TREATING PEOPLE WITH INTELLECTUAL DISABILITIES AND SEX OFFENDING BEHAVIOR

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Statistics

- 10% to 15% of all sex offenses are committed by individuals with Intellectual Disabilities (Murphy et al, 1983).
- Study (Ward et al, 2001) surveyed 243 community agencies. Most common sexual offenses committed by Intellectually Disabled Sex Offenders:
  - 62.2% engaged inappropriate sexual behavior in public
  - 42.6% engaged in sexual activity that involved a minor
  - 42.6% engaged in sexual behaviors and stimulation that involved another person

Terminology

Forensic/Mental Health Services	Developmental Disabilities Services
Sexual Offender	Person with inappropriate sexual behavior
Pedophilic Disorder	Relates better to children; children are friends; interacts inappropriately with children
Frotteuristic Disorder	Touches people inappropriately; grabs peers' genitals
Voyeuristic Disorder	Looks in other's windows; watches peers get undressed; lack of privacy
Exhibitionistic Disorder	Takes clothes off or masturbates in front of others/dayroom/outside

Terminology

Forensic/Mental Health Services	Developmental Disabilities Services
Sexual Masochism Disorder	Person who displays self-harm or has accidents that result in them being injured
Sexual Sadism Disorder	Person who hurts others; physical aggression; enjoys scaring people
Fetishistic Disorder	Touches others' shoes/feet or hair; takes others' clothes/underwear
Other Specified Paraphilic Disorder	Makes obscene phone calls; tries to have sex with animals
Unspecified Paraphilic Disorder	Occasionally touches others inappropriately; Not clear about the function of the behavior

When Is the Behavior Problematic?

- **Paraphilia:** Intense and persistent unusual/ problematic sexual interest

- **Paraphilic Disorder**: paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm to others

Use of Functional Behavior Assessment (LeMay et al)

- 75 Archival Records Reviewed
- Criteria for Inclusion: 10+ Incidents
- Range of Incidents: 10-341
- Functional Assessment of Each Incident
- Statistical Analysis Yielded Two Groups
  - Group 1: Behavior Driven by Want for Attention (higher incidents)
  - Group 2: Functional Component was a Need to Communicate Sexual Interest and Desire

Common Pitfalls

- Minimizing the behavior
  - “Oh, but he just doesn’t understand.”
  - “He is mentally a child, so of course he would be interested in children.”
- Inflating the behavior
  - “He’s a predator!”
- Ignoring precursors to the behavior
  - “We had no idea it was coming.”
  - “He never does this when he is with us.”
- Attributing intent based on outcome
  - “He’s just doing that so she’ll take him to his room.”

‘Counterfeit Deviance’

- Understanding both the individual and the system in which they live
  - Structural Hypothesis: Sexuality restricted
  - Modeling Hypothesis: Model privacy behaviors
  - Behavioral Hypothesis: Function of behavior
  - Partner Selection Hypothesis: Few peer interactions
  - Inappropriate Courtship Hypothesis: Lack of skills
  - Sexual Knowledge Hypothesis
  - Perpetual Arousal Hypothesis
  - Learning History Hypothesis

Working with Sex Offenders – Staff Responsibilities

- Being aware of your own boundaries/limitations
- Modeling appropriate relationships with others
- Responding to clients' behaviors
- Helping the individual set realistic goals/expectations
- Monitoring & aiding treatment progress
- Language & Jargon
- Documentation, documentation, and more documentation

Sex Offender Treatment

- Treatment goals
  - Willingness & commitment
  - Education
    - Sexual knowledge
    - Boundaries and Consent
    - Interpersonal & communication skills
  - Components specific to problematic sexual behavior
    - Identifying self-regulatory deficits & increasing adaptive skills
    - Personal responsibility & responsible behavior
    - Trauma
    - Management & supervision

Sex Offender Treatment

- Measuring treatment outcomes
  - Assessment-based approach
  - Improved interpersonal functioning
  - Development of adaptive sexual behavior
  - Reduction of maladaptive sexual behavior
    - Overt & subtle behaviors
    - Compliance with supervision requirements

Sample Scenario #1

- Joe moved from a residential home (with 5-6 people living there) to his own apartment. Since he is in a different area of town, he is no longer employed (although he is looking for a job). He does not see his former housemates as the drive is too far for staff to set up activities. Sue, an assistant at the agency that works with Joe, reports that Joe calls her several times per day and says inappropriate things to her on the phone.

