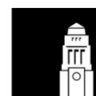
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A realist analysis of treatment programs for sex offenders with intellectual disabilities

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A realist analysis of treatment programs for sex offenders with intellectual disabilities

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Method: A realist evaluation of seven programs from the UK, Canada, USA, Switzerland and Germany was conducted. In semi-structured interviews program designers elucidated how they are intended to work. The data analysis was driven by the realist concern to expose program mechanisms and intended outcomes.

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Keywords

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Introduction

Drawing on the literature and interviews with those who designed them, this paper offers a realist analysis of sex offender treatment programs for people with intellectual disabilities. We articulate the mechanisms through which they are intended to work and the outcomes they are expected to achieve. This analysis is important for two reasons. First, although there is an extensive literature describing and evaluating program resources, less has been written about how participants are expected to respond to these and thus, how the programs are thought to work. Second, while there are several evaluations, these have largely used methodologies such as psychometric testing and recidivism figures, which obscure how and why the treatments work and have focused on a specific set of outcomes, measured in particular ways, as indicators of effectiveness. Our analysis reveals the complex and contingent pathway through which change is achieved and highlights the need to evaluate these programs using a wider range of outcome indicators to gain a more comprehensive picture of their impact.

The paper is structured as follows: First, we provide a summary of how realists understand complex social programs. Then we use a realist framework to structure a review of the literature on sex offender treatment programs for people with intellectual disabilities, in terms of the resources they offer to participants, the outcomes they are expected to achieve and current evidence for their effectiveness. We describe our methodological approach to sampling and interviewing participants to explore how and why these programs are intended to work. We then present our findings and finally discuss these.

A realist understanding of complex social programs

Realist evaluation (Pawson & Tilley, 1997) is a methodological strategy for evaluating complex social programs and has been widely used across a range of policy contexts, most notably health [author's

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own 1]. It is worth noting some key principles that underpin this approach. First, realists argue that programs in and of themselves do not effect change. Rather, programs offer resources to participants (i.e. the examples from Lindsay's (2009) manual listed in the next section) and it is how participants respond to these, in terms of changes in their reasoning and behaviour, (known as 'mechanisms') that brings about change. Mechanisms refer to 'deeper', usually non-observable processes:

> We can experience a training program and observe that participants use different language at the end of it than they did at the beginning, but we cannot 'see' the new content being stored in memory or the new connections being forged in the brain that enables them to do so. That is, the causal processes happen at a different level [...] than the observable outcomes (Westhorp, 2014, p. 5).

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Individual's responses to resources are shaped by the characteristics of the participants, the ways in which the program is designed and implemented and the wider sets of relationships and resources available (known as context). Therefore, realist evaluation seeks to articulate the mechanisms through which a program works to produce outcomes and understand how context shapes these mechanisms. This means that instead of asking 'does this program work?', realists examine 'for whom in what circumstances and why does this program work?'.

The first phase of realist approaches starts by surfacing the ideas and assumptions underlying how programs are intended to work, known as program theories, through a review of the literature and interviews with those who designed the programs ('architects'). These program theories can be articulated as hypotheses about the resources that programs offer, the contexts that might be important in shaping the ways in which program works, the mechanisms through which the program is anticipated to work and intended but also unintended outcomes. In the second phase of a realist study these theories are tested and refined against empirical evidence of the program in

action through the collection of empirical data to produce a deeper explanation of how, in what circumstances and why programs work. In this paper, we venture no further than the first phase and present an analysis of the program theories underlying treatment. These are expressed within a realist framework in terms of the resources offered, the mechanisms through which programs are intended to work and the outcomes they are expected to achieve, gleaned from a literature review and interviews with program architects. The paper does not seek to judge the 'validity' of these program theories, nor provide an assessment of the effectiveness of different programs. It also does not set out to inductively generate a theory of how these programs work as a grounded theorist would do; rather it aims to represent how program architects articulate the underlying logic through which these programs are intended to effect change.

