A Practical Guide for the Evaluation of Sexual Recidivism Risk in Mentally Retarded Sex Offenders

Amy Phenix, PhD, and Shoba Sreenivasan, PhD

Although sex offender risk assessment has progressed greatly over the past decade and a half since most states implemented the sexually violent predator/sexually dangerous person (SVP/SDP) laws, there continues to be limited applicability of such models to intellectually disabled sex offenders because there has been no empirical validation. However, SVP/SDP civil commitment programs have reported increased admission of developmentally disabled sex offenders. Differentiating sexual deviance, the primary factor predisposing most individuals to criminal sexual violence, from impulsive, immature, and inappropriate behavior stemming from cognitive deficits presents yet another challenge to the clinician tasked with performing such evaluations. This article reviews actuarial risk models and their limited applicability to mentally retarded sex offenders and offers a conceptual method of assessing the risk of recidivism in intellectually disabled sex offenders under SVP/SDP evaluation.

J Am Acad Psychiatry Law 37:509–24, 2009

Although sex offender risk assessment has progressed greatly over the past 17 years since most states have implemented the sexually violent predator (SVP) or sexually dangerous person (SDP) civil commitment statutes,[1,2] few intellectually disabled offenders have been studied, thereby limiting the application of existing methods. Nonetheless, Haaven and Schlank[3] found that, throughout the nation, SVP/SDP civil commitment programs have seen increased admission of developmentally disabled sex offenders. Moreover, there remain persistent societal myths that developmentally delayed individuals are sexually impulsive and out of control and that intellectually disabled individuals are at increased risk of sexual offending. However, mentally retarded individuals have not been found to be significantly different from those without mental retardation in their ability to explore and control their sexual impulses.[3] Empirically, most studies suggest that the rate of developmentally delayed individuals who sexually offend is higher than would be expected based on population statistics alone,[4–8] although a few studies do not.[9,10]

The purpose of this article is to review actuarial risk models and their applicability to mentally retarded sex offenders and to offer by sample cases a practical and evidence-based method of applying existing models of sexual offender risk assessment to the population of intellectually disabled sex offenders under SVP/SDP evaluation.

The SVP/SDP laws require a statutorily defined finding of a mental disorder that predisposes the individual to violent sexual offenses. Differentiating sexual deviance, the primary factor predisposing most individuals to criminal sexual violence, from impulsive, immature, and inappropriate behavior stemming from cognitive deficits presents yet another challenge to the clinician tasked with performing such evaluations. The diagnosed mental disorder is broadly defined in most states to encompass congenital or acquired conditions that impact the volitional or emotional capacity of the individual, such that they predispose that individual to commit sexual crimes. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)[11] defines the essential feature of mental retardation as that of significantly subaverage intellectual abilities (generally, two standard devia-

Dr. Phenix is in Private Practice in Pullman, WA. Dr. Sreenivasan is Clinical Professor of Psychiatry and the Behavioral Sciences, Keck School, University of Southern California, and the Director of Forensic Outreach Services, GLA VA Medical Center, Los Angeles, CA. Address correspondence to: Amy Phenix, PhD, PMB 242, 630 Quintana Road, Morro Bay, CA 93442. E-mail: amy@amyphenix.com

tions below the mean), accompanied by social skills and functioning deficits that emerge before the age of 18. The American Association for Mental Retardation identified adaptive deficits as expressed limitations in conceptual, social, and practical adaptive skills. While the DSM-IV-TR[11] provides a classification system for mental disorders in general and for sexual deviancy disorders in particular, there is also a caution that sexual behavior thought to stem from mental retardation may not represent a true sexual disorder (Ref. 11, p xxxii). Moreover, there is an imperfect fit between DSM-IV-TR criteria and SVP/SDP mental disorders.[12,13]

A Practical Conceptual Model for Sexual Offender Recidivism Risk

At present, the existing actuarial schemes remain largely unvalidated in the intellectually impaired sex offender population. Social skills deficits, such as impairment in interaction and communication skills, may lead a mentally retarded individual to engage in inappropriate sexual behavior that is not driven by sexual deviancy. Indeed, it has long been noted that intellectually disabled sex offenders' deficits in social skills are a major causative factor in sexual acting out.[14] Lindsay *et al.*[15] have underscored a point pertinent to SVP/SDP evaluations, that those with intellectual limitations have difficulty understanding societal rules and may not understand that, for example, public masturbation violates social norms as well as the law. Such behavior may be misattributed to sexual deviancy.

Impulsivity and poorly planned behavior,[16] deficits in sexual knowledge,[14] and deficits in discriminating deviant from nondeviant sexual behavior[14] are associated with sexual offending. In addition, the context of the lives of mentally retarded individuals may result in limited sexual experience and a deficit in the skills that facilitate normal interactions. Harris and Tough[17] have argued that the nature and structure of most placement facilities repress the development of age-appropriate sexual behavior in mentally retarded clients. Moreover, any sexual touching between peers is frequently disallowed, and any expression of sexual urges is labeled as deviant. This repression may be exacerbated by offenders' spending years in an institution or being overprotected by their families. Formerly institutionalized clients who commit sexual offenses may be better characterized as having a skills deficit rather than sexual deviance.[18] Intellectually disabled sexual offenders may misinterpret friendly social interactions as an invitation to sexual behavior, even when they have been rejected. Nonparaphilic drives in those with mental retardation, such as the need for attention and affection and to be liked by peers, impaired social competence, limited social skills (e.g., dating), and difficulty in differentiating assertiveness from aggressiveness, have long been identified as factors that precipitate sexual acting out.[10,19,20] More recently, poor social skills and limited opportunities to develop sexual relationships have been confirmed repeatedly as precursors to sexual offense, rather than to primary sexual deviancy.[21,22]

How does a clinician incorporate impulsivity and social skills deficits in risk assessment of intellectually impaired sex offenders? When do such factors increase the risk of sexual recidivism? For the clinician tasked with evaluating the intellectually disabled person for the SVP/SDP process, it is essential to differentiate sexually deviant behavior from impulsive actions emanating from a behavioral disturbance related to brain damage. An empirically linked conceptual system would allow for the differentiation of those with mental retardation whose sexual impulsivity is driven by sexually deviant preoccupation from those whose social skills deficits are the cause of the inappropriate behavior.

Our method is one of risk rating, in which we identify research-based items linked to sexual recidivism, either conceptually or empirically, to form our practical guide. This method relies on an evidence-based approach—that is, clinical judgment that is informed by the literature. Table 1 presents this approach, a practical guide for encompassing empirical and conceptual risk factors in the assessment of risk in those who are mentally deficient and commit sexual offenses. The model encompasses eight broad categories of risk factors (Table 1). Two types of risk markers in those with intellectual disabilities were selected: those with a statistical association to sexual recidivism established in recent meta-analyses[23,24] and those identified conceptually as specific to the risk of sexual recidivism. Two sample cases are presented later in the article to demonstrate the model's use in cases that may arise in an SVP/SDP context.

