

Treating intellectually disabled sex offenders

Intellectually disabled offenders (who are also commonly referred to as psychosocially challenged, learning disabled or mentally retarded) are offenders who, like many persons who are mentally ill, tend to cycle through hospitals, community agencies and correctional facilities.

These offenders may be excluded from certain treatment programs as a result of their borderline intelligence, illiteracy, impulsiveness or inadequate social skills. However, if such an offender is deemed unsuitable for regular sex offender programming or is main-streamed through such a program, their likelihood of recidivism will probably not be significantly reduced - their unique treatment needs will not have been met.

These offenders are not treatment failures, rather they were simply not provided with suitable treatment. It was the realization that intellectually disabled offenders were having difficulty in conventional sex offender programs that prompted the creation of the Northstar Program at the Regional Health Centre (Pacific) more than seven years ago.

The Northstar Program is designed to meet a significant proportion of the treatment needs of these offenders through techniques ranging from psychoeducational modules, to arousal reconditioning, to individual treatment. This article examines why intellectually disabled sex offenders require this type of specialized treatment, as well as the specific treatment approaches that are utilized. How are intellectually disabled sex offenders different from other sex offenders? The majority of intellectually disabled sex offenders in the correctional system do not fall into the profound or severely retarded range of intellectual functioning. They instead fit into the mild to borderline range of mental retardation.⁽²⁾

In fact, not all intellectually disabled sex offenders are intellectually disabled according to intelligence tests. For example, several of these offenders have significant social functioning (social skills and knowledge) difficulties and/or problems gaining insight into their behavioural difficulties, but have low to average IQs. In general, however, intellectually disabled sex offenders are characterized by lower intellectual functioning than intellectually "normal" sex offenders.

It has been estimated that up to 74% of intellectually disabled sex offenders have organic brain syndrome as a result of brain injury. Intellectually disabled sex offenders with a brain injury tend to be more functionally impaired than those without such a problem, since the injury may further complicate their other learning disabilities.

Brain injury may also cause sexual disinhibition, hypersexuality, changes in sexual preference, poor abstract reasoning, an inability to sequence events, poor memory, aggressiveness, explosiveness and anxiety disorders.⁽³⁾

This likelihood of brain injury among intellectually disabled sex offenders, a higher incidence of substance abuse and deviant sexuality combine to burden these offenders with a complex set of problems. Although other sex offenders also suffer from many of these problems, low intellectual functioning exacerbates the problems for intellectually disabled sex offenders.

Intellectually disabled sex offenders also differ from other sex offenders in other ways, some of which suggest an increased risk of reoffending.

For example, although intellectually disabled sex offenders and other sex offenders do not differ as to offence type, intellectually disabled sex offenders tend to be more opportunistic and impulsive in both their everyday behaviour and offences. Further, they tend to have fewer victims, to establish no close relationships with their victims (choosing acquaintances as opposed to relatives), and to be indiscriminate about their victims' age, gender or appearance.

As such, it is more difficult to gauge the predatory behaviour of intellectually disabled sex offenders, because they don't have a specific type of victim.

These sex offenders also tend to use instrumental violence (the use of threats or violence sufficient to gain victim compliance) rather than expressive violence (causing injury as part of their arousal pattern) in their offences because they are less able to verbally manipulate their victims into compliance.

Intellectually disabled offenders also generally victimize individuals who are smaller, less able to verbally protest (more passive) and less able to defend themselves.⁽⁴⁾

There is some evidence that due to or social skills (and the resulting lack of intimate relationships), intellectually disabled sex offenders are primarily lonely men who spend an inordinate amount of time fantasizing and masturbating - in contrast to other sex offenders.

These sex offenders usually perceive themselves as victims, are unable to understand the needs of others, and tend to think that their only mistake was getting caught. They also tend to have little sense of self-worth, as their parents and peers have often ridiculed them during their childhood and adolescence.

A significant proportion of these sex offenders were also sexually victimized themselves. Further, their families often minimize the severity of their offences and the risk to others, reinforcing the offenders' views of themselves as victims and of their sentences as excessively harsh.⁽⁵⁾

Finally, intellectually disabled sex offenders tend to lack assertion skills and, therefore, routinely give in to the demands of their peers.

In short, it appears that despite some similarities, intellectually disabled sex offenders present a broader constellation of problems and treatment needs than other sex offenders. Further, their unique problems appear to place these offenders in the high-risk/high-needs category.⁽⁶⁾ Treatment methods The Northstar Program uses a wide variety of treatment methods to address the treatment and criminogenic needs of intellectually disabled sex offenders. All program components are supported by research that demonstrates their effectiveness with this group of offenders.

A multidisciplinary team delivers the program's various components. It has been demonstrated that consistent messages from a variety of program deliverers in a variety of modalities is the most effective way to help these offenders change their behaviour.

