AN ATTEMPT TO IDENTIFY OBSERVABLE
BEHAVIORAL CHARACTERISTICS ASSOCIATED
WITH MENTALLY RETARDED SEX OFFENDERS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the
Graduate School of the Ohio State University

By
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* * * * *

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Dedicated in loving memory to
my father Quintino Nardis
ACKNOWLEDGEMENTS

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CHAPTER I
INTRODUCTION

The sexuality of retarded individuals has historically been replete with myths, stereotypes, and misunderstandings - even among their caretakers (Baroff, 1986). Wolfensberger (1972) indicated that the sexuality of retarded persons was portrayed by authority figures as menacing and dyseugenic. Sexual information was purposely withheld and many of them were sterilized, typically without their consent (Schoen & Hoover, 1990).

During the early 20th century the professional community armed with data from heredity studies, aggressively, pursued restrictive measures to control marriage, enforce sterilization, and produce segregation through institutionalization. The misconception of heredity and its role in mental retardation is aptly illustrated by Barr's (1904) analysis of 3,050 cases published in 1904. In each case Barr carefully distinguished between the various known and supposed causes acting before birth, at birth, or after birth. In this review Barr listed a number of etiological factors such as syphilis, premature labor
and accidents, but, he indicated that each ailment or condition was directly attributable to the individuals heredity. Barr (1904) went on to write that

"the transmission of imbecility is at once the most insidious and most aggressive of degenerative forces; attacking alike the physical, mental, and moral nature, enfeebling the judgement and the will, while exaggerating the sexual impulses and the perpetuation of an evil growth, a growth to often parasitic", (Scherenbeegger, 1983).

During this period one of the most famous genealogical investigations which further perpetuated these misconceptions, was Goddard's study of the Kallikaks, published in 1912. Goddard wrote that the Kallikaks provided:

"as it were a natural experiment with a normal branch to compare our defective side. We have one ancestor giving us a line of normal people that shows thoroughly good all the way down the generations, with the exception of the one man who was sexually loose and the two who gave away to the appetite for strong drink. Over against this we have the bad side, the blood of the same ancestor contaminated by that of the defective mentality and bad blood having been brought into the normal family of good blood" (Goddard, 1912, pg 68. ).
Goddard's conclusion that feeblemindedness is inherited was quoted widely. The American Breeders' Association in 1913 summarized the sentiments of many and suggested that: "the following classes must be considered unfit and should if possible be eliminated from the human stock if we would maintain or raise the level of quality essential to the progress of the nation and our race: 1) the feebleminded, 2) paupers, 3) criminaloids, 4) epileptics, 5) the insane, 6) the constitutionally weak, 7) those predisposed to specific diseases, 8) the congenitally deformed, 9) those having defective sense organs" (Scheerenberger, 1983 pg. 154).

Nothing was discussed more frequently as a possible solution to the problem than was sterilization during the first several decades of the 20th century. Despite the absence of scientific data, the eugenics movement had a profound effect on our nations legislatures and courts (Abramson, Parker & Weisberg, 1988). In 1907 Indiana was the first state to pass sterilization legislation and by 1912 eight states had passed such legislation. These laws were supported solely for the prevention of mental retardation (Scheerenberger, 1983). Of the eight states which imposed sterilization, five included rapists, all included confirmed criminals, six made reference to idiots, imbeciles, and
the feebleminded, four included the insane, and two included epileptics. By 1926, 23 states had enacted related laws; however, some of those were declared unconstitutional, (e.g. Indiana, Nevada, New Jersey, and New York). In contrast Michigan and Virginia were declared constitutional. The United States Supreme Court addressed the constitutionality of this statute in the Virginia case of Buck v. Bell, 274 U.S. 200 (1927). This case, which received national attention, involved Carrie Buck an 18 year old woman who had been committed to the State Colony for Epileptics and Feebleminded of Virginia. The counsel argued that this statute was void under the 14th Amendment because it denied her due process of the law and equal protection of the laws. The court implied that mental retardation was inherited, indicating that Carrie Buck was a feeble minded woman, the daughter of a feebleminded mother, and the mother of an illegitimate feebleminded child (Abramson, Parker, & Weisberg, 1988). Consequently, the court upheld the constitutionality of the statute and reasoned "it is better for all the world, if instead of waiting to execute degenerate offspring for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover the cutting of the Fallopian tubes....three generations of imbeciles are enough "(Scheerenberger. 1983).
It was not until the mid 1960's that the sexuality of persons with mental retardation came out of the shadows. At this time nearly all professional organizations working with people with mental and physical handicaps accepted the statement of rights, "Declaration of General and Special Rights of the Mentally Retarded". This seven article statement drafted by the International League of Societies for the Mentally Handicapped in 1968 indicated under Article IV; that

"the person has the right to live with his own family or with foster parents; to participate in all aspects of community life, and to be provided with appropriate leisure time activities. If care in an institution becomes necessary it should be in surroundings and circumstances as close to normal living as possible. This includes the right to marry and have children and to maintain a "normal" social life" (Declaration of General and Special Rights of the Mentally Retarded, Article IV, 1968)

With these "rights" professionals, advocacy groups, and parents, have begun to recognize the normalcy of sexual functioning among mentally retarded individuals (Craft & Craft, 1981; Edmonson, McCombs, & Wish, 1979). Schilling and Schinke (1989) postulate a continuum of controversy around persons with mental retardation, ranging from the strong-advocacy position, where sexuality is considered a necessary part of being human; the moderate-advocacy, where sexual intercourse
is not encouraged but caretakers accept that sexual intimacy may occur; the value-free position, where individuals would be neither encouraged to engage in any kind of sexual practice nor discouraged from doing so; and lastly, the negative position where persons with mental retardation should abstain from all sexual conduct.

This continuum offers clear evidence that society is "struggling with issues involving mentally retarded persons and "normal" sexuality", (Schilling, & Schinke, 1989). Surprisingly, despite the vast amount of literature addressing the issue of "normal" sexuality, little has been published about the extent to which intellectual deficits and sexual deviance may be related (Schilling, & Schinke, 1989).

What is often ignored or simply misunderstood is the fact that systematic limitations on the normative expression of sexuality can have an impact on the rest of the social behaviors of this population and criminality may be one of the results. For example, persons with mental retardation face greater difficulties, in the sense that persons whom they may encounter and whom they may find appealing, are forbidden as partners. This type of social-historical-experiential understanding is critical. However, the literature indicates that caretakers are resistant to provide heterosexual skills training or assign alternative permitted methods of sexual expression. Ultimately,
the individual is isolated from obtaining or understanding the appropriate environmental cues and stimuli which are learned, shaped, and reinforced within a mainstream developmental environment (Edmonson, Leland, deJung & Leach, 1967). Gebhard (1973) indicates that when mentally retarded individuals reside in atypical environments (e.g. institutions or their equivalent), their behavior is correspondingly atypical (e.g. inappropriate masturbation, non-volitional homosexuality). Thus, as Schilling and Schinke (1989) point out, it may be possible that the societal proscription intended to prevent undesirable sexual conduct may actually encourage the commission of sexual offenses among the retarded population.

Sexual deviance includes a wide range of behavior. Some deviant behavior may not always involve a violation of public standards or lead to an abuse of an individual's rights (i.e., fetishes or transvestite practices which occur behind closed doors), and therefore not generally a concern for society since they are not observed as a threat to another person (Schilling & Schinke, 1989). In contrast, other sexual phenomena, such as rape, are clearly offenses against individuals has thus produced a classification scheme for necessary for legal, and therapeutic purposes. Further, persons with mental retardation are typically no allowed the social tolerance otherwise afforded minor deviance, (Leland & Smith, 1974).
According to the American Psychiatric Association's (1987) Diagnostic and Statistical Manual of Mental Disorders: Third Edition - Revised (DSM III-R), the Sexual Disorders are a separate category from Anti-Social Behavior in General and Personality Disorders. Sexual Disorders now include Gender Identity Disorders, Psychosexual Dysfunction, and Paraphilias.

Paraphilias are manifested by 1) recurrent deviant fantasies, 2) intense erotic cravings, and 3) relatively stereotyped behaviors as a response to those cravings. Overall, nine categories of Paraphilias are listed: pedophilia, exhibitionism, transvestism, voyeurism, zoophilia, fetishism, erotic sadism, erotic masochism, and other sexual acts that do not fit into these aforementioned categories (APA, DSM III-R, 1987 pps. 183).

This dissertation and the related research will be primarily centered on the category of Pedophilia as it varies in individuals with mental retardation or developmental disability. According to the DSM III-R,

"the essential feature of pedophilia, is recurrent, intense sexual urges "and arousing fantasies, of at least 6 months in duration involving sexual activity with a prepubescent child. The person has acted on these urges, or is markedly distressed by them. The age of the child is generally 13 or younger. The age of the person is arbitrarily at age16 years or older, and
at least 5 years older than the child. For late adolescents with the disorder, no precises age difference is specified, and clinical judgement must be used; both sexual maturity of the child and the age difference must be taken into account. People with Pedophilia generally report an attraction to children of a particular age range, which may be as specific as within a range of only one or two years. Those attracted to girls usually prefer eight to ten year olds, those attracted to boys usually prefer slightly older children. Attraction to girls is usually twice as common as attraction to boys. Many people with Pedophilia are sexually aroused by both young boys and young girls. Some people with Pedophilia are sexually attracted only to children (exclusive type), whereas others are sometimes attracted to adults (nonexclusive type). People with this disorder who act on their urges with children may limit their activity to undressing the child and looking exposing themselves, masturbating in the presence of the child, or gentle touching or fondling of the child. Others, however, perform fellatio or cunnilingus or penetrate the child's vagina, mouth, or anus with their fingers, foreign objects, or penis, and use varying degrees of force to achieve these ends. These activities are commonly explained with excuses or rationalizations that they have "educational value" for the child, that the child derives "sexual pleasure" from them, or that the child was
"sexually provocative" themes that are also common among pedophilic pornography. The person may limit his activities to his own children, step children, or relatives or may victimize children outside his family. Some people with the disorder threaten the children to prevent disclosure. Others, particularly, those who frequently victimize children, develop complicated techniques for obtaining children, which may include winning the trust of a child's mother, marrying a woman with an attractive child, trading children with others who have the disorder, or, in rare instances, bringing foster children from nonindustrialized countries or abducting children from strangers. Except in cases in which the disorder is associated with Sexual Sadism, the person may be generous and very attentive to the child's needs in all respects other than the sexual victimization in order to gain the child's affection, interest, and loyalty and to prevent the child from reporting the sexual activity.

Age at onset: The disorder usually begins in adolescence, although some people with Pedophilia report that they did not become aroused by children until middle age.

Course: The course is usually chronic, especially those attracted to boys. The frequency of pedophilic behavior often fluctuates with psychosocial stress. The recidivism
rate for those people with Pedophilia involving a preference for the same sex is roughly twice that who prefer the opposite sex.

Predisposing factors: Many people with this disorder were themselves victims of sexual abuse in childhood.

Differential diagnosis: Isolated acts with children do not necessarily warrant the diagnosis of Pedophilia. Such acts may be precipitated by marital discord, recent loss, loneliness. In such instances the desire for sex with a child may be understood as a substitute for a preferred but unavailable adult. When pedophilic behavior involves a family member (incest), a diagnosis of Pedophilia should be made if the diagnostic criteria are met. In such cases there is pedophilic behavior with children outside of the family. In Mental Retardation, Organic Personality Syndrome, Alcohol Intoxication, or Schizophrenia, there may be a decrease in judgement, social skills, or impulse control, particularly in the elderly, that, in rare instances, leads to isolated sexual acts with children; but in such cases sexual activity with children is generally not the consistently preferred method for achieving sexual satisfaction. In Exhibitionism exposure may be to a child, but the act is not a prelude to further sexual activity with the child. Sexual sadism may, in rare
instances, be associated with Pedophilia, in which both diagnoses are warranted.

