WORKING WITH DEVELOPMENTALLY DELAYED SEXUAL OFFENDERS: MYTHS AND TREATMENT

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ABOUT THE PRESENTERS – R. DEMPSEY, PSY.D

Rachyll Dempsey, Psy.D., QME is a Forensic Neuropsychologist and Qualified Medical Evaluator who has worked with individuals of all ages using evidence based treatments and measures in clinics, schools, medical, and forensic settings for over a decade. She is a California licensed psychologist who completed her Doctorate in Clinical Psychology at Argosy University, an American Psychological Association (APA) fully accredited program. Dr. Dempsey founded Psychological Assessment, Inc. in 2014 to offer quality psychological assessment on a larger scale. Psychological Assessment, Inc. is centrally located in Oakland, CA and employs experts in the areas of Competency Restoration, Forensic Evaluation and symptom validity testing, Neuropsychology including pediatric and geriatric, and Sex Offender Treatment.

ABOUT THE PRESENTERS - M. WYSOPAL, PSY.D.

Michelle Wysopal, Psy.D. is currently a Psychological Assistant for PAI, working as Program Director for the PAI Competency Restoration Program, Program Director for the Shaping Success Program (a Sex Offender Treatment Program) and as Assistant Training Director. She graduated from Alliant International University in 2014 with a doctorate in Clinical-Forensic Psychology. Dr. Wysopal has specialized in working with sex offenders on parole and probation, is CASOMB certified, and is looking forward to building her practice with sex offenders in the future.

PROGRAM DESCRIPTION

This presentation will aim to raise awareness about common myths about intellectually disabled and developmentally disabled individuals and provide concrete techniques in providing sex offender treatment with them.

OBJECTIVES

- Participants will be able to identify at least three myths about developmentally delayed sexual offenders.
- Participants will be able to describe at least three techniques for working with developmentally delayed sexual offenders.

BEFORE WE GET INTO THE CONTENT, LETS CLARIFY:

- DEVELOPMENTAL DISABILITY: A broad term that includes Autism Spectrum Disorders, Developmental Delay, Cerebral Palsy, Epilepsy, Fetal Alcohol Spectrum Disorders, and other disorders that occur during the developmental period.

DEFINITIONS

- INTELLECTUAL DISABILITY: An individual with an intellectual disability has below-average cognitive abilities. They must meet the following three criteria:

1. Deficits in intellectual functions (reasoning, problem solving, planning, abstract thinking, judgment, academic learning, etc.).

2. Deficits in adaptive functioning and a failure to meet developmental and sociocultural standards for personal independence and social responsibility.

3. Onset of intellectual and adaptive deficits during the developmental period.

DEFINITION SEXUAL OFFENDER

- An Individual who has been charged with and convicted of illegal sexual behavior.

EXAMPLES:

- Molestations/Lewd Act with a Minor
- Possession of Distribution of Child Pornography
- Prostitution, Solicitation, Pandering, or Pimping
- Rape
- Unlawful Sexual Intercourse
- Indecent Exposure
- Lewd or Lascivious Conduct
- Sexual Assault

DEFINITION OF INDIVIDUALS ENGAGING IN SEXUAL ACTING OUT BEHAVIORS

- Typically considered someone who is engaging in inappropriate or illegal sexual behavior that has not had contact with law enforcement.

Ex: Sexual Acting Out:

- Peeping tom activities
- Stealing underwear for sexual stimulation
- Viewing child pornography
- Solicitation of sex
- Masturbation in public

DEVELOPMENTALLY DELAYED SO

- 10-15% of people who commit sexual offenses have Intellectual Disability with a much higher percentage estimated for people with Borderline Intellectual Functioning.

(Nezu, 2005)

LAWS

- In 2004, Megan's Law was passed requiring sexual offenders to register with local law enforcement and providing the public with access to their information. (Megan's Law, 2009)
- In 2006, Jessica's Law was passed which, among other things, prohibited sexual offenders from residing within 2,000 feet of any school and park where children congregate. (CASOMB, n.d.)
- Penal Code Section 290 – requires all sexual offenders to register as such, providing their residence, for the remainder of their life. (CASOMB, n.d.)
- In 2006, Governor Arnold Schwarzenegger signed Assembly Bill 1015, which created The California Sex Offender Management Board. (CASOMB, n.d.)

CALIFORNIA SEX OFFENDER MANAGEMENT BOARD (CASOMB)

- CASOMB describes their vision as “decreasing sexual victimization and increasing community safety.”
- Every provider in the state of California that offers Sexual Offender Treatment has to be certified through CASOMB.
- CASOMB requires that its providers follow the Containment Model, which is a collaborative approach to sex offender management and became mandatory beginning in July of 2012.
- In addition, CASOMB recommends that its providers incorporate the Risk-Need-Responsivity Model in their approach to working with offenders.
- CASOMB providers and programs incorporate risk assessments into their treatment, in addition to creating treatment plans focused on reducing the risk level.