The program's various components include individual sessions, behavioural therapies, medical interventions, adjunctive therapies and group therapy modules (see Table 1). The overall program is made up of three trimesters.

In general, the various group therapy modules are based on social learning theory and follow a logical, hierarchical sequence, with the goal being that offenders learn new, more rewarding and adaptive behaviour.

For example, the anger management module begins with an education phase about the nature of anger. This is followed by a skills acquisition phase that emphasizes learning new ways of dealing with anger through analysis of current situations and discussion of appropriate responses. Finally, an application phase helps offenders apply the techniques to their specific preincarceration experiences.

The sexual deviance, feelings, victim empathy, relationship skills and sex education modules have a similar setup - offenders learn basic information and then apply it to important past and present aspects of their lives.

Due to the cognitive limitations of these offenders, conceptual jargon is kept to a minimum. Therefore, "seemingly unimportant decisions" becomes "thinking mistakes," "abstinence violation effect" becomes "the what the heck, I deserve it effect," and "cognitive distortions" becomes "excuses."

One particular program component is made up of the disclosure, crime cycle and relapse prevention modules. The disclosure module gives offenders a non-confrontational opportunity to describe, from their viewpoint, what their offence(s) involved. A set of standardized questions is used to identify any differences between the offender and official versions. This process allows for the expression of each offender's thoughts and feelings (and minimizations), which is invaluable to formulating an offender's crime cycle.

The crime cycle module identifies the risk factors and cognitive-behavioural patterns that typify the offender's criminal actions - in a manner clearly understandable to the offender. Finally, the relapse prevention module is designed to help individuals cope effectively with high-risk factors and to identify (and respond to) early warning signals that indicate that high-risk factors are imminent.

Three modules run throughout the nine month program cycle: the personal concerns, communications and goal review modules. The personal concerns module is a forum for learning and applying basic problem-solving skills. The communications module is a systematic, structured educational program that teaches offenders to communicate effectively with the wide range of people they encounter daily. The goal review module helps offenders formulate reasonable and attainable goals within time frames that provide an opportunity for success.

The program uses a wide variety of other therapeutic methods to address offender treatment needs. It uses individual issue-focused sessions to reinforce information obtained from group modules and behavioural contracts to address specific offender deficits or problematic behaviour. The program also

uses self-monitoring, arousal reconditioning and sex-drive reducing medication, as well as adjunctive therapies (such as horticulture, art, school and recreation), to encourage skill development and increase offender repertoires of appropriate behaviour.

Table 1

The Northstar Program's Group Therapy Modules		
Trimester 1	Trimester 2	Trimester 3
Sex education	Relationship skills	Substance abuse
Goal review	Goal review	Goal review
Communications	Communications	Communications
Personal concerns	Personal concerns	Personal concerns
Anger management	Anger management	Problem solving
Disclosure	Crime cycle	Relapse prevention
Sexual deviancy	Managing deviancy	Victim empathy
Identifying feelings	Managing feelings	Living without violence
Note: One trimester = three months		

A principled approach The Northstar Program is based on several fundamental premises. Every module or therapy delivered must have firm research support for its effectiveness with intellectually disabled sex offenders.

Concepts are kept simple, taught thoroughly, practised often and reinforced consistently through a variety of therapeutic methods by a variety of therapists. Therapeutic relationships must also be well managed because these clients are dependent and demanding.

Finally, to ensure continued progress, community follow-up personnel need to be fully informed of the treatment needs and gains of these offenders. By following these guidelines and, therefore, meeting the treatment needs of intellectually disabled sex offenders more effectively, it is hoped that more of these offenders will ultimately be classified as treatment "successes" rather than "failures."

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(2)W.D. Murphy, E. M. Coleman and M. R. Haynes, "Treatment and Evaluation Issues with the Mentally Retarded Sex Offender," *The Sexual Aggressor: Current Perspectives on Treatment*, J.G. Greer and I. R. Stuart, eds. (New York: Van Nostrand Reinhold Company, 1983).

(3)J. Haaven, R. Little and D. Petre-Miller, *Treating Intellectually Disabled Sex Offenders: A Model Residential Program* (Orwell: The Safer Society Press, 1990).

(4)S.L. Lane, "Special Offender Populations," *Juvenile Sexual Offending: Causes and Consequences*, G. D. Ryan and S. L. Lane, eds. (Lexington: Lexington Press, 1991): 229-332.

(5)J. Schoen and I. H. Hoover, "Mentally Retarded Sex Offenders," *Journal of Offender Rehabilitation*, 16, 1, 2 (1990): 81-91.

(6)D. A. Andrews, I. Bonta and R. D. Hoge, "Classification for Effective Rehabilitation: Rediscovering Psychology," *Criminal Justice and Behaviour*, 17 (1990): 19-52.