Functional Assessment of Behavior

Behavior	Thought	Feeling	Urge
Sitting in house	“Nothing to do, nobody wants to talk to me”	Bored – 10 Lonely - 10	Talk to someone on the phone– 10
Called agency – Sue answered; I told her she was sexy and I wanted to have sex with her	“I like her, she’s cute, she always talks with me, I know that she’s interested in me”	Excited – 10	Have sex – 10
Sue hung up; staff came over to house	“I’m in trouble now; at least the staff is here with me; they want to know if I need something”	Happy – 10	Talk to staff – 10

Questions Based on Previous Scenario

- Boredom: Does Joe have leisure skills/hobbies? Does Joe have a job?
- Peer relationships: Does Joe have skills to make friends? Does Joe have skills to make appropriate phone calls?
- Staff Concerns: Does staff routinely respond to inappropriate behavior by being supportive/reinforcing?
- Legal Concerns: Does Joe have information about phone calls? Does he also call others?
- Sexual Concerns: Do phone calls result in Joe masturbating (either while on the phone or thinking of this interaction later)? Is talking on the phone rewarding sexually? Or, more related to connecting with someone? Does he think he is in a relationship with Sue?
- Risk: What are the risks of him continuing to do this? How would he interact with Sue if he saw her in person?

Treatment Planning

- Target interventions for Boredom
- Target Social Relationships
- Provide education on Sexuality and Healthy Relationships
- Provide Behavior Support Training to staff regarding responses to inappropriate behavior
- Legal Information provided to client
- Phone Issues? Restrict him Joe from using the telephone, monitor his phone calls, or tell him he can no longer call Sue?

Sample Scenario #2

- Jeff moved into a home with your agency. You have noticed that he watches the kids next door when they are outside. He says “I like kids, they’re fun.” His behavior is typically appropriate, he interacts with staff, no behavioral problems have been noted since his move. He continues to watch the kids next door, but he just seems interested in what they are doing. On Saturday, Jeff is in the yard raking leaves. Later, the next door neighbor says that Jeff touched her daughter inappropriately and will call the police if it happens again.

Functional Assessment of Behavior

Behavior	Thought	Feeling	Urge
Watching little girl next door	"She's cute; so full of life; she's having fun"	Happy – 10	To talk to her – 10
Walked over to little girl	"I'll talk to her and see if she wants to talk to me"	Excited – 8	To talk to her – 10
She smiled at me when I said 'hello'; asked me if I wanted to play	"She likes me; she wants to be with me; maybe I can touch her"	Excited - 10	To touch her – 10
Touched her; she squirmed, giggled	"She wants me to touch her"	Excited – 10	To have sex – 10
Her mom came out; I stopped	"Mom looks mean; I need to leave"	Still excited – 10 A little scared – 5	To masturbate - 10

Questions Based on Previous Scenario

- History: Does Jeff have a history of touching children inappropriately?
- Beliefs: Does he believe that children are the only people who understand him? Does he feel like he has a special/close relationship with the child or that children want to have sex with him?
- Sexual Interest: Does he masturbate after watching kids play? Does Jeff fantasize about children? Is he sexually interested in girls only? Has Jeff had a sexual or romantic relationship with an adult?
- Interpersonal Skills: Does Jeff have friends that are adults or does he feel that only children understand him?
- Legal Issues: Does Jeff understand it is against the law to have a sexual relationship with children?

Treatment Planning

- Is a diagnosis of Pedophilic Disorder appropriate?
- Does he need Sex Offender Treatment?
- Do you need a Risk Assessment for him to remain in the community?
- Does he need to live at a placement that is further away from children?
- What about supervision? Does he need stipulations about where he can go or who he can interact with?
- What opportunities are available for peer relationships?
- Target Social Relationships
- If diagnosed with Pedophilia, address deviant sexual interest
- Provide Education about Consent and Appropriate/Healthy Relationships

Are There Treatment Guides Out There?