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Treatment aims, resources and measures of effectiveness

The programs described herein are often termed adapted sex offender treatment programs. However, this runs risk of sounding as if something that is known to be successful in mainstream programs was 'dumbed down' for people with intellectual disabilities. Haaven and Coleman (2000) are clear that treatment must go beyond. None of the programs included in this study were merely 'adapted', even though two carried this term in their title. Instead, each one was carefully designed to be responsive, drawing on and often pioneering best practices for engaging people with intellectual disabilities. Due to the limited scope of this paper these issues cannot be further explained. However, examples of the ways in which treatment content is made accessible are included in other sources, such as Lindsay (2009) and [author's own 2].

The roots of modern treatment for sex offenders with intellectual disabilities can be traced to two seminal texts published around the same time. The first describes Oregon State Hospital's residential Social Skills Program, which began in 1983 (Haaven, Little, & Petre-Miller, 1990) and the second a community based approach at York Central Hospital in Ontario, Canada, which started in

1977 (Griffiths, Quinsey, & Hingsburger, 1989). These programs were underpinned by a theory of positive psychology. They encouraged individuals to grow and develop personally, so that they could strive towards a better, offence-free future (Haaven, 2006). Picking up on some of these themes Ward and Stewart (2003) later formulated the Good Lives Model (GLM), which focusses on

> the importance of constructing a balanced, prosocial personal identity in offenders. This is achieved through the utilization and development of internal capabilities such as skills, attitudes and beliefs and the promotion of external conditions such as supports for the offender and opportunities for development (Lindsay, Ward, Morgan, & Wilson, 2007, p. 39).

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The rational is that, 'according to the GLM, individuals commit criminal offences because they lack the opportunities and/or the capabilities to realize valued outcomes in socially acceptable ways' (Lindsay, Ward, et al., 2007, p. 48). In other words, it is assumed that 'assisting individuals to achieve goods via non-offending methods may function to eliminate or reduce the need for offending' (Ward & Maruna, 2007, p. 108). Thus, treatment goes beyond changing thinking patterns and risky behaviours. For instance, Oregon State Hospital's Social Skills Program (SSP) was described as focussing on

> creating a total change in how each client relates to himself and the world. The resident is placed in a position where his old ways of thinking and behaviour do not meet his basic survival needs [...]. Working through an "old me – new me" identification process, the resident learns how to establish his new identity (Haaven et al., 1990, p. 21).

This Old Me/ New Me model is still used in many programs around the world today, with 'old me' referring to characteristics and behaviours associated with the offending lifestyle and programs

encouraging participants to develop new characteristics and behaviours ('new me') of a non-offending life (Haaven & Coleman, 2000). The building of a new identity is thus intertwined with behaviour modification that focusses on a pro-social, non-offending lifestyle.

All the programs described in this paper offer cognitive behavioural therapy (CBT).

> In cognitive-behavioural groupwork with sex offenders, cognitive restructuring and behavioural modification techniques are employed in an attempt to replace, with appropriate pro-social modes of thinking and conduct, those cognitions (e.g. children are not harmed by sexual contact with adults), attitudes (e.g. some women deserve to be raped) and behaviours (e.g. abusive fantasies) thought to contribute to the maintenance of sexual abuse (Allam, Middleton, & Browne, 1997, p. 70).

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Programs offer resources that aim to facilitate such change. Those are itemised in treatment manuals. For instance, Lindsay's (2009) manual includes contents on offence disclosure, offence pathways, cognitive distortions and attitudes, personal physical and sexual abuse, victim awareness and empathy, use of pornography and relationships. An individual's progress with changing thinking patterns can be assessed through psychometric tools, such as the Questionnaire on Attitudes Consistent with Sexual Offending (Lindsay, Whitefield, & Carson, 2007) and the Victim Empathy Scale (Beckett & Fisher, 1994). Evaluations have returned positive results in these respects (Jones & Chaplin, 2018).

However, the systematic reviews by Jones and Chaplin (2018) and Marotta (2017) found inconsistent findings in respect to reductions in sexual reoffending longer-term, leading them to concluded that there is currently limited evidence of the 'effectiveness' of the programs. Schmucker and Lösel (2015, p. 623) concluded their meta-analysis of sex offender treatment by suggesting that research 'should ask more frequently what works with whom, in what contexts, under what

conditions, with regard to what outcomes, and also why'. Realist approaches are ideally suited to addressing this need.