Diagnostic Criteria for 302.20 Pedophilia
A. Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving sexual activity with a prepubescent child or children (generally age 12 or younger).

B. The person has acted on these urges, or is markedly distressed by them.

C. The person is at least 16 years old and at least 5 years older than the child or children in A.

Note: Do not include a late adolescent involved in an ongoing sexual relationship with a 12 - or 0 13 year old.

Specify: same sex, opposite sex, or same and opposite sex. Specify if limited to incest.

Using pedophilia in a broader sense, Groth (1983) differentiated "fixated" from the "regressed" pedophiles. The "fixated" individual is developmentally arrested so that children remain
the primary sexual interest and a sexual interest in adults fails to develop. The regressed individual has had adult sexual relationships but reverts to an interest in children when frustrated with the adult relationship (Rowan, 1988).

Araji and Finkelhor (1985) reviewed the existing literature and proposed a four factor model: 1) **Sexual arousal**: In order for an adult to be "excited" by a child, there would have to have been familial conditioning to sexual activity with children, victimization as a child, or early fantasy reinforced by masturbation, 2) **Emotional congruence**: occurs when there exists a level of comfort and satisfaction in relating to a child and a fit of emotional need. This is reportedly due to arrested development either through retardation, immaturity, or low self-esteem, 3) **Blockage**: involves the absence of adult sexual experiences by traumatic experience with adult sexuality, sexual dysfunction, and/or inadequate social skills, and 4) **Disinhibition**: which involves the loss of control via an impulse disorder, senility, mental retardation, or through alcohol, drugs, stress, or nonexistent family rules. This four factor model is helpful not only in summarizing the literature but also aiding in the treatment and prevention of pedophilia (Rowan, 1988). Furthermore, according to Pithers (1989), a thorough analysis of clinical and criminal records, social and sexual histories, self-reports, court, institutional, and victim reports, allows the clinician a preliminary assessment of both high risk situations
as well as a wide range of offense precursors of the maladaptive behavior. According to Knopp and Lackey (1987), while no validated offender typologies or longitudinal outcome studies on specific models of treatment for adult sex offenders currently exist, working guidelines and data sources used to assess risk for nondisabled sex offenders are generally useful for assessing disabled clients. Risk issues characteristically found among these offenders are stated as follows (Haaven, Little, & Petrre-Miller, 1990 p.p. 4-7):

1. **Impulsivity** - because internal controls are sometimes lacking, the intellectually disabled sex offender's life may be characterized by an even greater degree of impulsivity than the nondisabled sex offender. These individuals are less likely to envision a productive future and are further impaired by an inability to understand the relationship between their behavior and its respective consequences. They have a highly externalized "locus of control" and are therefore dependent on the "cues" from society to guide their behavior. Feelings of frustration, anger and disempowerment, obscure their thinking and often result in poor coping strategies in dealing with the ordinary demands of everyday life. A high degree of impulsivity in an individuals nonsexual history may heighten the risk of offending sexually.

2. **Predatory Behavior** - Sex offenders with mental retardation seem to be less covertly predatory than their non-retarded counterparts. Their victims are often the result of an impulsive act with little discrimination for the victim selected. It may then be very difficult to predict "high risk" situations or a specific age or gender group that might trigger sexually aggressive behavior.
3. Fire setting, Animal Torture, Enuresis - The propensity for aggressive behaviors appears to increase dramatically with intellectually disabled sex offenders whose histories are comprised of fire setting, animal torture, and enuresis. It is also noted that setting fires to occupied dwellings places the individual at a greater risk to reoffend.

4. Expressive vs Instrumental Violence - Those using expressive violence in the commission of crime are at the highest risk for reoffending because the violence is intentional, since the inflicted injury maybe a part of the arousal pattern. Whereas, instrumental violence is characteristic of offenders who have lost control and use violence as a means to ensure compliance. The intellectually disabled offender is more likely to use instrumental violence since he may lack the verbal skills of coaxing, bribing, and manipulating, and his tendency to panic in novel situations.

5. Chronic Substance Abuse - Substance abuse has a tendency to exacerbate the lack of control and will-power characteristic of many individuals with mental retardation. Invariably, the abuse of an illicit drug only lowers their inhibitions and place the intellectually disabled offender at a greater risk to reoffend.

6. Social Skill Deficits - The intellectually disabled sex offender often exhibits significant deficits in accepting responsibility for their own behavior, independent living skills, establishing and maintaining adult relationships, and solving life crises.

It is recognized that this typology does not exactly fit with our knowledge of Mental Retardation so that it will be the purpose of this study to investigate these elements plus what other characteristics may emerge, through an exploration of the
behavioral and developmental history of adult male pedophiles with mental retardation, who have been charged or convicted of a criminal offense.

The following table (TABLE 1) is a review of various studies in this area, and the characteristics they derived. These derived characteristics, are not necessarily present in all persons with pedophilia, and there is no available literature identifying them with level of intelligence.

Little is known or reported in the literature about how sexual deviance is related to intelligence or to intellectual deficits. Problems in adaptation, and social compliance in persons with mental retardation and/or developmental disabilities may play an important role in gender development. Although the sexual offender with mental retardation represents the exception rather than the rule, pedophiles with mental retardation present unique treatment, and assessment problems. Most professionals who specialize in treating sex offenders with "normal" intellectual functioning, have limited experience with individuals also diagnosed with mental retardation, while those who treat individuals with mental retardation often lack the knowledge regarding the treatment of sex offenders (Murphy, Coleman, & Haynes, 1983). Currently, we have no satisfactory solution to the question of the optimal treatment, setting, or
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<td>Gilby, Wolf, and Goldberg (1989) (Survey) SAMPLE/ Sexual pros of 74 MR and 121 Non MR</td>
<td>exhibit non-assaultive sexual behaviors, public masterbation, exhibitionism</td>
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<td>Reviewed 7 year data SAMPLE/ 10 adolescents with MR</td>
<td>school problems, social deficits, behavior problems, theft, fire setting, 72 arrested for sex assault; 33 for sex offenses</td>
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<td>social skill deficits</td>
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<td>failed prior treatment</td>
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<td>Gross (1985) (Survey)</td>
<td>SAMPLE/ 154 MR/DD OFFENDER FILES</td>
<td>35% arrested for sexual assault</td>
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<td>poor peer relations</td>
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<td>Schoen and Hoover (1990)</td>
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procedure; there are no specific measures which are presently available for use by clinicians; and there are no identified general characteristics associated with pedophiles who also have mental retardation. Therefore, the main purpose of this dissertation is to examine the characteristics of individuals with pedophilia who have also been identified as having mental retardation.

Problem Statement

Following a period of considerable speculation as to whether individuals with mental retardation may also exhibit mental disorders (Lewis & Maclean, 1982), research has concluded that such disorders are common among the mentally retarded/developmentally disabled population. According to Matson (1985), individuals with mental retardation may be at an increased risk to develop a mental illness due to the presence of significant brain damage, the co-incidence of sensory impairment and seizure disorders, aberrant behaviors associated with genetic syndromes, and the atypical social and emotional experiences associated with delayed development. Despite the increased level of risk, professional attention devoted to the development and standardization of assessment instruments specifically aimed at identifying psychopathology among individuals with mental retardation has been relatively slow. For example, as recent as 1990, Reiss concluded that
there has been so little research on the occurrence of mental health disorders among individuals diagnosed with mental retardation that "scientists are still in the early stages of developing valid measures and defining research issues" (Reiss, 1990).

To date, Matson and Coe (1993) postulate that disturbances such as psychosis, self-injury, affective disorders, anxiety, and conduct disorders continue to receive the most coverage because these conditions create substantial behavior management problems. However, it is becoming more apparent that individuals with mental retardation are also at risk for developing other disabling conditions including the largely neglected area of sexual deviancy. Despite, the substantial material published regarding the gender development and identity of individuals with mental retardation, lacking from this literature is research aimed at assessing and diagnosing sexual disorders.

In the case of pedophilia and mental retardation, classical theories that rely on underlying causality are difficult to apply since lower functioning individuals are unable to provide reliable interview data, or to respond typically to assessment instruments used with their non-retarded counterparts. However, by applying the definition of diagnosis as stated in Leland and Smith (1974), preventative measures can be
explored on the basis of structural observations and tests including: 1) previous history, 2) field observations of behaviors and symptoms, 3) expected behaviors for age group and cultural group, and 4) developmental expectations. For this particular study, the following (and most frequently cited in the research literature) 4 specific characteristics have been identified and will be explored in an attempt to identify specific characteristics associated with mentally retarded pedophiles:

1. Sexual Knowledge
2. Social Skills
3. Impulse Control
4. Aggressive Tendencies

Research Questions:

Among groups of persons with mental retardation:

1. Will the pedophilic and offender groups show similar or different sexual knowledge when compared to each other or to the non-offender group as measured by the SSKAT?

2. Will the pedophilic and offender groups show similar or different behavioral control when compared to each other or to the non-offender group as measured by the ABS-RC:2?
3. Will the pedophilic and offender groups reveal similar or different impulse control scores when compared to each other or to those obtained by the non-offender group as measured by the Prout-Strohmer?

4. Will the pedophilic and offender groups demonstrate similar or different social skill competency and behavior when compared to each other or to the non-offender group as measured by the Social Judgement Scale?

Definition of Terms

Adaptive Behavior - refers to the effectiveness with which an individual meets the standards of personal independence and social responsibility expected of one's age and cultural group (Grossman, 1983).

Adolescent Child molester - An individual between the ages of 13 and 18 who engages in sexual behavior with a prepubescent male or female

Child molester - one whose whose conscious sexual desires and actions are directed at least in part toward dependent
developmentally immature children and adolescents who do not fully comprehend these actions and cannot give informed consent (Barnard, Fuller, Robins, & Shaw, 1989).

Mental retardation - refers to subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period (Grossman, 1983).

Paraphilia - the existence of unusual or bizarre imagery or acts which are necessary for sexual excitement. Such imagery or acts involve either: 1) preference for use of a nonhuman object for sexual arousal, 2) repetitive sexual preference with humans involving real or simulated suffering or humiliation, 3) repetitive sexual activity with nonconsenting or inappropriate individuals (APA, DSM III-R, 1987).

Pedophile - an individual whom exhibits recurrent intense sexual urges (over a 6 month period), and sexually arousing fantasies involving sexual activity with a prepubescent child or children. The individual, who is at least 16 years old and at least 5 years older than the child or children, has acted out on these urges or is significantly distressed by them (APA, DSM III-R, 1987).
Sex offender - An individual whose behavior with a non-consenting person has resulted in a legal charge or action.

Victim - an individual who has been coerced or forced to submit to non-consentual behavior.
CHAPTER II
REVIEW OF THE LITERATURE

In order to gain a better understanding of people with pedophilia and mental retardation the following chapter will be divided into two sections; Section I, will review the theoretical formulations of psychosexual development and psychosexual pathologies noting that most of the literature is based on hypothetical "norms" and makes no attempt to explore the complexities associated with each diagnoses. Section II, will be devoted specifically to the analysis of Pedophilia, through a review of its definition, and will outline current treatment strategies aimed exclusively at rehabilitating persons with pedophilia and mental retardation or developmental disability.

