Assessment of Sexual Deviance in Adults With Developmental Disabilities

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Persons with developmental disabilities (DD) who have committed sexual offenses pose a special challenge in assessment and treatment. Accurate diagnosis is an important precursor to development of appropriate treatment interventions. This article describes commonly seen types of sexual offenders with DD. The variety of frequently seen skill deficits, and their implication for re-offense risk are presented. The article concludes with a presentation of issues that should be the focus of an assessment, and a survey of useful procedures and instruments used in evaluating sex offenders with DD.

Keywords: developmental disability, intellectual, mental retardation, paraphilia, sexual deviance

Diagnosis and treatment of the sex offender with developmental disabilities (DD) represents a considerable challenge for both the mental health and criminal justice systems. Poorly understood as a group, when the person with DD acts out sexually, it often provokes two opposite reactions: to dismiss and excuse the behavior as innocent and therefore relatively benign and harmless; or, to label the behavior as especially dangerous, and with an especially poor prognosis for change. As a result, two paradoxical interventions are sometimes the result - either no intervention at all, or a draconian intervention that typically involves total restriction of movement and curtailment of all community activities. The focus of this paper is the presentation of a model for assessment of such behaviors in such individuals.

People with DD are a heterogeneous group, and can include relatively circumscribed intellectual impairments, as well as dual diagnoses with psychiatric disorders, neurological deficits, sexual deviations, and other character disorder.

Sexually inappropriate, or deviant sexual behavior, just as in other clinical groups, can have its etiological roots in any of these singly, or in combination with others. Additionally, individuals with DD, because of their backgrounds, may also present with a number of relatively severe historical traumas (such as neglect, abuse, institutionalization, stigmatization), that further complicate the diagnostic picture.

Assessment serves three major functions in our work with individuals, whether or not they have a developmental disability:

a) Because sexually deviant behavior usually involves a victim, the first and most important purpose of assessment is to make some estimation of the potential risk that the individual may either act out repeatedly, or in an increasingly sexually violent manner. That is, whatever treatment interventions may be indicated, can they occur while the individual continues at the same level of community involvement, or must some significant change be made in his or her freedom of movement, to minimize the potential risk to the community?

b) At the same time, the assessment should, by its very nature, help us diagnose the problem, as well as identify and focus the goals of the treatment. That is, the assessment should identify specific areas and problems which, if successfully remediated, stand a good chance of increasing the likelihood of appropriate and prosocial behaviors, and lowering the risk of re-offense. Assessments can also identify areas of strength that can be utilized by the treaters.

c) Finally, the assessment serves as a baseline against which we can evaluate change and assess the response of the individual to our treatment efforts.

Types of Sexual Offenders With Developmental Disabilities

Sexual offenses occur as the result of the interaction and confluence of a set of environmental and situational factors, with an individual person in whom deviant behaviors are triggered. Additionally, sexually deviant or
offensive acts can themselves be the final path for a number of underlying etiological factors within the person; that is, there is no single causal factor that underlies all such behaviors. Among the people who have DD, aspects of the disability itself may further complicate the picture. This situation can be seen in some of the following five subtypes of offender frequently seen in the populations of people with DD.

a) **Abuse-Reactive Offenders**

Individuals with DD are themselves at greater risk of sexual victimization than other persons in the population. Their naivete and suggestibility can be readily exploited, and they are often ill-protected in the institutions. And, much as younger children who have been prematurely sexually stimulated or sexually abused, individuals with DD may show sudden awareness of sexuality for which they have not been prepared, and may act it out inappropriately.

b) **Immature Offenders**

Many citizens with DD receive little or no sexual education or other preparation for leading lives as sexual adults. Sexually inappropriate behaviors may not be deviant sexuality but may be abnormal expressions of otherwise appropriate and normal sexual urges. Such individuals are not appropriately labeled sex offenders or sexual deviants, and to do so harmfully stigmatizes them.

c) **Impulsive Offenders**

Impulsivity in individuals with DD may be related to underlying neurological deficits that impair impulse control generally. Even appropriate sexual impulses may find poorly modulated expression because of difficulties with response inhibition. As such, individuals become more sexually aware and active, and impulses may be acted upon in inappropriate contexts and with inappropriate objects.

