REGULAR ARTICLE

The State of Forensic Literature on Persons with Intellectual Disability Who Sexually Offend

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Persons with intellectual disability charged with sexual crimes (PWID/SC) pose a unique challenge for the forensic psychiatrist. They represent a heterogeneous group whose motivations and pathology range from a simple lack of adaptive functioning to more complex comorbid paraphilic disorders. Although there is a growing body of literature on the risk assessment and treatment of PWID/SC, there is a relative lack of guidance and research on the evaluation of these individuals throughout the legal processes that follow being charged with a sexual crime. To address this deficit, this article reviews the literature germane to several key aspects of this process. We first review the current understanding of intellectual disability and sexual pathology. We identify landmark legal decisions that may relate to PWID/SC. We then review the literature related to PWID/SC and competency assessments, defenses involving mental disease or impairment, sexually violent predator evaluations and court-mandated pharmacotherapy. We aim to both bring attention to this unique forensic population and highlight areas for further research and exploration.

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Walter Wooden was convicted of several sexual offenses against children over the course of his lifetime. In 2010, he was serving a federal sentence when proceedings for his civil commitment under the Adam Walsh Child Protection and Safety Act were initiated.[1] This act allows the government to civilly commit federal inmates after the completion of their prison sentence if the inmate is deemed to be a "sexually dangerous person" who committed a crime of child molestation or sexual violence. Several experts previously diagnosed Mr. Wooden with pedophilia. These experts further opined he would be a danger to others if released. He was civilly committed in 2014.[1]

In 2016, Mr. Wooden filed a petition for release. Dr. Frederick Winsmann, a psychologist retained by Mr. Wooden's attorneys, found that Mr. Wooden had an intellectual disability (ID) and functioned at the intellectual level of a 3rd to 5th grader. Dr. Winsmann opined that Mr. Wooden's actions, when viewed through the lens of his ID, did not flow from pedophilia, but from adaptive difficulties that caused him to seek contact with those whose mental age was similar to his own. The initial experts maintained their opinions despite acknowledging Mr. Wooden's ID. The Fourth Circuit Court of Appeals ultimately agreed with the opinion of Dr. Winsmann. The court concluded that Mr. Wooden's conduct was secondary to ID, not pedophilia, and he had been rehabilitated enough to reside safely in the community.[1]

This case highlights the difficult questions involved in examining a defendant who has ID and commits a sexual offense. Despite the challenges inherent in the evaluation of persons with intellectual disability charged with sexual crimes (PWID/SC), there is a dearth of literature and guidance on the subject. In this article, we explore the current understanding of PWID/SC and their journey through several key aspects of the legal system. We first define intellectual disability, then compare past and current Diagnostic

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and Statistical Manual (DSM) criteria and discuss their impact on the legal process. We then define sexual pathology and highlight landmark legal cases that relate to sexual offenses. Finally, we review literature in several key parts of the legal system in which forensic mental health providers may encounter PWID/SC, namely, competency assessments, defenses of mental disease or impairment, sexually violent predator (SVP) evaluations, and court-mandated pharmacotherapy. We highlight gaps in the literature in each section and conclude with a call for further exploration and research to fill those gaps.

Intellectual Disability

The approach to diagnosing intellectual disability has been refined over time. The most recent installment of the Diagnostic and Statistical Manual (DSM-5)[2] defines intellectual disability as "a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains" (Ref. 2, p 33). The diagnosis requires deficits in intellectual functioning (such as problem solving, learning from experience, and judgment) evaluated through both standardized and clinical assessments. Also required are deficits in adaptive functioning (such as communication and social participation) across multiple domains. Both intellectual and adaptive deficits must have onset during the developmental period. The clinician can then specify mild, moderate, severe, and profound subtypes based on the level of adaptive functioning.

By contrast, the DSM-IV-TR[3] defined intellectual disability (called "mental retardation" in this version of the text) as sub-average IQ (approximately less than 70), with co-occurring adaptive deficits in two or more areas (i.e., communication, social/interpersonal skills, work, and safety), and an onset prior to the age of 18. The DSM-5 expands the language of the intellectual assessment to include both clinical assessment and standardized measurement, whereas the earlier iteration defined general intellectual functioning as derived from "one or more of the standardized, individually administered intelligence tests" (Ref. 3, p 41). Other than the important change in the name of the diagnosis, the most striking difference between the texts is in severity classification, which was based on IQ in DSM-IV and adaptive functioning in DSM-5. With this change, the DSM moved the focus of assessment away from standardized measures to clinical assessment, and the importance of adaptive functioning was reinforced. Interestingly, one study looking at children evaluated for intellectual disabilities using both DSM-IV-TR and DSM-5 diagnostic criteria found that nine percent fewer evaluees met diagnostic criteria under DSM-5 compared with DSM-IV-TR.[4]

In some criminal cases, the courts have maintained that persons with ID should have special consideration based on the nature of their impairment. In the 2002 case of *Atkins v. Virginia*,[5] the Supreme Court determined that executing an individual with ID constituted cruel and unusual punishment. Delivering the majority opinion, Justice Stevens noted:

> Because of their impairments, however, by definition, they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others . . . their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability (Ref. 5, p 318).