CONTAINMENT MODEL

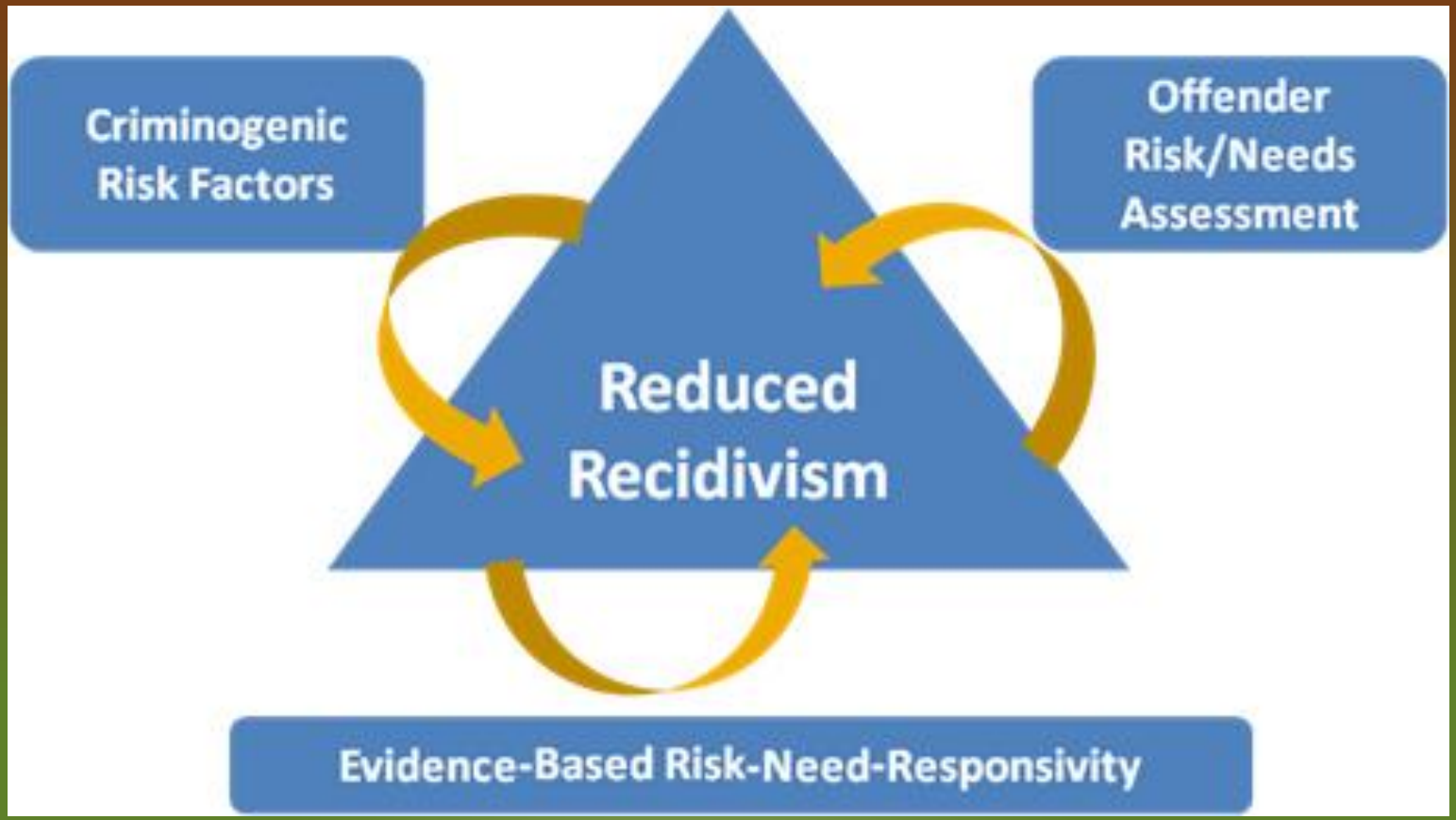
- Requires collaboration between the supervising officer, sex offender treatment provider, and polygraph examiner and is a victim-centered approach.
- Individual held accountable, obedience to parole/probation
- Preserve safety of community
- Continue to let individual live in community
- Line-of-sight supervision and case management

RISK-NEED-RESPONSIVITY

- RISK: Matching the level of treatment to the individual's risk level
- NEED: Identifying the criminogenic needs to address in treatment
- RESPONSIVITY: Adapting interventions to the learning style, motivation level, and strengths of the individual

(Bonta,J. and Andrews, D.A., 2007)

- Reduce maladaptive behavior
- Eliminate distorted beliefs
- Remove problematic desires
- Modify offense-supportive emotions and attitudes


Criminogenic Risk Factors
Offender Risk/Needs Assessment
Reduced Recidivism
Evidence-Based Risk-Need-Responsivity

MYTHS ABOUT DEVELOPMENTALLY DELAYED SEX OFFENDERS

- Individuals with developmental delay are often viewed as either sexually impulsive or child-like and asexual.
- Individuals with developmental delay who sexually offend against children are simply interacting with their emotional or intellectual peers.
- An individual with developmental delay who has sexually offended cannot understand that he or she has done something wrong.
- Treatment cannot benefit a developmentally delayed individual who engages in sexual offending behavior.