It should be noted to the reader that there is great deal of difficulty in comparing the data presented in the following chapter because of the changing definition of mental retardation on one hand, and because of continuous differences between states and between departments of MR/DD; MH; and corrections
in defining who is or is not retarded. Under many circumstances the human organism is challenged to adapt to various social and physical environments. The acquisition and utilization of appropriate adaptive behaviors is the essence of a successful existence throughout the human life span (Sherwood, 1980). Although in the human species there is a repertoire of behavioral responses which are innate, the majority of coping strategies must be acquired through both formal and experiential learning obtained in the context of interpersonal relationships with other members of the species (Leland, 1978). Throughout the development of a human organism, qualitatively different adaptive competencies are needed at different developmental periods. Thus, the emergence of new coping strategies have a basis in the adaptive skills learned during prior developmental stages (Sherwood, 1980).

**Psychosexual Development**

According to Psychoanalytic Theory early psychosexual development determines; the quality of relationships an individual will develop with his/her family; future interpersonal adult relationships; and the general social order of one's life (Chaplin and Krawiec, 1960). Freud viewed personality development as a succession of five invariant stages each characterized by dominant methods of achieving sexual pleasure. Despite the major emphasis on early experiences, Freud did
acknowledge the relative importance of the period following puberty in which he named the "genital stage". At this time, due to physiological changes, the genital organs become capable of sexual functioning, and a "resurgence of narcissism and and autoeroticism accompanies the development of the sexual organs" (Chaplin and Krawiec, 1960). Hence, following the latent period in which sexuality lies dormant, the revival of sexual urges results in conflict between the id and the superego upsetting the balance between the intrapsychic systems. According to Freud this is one reason why adolescence is often a period of emotional turbulence. The child is physically mature and strongly attracted to the opposite sex, while at the same time, he is attempting to cope with the fear of this reactivated attraction. Freud believed that appropriate gratification at each stage is essential for the for the development of a satisfactory heterosexual relationship. However, he cautions that at any stage during the course of psychosexual development, fixations, can interfere with the child's motivational system resulting in a disturbance in personality development. Like Freud, Adler, stressed the importance of the early years as the critical factors in the development of the child's character structure. Although, Adler did not assign a fundamental role in personality development to sexuality. Instead, he believed that Freud neglected the importance of the child's social relationship with its parents and siblings, suggesting that both the pampered child
and the rejected child are at risk of becoming maladjusted (Chaplin & Krawiec, 1960).

Ellis (1936) proposed a view of human sexuality which takes into account an integration of the senses, early experiences, social and cultural influences, while moving away from the notion of a universal measure of normalcy. Ellis describes sexual deviation as: "a condition in which the psychological sexual processes either abridged or deviated in such a way that some special part of the process or some object or action normally on its margin or even outside it altogether, becomes, often at an early stage the chief focus of attention" (Ellis, 1937, p. 149). Inevitably, children within whom an atypical sexual element is discerned, are considered, by Ellis, at an increased risk to develop antisocial behaviors unrelated to the area of sexuality.

Blos (1941) states that the direction of normal adolescent development can be described as necessary tasks that must be accomplished in order to achieve personal maturity. First, is the attainment of sexual development, which is achieved by the adolescent freeing himself from the childhood dependence upon his parents. He must redirect this affection toward people outside of the family structure. The method by which the individual meets this demand is strongly influenced by childhood experiences with the family. Second, is the
attainment of sexual maturity which involves the individuals ability to develop appropriate heterosexual relationships and establish a code of ethics and expectancies within this relationship. Finally, the adolescent must achieve economic independence. This allows independent mobility and personal privacy which the child is denied and for which the adolescent seeks (Blos, 1941). Blos also theorized that adolescent development proceeds through six stages, each requiring a transformation in psychic structures. The structures are the following: drive motivation, ego development, physical maturation, conflict recognition and resolution. Blos indicates that sexual deviance can result from a disturbance during any of the noted stages, although, he stresses that the potential danger is during the earlier stages (Porter, 1989).

By contrast, Erickson (1963), mitigates the significance of sexual development by emphasizing the need for the adolescent to make the transition from childhood to adulthood by developing a sense of identity. According to Erickson the adolescent crisis is essentially psychosocial rather than biological. Although, he indicates that most adolescents eventually succeed in making this transition, "The danger of this stage is role confusion. To keep themselves together they temporarily over identify, to the point of apparent loss of identity with the heroes of cliques and crowds. This initiates the stage of "falling in love" which is by no means entirely or even primarily a sexual matter. To a
considerable extent adolescent love is an attempt to arrive at a
definition of one's identity by projecting one's diffuse ego image
on another and by seeing it thus reflected and gradually
clarified. This is why so much love is conversation" (Erickson,
1963 p. 262). Essentially, if sexual identity remains diffuse
the ego identity is then obscure, possibly resulting in future
sexual disturbances.

According to Porter (1989), normal adolescents are less secure
about body image than their 1960's predecessors and exhibit a
greater focus on their ability become competent adults. They
demonstrate a greater sense of self-worth, a high self-esteem,
and are generally more optimistic about the future. Coping with
sexual feelings and impulses are less of a problem and these
adolescents demonstrate a more realistic perception of sexual
expression. On the other hand, the adolescent sex offenders
exhibit a low self-esteem, a general disturbance in their ability
to develop worthwhile reciprocal relationships, and cope with
the demands of reality through distancing behaviors and
emotional detachment. They are also more likely to act upon
their sexual fantasies since their perceptual distortions are not
modified by environmental cues. Overall, the adolescent
offender "has not been found to be a sub set of delinquency but
instead, is a unique group motivated by a series of
developmental and cognitive disturbances. They reflect atypical
adolescent development characterized by constriction, inhibition,
and a "god like" ability to define morals and ideal life styles" (Porter, 1989, p.129). (For a more comprehensive discussion of psychosexual development please refer to the Porter (1989) doctoral dissertation).

Sexual Psychopathology

In his historical survey of sexual psychopathology Rada (1978) reported two events that directly influenced the study of sexuality: the publication of Kinsey, Pomeroy, and Wardell, (1948) *Sexual Behavior in the Male*, and the enactment of "sexual psychopath statutes in various states throughout the country" from the period of 1948 through 1965 (Finkelhor & Russell, 1984). The Kinsey report established the area of sexual behavior as being suitable for empirical research. Following this survey, a majority of states, across the country, instituted statutory regulations regarding psychopathic sexual behavior, and a number of institutions have been established for the purpose of research and rehabilitation of sex offenders (Barnard, Fuller, Robbins & Shaw, 1989).

In an attempt to profile defendants charged with child molestation and rape, Hen, Herjanic, and Vanderpearl, (1976), revealed that over 75% of the rapists fell in categories of personality disorders or no psychiatric illness. Furthermore,
among the child molesters personality disorders were not predominant, and only 6% were found to be "antisocial". The dominant diagnosis was pedophilia without other disorder, and was given to 29% of the noted population. Other factors which contributed to this group were organic brain syndrome, mental retardation, and schizophrenia. Drug abuse and Alcoholism were the predominant secondary diagnosis in both groups (rapists and child molesters). However, it was noted that the relatively high rates of mental retardation, organic brain syndromes, and schizophrenia were most likely due to the fact that the majority of the subjects in the sample population were specifically referred for a comprehensive psychiatric evaluation. Hen, Herjanic, and Vanderpearl, (1976) went on to conclude that youth and antisocial tendencies are two very common features among rapists. More interestingly, they suggested that the myth of the "crazy rapist" appears to be the exception, since psychoses may, in fact, "protect" individuals from this type of criminal activity.

A study conducted by Gibbens, Way, and Soothill (1977) reported similar findings of anti-social personalities, non-sexual criminality and drug and alcohol abuse among rapists, while the pedophiles were generally introverted, over inhibited, frustrated and pleaded guilty 70% percent of the time. Similar findings were also noted in a study conducted by Guze, Woodruff, and Clayton, (1974) in which alcoholism, and drug
dependence were the principal psychiatric disorders associated with the adult sexual deviations.

Prentky and Knight (1986) identified 3 distinct categories of impulsive behaviors each of which correlated positively with different aspects of antisocial behavior. The first category represented the amount of planning and forethought of the sexual offense (offense-related impulsivity). The second category covaried with a lifestyle of impulsivity, beginning with childhood behavioral problems and leading to poor scholastic performance and an inability to develop close interpersonal relationships. The high impulsivity reflected a failure in the development of internal controls. Individuals in this category were found to develop a pattern of antisocial acting out in adolescence which persists throughout adulthood. At first, their offenses appear to be more compulsive than impulsive due to frequency of assault, however, early developmental styles clearly reflect inhibited adaptation. The third category of impulsivity which was particularly important due to its correlation with child molesters, was an enduring pattern of maladjusted behavior indicative of seclusiveness and avoidance of relations with others. Characteristic behaviors of this subgroup consisted of cruelty to animals in adolescence and frequent episodes of unsocialized aggression in adulthood.
Studies of adult sex offenders (Bell & Hall, 1971; Rada 1978; Groth, 1979, 1987) have reported the following three clusters of information (Porter, 1989):

1. Psychosocial - Sex offenders in general tend to be withdrawn, exhibit poor interpersonal skills, exhibit a low tolerance for frustration, are impulsive, and tend to act out when responding to stress. They are unsuccessful in academic achievement and are overwhelmed by the daily demands of their environment.

2. Psychological - Sex offenders (particularly child molesters), are passive, inept individuals who are less threatened and consequently more comfortable with children than with their peers. Furthermore, they are more passive and immature in most aspects of their lives. Generally, these offenders are rarely violent and tend to coax or pressure children into sexual activity in exchange for attention, acceptance, recognition or material gain.

3. Developmental - According to Groth (1979), an act of rape may represent a symptom of a developmental defect: "a failure to achieve an adequate sense of self-identity, the consequences of which become especially acute in adolescence" (Groth, 1979, p. 184).
Longitudinal studies have revealed that adolescents who demonstrate maladaptive coping styles in response to environmental demands are more likely to be identified as juvenile delinquents, to drop out of school, and to experience mental health problems as adults, than are children who are not isolates from peer interaction and develop appropriate coping strategies (Rolf, Sells, & Golden, 1972). Furthermore, these deviant patterns of development would appear to be fertile grounds for the development of aberrant sexual behaviors among the adolescent population.

**Sex Offenders with Mental Retardation**

Developmental research has revealed that the learning of adaptive coping strategies, especially psycho-social competencies occur not only in the context of adult-child relationships, but more importantly from the learning experiences which are produced by relationships with peers (Hartup, 1978). Thus, dependent on parental interactions or within the peer group, the mentally retarded individual, while continually expanding the contexts from which coping strategies are learned may be very restricted in the variety of opportunities. Consequently, these limited opportunities for social learning may result in maladaptive "instead" behaviors,
which further isolate individuals with mental retardation from their respective peer groups (Leland, 1978).

