Developmental Disabilities and Sexual Offending Behaviour: An Information Package

by

Hayley Shields

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The information in this package is meant to be a reference tool for the agency staff members.
Abstract

This thesis aims to increase knowledge and awareness of developmental disabilities and sexual offending behavior amongst staff members in a group home. Material was gathered from various empirical resources and was synthesized into an information package. Four major sections are outlined in the information package. The first section focuses on developmental disabilities. The second section focuses on sexual paraphilias described in the DSM-V (American Psychological Association, 2013), as well as phallometric testing. The subsequent section presents several possible theories on why people with developmental disabilities engage in sexual offending behaviour. The final piece of the information package describes different treatment strategies, as well as the risk assessment and recidivism rates within this population. After the information package was developed, it was given to staff along with feedback forms to give proper feedback and to increase validity. Only two feedback forms were completed, so validity was extremely low. Recommendations for future research involve implementing pre- and post-test measures to demonstrate if there is a clear increase in staff knowledge and obtaining more staff feedback. Further research on the topic of developmental disabilities and sexual offending also needs to be done so that more information can be added to the overall product.
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Chapter I: Introduction

Throughout history, individuals with any sort of disability have been regarded negatively. Scheerenberger (1983) reports that in the 19th and 20th centuries, people who had disabilities were seen as individuals who possessed almost no sense of morality, had minimal control over their impulses and who, as a whole, were viewed as either being an evil to humanity, a social parasite, a prostitute, or a criminal (as cited in Lindsay, 2009). Thankfully, in the 21st century, individuals who have a disability are not viewed in such a negative manner.

With respect to antisocial behaviour, it remains unclear whether or not people with disabilities commit less crime, more crime, or the same level of crime, as those individuals without disabilities (Lindsay, 2009). It has only been in recent years that research has started focusing on individuals with developmental disabilities who engage in sexual offending behaviour (Craig & Hutchinson, 2005). Because the group home for whom this information package was prepared deals solely with developmentally delayed men who have sexually offended, this document provides some general information on developmental disabilities and paraphilias, with the main focus being on developmentally delayed sexual offenders.

The following information package summarizes information on the topic of developmental disabilities and sexual offending. Chapter One gives information on developmental disabilities, offering information on the level of support required, transition into adulthood, employment, social relationships, and mental health. Chapter Two contains definitions of different paraphilias and their characteristics. Chapter Three focuses on developmental disabilities and sexual offending and the different theories that have been suggested through research. The fourth chapter suggests treatment options, and information on risk assessment and recidivism rates for offenders with developmental disabilities.
Chapter II: Literature Review

Developmental Disabilities

The prevalence of developmental disabilities was reported to be 1 in 6 in the United States, and is currently on the rise (Boyle et al., 2011). The definition of a person with a developmental disability as stated by the Administration on Developmental Disabilities (ADD) is an individual who has a life-long mental and/or physical impairment that causes significant limitations in at least three of the following areas: independent living skills, personal finance skills, learning, language skills, self-care skills, or their mobility, which has manifested before the age of 22 (as cited in Odom, Horner, Snell, & Blacher, 2007). This definition encompasses various other disorders such as Autism Spectrum Disorder, Down syndrome, or cerebral palsy, and has thought to be an ‘umbrella term’ for other disabilities that share some of the same characteristics (Odom et al., 2007).

Services provided for these individuals are aimed at providing them with educational and social services that increase their independent living skills and help them live as independently as possible (Odom et al., 2007). In recent years, the American Association on Intellectual and Developmental Disabilities (AAIDD) has started classifying individuals as needing different levels of support, which helps identify the person’s specific support needs. These four levels of support are: intermittent (provided on an as needed basis), limited (time limited but given on a consistent time line), extensive (support is ongoing in certain environments), and pervasive (support is ongoing through all environments) (Odom et al., 2007). Certain systems use the level of support approach to determine what types of supports the individual needs, and to what extent they need it. These systems should attempt to incorporate all of the person’s individual, intellectual, developmental, physical, emotional, and behavioural needs (Odom et al., 2007).

For the present research project, individuals with developmental disabilities in their post-school and adult life were the primary focus. These individuals have been through the educational system and are now transitioning from high school into adulthood. A successful transition from youth to adulthood for the developmentally disabled population is not an easy process and requires careful planning and skill building over several years (Odom et al., 2007). For an individual to have a successful outcome, the resources for support have to link the person and his or her family to the agency which will be providing the service (Odom et al., 2007). Ferguson and Ferguson (2006) state that adulthood for an individual with a developmental disability consists of three aspects: autonomy or independence, membership to a community, a group, or organization, and to demonstrate personal growth (as cited in Bambara, Wilson, & Mackenzie, 2007). These skills should be of focus during the high school years. Additionally, Bambara et al. identified several practices that are to be predictors of success in adulthood. These practices include: vocational education, creating an individualized program based on the individual’s needs and interests, teaching
independent and self-determination skills, having opportunities that have an inclusive environment, actively involving the family in the transition process, and interagency collaboration (Bambara et al., 2007).

In terms of employment for the developmentally disabled, there has been much advancement. In the 1960’s, people with developmental disabilities were not seen as being capable of learning daily living skills or vocational tasks (Mank, 2007). Wehman et al. (2003) state that the number of people with developmental disabilities who are employed has risen from several thousand in 1984, to more than 150,000 just twenty years later (as cited in Mank, 2007). Thus, it is becoming more accepted that people with a developmental disability are able to be employed, but only less than 30% of those have jobs within the community (Mank, 2007). Those with jobs also have social benefits. In general, people who have a job are more apt to have a social network, which provides the individual with a sense of belonging, and that they are being an active participant in the community (Mank, 2007). As well as feeling a sense of belonging and involvement, being employed gives structure to a person’s day-to-day life (Mank, 2007). Individuals with disabilities often identify themselves as being lonely, but having a consistent schedule, friends, and a job, can aid in decreasing this feeling (Mank, 2007).

Two other aspects that are important factors for a good quality of life are having adult social relationships and stable mental health. Within the general population, positive social relationships have been recognized as being correlated with increased happiness (Chadsey, 2007). Fehr (1996) outlines four factors that can influence the formation of relationships between friends: environmental, individual, situational, and dyadic (as cited in Chadsey, 2007). Fehr states that environmental factors are factors that are related to the individual’s proximity to social situations, such as school, work, or even cyberspace, while individual factors are directly related to personal factors such as physical appearance, social skills, and similarity to the other person (as cited in Chadsey, 2007). Situational factors such as the frequency of contact, the amount of exposure, and the engagement in mutual activities with another person can directly influence a friendship as well (as cited in Chadsey, 2007). The last factor stated by Fehr is dyadic and includes the reciprocity and self-disclosure by the other person (as cited in Chadsey, 2007). All of these factors need to be taken into consideration in establishing a supportive home environment.

As well as creating and supporting the development of friendships, mental health needs to be assessed and treated. Although diagnosing is not a simple process, it is important to identify mental health issues (Chadsey, 2007). The most commonly diagnosed mental health problems that occur to a person who has a developmental disability are: schizophrenia, depression, bipolar disorder, anxiety disorders, personality disorders, and substance abuse disorders (Chadsey, 2007). To have successful integration into society, the individual needs to be able to have access to good quality mental health services (Chadsey, 2007).
Sexual Offending

Contrary to what the general population may believe, the rate of sexual offending is not on the rise (Serin et al., 2011). Moreover, the Uniform Crime Reporting (UCR) survey of Canada has not reported any rise in victimization over the past decade (Serin et al., 2011). Sexual assault defined by Statistics Canada (2008) is an act of “unwanted sexual activity, including sexual attacks and sexual touching.” The UCR survey reports on four levels of sexual assault outlined in the criminal code, which are differentiated by the level of injury caused to the victim. Although everyone can be a potential victim, women between the ages of 15-24 are most likely to be victimized (Justice Institute of British Columbia). Statistics Canada has also found that 1 in 4 girls and 1 in 8 boys have been victims of sexual abuse by the time they are 18 years of age.

Individuals who have committed a sexual offense may have a co-existing sexual disorder. It is important to have knowledge of these disorders because it serves as a direction for treatment and further supports that are needed (Paschos & Bouras, 2007). Outlining the different sexual paraphilias is important for the current thesis as the clients within the home have some of these disorders.

Paraphilic disorders as defined by the DSM-V (American Psychiatric Association, 2013) are behaviours, fantasies, or urges that elicit intense sexual arousal, which generally involve: objects that are non-human, the physical or psychological humiliation of one’s partner or oneself, or children or other non-consenting persons. These behaviours, fantasies, or urges are generally recurrent, and last at least six months (American Psychiatric Association, 2013). There are several types of paraphilias that have been identified by the DSM-V: pedophilic disorder, voyeuristic disorder, exhibitionist disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, fetishistic disorder, and transvestic disorder (American Psychiatric Association, 2013).

Pedophilia is derived from two Greek words, pedeiktos, meaning young children, and philia meaning love (Serin et al., 2010). Diagnostic criteria for pedophilic disorder as outlined in the DSM-V are sexual behaviours, fantasies, or urges towards children that are prepubescent or under the age of 13 (American Psychiatric Association, 2013). These fantasies or urges must cause personal distress or difficulty with interpersonal issues (American Psychiatric Association, 2013). The person in question must be at least 16 and 5 years older than the adolescent or child. These behaviours, fantasies, or urges are generally recurrent and last for a period of at least six months (American Psychiatric Association, 2013). The most effective way of diagnosing an individual with this disorder, and other sexual disorders, is through a phallometric assessment, which involves measuring the arousal level of a person’s genitals by showing sexually stimulating pictures or videos (American Psychiatric Association, 2013).
A voyeuristic disorder as outlined in the DSM-V involves sexual behaviours, fantasies, or urges that occur from seeing an unsuspecting and nonconsenting person who is naked, in the process of taking off their clothes, or engaging in sexual activities (American Psychiatric Association, 2013). This must occur for at least a period of six months, must be recurrent, and intense, and has to cause social or occupational distress in a clinically significant way (American Psychiatric Association, 2013). The individual who experiences these issues has to be at least 18 years of age (American Psychiatric Association, 2013). The highest prevalence that has been documented in a lifetime is approximately 4% in females, and 12% in males (American Psychiatric Association, 2013).