(Tudiver,J., Broekstra,S., Josselyn,S., & Barbaree,H., 1998)

MYTHS ABOUT DEVELOPMENTALLY DELAYED SEX OFFENDERS, CONT

- "Menace of the Feeble-Minded"

(Lambrick, 2004)

- Sexual offenses by Developmentally Delayed or Intellectually Disabled are just impulsive acts

(Parry, 2003)

TRUTHS

- Almost all intellectually/developmentally disabled individuals are able to gain an understanding of their offending behavior
- As such they can also take responsibility for it
- It is important to understand that ID/DD individuals have often been subjected to stigma, ostracism, and inappropriate or inadequate messages about their sexuality and relationships.
- Every offender, regardless of disability, must be treated with respect

TRUTHS

- Individuals with developmental delay do develop sexual interests, desires, and behaviors. Sexual behavior occurs on a continuum.
- Although some people view individuals with developmental delay a having a young “mental age,” they are not equivalent to children.
- Individuals with developmental delay can make appropriate decisions between a right and wrong action in most areas of their lives.
- There is some evidence that treatment may reduce recidivism rates for sexual offenders with developmental delay.
- Effective interventions could focus on the individual being more capable of managing their lives and being re-integrated in the community.

(Tudiver,J., Broekstra,S., Josselyn,S., & Barbaree,H., 1998)

STATISTICS

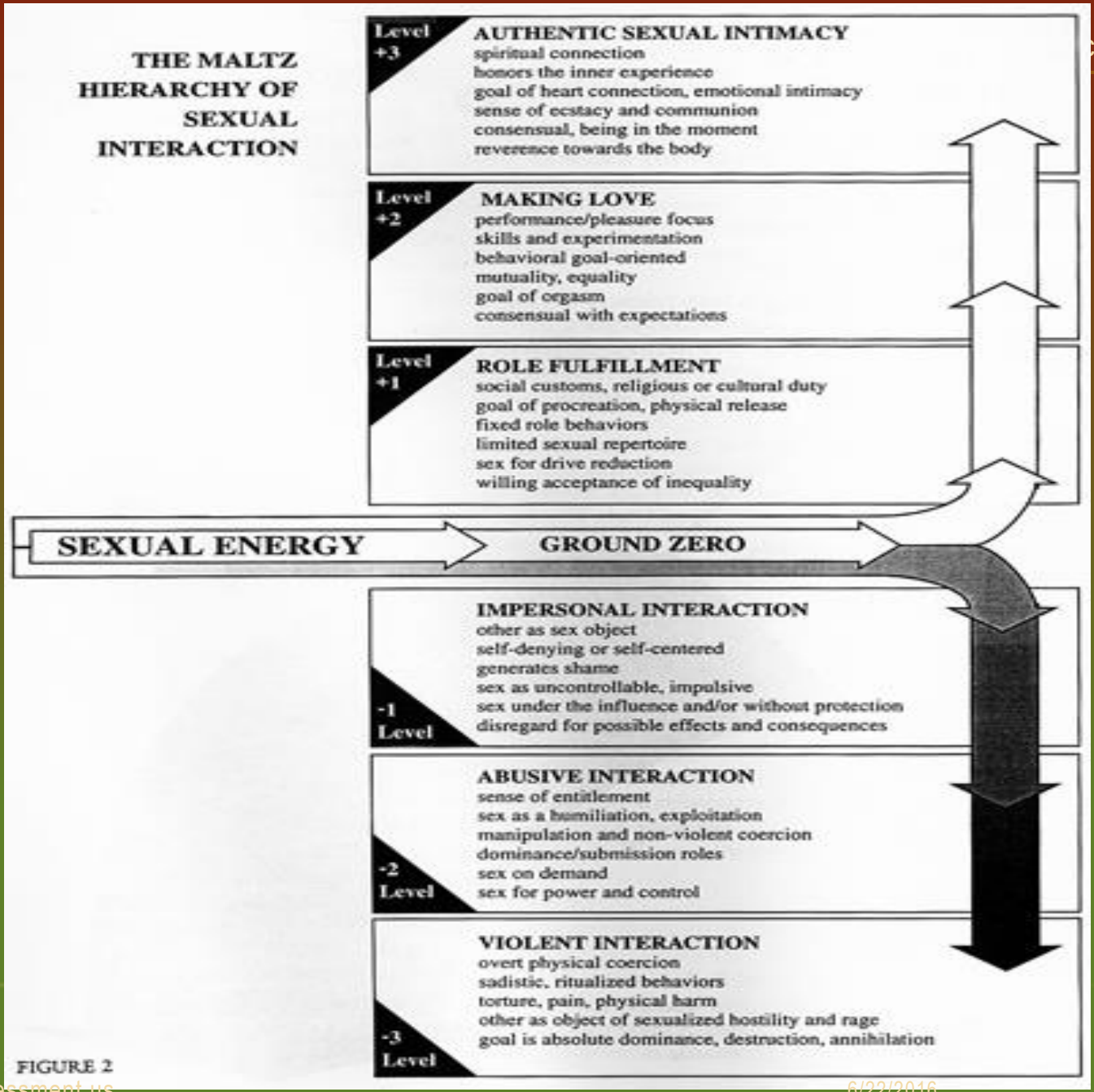
Compared to adult Non DD sex offenders, adult DD sex offenders:

- Have fewer victims
- Commit fewer “serious” sex offences but more “minor” or “nuisance” offences
- Females make up a smaller portion of their victims
- Deficit in social skills is more significant
- Can lack interpersonal skills and struggle in their interactions with the opposite sex
- Those who reoffend may not show a specific pattern in terms of offense type, age and sex of victim

(Tudiver,J., Broekstra,S., Josselyn,S., & Barbaree,H., 1998)

HEALTHY SEXUALITY

- Recognizing that all people are sexual begins.
- "Healthy sex involves the conscious, positive expression of our sexual energy in ways that enhance self-esteem, physical health, and emotional relationship. It is mutually beneficial and harms no one." (Maltz, W., 2016).
- Wendy Maltz and Beverly Holman (1987) presented the **C E R T S** Model:
  - **C**ONSENT
  - **E**QUALITY
  - **R**ESPECT
  - **T**RUST
  - **S**AFETY


THE MALTZ HIERARCHY OF SEXUAL INTERACTION
Level +3
AUTHENTIC SEXUAL INTIMACY
spiritual connection
honors the inner experience
goal of heart connection, emotional intimacy
sense of ecstacy and communion
consensual, being in the moment
reverence towards the body
Level +2
MAKING LOVE
performance/pleasure focus
skills and experimentation
behavioral goal-oriented
mutuality, equality
goal of orgasm
consensual with expectations
Level +1
ROLE FULFILLMENT
social customs, religious or cultural duty
goal of procreation, physical release
fixed role behaviors
limited sexual repertoire
sex for drive reduction
willing acceptance of inequality
SEXUAL ENERGY
GROUND ZERO
IMPERSONAL INTERACTION
other as sex object
self-denying or self-centered
generates shame
sex as uncontrollable, impulsive
sex under the influence and/or without protection
disregard for possible effects and consequences
-1 Level
ABUSIVE INTERACTION
sense of entitlement
sex as a humiliation, exploitation
manipulation and non-violent coercion
dominance/submission roles
sex on demand
sex for power and control
-2 Level
VIOLENT INTERACTION
overt physical coercion
sadistic, ritualized behaviors
torture, pain, physical harm
other as object of sexualized hostility and rage
goal is absolute dominance, destruction, annihilation
-3 Level
FIGURE 2

SEXUAL DEVELOPMENT (SRCP, 2016)

- 0-18 months: Children begin to differentiate between female and male roles. They discover their genitals and begin to touch themselves for pleasure (not orgasm).
- 18 months-3 years: Children learn the language for body parts and functions. They begin to behave and perceive others in gender-typed ways.
- 3-5 years: Children show a growing awareness of the body and its functions. They display curiosity about their own and the bodies of others. They may begin engaging in sex play.
- 5-6 years: Gender role differentiation and sexual identity development continues. Masturbation for pleasure (not orgasm).

SEXUAL DEVELOPMENT CONT.

- 6-9 years: As intellectual development continues, children are more able to understand the facts about sex, although not the emotional and erotic feelings. Possible beginning of puberty for females.
- 9-14 years: Beginning of puberty for males. Beginning or continuation of puberty for females. Possible concern about penis and breast size. Dissatisfaction with body. Possible interest in dating. Masturbation to occur in private. May ask questions about sexual orientation.
- 14-18 years: May experience problems with self-esteem and explore where they fit in. Peer pressure may be present. Engage in early sexual experiences. Learning about emotional readiness.