d) **Sexually Compulsive Offenders**

We have described elsewhere the condition of Sexual Compulsive Disorder (SCD), that afflicts a wide variety of sexually deviant and paraphilic offenders and non-offenders. The mechanism for this disorder is the repetitive and compulsive use of sexual discharge as a means of self-medication for underlying and unrecognized feelings of depression and/or anxiety. Such persons discover, often early in life, that sexual stimulation and release provide some immediate, if temporary, respite from such tension, and when depression and anxiety intensify, the urge to act out, even if inappropriately, also increases. Individuals with DD also find such outlets, especially in response to isolation, boredom, and depression.

e) **Sexually Fixated/Pedophilic Offenders**

In some offenders, whatever the initial underlying mechanism, the sexually deviant behavior has become incorporated into their “character armor,” and is an ego-syntonic aspect of their personalities. They feel most comfortable in relationships with children, sexualize their relationships with them, and feel justified in sexually abusing them. Whether the victim is a child or an adult, there is usually the distorted thinking that the victim invited and even enjoyed the offense.

Careful assessment of the offender with DD is thus of considerable importance. From the risk management point of view, it may help us to intervene in high risk situations without exposing lower risk individuals to levels of control and intrusion that may be both unwarranted and wasteful of limited treatment resources. From a treatment planning perspective, careful assessment of deficit areas may serve to guide the treatment itself. The approach to and needs of the abuse-reactive offender will differ greatly from those of the sexual compulsive, or fixated offender.

Table 1 summarizes the commonly observed deficits that often contribute to sexually offensive behavior in all offenders, and which may be especially relevant in individuals with DD. The groups of skills can be divided into those which affect the person’s ability to regulate internal states, those which govern one’s ability to negotiate with one’s environment, and those aspects of one’s own history that may have distorted or otherwise affected one’s repertoire of pleasurable behaviors and activities. For instance, most sexual offending behavior generally involves a victim whose personal boundaries and trust are violated during the offense. This, in turn, involves either a lack of awareness of the position of the victim, or equally common, an actual distortion of the victim’s role - either that he or she enjoyed it, or even that they invited the assault. The offender with DD often has little awareness of the actual triggers to their offending. Urges may be experienced as erupting suddenly, with no
TABLE 1: SKILL DEFICITS COMMONLY FOUND IN SEX OFFENDERS WITH DD

<table>
<thead>
<tr>
<th>Deficit</th>
<th>Impact of Deficit</th>
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<tr>
<td>Cognitive distortions</td>
<td>Allows offender to rationalize or justify his/her actions (i.e., “he wanted me to do it,” “the little girl seduced me”)</td>
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<tr>
<td>Lack of empathy</td>
<td>Allows offending behavior because the offender is unable to identify with a victim’s fear, pain or helplessness</td>
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<tr>
<td>Poor sexual knowledge</td>
<td>Makes it difficult to negotiate needs with peers and promotes turning to children</td>
</tr>
<tr>
<td>Poor communication skills</td>
<td>Interferes with negotiating and appropriately fulfilling social, emotional, and physical needs in an appropriate fashion</td>
</tr>
<tr>
<td>Anger management problems</td>
<td>Can lead to inappropriate responses to frustration and deprivation of needs</td>
</tr>
<tr>
<td>Deviant sexual development</td>
<td>Distortions may have reinforced deviant or distorted sexual ideas, attitudes, and behaviors</td>
</tr>
<tr>
<td>Lack of self awareness</td>
<td>Triggering moods and feelings can recur and lead to cycle of further offenses</td>
</tr>
<tr>
<td>Deviant arousal pattern</td>
<td>Conditioned patterns may involve antisocial or other inappropriate ways of obtaining sexual gratification</td>
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warning, and under little control. Once experienced, individuals may not see themselves as being able to interrupt or control the behavior. The offending individual may not even be fully aware of the inappropriateness of his or her behavior. If they have been prematurely exposed to sexual stimulation during their own abuse, and if they have found it at all directly pleasurable, or gratifying because it brought them attention or other rewards, they may be confused by the negative reaction of those around them. Also, because their own experiences in being exploited may have brought them some gratification, they may have great difficulty in shifting their perception. Finally, generalized neurological deficits may significantly impair the ability to self modulate sexual arousal and control of sexual impulses, and may be part of a larger problem of modulation of any state of arousal.