It is worth pausing to consider the limitations to recidivism statistics. First, definitions of recidivism differ between settings, making comparisons difficult. Second, recidivism is influenced by social contexts. For instance, those who have been diverted from the penal system may remain in forensic accommodation after treatment, which reduces opportunities to offend in the community, but it may give rise to sexually inappropriate behaviours linked to environmental issues, such as lack of opportunities for appropriate sexual outlets (Griffiths, Hingsburger, Hoath, & Ioannou, 2013). Furthermore, even within community-based settings many sex offenders with intellectual disability continue to be subjected to high levels of supervision to manage risk post-treatment and this will result in better prevention or earlier detection of inappropriate behaviours. Thus, the environment impacts on the likelihood of a reoffence occurring and whether it is recorded. Mere statistical data does not capture this complexity.

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Methodology and methods

We examined how treatment recipients are expected to respond to the treatment resources and we sought to explore what sort of changes programs are expected to produce. To do this, we interviewed key informants who designed programs for sex offenders with intellectual disabilities to elicit the theories underlying them.

The sample

We wanted to achieve a geographical spread across the English and German speaking regions to explore practice variations between different linguistic groups. In addition, the aim was to include the leading programs in each country, as identified by the literature review. For each program

included the program architects were identified. Those are the therapist practitioners who play a key role within their organisation in the design, implementation, review and updating of their programs. The resulting sample of seven programs were based in Canada, Germany, Switzerland, the UK and the USA. At each program we spoke to one, two and in one case three program architects. An overview is presented in table 1. This is however not linked to the countries were programs occur, to ensure anonymity.

Table 1: Overview of participating programs

Prog.	Nr. of respondents	Out- or inpatient	Large institutional setting	Specialist ID service only	Group treatment	Individual treatment
1	2	In	Yes	Yes	Yes	No
2	2	In	Yes	No	Yes	No
3	2	Out	n/a	No	Yes	If required
4	3	Out	n/a	No	Yes	Yes
5	1	In	Yes	Yes	Yes	No
6	1	Out	n/a	Yes	Yes	No
7	2	In	No	Yes	Some	Yes

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As table 1 indicates, three programs were set within community based psychological outreach services, one was set within prisons and a further three run within forensic inpatient settings. Two of those were based within a large institution. The other one provides forensic accommodation in small group settings. Three programs were based in settings that also provide treatment for non-disabled populations. Six offered mainly group treatment. In one program this is accompanied by individual therapy for all participants and in another individual therapy is offered to those who have additional needs that cannot be met through group alone. The seventh program designs individual treatment

packages. Therapy is mostly delivered individually, although monthly group meetings have recently started.

All providers worked with males and three also worked with female sex offenders, who received individual therapy, as numbers were too low to make groups viable. In line with the risk, need and responsivity model (Andrews, Bonta, & Hoge, 1990) programs admitted individuals who had committed serious sexual offences and were classed as medium to high risk. In addition, they typically had intelligence quotient (IQ) scores between 80 and 60, thus programs treated those who have mild intellectual disabilities and borderline or below average intellectual functioning. (For brevity the term 'intellectual disabilities' is used throughout this paper.) Some individuals with dual diagnoses of IQ 80-60 and autism or/and personality disorder were also included where it was felt that they would benefit.

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The interviews

Interviews were semi-structured and adopted the 'teacher learner method' (Manzano, 2016; Pawson, 1996), designed to investigate participants' ideas about how the programs are intended to work (program theories). They began with a series of introductory questions about the interviewee's role, experiences and views about the program and moved on to a process of theory gleaning (accessing participants' assumptions about how the program was intended to work) and then on to theory refining, whereby fragments of the program theories identified during the literature review and previous interviews were put before participants and they were asked to comment, refine and expand on these ideas.

Table 2 presents some example questions to illustrate the approach used. Question 3 focusses on a specific treatment resource (victim empathy). This prompt was used to explore how participants thought that program recipients would respond. This question further explicates how the realist interviewer refrains from pretending incompetency, as is often recommended in guidance

on qualitative interviewing, as this is supposed to avoid data contamination (Kvale and Brinkmann, 2009 cited in Manzano, 2016:351). Instead, the realist interviewer creates a forum for the deliberation of propounded program theories. Interviews were thus theory-driven, meaning that 'the researcher's theory is the subject matter of the interview, and the subject is there to confirm and falsify and, above all, to refine that theory' (Pawson, 1996: 299). However, question 3 also demonstrates that, in order to avoid allegations of 'leading the interview', multiple and at times contradictory theories about the same aspect of the program are put to the same respondent (RAMSES II Project, 2017).