An exhibitionistic disorder as defined by the DSM-V are sexual behaviours, fantasies, or urges that occur from showing an unsuspecting and nonconsenting person their genitals (American Psychiatric Association, 2013). To receive the diagnosis, one must have acted on these urges (American Psychiatric Association, 2013). This must occur for a period of at least six months, be recurrent in nature, and must cause significant distress in their social, occupational, or other important areas of their life (American Psychiatric Association, 2013).

A frotteuristic disorder is defined in the DSM-V are sexual, fantasies, urges, or behaviours that occur from rubbing against or touching an unsuspecting or nonconsenting person (American Psychiatric Association, 2013). To receive a diagnosis, one has to have engaged in this behaviour (American Psychiatric Association, 2013). It must also cause distress in social, occupational, or daily functioning (American Psychiatric Association, 2013). Frotteuristic disorder has to occur for a period of at least six months and be recurrent and intense in nature (American Psychiatric Association, 2013). Frotteuristic acts has been said to occur in up to 30% of the adult male population (American Psychiatric Association, 2013).

The DSM-V defines sexual masochism disorder as having intense sexual fantasies, urges, or behaviours from the act of being tied up, beaten, humiliated, or caused bodily harm (American Psychiatric Association, 2013). It must cause social or occupational distress in their daily lives, and last up to a period of six months (American Psychiatric Association, 2013).

In contrast to sexual masochism, sexual sadism is defined in the DSM-V as having sexual fantasies, urges, or behaviours from inflicting physical or psychological harm on another person (American Psychiatric Association, 2013). The person receiving this diagnosis must have acted on these fantasies or urges (American Psychiatric Association, 2013). This disorder must have occurred for a period of at least six months,
and be impairing social, occupational, or daily life functioning (American Psychiatric Association, 2013).

A fetishistic disorder as defined in the DSM-V is sexual fantasies, urges, or behaviours that include using nonliving objects, or has a focus on body parts that are not genitals (American Psychiatric Association, 2013). These objects can include articles of clothing, or devices that are used for genital stimulation (American Psychiatric Association, 2013). This disorder must be recurrent in nature, last for a period of at least six months, and cause impairment in social, occupational or daily functioning distress (American Psychiatric Association, 2013).

A transvestic disorder defined in the DSM-V is having sexual fantasies, urges, or behaviours from cross-dressing (American Psychiatric Association, 2013). This behaviour must last for a period of at least six months, be recurrent and intense in nature, and cause social, occupational, or daily functioning distress (American Psychiatric Association, 2013). Transvestic disorders are usually accompanied by autogynephilia, the tendency to be sexually aroused from imagining yourself as the other sex (i.e., a male imagining himself as a woman) (American Psychiatric Association, 2013). This may include the person exhibiting behavioural tendencies that the other sex engages in such as putting make-up on or knitting (American Psychiatric Association, 2013). The prevalence of transvestic disorder is very low, occurring in less than 3% of the adult male population (American Psychiatric Association, 2013).

**Developmental Disabilities & Sexual Offending**

Thompson and Brown (1997) state that, of the developmentally disabled population, approximately 6% show signs of severe sexual aggression (as cited in Craig & Hutchinson, 2005). McBrien, Hodgetts, and Gregory (2002) also found a similar theme. They found that 41% of people with developmental disabilities engage in sex-related challenging behaviours and out of these people, 17% of the behaviours resulted in police contact and 4% were convicted (as cited in Craig & Hutchinson, 2005). Overall, the prevalence rate of sexual offenders who are diagnosed with a developmental disability is greatly debated and a few factors influence these prevalence rates such as the IQ range of the individual. Ashman and Duggan (2003) state that prevalence rates rely on data from some prison populations and it does not account for individuals that have been diverted away from the justice system (as cited in Lindsay, 2002).

Several different theories have been postulated to explain sexual offending in individuals with developmental disabilities (Hingsburger, Dalla Nora, & Tough, 2010). The book *The Key: A Community Approach to Assessment, Treatment, and Support for People with Intellectual Disabilities Who Sexually Offend* takes more of a disability services approach than a sexual offender approach. Their hypotheses are divided into categories: environmental and historical hypotheses, abuse hypotheses, medical and
psychiatric hypotheses, and deviance hypotheses (Hingsburger et al., 2010).

Some environmental concerns that may have caused an individual to abuse are the structure of the environment as well as the attitudes and the modeling of the caregivers. The structure of the environment includes the living situation and the rules that are in place. The environment needs to encourage and not punish healthy sexual behaviours. Individuals with disabilities have the same rights as every other citizen and instilling a ‘no sex’ policy would be violating their rights. Caregivers are important role models that are a part of the person’s environment and life and need to be aware that their attitudes, as well as their actions, are noticed and can play a part in the learning of a person with a disability. Negative attitudes towards sexuality in people with disabilities may cause the person to adopt fears or anxiety towards adult sexual relationships, making sexual relationships with children seem less threatening (Hingsburger et al., 2010).

Knowing the amount of sexual knowledge that people with disabilities have is important because they could have false information that is leading them to engage in inappropriate behaviour (Hingsburger et al., 2010). It is also important to gain information on their home environment; Day (1993) noted in his study some similar characteristics among offenders with disabilities, noting that their home environment was depicted as having marital disharmony, separated parents, violence, poor control, and neglect (as cited in Lindsay, 2002). These individuals are also likely to come from negative sex environments and have been told lies with regard to their sexuality (Hingsburger et al., 2010); for example, false information such as “women have teeth in their vagina and your penis will get bit off if you have sex with them.” It is important to be aware of such misinformation so these types of attitudes and beliefs can be challenged and replaced. Providing education about healthy sexuality is considered critical to helping avoid inappropriate behaviour.

Early childhood abuse is seen as a common theme in the disability population. Lindsay et al. (2001) compared 48 offenders with disabilities who had committed a sexual offence with 50 offenders with disabilities who had committed a non-sexual offence and found a much higher rate of childhood sexual abuse among the sex offenders (as cited in Lindsay, 2002). That being said, abuse does not excuse abusing (Hingsburger et al., 2010). In certain residential systems, sexual abuse occurs on a daily basis and, in some situations, the individual perceives it as almost a part of their lifestyle (Hingsburger et al., 2010). The people with disabilities in this setting may therefore believe that abuse is acceptable (Hingsburger et al., 2010).

Medical and psychiatric hypotheses look at medication or mental illness that may be causing individuals to act out in an inappropriate sexual nature. In assessing someone with a disability, medications need to be analyzed to ensure they are not having a direct impact on sexuality (Hingsburger et al., 2010).

The deviance hypothesis outlined by Hingsburger et al. is very well known. Counterfeit deviance attributes inappropriate sexual behaviour exhibited by individuals with disabilities to a lack of knowledge that their behaviour is inappropriate. Griffiths,
Quinsey, and Hingsburger (1989) support this hypothesis stating that because people with disabilities do not have access to normal learning experiences, are segregated, have many restrictions placed upon them, have limited privacy, and possess little knowledge about their sexual rights, they tend to engage in these behaviours (as cited in Lunsky et al., 2007). Lunsky et al. believe that the inappropriate behaviour has been learned as a result of their past life experiences, which goes hand in hand with some of the other hypotheses provided by Hingsburger et al. Although many within the disability field have acknowledged the counterfeit deviance hypothesis, it has been found that counterfeit deviance does not hold true with all offenders. Lunsky et al. tested the counterfeit deviance hypothesis with two groups of offenders and found that the group of individuals with an intellectual disability actually had more sexual knowledge than the other group of non-offenders (Lunsky et al., 2007), proving that with this cohort of offenders, the theory does not apply.

**Theory Classification System**

Keeling, Rose, and Beech (2009) outlined a three level system theory to explain sexual offending in this population. Level I theories suggest multiple different factors that may be relevant to offending, while Level II theories focus on single factors, and Level III theories are more specific by addressing cognitive, motivational, behavioural, or social factors that may present themselves within the offending or relapse chain.

Lindsay (2005) has done extensive research in the field of developmental disabilities and sexual offending and his research has contributed to the Level I theories of offending. Motivational factors proposed by Lindsay for offenders with disabilities include: inappropriate sexuality, psychological or developmental factors, and issues with personality (as cited in Keeling et al., 2009). Inappropriate sexuality according to Lindsay (2005) goes hand in hand with deviant sexual interests, which includes paraphilias (as cited in Keeling et al., 2009). Psychological or developmental factors refer to how a person develops socially and problems such as negative self-perception or stigmatization that may arise from these factors (as cited in Keeling et al., 2009). Personality issues identified by Lindsay (2005) as well as Hanson and Harris (2000) include antisocial personality traits and impulsivity (as cited in Keeling et al., 2009).