The legal parameters for diagnosing intellectual disability were clarified in the 2014 case of *Hall v. Florida*.[6] The Florida statute defined a person with intellectual disability as one who scored two standard deviations below the mean on IQ testing. The U.S. Supreme Court ruled that the Florida Supreme Court erred in interpreting Florida's statute as requiring an IQ cutoff of 70. As IQ scores are imprecise, a firm cutoff did not allow for medical experts to weigh other important factors that may influence diagnosis, such as the standard error of measurement. The *Hall* decision also emphasized the importance of a more comprehensive assessment of the individual, including testing, collateral data, clinical judgment, and assessment of adaptive functioning,[7] a fact reflected in Justice Kennedy's oft-cited quote, "Intellectual disability is a condition, not a number" (Ref. 6, p 723). With the decision to place less emphasis on IQ score in its interpretation of the definition of intellectual disability, the Court reflected the changes made in the DSM-5 about the same time, which placed a heavier emphasis on clinical assessment of an individual's adaptive and intellectual functioning.

The Supreme Court revisited questions relating to standards for intellectual disability assessment in 2017 and again in 2019 in the case of *Moore v. Texas I* and *II*.[8,9] The question before the Court was whether the Texas Court of Criminal Appeals had

Table 1 Paraphilic Disorders[2]

Paraphilic disorder
Voyeuristic disorder
Exhibitionistic disorder
Frotteuristic disorder
Sexual masochistic disorder
Sexual sadistic disorder
Pedophilic disorder
Pedophilic disorder
Fetishistic disorder
Transvestic disorder
Other specified paraphilic disorder (i.e., zoophilia, necrophilia)
Unspecified paraphilic disorder

erred in its evaluation of Mr. Moore's intellectual disability, specifically its evaluation of his adaptive deficits. At the time, Texas relied on standards (called "Briseno factors") drawn from a stereotyped understanding of PWID which were considered outdated and did not appreciate the range of adaptive deficits and presentations PWID may display. The Supreme Court granted *certiorari* twice and ultimately found Mr. Moore to have an intellectual disability, thus making him ineligible for execution. Following these decisions, Mr. Moore was ultimately removed from death row and released from prison in 2020. The *Moore* decisions highlight the importance of the legal and the medical fields' evolving understanding of intellectual disability and the standards used to define it. It is also notable that the Briseno factors were based on the fictionalized character of Lennie in John Steinbeck's *Of Mice and Men*;[10,11] the reliance on this stereotyped portrayal reflects the prevailing stigma surrounding PWID in the community, stigma that lingers to this day.

Sexual Pathology

Definition

The DSM-5 lists ten diagnoses in the section entitled Paraphilic Disorders. A paraphilia is generally defined as ". . . any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (Ref. 2, p 685). See Table 1 for a list of disorders subsumed under this heading.

To be diagnosed with a paraphilic disorder, an individual must have a paraphilia and this paraphilia either causes distress, impairment or, by its nature, has the potential to harm oneself or another. Unlike in other sections of the DSM, this distress is not just subjective. As noted in the AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense,[12] the distinction between paraphilias and paraphilic disorders in legal and clinical literature was not made prior to DSM-5. Some paraphilic disorders, by their nature, do not directly involve harm to others or breaking the law; these include masochistic disorder, transvestic disorder and fetishistic disorder (although individuals could receive criminal charges by illegally obtaining fetishistic items, i.e., stealing women's lingerie). Some sexual paraphilias, if acted on with a nonconsenting individual or children (who are unable to consent), are considered criminal by their very nature and subject to prosecution.