For individuals with mental retardation, adolescence is a unique stage of development during which they experience the same biological changes, sexual drives, and cultural forces as their nonretarded agemates (Leland, 1978). Based on interviews and field notes of individuals with mental retardation, Zetlin and Turner (1985) found that these adolescents were concerned with issues of emancipation, self-concept, and sexuality. However, these preoccupations were most likely exacerbated by various cognitive, familial, social, and emotional factors which made it increasingly more difficult to adjust behaviorally and emotionally to the demands of puberty and adolescence. An investigation conducted by Levy-Shiff, Kerdem, and Sevillia (1990) revealed that the identity profiles of adolescents with mental retardation differed from that of their nonretarded agemates, and younger preadolescents of similar mental age. Most notably, it was found that the adolescents with mental retardation reflected a developmental delay exhibiting a "unique" profile of identity. Sample differences also revealed that these adolescents often expressed that their lives were uninteresting, empty, and meaningless. They exhibited a more diffuse sense of mastery and self-control finding it difficult to direct and modify their drives and impulses. Similar results were also reported by Herne, Zetlin, and Turner (1985) in which
they reported that 84% of their population of adolescents with mental retardation exhibited some type of emotional or behavioral reaction that became apparent and often intensified during adolescence.

In a case study of 25 adults with mild mental retardation Zetlin and Turner concluded that 83% of their sample population reported that during adolescence they became aware of their "differentness", 64% experienced some form of rejection from family members or friends, 84% were taunted and teased by their peers, and 23% reported disappointment with having no boyfriend or girlfriend like their peers. In reviewing problem behaviors 84% experienced behavior problems including violence and destruction, antisocial behaviors, withdrawal, self-abuse, and drug and alcohol abuse. Of this sample 6 individuals committed delinquent or deviant acts of whom 2 molested a young child. In regards to their sexuality, it was noted that parents imposed strict restrictions which resulted in either inhibiting their sexual development or defiance of these parental controls (Zetlin and Turner 1985). Moreover, parental reactions were more likely to encourage dependency, obedience, and child-like behavior rather than independence, self-direction, assumption of responsibility and sexual awareness.

According to Morgenstern (1973) adolescent development is viewed much like that " of the normal young person, which is to
strengthen his sense of identity, to assume his sex role, and achieve a measure of independence". Although, within broad limits, the individuals development follows the same schedule as the "normal" person, except that the person with mental retardation requires more time to advance from one stage to the next due to poor socialization skills, problem solving deficits, and emotional immaturity. There also may be numerous developmental gaps which prevent some developmental areas from ever reaching maturation.

For individuals with mental retardation, adolescence may in fact be a time of increased turmoil and stress as part of the struggle to determine their developmental expectations and societal proscriptions. A discrepancy exists between their chronological age, physical maturity, and their cognitive ability. The individual with mental retardation who is at the brink of adulthood is struggling for self-expression, is at the same time poorly aware of his/her own identity, lacks self-esteem and self-confidence, is less in touch with peers, and often exhibits a behavioral repertoire comprising numerous maladaptive behaviors.

Recent evidence indicates substantial variability in incidence rates of sex offenses among the mentally retarded population (Murphy, 1983). In an earlier report Selling (1939) concluded that 51% of a group of rapists and 43% of a group of individuals
charged with indecent conduct had documented I Q's below 70. On the other hand, Mohr, Turner and Jerry (1964) stated that 4% of their sample of pedophiles and 3% if their exhibitionists had I.Qs below 79 compared to an expected population rate of 9%. However, Murphy, Coleman and Haynes (1983) conclude that "the majority of reports" suggest prevalence rates in the 10 to 15% range. Furthermore, their clinical experience suggests that a majority of the sex offenders treated were found to function in the mild to borderline range of retardation, though they exhibited behaviors similar to those seen in nonretarded offenders, such as rape, pedophilia, and exhibitionism (Murphy, Coleman, & Haynes, 1983).

In studying sex offenders with mental retardation, Hingsburger (1987) reported that these offenders have been described as having confused self-concepts, poor peer relations, a lack of sexual and social knowledge, negative early sexual experience, and a perceived lack of personal power. In comparison to sexual offenders of average intellect, Griffiths (1985) found that lower functioning offenders have fewer victims, victimize fewer females, and tend to exhibit greater social skill deficits. Aadland, Afwerke, and Schumacher (1988) noted the following categories of problem behavior among offenders with mental retardation offenders: 1) poor coping responses, which could result in inward frustration, aggression, and/or revengeful behavior; 2) impulsivity, which will lead to acting out without
consideration of consequences; 3) Social skill deficits; 4) a tendency to acquiesce; 5) a lack of assertion skills; 6) other adaptive deficits and poor discrimination skills.

Caprulo (1988) described the intellectually disabled offender as an individual exposed to rejection by society, and who is often reminded of his differences by being labeled 'retardo' or 'dummy' (Schoen and Hoover, 1990). He went on to state that these offenders have little self-worth, fail to understand the consequences of their actions, and exhibit a high degree of impulsivity which includes an inability to understand the legitimate needs of others. He also indicated that their cognitive distortions paralleled those of nondisabled offenders, including blaming the victim, holding stereotypic myths about women, minimization of the seriousness of the abuse. Schoen (1990) also reported similar findings, adding that their techniques "differed only in terms of their sophistication"

A more recent survey of adults in a Washington State correctional facility turned up 155 subjects who met the federally established criteria for developmental disability (Gross, 1985). Of these cases 72 were incarcerated for sexual assault. Of the prisoners with IQs below 70, 33 had been convicted of sexual offenses. This same report also examined felony records of 63 mentally retarded persons on developmental disability case loads. Similar to the felons in the
Washington State prison, the most frequent crimes were sexual offenses. Lastly, the survey sampled 154 persons in state institutions for the developmentally disabled and reported that 21% of those individuals had been convicted of sexual crimes.

Morgenstern (1973) found that mentally retarded individuals demonstrated a more restricted and naive interest in sex with less focus on sexual intercourse. In a study conducted by Gilby (1989) 196 inpatient and outpatient adolescents (40% were mentally retarded) were surveyed for problematic sexual behaviors. Case materials on each client were reviewed and problem behaviors were considered to fall into 3 categories: "consented to", including consenting sexual activity determined to be inappropriate because of societal standards; "assaultive", included assaultive behavior with a nonconsenting partner, or a partner too young to give consent; "nuisance", this category included behaviors that were determined to be inappropriate and may have involved non-consenting victims, (e.g. inappropriate masturbation, exhibitionism, voyeurism, fetishism, and verbal threats of sexual aggression). The findings revealed the mentally retarded outpatients were more likely to display "nuisance" types of sexual behaviors, whereas average intellect outpatients with sexual problems were more likely to display "consented to " behaviors. Among the inpatients, mentally retarded inpatients were more likely to display "nuisance" behaviors. Furthermore, among inpatients, there was only a
slight difference in the percentages engaging in "consented to" behaviors. Overall, the individuals with mental retardation were more likely to exhibit inappropriate, non-assaultive sexual behaviors such as public masturbation and exhibitionism, and less likely to engage in assaultive behavior. These individuals were also found to be less indiscriminate in their sex play as evidenced by the greater frequency of both homosexual and heterosexual activity.

To gain a more indepth perspective the same author reviewed additional client files over a period of several years. Three groups of ten each were matched for age (adolescence), and sex (male). The comparisons of the offenses by the mentally retarded and non-retarded offenders demonstrated than a large majority (80% vs 90% respectively) committed a pedophilic offense. The majority of adolescents in both groups offended previously and most knew their victims, however, this was less often the case of the mentally retarded. Also, as the previous literature has shown, the mentally retarded offender offended equally against both males and females, whereas the average intellect offenders chose mostly females.
PEDOPHILIA

The first edition of the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders (DSM), categorized Pedophilia as a "sexual deviation". The sexual deviations in turn were classified as one of several different types of "sociopathic personalities". Consequently, sociopathic personalities were described as individuals who "are ill primarily in terms of society and of conformity with prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals" (APA DSM, 1952). Sexual deviations were described as the following:

"This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenia and obsessional reactions. The term includes most of the cases formerly classed as "psychopathic personality with pathologic sexuality". The diagnosis will specify the type of pathologic behavior such as homosexuality, transvestism pedophilia, fetishism, and sexual sadism" (APA DSM, 1952, p. 182).

In 1968 the second edition of the diagnostic and statistical manual (DSM-II), continued to categorize Pedophilia as a "sexual deviation". However, "sexual deviations" were no longer grouped as a type of sociopathic personality, instead, they were
placed under the category of "nonpsychotic personality disorders" (Barnard, Fuller, Robbins, & Shaw, 1989). The "sexual deviation category" was described as the following:

"This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstance as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sex objects are not available to them" (APA DSM-II, 1968, p. 191).

In the DSM-III the use of the term "sexual deviation" was dropped and replaced with the term "paraphilias". The "paraphilias" are grouped as one of three major subtypes of the psychosexual disorders. The DSM-III description of Pedophilia is the following:

"The essential feature is the act or fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement. The difference in age between the adult with this disorder and the prepubertal child is arbitrarily set at ten years or more. For late adolescents with the
disorder, no precise age difference is specified; and clinical judgement must be used the sexual maturity of the child as well as the age difference being taken into account" (APA DSM-III, 1980, pg. 271).

It was not until the DSM-III that explicit criteria for Pedophilia was provided. Furthermore, the DSM-III, "unlike its predecessors defined Pedophilia more in terms of psychological features than deviant behavior (Barnard, Fuller, Robbins, and Shaw, 1989). The revision of DSM-III to DSM III-R stipulated the following criteria for the diagnosis of pedophilia:

"the essential feature of this disorder is recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months in duration, involving sexual activity with a prepubescent child. The person has acted on these urges, or is markedly distressed by them. The age of the child is generally 13 or younger. The age of the person is arbitrarily set at 16 years or older, and at least 5 years older than the child. For late adolescents with this disorder, no precise age difference is specified, and clinical judgement must be used; both the maturity of the child and the age difference must be taken into account " (APA, DSM III-R, 1987 pg. 284).
A late adolescent involved in an ongoing sexual relationship with a 12 or 13 year old may not be included in this criteria. It should be noted that isolated sexual acts with children do not necessarily warrant the diagnosis of Pedophilia. According to the DSM-III-R, such offenses may be precipitated by marital discord, recent loss, or intense loneliness. In these cases the desire for sex could be understood as a substitute for a preferred but unavailable adult. It is further pointed out that in Mental Retardation, Organic Personality Syndrome, Alcohol Intoxication, or Schizophrenia, there may be a decompensation in judgement, social skills, or impulse control that in rare instances, leads to isolated sexual acts with children; "but in such cases the sexual activity with children is generally not the consistently preferred method for achieving sexual satisfaction" (APA, DSM III-R, 1987, p.285). Moreover, the DSM III-R also provided for differentiation in the areas within the subcategory of pedophilia. First the clinician is to specify whether children of the same sex, opposite sex, of same and opposite sex. Secondly, sexual activity if limited to incest must be specified, and Lastly, the clinician must specify if the perpetrator is attracted only to children (exclusive type) , or if he is also attracted to adults (nonexclusive).
TREATMENT

Currently, there is no sexual behavior or misbehavior specific to persons with mental retardation or other developmental disability. Nonetheless, individuals with mental retardation are arrested for pedophilia and the question of "what to do for or with them" often arises (Myers, 1991). Although, there exists a great deal of research in the general area of "sex offenders", the identified treatment techniques are those which require certain cognitive, verbal, and other adaptive abilities that are lacking or limited in the mentally retarded sex offender (Murphy, Coleman, & Haynes, 1983).

DEVIANT AROUSAL.

According to Murphy, Coleman and Haynes (1983) due to the limited available data for treating sex offenders with mental retardation, one method is to modify techniques identified in the general literature on sexual deviance. It appears to be widely accepted that sexual deviation encompasses numerous behavioral excesses and deficits. According to Barlow (1974) the most notable behavior is sexual arousal to non-normal or deviant persons, objects, or activities. Accordingly, he noted three problems that occur either independently or interactively which are often associated with deviant sexual arousal.
1. Deficiencies in Heterosexual Arousal - deviant arousal was felt to be associated with the absence or minimal level of heterosexual arousal.