HEALTHY SEXUALITY

- Develops naturally when a person is afforded:
  - Accurate information
  - That is age appropriate
  - Does not shame for curiosity

Normal Sexual Behavior often involves:

- Confirmation of one's masculinity or femininity
- To get affection/keep a partner
- Rebel against parents
- Discharge anger/relieve boredom

(Blasingame, 2005)

CHILDHOOD SEXUAL ABUSE

- 15-33% of females and 13-16% of males in clinical populations
- 26-83% of developmentally delayed children
- Some studies estimate up to 1/3 of abuse victims have sexual acting out behavior later

SIGNS OF POSSIBLE SEXUAL ABUSE

- Knowledge or behavior not appropriate for a person's age or developmental level
- Excessive sexual activity
- Onset of sexual behaviors that were not seen in an individual (ex: sexual behavior toward a staff member)
- Change in sexual status
- Avoidance of people or places a person was previously confrontable with
- Changes in sleeping or eating patterns

(Blasingame, 2005)

SEXUAL ACTING OUT VS SEXUAL DEVIANCY

Phenix (2009) urges treatment providers to keep in mind the difference between:

- Social Skills deficit driven sexual acting out (ex: impairment in interaction and communication skills)

versus

- Sexual Deviancy (ex: pedophilia, sadomasochism)

THEORIES

Deviance Vulnerability

- Sexual Conditioning Theories
- Deviant Fantasies (and use of denial, minimization, rationalization)

Deficit Vulnerability

- Links problems with social incompetence, poor interpersonal skills, poor coping skills

(Nezu, 2005)

HIGHER RISK

- Family life includes parental separation, violence, and neglect
- Poor adjustment in school, relationships, behavioral problems, delinquency
- Inability to understand normal sexual relationships and lack of skills to form such bonds, susceptibility to the influence of others
- Impulsivity

(in Phenix, 2009)

COLLABORATION

- Cross Training is essential
  - Social Workers
  - Service Coordinators
  - Care Home Staff
  - Therapists
  - Probation Officers

(Blasingame, 2001)

COUNTERFEIT DEVIANCE HYPOTHESIS

- Individuals with intellectual disabilities often reside in environments in which appropriate heterosexual relationships, sexual developments, and the acquisition of sexual knowledge are not supported.
- Their development of sexual relationships may be ignored or discouraged.
- As a result, many individuals will have a limited opportunity for learning about a variety of issues related to sexuality, with a broad range of factors contributing to inappropriate sexual behaviors which are related to developmental and environmental issues – not sexual deviance.
- Lack of sexual knowledge, poor understanding of social conventions, and lack of opportunity for appropriate sexual expression contributes to inappropriate sexual behavior.

(As cited in Lindsay, W., 2009)

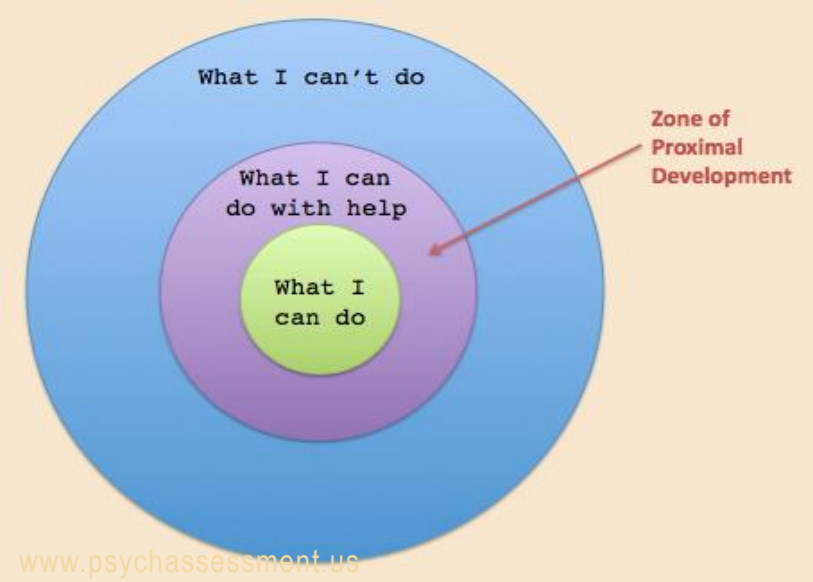
Treatment

AREAS TO ADDRESS IN INTAKE AND TREATMENT:

- Legal History
- Employment History
- Relationship History
- Medical/Mental Health History
- Abuse History
- Substance Abuse History
- Sexual Interests
- Deviant Interests
- Cognitive Distortions/Thinking Errors
- Pro-Social Skills
- Communication Skills
- Social Support
- Victim Empathy
- Offense Cycles
- Other Barriers to Success

ZONE OF PROXIMAL DEVELOPMENT

The Zone of Proximal Development helps clinicians and other professionals understand what the individual already knows, what the next learning steps will be, and what the individual can do alone versus what the same person can do with some help



(Blasingame, 2001)

TREATMENT

- Group Treatment
- Cognitive-Behavioral Therapy Theory
  - Cognitive Restructuring
  - Relapse Prevention

(Lambrick, 2004; Blasingame, 2001; Nezu, 2005)

MOST MODELS

- Implement an explanation/understanding of the cycle of offending
- Motivation to abuse
- Aversive developmental factors (biological, social, situational) which lead to getting needs met through offending.