Regarding those with ID, the Diagnostic Manual for Intellectual Disabilities (2nd ed.)[13] notes that one must ensure that sexual behaviors that appear to be paraphilias are not just the sequelae of poor psychosexual education, limited understanding of social norms or learned behavior (in the case of perpetrators who are themselves abuse victims). Care must be taken to differentiate a true paraphilia (behavior driven by persistent, recurrent, and preferred sexual interest) and problematic sexual behavior. For example, an individual with ID who has poor understanding of social norms may choose to masturbate in a public space without realizing the implications and potential harm to others walking by. The arousal comes not from exposure, but from the act of masturbating, and therefore would not meet the criteria for exhibitionistic disorder. Griffith *et al.*[13] provide guidance on factors to consider before diagnosing a person with intellectual disability with a paraphilic disorder, such as evaluating the impact of socio-sexual knowledge, the potential of learned behavior from abuse, or whether the person was mirroring institutionally learned behavior when diagnosing exhibitionistic behavior.

Landmark Supreme Court Cases

The U.S. Supreme Court's rulings relating to sexual offenders over the last few decades seem to reflect beliefs that: these individuals constitute a group at high risk for recidivism; their crimes may be related to an inability to control their actions; and their actions may be attributed to other mental health problems such as personality disorders or psychopathy.[14]

In *Allen v. Illinois*[15] the Supreme Court ruled that the process of committing someone as a SVP was a civil, and not criminal, process. Therefore, although

SVPs retained some safeguards found in criminal proceedings (e.g., the right to counsel), not all constitutionally mandated privileges were inherent in the process (e.g., the right to avoid self-incrimination). The Supreme Court went on to highlight that such statutes were instituted to provide treatment and were therefore not considered punishment. The constitutionality of civilly committing SVPs was challenged in *Kansas v. Hendricks*,[16] when the Supreme Court ruled states could adopt procedures to civilly commit persons who are found guilty of a sexual offense and are determined to be dangerous because of a "mental abnormality," "mental illness," or "personality disorder" (Ref. 16, p 358). The Court held due process was not violated in this case as it was civil (not criminal) in nature and required only proof of mental illness and dangerousness as grounds for commitment. Further, because of the civil nature of the proceedings, the principles of double jeopardy and *ex post facto* were not applicable.[17]

In 2002, the Kansas statute against sexually violent offenders was again brought before the Supreme Court in *Kansas v. Crane*.[18] Mr. Crane argued that the state had to prove he possessed a complete absence of control to civilly commit him under a SVP statute. The Court held, however, that a complete lack of control was unnecessary; rather the state was only required to prove Mr. Crane had difficulty controlling himself because of a mental disease or defect.[18]

After the Adam Walsh Act in 2006, Congress enacted 18 U.S. Code § 4248,[19] which allows for the civil commitment of federal prisoners deemed to be sexually violent. In *U.S. v. Comstock*,[20] the Supreme Court considered whether Congress had the authority to civilly commit federal prisoners found to be mentally ill and sexually dangerous after their prison sentence. They determined such an action was constitutional citing, "The Federal Government, as custodian of its prisoners, has the constitutional power to act to protect nearby (and other) communities from the danger such prisoners may pose" (Ref. 20, p 1952).

Other court decisions demonstrate a clear trend toward restricting the constitutional rights of sexual offenders. For instance, in *McKune v. Lile,*[21] the Supreme Court held that using incentives to encourage participation in a Sexual Offender Treatment Program, which included a polygraph test in which one may be required to confess to additional criminal activity, did not violate one's fifth amendment right against self-incrimination. It should be noted that failure to comply in this case led to loss of privileges (e.g., visitation rights) and potential transfer to a higher security prison. While the lower courts felt that the potential loss of such privileges constituted coercion, the Supreme Court noted reduction of penalties and other incentives have been used in cases to encourage acceptance of criminal responsibility throughout the justice system. In *Connecticut Department of Public Safety v. Doe*,[22] the Court allowed for community notification of a nearby offender using his picture and location as it served the purpose of protecting the public, which restricts the right to privacy suggested by the Constitution.

While the Supreme Court has not weighed in on the constitutionality of compulsory pharmacotherapy for sexual offenders upon release from prison, the above rulings indicate they may condone state-specific statutes permitting such procedures, especially if they are enacted under the stated purpose of treatment. In fact, several states, including Florida, California, and Alabama, currently have some form of "chemical castration" laws for sexual offenders.[23–25] These laws suggest that (depending on one's state of practice) a forensic psychiatrist who works with sexual offenders may come across this form of compulsory treatment.

PWID/SC

Persons with intellectual disabilities may commit a wide array of sexual offenses, from secretive voyeurism to violent rapes.[26–28] Although the nature and character of the PWID/SC population is beyond the scope of the current paper, it should be noted that they represent a heterogeneous group whose offenses can sometimes be driven by paraphilias or sociopathy,[27,29,30] and at other times, by factors such as inexperience, limited socialization, lack of education, and misunderstanding.[30–32]

The intellectual disabilities of some defendants may go unnoticed by the legal system, particularly if the deficits are not profound or disruptive.[33–34] Further, given that sexual crimes are seen as particularly abhorrent, investigators might be willing to overlook indications of disability in an effort to prosecute offenders more harshly.