As previously stated, the Level II theories attempt to explain sexual offending within the developmental disabled population through single factors that may affect the maintenance of sexual offending (Keeling et al., 2009). Such single factors include cognitive distortions, victim empathy, deviant sexual interests, socio-affective functioning, poor attachment, and low intellectual functioning (Keeling et al., 2009). Cognitive distortions are thoughts that are often construed to make the offender justify his crime (Keeling et al., 2009). Socio-affective functioning has recently been a topic of research. Thorton (2002) states that socio-affective functioning is the way that an individual relates to another and the emotions that the individual has as a result of the interaction (as cited in Keeling et al., 2009). These factors can include self-esteem, relationships skills, loneliness, and intimacy (Keeling et al., 2009). Lindsay (2005) has also noted in his research that socio-affective functioning can play a vital role in the first offence, and the maintenance thereafter (as cited in Keeling et al., 2009).
Poor attachment has been hypothesized to play a role in the onset of a number of psychological problems. Marshall (1989) states that difficulty with early parental attachment can lead to trouble with adult relationships, and could be followed by emotional struggles such as poor self-confidence and loneliness (as cited in Keeling et al., 2009). Poor self-confidence and loneliness could then lead to fulfillment of these needs through sexual offending (Keeling et al., 2009). Low-intellectual functioning has been identified as a factor that could be a result of abusive parenting, which can lead to poor parental attachments, emotional struggles, and offending (Keeling et al., 2009).

Level III theories focus on the offending and relapse chain. Ward and Hudson (2000) have found that self-regulation is an issue that many offenders have that may increase the likelihood to reoffend (as cited in Keeling et al., 2009). Self-regulation motivates the individual to engage in goal achieving behaviour, which can direct the individual to either offend or reoffend (Keeling et al., 2009).

**Treatments, Risk Assessment, and Recidivism**

The purpose of assessment is to determine the nature and extent of the offender’s sexual offending problem, as well as their level of risk, treatment needs, and treatment recommendation (Coleman & Haaven, 2001). A complete assessment requires information from several sources including a general history, mental status examination, sexual history, psychometric testing, and possibly phallometric testing. The general history includes information on the individual’s education and employment, substance abuse or other addictions, history of suicide or suicidal ideation, other criminal behaviour engaged in, previous psychiatric hospitalizations, current medication and medical history, past victimizations, and knowledge of their past physical, emotional, or sexual abuse or neglect (Coleman & Haaven, 2001). A mental status examination takes into consideration a person’s mood, appearance, memory, affect, cognitive function, insight, judgment, and the content and quality of their thoughts. Most of the above information can be gathered from the individual, but usually third parties, such as family or previous staff members, also need to be interviewed to obtain an abundance of information and to determine the accuracy of the information. Additionally, psychometric testing can be employed to determine deficiencies in certain areas.

There are different treatment options, though the most common types of treatments are pharmacological, behavioural, cognitive, or an interplay of the three. Sometimes these treatments are used together to create a more comprehensive treatment approach. Craig and Hutchinson (2005) found that many treatments programs were adapted from other programs for individuals with learning disabilities, and tailored to sexual offenders who have disabilities. Green, Gray, and Wilner (2002) have found that sexual offenders who have a disability usually need specialized treatment interventions and are likely to be diverted away from the criminal justice system to disability services in a rural area (as cited in Lindsay, 2002).

Pharmacological treatment is not a new concept for sexual offenders (Lindsay, 2002). There are two common categories of pharmacological treatments: direct hormonal
intervention, and indirect hormonal intervention (Lindsay, 2002). Direct hormonal intervention targets the effects of sex hormones that maintain and create sexual urges within the different parts of the brain, while indirect hormonal intervention attempts to decrease the others conditions that are comorbid with the sexual problems, such as impulsivity, psychiatric disorders, or aggression, which may play a part in their sexual behaviour (Lindsay, 2002). Medroxyprogesterone Acetate (MPA) and Cyproterone Acetate (CPA) are the two most common hormonal treatments (Lindsay, 2002). Clarke (1989) used hormonal treatments in a study of male offenders who had intellectual disabilities and found an improvement in the sexual behaviours of half of the participants (as cited in Lindsay, 2002). Cooper (1995) noted in his studies, that hormonal interventions decrease the intensity of the individuals sex drive, but not reduce it totally, and if the medication is discontinued, might result in a quick relapse (as cited in Lindsay, 2002).

Plaud, Plaud, Colstoe, and Orvedal (2000) have found that behavioural treatments are the most common form of treatment for managing the inappropriate sexual behaviour of individuals with disabilities (as cited in Lindsay, 2009). A study by Griffiths, Quinsey, and Hingsburger (1989) used a behavioural management system to decrease inappropriate sexual behaviour (as cited in Lindsay, 2009). Their programme included educating their clients to address their sexual behaviour as being inappropriate, training them to be socially competent and to improve their personal relationships, teaching relapse prevention strategies that they could use on a daily basis, and going over responsibility issues (as cited in Lindsay, 2009). Griffiths et al. (1989) successfully reported that in over 30 case studies, there was no re-offending (Lindsay, 2002).

Currently, treatments have been employing the use of cognitive and problem solving techniques (Lindsay, 2009). Rose, Jenkins, O’Conner, Jones, and Felce (2002) conducted a 16-week group treatment with five men with disabilities who had previously abused (as cited in Lindsay, 2009). Their treatment included discussion about self-control, victim impact, identifying their personal emotions, sexual education, appropriately asserting themselves, and managing risk (as cited in Lindsay, 2009). Rose et al. (2002) measured their beliefs on the Questionnaire on Attitude Consistent with Sexual Offending (QACSO; Lindsay et al., 2005), and only reported a difference from baseline on the locus of control subscale (as cited in Lindsay, 2009).

In the book, *Handbook for Sexual Abuser Assessment and Treatment*, chapter eleven outlines the assessment and treatment of intellectually disabled sex offenders, specifically the components that need to be integrated into treatment when working with the intellectually disabled sex offender population. These components include teaching self-control skills, interpersonal skills, sexual education, cognitive restructuring, and relapse prevention. The authors recommend group treatment for teaching these skills to offer support and feedback from other group members. Role-playing situations such as an individual’s sexual abuse cycle can help the individual to practice self-control and coping skills. The role-play can also be adjusted to represent an aversive outcome so that the offender can see and feel what it would be like for this aversive situation to occur (Coleman & Haaven, 2001).
Teaching interpersonal skills can be taught through social skills training. Lundervold and Young (1992) state that social skills training is considered to be one of the better treatments for intellectually disabled and non-disabled sex offenders (as cited in Coleman & Haaven, 2001). Interpersonal skills, in particular, encompass a variety of skills including assertiveness, empathy, and perceptive skills, as well as, time, stress, and anger control management. Managing leisure time can be important for an individual to establish. Boredom has been recognized as a factor that may influence an individual to sexually offend, and engaging in these activities or hobbies can directly aid in relapse prevention. Perceptive and empathy skills often need to be taught because these skills are not skills that come naturally to offenders with intellectual disabilities. Sexual offenders with intellectual disabilities can frequently misperceive social cues in a way that can provide justification to their sexual offending (Coleman & Haaven, 2001).

Kempton (1993) has recognized an increase in sexual education resources for the intellectually disabled (as cited in Coleman & Haaven, 2001). Sexual education needs to include topics such as the male and female anatomy and their sexual functions, birth control methods, sexually transmitted infections, safe sex practices, sexual dysfunctions that can occur, heterosexuality, and homosexuality. The primary focus of the sexual education program should be their attitudes towards sexuality and their values, but also each topic should emphasize its relevance to sexual offending (Coleman & Haaven, 2001).

Cognitive restructuring is a way to help the individual think in a different way. Often offenders who have a disability think in a different way, not in a slower manner, than a non-disabled person (Coleman & Haaven, 2001). For example, an offender with an intellectual disability can use messages that normalize violence or sexism to justify his sexual offending behaviour, which is why cognitive restructuring is seen as a crucial part of treatment. An ‘old me’ and ‘new me’ approach can be used with offenders who have intellectual disabilities to simplify the cognitive restructuring skill. The ‘old me’ represents the self-talk or distorted thinking that lead the offender to sexually offend, while the ‘new me’ is who the offender is attempting to be. Role-play in front of a group can also be helpful in this situation to identify distorted thoughts and possible actions (Coleman & Haaven, 2001).

Laws (1989) and Pithers & Katka (1990) have stated that relapse prevention is regarded as one of the most vital parts of the treatment plan for the sexual offending population (as cited in Coleman & Haaven, 2001). A crisis card is a tool that can be used to help the individual in times where he comes in contact with an urge to sexually offend. The crisis card is shaped as a stop sign, and has triggers and coping mechanisms written on it for the individual’s reference. Another important part of the relapse prevention process is setting up a support network. An offender should have specific people in the community that are open to support when it is needed. The offender should explain his specific risk factors, offence cycle, and self-management/relapse prevention plans to his supports (friends, family members, peers) in order to garner the best support possible.
Other Considerations

The treatments need to be adapted for the individual with lower intellectual functioning for the treatment to be the most effective (Lindsay, 2009). Effective communication is a necessary requirement for any interpersonal communication, including therapeutic ones, so the therapist needs to use self-monitoring techniques to be aware of his or her language (Lindsay, 2009). Also, teaching an individual with a disability needs to be fun, dramatic, and even bizarre because it has been said that linking treatment with emotions will facilitate more effective and easy learning (Coleman & Haaven, 2001).

Serran, Fernandez, Marshall, and Mann (2003) have also articulated that it is important to create a therapeutic alliance by being warm, empathetic, flexible, and encouraging towards the client through their personal developments in therapy (as cited in Prentky et al., 2010). As previously mentioned, offenders can present with low self-esteem, therefore, as Serran et al. suggest, boosting self-esteem in treatment can increase the effectiveness, their participation, and their change throughout the treatment process (as cited in Prentky et al., 2010).