- Safe Offender Strategies – Stinson & Becker
- The Good Lives Model – Tony Ward
- Dialectical Behavior Therapy – Linehan
- Others
  - Old Me/New Me - Haaven
  - Relapse Prevention

Safe Offender Strategies

- Manualized Treatment - 10 Treatment Modules
- Safe Offender Strategies views sex offending behavior as a maladaptive coping skill
- Addresses:
  - Goal/objectives of treatment
  - Four Forms of Dysregulation: Emotional, Cognitive, Interpersonal, and Behavioral
  - Defining Emotions
  - Sexuality and sexual behavior
  - Expectations and beliefs about interpersonal relationships
  - Coping with the past
  - Managing urges and behaviors in a healthy way
  - Motivation and commitment, and treatment goals

Good Lives Model

- Self Regulation Model
- Good Lives Model views sex offending behavior as a way an individual attempts to satisfy achieving a primary good.
- Helps individuals understand the relationship between their life goals and how to achieve these goals without harming others.
- Focuses on teaching individuals how to build capabilities and strengths to reduce risk.
- Identifies primary goods and secondary goods
  - Goods include: Life, knowledge, excellence in play, excellence in work, excellence in agency, inner peace, relatedness, community, spirituality, pleasure and creativity

Dialectical Behavior Therapy (DBT)

- DBT Skills Groups – Teaches individuals emotion regulation; mindfulness; interpersonal skills (including making friends); and distress tolerance skills
- Individual Therapy – Targets identified are problematic sexual behavior (monitor urges/actions)
  - The individual would complete chain analysis of problematic sexual behaviors and sexual urges
  - The Individual Therapist would offer Coaching Calls – these would help the individual generalize skills usage
  - The Individual Therapist would participate in a Consultation Team – this would assist the therapist with targeting treatment goals and identify new ways to approach dangerous and therapy interfering behaviors

Other Treatments

- Old Me/New Me
  - Focus on:
    - Avoidance Goals based on risk factors related to the 'Old Me'
    - Approach Goals based on human needs and the 'New Me' needs
  - Teaches individual to identify characteristics of the 'Old Me' and 'New Me'
  - Treatment Goals include increasing self-efficacy, meeting basic needs, managing dynamic risk factors, and developing approach goals.
- Relapse Prevention
  - Focus on avoidance techniques, patterns of offending, and thinking errors

Assessing Risk

- STATIC-99R
  - Evaluator's Manual and Norms were updated in 2016
  - Originally developed by Hanson and Thornton
- ARMIDILO-S
  - Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend Sexually
    - Developed by Boer, Haaven, Lambrick, Lindsay, McVilly and Frize
    - Web Version 1.1 (2013)
- DD Predictors of SO Recidivism
  - Developed by Lindsay, Elliot & Astell in 2004
- Questionnaire on Attitudes Consistent with Sexual Offending
  - Broxholme & Lindsay, 2003

Static-99R

- Can be used to assess males 18 or older who have been convicted of a sexual offense
- Uses Static Risk Factors such as age, history of sexual offenses, history of convictions, victim characteristics (male victim, unrelated, stranger victim)
- Used to estimate risk of sexual recidivism
- Limitation: May underestimate risk of individuals who have uncharged sexual behaviors or are found Incompetent to Stand Trial

ARMIDILO-S

- Can be used to assess males ages 18 or older who have committed sexually offending behavior
- Borderline range of intellectual functioning or Intellectual Disabilities
- Can be used a risk predictive tool
- Can be used to Identify treatment targets (‘critical’ risk or protective factors)
- Can be used to develop support strategies (decrease risk and increase protective for each factor)
- Can be used to measure on-going progress in treatment

ARMIDILO-S Acute Risk Factors

- Changes in compliance with supervision or treatment
- Changes in sexual preoccupation/sexual drive
- Changes in victim-related behaviors
- Changes in emotional coping
- Changes in use of coping strategies
- Changes in social relationships
- Changes in monitoring
- Situational changes
- Changes in victim access
- Unique considerations (client and environment)

DD Predictors of SO Recidivism (Lindsay, 2016)

- Offense involving violence (previous violence)
- Juvenile Crime
- Sexual Abuse
- Poor relationship with mother (attachment)
- Anti-social attitude
- Low self-esteem
- Poor response to treatment
- Denial
- Low treatment motivation
- Poor compliance with man/treat routine
- Allowances made by staff

Questionnaire on Attitudes Consistent with Sexual Offending

- Broxholme & Lindsay (2003)
- Developed over the last 10 years to assess cognitive distortions in men with intellectual limitations
- Assesses seven offence areas:
  - Rape and sexual assault
  - Voyeurism
  - Exhibitionism
  - Dating abuse
  - Stalking
  - Homosexual assault
  - Offences against children
  - Also includes a Social Desirability scale

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