2. Deficiencies in Heterosocial skills - Deviant arousal was felt to be associated to deficits in skills necessary for meeting, dating and relating to individuals of the opposite sex.

3. Gender Role Deviation - Deviant arousal was associated with individuals who adopt/prefer opposite sex role behaviors.

In following with this typology, it is the explicit goal of any prescribed treatment approach to eliminate or at least reduce the deviant arousal. A number of approaches have been outlined and represent the "state of the art" for treating sexual deviancy among the retarded population. A derivation of a an assessment and treatment model proposed by Abel, Blanchard, and Becker, (1978) and Barlow and Abel, (1976), was revised and tailored specifically for the assessment and treatment of the sex offender with mental retardation by Murphy, Coleman, and Haynes (1983). Treatment approaches identified within this model include covert sensitization, electrical aversion, odor aversion, bio-feedback suppression, chemical aversion and satiation. Generation of arousal to nondeviant cues include
masturbatory reconditioning, systematic desensitization, fading, and exposure. Sex education, heterosocial and social skill training were also identified as valuable adjunctive approaches. Additional techniques not identified in this model include group psychotherapy, individual psychotherapy, and the use of psychopharmacological agents.

It should be noted that it is not the intention or the scope of this dissertation to review the relative efficacy of any of the aforementioned methods recognized. This is due to the fact that although specific treatment and assessment strategies are both identified and applied, the literature is replete with remarks that very little outcome data on treating sex offenders with mental retardation currently exists.
CHAPTER III

METHODOLOGY

INTRODUCTION

The present study involves 2 closely defined experimental groups. The first group consists of individuals with a medical psychiatric, court established diagnosis. These subjects have been convicted of a sexual offense, were diagnosed with both pedophilia and mental retardation and have the "paper" to validate the criminal charge. The second group consists of individuals who have been charged with or convicted of non-sex related offenses and also carry the diagnosis of mental retardation. An arrangement was made with both Ralph W. Alvis House (Alvis House), and an ICF/MR Unit located on the grounds of the Central Ohio Psychiatric Hospital, for recruiting the individuals who participated in this study.

Alvis House, is a Columbus based residential treatment facility which provides vocational, and counseling services for individuals with mental retardation and convicted of either a
sexual offense or a non-sex related crime. The ICF/MR Unit also located near downtown Columbus, consists of a 14-bed Unit focussed toward treating individuals diagnosed with both a psychiatric disorder and Mental Retardation. The control group was drawn from a privately funded community based program called "On My Own" and from a subject pool provided by ADD (Aid for the Developmentally Disabled) also a county based community program, both of which are aimed specifically toward servicing the needs of individuals with mental retardation/developmental disabilities.

**Subjects**

The subjects for this study included adult males between the ages of 21 and 47. The entire subject pool consisted of 36 individuals diagnosed by the participating agencies with mild to moderate mental retardation (I.Q.'s ranged from 55 - 68), of which, 15 of the subjects carried a DSM III-R Axis I diagnosis of Pedophilia, 15 subjects were charged with or convicted of a non-sex related crime, and the remaining 15 subjects will have no criminal record (Table 2). Demographic data were matched for age, race, and level of intellectual functioning. Because of the limited number of subjects no attempt was made to control for ethnic differences. While not specifically matched these individuals will represent a group of individuals similar in demographic characteristics (See Appendix A). Letters and
consent forms were sent to each of the participating facilities and following their approval, potential candidates were presented a description of the study and a letter of consent (See Appendix D). Each letter indicated that the subject had a thorough understanding of the nature and purpose of the study, as well as their right to withdraw. This information was reviewed with each candidate to insure that an informed decision was made. In order to increase their likelihood of completing the testing, each subject was also told that he would receive five dollars for his participation. Following their verbal and written approval, each subject was assigned a code number and reminded of the confidentiality associated with the study. This code number was the only source of identification for the tests administered and other information gathered. The subjects were also instructed that they would not be required to discuss their offense (if applicable), or any charges pending. This was done to increase confidentiality and maximize participation. All subjects, information about subjects, and test results were handled in a manner which is in direct agreement with the guidelines in the Ohio State University's Revised Guidelines for Use of Human Subjects in Research, and the American Psychological Associations code of ethics (APA, 1981, pps. 635-636), regarding confidentiality.
Table 2  
Demographic data for subject sample

<table>
<thead>
<tr>
<th></th>
<th>Group SO</th>
<th>Group O</th>
<th>Group NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>34.08</td>
<td>31.25</td>
<td>32.83</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>7.751</td>
<td>8.54</td>
<td>7.87</td>
</tr>
<tr>
<td>F-Test Across groups:</td>
<td>.372</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-Probability Across groups:</td>
<td>.692</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean I.Q.</td>
<td>64.83</td>
<td>62.33</td>
<td>62.66</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>3.88</td>
<td>4.52</td>
<td>4.44</td>
</tr>
<tr>
<td>F-Test Across groups:</td>
<td>1.198</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-ProbabilityAcross groups:</td>
<td>.315</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: degrees of freedom = 2.
Procedure

After obtaining the necessary consent forms, archival material was first reviewed for the purposes of obtaining demographic information. This involved a thorough analysis of various documents included in each of the participants record to provide accurate information concerning age, date of birth, race, diagnosis, and the nature of prior criminal acts.

INTERVIEW AND TESTING

The testing and interviews were assigned at two hour intervals. Participants were given convenient appointment times by the examiner. Each subject recruited for the study who agreed to participate completed the entire examination, and consequently no refusals or withdrawals were encountered by the examiner.

The procedure involved the following steps:

1. Each subject was contacted and escorted to a designated office for testing by the examiner.

2. The interview consisted of a simple question and answer format in which the subject was asked his age, date of birth,
place of birth, and length of stay or affiliation with the respective facility or agency.

3. The examiner collected their consent form, reviewed the method being used to assure confidentiality, questioned the subject on the understanding of the study, answered any of the subjects questions and then coded all materials with the subjects identification number.

4. The examiner then administered the Social Judgement Scale, the Socio-Sexual Knowledge and Attitudes Test, and then the Emotional Problem Scale.

5. Following completion of each instrument, the subject returned the protocol to the examiner, following completion of the last test, the subject was paid his five dollars, thanked for his participation, and escorted out of the office.

Information for the ABS-RC:2 was obtained from the subjects' primary service provider. All scales were scored and interpreted by the examiner. Also, for reliability purposes, during the administration of the Social Judgement Scale (SJS), each response was audio-tapped by the examiner and later transcribed verbatim to each of the protocols. Each tape was appropriately coded to assure confidentiality and erased immediately following the transcription.


**Instruments**

1. **The Social Judgement Scale.** (Spragg, P. 1983)

The Social Judgement Scale (SJS) is an open-ended scale used to assess an individuals ability to express adaptive social responses when presented with a variety of hypothetical situations. The SJS was designed for evaluating adults with mild to moderate mental retardation. The scale is comprised of 22 questions which are intended to evoke responses of anger, fear, gladness and sadness. Each response is scored with a 0-(socially unacceptable response), 1-(marginal response), or 2-(appropriate response). The possible range of scores extends from a low of 0 to a high of 44. The raw scores are converted to T-scores with a mean of 50 and a standard deviation of 10. Thus, a mildly retarded person with a raw score of 29 achieves a T-score of 51 and a percentile rank of 54. On the other hand, a moderately retarded individual obtaining a raw score of 29 achieves a T-score of 12 and a percentile rank of 99.

The standardization of this instrument was based on scores derived from 48 mildly and moderately retarded adults. According to Spragg (1983) determination of functioning level was based on the dual criteria of adaptive and intellectual functioning outlined by the American Association on Mental
Deficiency (Grossman, 1983). The subjects resided in independent or semi-independent community placements and the majority were either employed or received day programming in a rural Colorado county. Concurrent validity was determined by using a socialization subscale of an adaptive behavior inventory. The reported validity coefficient reflected a moderately positive relationship between the two measures. Internal consistency of the scale revealed a split half reliability coefficient of .91 and a Cronbach's alpha reliability coefficient of .88 (Spragg, 1983). Aman (1990) suggests the following clinical applications:

1. Screening of individuals prior to placements in less restrictive settings.
2. Assignment of individuals to various types of social skill programs.
3. Assisting in the evaluation of the dually-diagnosed person.

2. Socio-Sexual Knowledge and Attitudes Test, (Wish, J., McCombs, K., & Edmonson, B. 1980)

The Socio-Sexual Knowledge and Attitudes Test (SSKAT), is a measure designed to assess socio-sexual knowledge and attitudes of adult individuals with mental retardation. The rating portion of this instrument contains 240 questions which
are summarized and resolved into 13 subtests: I. Anatomy, II. Menstruation, III. Dating, IV. Marriage, V. Intimacy, VI. Intercourse, VII. Pregnancy, Childbirth, and Childrearing, VIII. Birth Control, IX. Masturbation, X. Homosexuality, XI. Venereal Disease, XII. Alcohol and Drugs, XIII. Community Risks and Hazards.

Questions are scored on a point system of 0-2, (0-incorrect, 1-partially correct, and 2-correct). Raw scores are summarized and converted to percentile scores for each respective subtest. Higher scores on each subtest are generally indicative of a well informed/knowledgeable individual.

The standardization of this instrument included a total of 200 subjects of which 50 males and 50 females were recruited from an institutional population and 50 males and 50 females from a community population. The selected individuals were either mildly or moderately retarded and between the ages of 18 and 42. Test - retest reliability was assessed in two administrations of the test to a sample of 100 retarded men and women at intervals of a week to ten days (Wish, McCombs, & Edmonson, 1980). The mean test-retest agreement was reported to be high with ranges from 78.2 to 91.5. Based on the responses from the 199 retarded adults an internal consistency was arrived by using the Kuder-Richardson equation for scale reliability. Item reliabilities were correlated and the findings
revealed scale reliability coefficients ranging from .53 to .83. The authors noted that the consistency of the subtests could be improved by removing both overly simplistic or more difficult questions, and by removing items that are not homogeneous.


The AAMD Adaptive Behavior Scale RC:2 (ABS RC:2) is an informant measure specifically designed to assess the adaptive and maladaptive behaviors of mentally retarded, emotionally disturbed, and developmentally disabled individuals. The ABS is divided into two major parts. Part I covers 10 behavioral domains and is intended to evaluate the individuals survival skills and habits which are important for personal independence in daily living. The part I domains are as follow: (1) Independent Functioning, (2) Physical Development, (3) Economic Activity, (4) Language Development, (5) Numbers and Time, (6) Domestic Activity, (7) Pre-Vocational/Vocational Activity, (8) Self-Direction, (9) Responsibility, (10) Socialization. Higher scores correspond to a higher level of adaptive functioning.

Part II of the ABS is broken down into 8 domains which focus primarily on maladaptive behavior related to personality and
behavioral disorders. The part II domains are as follow: (11) Social Behavior, (12) Conformity, (13) Trustworthiness, (14) Stereotyped and Hyperactive Behavior, (15) Sexual Behavior, (16) Self-Abusive Behavior, (17) Social Engagement, (18) Disturbing Interpersonal Behavior. Lower scores correspond to a higher level of adaptive functioning. Although the entire instrument was administered, for the purpose of this study, the primary interest was the Part II domains of this scale.