THE ASSESSMENT PROCESS

In their compendium of over 90 instruments, questionnaires, inventories, and procedures used by clinicians who work with sex abuse offenders and victims, Prentky and Edmunds\(^4\) provided groupings for adolescents and adults, males and females, but failed to identify instruments that would be appropriate for use with individuals with DD. It is clear, however, that no single test or assessment protocol exists for assessing offenders whether they are developmentally intact or have a disability. In recent years, there have been efforts to develop specific sex offender risk assessment scales, (most notably the VRAG\(^5\) and RRASSOR\(^3\)) but this work is in its infancy. Although these scales have been applied to various criminal populations, they have not been validated with offenders who have DD. It is important to stress, however, that any test result should be understood in the overall context of the individual’s total adjustment, past history, results of previous diagnostic studies (current intellectual, neurological or, neuropsychological tests should be completed and the data available prior to beginning this assessment process), and his or her response to previous treatment interventions. Freeman-Longo,\(^4\) for example, in his risk assessment instrument, focuses on a number of key variables, including previous sexual acting out, general antisocial personality
### Table 2: Assessing Risk in Offenders With DD

<table>
<thead>
<tr>
<th>Risk Variable</th>
<th>Indicates Higher Risk</th>
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<tbody>
<tr>
<td>Cooperation with evaluation</td>
<td>Resistance to questions, evasiveness, or refusal</td>
</tr>
<tr>
<td>Sexual offense history</td>
<td>Multiple accusations and more than one prior conviction</td>
</tr>
<tr>
<td>Criminal history</td>
<td>One or more prior antisocial offenses</td>
</tr>
<tr>
<td>Violence in history</td>
<td>In any crime, or in present offense</td>
</tr>
<tr>
<td>Management of anger</td>
<td>Consistent and repeated problems with anger</td>
</tr>
<tr>
<td>Willingness to discuss offense</td>
<td>Avoidance of discussion or denial of offense</td>
</tr>
<tr>
<td>Acceptance of responsibility</td>
<td>Minimizes responsibility, or blames others or victim</td>
</tr>
<tr>
<td>Expression of remorse</td>
<td>No remorse, or defends the offense</td>
</tr>
<tr>
<td>Deviant sexual interests</td>
<td>Interest in deviant rather than non-deviant sexual acts</td>
</tr>
<tr>
<td>Perversions</td>
<td>Evidence of multiple perversions and deviant interests</td>
</tr>
<tr>
<td>Victims</td>
<td>Multiple victims</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Evidence of drug or alcohol abuse or addiction</td>
</tr>
<tr>
<td>Empathy for victim</td>
<td>Indifference to victim, or blames victim</td>
</tr>
<tr>
<td>Other adjustment</td>
<td>Other problems in school, work placement, or residence</td>
</tr>
<tr>
<td>Mental illness</td>
<td>Currently active mental illness</td>
</tr>
<tr>
<td>History of abuse</td>
<td>History of chronic physical or sexual abuse, or neglect</td>
</tr>
<tr>
<td>Motivation for treatment</td>
<td>Denial of need for, or refusal to participate in treatment</td>
</tr>
</tbody>
</table>

Tendencies, degree of anger and aggression, acceptance of responsibility for behavior, presence of deviant sexual thoughts and urges, evidence of other paraphilic behavior, degree of compulsivity, and capacity for empathy. A summary of these variables are presented in Table 2.

Based on our experience, a number of specifically designed scales can be helpful as part of a comprehensive assessment. It is useful to be aware of what the procedures are, how they are used, and what they contribute to our understanding of the offender.

**Specialized Sexual Testing**

Individuals with DD, like most other patients, frequently are uncomfortable with, and therefore deny the extent of their deviant sexuality. Furthermore, they may not be able to explain with any detail the specific triggers that start their deviant offense cycle. Over the past twenty years researchers have developed a number of procedures for objectively evaluating sexual arousal patterns. The two currently accepted procedures are outlined below.