Table 1 Assessment Guide for Evaluation of Sexual Recidivism Risk Among MR/ID Offenders

	Present	Absent
I. Global Risk Factors		
a. Actuarial-RRASOR (high risk) or Static-99 (high-risk)	☐	☐
b. Multiple victim types	☐	☐
c. Young children targeted for substantial conduct	☐	☐
d. Sex offenses occurring during period supervision	☐	☐
e. Unplanned discharge	☐	☐
f. Offenses involving violence	☐	☐
GLOBAL FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐
II. Diagnosis		
a. Pedophilia or paraphilia DSM-IV-TR	☐	☐
b. Antisocial history, behaviors, or diagnosis	☐	☐
c. PCL-R high scores for those with ASPD traits	☐	☐
d. Sex offences occurring during period supervision	☐	☐
e. Drug or alcohol abuse (increases impulsivity)	☐	☐
f. Comorbid psychiatric disturbance (mood/psychotic)	☐	☐
DIAGNOSTIC FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐
III. Social Skills Deficits		
a. Poor social skills leading to associations with children	☐	☐
b. Inability to form peer sexual relationships	☐	☐
c. Targets lower functioning peers for sex	☐	☐
d. Long-term institutionalization, with resultant skills deficits and restrictive environment	☐	☐
e. Difficulty internalizing societal expectations	☐	☐
f. Lack of assertiveness, is a follower	☐	☐
g. Loneliness, lack of friends or other social support	☐	☐
SOCIAL SKILLS FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐
IV. Behavioral Tendencies		
a. Low frustration tolerance	☐	☐
b. Poor impulse control linked to sexual acting out	☐	☐
c. Difficulty in delaying immediate sexual gratification	☐	☐
d. Low self-esteem	☐	☐
e. Lack of assertiveness	☐	☐
f. Lack of compliance with supervision (probation/parole/conditional release)	☐	☐
BEHAVIORAL FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐
V. Knowledge Levels		
a. Little sexual knowledge	☐	☐
b. Poor understanding of laws related to sexual behavior	☐	☐
c. Unrealistic sexual expectations?	☐	☐
d. Lack of sexual experience with peers	☐	☐
KNOWLEDGE FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐
VI. Treatment Progress		
a. Reverting back to pretreatment attitudes	☐	☐
b. Poor response to treatment	☐	☐
c. Staff complacency, allowing negative behavior	☐	☐
d. Manipulative behavior in treatment	☐	☐
e. Treatment dropout or erratic attendance	☐	☐
f. Cognitive distortions present	☐	☐
TREATMENT PROGRESS FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐

(Continued)

Table 1 Assessment Guide for Evaluation of Sexual Recidivism Risk Among MR/ID Offenders (Continued)

	Present	Absent
VII. Release Environment		
a. Unstructured environment	☐	☐
b. Lack of mandated supervision	☐	☐
c. Inadequate community support	☐	☐
RELEASE FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐
VIII. Acute Dynamic Risk Factors		
a. Changes in social support (loss of family, involvement with negative peers)	☐	☐
b. Changes in substance abuse	☐	☐
c. Increase of sexual preoccupation	☐	☐
d. Negative emotional states	☐	☐
e. Change in attitude toward supervision	☐	☐
f. Changes in ability to cope (lowered), feeling overwhelmed	☐	☐
g. Changes to routine	☐	☐
h. Offender-specific characteristics (conflict with others, impulsive decision to quit job)	☐	☐
ACUTE FACTORS SUPPORT LIKELY RISK?	**YES** ☐	**NO** ☐

Risk Factor Summary	Supports Likely Risk
1 Global risk factors	YES/NO
2 Diagnosis	YES/NO
3 Social skills deficits	YES/NO
4 Behavioral tendencies	YES/NO
5 Knowledge levels	YES/NO
6 Treatment progress	YES/NO
7 Release environment	YES/NO
8 Acute dynamic risk factors	YES/NO

Base Rate of Sexual Deviance in Those With Mental Retardation

Assessing the base rate of sexual reoffending in those with mental retardation, as well as the general incidence of such behavior in this population, is critical in risk assessment. When the base rate of sexual recidivism is low, the ability of the clinician to differentiate a recidivist from a nonrecidivist accurately is also low, and the risk of falsely labeling a recidivist is therefore greater.[25] However, much of the empirical evidence for base rates of sexual deviance in those with mental retardation is almost two decades old. Lund[26] reported that up to one-fourth of offenders with intellectual disabilities have committed violent offenses. Klimecki *et al.*[27] found high rates of general reoffense (including sexual offenses) in their sample of intellectually impaired sex offenders in an Australian study. Their sample consisted of 75 intellectually impaired offenders (IQ 65–75) who had served a prison term for a broad range of offenses and then had been released from custody. There was a 41.3 percent overall general recidivism rate in the follow-up period of three and one-half years, with 84 percent of the reoffending occurring within a year of release. Approximately 31 percent of the reoffenses were sexual. Unemployment, psychiatric history, and substance abuse were considered important antecedents of recidivism.

Lindsay,[28] in summarizing the literature related to the incidence of sexual offending in those with intellectual disabilities, noted variability in the observed rate. For example, Gross,[29] in a review in Washington state, reported that 21 to 50 percent of those with intellectual disabilities had committed a sexual crime. Sundram[30] found a 38 percent rate of serious crimes in a sample of New York State inmates with

IQs below 70. Hodgins,[31] in a review of all offenders in Copenhagen, found that those with intellectual disability were five times more likely to commit a violent offense. Lund[26] in a follow-up of a small group ($n = 93$) of Danish mentally disabled offenders released to supervised care found a general reoffense rate of 72 percent within 10 years. Finally, Quinsey *et al.*[32] examined the recidivism rates of 58 men with intellectual disabilities and histories of antisocial behavior who had been deinstitutionalized. In a 16-month follow-up, 67 percent exhibited antisocial behavior of some kind and 47 percent exhibited hands-on violence or sexual misbehavior directed toward other clients or staff.

Of note, many of these studies did not specify rates of sexual offense in those with intellectual disability; rather, they examined the collective category of violent offenses. Therefore, the high rates of recidivism cited in the studies may not be specific to sexual recidivism. Lindsay[28] concluded that those studies finding high rates of sexual offenses in the intellectually disabled also had highly select sample sources such as maximum-security prisons and high-security hospitals. Hayes[33] concluded that when outpatient samples are examined, those with intellectual disabilities tend to have a low incidence of serious crimes. Lindsay[28] reported findings from a database of 62 sex offenders with intellectual disabilities in a four-year follow-up. Sixty-two percent of the sample had a prior conviction or clear documented evidence of committing a sexual offense. Fifty-three percent had a prior sexual offense that would be considered serious. Sexual reoffense was broadly defined as any documented report of sexual abuse, but also included behaviors such as being in the company of children or frequenting a park where the offender had once been arrested for indecent exposure. They found a 9 percent rate of sexual reoffense where there was clear evidence of such and a 14 percent rate of suspicion of reoffense. The rate of sexual reoffense increased as the time of follow-up was extended. For those for whom Lindsay[28] had complete cohort data, the rate of sexual reoffense was 12.5 percent. Twenty-nine were observed for three years and had a reoffense rate of 13 percent, and in the 19 observed for four years, the rate was 21 percent. Lindsay *et al.*[34] in their study of 52 intellectually impaired Scottish sex offenders found that approximately 34 percent of the total sample were suspected of sexual reoffending or were known to have reoffended.