Risk Assessment

There have been many different risk measures created to assess risk within normally functioning individuals who have sexually offended, but few have been validated for sexual offenders with disabilities (Lofthouse et al., 2013). As with findings in the mainstream offending population, there is conflicting evidence as to which risk assessment tools are the most valid at predicting recidivism (Lofthouse et al., 2013). Craig and Hutchinson (2005) state that two risk scales that have been widely used with this population are the Rapid Risk Assessment for Sexual Offender Recidivism (RRASOR: Hanson, 1997) and the Static-99 (Hanson & Thornton, 2000).

Andrews and Bonta (2006) have suggested that there needs to be a focus on the dynamic risk factors, or factors that can change with the individual over time (as cited in Lofthouse et al., 2013). Lindsay (2004) completed a study and determined that dynamic risk factors have been shown to be better predictors of recidivism than static, or unchanging, factors (as cited in Lofthouse et al., 2013). The central eight dynamic risk factors that have been outlined by Andrews and Bonta (2006) are: a history of antisocial behaviour, an antisocial personality pattern, having antisocial thoughts or cognitions, possessing antisocial friends, problems within their family or friends, poor performance in school and/or work, low levels of performance or involvement in leisure or recreational activities, and substance abuse (as cited in Serin et al., 2011). These factors have been proven to be the most correlated with general crime, and are factors that are measured in many assessments (Serin et al., 2011).

Recently, Boer et al. (2004) have created one of the first assessment tools for intellectually disabled sexual offenders. The Assessment of Risk and Manageability for Individuals who Offend Sexually (ARMIDLO-S) is an assessment tool that focuses on stable factors (i.e., factors unlikely to change quickly) and acute factors (i.e., factors in the environment that are likely to change quickly), which refer to the person or their surrounding environment (as cited in Lofthouse et al., 2013). Although only one study...
has assessed the validity of the scale, it yielded higher results regarding sexual re-offending than actuarial assessments that were developed for non-disabled offenders (as cited in Lofthouse et al., 2013). Lofthouse et al. (2013) completed another study to assess the ARMIDILLO-S against the Static-99 and the Violence Risk Appraisal Guide Quinsey et al., 1998). The ARMIDILLO-S was shown to be more effective at predicting recidivism than both the other actuarial measures, making it the most favorable risk assessment for individuals who have an intellectual disability (Lofthouse et al., 2013).

**Recidivism**

Lindsay (2002) has stated that, since there are few published well-controlled studies, studies that report re-offending need to be closely examined. In a recent study by Lindsay et al. (2002), it was reported that only 4% of offenders with learning disabilities had re-offended within the first 12 months and 21% within 4 years (as cited in Craig & Hutchinson, 2005). On a different note, Lund (1990) found in his study of 93 patients who were in statutory care that 72% had reconvicted over a period of 10 years (as cited in Lindsay, 2002). Overall, in Lindsay’s (2002) review of the literature, there were recidivism rates ranging from 39-72%, with Griffiths et al.’s (1989) study reporting no reoffending in 30 subjects. Recidivism rates vary depending on whether the offender receives treatment or not, however considering that sexual re-offense overall has a low base rate, it is quite concerning that rates of 39-72% are reported, as even in cases where an offender is high risk, the rates are typically no higher than 40%. In relation to recidivism rates and length of treatment, Day (1993) found a positive correlation between a two-year stay in care, and a better outcome (as cited in Lindsay, 2002). Additionally, Walker and McCabe (1973) reported that a shorter stay in an institutional care environment was related to an increased likelihood of reconviction (as cited in Lindsay, 2002). Although research is still being done, there will most likely be errors in predicting risk (Lindsay & Beail, 2004).

**Gaps Within the Literature**

In looking at the research that has been done on developmentally delayed sex offenders, there is further work that needs to be done. In terms of the studies that have been conducted which examine treatment effects, many have reported a flaw in the collected participants whose IQ level may have influenced the outcomes of the study. There needs to be a set IQ bracket established within studies, or outliers need to be excluded. Another factor that needs to be considered when doing studies with these individuals is not to include the offenders that are still incarcerated or offenders who do not have direct access to the community. Klimecki et al. (1994) reported an overall re-offending rate of 30.8% within a two-year period, but suggested that this statistic could be compressed because of the inclusion of some offenders that are still in incarceration (as cited in Lindsay, 2002).

In assessing risk with individuals with developmental disabilities, it has been identified by Wilcox et al. (2009) that some static or dynamic factors may not be applicable, or difficult to score, on certain risk assessment scales (as cited in Lofthouse et al., 2013). Wilcox et al. give the example that some characteristics such as the absence of long-term relationships, are likely to be a factor for a person with a developmental
disability, which may inflate the score on the risk assessment scale, making them appear to be a higher risk than necessary (as cited in Lofthouse et al., 2013).

To demonstrate that a treatment is effective, there needs to be a group of individuals who receive the treatment, and a group that does not. In working with sex offenders, there is an ethical concern because having a no-treatment condition for a group of sex offenders would be dangerous for the general public (Lindsay, 2002).

The above literature review provides all of the necessary information that was included in the information package (Appendix A). All of the necessary research has been reviewed to complete all chapters of the information package including developmental disabilities and its prevalence rates, the different types of sexual offenses, developmental disabilities and sexual offending prevalence rates, as well as treatments, risk assessments, and recidivism rates for sexual offenders who have a developmental disability. Hopefully, this information package will serve as a useful reference tool for staff to obtain more knowledge about the population they work with. It may also be useful in directing their care towards a more empirical and evidence based approaches, such as recommending them to participate in behavioural treatment options and to conduct risk assessments before the residents enter the community on their own.
Chapter III: Method

The information package (Appendix A) was developed for staff employed in the group home for young adult males who have developmental disabilities. The individuals who reside at the group home are five males, ranging from ages 19 to 24. All residents have dual diagnoses such as: attachment disorder, oppositional defiant disorder, bipolar disorder, XYY syndrome, seasonal affective disorder, anti-social personality disorder, and fetal alcohol effects. Four out of the five males have issues with sexuality and have engaged in sexual offending behaviour.

There are 13 female staff members, and nine male staff members who are employed at the group home. Their ages range from 18 to 65 years old. All staff have a variety of educational backgrounds including Child and Youth Worker, Behavioural Science and Technology, Behavioural Psychology, Developmental Service Worker, Personal Support Worker, and Early Childhood Education. Although the educational backgrounds of staff members are relevant in working with individuals with disabilities, there is a gap in education on the offender population, including sexual offenders. Creating an information package providing information regarding developmental disabilities and sexual offending will further educate the staff members and may help with behavioural strategies and future programming.

The information package outlined several key components of the subject of developmental disabilities and sexual offending. The key concepts in the manual were the definition of developmental disabilities, prevalence rates of developmental disabilities, sexual offending and the different types of sexual offenses, paraphilias, and prevalence rates of sexual offending within the developmental disabled population, theories explaining sexual offending within this population, risk assessment strategies, best and most effective treatment practices, recidivism rates, and ways to reduce recidivism. Each of these concepts were divided into separate chapters and organized in a manner to best serve the readers.

Information was gathered using the St. Lawrence College and Queen’s University library databases. A variety of journals were used: The Journal of Psychiatry, Psychology, and Law; The Journal of Sexual Aggression; The International Journal of Offender Therapy and Comparative Criminology; The Journal of Applied Research in Intellectual Disabilities; The Journal of Intellectual & Developmental Disability; The Journal of Applied Research in Intellectual Disabilities; and The Journal of Intellectual Disability and Research. Books were also obtained from the St. Lawrence College library. The five books reviewed were: “The Child Molester: An Integrated Approach to Evaluation and Treatment” (Barnard, Fuller, Robbins, & Shaw, 1989), “Handbook of Developmental Disabilities” (Odom et al., 2007), “Handbook for Sexual Abuser Assessment and Treatment” (Carich & Mussack, 2000), “Psychology of Criminal Behaviour: A Canadian Perspective” (Serin et al., 2011), and “The Key: A Community Approach to Assessment, Treatment, and Support for People with Intellectual Disabilities who Sexually Offend” (Hingsburger et al., 2010). All of the information was separated and synthesized into the different subject material, and then separated into the relevant
Once the information package was completed, it was given to staff members to read at their leisure. No staff members were excluded from reading the package, and it was strictly voluntary. The reading of this package was done within the group home. Several copies of a brief questionnaire eliciting staff opinion and an informal comments section was attached to the back of the package for staff to provide their general thoughts on the applicability information value, and usefulness (Appendix B). These comments were not classified as data, but served as feedback for the author, and will be summarized in the results section.
Chapter IV: Results

Final Product

The information package (Appendix A) is the final product of this thesis. The information package on developmental disabilities and sexual offending includes four major sections. The first section includes material on developmental disabilities such as the definition of developmental disability, required levels of support, transitional concerns from high school to adulthood, employment, social support, and mental health. The second section contains DSM-V diagnoses of paraphilic disorders. The third part of the information package focuses on developmental disabilities and sexual offending, taking into consideration the theories of why people with developmental disabilities sexually offend. The final portion of the package includes treatment approaches, risk assessment, and recidivism rates. This information package was designed for the staff at the group home as a means to improve their knowledge.

Feedback Received

Although ten feedback forms were included with the information package, only two staff members completed them. These staff members had educational backgrounds in early childhood education and developmental service worker. They reported that their knowledge regarding the topic of developmental disabilities and sexual offending before reading the package was a fair amount, and extensive, respectively. One improvement that was noted by one staff member was to include footnotes within the information package for better reference. Unfortunately, the staff members who chose to provide feedback already had reasonably good knowledge about the areas described in the information package.