**Penile Plethysmograph Laboratory Assessment**

Numerous scientific studies have demonstrated the reliability and validity of the penile plethysmograph in assessing sexual arousal patterns. In cases where a pattern of inappropriate or deviant arousal is relatively strong in comparison with arousal to appropriate stimuli, we can assess the potential to act on such impulses, and therefore, on the need for
treatment. The computerized procedure involves exposure to a series of standardized stimulus materials while recording actual arousal as it occurs during the assessment session. The measurement is done by means of an electronic gauge that the individual wears directly on his penis (the gauge is sensitive enough to measure the blood pulse rate). The resulting data, gathered during the course of a 60-90 minute laboratory session involving 15-30 different scenarios and scenes, are then statistically analyzed for the amount and duration of arousal to each class of stimuli. The stimuli can vary depending on the specific focus of the assessment, and may include slides as well as audiotaped stories that describe various kinds of sexual interaction, both appropriate contact with other adults, and inappropriate sexual contact with children of either sex. Audiotaped stimulus material also allows for specialized evaluations of arousal by aggressive or paraphilic stimuli, including exhibitionism, rape, and other sexual deviations.

Abel Screening Assessment

Work on the assessment of sexual offenders by Dr. Gene Abel (a noted researcher on sexual violence), has led to the development of the Abel Screen, another computer-based assessment system that indirectly measures and analyzes the relative strength of normal and deviant sexual interests. Ongoing research has demonstrated its validity, reliability, resistance to faking, and correlation with the extensively used Penile Plethysmographic procedure. The Abel Screen requires a person to complete an extensive questionnaire, and to rate 160 slides while his or her physiological responses are recorded and analyzed. The final analysis yields a relative ranking of sexual interests in 22 distinct areas, including age-appropriate sexual interest in adults and deviant interest in variously aged children of both sexes. It also includes a supplemental set of slides that specifically target interests in voyeurism, exhibitionism, fetishism, aggression, sadomasochism, and violence. The advantage of this test over phallometric assessment is that it can be used with both males and females, and the absence of sexually explicit stimuli or nude figures makes it more acceptable for use with populations where these stimuli are inappropriate. It is not as specific, however, as the phallometric assessment in assessing arousal by aggression.

Special Inventories

There are a number of inventories and self-report instruments that have been shown to be useful in evaluating specific components of deviant sexual interests These methods assess cognitive distortions that allow offending behavior to occur and will need to be corrected as part of a relapse prevention-based treatment plan. Three examples are described below:

Haaven Modified Cognition Scale (MCS)

Abel et al. developed the Cognition Scale to assess the presence of thought patterns that are used by sexual offenders to justify their pedophilic or rape behaviors. Haaven et al. modified these scales for use with offenders with DD. The scale consists of 28 typical beliefs that are used to justify pedophilia, and 17 cognitions that are used to rationalize and justify rape. It includes such items as “children can make up their own mind if they want to have sex with an adult,” and “having sex with an adult is a good way for a child to learn about sex,” and “when children walk around with no clothes on, they are trying to turn you on.”

Attitudes Towards Women Scale (AWS)

The AWS Scale, as developed by Spence and Helmreich, is intended to assess the perception of desired roles between men and women. The AWS is scaled along a traditional/conservative-feminist dimension. It assesses such factors as traditional notions about masculine superiority and patriarchy, equality of opportunity, and traditional perceptions of femininity.

Finally, as part of an assessment of individuals with DD, it is often useful to develop a baseline of the individual’s level of knowledge and awareness of human sexuality, to determine whether a sexual education component should be included in the treatment.

Socio-Sexual Knowledge and Attitudes Test (SSKAT)

The SSKAT is an individually administered test of basic sexual knowledge and attitudes. The scales include knowledge of anatomy and sexual functioning, dating, marriage, intimacy, birth control, and pregnancy, as well as knowledge about sexually transmitted diseases. Feelings and attitudes about each of these are also assessed.

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CONCLUSION

Putting an individual with DD through the sort of procedures described in this paper is time-consuming, labor-intensive and not inexpensive. Why then, go through the exercise? If we are to serve and balance the needs of both individuals with DD who have offended or exhibited sexually deviant behavior, and the needs of the community for safety, we need to balance the two opposing tendencies--to demonize people with DD versus viewing them as naive children--by adequately evaluating the significance of deviant behaviors just as important, our evaluations should inform and guide our treatment interventions--give them a solid conceptual basis that will allow us to assist them to move towards maximal fulfillment of their potential. As Keating\textsuperscript{8} has demonstrated in his work with persons who have sexually offended and have DD and mental illness, such work can assist for the safe reintegration of such individuals into the community.

REFERENCES