In sum, the true rate of sexual reoffense in those with developmental disabilities remains difficult to quantify. As the summary just presented indicates, some studies demonstrate high rates (e.g., 25–30 percent) but are limited by broad definitions of recidivism that include any violent act. When recidivism is limited to sexual reoffense, the rates appear low, on the order of four to nine percent, although these statistics are for non-U.S. samples.

Characteristics and Types of Sexual Offenses in Those With Mental Retardation

Of relevance to risk assessment is the identification of characteristics that differentiate those with intellectual disabilities who sexually offend from those who do not. Some, such as Murphy *et al.*,[10] have concluded that most of the mentally retarded sex offenders that they have studied appear to be just that, sex offenders (i.e., those who have developed a deviant sexual arousal pattern and demonstrate a deviant sexual preference). Others, such as Day,[35] Hayes,[33] and Langevin and Pope,[36] have sought to identify specific characteristics of sex offenders with intellectual disabilities. These have emerged to include a family life characterized by parental separation, violence, and neglect or poor control. In addition, intellectually disabled sex offenders had histories of poor adjustment at school, relationship and behavior problems, delinquency, and psychiatric illness. Day[35] also noted the presence of an inability to understand normal sexual relationships and a lack of skills to form such bonds, poor impulse control, and susceptibility to the influence of others. Another driving element in sexual offending in those with mental retardation may be related to impulsivity. Glaser and Deanne,[16] in comparing intellectually impaired offenders with sex offenses to those with no such offenses, found that sex crimes appeared to arise from a general pattern of impulsivity and poorly controlled behavior, rather than from a predilection to sexual deviancy.

Lindsay's[28] review indicated that sex offenders with intellectual disabilities tended to be nondiscriminating in their choice of victims; that is, they had a wide range of victim types. Day[35] found that their sample was more likely to target adult victims and to commit heterosexual offenses. Conversely, Hayes[33] found in their sample that males were more often victimized than females. Blanchard *et al.*[37] in a

large-scale study of 950 sex offenders found that those with intellectual disabilities were more likely to offend against males and younger children. Hodgins[31] in a Danish study, found a predominance of violent offenses in the mentally retarded, as did Sundram[30] in a New York state study of offenders with IQs under 70. These studies did not differentiate between general violence and sexual violence.

Validity of Risk Assessment Tools and Methods of Risk Assessment in Intellectually Disabled Sex Offenders

The Sex Offender Risk Assessment Guide (SORAG), the Rapid Risk Assessment of Sex Offender Recidivism (RRASOR), the Static-99, the Minnesota Sex Offender Screening Tool-Revised (MnSost-R), and the Violence Risk Assessment Guide (VRAG) are the most frequently used sex offender actuarial schemes. In a meta-analysis, Hanson and Morton-Bourgon[23] demonstrated that all the methods are associated with a moderate degree of predictive accuracy with respect to sexual recidivism. However, the validity of existing risk assessment scales and methods in assigning risk level in intellectually disabled sex offenders remains an open empirical question. Some[3] have described the validity of existing methods as questionable when applied to developmentally delayed sex offenders. Haaven and Schlank[3] recommend that risk assessment in this population examine individual characteristics, treatment progress (if in treatment), and the type of support available in the community. Although there is a lack of research with intellectually disabled samples, data from other studies of forensic populations consistently show that the use of actuarial methods improves prediction of future nonsexual and sexual violence.[23,38]

Boer *et al.*,[39] in their recent work, noted that there are no validated risk assessment tools for intellectually disabled sex offenders. Tough[40] determined the predictive accuracy of the Static-99 and RRASOR in a small group of sex offenders with intellectual disabilities. She found that the Static-99 may overestimate risk and that the RRASOR may be a more accurate tool. The static variables, such as those subsumed in the Static-99 and typically reviewed in a nondisabled group, may not have applicability to an intellectually disabled sex offender sample.[40] Hanson recommended the Static-99 for use with developmentally disabled sex offenders.[41] However, Quinsey[42] found that the VRAG had a predictive ability in a small group of sex offenders with intellectual disabilities ($n = 52$) similar to that in their normative sample.

The dynamic factors of employment status, substance abuse, and unplanned discharge have been related to reoffense (encompassing sexual recidivism) in an intellectually impaired sample.[29,43] Lindsay *et al.*[34] examined 52 Scottish sex offenders with intellectual disabilities and found several variables to be predictive of sexual reoffending. These included antisocial attitude, low self-esteem, lack of assertiveness, poor relationship with the mother, allowances made by staff, staff complacency, poor response to treatment, and offenses that involved violence. When these variables were combined, allowances made by staff, antisocial attitude, and poor relationships with the mother were highly significant in their association with sexual reoffending.

Research examining dynamic risk factors and their relationship to sexual recidivism has received empirical support,[23,44] but its importance in risk assessment of intellectual disabled sex offenders has not been as well studied. Lindsay *et al.*,[43] in an effort to address this gap in knowledge, developed the Dynamic Risk Assessment and Management System (DRAMS) to assess dynamic and proximal risk factors in those with intellectual impairment. They[43] concluded that the instrument was reliable in predicting aggressive incidents in residential settings. In earlier work, they[45] found that cognitive distortion related to anger was a salient variable in an intellectually disabled sex offender group convicted of exhibitionism.

We have provided two case examples that were composed by the authors and are fictional. They do not represent the life stories of specific patients.

Case A: Frontal Lobe Impulsivity and Sexual Acting Out

Mr. A., who is in his thirties, is identified as mildly mentally retarded and requiring special placement within the prison system. He has an additional condition of intermittent explosive disorder reflecting poor anger management and aggression. He has been referred for an SVP evaluation, as he is currently nearing the end of a prison term for a conviction of rape by force of a developmentally disabled adult female peer. The attack occurred when Mr. A. was in his twenties and was living in a group home run by

the regional center. He has been released from prison on parole on two occasions, both resulting in return to custody due to failure to comply with parole conditions. In one instance, he was seen at a playground interacting with young children. On another occasion he became angry and frustrated at staff requests and punched a wall in the group home where he was placed. If released, he will remain on parole supervision for one year. The regional center in his county has agreed to place him in a male-only group home. The setting is not locked and, other than parole mandates, the staff would have no authority to compel him to stay or to take medications.

Mr. A.'s mother drank alcohol during her pregnancy, resulting in his having fetal alcohol syndrome and related neurodevelopmental disorders. He exhibits two of the physical correlates of fetal alcohol syndrome: a short stature due to growth deficiency and facial dysmorphia. Moreover, there is a history of seizure disorder since infancy, and early educational records mark abnormal neuropsychological functioning in the domains of attention, executive functioning, learning, memory, and judgment that have persisted into adulthood. The records describe Mr. A.'s IQ scores as falling in the mild mental retardation range of 64 to 66 throughout his developmental history. Prison records note reading and language skills at the second grade level.