In the case described in the introduction (*U.S. v. Wooden*), the Fourth Circuit Court of Appeals opined that an individual's ID likely contributed to his offending behavior and thus had implications for

his civil commitment.[1] This decision was made only after an expert recognized the interplay between sexual behavior and intellectual disability.

Although there is limited guidance within the psychiatric community on the assessment of the PWID/SC population in the forensic court setting, AAPL has taken notice of this group. The AAPL Practice Guideline for the Forensic Assessment [35] encourages psychometric testing in the evaluation of sexual offenders. Phenix and Sreenivasan[36] provide guidance on sexual recidivism risk assessment in the PWID/SC population. Wood *et al.*[37] provide guidance on modifications necessary for the evaluation and adjudication of all defendants with ID. While there remains a need for more guidance on how to evaluate the PWID/SC population, it is encouraging that forensic scholars have not remained silent on the topic. To better illuminate the importance of research and guidance about PWID/SC, we turn our focus to four specific aspects of the legal process that such individuals may encounter on their path through the legal system, highlighting areas for future research.

Legal Process and PWID/SC

Competency to Stand Trial

Although questions abound in the assessment of a defendant who has ID, one of the most frequent referral questions for a forensic examiner is that of competency to stand trial (CST). As mentioned previously, the court and the defendant's attorney may have difficulty discerning whether a defendant has ID. In the event such an individual's competency is in question, the forensic examiner should be aware of some unique features of this population that may cause their needs and deficits to be overlooked by an unsuspecting evaluator.

PWID/SC pose unique challenges for forensic psychiatrists, as there is a lack of education about intellectual disability throughout psychiatric training.[38–41] This may make it harder for an unfamiliar examiner to notice a deficit or how a deficit may influence examinees' responses. People with ID are more likely to look for external cues from others to know how to answer or behave, particularly during difficult or complex tasks.[42] They are more likely to acquiesce[43,44] or attempt to provide the "right" response as opposed to the accurate one.[45] They may be more suggestible[46–47] and this suggestibility may be enhanced when those interviewing them take a friendly approach.[47,48] Evaluators need to be aware of the tendency toward acquiescence and of their framing of questions when working with this population.[37] Examiners should also be aware that individuals with ID may try to hide their deficits.[34,35,37,49] Wood *et al.*[37] argue for a modified approach to CST assessments for this population, employing a variety of interview techniques to determine factual knowledge.

While the AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial[50] provides limited guidance for evaluations of offenders with ID, the AAPL Practice Guideline for the Forensic Assessment[35] provides a section on Assessments of Persons with Intellectual Disability, urging practitioners to be aware of specific laws regarding persons with ID in their jurisdictions. Recommendations are offered regarding behaviorally disruptive evaluees and evaluating capacity for consent to interview.

The topic of consent generates important ethics considerations. Depending on the nature of the evaluation, informed consent may not be legally required, although disclosure of the purpose and scope of the evaluation, as well as limits of confidentiality and rules regarding mandatory reporting, should always be included.[35,51] A defendant need not necessarily have a full understanding of all the pertinent information for court-ordered examinations to legally proceed.[35,51] According to guidelines, if the defendant is too impaired to understand the disclosures, it is considered ethically permissible to continue with the interview in the presence of a court order or with the permission of the defendant's attorney.[50] In general there is limited research on the degree to which those with intellectual disabilities understand these disclosures and to what degree this lack of understanding affects their engagement in these evaluations.

The same impairments that may make individuals with ID more vulnerable in interview settings may also prevent them from being competent to stand trial. Depending on the nature and extent of these impairments, difficulties with communication, tendency toward acquiescence, and poor abstract reasoning may limit such defendants' ability to work with their attorney, to testify, and to answer questions appropriately in a manner that serves their best interest.[47] In a 1991 report of 894 pretrial evaluations,

intellectual disabilities were an associated factor in 16 percent of the cases in which the defendant was opined to be incompetent to stand trial; most defendants with ID (64%) were found to be competent.[52] Incompetency was found in nine percent of those with sexual offense charges,[52] although the authors did not report whether persons with intellectual disabilities who were charged with a sexual offense were more or less likely to be opined incompetent. In a South African study, researchers noted that 90 percent of their sample of defendants with ID were found incompetent to stand trial and most were accused of sexual crimes; specifically, 58 percent were accused of rape and 7.5 percent were accused of "sex related offenses."[53] To date, there are no studies looking at the rate of incompetency among PWID/SC.