The ABS-RC:2 was standardized using 4,103 individuals with developmental disabilities residing in the community or in residential facilities in 46 states and the District of Columbia. Internal consistency was examined using the coefficient alpha procedure and resulted in coefficients ranging from .81 to .99. Test-retest reliability was completed on a sample of 45 employee's in a sheltered workshop over a period of 2 weeks. Using the Anastasi (1988) procedure the results concluded that the coefficients suggested that the instrument yielded consistent results over time. Criterion-related validity was examined by correlating this instrument with the adaptive behavior domains on the Vineland Adaptive Behavior Scales and the Adaptive Behavior Inventory. The comparisons revealed higher agreement among Part I of the Adaptive Behavior domains than the respective correlation coefficients of the Part II domains.

The Emotional Problem Scales is comprised of two instruments: the Behavior Rating Scales (BRS) and the Self-Report Inventory. For the purpose of this study only the Self-Report Inventory (SRI) was administered. Consequently, the SRI is a self-report instrument intended to identify maladaptive personality patterns for adolescents and adults with mild to moderate mental retardation. The inventory is made up of 147 items which resolve into five clinical scales: 1) Thought/Behavior Disorder, 2) Impulse Control, 3) Anxiety, 4) Depression, and 5) Self-esteem. Responses to each of the items are either a "yes" or a "no" for each subscale. Higher subscale scores are indicative of more serious personality disturbances.

The standardization of this scale was conducted from a sample of 708 adolescent and adult subjects with mild mental retardation or borderline intelligence. Of the 708 subjects SRI data was obtained from a total of 206 of the total subject sample. In addition to the diagnosis of mild mental retardation and borderline intelligence, it was estimated that 9% of the sample population had received a psychiatric diagnosis. An examination of the internal consistency of this instrument revealed alpha coefficients ranging from .77 to .96 with a mean of .86. Correlations between items and respective subscales
revealed coefficients ranging from .20 to .66. A two week test-retest interval revealed correlation coefficients ranging from .66 to .90.

Each instrument was selected on the basis of its ability to identify specific behavioral characteristics most frequently cited in the research literature. Furthermore, each of the instruments have been identified as as both valid and reliable tools for assessing specific adaptive and maladaptive behaviors associated with individuals diagnosed with mental retardation.
CHAPTER IV
RESEARCH RESULTS

This chapter will review the findings of this study in an attempt to identify observable behavioral characteristics associated with mentally retarded sex offenders. For this study, 36 individuals with mental retardation ages 21 to 47 resolved into the following three groups:

Group 1 - 12 sex offenders (SO)
Group 2 - 12 offenders of non-sex related crimes (O)
Group 3 - 12 non-offenders (NO)

For each participant archivial data was reviewed in their respective records in order to verify age, diagnosis, and criminal history. Characteristics were assigned to each hypothesis using similar items cited in the research literature. Sub scales were then chosen on the basis of relevance to each of the 4 respective hypotheses.

An Analysis of Variance (ANOVA) was selected for this
particular study as the statistical analysis of choice to determine the significance of the variables selected. Tukey's Honestly Significant Difference (HSD), post hoc test was applied to the ANOVA analysis to reduce the probability of chance occurrences. Although a MANOVA would apply, it was not chosen due to the small sample population available for this study. In an attempt to provide a more powerful method of controlling experimentwise error rate the Bonferroni procedure (Bird, 1975) has also been applied.

**Hypothesis 1 - Sexual Knowledge**

Hypothesis one predicted that the sex offenders and offenders would achieve similar sexual knowledge scores on all the scales. The non-offenders would also receive similar scores as the sex offenders and offenders on the Anatomy and Terminology scale, however, the non-offenders would yield higher scores on the other 6 subscales. A total of 7 subscales were chosen from the Social Sexual Knowledge and Attitudes Test and assigned to this hypothesis. They are presented as the following:

1. Anatomy Terminology
2. Dating
3. Marriage
4. Intimacy
5. Intercourse
6. Masturbation
7. Homosexuality

Tables 3 & 4 reveal ANOVA analysis using the Tukey HSD procedure of multiple comparisons.
# TABLE 3

Analysis of means and standard deviations for significant subscales for the sexual knowledge hypothesis

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group SO</th>
<th>Group O</th>
<th>Group NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy/Terminology</td>
<td>24.90</td>
<td>22.17</td>
<td>23.76</td>
</tr>
<tr>
<td></td>
<td>2.11</td>
<td>2.43</td>
<td>2.70</td>
</tr>
<tr>
<td>Dating</td>
<td>23.16</td>
<td>22.33</td>
<td>20.75</td>
</tr>
<tr>
<td></td>
<td>1.90</td>
<td>2.35</td>
<td>3.60</td>
</tr>
<tr>
<td>Marriage</td>
<td>18.83</td>
<td>17.50</td>
<td>18.40</td>
</tr>
<tr>
<td></td>
<td>2.50</td>
<td>3.25</td>
<td>6.02</td>
</tr>
<tr>
<td>Intimacy</td>
<td>16.33</td>
<td>15.00</td>
<td>15.60</td>
</tr>
<tr>
<td></td>
<td>2.35</td>
<td>2.30</td>
<td>1.67</td>
</tr>
<tr>
<td>Intercourse</td>
<td>31.00</td>
<td>29.08</td>
<td>29.50</td>
</tr>
<tr>
<td></td>
<td>2.50</td>
<td>4.23</td>
<td>3.20</td>
</tr>
<tr>
<td>Masturbation</td>
<td>12.66</td>
<td>12.08</td>
<td>12.58</td>
</tr>
<tr>
<td></td>
<td>1.30</td>
<td>2.07</td>
<td>1.44</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>13.00</td>
<td>11.083</td>
<td>13.10</td>
</tr>
<tr>
<td></td>
<td>2.09</td>
<td>3.32</td>
<td>1.89</td>
</tr>
</tbody>
</table>
**TABLE 4**

Analysis of variance table for examining if sex offenders will demonstrate different social sexual knowledge than the offenders of non-sex related crimes or non-offenders for the sexual knowledge hypothesis.

<table>
<thead>
<tr>
<th></th>
<th>F-Test</th>
<th>F-Probability</th>
<th>Bonferroni</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy/Terminology</td>
<td>3.081</td>
<td>.059</td>
<td>.007</td>
</tr>
<tr>
<td>Dating</td>
<td>2.460</td>
<td>.101</td>
<td>.007</td>
</tr>
<tr>
<td>Marriage</td>
<td>.318</td>
<td>.730</td>
<td>.007</td>
</tr>
<tr>
<td>Intimacy</td>
<td>1.179</td>
<td>.320</td>
<td>.007</td>
</tr>
<tr>
<td>Intercourse</td>
<td>1.065</td>
<td>.356</td>
<td>.007</td>
</tr>
<tr>
<td>Masturbation</td>
<td>.445</td>
<td>.644</td>
<td>.007</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>2.439</td>
<td>.103</td>
<td>.007</td>
</tr>
</tbody>
</table>

Note: *denotes pairs of groups significantly different at the .05 level using the Tukey HSD procedure.

†denotes pairs of groups significantly different using the Bonferroni adjusted p-value.

**degrees of freedom = 2.**
Application of the ANOVA analysis using the Tukey HSD procedure with significant ranges at the .05 level indicates no significant group differences between the SO and O groups or between the SO and NO groups across all seven of the identified social-sexual knowledge scales. This would suggest that the general fund of sexual knowledge among the three groups demonstrates minimal differences. Based on these findings it seems that all three groups are equally proficient in each of the 7 reported subscales.

**Hypothesis 2 - Physical Aggression**

Hypothesis 2 predicted that the sex offenders and offenders would reveal similar findings on the Social Behavior and Conformity domains than those obtained by the non-offenders. Furthermore, it was also predicted that the sex offenders would exhibit different findings on the Sexual Behavior domain than those obtained by both the offender and non-offender groups. A total of 3 domains were chosen from the Adaptive Behavior Scale RC:2 (Part II) and assigned to this hypothesis. They are presented as the following:

The Adaptive Behavior Scale RC:2 - Part II

1. Social Behavior
2. Conformity
3. Sexual Behavior
Tables 5 - 9 reveal ANOVA analysis using the Tukey HSD procedure with ranges for the .05 level suggest that based on the findings obtained from the Social Behavior domain, the SO and the O groups demonstrate no statistical differences (more similar - pairwise probability of .821), although both the SO and O groups did reveal a statistical difference when compared to the NO group (pairwise probability of .000 and .000 respectively). This indicates that the items measured by the Social Behavior domain are behaviors more often exhibited by sex offenders (m=26.583) and offenders (m=20.833) than the non-offenders (m=72.500). Accordingly, incidents associated with threats, physical violence, temper tantrums, teasing, foul language, increased frustration, and disruptive behavior, appear to occur at a much higher rate among the SO and O groups than the NO group. As for the Conformity domain, the ANOVA analysis suggests that the SO and O groups revealed no statistical differences (more similar - pairwise probability of .096), although both the SO an O groups did demonstrate a statistical difference when compared to the NO group (pairwise probability of .014 and .000 respectively). This indicates that the items measured by the Conformity domain are behaviors more often exhibited by sex offenders (m=43.000) and offenders (m=27.583) than the non-offenders (m=64.583). These items include acts of misbehavior in group settings, impudent attitude towards authority, abstinence toward rules and regulations,
### TABLE 5

Analysis of means and standard deviations for significant subscales for the physical aggression hypothesis.

<table>
<thead>
<tr>
<th></th>
<th>Group SO</th>
<th>Group 0</th>
<th>Group NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Behavior</strong></td>
<td>Mean</td>
<td>18.60</td>
<td>67.75</td>
</tr>
<tr>
<td></td>
<td>Std. Dev.</td>
<td>17.07</td>
<td>11.34</td>
</tr>
<tr>
<td><strong>Social Behavior</strong></td>
<td>Mean</td>
<td>26.58</td>
<td>20.83</td>
</tr>
<tr>
<td></td>
<td>Std. Dev.</td>
<td>26.124</td>
<td>20.38</td>
</tr>
<tr>
<td><strong>Conformity</strong></td>
<td>Mean</td>
<td>43.00</td>
<td>27.58</td>
</tr>
<tr>
<td></td>
<td>Std. Dev.</td>
<td>26.44</td>
<td>11.58</td>
</tr>
</tbody>
</table>
TABLE 6

Analysis of variance table for examining if sex offenders will demonstrate different aggressive tendencies than the offenders of non-sex related crimes or non-offenders

<table>
<thead>
<tr>
<th></th>
<th>F-Test</th>
<th>F-Probability</th>
<th>Bonferroni</th>
</tr>
</thead>
<tbody>
<tr>
<td>*†Sexual Behavior</td>
<td>41.870</td>
<td>.01</td>
<td>.016</td>
</tr>
<tr>
<td>*†Social Behavior</td>
<td>17.500</td>
<td>.01</td>
<td>.016</td>
</tr>
<tr>
<td>*†Conformity Behavior</td>
<td>13.405</td>
<td>.01</td>
<td>.016</td>
</tr>
</tbody>
</table>

Note: *denotes pairs of groups significantly different at the .05 level using the Tukey HSD procedure.
†denotes pairs of groups significantly different using the Bonferroni adjusted p-value.
**degrees of freedom = 2.
**TABLE 7**

Tukey HSD Multiple Comparisons Matrix of pairwise comparison probabilities for the physical aggression hypothesis.