In addition, since childhood, Mr. A. has demonstrated distractibility, hyperactivity, difficulty understanding social cues, and erratic and impulsive aggressive and sexual behaviors. He has engaged in head banging beginning in childhood and persisting into adulthood. His developmental history is also notable for physical abuse by his mother and her boyfriends during his childhood. He was abandoned frequently by his mother and placed in foster homes. His hyperactivity and aggression (sexual and physical) toward peers escalated in adolescence, resulting in placement in a group home for the developmentally disabled. He has a history of sexually touching others frequently and impulsively, a behavior that escalated as he reached pubescence. He can be redirected marginally, and treatment with Depakote has the dual effects of seizure control and control of impulsive and erratic behaviors.

Mr. A. has been described as behaviorally impulsive and indiscriminate in his actions. He is easily angered, masturbates frequently in his cell, has been counseled about horseplay such as grabbing the buttocks of other inmates, and generally resists following rules within a residential unit in the prison. Staff at various group facilities have noted that he tends to use his disability manipulatively, and they suspect exaggeration of cognitive deficits when he is confronted with wrongdoing. He has been enrolled at various times in work programs in both the community and prison settings, as his IQ is sufficient to warrant attempts at independent living. He has resisted such attempts by sabotaging work placements (e.g., not following the employer's directions, yelling) and has been viewed as lazy. Staff at group homes have also described him as developing sexualized relationships with lower functioning female peers. He has called these peers his girlfriends, but staff note that Mr. A.'s social skills are very poor. He has resisted attempts at social skills development and has reacted to redirection with explosive anger. A Hare Psychopathy Checklist-Revised (PCL-R) was administered while Mr. A. was in custody, and his overall score fell in the moderate-low range of psychopathy.

While in prison custody and in a residential unit for the developmentally disabled, Mr. A. incurred rules infractions reports for refusing to work, disrespect to staff (yelling and cursing), indecent exposure (masturbating in his cell during count times), refusing prescribed medications, refusing to wear a protective helmet, and engaging in mutual combat and self-destructive behavior (numerous incidents of head banging). He was observed to steal food and other personal items from lower-functioning peers, and was suspected of assaulting peers to get such items. He was enrolled in a sex offender group treatment program for intellectually disabled offenders, but was described as frequently missing group sessions, sleeping through sessions, and unable to identify any risk factors for reoffense. More recently, he has been associating with peers who openly flout the rules, and he has mimicked higher functioning peers' cursing at the staff. He has no family visits.

Mr. A.'s criminal history includes an arrest for lewd and lascivious acts against a child under the age of 16 that occurred when he was 17. Mr. A. was adjudicated in juvenile court and placed on juvenile probation for two counts of lewd and lascivious acts on a child under the age of 16. As a young adult, he was arrested for two counts of sexual battery that involved his touching the breasts and vaginal area of a female same-aged peer at a group home. This victim initially stated that he had

forcibly touched her, but she later called him her boyfriend. Given her poor language skills, the case was ultimately dismissed by the district attorney. Also as a young adult, Mr. A. was arrested for lewd and lascivious acts on a child under the age of 14. The victim was a boy who was visiting Mr. A.'s group residence for a Christmas party sponsored by a local church. The child was the son of a volunteer at the church who was assisting with the decorations. During the party, Mr. A. was seen with the child sitting on his lap. Later the child reported that Mr. A. had touched him on the crotch, through his clothing. Mr. A. was convicted of one count of lewd and lascivious acts on a child and received five years of probation. About three years later, he was arrested for rape by force and fear, forced oral copulation, penetration with a foreign object, and assault. This incident involved a female peer residing in a group home with him. She was said to be functioning at a mild to moderate range of mental retardation and with severe behavioral disturbances. She frequently tore off her clothes and was sexually provocative, often grabbing the genital areas of male peers, including Mr. A. He was said to have gone into her room where staff later responded when they heard her crying out. When the staff arrived, Mr. A. was engaged in an act of sexual intercourse with her. The staff removed Mr. A. from the victim and noted that her face was bruised. She stated that she had been undressing in her room when he came in and assaulted her. He admitted to having sex with her, but reported that she had said it was "okay" and had touched his penis first. He appeared angry and agitated.

The Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR) was used to identify an approximate base rate for the risk for sexual reoffense. According to the Static-99 Coding Rules Revised-2002 the Static-99 is also appropriate for use with developmentally delayed offenders.[41]

The RRASOR of Mr. A. estimated that the sexual recidivism rate for a score of 4 after five years' release to the community is 32.7 percent and 48.6 percent after 10 years' release to the community.

RRASOR Score Summary

	Risk Factor	Score (Yes, 1; No, 0)
1	Prior sex offenses?	2
2	Younger than age 25 at release?	0
3	Victim gender (any males)?	1
4	Any unrelated victims?	1
	Total score	4

On the Static-99, Mr. A. received a score of 5 in the moderate-high range while the RRASOR score was in the high range.

Assessment Guide for Evaluation of Sexual Recidivism Risk in Mentally Retarded/Intellectually Deficient Offenders

The RRASOR classifies Mr. A. as a moderate-high risk, with several of the global risk factors. He has targeted a boy, committed sex offenses while under group home supervision, and inflicted injury. (Bruises were found on his last victim.)

GLOBAL FACTORS SUPPORT LIKELY RISK? YES

I. Global Risk Factors		
a.	Actuarial-RRASOR (high risk) or Static-99 (high-risk)	Yes
b.	Multiple victim types	Yes
c.	Young children targeted for substantial conduct	Yes
d.	Sex offenses occurring during period supervision	No
e.	Unplanned discharge	No
f.	Offenses involving violence	Yes

Mr. A.'s criminal sexual history involves assault on a similar-aged male peer, a boy, and two separate similar-aged female peers. The pattern could be argued to meet the minimum DSM-IV-TR criteria of paraphilia not otherwise specified (NOS), given that the six-month time span criterion is met. In addition, the context of his sexual acting out appears to be related to impaired behavioral controls stemming from brain damage resulting from fetal alcohol syndrome and exacerbated by ongoing seizures and head injuries from head banging. The neurobehavioral impact of fetal alcohol syndrome can be severe behavior disruption, such as the anger and poor judgment that Mr. A. exhibits. His sexual aggressiveness appears less driven by an identifiable sexual psychopathology than by behavioral dyscontrol related to a frontal lobe syndrome. Additional psychophysiological testing could be conducted to clarify a deviant sexual arousal response to penile plethysmography. Complicating the picture is that he has also been identified as manipulative, suggesting a higher degree of control than he appears to possess. Overall, we argue that he clearly be-

haves repeatedly in a sexually inappropriate manner and does not seem to be affected by sanction. Currently, there are no PPG (penile plethysmography) results that, if abnormal, would support a diagnosis of paraphilia. Another diagnostic consideration would be that of cognitive disorder NOS. However, for the purposes of an SVP/SDP commitment, it would be difficult to support an argument that the intellectual disability or even cognitive disorder NOS represents a diagnosable mental disorder. Moreover, a sexual deviancy disorder is not clearly present.