Changes to the Information Package

Based on the feedback provided by the two staff members, only minor changes were made to the information package. Of the minor changes, most were grammatical or punctuation errors. One staff member recommended the use of endnotes, but due to the format requirements of this project, none were added to the package.
Chapter V: Discussion

Summary of Thesis
The goal of preparing this thesis was to increase the agency staff’s knowledge of various issues relevant to sexual offending, with specific sections on sexual offending and developmental disabilities. Many staff members reported that they had limited knowledge in this domain and that an information package integrating various topics on sexual offending would be helpful. The information package on developmental disabilities and sexual offending behaviour was created for the staff to read at their leisure and for their reference. Information from various sources was synthesized to create the information package. It included sections such as: developmental disabilities, sexual paraphilias, theories of sexual offending, treatment, and risk and recidivism rates. All sections focused on individuals with developmental disabilities who were out of high school and advancing into adulthood, which was due to the client population within the group home. The chapters also focused on sexual offending behaviour within the developmentally disabled population, and did not include treatments, risk assessments, or recidivism rates from the normally functioning population.

For the first section of the package, developmental disabilities was the focus. This section included information from several chapters of a book, mainly focusing on individuals with developmental disabilities in the young adulthood stage of life. Different areas of concern such as level of support, transition, employment, mental health, and social relationships were described and areas of concern were addressed. The second section focused on sexual paraphilias that are outlined in the DSM-V (2013). This section was generally paraphrased from the DSM-V and gave definitions and diagnostic criteria for each paraphilia. The end of the chapter described the process of phallometric assessments. The third part of the information package focused on theories that have been postulated as to why individuals with developmental disabilities engage in sexually inappropriate or offending behavior. This section takes a disability services approach to the sexual offending problem, and does not focus on typically functioning sexual offending pathways. The final section, which focuses on treatment, risk assessment, and recidivism, has combined information from various journal articles that have employed different treatment techniques and assessment tools.

Upon completion of the manual, a feedback form was filled out by two staff members at the group home to ensure that the information was practical. Only minor changes were made from the feedback provided.

Strengths
The major strength of this project is the empirical literature that is the foundation for the information package. An extensive literature review was completed using several Internet databases, as well as textbooks, and reference books on the specific topics covered. This material was then simplified and put into chapters to best serve the staff members. Another strength is the feedback that was gathered from several staff members and then incorporated into the package. Gathering this feedback made it more valid and useful for the staff members.
Limitations and Challenges

While the information package has strengths, there are several shortcomings. Since the scope of research for this population is limited, there was limited information that focused specifically on sexual offenders who have a developmental or intellectual disability. Thus, there can be an improvement to the information package in the future once there is more research conducted on this population.

Another limitation was the number of staff members that filled out the feedback form. Since there were only two out of the twenty-two staff members that completed the form, it is difficult to determine if the information package was useful or practical for all the staff members. As well, the two staff who provided feedback reported fair to high levels of knowledge prior to reviewing the manual. If more staff provided feedback, it would increase the social validity of the information package and may better serve the agency.

An additional limitation to this information package was the inability to determine if there was an increase in staff knowledge after reading it. Due to time constraints and the agency’s ethics board, it was not feasible to administer pre- and post- tests. Instead, only informal feedback was collected, which does not prove statistically that there was any change in the knowledge of the staff members.

Multilevel Challenges to Service Implementation

Client Level. Young adult males with developmental disabilities often have multiple diagnoses, and in this case live in a group environment. Living in a group home with multiple males who have dual diagnoses is an everyday challenge, especially with so many contrasting personalities and issues. Also, living in a group home can inhibit development of some critical life skills, such as cooking and doing laundry, which are things that staff do for them that are inhibiting them from learning the skills themselves. Although these tasks are a part of the staff’s job, it is inhibiting the development of autonomy that the males will likely need when they move out of the home and on their own.

Program Level. Unfortunately due to practical considerations, it was not possible to complete a counseling or behavioural program in the group home. In discussion with staff, it was noted that a previous student had difficulties getting consent and that her project was late and had to be changed. To avoid delays and difficulties an information package was developed instead of a program. In general, doing a behavioural modification or counselling program would have been more beneficial professionally and as a student conducting their thesis. In hindsight, a good option for a thesis topic within this agency would be to do a workshop or thesis on staff burnout, as many of the individuals within the group home have expressed frustration with the clients at the home and the difficult environment they work in.

Agency Level. Within the agency, there is one male in particular that presents as very defiant, has violent outbursts, anger issues, as well as is a high risk sexual offender within
the community. This individual is a challenge to work with every day, and many staff believe that he will never change his behaviour. Few staff have hope for him, and most staff try to avoid him on a daily basis. This is not good practice and does not create a supportive environment, which is the purpose of the group home. Another consideration within the agency level is the limitations that are put on the clients within the agency, such as not having access to their family or friends as much as they would like. Of course, these limitations that the agency puts on the clients are reasonable at most times, but again, it is limiting the client’s ability to further develop relationships with peers, an important factor for a good quality of life.

**Societal Level.** When one of the clients at the group home plans to go on an outing in the community, there are some precautions that need to be taken and one of these is that the individual needs to be closely accompanied. Being accompanied by staff within the community can make the public easily identify them as being individuals with disabilities and it inhibits the individual to develop a sense of autonomy. As well as inhibiting a sense of autonomy, making the disability evident can create stigma. This stigma can result in negative interactions within the community.

**Implications for the Behavioural Psychology Field**
Although there is minimal research conducted on this specific population, synthesizing the information on this topic is important because the Behavioural Psychology field emphasizes the importance of empirically validated interventions and information backed by literature. By creating an information package on developmental disabilities and sexual offending behaviour, two different fields of study are combined to provide the reader with the research done thus far, and future research that needs to be completed.

**Recommendations for Future Research**
It is recommended that this information package include a pre- and post-test measure to determine if there is a change in the reader’s knowledge from reading the information package. There also needs to be more feedback provided by the readers so that improvements can be made, and that social validity can be increased. As previously stated, there is a need for more research to be conducted in the field of developmental disabilities and sexual offending.
References


Lindsay, W.R. (2002). Research and literature on sex offenders with intellectual and


Hersen (Eds.), *Handbook of clinical psychology competencies*. Springer Science & Business Media.

Developmental Disabilities and Sexual Offending: An Information Package

Created for: [Redacted]
By: Hayley Shields 4th Year Behavioural Psychology Student
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Throughout history, individuals with any type of disability have been regarded negatively. Scheerenberger (1983) reports that in the 19th and 20th centuries, people who had disabilities were seen as individuals who possessed almost no sense of morality, had minimal control over their impulses and were viewed as either being an evil to humanity, a social parasite, a prostitute, or a criminal (as cited in Lindsay, 2009). Thankfully, in the 21st century, individuals who have a disability are not viewed in such a negative manner.

With respect to antisocial behaviour, it remains unclear whether or not people with disabilities commit less crime, more crime, or the same level of crime, as those individuals without disabilities (Lindsay, 2009). It has only been in recent years that research has started focusing on individuals with developmental disabilities who engage in sexual offending behaviour (Craig & Hutchinson, 2005). Because the group home for whom this information package was prepared deals solely with developmentally delayed men who have sexually offended, this document provides some general information on developmental disabilities, paraphilias, with the main focus being on developmentally delayed sexual offenders.

The following information package summarizes information on the topic of developmental disabilities and sexual offending. Chapter one gives information on developmental disabilities, offering development of services, transition into adulthood, employment, social relationships, and mental health. Chapter two contains definitions of different paraphilias and their characteristics. Chapter three focuses on developmental disabilities and sexual offending and the different theories that have been suggested through research. The fourth chapter suggests treatment options, and information on risk assessment and recidivism rates for offenders with developmental disabilities.
What is a Developmental Disability?

The definition of a developmental disability as stated in the Administration on Developmental Disabilities (ADD) is a life-long mental and/or physical impairment that causes significant limitations in at least three of the following areas:

- Independent living skills,
- Personal finance skills,
- Their ability to learn,
- Language skills,
- Self-care skills,
- Mobility,

which has manifested before the age of 22 (as cited in Odom, Horner, Snell, & Blacher, 2007).

This definition encompasses various other disorders such as Autism Spectrum disorder, Down’s syndrome, or cerebral palsy, and has thought to be an ‘umbrella term’ for other disabilities that share some of the same characteristics (Odom et al., 2007). The prevalence of developmental disabilities was reported to be 1 in 6 in the United States, and is currently on the rise (Boyle et al., 2011).

Levels of Support
Services provided for these individuals are aimed at providing educational and social services that would increase their independent living skills, helping them live as independently as possible (Odom et al., 2007). In recent years, the American Association on Intellectual and Developmental Disabilities (AAIDD) has started classifying individuals as needing different levels of support, which helps identify the person’s specific support needs. These four levels of support are: intermittent - or given on a needed basis, limited - time limited but given on a consistent time line, extensive - support is ongoing in certain environments, and pervasive - support is ongoing through all environments (Odom et al., 2007). Certain systems use the level of support approach to determine what types of supports the individual needs, and to what extent they need it. These systems should try and incorporate all of the person’s individual, intellectual, developmental, physical, emotional, and behavioural needs (Odom et al., 2007).

Transition

For the present information package, individuals with developmental disabilities in their post-school and adult life are the main focus, as these are the individuals typically involved in the agency for which the information package was developed. These individuals have been through the educational system and are now transitioning from high school into adulthood. A successful transition from youth to adulthood for the developmentally disabled population is not an easy process and requires careful planning and skill building over several years (Odom et al., 2007). For an individual to have a successful outcome, the resources for support has to link the person and their family to the agency which will be providing them service (Odom et al., 2007). Ferguson and Ferguson (2006) state that adulthood for an individual with a developmental disability consists of three aspects: autonomy or independence, membership to a community, a group, or organization, and to demonstrate personal growth (as cited in Bambara, Wilson, & Mackenzie, 2007). These skills should be of focus during the high school years. Additionally, Bambara et al. identified several practices that have shown to be predictors of success in adulthood. These practices include: vocational education, creating an individualized program based on the individual’s needs and interests, teaching independent and self-determination.
skills, having opportunities that have an inclusive environment, actively involving the family in the transition process, and having interagency collaboration.