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Table 2: Sample questions[1]

	Question	**Rationale**
1	What are the overall aims of your program?	Introductory, to get them talking.
2	How do you know that the program has 'worked'? What are the markers of success?	Looking for intended outcomes
3	I have read contradictory evidence about victim empathy. My understanding is that [explain how it is supposed to work, but why some authors have argued it does not impact on treatment success]. Where do you stand with this debate and why?	Explore the use of a program resource and to what extent it feeds program mechanisms.
4	For what kind of person does the program work best? **a.** Give a positive case study example and **b.** A negative case study example from your practice and explain what makes them positive/ negative.	Exploring contexts

[1] This overview is inspired by (Manzano, 2016:353), who provides a detailed discussion of realist interviewing techniques.

Two interviews were conducted in groups with three and two team members from the same program respectively; the remaining eight were conducted individually. As the purpose was for respondents to share their professional insights on the contexts, mechanisms and outcomes of their programs, respondents in groups tended to add to each other's points, rather than contradict one another. Interviews with European participants took place face to face, those with respondents in Canada and the USA were conducted over the phone, as overseas visits were not feasible. Nonetheless, telephone interviews were of similar length and depth as those conducted face-to-face (approximately 60 to 90 mins) and the researcher was aware of and responsive to the specific ways in which these differed from face-to-face ones, for instance by allowing respondents more scope to clarify what was asked (Irvine, Drew, & Sainsbury, 2013). The first author led all interviews. They are bilingual and conducted interviews with German speaking participants in German. The interviews were recorded and fully transcribed.

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Data analysis

The analysis was driven by the realist concern to expose program mechanisms and outcomes. Our analytical strategy involved the process of retroduction, whereby the first author looked across participants' accounts to first identify the range of outcomes the programs sought to achieve and then 'looked backwards' through their narratives to identify HOW those outcomes were thought to be achieved. This involved identifying the connections informants made between the resources offered by the programs and how participants were expected to respond to these (mechanisms) and how, in turn, this led to intended outcomes. To do this the first author read and re-read the transcripts and coded interviews using realist concepts, for example, whether the text referred to outcomes, how mechanisms lead to outcomes, how resources trigger mechanisms, etc. The first author then thematically analysed these across programs to identify similarities and differences in

the resource-mechanism-outcome configurations within and between programs. Findings were discussed regularly between the first and second author, who asked further questions about the emerging configurations, prompting further interrogation of the transcripts by the first author. Following several iterations, we identified two outcomes and disentangled which resources were delivered by the programs to achieve them and how they effected change.

Ethical considerations and anonymity

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Ethical approval was granted by appropriate ethics boards within the UK and Switzerland. One consideration was that this is a narrow field of practice and care is taken to preserve the anonymity of respondents. Personal identifiers were removed, including references to interviewee's gender or the country where their program runs. Terms used in citations that give away the setting context, such as 'cell' or 'ward' have been overwritten, for instance by 'living unit'. Quotes are not linked to pseudonyms to ensure that, even where a reader has guessed who has made a particular comment, they are then not able to make links to that respondent's other comments.

Results

This section is structured around the two key outcomes that treatment seeks to achieve: increasing risk management capacities and cultivating pro-social identities. We work backwards to think about the resources that are provided to secure these outcomes and we explore how participants respond to these (mechanisms). The anonymity of respondents has the advantage that it is possible to look beyond specific programs and their contents, which could side-track into debates about the benefits of one treatment resource over another. These differ, whilst the underpinning mechanisms, as will be shown, are surprisingly similar.

Increasing risk management capacities

The key objective of sex offender treatment is the prevention of future victims. In other words, the aim is to change participant's thoughts and behaviours to encourage desistance. Yet, many respondents would agree that 'the term "treatment" is somewhat misleading, because it implies that people can be "cured"'. The consensus was that treatment may help individuals and their support networks to better understand risks and manage these, but it will not provide a 'cure', as risk management will be a life-long responsibility. This section summarises the key resources and mechanisms that are linked to this pivotal outcome.