DIAGNOSTIC FACTORS SUPPORT LIKELY RISK? NO

II. Diagnosis		
a.	Pedophilia or paraphilia DSM-IV-TR	No?
b.	Antisocial history, behaviors, or diagnosis	No
c.	PCL-R high scores for those with ASPD traits	No
d.	Sex offenses occurring during period supervision	Yes
e.	Drug or alcohol abuse (increases impulsivity)	No
f.	Comorbid psychiatric disturbance (mood/psychotic)	No

Mr. A.'s history is notable for a very poor ability to engage in normal peer sexual relations, with targeting of lower functioning peers noted in both prison and the community. He has skills deficits and has been institutionalized. He puts little effort into learning self-management skills. Although a degree of external control is achieved by medication, his progress is derailed by chronic noncompliance.

SOCIAL SKILLS DEFICIT FACTORS SUPPORT LIKELY RISK? YES

III. Social Skills Deficits		
a.	Poor social skills leading to associations with children	No
b.	Inability to form peer sexual relationships	Yes
c.	Targets lower functioning peers for sex	Yes
d.	Long-term institutionalization, with resultant skills deficits and restrictive environment	Yes
e.	Difficulty internalizing societal expectation	Yes
f.	Lack of assertiveness, is a follower	No
g.	Loneliness, lack of friends or other social support	No

Mr. A. demonstrates very low tolerance of frustration, as evidenced by his angry and aggressive behavior while in the group home and by his engaging in mutual combat and evincing temper dyscontrol in prison. He has been observed to grab the buttocks of peers in prison and engages in frequent masturbation in his cell. His criminal sexual behaviors also suggest poor impulse control, leading to sexual acting out (e.g., raping the peer after she touched his penis and hitting her).

BEHAVIORAL FACTORS SUPPORT LIKELY RISK? YES

IV. Behavioral Tendencies		
a.	Low frustration tolerance	Yes
b.	Poor impulse control linked to sexual acting out	Yes
c.	Difficulty in delaying immediate sexual gratification	Yes
d.	Low self-esteem	No
e.	Lack of assertiveness	No
f.	Lack of compliance with supervision (probation/parole/conditional release)	Yes

Mr. A.'s history supports an individual who has a knowledge deficit about laws governing sexual contact as well as a limited history of appropriate intimate relationships. In this case, Mr. A.'s capacity for developing this knowledge base is further impeded by his oppositional style and lack of a combination of ability and motivation to behave within the confines of rules and regulations.

KNOWLEDGE FACTORS SUPPORT LIKELY RISK? YES

V. Knowledge Levels		
a.	Little sexual knowledge	Yes
b.	Poor understanding of laws related to sexual behavior	Yes
c.	Unrealistic sexual expectations?	Unclear
d.	Lack of sexual experience with peers	Yes

Mr. A. has had some treatment within the prison, but his behavior has been notable for very poor compliance and little progress. There is no indication that he has developed self-management skills related to his sexual acting out.

TREATMENT PROGRESS FACTORS SUPPORT LIKELY RISK? YES

VI. Treatment Progress		
a.	Reverting back to pretreatment attitudes	Yes
b.	Poor response to treatment	Yes
c.	Staff complacency, allowing negative behavior	No
d.	Manipulative behavior in treatment	No
e.	Treatment dropout or erratic attendance	Yes
f.	Cognitive distortions present	Yes

Mr. A. could be released again under parole supervision, but only for a year, at which time his term expires. There could be mandated supervision, but previous efforts at supervision have been ineffective, in that he has violated parole conditions on two occasions. He could be placed in a group home for the developmentally disabled, but he has a history of committing sex crimes in this setting. Although activities at the group home are structured, the controls appear inadequate to contain him, as he has been essentially a life-long resident of such facilities and has acted out nonetheless. In addition, the group home setting has not been effective in compelling him to take medications or remain in the home (it is unlocked). As for community support, the group home is likely to be adequate in offering some degree of social support and assistance in activities of daily living. Although there is mandated support and adequate community support, because the group home environment would be identical with the one where he has sexually acted out, this factor is weighted heavily as contributing to risk. A locked setting would be optimal, where involuntary medication orders can be enforced.

RELEASE ENVIRONMENT FACTORS SUPPORT LIKELY RISK? YES

VII. Release Environment		
a.	Unstructured environment	Yes
b.	Lack of mandated supervision	No
c.	Inadequate community support	No

Mr. A. has largely no acute dynamic factors. Many of his factors are long-standing descriptors rated in other categories. He is chronically sexually preoccupied, angry and disruptive, and noncompliant with directions. He has more recently joined with peers who engage in negative behavior, which has led to more conflicts with staff.

ACUTE DYNAMIC FACTORS SUPPORT LIKELY RISK? NO

VIII. Acute Dynamic Risk Factors		
a.	Changes in social support (loss of family, involvement with negative peers)	Yes
b.	Changes in substance abuse	No
c.	Increase of sexual preoccupation	No
d.	Negative emotional states	No
e.	Change in attitude toward supervision	No
f.	Changes in ability to cope (lowered), feeling overwhelmed	No
g.	Changes to routine	No
h.	Offender-specific characteristics (conflict with others, impulsive decision to quit job)	Yes

Conclusion

Despite the presence of six of the eight categories of risk factors rated as supporting a likely risk to sexually reoffend, the key factor, that of a clearly established sexual deviancy disorder, is absent. For SVP/SDP purposes, Mr. A. does not meet the criterion of having a diagnosed mental disorder or mental abnormality that makes it likely that he will sexually reoffend. That is, his sexual behavior appears to stem more from neurobehavioral deficits associated with fetal alcohol syndrome than from paraphilia. This condition has led to seizures, low intellectual functioning, poor judgment, and poor behavioral control. It could be argued that such a disorder, that of mild mental retardation and intermittent explosive disorder would be a diagnosed mental disorder or mental abnormality, in that it is congenital and has led to sexual dyscontrol. On the other hand, it could be countered that the behavioral sequelae of the fetal alcohol syndrome would be insufficient to qualify Mr. A. as having an SVP/SDP diagnosed mental disorder. His sexual acting out appears to occur in the context of general behavioral dyscontrol. He clearly requires a structured and locked environment, but such a placement may be better obtained via other types of civil commitment that are crafted for dangerousness in developmentally delayed offenders. Our protocol allows the clinicians

to rate and review numerous risk factors and to provide the rationale for their opinions, but also to apply the findings in the context of the law. Medical versus legal concerns may be a thorny problem when public safety is the governing element, such as in SVP/SDP civil commitment. Nonetheless, we argue that it would be ethically inappropriate for the forensic clinician to bend civil commitment statutes to fit an individual when an unequivocal conclusion of a diagnosed mental disorder is absent.

Case B: Strong Sexual Deviance With Planning Capability

Mr. B. is in his fifties and identified as mildly mentally retarded with a third-grade literacy level and childlike presentation. He was referred for a sexually violent predator evaluation after completing a prison term. His first sexual offense resulted in a conviction for molesting a young adolescent boy at the Special Olympics. He was placed on formal probation, where he participated in counseling as directed by his local regional center and the probation department. In a later incident, he was convicted of sodomy on an incompetent person, an adult developmentally disabled man with the mental capacity of an 8-year-old. After sodomizing the victim, Mr. B. threatened to "send the Hell's Angels after him" if he told. One year later, he sexually assaulted the man again. He received a suspended sentence and was placed on formal probation again. Finally, he was convicted of lewd and lascivious acts on a child under 14 for molesting a boy who was staying with him and his wife. He got on top of the child, kissed him, and fondled him. He then violated his parole for that offense by committing sexual battery.