**Employment**

In terms of employment for the developmentally disabled, there have been many advancements. In the 1960’s, people with developmental disabilities had very few expectations, and were not seen as being capable to learn daily living skills or vocational tasks (Mank, 2007). Wehman et al. (2003) state that the amount of people with developmental disabilities who are employed has risen from several thousand in 1984, to more than 150,000 just twenty years later (as cited in Mank, 2007). Thus, it is becoming more accepted that people with a developmental disability are able to be employed, but only less than 30% of those have jobs within the community (Mank, 2007). Those with jobs also have social benefits. In general, people who have a job are more apt to have a social network, which makes the individual feel a sense of belonging, and that they are being an active participant in the community (Mank, 2007). As well as feeling a sense of belonging and involvement, being employed gives structure to a person’s day-to-day life (Mank, 2007). Individuals with disabilities often identify themselves as being lonely, but having a consistent schedule, friends, and a job, can aid in decreasing this feeling (Mank, 2007).
Social Relationships

Two other aspects that are important factors for a good quality of life are having adult social relationships and stable mental health. Within the general population, positive social relationships are recognized as being correlated with increased happiness (Chadsey, 2007). Fehr (1996) outlines four factors that can influence the formation of relationships between friends: environmental, individual, situational, and dyadic. Fehr states that environmental factors such as the proximity to social situations, such as school, work, or even cyberspace, while individual factors are directly related to personal factors such as physical appearance, social skills, and similarity to the other person. Situational factors such as the frequency of contact, the amount of exposure, and the engagement in mutual activities with another person can directly influence a friendship as well. The last factor stated by Fehr is dyadic and includes the reciprocity and self-disclosure by the other person (as cited in Chadsey, 2007). All of these factors need to be taken into consideration when supporting individuals in a supportive home environment.

Mental Health

As well as creating and supporting the development of friendships, mental health needs to be assessed and treated. Although diagnosing is not a simple process, it is important to identify mental health issues (Chadsey, 2007). The most commonly diagnosed mental health problems found in a person who has a developmental disability are: schizophrenia, depression, bipolar disorder, anxiety disorders, personality disorders, and substance abuse disorders. To have a successful integration into society, the individual needs to be able to have access to a variety of different mental health supports, as well as good quality ones (Chadsey, 2007).

REFERENCES & FURTHER READING

Contrary to what the general population may believe, sexual offending is not an offense that is on the rise (Serin et al., 2011). Moreover, the Uniform Crime Reporting (UCR) survey of Canada has not reported any rise in victimization over the past decade (Serin et al., 2011). Sexual assault as defined by Statistics Canada (2008) is an act of “unwanted sexual activity, including sexual attacks and sexual touching.” The UCR survey reports on four levels of sexual assault outlined in the criminal code, which are differentiated by the level of injury caused to the victim. Although everyone can be a potential victim, women between the ages of 15-24 are most likely to be victimized (Justice Institute of British Columbia). Statistics Canada has also found that 1 in 4 girls and 1 in 8 boys have been victims of sexual abuse by the time they are 18 years of age. Individuals who have committed a sexual offense may have a co-existing sexual disorder. It is important to have knowledge of these disorders because it serves as a direction for treatment and further supports (Paschos & Bouras, 2007).

Paraphilic disorders defined by the DSM-V (American Psychiatric Association, 2013) are behaviours, fantasies, or urges that elicit intense sexual arousal, which generally involve: objects that are non-human, the physical or psychological humiliation of one’s partner or oneself, or children or other non-consenting persons. These behaviours, fantasies, or urges are generally recurrent, and last at least 6 months in length (American Psychiatric Association, 2013). There are several types of paraphilias that have been identified by the DSM-V: pedophilic disorder, voyeuristic disorder, exhibitionist disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism


disorder, fetishistic disorder, and transvestic disorder (American Psychiatric Association, 2013).

**Pedophilic Disorder**

Pedophilia is derived from two Greek words, pedeiktos, meaning young children, and philia meaning love (Serin et al., 2010). Diagnostic criteria for pedophilic disorder as outlined in the DSM-V are sexual behaviours, fantasies, or urges towards children that are prepubescent or under the age of 13 (American Psychiatric Association, 2013). These fantasies or urges must cause personal distress or difficulty with interpersonal issues (American Psychiatric Association, 2013). The person in question must be at least 16 and 5 years older than the adolescent or child. These behaviours, fantasies, or urges are generally recurrent and last for a period of at least 6 months (American Psychiatric Association, 2013). The most effective way of diagnosing an individual with this disorder, and other sexual disorders, is through a phallometric assessment, which involves measuring the arousal level of a person’s genitals by showing sexually stimulating pictures or videos (American Psychiatric Association, 2013).

**Voyeuristic Disorder**

A voyeuristic disorder as outlined in the DSM-V involves sexual behaviours, fantasies, or urges that occur from seeing an unsuspecting and nonconsenting person who is naked, in the process of taking off their clothes, or engaging in sexual activities (American Psychiatric Association, 2013). This must occur for at least a period of six months, must be recurrent, and intense, and has to cause social or occupational distress in a clinically significant way (American Psychiatric Association, 2013). The individual experiences these issues has to be at least 18 years of age (American Psychiatric Association, 2013). The highest prevalence that has been documented in a lifetime is approximately 4% in females, and 12% in males (American Psychiatric Association, 2013).

**Exhibitionistic Disorder**

An exhibitionistic disorder as defined by the DSM-V are sexual behaviours, fantasies, or urges that occur from showing an unsuspecting and nonconsenting person their genitals (American Psychiatric Association, 2013). To receive the diagnosis one must have acted on these urges (American Psychiatric Association, 2013). This must occur for a period of at least six months, be recurrent in nature, and must cause significant distress in their social, occupational, or other important areas of their life (American Psychiatric Association, 2013).
Frotteuristic Disorder

A frotteuristic disorder is defined in the DSM-V as sexual, fantasies, urges, or behaviours that occur from rubbing against or touching, a unsuspecting or nonconsenting person (American Psychiatric Association, 2013). To receive a diagnosis, one has to have engaged in this behaviour (American Psychiatric Association, 2013). It must also cause distress in social, occupational, or daily functioning (American Psychiatric Association, 2013). Frotteuristic disorder has to occur for a period of at least six months and be recurrent and intense in nature (American Psychiatric Association, 2013). Frotteuristic acts has been said to occur in up to 30% of the adult male population (American Psychiatric Association, 2013).

Masochism Disorder & Sadism Disorder

The DSM-V defines sexual masochism disorder as having intense sexual fantasies, urges, or behaviours from the act of being tied up, beaten, humiliated, or caused bodily harm (American Psychiatric Association, 2013). It must cause social or occupational distress in their daily lives, and last up to a period of six months (American Psychiatric Association, 2013).

In contrast to sexual masochism, sexual sadism is defined in the DSM-V as having sexual fantasies, urges, or behaviours from inflicting physical or psychological harm to another person (American Psychiatric Association, 2013). The person receiving this diagnosis must have acted on these fantasies or urges (American Psychiatric Association, 2013). This disorder must have occurred for a period of at least six months, and be impairing social, occupational, or daily life functioning (American Psychiatric Association, 2013).

Fetishistic Disorder

A fetishistic disorder as defined in the DSM-V is sexual fantasies, urges, or behaviours that include using nonliving objects, or has a focus on body parts that are not genitals (American Psychiatric Association, 2013). These objects can include articles of clothing, or devices that are used for genital stimulation (American Psychiatric Association, 2013). This disorder must be recurrent in nature, last for a period of at least six months, and cause impairment in social, occupational or daily functioning distress (American Psychiatric Association, 2013).

Transvestic Disorder
A transvestic disorder defined in the DSM-V is having sexual fantasies, urges, or behaviours from cross-dressing (American Psychiatric Association, 2013). This behaviour must last for a period of at least six months, be recurrent and intense in nature, and cause social, occupational, or daily functioning distress (American Psychiatric Association, 2013). Transvestic disorders are usually accompanied by autogynephilia, the tendency to be sexually aroused from imagining yourself as the other sex (i.e., a male imagining himself as a woman) (American Psychiatric Association, 2013). This may include the person exhibiting behavioural tendencies that the other sex engages in such as putting make-up on or knitting (American Psychiatric Association, 2013). The prevalence of transvestic disorder is very low, occurring in less than 3% of the adult male population (American Psychiatric Association, 2013).

**Phallometric Assessment (Penile Plethysmograph)**

Within the past two decades, phallometric assessments have been used to measure the physiological response of offenders (Barnard, Fuller, Robbins, & Shaw, 1989). The assessment measures the offender’s erectile response to deviant as well as nondeviant sexual stimuli and is useful in the assessment and treatment stages (Barnard et al., 1989). During the process, the individual sits in a sound proof room in which a mercury strain gauge is fitted on the shaft of the individual’s penis (Barnard et al., 1989). The visual or auditory stimuli are then presented to the individual and a computer measures the percentage of their erection and the length of time that it is maintained (Barnard et al., 1989). Different categories of stimuli are presented for a certain amount of time. Fuller, Barnard, Robbins, and Spears (1988) state that the visual categories are: consensual heterosexual sex, consensual homosexual sex, prepubescent females, prepubescent males, a prepubescent female interacting with an adult male, a prepubescent male interacting with an adult male, a prepubescent female and a prepubescent male interacting, violence without nudity, and violence without nudity (as cited in Barnard et al., 1989). Audio stimuli categories outlined by Tanner (1978) are consensual sexual activity, violent threats, violent sexual activity, and violent activity without sex (as cited in Barnard et al., 1989).