One resource that appears early on across the programs is sex education. This has two interacting components: knowledge and implementation guidance. This distinction was made explicit in one of the group interviews:

Interviewer: No sex with children… You said before that this is something most men already know.

Respondent 1: Everyone knows that… What the men struggle with is putting it into practice.

Respondent 2: Or knowing that there will be consequences if you don't stick to it.

Note that this view that participants generally have good sexual knowledge prior to treatment was held by respondents in two of the programs. Respondents from the other five had encountered at least some individuals with considerable knowledge deficits, but the view that implementation guidance is needed was shared by all. This may take the shape of advising men on issues, such as age of consent and how to check a person's age, for instance by recognising clues in their appearance. A

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further respondent commented that some were not aware of the extent to which sex with children is considered a social taboo, in other words, how and why a sexual offence is looked upon differently compared to other crimes, such as shoplifting. The sex education component seeks to address such knowledge deficits. Hence, it is hoped the men will gain insight into boundaries of sexual behaviour.

Until recently a central resource used in all programs was the offence account. This tool enables participants to fully explain their thinking and reasoning, with the intention to lead to insights into their behaviour. Based on this account the therapist develops a clear understanding of a person's risk factors, which can help them with assigning offenders to pathways (Lindsay, Steptoe, & Beech, 2008) and with understanding their cognitive distortions, which is needed to dismantle these:

> We know what their lies and distortions in their head were about offending, so we can replace those with more appropriate cognitions. Loving children isn't having sex with them. Children like you because you talk to them and pay attention to them, not because you're likeable. Children sit on your knee because children like cuddles from adults. They don't want sex from adults.

The offence account was described as the most important resource used in treatment by eight of the 13 respondents. However, all agreed that it can sometimes trigger mechanisms and outcomes that were unintended. For instance, respondents commented that this work can instil shame (mechanism) and this can lead to the unintended outcome of 'an adversarial relationship between treatment facilitators and client'. The client may distrust the therapist and may 'not wish to reveal more'. A further respondent explains: 'Trying to change from a shame-based perspective is not effective. […] it's one thing to say: "I did bad things", it's another thing to say: "I'm a bad person"'.

Three respondents argued that the fact that some of the cognitive distortions that have hitherto acted to preserve a person's sense of self are being dismantled is emotionally difficult. One adds that 'some aspects of denial are protective and quite a natural thing for people to have'. They

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quote research that found that denial is not a significant indicator for predicting recidivism (e.g. Craissati, 2015). This adds to justify why two programs no longer work on dismantling cognitive distortions. This debate further highlights how responses to unanticipated outcomes lead to program modifications, a phenomenon that Pawson (2013) calls 'emergence'. The five programs that still run with this content put much thought into minimising negative consequences, for instance by reducing the 'confessional' aspect. One of the programs that phased out offence focussed work uses

> life maps as a vehicle to explore the presence or absence of the risk and success factors in their life. You can do that without having to talk about an offence. […] The men will identify things that were problematic in their lives. Let's say one of their problems was about struggling to build adult close relationships. […] You can often get [even those in full denial] to recognise: 'Actually, there were problems going on in my life'.

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This is intended to optimise the likelihood of triggering the intended mechanism of 'insight' but also reduces the risk of triggering the unintended mechanism of 'shame' – because it takes the 'blame' element out. A further addition is the discussion of 'near misses', so situations in which someone had the opportunity to offend but decided not to. By exploring such incidents the participants are encouraged to recognise their own strength and capabilities, which can also inform their understanding of how they may 'take control'. This is also intended to increase self-esteem.

Finally, the programs help participants to develop their (sexual) self-regulation skills. This is achieved through work on emotional self-management and on persistence. Programs focus on enabling participants to see the connections between their thoughts, feelings and actions. 'This group is very poor at looking at feelings. Their vocabulary is really poor. […] So, we spend some time teaching words to go with behaviours and sensations.' Participants emerge with the ability to recognise their feelings and the vocabulary to describe them. The assumption is that this is the first step towards finding more appropriate means of dealing with painful emotions, such as anger,

jealousy or rage, as well as with regulating sexual impulses, but this also requires persistence. One respondent explains how persistence may be problematized in treatment:

> Sometimes I have folks that are smokers and we try to see if we can have everybody not smoke for two days. There's a concept of: 'Here's what persistence is.' So, we see if the person has tenacity to hang in when the going gets tough.