Mr. B.'s history is notable for sexual abuse by his father and brother and sexual misconduct as a child, resulting in juvenile adjudication. He was placed in special education classes at the age of seven and was a long-term client of the regional center. He worked in sheltered workshop programs and at age 18 received Social Security Disability. In his twenties, he married a woman whom he met when both were residents at a board-and-care facility for the developmentally delayed; they divorced nearly 20 years later.

His sexual history is significant for sexual behavior with his sister when both were children. He had sex play with her on two occasions and later had actual sexual intercourse with her on two occasions. His father abused him during childhood by subjecting him to sodomy, oral copulation, and "everything." He admits that he continues to fantasize about his earlier sexual activities with his sister. He admits to having sexual fantasies about children from childhood until he was almost 40 and confesses to 10 incidents of sexual activity with children. He accessed the children by involving them in games of "Simon Says" and tricking them into disrobing. He has also admitted to approximately 10 adult female and 10 adult male sexual partners. In regard to other paraphilic behavior, he admitted engaging in sexual activity during young adulthood with a cow and a goat. He cross-dressed from the ages of 12 to 22. Records from a regional center placement that began in his teens, after he had engaged in sexual contact with minors, indicate that he admitted to voyeurism, masochistic episodes with his wife during which she would tie him up, and child molestation numerous times. He also acknowledged obsessive use of pornographic material while in his twenties. Recent treatment reports indicated that Mr. B. was masturbating twice daily, well above average for his age. One evaluator reported that Mr. B. admitted that he "just sucks penises every chance he gets."

Test results on the Abel Assessment for Sexual Interest indicated arousal to girls as young as two years. A phallometric assessment several years ago indicated the presence of a deviant arousal pattern with a preference for young prepubescent girls between six and seven years of age, deviant interest in compliant fondling and noncoercive sexual activity with underage boys and girls, and the possible rape of an underage boy. Arousal to sexual aggression toward female adults was suggested.

Mr. B. has a diagnosis of pedophilia, sexually attracted to males, nonexclusive type; paraphilia not otherwise specified, nonconsenting males; and mild mental retardation. His psychiatric history indicates a history of successful treatment for depression in prison. He has been treated for insomnia and for depression. His medical history shows an electrocution at age six that he barely survived. He has no significant history of substance abuse. Recent testing in a sex offender treatment program revealed mild to moderate deficits in all language

and cognitive areas that were assessed in the speech and language evaluation.

Aside from sexual offenses, Mr. B. has no criminal history. Mr. B.'s community release from prison after the molestation of a boy was not successful. He was paroled after serving five years and was placed in a group home where he worked as a janitor. Three years later he sexually assaulted an autistic man who had extremely limited language skills.

Mr. B. was admitted to a state sex offender commitment program. His primary infractions were having multiple sexual relationships with peers, sexually touching peers, trading goods for sex, and soliciting peers for sex. He approached staff and reported having sexual thoughts. He had a history of providing sexual favors while on other units. Because of inappropriate touching of peers he was housed in a single room. He was described as having labile mood. In treatment, Mr. B. progressed slowly. He accepted only partial responsibility for his past illicit sexual behavior and was unable to empathize with the hurt and harm he had caused his victims. Mr. B. does not have any structured release plans.

Psychological testing indicated that he scored in the low range on the Hare Psychopathy Checklist-Revised, with a score of 11.

The Rapid Risk Assessment for Sexual offense Recidivism (RRASOR) was used to identify an approximate base rate for the risk of sexual reoffense.

The RRASOR of Mr. B. estimates that the sexual recidivism rate after five years' release to the community with a score of 5 is 49.8 percent and 73.1 percent after 10 years' release to the community.

On the Static-99, Mr. B. received a score of 6 in the high range of risk similar to the RRASOR score.

	Risk Factor Summary	Supports Likely Risk
1	Global risk factors	YES
2	Diagnosis	NO
3	Social skills deficits	YES
4	Behavioral tendencies	YES
5	Knowledge levels	YES
6	Treatment progress	YES
7	Release environment	YES
8	Acute dynamic risk factors	NO

Assessment Guide for Evaluation of Sexual Recidivism Risk in Mentally Retarded/Intellectually Deficient Offenders

RRASOR Score Summary

	Risk Factor	Scores (Yes, 1; No, 0)
1	Prior sex offenses?	3
2	Under age 25 at release?	0
3	Victim gender (any males)?	1
4	Any unrelated victims?	1
	Total score	5

Mr. B. scored in the high range on the Static-99 and he has several of the global risk factors. He has targeted both pre- and postpubescent males for sexual activity, he has violated conditional release by grooming and sexually assaulting an autistic man, and he has no structured release plans.

GLOBAL FACTORS SUPPORT LIKELY RISK? YES

I. Global Risk Factors		
a.	Actuarial-RRASOR (high risk) or Static-99 (high-risk)	Yes
b.	Multiple victim types	Yes
c.	Young children targeted for substantial conduct	Yes
d.	Sex offenses occurring during period supervision	Yes
e.	Unplanned discharge	Yes
f.	Offenses involving violence	No

Mr. B.'s sexual criminal history involves assaults on four boys and adult males and both the Abel Assessment for Sexual Interest and phallometric testing indicate sexual arousal to children. He has a classic expression of pedophilic behavior, having initiated sexual activity with younger children when he was not yet an adolescent. He admits to molesting 8 victims with 99 incidents of molestation over many years. Furthermore, he was aroused to sexual activity with nonconsenting adult male victims in his sexual offense and conditional release violations. His sexual offending is driven by his sexual deviancy rather than by antisocial behavior. Although he has a history of treatment for

depression, he currently does not have a mood disorder.

DIAGNOSTIC FACTORS SUPPORT LIKELY RISK? YES

II. Diagnosis		
a.	Pedophilia or paraphilia DSM-IV-TR	Yes
b.	Antisocial history, behaviors or diagnosis	No
c.	PCL-R high scores for those with ASPD traits	No
d.	Sex offenses occurring during period supervision	Yes
e.	Drug or alcohol abuse (increases impulsivity)	No
f.	Comorbid psychiatric disturbance (mood/psychotic)	No

Mr. B.'s history is notable for difficulty in engaging in appropriate peer sexual relations and repeatedly targeting lower functioning peers in institutions and the community. His sexual preoccupation interferes with his ability to maintain reciprocal relationships. He develops relationships to manipulate others for the purpose of meeting his sexual needs. He is high functioning enough to know what behavior is appropriate, but chooses to act in his own self-interest.