(Courtney, 2006)

MOST MODELS INCLUDE:

- Discussion of Healthy Sexuality
- Right vs Wrong touching
- Right vs Wrong thinking
- Cycle of Offending
- Danger Zones and Triggers
- Victim Empathy
- Relapse Prevention

COGNITIVE-BEHAVIORAL TREATMENT

Three Stages of Learning:

1. Knowledge of social manners and practice of those behaviors in proper locations
2. Individual rehearsal of skills
3. Personal modification and maintenance of skills in a number of settings

(Blasingame, 2001)

COGNITIVE-BEHAVIORAL TREATMENT

- Help individual to separate the problem action from themselves
  - Ex: "I did a bad thing," vs "I am a bad person."
- Identify maladaptive behaviors that have been learned
  - Ex: Use of pornography to cope…
- Identify automatic thoughts that encourage bad habits
  - "I am disgusting/bad, I might as well watch that video."

(Blasingame, 2001)

ABUSIVE SEXUAL BEHAVIOR

Are often…	Are corrected by…
Automatic Thoughts	Cognitive Restructuring
Followed by instant gratification	Reconditioning
Maladaptive and Learned	Learn New Positive Skills
Coping Mechanisms	Accept Responsibility

NEGATIVE THOUGHTS

- "Stinkin' Thinkin"
- Wrong Way thinking
- Overgeneralization
- Filtering
- All or Nothing Thinking
- Personalizing
- Catastrophizing
- Emotional Reasoning
- Mind Reading
- Fortune Telling Error
- Should Statements
- Magnification/Minimization
- Rationalization
- Justification
- Denial

POSITIVE THOUGHTS

- Smart Talk.
- Self empowering beliefs.
- Optimism.
- If at first you don't succeed, try, try, again.
- Approaching problems from a different angle.
- Knowing one's limitations while striving to exceed expectations.
- Use of mantras.
- Visual cues can be used.

Danger Zones

- Places, people, or things that are likely to lead to relapse

High Risk Factors / Triggers

- Emotional States or risky situations which would lead to re-offense

(Blasingame, 2001)

SAFE PLANS

- Intervention strategy for when an individual is in a Danger Zone or High Risk Situation
- Helps to set boundaries
- Helps to redirect thoughts/behaviors
  - “Stay Away from the Park/kids”
  - “Call my mom”
  - “Use my words”

(Blasingame, 2001)

RELAPSE PREVENTION

- Identification of Triggers, High Risk Situations
- Taught coping mechanisms
  - Avoidance
  - Support System
  - Thought Stopping

(Blasingame, 2001)

RELAPSE PREVENTION

- Life Skills
  - Stress management
  - Communication
  - Stability/Structure
  - Support System

(Blasingame, 2001)

CONCRETE METHODS:

- **Use of Socratic Questioning:**

  Make an attempt not to provide the individual will all of the answers. Make an attempt to ask questions that may elicit the information from participants. This will help them retain the information.

- **Use of Role Play:**

  Allows the individual to engage in the pretend scenario in a genuine way which then can elicit feedback from the clinician. Afterwards, the individual can analyze the situation and the potential consequences.

- **Use of Metaphor:**

  Allows the individual to explore the relevant areas of a problem without the personal threatening context of the real situation. Eventually, the person can move from the metaphor to discussing their specific offense.

(Lindsay, 2009)

ADDITIONAL METHODS:

- **Use of Recording:**

  Allowing the individual to take notes during the session, or to take notes during a group session. Can help them recall what occurred the previous session and increase accountability for assignments in which they discuss their case that they attempt to deny at a later time.

- **Skills Teaching:**

  Teaching appropriate social skills and establishing appropriate knowledge of sexual behavior. (Craig, L., 2010)

- **Information Presented Concretely:**

  Individuals with developmental delay are not always capable of understanding the nuances of language or the “gray area.” Presenting them with facts and potential consequences allows them to further develop their understanding of right from wrong.

ADDITIONAL METHODS CONTINUED

- **Use of Repetition:**

  Using repetition through didactic and homework assignments will contribute to retention. Problems with memory, processing, or attention, may impact the individual's ability to remember important information if it is only presented once.

- **Teaching Problem Solving Skills:**

  Identifying the problem, creating alternatives, evaluating and selecting alternatives, implement the solution.