Domain: SOCIAL BEHAVIOR

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>S0</th>
<th>O</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0</td>
<td></td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>O</td>
<td>0.821</td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>NO</td>
<td>†0.000</td>
<td>†0.000</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note: * denotes significant group difference at the .05 level using the Tukey HSD procedure.

†denotes significant group difference at the .016 level using the Bonferroni adjusted p-value.
### TABLE 8

Tukey HSD Multiple Comparisons Matrix of pairwise comparison probabilities for the physical aggression hypothesis.

**Domain: CONFORMITY**

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>SO</th>
<th>0</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0.096</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>*0.014</td>
<td>*†0.000</td>
<td>1.000</td>
</tr>
</tbody>
</table>

**Note:** *denotes significant group difference at the .05 level using the Tukey HSD procedure.

†denotes significant group difference at the .016 level using the Bonferroni adjusted p-value.
TABLE 9

Tukey HSD Multiple Comparisons. Matrix of pairwise comparison probabilities for the physical aggression hypothesis.

Domain: SEXUAL BEHAVIOR

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>S0</th>
<th>0</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>*†0.000</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>*†0.000</td>
<td>0.981 1.000</td>
<td></td>
</tr>
</tbody>
</table>

Note: * denotes significant group difference at the .05 level using the Tukey HSD procedure.

† denotes significant group difference at the .016 level using the Bonferroni adjusted p-value.
absence for appointments or required places, and a general resistance toward following instructions and requests. The Sexual Behavior domain was used for purposes of reliability, consequently, the ANOVA analysis revealed that the SO group was statistically different than the O and NO groups (pairwise probability of .000 and .000 respectively), and that groups O and NO exhibited minimal differences (pairwise probability of .981). As anticipated the sex-offenders were more likely to demonstrate a greater degree of sexually aberrant behaviors (m=18.583) than either the offender (67.750) and non-offender (68.917) groups.

**Hypothesis 3 - Impulse Control**

Hypothesis 3 predicted that the sex offenders and offenders would exhibit a greater degree of impulsivity than that of the non-offenders. One sub scale was chosen from the Emotional Problem Scales - Self-report Inventory and assigned to this hypothesis. In Tables 10-12, the results of the ANOVA analysis using the Tukey HSD procedure with ranges for the .05 level indicated that the SO and the O groups revealed no significant statistical differences (more similar - pairwise probability of .667), although both the SO and O groups did reveal a statistical difference when compared to the NO group (pairwise probability of .019 and .002 respectively). This indicates that the items measured by the sub scale Impulse
TABLE 10

Analysis of means and standard deviations for significant subscales for the impulse control hypothesis.

| Impulse Control | Group SO | Group 0 | Group  
|----------------|---------|---------|--------
| Mean           | 15.08   | 17.17   | 8.17   
| Standard Deviation | 7.23   | 6.74    | 2.66   |
TABLE 11

Analysis of variance table for examining if sex offenders will demonstrate different impulse control than the offenders of non-sex related crimes or non-offenders for the impulse control hypothesis.

<table>
<thead>
<tr>
<th></th>
<th>F-Test</th>
<th>F-Probability</th>
<th>Bonferroni</th>
</tr>
</thead>
<tbody>
<tr>
<td>*†Impulse Control</td>
<td>7.628</td>
<td>.002</td>
<td>.05</td>
</tr>
</tbody>
</table>

Note: * denotes pairs of groups significantly different at the .05 level using the Tukey HSD procedure.

†denotes pairs of groups significantly different using the Bonferroni adjusted p-value.

**degrees of freedom = 2.
TABLE 12

Tukey HSD Multiple Comparisons Matrix of pairwise comparison probabilities for the impulse control hypothesis.

Scale: IMPULSE CONTROL

<table>
<thead>
<tr>
<th>GROUPS</th>
<th>SO</th>
<th>O</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>0.667</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>*‡0.019</td>
<td>*‡0.002</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note: * denotes significant group difference at the .05 level using the Tukey HSD procedure.

‡denotes significant group difference at the .05 level using the Bonferroni adjusted p-value.
Control suggests that the sex-offenders (m=15.083) and offenders (m=17.167) were more apt to demonstrate a greater degree of disturbance in the area of impulse control (i.e. listening to others, sitting still, having difficulty paying attention, becoming easily bored, acting without considering the relative consequences), than the non-offender comparison group (m=8.167).

**Hypothesis 4 - Social Judgement Skills**

Hypothesis 4 predicted that the non-offenders would exhibit greater skill competency and behavior when compared to the sex offenders and offenders. The Social Judgement Scale was utilized for this particular measure and the findings were assigned to this hypothesis. In Tables 13 - 15, the results of the ANOVA analysis using the Tukey HSD procedure with significance at the .05 level showed that the SO and the O groups revealed no significant statistical differences (more similar - pairwise probability of .653), although the O group compared to the NO group did reveal a statistical difference (pairwise probability of .007). This suggests that the items measured by the Social Judgement Scale (i.e. social inference, social problem solving, identifying appropriate response alternatives), revealed no significant differences among the sex-offenders (m=29.333) and non-offenders (m=33.333), although,
**TABLE 13**

Analysis of means and standard deviations for significant scales for the social skills hypothesis

<table>
<thead>
<tr>
<th>Social Judgement</th>
<th>Group SO</th>
<th>Group 0</th>
<th>Group NO</th>
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<tr>
<td>Mean</td>
<td>29.33</td>
<td>27.83</td>
<td>33.33</td>
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<td>Standard Deviation</td>
<td>4.70</td>
<td>4.49</td>
<td>3.06</td>
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**TABLE 14**

Analysis of variance table for examining if sex offenders will demonstrate different social skills than the offenders of non-sex related crimes or non-offenders for the social skills hypothesis.

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<th>F-Test</th>
<th>F-Probability</th>
<th>Bonferroni</th>
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<td>*†Social Judgement</td>
<td>5.646</td>
<td>.008</td>
<td>.05</td>
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</table>

Note: * denotes pairs of groups significantly different at the .05 level using the Tukey HSD procedure.

† denotes pairs of groups significantly different using the Bonferroni adjusted p-value.

**degrees of freedom = 2.**
**TABLE 15**

Tukey HSD Multiple Comparisons Matrix of pairwise comparison probabilities for the social skills hypothesis.

Scale: SOCIAL JUDGEMENT

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<thead>
<tr>
<th>GROUPS</th>
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<th>NO</th>
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<tr>
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<td>O</td>
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<tr>
<td>NO</td>
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<td>*\dagger 0.007</td>
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Note: *denotes significant group difference at the .05 level using the Tukey HSD procedure.

\dagger denotes significant group difference at the .05 level using the Bonferroni adjusted p-value.
a significant difference was noted among the offenders (m=27.833) and non-offenders (m=33.33).

Summary of the Analyses

In this study 4 hypothesis were proposed in an attempt to identify observable behavioral characteristics associated with mentally retarded sex offenders. In reviewing the findings for hypothesis one. The data obtained revealed that the lack of sexual knowledge was not an underlying characteristic frequently associated with mentally retarded sex offenders. In this case it was quite the contrary, since across all seven of the knowledge subscales the sex offenders scored higher than the offenders and non-offenders on all but 1 of the reported scales. As for hypothesis 2, the findings revealed that the sex-offenders and offenders showed considerable disturbances in the areas of social behavior and conformity as compared to the results of the non-offender group. For reliability purposes, sexual behavior was also included in order to validate the sexually aberrant behavior of the sex-offender group. As suspected, the findings concluded a high correlation between the offender and non-offender groups, as well as a significant statistical difference between the sex-offenders and the other 2 groups. Consequently, means scores suggested a greater degree of sexually aberrant behavior in group 1 as opposed to more socially acceptable behavior among groups 2 and 3. Hypothesis
3, suggested that the sex-offenders and offenders would exhibit a greater degree of impulsivity than the non-offenders. The findings did in fact conclude a similar lack of impulse control for the sex-offenders and offenders when compared to the non-offender control group. Hypothesis 4 proposed that the non-offender group would demonstrate greater social skill competency than the sex-offender and offender groups. The resulting analysis revealed that no significant differences were ascertained between the non-offenders and sex-offenders, but instead the offenders deviated significantly from the other 2 groups. These findings concluded that similar skill competency was identified between the non-offenders and offenders, although a significantly lower skill competency can be attributed to the offender group.

In the next chapter, these results will be discussed and related to the already existing body of literature in the field.
CHAPTER V
OVERVIEW

Although the 36 subjects resolved into three groups it is imperative that the various characteristics arising out of the obtained data, assessment observations, and familiarity with certain subjects through professional contact be incorporated into this chapter. This approach is being presented in order to develop a more comprehensive profile of a pedophile with mental retardation.

I. Group - SO-(Sex-offenders)

Individuals with mental retardation exhibit specific behavioral deficits (i.e. impulsivity, short attention span), as well as general deficits (i.e. social functioning, social knowledge, behavioral disturbances). Keeping these related factors in mind, group 1 (designated a "SO") of this study, is comprised of 12 individuals
who were grouped together due to their concomitant psychiatric histories. It must, however, be brought to the readers attention that although common behavioral and personality characteristics were identified among this particular pedophilic subject pool these findings must also be compared and contrasted with those obtained from the other 2 data pools.

In reviewing the general findings associated with this group, the first item which needs to be addressed is their overall group performance on the Social Judgement Scale. The ANOVA analysis confirmed that these individuals (initially perceived as significantly deficient in the area of social judgement), deviated very little from the findings obtained by the control group. It appears that for the most part, the sex offenders are adequately skilled in the social arena, and subsequently, may use this knowledge as a method for luring children into their scheme of sexual deviancy. It is then these skills coupled with an inability to suppress maladaptive urges (as measured by the EPS), that may result in the commission of a sexually aberrant behavior. Although, this is speculation, the data does confirm that the lack of an internal locus of control may lead to other maladaptive behaviors that have little regard for social consequence (similar to group O), and are both personally and socially destructive. This is clearly reflected in the part II domains of the ABS-RC:2 which indicates significant deficits in their tolerance for frustration, increased use of both physical and verbal
aggression, and a general impudent attitude toward authority, as well as other acts of personal rebelliousness. Contrary to the research literature, it appears that the lack of sexual knowledge and/or negative sexual attitude, coupled with impulsivity, is not an inherent underlying feature which results in pedophilic behavior. If this were true, then all of the subjects in Group O would exhibit some form of sexual deviancy which would have come to the attention of the local authorities. Most strikingly, is the finding that the SO group scored higher on 12 of the 13 reported subscales on the Sexual Knowledge Test and also prevailed in demonstrating the most positive sexual attitude as measured by the attitude scales, than both the O and NO groups. This would imply that the sexual deviants share a greater interest in sexually related matters and make it a point to project a positive attitude to anyone who desires to question their behavior.

II. Group - O-(Offenders)

In comparing the O group data with the data obtained from the SO group, it may at first appear that these 2 groups are significantly more similar to one another than to the control group. However, a closer inspection of the data suggests that this group exhibits a greater degree of pathology far more intense than the SO group. For example, as reported on the ABS-RC:2 they obtained a lower score on the Domain of Social
Behavior and Conformity than both the SO and NO groups. Thus, implying that they exhibit a greater degree of impairment in their tolerance for frustration, an increased tendency for physical aggression, and an intensified disregard for following general rules and social responsibilities. Their performance on the SSKAT reflected an overall group performance that was the lowest on 6 of the 7 reported subscales. Furthermore, this group also demonstrated the greatest degree of impulsivity which is in accordance with their tendencies to engage in behaviors without reference to relative consequences associated with their actions. Lastly, this group, achieved the lowest mean scores on the Social Judgement Scale. Hence, at first glance these 2 groups (SO and O), appear quite similar, but a closer observation reveals that the O group is considerably more anti-social and exhibits a far greater degree of disrespect for the laws and mores of our society.