This is a difficult skill to acquire. Programs do not rely solely on this and more formal ways of working are embedded. For instance, in one program the participants complete regular diary sheets to reflect on risks. In another they work on their 'protection & control plan', which guides the participants on how to 'take control' of their own thoughts, feelings and actions. The plan highlights a person's unique risk factors and provides prompts that can be followed to de-escalate these. The expectation is that participants become able to manage risks in their daily lives. The mechanisms discussed here, namely insight into boundaries of sexual behaviour and personal risks and (sexual) self-regulation skills can help with achieving this aim. In those programs that had established strong links with the individual's social care providers outside the treatment there was an understanding that this risk management need not be done by individuals alone. One program architect made this point explicit:

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> We are clear to people who are coming into the program, that they aren't to expect a miracle cure; that one of two things we hoped will happen: One is that the person learns the skills necessary to be able to move on in their life into environments with much less restriction, even living freely within the community. The other is if that isn't possible, then we will look at determining [over the course of treatment] exactly what support the person needs to live the least restricted life in the community.

Thus, if and when it becomes apparent that individuals will be unable to manage their risks independently, treatment can be used as an extended assessment period in which the therapeutic team work out exactly what external support is needed. This could be delivered in the context of 24/7 supervision or less intensive community support packages. Support staff would be trained on a person's risks and triggers, ready to direct them away from risky situations. For a man who struggles with paedophilia this may be to avoid urban areas at school drop-off and pick-up times or to avoid watching television programs with child actors in the main cast. If risky situations arise nonetheless, staff help to deescalate these and talk about what happened, using tools learned in treatment, such as diary sheets.

To conclude, individuals are initially encouraged to develop, practice and refine new risk management skills within the safe treatment environment. The real challenge arises when they are expected to transfer new skills to the real world. Two of the three community-based programs were therefore set up to achieve a consistent dialogue between therapists and their social support networks (context), which allowed for the program to build in 'learning by doing' opportunities outside treatment. Even the prison-based and secure forensic programs made similar arrangements within the available resources. The facilitating context was the possibility of a dialogue between therapists and wing or ward staff. Even in confined settings, learning opportunities may arise, such as someone being 'angry about not being able to buy something from the canteen or to get a particular [room] they want'. These issues can be problematized within treatment.

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Cultivating pro-social identities

As outlined earlier, considerations about quality of life are central to modern programs for sex offenders with intellectual disabilities. However, one architect asserts: 'Just using Good Lives by

itself makes for very happy, very dangerous individuals.' Program architects are thus clear that work in this area is only possible in conjunction with work around risk management:

> And then the Good Lives is really the part that helps that person say: 'I'm here in treatment, I maybe don't want to a hundred percent be here, but if I really want these other things that are important to me in my good life plan, I need to get working on this other stuff.'

Identity work is important on two grounds. First, many men with intellectual disabilities have been exposed to negative attitudes towards their impairment throughout their lives. Second, one program architect explains that in the past 'we focussed so much on peoples' offending behaviour, they all came to identify as offenders. […] Part of the job is building up peoples' sense of themselves and the strengths they have.' One means through which this can be achieved is to work on developing skills that give meaning:

> We want people to be proud of who they are, and of actual achievements. […] We have people who have been told their entire lives that they would never learn, they would never be free, and now they're living in their own apartment, they've got girlfriends, they've got boyfriends.

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A further program architect asserts that participants 'need to have successes and integrate those into their perception of what they are capable of'. Opportunities to take pride can arise outside and within the treatment context. For instance, the technique of considering 'near misses' discussed earlier helps individuals to appreciate their personal resources: 'actually I can manage myself because I have done it before'. A potential social role within the treatment context is that of a supportive peer. Program architects who ran groups in an open format described how they rely on

experienced members to help any new arrivals settle into the group. In one closed group setting a group of four brought together men who had previously limited social competencies:

> They were four total loners, very isolated. Never managed to bond within the intellectual disabilities world, nor the offender world. … Now [beyond the life of treatment] those four are a support group. They call each other if something comes up and stand by one another.