CREATIVE TREATMENT METHODS

- Multi-media – Videos, movie clips
- Pictures, Posters
- Collages
- Board Games
- Songs
- Client as teacher

(Blasingame, 2001)

CREATIVE REINFORCEMENT METHOD

- Token Economy
- Positive Reinforcement
- Sense of Humor
- The Fan Club Book (Client creates a book that is written in by staff)
- Behavior Contracts

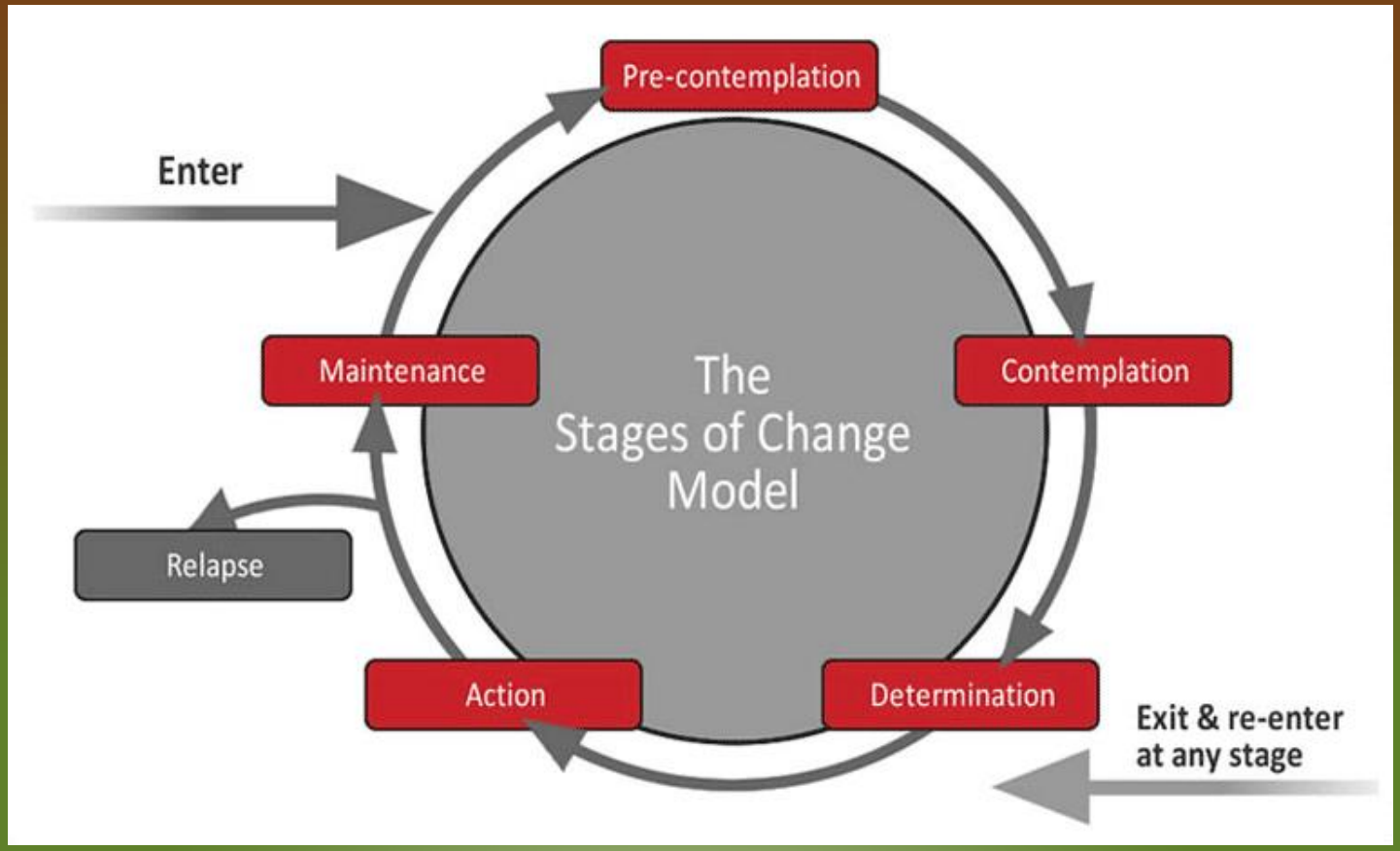
(Blasingame, 2001)

VARIOUS PROGRAMS

- The "New Me" Program (Craig, 2010)
- Good Lives Model (Lindsay, 2009)
- The Reiss Model (Lindsay, 2009)
- DD-SORT (Blasingame, 2001)
- Project STOP (Nezu, 2005)

- Work Book – Footprints, Steps to Healthy Life, 2nd ed.
  Hansen, K., and Kahn, T.L., 2012

PROCHASKA AND DICLEMENTE'S STAGES OF CHANGE MODEL



BECOMING NEW ME (TREATMENT PROGRAM) (CRAIG, 2010)