Although it has been useful in identifying paraphilic disorders and arousal to deviant stimuli, it is not ‘a crystal ball’ or a ‘truth serum’ (Barnard et al., 1989). Sometimes, the individual becomes so anxious, there is no response to any stimuli that is shown, and others do not want others to know their deviant arousal patterns and are successful at creating no response. Although there may be assessments that can turn out inconclusive, the phallometric assessments are still seen as the most reliable indicator of deviant sexual arousal patterns (Barnard et al., 1989).


Thompson and Brown (1997) state that of the developmentally disabled population, approximately 6% show signs of severe sexual aggression (as cited in Craig & Hutchinson, 2005). McBrien, Hodgetts, and Gregory (2002), also found a similar theme. They found that 41% of people with developmental disabilities engage in sex-related challenging behaviours and out of these people, 17% of the incidents resulted in police contact and 4% were convicted (as cited in Craig & Hutchinson, 2005). Overall, the prevalence rate of sexual offenders who are diagnosed with a developmental disability is greatly debated and a few factors that influence these prevalence rates such as the definition of what constitute a disability. Ashman and Duggan (2003) state that prevalence rates rely on data from some prison populations and it does not account for individuals that have been diverted away from the justice system (as cited in Lindsay, 2002).

Theories

Several different theories have been postulated to explain sexual offending in individuals with developmental disabilities. Hingsburger, Dalla Nora, and Tough (2010) have many different theories that they think may explain how a person with a disability is likely to offend. Their book *The Key: A Community Approach to Assessment, Treatment, and Support for People with Intellectual Disabilities Who Sexually Offend*, takes more of a disability services approach than a sexual offender approach. Their hypotheses are divided into categories: environmental and historical hypotheses, abuse hypotheses, medical and psychiatric hypotheses, and deviance hypotheses (Hingsburger et al., 2010).

Environmental and Historical

Some environmental concerns that may have perpetrated an individual to abuse are the structure of the environment, as well as the attitudes and the modeling of the caregivers. The structure of the environment includes the living situation and the rules that are in place. The environment needs to encourage and not punish healthy sexual behaviours. Individuals with disabilities have the same rights as every other citizen and instilling a ‘no sex’ policy would be violating their rights. Caregivers are important role models that are a part of the person’s environment and life and need to be aware that their attitudes, as well as their actions, are being noticed and can play a part in the learning of a
person with a disability. Negative attitudes towards the sexual behavior of the developmentally delayed may cause the person to become opposed towards adult sexual relationships, and when these are punished, having sexual relations with children may be seen as less threatening (Hingsburger et al., 2010).

Knowing the amount of sexual knowledge that they have is important because they could have false information that is leading them to engage in inappropriate behaviour (Hingsburger et al., 2010). As well as knowing the person’s sexual knowledge, it is also important to gather information on their home environment. Day (1993) noted in his study some similar characteristics among offenders with disabilities, noting that their home environment is depicted as having marital disharmony, separated parents, violence, poor control, and neglect (as cited in Lindsay, 2002). These individuals are also likely to come from negative sex environments and have been told lies in regards to their sexuality (Hingsburger et al., 2010); for example, “women have teeth in their vagina and your penis will get bit off if you have sex with them.” It is important to be aware of such misinformation so these types of attitudes and beliefs can be challenged and replaced. Providing education about healthy sexuality is considered critical to helping avoid inappropriate behaviour.

Abuse

Early childhood abuse is seen as a common theme in the disability population. Lindsay et al. (2001) compared 48 offenders with disabilities who had committed a sexual offence with 50 offenders with disabilities who had committed a non-sexual offence and found a much higher rate of childhood sexual abuse among the sex offenders (as cited in Lindsay, 2002). That being said, abuse does not excuse abusing (Hingsburger et al., 2010). In certain residential systems, sexual abuse occurs on a daily basis, and in some situations, the individual perceives it as almost a part of their lifestyle (Hingsburger et al., 2010). The people with disabilities in this setting may therefore believe that abuse is acceptable (Hingsburger et al., 2010).

Medical & Psychiatric

Medical and psychiatric hypotheses look at medication or mental illness that may be causing individuals to act out in an inappropriate sexual nature. In assessing someone with a disability, medications need to be analyzed to ensure they are not having a direct impact on sexuality (Hingsburger et al., 2010).
Deviance

The deviance hypothesis outlined by Hingsburger et al. is very well known. Counterfeit deviance postulates that inappropriate sexual behaviour exhibited by individuals with disabilities is due to a lack of knowledge. Griffiths, Quinsey, and Hingsburger (1989) support this hypothesis stating that because people with disabilities do not have access to normal learning experiences, are segregated, have many restrictions placed upon them, have a limited privacy, and possess little knowledge about their sexual rights, they tend to engage in these behaviours (as cited in Lunsky et al., 2007). Lunsky et al. believe that the inappropriate behaviour has been learned as a result of their past life experiences, which goes hand in hand with some of the other hypotheses given by Hingsburger et al. Although many within the disability field have acknowledged the counterfeit deviance hypothesis, it has been found that counterfeit deviance does not hold true with all offenders. Lunsky et al. tested the counterfeit deviance hypothesis with two groups of offenders and found that the group of individuals with an intellectual disability actually had more sexual knowledge than the other group of non-offenders (Lunsky et al., 2007), proving that with this cohort of offenders, the theory does not apply.

REFERENCES & FURTHER READING


The purpose for an assessment is to determine the nature and extent of their sexual offending problem, as well as their level of risk, treatment needs, and treatment recommendation (Coleman & Haaven, 2001). A complete assessment requires information from several sources including a general history, mental status examination, sexual history, psychometric testing, and possibly phallometric testing. The general history includes information on the individual’s education and employment, substance abuse or other addictions, history of suicide or suicidal ideation, other criminal behaviour they have engaged in, previous psychiatric hospitalizations, current medication and medical history, past victimizations, and knowledge of their past physical, emotional, or sexual abuse or neglect. A mental status examination takes into consideration a person’s mood, appearance, memory, affect, cognitive function, insight, judgment, and the content and quality of their thoughts. Most of the above information can be gathered from the individual, but usually third parties, such as family or previous staff members, also need to be interviewed to obtain an abundance of information. Additionally, psychometric testing can be employed to determine deficiencies in certain areas.

**Treatment**

Different treatment options have been used, although the most common types of treatments have been pharmacological, behavioural, cognitive, or an integration of the three. Sometimes these treatments are used together to create a more comprehensive treatment approach. Craig and Hutchinson (2005) found that many treatments programs have been adapted from other programs for individuals with learning disabilities, and have been tailored for sexual offenders who have disabilities. Green, Gray, and Wilner (2002) have found that sexual offenders who have a disability usually need specialized treatment interventions and are likely to get diverted away from the criminal justice system to disability services in their rural area (as cited in Lindsay, 2002).

**Pharmacological Treatments**

Pharmacological treatment is not a new concept for sexual offenders (Lindsay, 2002). There are two common categories of pharmacological treatments:
direct hormonal intervention, and indirect hormonal intervention (Lindsay, 2002). Direct hormonal intervention targets the effects of sex hormones that maintain and create sexual urges within the different parts of the brain, while indirect hormonal intervention attempts to decrease the others conditions that are comorbid with the sexual problems, such as impulsivity, psychiatric disorders, or aggression, which may play a part in their sexual behaviour (Lindsay, 2002). Medroxyprogesterone Acetate (MPA) and Cyproterone Acetate (CPA) are the two most common hormonal treatments (Lindsay, 2002). Clarke (1989) used hormonal treatments in a study of male offenders who had intellectual disabilities and found an improvement in the sexual behaviours of half of the participants (as cited in Lindsay, 2002). Cooper (1995) noted in his studies, that hormonal interventions will decrease the intensity of the individuals sex drive, but not reduce it totally, and if the medication is discontinued, might result in a quick relapse (as cited in Lindsay, 2002).

**Behavioural Treatments**

Plaud, Plaud, Colstoe, and Orvedal (2000) have found that behavioural treatments are the most common form of treatment for managing the inappropriate sexual behaviour of individuals with disabilities (as cited in Lindsay, 2009). A study done by Griffiths, Quinsey, and Hingsburger (1989) used a behavioural management system to decrease inappropriate sexual behaviour (as cited in Lindsay, 2009). Their programme included educating their clients to address their inappropriate sexual behaviour, training them to be socially competent and to improve their personal relationships, teaching relapse prevention strategies that they could use on a daily basis, and going over responsibility issues (as cited in Lindsay, 2009). Griffiths et al. (1989) successfully reported that in over 30 case studies, there was no re-offending (Lindsay, 2002).

**Cognitive Treatments**

Currently, treatments have been employing the use of cognitive and problem solving techniques (Lindsay, 2009). Rose, Jenkins, O’Conner, Jones, and Felce (2002) conducted a 16-week group treatment with five men with disabilities who had previously abused (as cited in Lindsay, 2009). Their treatment included discussion about self-control, victim impact, identifying their personal emotions, sexual education, appropriately asserting themselves, and managing risk (as cited in Lindsay, 2009). Rose et al. (2002) measured their beliefs on the Questionnaire on Attitude Consistent with Sexual Offending (QACSO), and only reported a difference from baseline on the locus of control subscale (as cited in Lindsay, 2009).