Nonetheless, achieving meaningful social roles is always more challenging within institutional settings, as one program architect explains: 'it's a projection of what life will be, with community based you can be focussing on what is happening that day.'

Work on quality of life can occur at any stage throughout treatment. In the opening phase participants can be encouraged to identify personal life goals; towards the end they make future plans. Moreover,

> we try and identify what good life needs the sex offending they committed was trying to meet. For some it may have been to have a girlfriend […]. For others, it might have been to have friends, because maybe they were involved in a group offence. […] We then identify socially appropriate ways that they could still meet those Good Life needs.

However, one program architect warns that 'goals can easily become an exercise in listing one's external wants' and that treatment must also emphasise the development of pro-social values.

The objective of encouraging individuals to care about others has traditionally been delivered through victim awareness and victim empathy work (Marshall, Hudson, Jones, & Fernandez, 1995). Victim awareness is thought to be a precondition to empathy. This focusses on enabling men 'to understand the harm they are likely to have caused to the victim' (Williams & Mann, 2010, p. 303). They are also invited to think of consequences for themselves and their

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families. Victim empathy goes deeper. It refers to 'a cognitive and emotional understanding by a sexual offender of the experience of the victim of his or her sexual offense, resulting in a compassionate and respectful emotional response to that person' (Mann & Barnett, 2013, p. 284). It is assumed that those who have acquired such a mind-set are less likely to repeat an offence, as their new ability to feel compassion would motivate them to refrain from harming others.

Research in recent years has shown that empathy work does not impact on recidivism figures (for example, compare to Mann & Barnett, 2013; Ralfs & Beail, 2012). In addition, program architects reported difficulties in engaging men with intellectual disabilities, especially those with a dual diagnosis that also includes autism. Therefore, only two of the seven programs retain this, whilst the remaining five have some limited content on victim awareness. However, one respondent argues that victim empathy has been misunderstood:

> I don't think we know properly what victim empathy is. The literature on empathy is a bit vague [...]. It could well end up that victim empathy is just a facet of cognitively distorted thinking. It could be in a way an outlier of prejudice and discrimination, so that certain groups don't warrant a fully human entitlement.

What this program architect seeks to achieve with victim empathy work is to dismantle such distorted thinking. This process generally starts off with reflecting on men's personal victimisation experiences, which may include own sexual abuse histories, childhood bullying and so forth. It takes a skilled clinician to 'help [participants] understand that how they felt in those situations is similar to how others feel'. It is worth noting that this strategy is used explicitly in only one program, with emergence giving rise to a phasing out of this content from the other seven programs. Aspects that are retained are the focus on 'teaching persons to care about others and incorporating caring as a value in the client's value system, so that it becomes a central aspect of their identity'.

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To conclude, work on quality of life provides, as one respondent puts it, a 'hook for change'. It gives the participant 'that confidence to think: Yes, I can do this!', as well as the motivation to stay engaged with risk management beyond the life of treatment. The fact that all this is underwritten by a change in the person's value base gives this new, good life extra hold.

Discussion and conclusion

This paper examined practice across seven international CBT based treatment programs for sex offenders with intellectual disabilities, which arose from similar routes. It was shown that emergence is resulting in changes to some of the treatment resources that had been linked to unintended mechanisms and outcomes. However, in spite of these changes there was little differences between the programs in terms of the intended mechanisms that are activated, and the outcomes strived for and these remained consistent over time.

As shown in figure 1, treatment seeks to change behaviours (outcome 1: increasing risk management capacities) and identities (outcome 2: developing a pro-social identity). There is an implementation chain here, in that achieving outcome 1 is the immediate objective. The second outcome relies on good progress made towards the first and needs to mature longer-term. Even though work on this begins within the treatment context, the formation of pro-social identities relies on participants envisioning or actively building their futures post-treatment.