Once found incompetent, the likelihood of restoration appears to be proportional to IQ, with higher IQ scores correlated to a greater chance of restoration.[54–55] Further, the term "restoration" is a misnomer in the case of most PWID/SC, as competency would be gained, meaning one cannot restore knowledge and abilities that did not exist in the first place.[55] Defendants with ID may need specific tools and training to prepare them for the next stage in the legal process. For instance, Wall and Christopher[56] describe a training program specifically designed for defendants with ID. Other authors caution those involved in competency restoration programs to clarify whether defendants with ID have gained knowledge and understanding or whether they have memorized enough answers to appear competent.[57]

Although CST evaluations of defendants with ID and PWID/SC are similar at their core, evaluators should be especially aware of bias when formulating a forensic opinion regarding PWID/SC. As noted by the AAPL Practice Guideline,[35] evaluator biases may be introduced by evaluator expectations, the hiring entity, political considerations, and preferred outcome. Unfortunately, the degree to which bias related to the nature of the crime may influence the competency assessment of a PWID/SC is not clear from the available literature. Further, no studies could be found on the degree to which evaluators' prior education and training (or lack thereof) with persons with ID affected their ability to discern intellectual impairments or their comfort in determining competency among defendants with intellectual disability.

Defenses of Mental Illness or Impairment

In general, psychosis is the most often cited symptom present in insanity acquitees.[52,58] Although less common than other psychiatric diagnoses, intellectual disabilities can be a factor in evaluating insanity as well. In a 2004 study, 11 percent of defendants with "mental retardation/learning disorders" were opined to meet insanity standards by forensic evaluators.[58] Another study found similar results, with five of 39 defendants diagnosed with ID opined to meet insanity standards by evaluators.[52] Of note, individuals with ID are not discussed in the latest iteration of the AAPL Practice Guideline for Forensic Psychiatric Evaluation of Defendants Raising the Insanity Defense.[12] Further, we could not find any studies on how often those with PWID/SC raise an insanity defense or how often it is successful.

In the United States, if a state provides for an insanity defense, it generally adopts either the language of the M'Naughten standard or that of American Legal Institute (ALI). M'Naughten incorporates a cognitive prong only, such that defendants are considered insane who do not know the nature of their actions or the wrongfulness of the act.[12,58] In contrast, the ALI standard offers a volitional and a cognitive prong, such that defendants are considered insane who, because of mental disease or defect, are unable to appreciate the criminality (also known as wrongfulness; cognitive prong) of the action or to conform their conduct to the requirements of the law.[59–60] There is variation in the wording and use of the insanity defense standard by state.[59]

AAPL guidelines note that paraphilias may be the basis of an insanity defense depending on jurisdiction.[12] These guidelines do not address the impact of intellectual disabilities on sexual actions, arguably a more compelling basis for legal insanity. Consider a PWID/SC whose actions resulted from difficulty navigating social norms and lack of knowledge about sex, with deficits in learning and appreciation in these areas related to the nature of the disability.[30–32] Such a lack of appreciation of societal standards and education on sexuality may meet the requisite M'Naughten standard. The psychiatric literature is relatively silent on such interplay and would be fertile grounds for future research.

Further, there do not appear to be any studies evaluating the consequences of intellectual disability combined with a paraphilic disorder in terms of the

volitional prong of the insanity defense. We have found mixed results in the literature on the degree to which impulsivity drives the actions of PWID/SC.[26,61,62] In one study by Warren *et al.*[58] in Virginia (which employs volitional and cognitive prongs), all 30 individuals diagnosed with a paraphilia were opined to be sane. Warren *et al.*[58] did not code psychiatric comorbidities, thus it was unclear how many of those diagnosed with paraphilias also had an intellectual disability. Further, it appears that reliance on the volitional prong is limited. Warren *et al.*[58] found only 51 cases were based on the volitional prong alone among the 563 cases opined as meeting the insanity defense standard. In another study of 188 individuals opined to meet the insanity defense standard in Virginia, only sixteen opinions were based on the volitional prong alone.[63] Sixteen states allow for reliance on the volitional prong alone for an insanity defense, and many states have eliminated that prong entirely.[12]