SOCIAL SKILLS DEFICIT FACTORS SUPPORT LIKELY RISK? YES

III. Social Skills Deficits		
a.	Poor social skills leading to associations with children	Yes
b.	Inability to form peer sexual relationships	No
c.	Targets lower functioning peers for sex	Yes
d.	Long-term institutionalization, with resultant skills deficits and restrictive environment	No
e.	Difficulty internalizing societal expectation	Yes
f.	Lack of assertiveness, is a follower	No
g.	Loneliness, lack of friends or other social support	No

Mr. B. has very poor impulse control regarding his sexual acting out. In his community residential placements, he seeks out children and low-functioning peers for sexual activity. In one placement he was said to spend most of the day seeking sexual outlets. In the sex offender treatment program, he has been promiscuous and has engaged in excessive grooming and sexual touching of other patients.

BEHAVIORAL FACTORS SUPPORT LIKELY RISK? YES

IV. Behavioral Tendencies		
a.	Low frustration tolerance	No
b.	Poor impulse control linked to sexual acting out	Yes
c.	Difficultt in delaying immediate sexual gratification	Yes
d.	Low self-esteem	No
e.	Lack of assertiveness	No
f.	Lack of compliance with supervision (probation/parole/ conditional release)	Yes

Mr. B.'s history shows an individual who has adequate knowledge of appropriate sexual behavior, as he is actively involved in sex offender treatment. He understands the illegal nature of sexual offending but has been unable to control his sexual deviancy.

KNOWLEDGE FACTORS SUPPORT LIKELY RISK? NO

V. Knowledge Levels		
a.	Little sexual knowledge	No
b.	Poor understanding of laws related to sexual behavior	No
c.	Unrealistic sexual expectations?	Unclear
d.	Lack of sexual experience with peers	No

Mr. B.'s treatment compliance is mixed. While his good attendance and work on his assignments has been acknowledged, he has continued to act out sexually and behaviorally. In essence, he is talking the talk, but not walking the walk. On the positive side, he has never dropped out of treatment.

TREATMENT PROGRESS FACTORS SUPPORT LIKELY RISK? YES

VI. Treatment Progress		
a.	Reverting back to pretreatment attitudes	Yes
b.	Poor response to treatment	Yes, some progress
c.	Staff complacency, allowing for negative behavior	No
d.	Manipulative behavior in treatment	Yes
e.	Treatment dropout or erratic attendance	No
f.	Cognitive distortions present	Yes

Mr. B. has no structured release plan, and his community supervision term has expired. He will once again be supported by services at the regional center and placed in some type of supportive living with similarly functioning peers. Unfortunately, this environment is identical with one in which Mr. B. has sexually acted out in the past. A program in a locked setting would be optimal, where he could continue to attend treatment. He could also be evaluated for a trial of antiandrogen medication to reduce his deviant sexual arousal.

RELEASE ENVIRONMENT FACTORS SUPPORT LIKELY RISK? YES

VII. Release Environment		
a.	Unstructured environment	Yes
b.	Lack of mandated supervision	Yes
c.	Inadequate community support	Yes

Mr. B.'s acute dynamic factors are largely not present, save for recent sexual preoccupation, which is his primary risk factor. His emotional states, routine, and compliance with supervision are generally improved in an inpatient setting, where he benefits from greater structure and direction.

ACUTE DYNAMIC FACTORS SUPPORT LIKELY RISK? NO

VIII. Acute Dynamic Risk Factors		
a.	Changes in social support (loss of family, involvement with negative peers)	No
b.	Changes in substance abuse	No
c.	Increase of sexual preoccupation	Yes
d.	Negative emotional states	No
e.	Change in attitude toward supervision	No
f.	Changes in ability to cope (lowered), feeling overwhelmed	No
g.	Changes to routine	No
h.	Offender-specific characteristics (conflict with others, impulsive decision to quit job)	Yes

Conclusion

Six of eight categories of factors support a risk that Mr. B. is likely to offend again. His primary risk factors are his deviant sexual preference, ongoing sexual preoccupation, and impulsive sexual acting out. His paraphilias qualify him for a mental disorder or mental abnormality for SVP/SDP purposes. That is, Mr. B.'s sexual behavior is more directly related to his sexual deviance rather than his neurobehavioral deficits. His mild mental retardation aggravates his sexual deviance by causing him more readily to act out his deviant sexual fantasies and urges.

	Risk Factor Summary	Supports Likely Risk
1	Global risk factors	YES
2	Diagnosis	YES
3	Social skills deficits	YES
4	Behavioral tendencies	YES
5	Knowledge levels	NO
6	Treatment progress	YES
7	Release environment	YES
8	Acute dynamic risk factors	NO

Summary

As the literature review and the case examples have underscored, assessing the level of risk that a mentally retarded/intellectually disabled sex offender poses for sexual recidivism is a challenge, one in which the empirical markers available from the overall study of sex offenders may be of limited value. Determining whether the risk level falls at the threshold needed to render a determination for SVP/SDP commitment (that is, generally in a high range) is an even more difficult task. Risk assessment in this population necessitates an examination of multiple factors, many of which may well be specific to a mentally retarded population. In this vein, Boer *et al.*[39] recommend a convergent assessment approach guided in part by the relevant data and the degree to which the instruments contribute to a comprehensive "risk" picture. They therefore suggest that instruments such as the RRASOR that have demonstrated some validity in the intellectually disabled population be more heavily weighted over other measures such as the PCL-R. They have constructed a model that represents at least a preliminary approach in conducting structured clinical assessments of risk in the intellectually disabled sex offender group. They suggest using the RRASOR, or the PCL-R in those demonstrating psychopathy, and noting stable dynamic factors related to the environment as well as the offender and acute dynamic factors related to changes in the environment as well as the offender.

We have sought to present a broad-based idiographic approach, one that utilizes some of the empirically identified risk markers, actuarial risk assess-

ment, and factors specific to a mentally retarded group. The risk factors considered in this guide were identified in the research as being related to sexual reoffense. This practical guide offers a model that is likely to lower the risk of both false-positive and -negative assessment results and to permit the clinician to render an opinion to a reasonable degree of certainty. A limitation to the approach is that it is not an exhaustive list of potential risk factors. For example, recent research has indicated that neurodevelopmental events that result in lower IQ or non-right-handedness may predispose an individual to pedophilic arousal.[46] Clearly, additional cross-validations of existing actuarial instruments and more refined risk variables specific to a mentally retarded sex offender population are needed to provide the empirical markers for risk assessments such as those required in the SVP/SDP process. For example, instruments such as the one presented this practical guide (Table 1) that consider risk factors that may be specific to the developmentally disabled sex offender can be subjected to validation that will derive empirical weights for the items and a measure of overall predictive accuracy.