**Necessary Components**

In the book, *Handbook for Sexual Abuser Assessment and Treatment*, chapter 11 outlines the assessment and treatment of intellectually disabled
sex offenders. This chapter outlines specific components that need to be integrated into treatment when working with the intellectually disabled sex offender population. These components include teaching self-control skills, interpersonal skills, sexual education, cognitive restructuring, and relapse prevention (Coleman & Haaven, 2001). The authors recommend group treatment for teaching these skills to offer support and feedback from other group members. Role-playing situations such as an individual’s sexual abuse cycle can help the individual to practice self-control and coping skills. The role-play can also be tweaked to represent an aversive outcome so that the offender can see and feel what it would be like for this aversive situation to occur (Coleman & Haaven, 2001).

Interpersonal skills can be taught through social skills training. Lundervold and Young (1992) state that social skills training is considered to be one of the more effective treatments for intellectually disabled, and non-disabled sex offenders (as cited in Coleman & Haaven, 2001). Interpersonal skills in particular encompass a variety of skills including assertiveness, empathy, and perceptive skills, as well as, time, stress, and anger control management. Managing leisure time can be important for an individual to establish. Boredom has been recognized as a factor that may influence an individual to sexually offend, and engaging in these activities or hobbies can directly aid in relapse prevention. Perspective-taking and empathy skills often need to be taught because these skills are not skills that come naturally to offenders with intellectual disabilities. Sexual offenders with intellectual disabilities can frequently misperceive social cues in a way that can provide justification to their sexual offending (Coleman & Haaven, 2001).

Kempton (1993) has recognized an increase in sexual education resources for the intellectually disabled (as cited in Coleman & Haaven, 2001). Sexual education needs to include topics such as the male and female anatomy and their sexual functions, birth control methods, sexually transmitted infections, safe sex practices, sexual dysfunctions that can occur, heterosexuality, and homosexuality. The primary focus of the sexual education program should be their attitudes towards sexuality and their values, but also each topic should emphasize its relevance to sexual offending (Coleman & Haaven, 2001).

Cognitive restructuring is a way to help the individual think in a different way. Often offenders who have a disability think in a different way, not in a slower manner, than a non-disabled person (Coleman & Haaven, 2001). For example, an offender with an intellectual disability can use messages that normalize violence or sexism to justify his sexual offending behaviour, which is why cognitive restructuring is seen as a crucial part of treatment. An ‘old me’ and ‘new me’ approach can be used with offenders who have
intellectual disabilities to simplify the cognitive restructuring skill. The ‘old me’ represents the self-talk or distorted thinking that lead the offender to sexually offend, while the ‘new me’ is what the offender is attempting to be. Role-play in front of a group can also be helpful in this situation to identify distorted thoughts and possible actions (Coleman & Haaven, 2001).

Laws (1989) and Pithers and Kafka (1990) have stated that relapse prevention is regarded as one of the most vital parts of the treatment plan for the sexual offending population (as cited in Coleman & Haaven, 2001). A crisis card is a tool that can be used to help the individual in times where he comes in contact with an urge to sexually offend (Coleman & Haaven, 2001). The crisis card is shaped as a stop sign, and has triggers and coping mechanisms written on it for the individual’s reference. Another important part of the relapse prevention process is setting up a support network.

An offender should have specific people in the community that are open to support when it is needed (Coleman & Haaven, 2001). The offender should explain his specific risk factors, offence cycle, and self-management/relapse prevention plan to his support system (e.g., friends, family, or peers).

Other Considerations

These treatments need to be adapted for the individual with lower intellectual functioning, for the treatment to be the most effective (Lindsay, 2009). Effective communication is a necessary requirement for any interpersonal communication, including therapeutic ones, so the therapist needs to use self-monitoring techniques to be aware of their language (Lindsay, 2009). Teaching an individual with a disability needs to be fun, dramatic, and even bizarre because it has been said that linking treatment with emotions will facilitate more effective and easy learning (Coleman & Haaven, 2001). Serran, Fernandez, Marshall, and Mann (2003) have also articulated that it is important to create a therapeutic alliance by being warm, empathetic, flexible, and encouraging towards the client through their personal developments in therapy (as cited in Prentky et al., 2010). As previously mentioned, offenders can possess low self-esteem, Serran et al. suggest that boosting self-esteem in treatment can increase the effectiveness, their participation, and their change throughout the treatment process (as cited in Prentky et al., 2010).
Risk Assessment

There have been many different risk assessment measures developed to assess risk within normally functioning individuals who have sexually offended, but few have been validated for sexual offenders with disabilities (Lofthouse et al., 2013). As with findings in the mainstream offending population, there is conflicting evidence as to which risk assessments are the most valid for predicting recidivism (Lofthouse et al., 2013). Craig and Hutchinson (2005) state that two risk scales that have been widely used with this population are the Rapid Risk Assessment for Sexual Offender Recidivism (RRASOR: Hanson, 1997) and the Static-99 (Hanson & Thornton, 2000).

Andrews and Bonta (2006) have said that there needs to be a focus on the dynamic risk factors, or factors that can change with the individual over time (as cited in Lofthouse et al., 2013). Lindsay (2004) completed a study and determined that dynamic risk factors have been shown to be better predictors of recidivism than static, or unchanging, factors (as cited in Lofthouse et al., 2013). The central 8 dynamic risk factors that have been outlined by Andrews and Bonta (2006) are: a history of antisocial behaviour, an antisocial personality pattern, having antisocial thought or cognitions, possessing antisocial friends, problems within their family or friends, poor performance in school and/or work, low levels of performance or involvement in leisure or recreational activities, and substance abuse (as cited in Serin et al., 2011). These factors are found to be more strongly correlated with general crime, and are factors that are measured in many assessments (Serin et al., 2011).

The ARMIDILLO-S

Recently, Boer et al. (2004) have developed one of the first assessment tools for intellectually disabled sexual offenders. The Assessment of Risk and Manageability for Individuals who Offend Sexually (ARMIDILLO-S) is an assessment tool that focuses on stable factors (i.e., factors unlikely to change quickly) and acute factors (i.e., factors in the environment that are likely to change quickly), which refer to the person or their surrounding environment (as cited in Lofthouse et al., 2013). Although only one study has assessed the validity of the scale, it yielded higher results in sexual re-offending than actuarial assessments that were developed for non-disabled offenders (as cited in Lofthouse et al., 2013). Lofthouse et al., (2013) ran another study to assess the ARMIDILLO-S against the Static-99 and the VRAG. The ARMIDILLO-S was shown to be more effective at predicting recidivism than both the other actuarial measures, making it the most favorable risk assessment for individuals who have an intellectual disability (Lofthouse et al., 2013).
Recidivism

Lindsay (2002) has stated that since there are few controlled studies that have been reported, studies that report re-offending need to be closely examined. In a recent study done by Lindsay et al. (2002), it was reported that only 4% of offenders with learning disabilities had re-offended within the first 12 months and 21% within 4 years (as cited in Craig & Hutchinson, 2005). On a different note, Lund (1990) found in his study of 93 patients who were in statutory care that 72% had reconvicted over a period of 10 years (as cited in Lindsay, 2002). This rate is incredibly high and it is difficult to determine why the recidivism rates were so high, given that even in high risk offenders the rates are typically only 40-50%. Overall in Lindsay’s (2002) review of the literature, there were recidivism rates ranging from 39-72%, with Griffiths et al.’s (1989) study reported no reoffending in 30 case studies. In relation to recidivism rates and length of treatment, Day (1993) found a positive correlation between a two-year stay in care, and a better outcome (as cited in Lindsay, 2002). Additionally, Walker and McCabe (1973) reported that a shorter stay in an institutional care environment was related to an increased likelihood of reconviction (as cited in Lindsay, 2002). Risk prediction is challenging and there is a certain level of error associated with any risk prediction, therefore further research is recommended (Lindsay & Beail, 2004).
Gaps Within the Literature

Further research is required with respect to developmentally delayed sexual offenders. In terms of the studies that have been conducted which examine treatment effects, many have reported a flaw in the collected participants whose IQ level may have influenced the outcomes of the study. There needs to be a set IQ bracket established within studies, or outliers need to be excluded. Another factor that needs to be considered when doing studies with these individuals is to exclude the offenders that are still incarcerated or offenders who do not have direct access to the community since they do not face the same risk factors as those in the community. In the study done by Klimecki et al. (1994) they stated an overall re-offending rate of 30.8% within a two-year period, but it was said that this statistic could be compressed because of the inclusion of some offenders that are still in incarceration (as cited in Lindsay, 2002).

In assessing risk with individuals with developmental disabilities, Wilcox et al. (2009) note that some static or dynamic factors may not be applicable, or difficult to score, on certain risk assessment scales (as cited in Lofthouse et al., 2013). Wilcox et al. give the example that some characteristics such as the absence of long term relationships, are likely to be a factor for a person with a developmental disability, which my inflate the score on the risk assessment scale, making them appear to be a higher risk than necessary (as cited in Lofthouse et al., 2013).

Some have argued that in order to demonstrate that a treatment is effective, there needs to be a group of individuals who receive the treatment, and a group that does not. In working with sex offenders, there is an ethical concern because having a no-treatment condition for a group of sex offenders would be dangerous for the general public (Lindsay, 2002).

REFERENCES & FURTHER READING


Appendix B: Feedback Form

Please complete the questions below for feedback. It is anonymous and voluntary to complete this form. Some comments may be used in the formal thesis report.

1. What kind of educational background do you possess?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. Before reading this information package, did you possess any knowledge regarding developmental disabilities and sexual offending?

□ None at All
□ Some
□ A fair Amount
□ Extensive

3. Did this information package increase your knowledge on developmental disabilities and sexual offending?

__________________________________________________________________
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__________________________________________________________________

4. Are there any improvements that could be made?

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5. Additional Comments:

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