The idea of finding individuals culpable for their crimes implies they possess the cognitive skills and awareness necessary to understand the consequences of their behavior and of social/legal norms, to rationally make a choice voluntarily and without coercion, and to control their behavior. Nevins-Saunders[49] argues some defendants with ID are unable to meet these requirements because of their disabilities and should be considered less criminally culpable. In *Atkins v. Virginia,* the Supreme Court also opined individuals with ID should be considered less culpable because of the nature of their mental defect.[5,37] This leads to another potential proffered defense: diminished capacity. The defense is based on evidence the defendant lacked the ability to form the necessary *mens rea* for the crime because of a mental abnormality. The definition varies by jurisdiction and some states have banned the defense (such as California and Arizona) or restricted its use significantly.[49]

It should also be noted that some states do not allow for the submission of an expert opinion on a defendant's capacity to form the necessary *mens rea* for a crime.[58] This was supported by the 2006 U.S. Supreme Court's decision in *Clark v. Arizona*,[64] in which the Court held that a state may bar expert testimony on the impact of the defendant's mental state on *mens rea.*[65] Arizona is one of thirteen states with such a restriction. Further, as pointed out by Nevins-Sanders,[49] the defense would not provide relief for defendants with ID who acted impulsively or because of emotional dysregulation but nevertheless intended the act. As with the insanity defense, the literature on diminished capacity in defendants with ID lacks guidelines and considerations for forensic clinicians called on to provide evaluation on such matters.

Table 2 States with Sexually Violent Predator/Offender Commitment Laws

Arizona[69]
California[70]
Florida[71]
Illinois[72]
Iowa[73]
Kansas[74]
Massachusetts[75]
Minnesota[76]
Missouri[77]
Nebraska[78]
New Hampshire[79]
New Jersey[80]
New York[81]
North Dakota[82]
Pennsylvania (juveniles only)[83]
South Carolina[84]
Texas[85]
Virginia[86]
Washington[87]
Wisconsin[88]

SVP Evaluations

There are currently 21 jurisdictions with SVP statutes (20 state, one federal; see Table 2)[14,66–68] that allow "sexually violent" individuals to be civilly committed after serving their prison sentence or after being released from a forensic hospital (in the case of insanity acquittees). Statues vary in their definition of SVP, burden of proof, and handling of requests for jury trials.[66]

States vary in the definition of mental abnormalities in their SVP statutes. Some states, such as Arizona, specifically identify a paraphilic disorder diagnosis as an appropriate mental abnormality under their statute. Other state statutes, like that of New Jersey, do not specifically discuss paraphilic disorder diagnoses but allow for them under case law.[66] Very few statutes address intellectual disabilities specifically. The North Dakota statute states intellectual disability does not qualify as a "mental disorder or dysfunction." While Texas does not specify intellectual disability within its definition, it does state it will provide services for those whose ID prevents them

from participating in treatment. No other state specifically discusses intellectual disabilities, and we could not find case law supporting the use of intellectual disability as the sole qualifying diagnosis.

SVP commitment statutes affect the PWID/SC population. In a 2012 study of 138 male defendants committed under Nebraska's SVP statute, eleven (8.2%) were found to have borderline intellectual functioning or "mental retardation."[89] In an earlier study of 190 defendants admitted under Washington State's SVP statute, nine (4.7%) were diagnosed with "mental retardation."[90] Other studies have found evidence of borderline intellectual functioning and ID in their samples of SVPs (26.9 to 28.5% and 7.7 to 14.2%, respectively) based on IQ scores.[91–92] Most diagnoses leading to commitment were paraphilic disorders. Unfortunately, these studies do not report data on the comorbidity between intellectual disability and paraphilic disorders or whether any PWID/SC was committed who did not have a paraphilic disorder. The presence of PWID/SC committed under these statutes again highlights the importance of forensic clinicians' familiarity with the evaluation and treatment of this unique group. In general, the prevalence of PWID/SC committed under these statutes, discussions of competency to consent to be interviewed for these evaluations, and whether forensic clinicians feel competent in assessing the role an intellectual disability may have on the risk of violent recidivism is unclear based on current literature.

This is not to say that there is no research at all pertinent to the PWID/SC in SVP evaluation and commitment. For instance, actuarial tools such as the STATIC-99R[93] and PCL-R[94] have been shown to be reliable and valid instruments in the ID population. Risk assessment in the PWID/SC population in general has received more attention in the literature than other forensic considerations within this population. Treatment has also received consideration in the literature.[95–97]

Questions have been raised about the reliability and validity of a paraphilic disorder diagnosis made by SVP evaluators.[98] This may be due, in part, to the relative lack of education of psychiatric residents in paraphilic disorders, including both didactics and clinical experience.[99,100] As discussed previously, psychiatric residents also lack education about ID and clinical opportunities to work with persons with intellectual disabilities. This lack of education would be particularly problematic for clinicians attempting to evaluate a PWID/SC for an SVP evaluation.