References

1. Jackson RL, Hess DT: Evaluation for civil commitment of sex offenders: a survey of experts. Sex Abuse 19:425–48, 2007
2. Sreenivasan S, Kirkish P, Garrick T, *et al*: Actuarial risk assessment models: a review of critical issues related to dangerousness and sex-offender recidivism assessments. J Am Acad Psychiatry Law 28:438–48, 2000
3. Haaven J, Schlank A: The challenge of treating the sex offender with developmental disabilities, in The Sexual Predator: Legal Issues, Clinical Issues, Special Populations. Edited by Schlank A. Kingston, NJ: Civic Research Institute, 2001, pp 13-1–13-19
4. Christie MM, Marshall WL, Lanthier RD: A descriptive study of rapists and pedophiles. Ottawa, Ontario, Canada: Report to the Solicitor General of Canada, 1977
5. Gebhard PH, Gagnon JH, Pomeroy WB, *et al*: Sex Offenders. New York: Harper & Row, 1965
6. MacDonald JM: Indecent Exposure. Springfield, IL: Charles C Thomas, 1973
7. Mohr J, Turner R, Jerry M: Pedophilia and Exhibitionism. Toronto: University of Toronto Press, 1964
8. Rundle AT, Sylvester PD: Evaluation at physical maturity in adolescent mentally retarded boys. J Ment Defic Res 89–96, 1973
9. Berdiansky HA, Parker R: Establishing a group home for the adult mentally retarded in North Carolina. Ment Retard 15:8–11, 1977
10. Murphy WD, Coleman EM, Abel GG: Human sexuality in the mentally retarded, in Treatment Issues and Innovations in Mental Retardation. Edited by Matson JL, Andrasik F. New York: Plenum, 1983, pp 581–643
11. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
12. Frances A, Sreenivasan S, Weinberger LE: Defining mental disorder when it really counts: DMS-IV-TR and SVP/SDP statutes. J Am Acad Psychiatry Law 36:375–84, 2008
13. Sreenivasan S, Weinberger LE, Garrick T: Expert testimony in sexually violent predator commitments: conceptualizing legal standards of mental disorder and likely to reoffend. J Am Acad Psychiatry Law 31:471–85, 2003
14. Lindsay WR, Smith AHW, Law J, *et al*: A treatment service for sex offenders and abusers with intellectual disability: characteristics of referrals and evaluation. J Appl Res Intellect Disabil 15:166–74, 2002
15. Murphy WD, Coleman EM, Haynes MR: Treatment and evaluation issues with the mentally retarded sex offender, in The Sexual Aggressor: Current Perspectives on Treatment. Edited by Greer JG, Stuart IR. New York: Van Nostrand, Reinhold, 1983, pp 22–41
16. Glaser W, Deanne K: Normalization in an abnormal world: a study of prisoners with intellectual disability. J Offend Ther Comp Criminol 43:338–50, 1999
17. Harris AJR, Tough S: Should actuarial risk assessments be used with sex offenders who are intellectually disabled? J Appl Res Intellect Disabil 17:235–41, 2004
18. Schoen JH, Hoover JH: Mentally retarded sex offenders. J Offend Rehabil 16:81–91, 1990
19. Aadland JK, Afwerke P, Schumacher K: Individual Justice Planning: A Training Manual. Revised Edition, State of North Dakota, Fargo, ND, 1988
20. Nezu CM, Nezu AM, Dudek JA: A cognitive behavioral model for assessment and treatment for intellectually disabled sexual offenders. Cogn Behav Pract 5:25–64, 1998
21. Hingsburger D: I Witness: History and a Person With a Developmental Disability. Mountville, PA: Vida Publishing, 1991
22. Luiselli JK: Presentation of paraphilias and paraphilia related disorders in young adults with mental retardation: two case profiles. Ment Health Asp Dev Disabil 3:42–6, 2000
23. Hanson RK, Morton-Bourgon L: Predictors of sexual recidivism: an updated meta-analysis. Corrections User Report No. 2004-02. Ottawa, Ontario, Canada: Public Safety and Emergency Preparedness Canada, 2004
24. Hanson RK, Morton-Bourgon KE: The accuracy of recidivism risk assessments for sexual offenders: a meta-analysis. Corrections User Report No. 2007-01. Ottawa, Ontario, Canada: Public Safety and Emergency Preparedness Canada, 2007
25. Meehl P, Rosen A: Antecedent probability and the efficiency of psychometric signs, patterns or cutting scores. Psychol Bull 52: 194–216, 1955
26. Lund J: Mentally retarded criminal offenders in Denmark. Br J Psychiatry 15:726–31, 1990
27. Klimecki M, Jenkinson J, Wilson L: A study of recidivism amongst offenders with an intellectual disability. Aust N Z J Dev Disabil 19:209–12, 1994
28. Lindsay WR: Research and literature on sex offenders with intellectual and developmental disabilities. J Intellect Disabil Res 46: 74–85, 2002
29. Gross G: Activities of a development disabilities adult offender project. Olympia, WA: Washington State Developmental Disabilities Planning Council, 1985
30. Sundram C: Inmates with developmental disabilities in New York correctional facilities. Albany, NY: New York State Commission on Quality of Care for the Mentally Disabled, 1990
31. Hodgins S: Mental disorder, intellectual deficiency and crime evidence from a birth cohort. Arch Gen Psychiatry 49:476–83, 1992
32. Quinsey VL, Book A, Skilling TA: A follow-up of deinstitutionalized men with intellectual disabilities and histories of antisocial behaviour. J Appl Res Intellect Disabil 17:243–53, 2004

33. Hayes S: Sex offenders. Aust N Z J Dev Disabil 19:201–19, 1991
34. Lindsay WR, Elliot SF, Astell A: Predictors of sexual offence recidivism in offenders with intellectual disabilities. J Appl Res Intellect Disabil 17:299–305, 2004
35. Day K: Male mentally handicapped sex offenders. Br J Psychiatry 165:630–9, 1994
36. Langevin R, Pope S: Working with learning disabled sex offenders. Ann Sex Res 6:149–60, 1993
37. Blanchard R, Watson M, Choy A, *et al*: Pedophiles: mental retardation, maternal age and sexual orientation. Arch Sex Behav 28: 111–27, 1999
38. Grove WM, Meehl PE: Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: the clinical-statistical controversy. Psychol Public Policy Law 2:293–323, 1996
39. Boer P, Tough S, Haaven J: Assessment of risk manageability of intellectually disabled sex offenders. J Appl Res Intellect Disabil 17:275–83, 2004
40. Tough SE: Validation of two standard risk assessments (RRASOR, 1997; Static-99, 1999) on a sample of adult males who are developmentally disabled with significant cognitive deficits. Master's thesis (unpublished). Toronto: University of Toronto, 2001
41. Harris A, Phenix A, Hanson RK, *et al*: Coding rules for the Static-99 Revised. Corrections research: manuals and forms. Ottawa: Department of the Solicitor General of Canada, 2003
42. Quinsey VL, Book A, Skilling TA: A follow-up of deinstitutionalized men with intellectual disabilities and histories of antisocial behavior. J Appl Res Intellect Disabil 17:243–53, 2004
43. Lindsay WR, Murphy L, Smith G: The Dynamic Risk Assessment and Management System: an assessment of immediate risk of violence for individuals with offending and challenging behaviour. J Appl Res Intellect Disabil 17:267–74, 2004
44. Hanson RK, Harris AJR: The sex offender need assessment rating (SONAR): a method for measuring change in risk levels. User Report No. 2000-1. Ottawa, Ontario, Canada: Department of the Solicitor General of Canada, 2000
45. Lindsay WR, Marshall L, Quinn K: The treatment of men with a learning disability convicted of exhibitionism. Res Dev Disabil 19:259–316, 1998
46. Blanchard R, Kolia NJ, Cantor JM, *et al*: IQ, handedness, and pedophilia in adult male patients stratified by referral source. Sex Abuse 19:285–309, 2007