positive role in the home and/or community. As a class they had become undesirable, frequently viewed as a great evil of humanity, the social parasite, criminal, prostitute, and pauper' (p. 116). In 1889, Kerlin (reviewed by Trent, 1994) argued that crime, rather than being the work of the devil, was the result of an individual's inability to understand moral sense and also their physical infirmity, both of which were non-remediable and inherited. Kerlin and others certainly linked ID with a range of social vices including drunkenness, delinquency, prostitution and crime, but Goddard (1910) moved these concepts on basing his arguments on Mendelian laws of hereditary. His first contribution was to reclassify ID using the term feeblemindedness to include all forms of ID. Those with the mental age of 2 years or less were termed 'idiots', with a mental age of 3–7 years 'imbeciles' and with a mental age of 8–12

The Treatment of Sex Offenders with Developmental Disabilities William Lindsay