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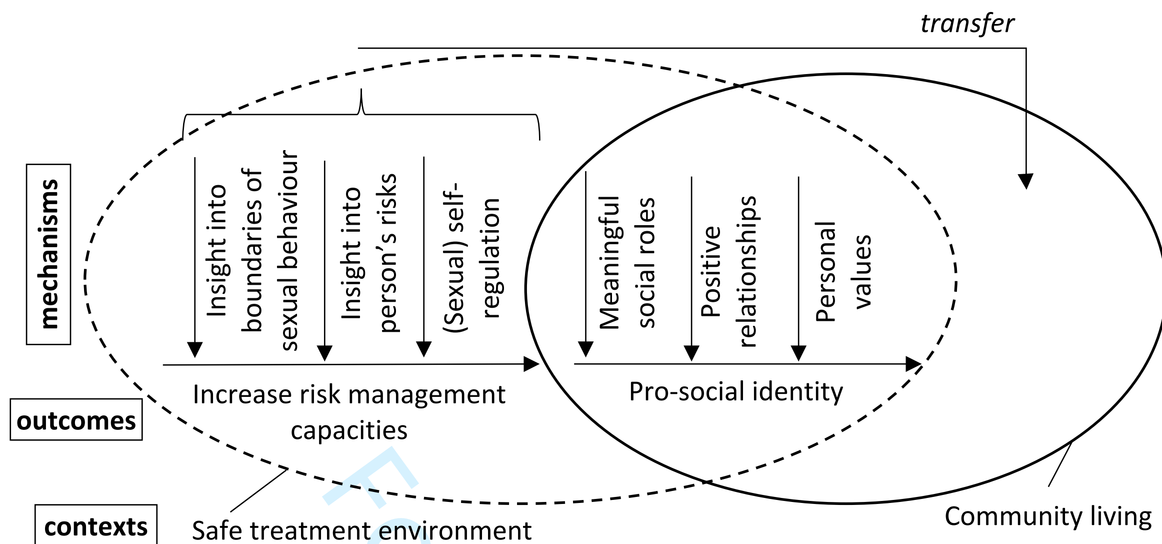
Figure 1: Mechanisms and intended outcomes of the treatment programs



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The aim of increasing risk management capacities is achieved through teaching participants about boundaries of sexual behaviour (resource) to enable them to develop insight into these boundaries (mechanism). A further mechanism is for the patient and his therapists to gain an in-depth understanding of the patient's risks. Mostly this is done through one resource, the offence account, but alternative tools, such as life maps, are also in use. Based on this understanding participants are encouraged to develop (sexual) self-regulation skills. Resources that were discussed focussed on enabling men to improve their ability to describe and recognise emotions, exercises in persistence and formally involving men in risk management planning.

For treatment to have lasting effects individuals must be able to transfer their newly acquired risk management capacities into the reality of community living during and/or post treatment. Risk management can be shared between the individual and his social support network (context). This network can also help with transitions from secure accommodation to community living. Some people with intellectual disabilities will always rely on support to manage their risks, but even with support they should be considered a success if risks have become manageable through treatment and they are now able to lead the least restrictive life possible post treatment.

The second intended outcome is cultivating a pro-social identity, which is required for successful community living. Pro-social personal values are encouraged through victim awareness and empathy work and the dismantling of cognitive distortions. Introducing pro-social ways of interpreting situations are also relevant. Two further mechanisms are taking on meaningful social roles and developing positive relationships. As figure 1 indicates, work on this happens within the treatment context, but always with an eye on a future of community living for those incarcerated during treatment. Community based programs may work on this in the here and now. There is also some limited scope to work on these areas in the treatment group through relationships within the group being used for positive modelling. Ideally, work on cultivating pro-social identities should be carried out in close collaboration with the individual's social support network, as they are in the best position to ensure that meaningful social roles and positive relationships outside the treatment context can flourish. Striving towards quality of life in these ways can act as a motivator for engaging with treatment, but also as a way of meeting needs by pro-social means.

To conclude, this realist evaluation explained how treatment programs for sex offenders with intellectual disability are intended to work. We highlighted that participants do not passively 'soak up' program content. Instead, change is achieved through complex interactions within the treatment group and beyond. Traditional outcome indicators, including psychometric tests and recidivism figures, are ill equipped to fully capture these processes. As realists we agree with Schmucker and Lösel (2015) that researchers should ask what works for whom, in what contexts, under what conditions and why and these questions guide the analysis in phase two of this research.

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