Antilibidinal Medications

The treatment of sexual offenders raises ethics questions. As noted by Glaser, "The boundaries between treatment and punishment have become increasingly blurred, with many treatment programs having primary aims which are mainly punitive in nature, e.g., protection of the community from the offender" (Ref. 101, p 144). The blurred line of therapist and punisher may be particularly confusing to an individual with ID who may have trouble navigating relationships at baseline.

Although many aspects of treatment of PWID/SC deserve a thorough understanding, we focus our attention here on the use of antilibidinal agents, sometimes known as "chemical castration." Despite its relevance to forensic psychiatry, it is an area not often discussed. Agents include GnRH agonists, steroidal antiandrogens, and SSRIs. There is a small but growing body of literature on the use of these agents, which demonstrates efficacy when used to treat paraphilic disorders.[102–105] Unfortunately, the quality of studies is often poor, with small sample sizes, lack of control groups, and relatively short follow up periods.[102–105] Researchers have examined the use of antilibidinal agents on persons with intellectual disabilities who have comorbid paraphilic disorders.[106–108] Yet, as noted by the most recent World Federation of Societies of Biological Psychiatry guidelines on the treatment of paraphilic disorders,[102] diagnosis of paraphilic disorders in persons with intellectual disabilities can be complicated and the use of antilibidinal agents in PWID/SC whose crimes are not sexually motivated is not indicated. Research does not support the use of other agents, such as antipsychotic medications, in the treatment of persons with or without a paraphilic disorder who commit a sexual offense; this would extend to persons with intellectual disabilities.[102]

While the use of antilibidinal agents shows promise in the treatment of paraphilic disorders, their use as part of court-mandated treatment is less clear. Eight states have active statues authorizing chemical (generally with medroxyprogesterone acetate or an equivalent agent) or surgical "castration" for sexual offenders, which vary by triggering crimes and whether treatments are mandatory or optional. Further, not all states with chemical castration statutes require an evaluation by a psychiatrist prior to mandating treatment (see Table 3).[24] Data on the number of

Table 3 Chemical/Surgical Castration Laws by State

State	Chemical or Surgical	Treatment Provided By	Informed Consent?
Alabama[109]	Chemical	Department of Health	Medical professional must inform individual of effects and potential side effects. Individual must sign acknowledgement of receipt of such information.
California[110]	Chemical (MPA or equivalent) or Surgical	Department of Corrections	Person must be informed of side effects of chemical treatment and must acknowledge receipt of this information.
Florida[111]	Chemical or surgical (choice of defendant)	Department of Corrections	Medical provider must determine whether defendant is a candidate. Informed consent is necessary if the defendant elects physical castration.
Iowa[112]	Chemical (MPA or other "approved" drug) or surgical (choice of defendant)	Department of Corrections	No information in the law regarding informed consent or involvement of medical professional.
Louisiana[113]	Chemical or surgical (choice of defendant)	Department of Public Safety and Corrections	Medical provider must determine whether defendant is an appropriate candidate. Informed consent is necessary if the defendant elects physical castration.
Montana[114]	Chemical (MPA or its chemical equivalent)	Department of Corrections	Person must be "medically informed of its effects."
Texas[115]	Surgical (elective)	Physician employed or retained by the department	Inmate must be evaluated by a psychologist or psychiatrist. A physician must obtain informed, written consent.
Wisconsin[116]	Chemical (antiandrogens or equivalent)	Licensed Physician	Must be assessed by a licensed physician. Treatment is monitored by a physician, who must also discuss the risks and benefits with the offender.

individuals mandated to treatment, outcome measures and the targeted diagnoses of these agents remain unclear based on current literature.

Chemical castration involves significant ethics considerations. When informed consent is required, such consent must be obtained from incarcerated individuals whose consent may be a requirement for their freedom. Further, chemical castration statutes do not always mandate an inquiry of informed consent and, when they do, it generally is limited to informing the defendant about the side effects only.[24]

Such informed consent is especially problematic for offenders with ID.[14] In cases where informed consent and physician involvement is required, the same concerns that were discussed in our section on competency to stand trial (such as a tendency to acquiesce or a lack of abstract reasoning) may interfere with capacity to consent to treatment. It is unclear whether physicians administering these agents feel comfortable with their use and monitoring and whether they are actively assessing the degree to which ID may be affecting the offender's ability to consent to treatment. In general, because of the limited data on court-mandated pharmacotherapy, relative lack of oversight, limited physician involvement, and unclear outcome measures, the current degree to which these agents are used on PWID/SC remains unknown.