- Block 1: Getting Going (Getting to know each other, developing rapport, developing rules and expectations).
- Block 2: New Me (Members present their background history, key life events, their families, interests, and hobbies).
- Block 3: New Me and Sex (Establishing a common starting point and giving group members access to vocabulary for sexual terms and acts).
- Block 4: My Feelings (Clarify words used to describe feelings, learn about link between feelings, thoughts, behaviors).
- Block 5: Making it OK (Taught to understand the concept and purpose of excuses, may excuse offending by external, unstable causes – identify risky thinking).
- Block 6: My Risky Things (Identify risky areas the lead to offending).
- Block 7: Old Me Versus New Me and Offending (Disclosure of offenses to the group, New Me thinking that was not strong enough to prevent the offending is explored, aim for an unminimized account of events).
- Block 8: Mid-treatment Individual Interview (an individual session is offered to strengthen motivation and commitment to change).
- Block 9: Other People's Feelings (Continuing emotional recognition and beginning an understanding of victim impact).
- Block 10: What My Offending Does to Victims (Increasing victim empathy).

MOTIVATION

GOOD LIVES MODEL:

Excellence in Work and Play
Inner Peace
Knowledge
Excellence in Agency
Friendship
Community
Spirituality
Happiness
Creativity

THE REISS MODEL:

Social Contact
Curiosity
Honor
Family
Independence
Power
Order
Idealism
Vengeance
Romance
Exercise
Acceptance
Tranquility
Eating and Saving
Status

(Lindsay, 2009)

DD-SORT PROGRAM

- Views inappropriate sexual behavior as learned.
- Relies on cooperation from multiple agencies including schools, family, referral agencies, residential care
- Multiple Phases
- Groups are co-lead and capped at 6 members
- Incorporates a gradual increase in difficulty level for new material
  - Role Play
  - Treatment Group using Different Behavior
  - Residential, Day, and school Settings
  - Community Activities

DD-SORT

- Phase #1 – Identify and own inappropriate sexual behavior
- Phase #2 – Deconstruct cognitive distortions
  - This is helpful most for individuals with developmental disabilities
- Phase #3 – Reconstruct cognitive process into positive process
- Phase #4 – Maintenance and follow-up

DD-SORT
BEHAVIORAL MODIFICATION INTERVENTIONS

- Positive Programming – encoding positive behaviors & thoughts
- Shaping – reward behaviors close to the target behavior
- Prompting & Fading – Prompts help alert individuals to a situation, then are phased out
- Task Analysis and Chaining – smaller tasks within larger tasks are identified and completed
- Generalization – teach caregivers the same prompts and skills used in sessions

(Blasingame, 2001)

PROJECT STOP

- Multi-component, Cognitive-Behavioral Model
- Individual, group and family therapy
- Individual treatment plans based on assessment
- Problem Solving, anger and stress management, cognitive restructuring, interpersonal skills training, social and sexual education, and functional family therapy.

(Nezu, 2005)

OTHER/ADDITIONAL INTERVENTIONS

- Medication Management
- Behavioral Interventions
- Family Therapy
- Leisure/Community Skills
- Job/Vocational Skills
- Parenting Skills

MEDICATIONS

- Group 1 – Works to reduce impulsivity and regulate mood:
  - Sertraline, Fluoxetine, Paroxetine, and Clomipramine
- Group 2 – Consists of a variety of hormone medications to decrease levels of testosterone
  - Cyproterone Acetate, Depo Medroxyprogesterone Acetate, and gonadotrophin releasing hormone agonists such as Triptoreline and Goserelin.

(Lambrick, 2004)

BEHAVIORAL INTERVENTIONS

Largely have fallen out of favor due to lack of scientific efficacy with ID SO

- Covert sensitization
- Masturbatory satiation
- Aversive therapy
- Biofeedback

(Courtney, 2006)

CASE STUDY

A 24 year old, Caucasian male with an intellectual disability has been referred to you by his mother for “inappropriate touching.” Upon further discussion, you find out that his mother has walked in on him masturbating in the living room on multiple occasions. Recently, the client was escorted home by the police because he was masturbating on a park bench. During treatment, you find out that the individual never learned about sex from his mother, referencing that he learned about sex by watching Sex and the City. You also learn that his mother grounded him as a result of the park incident but there was no further discussion of the incident. The individual has recently purchased a computer and has begun learning how to browse the internet. He has learned how to access pornography cites and his favorite category is “amateur.”

DISCUSSION

- What are some things to consider about his upbringing and background?
- Do you think that this individual has a clear understanding of norms surrounding masturbation and self-exploration?
- What do you think is the most concerning statement he has made in treatment?
- What would be your concerns for the future if no treatment interventions were offered?
- What areas would you address?
- What other information would you like to know?
- How would you work with this person?

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