There is evidence that more thorough oversight can and has been accomplished in other countries. For instance, a report on the use of antilibidinal agents for those with ID who sexually offended in Australia and New Zealand found deficits in the informed consent process and recommended use of pictures and oral checklists to ensure consent.[117]

As mentioned in our section on pertinent Supreme Court cases, the U.S. Supreme Court has not considered the constitutionality of court-mandated pharmacotherapy interventions for sexual offenders. It is interesting to note the Supreme Court ruled that the sterilization of a "feebleminded" eighteen-year-old was constitutional in *Buck v. Bell*.[118] Almost a century later, this ruling has yet to be overturned,[23] and stands as a bleak reminder of historical movements toward eugenics. This highlights the need to push for more oversight and research on the use of medications to "chemically castrate" those with ID, the degree to which

Table 4 Summary of Needed Areas of Research

Competency to Stand Trial (CST) Assessments in PWID/SC
Assess whether prior education affects evaluators' comfort in detecting intellectual disabilities and understanding how they manifest in CST assessments
Assess the degree to which PWID/SC understand disclosures made prior to CST assessments and to what degree lack of understanding affects their engagement in these evaluations and what they disclose to examiners
Determine rates of incompetency to stand trial among PWID/SC
Explore the role of bias in CST assessments in PWID/SC
Defenses of Mental Illness or Impairment in PWID/SC
Evaluate how often PWID/SC raise an NGRI defense and how often it is successful
Explore whether lack of appreciation of societal standards and lack of sexual education may, at times, meet insanity defense standards
Determine appropriate guidelines for the evaluation of diminished capacity in defendants with PWID/SC
SVP Assessments for PWID/SC
Determine the prevalence of PWID/SC who are committed under these statutes
Determine how often competency to consent to be interviewed is determined by forensic evaluators for these evaluations
Assess whether forensic clinicians feel comfortable evaluating the role an intellectual disability may have on determining whether a person is at risk for violent recidivism
Assess how accurate psychiatrists are in diagnosing a paraphilic disorder in a PWID/SC
"Chemical Castration" for PWID/SC
Determine how often these agents are being used on PWID/SC
Determine the process for obtaining informed consent (written, verbal) and how well those with ID understand the agents that they are receiving
Determine how comfortable psychiatrists are in treating those with PWID/SC with anti-libidinal agents

informed consent or coercion are employed, and whether these agents are being used to treat an underlying target of paraphilic disorders.

Conclusion

Overall, the PWID/SC poses a unique challenge for the forensic psychiatrist. There are two reasons for this challenge. The first is a relative lack of research, particularly in the United States legal system. This dearth of data is not consistent with other areas of research, including treatment and risk assessment of PWID/SC, where the literature is plentiful. It is often the work of colleagues in other countries such as Canada and Scotland that contributes most to our understanding of PWID/SC. There are few reports in the literature regarding the PWID/SC population from clinicians in the United States and within the U.S. legal system.

Throughout this article, we have reviewed available literature on PWID/SC while highlighting the relative gaps therein. We hope that juxtaposing what is known with what has yet to be explored will alert clinicians to the need for more research on PWID/SC. While this review and the concerns raised within it are by no means exhaustive, our hope is that it inspires further research and guidance in an area often overlooked by the forensic mental health community. Table 4 provides a summary of the areas of needed research cited throughout our paper.

A second reason for the challenging nature of PWID/SC is education, or lack thereof. Although we have not included a section devoted entirely to education on the topics of paraphilic disorders and intellectual disabilities among psychiatric residents and fellows in the United States, the impact of this lack of training discussed throughout our paper should highlight the importance of this topic. In an Editorial printed in a special edition of Academic Psychiatry devoted to topics of training in sexuality among American psychiatric residencies, Balon and Morreale[100] postulate that the lack of interest in research and involvement by psychiatrists in the field of sexuality (including paraphilias) may stem in part from a lack of exposure during training. In the case of PWID/SC, this concern is compounded by a similar lack of training in intellectual disabilities among residents. While there are many stakeholders, including accrediting bodies, department chairs, hospital leadership, and the trainees themselves, that would need to accept the inclusion of these topics, recognition of the lack of training by forensic clinicians is the first step in encouraging such curricula.

Similarly, acknowledging the gaps in our own field's research, understanding, and guidelines is an important first step in encouraging further exploration of the topic of PWID/SC. There is much fertile

ground for this exploration. As more fellows and early career psychiatrists join the field, there are more opportunities to expand our current knowledge base. It is only with more training, research, and guidance that we can ensure high-quality evaluation and treatment of PWID/SC within the legal system.

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