III. Group-NO-(Non-offenders)

In reviewing the relative performance of this group compared to the SO and O groups, it should be noted that the most significant differences were reflected in the domains of Sexual Behavior, Conformity, and Social Behavior as measured by the ABS-RC:2. By contrast, minor deviations were evidenced in the areas of impulse control as recorded by the EPS and social
judgement as identified by the SIS. As anticipated, this group demonstrated the highest degree of socialization skills, displayed the greatest amount of internal control over their behavior, and functioned in harmony with the rules governing our society. However, unlike the literature suggests, they did lack less refinement in their understanding of sexual knowledge and held a more neutral attitude toward sexual related matters than did the SO group, respectively.

IV. A Biographical Profile of 2 Pedophiles with Mental Retardation.

While self-serving narcissistic personality traits are generally the rule rather than the exception among sex offenders, profound character differences did emerge between two of the noted subjects (#03 and #07), therefore, a profile of these individuals will be shared with the reader. As with most of the individuals from the SO and O groups their developmental/social-historical information was for the most part sparse, although, an underlying element of family dysfunction earmarked with both physical and psychological abuse did appear as a common denominator. And similar to their criminal cohorts, these sociologic and psychologic factors served as "acceptable" excuses for their deviant behavior. However, in the following presentation there are particular
instances in which an individuals pathology does not fit the neatly organized diagnostic criteria as outlined in the DSM-III-R for the diagnosis of Pedophilia. Instead, the typical thirst for dominance, power, and control, achieves a new threshold, which in the absence of children, transforms into equally erotic power oriented acts of extreme physical violence and aggression.

As for #07 this mans history is replete with violent antisocial behaviors without regard or remorse for human suffering or consequence. He is notorious for his pathological lies, he is suspicious of others, and maintains a malingering attitude alluding any and all possible situations which could result in self-incrimination of past allegations. He, unlike the others in the SO group, invests minimal cognitive energy in social interactions, he withdraws if social conversations are felt to be intrusive, and relies on scare tactics (threats of physical violence) should he feel as though he is loosing control of a situation. He perceives himself as a productive member of society who faults others when held accountable for an infraction and mitigates his maladaptive behavior by claiming he is a victim of circumstance. Unlike the others, he savors revenge and without provocation will commit a heinous act to fulfill his distorted perceptions and achieve immediate self-gratification.
As for #03, this man presents a very different history, absent of violent or aggressive tendencies, but instead, filled with frequent incidents of verbal tantrumming and/or other child-like behaviors in response to limited social attention or situational delays in self-gratification. Unlike #07, he demonstrates an insatiable thirst for attention and without hesitation would engage in immature or socially inappropriate behaviors in order to obtain the immediate attention of individuals within his environment. He proclaims himself as a self-trained musician who would at anytime (and any place) perform a solo, should an audience be readily available. He frequently socializes and initiates activities which were later found to be clever manipulations to "scan the environment" in an attempt to identify a potential target. Unlike #07, his victims are selected at random and his plans less organized and sophisticated. Much like his counterparts, (and unlike #07), he operates on the basis of availability and therefore, individuals can be substituted, as long as his needs are gratified. However, within the context of a supervised controlled environment, he does give heed to his predatory instincts due to the aversive consequences associated with his potential acts. And, despite being thwarted by either staff or peers, one does not have to be on the alert for a violent retaliation. More generally, he is what some individuals would consider to be an "ideal" client as his behavior has a tendency to be quite predictable within a highly supervised and structured environment.
In summarizing the data gathered from the sex offender and offender groups, it appears that the following similarities emerged: 1. The fact that the majority of these individuals are repeat offenders would indicate that they lack the ability or desire to profit from previous experience, 2. For the most part, all the individuals divest themselves from responsibility; personal and social, 3. These individuals lack control over their impulses or urges, to the point that, their tendencies seem compulsive, often directed by obsessive thoughts or prompts, 4. There are deficits in their ability to identify and utilize social cues. Their resulting behavior is often immature, self-centered, and impotent in ability to exercise empathy.

It appears that from our society's perspective, these irresponsible unpredictable individuals, who, for the aforementioned reasons, are labeled as failures. Their lives are comprised of self-serving, self-gratifying behaviors which tend to dominate every aspect of their existence. Although, for the sexual deviant also diagnosed with mental retardation their pathology may represent a failure in maturation of both identity and personality.
CHAPTER VI

Summary, Conclusions, Clinical Implications, Limitations and Suggestions for Future Research

The purpose of this study was to compare a group of individuals with both mental retardation and pedophilia with a similar group of offenders of non-sex related acts and a control group comprised of individuals with no record of criminal activity. The participants selected for this study were adult males ages 21 to 47 who were all at the time of this study, residing in Columbus, Ohio.

Each subject was examined with the same instruments and the responses were recorded in the same fashion. Each instrument administered was selected for its sensitivity to identify the specific characteristics questioned by this examiner. This chapter will summarize the findings that emerged from this investigation, review the clinical implications, limitations, and suggestions for future research.
Summary of the Findings

Hypothesis-1 Sexual Knowledge

It was hypothesized that the sex offenders and offenders would achieve similar sexual knowledge scores on all the subscales. The non-offenders would also receive similar scores as the sex offenders and offenders on the Anatomy and Terminology scale, however, the non-offenders would yield higher scores on the other 6 subscales. A total of 7 subscales were chosen from the Social Sexual Knowledge and Attitudes Test and assigned to this hypothesis. Statistical analysis indicated that no significant findings were revealed when the SO and O groups were compared to the NO group and to each other. This finding suggests that the group of sex offenders were equally knowledgeable as the non-offenders in the areas of Anatomy and Terminology, Dating, Marriage, Intimacy, Intercourse, Masturbation, and Homosexuality. However, it must be noted that out of all seven of the scales administered the sex offenders, as a group, they obtained mean scores which were higher on 6 of the 7 reported subscales.

Therefore, based on this evidence it appears that hypothesis one was not accepted. Contrary to most research literature reviewed, the sexual knowledge (as measured by the SSKAT) of
the sex offenders for this particular study closely approximated the sexual knowledge of the non-offender groups. One could speculate that, although well versed, they may choose not to utilize their skills due to previous negative experiences, the unavailability of age-appropriate peers, or a simple desire not to use them since they are not a means to one's end. Hence, social-sexual knowledge, or at least the lack of it, does not seem to be a contributing factor to one's sexually aberrant behavior. Instead, it may reflect a heightened interest in this area, as well as, an attempt to "appear" more knowledgeable or "in control" should someone question their behavior.

**Hypothesis 2 - Physical Aggression**

It was hypothesized that the sex offenders and offenders would reveal similar findings on the Social Behavior and Conformity domains than the non-offenders. It was also predicted that the sex offenders would exhibit different findings on the Sexual Behavior domains than those obtained by both the offender and non-offender groups. A total of 3 domains were chosen from the Adaptive Behavior Scale RC:2 (Part II) and assigned to this hypothesis. Statistical analysis suggested that the sex offender and offender groups were significantly similar on the Social Behavior Domain and the Conformity Domain than the control group. Accordingly, sex offenders and offenders were similar in utilizing maladaptive strategies such threats, physical violence,
temper tantrums, teasing, foul language, increased frustration, and disruptive behavior, as accepted methods for coping with environmental demands. And if placed in restricted environments they would respond with acts of misbehavior in group settings, impudent attitude towards authority, obstinace toward rules and regulations, absence for appointments or required places, and a general resistance for following instructions or requests. On the Sexual Behavior domain, the sex offender group was significantly different than the offender and non-offender group thus confirming that sex offenders would reveal a greater degree of sexually aberrant behavior as measured by this domain.

Based on these findings, it appears that hypothesis two was accepted. Sex offenders and offenders are equally deficient in their abilities to identify and implement adaptive strategies for resolving conflict. It would appear that their maladaptive tendencies are instead "a way of life", behaviors useful in manipulating their environments and attaining their goals regardless of the resulting consequence.

**Hypothesis 3- Impulse Control**

It was hypothesized that the sex offenders and offenders would exhibit a greater degree of impulsivity than that of the non-offenders. One subscale scale was chosen from the Emotional
Problem Scales - Self-Report Inventory and assigned to this hypothesis. Statistical analysis showed that the sex offender and offender groups revealed no significant statistical differences, although they both were statistically different from the non-offender group.

Based on this evidence it appears that hypothesis three was accepted. This indicates that the items measured by the Impulse Control scale suggest that the sex-offenders and offenders demonstrate a greater degree of disturbance in the area of impulse control (i.e. listening to others, sitting still, having difficulty paying attention, becoming easily bored, and acting without considering the relative consequences). These individuals lack an internal locus of control and require external cues in order to guide and modify their actions. Consequently, when left to their own devices they would freely engage in spontaneous maladaptive behavior without regard to societal proscription.

**Hypothesis 4 - Social Judgement Skills**

It was hypothesized that the non-offenders would exhibit greater skill competency and behavior when compared to the sex offenders and offenders. The Social Judgement Scale was utilized for this particular measure and the findings were
assigned to this hypothesis. Statistical analysis revealed no significant statistical differences among the sex offenders and non-offenders although the offender group compared to the non-offender group did reveal a statistical difference. This suggests that the items measured by the Social Judgement Scale (i.e. social inference, social problem solving, identifying appropriate response alternatives), were of similar competency among the sex-offenders and non-offenders although, significantly different among the offenders.

Therefore, based on this evidence it appears that hypothesis four was not accepted. Contrary to most research literature, these identified subjects were very knowledgeable in the area of social judgement. One could speculate that these individuals were selective in which circumstances they would use their skills, thus implying, their need to be in control of most if not all social interactions. If in fact a social situation would prove to be self-serving these individuals would modify their behavior and implement the appropriate skills necessary to achieve the desired outcome.

Conclusions

The results of the summary of the findings that compare the sex offenders with both the offenders and non-offenders revealed
that the sex offenders, although a very unique group, were more similar to the offenders than the non-offender group. However, based on these similarities, it was interesting to find that the offender group did not choose to explore sexual deviancy as an additional expression of their maladjustment. Consequently, this is also true for the sexual offender, thus, they demonstrated minimal deviancy from their identified pathology. Although, not all pedophiles fit this description (as reviewed in the biographical profile of two mentally retarded pedophiles), it does suggest that these individuals have internalized their learned maladaptive behavior and assimilated it into their personalities in what they perceive as an "adaptive" normal response to their respective environments. Furthermore, the sexual offender portrays himself to be a knowledgeable individual who may in fact believe that he is acting in a socially acceptable moralistic fashion in which he is able to justify his actions by minimizing the seriousness of his offenses.

Clinical Implications

The focus of this study was to review specific observable behavioral characteristics commonly associated with individuals diagnosed both with mental retardation and pedophilia. The overall findings indicate that the specific characteristics attributed to these individuals are not adequate in distinguishing them from other offenders and to some degree
non-offenders. Instead, these individuals have a tendency to be sophisticated in their method of approach and only after the fact, are they identified and brought to local authorities. Similar to their criminal counterparts they are immune to treatment, and consequently, following correctional deterrents as well as rigorous therapeutic efforts provided by skilled clinicians, re-emerge in the legal system.

From a clinical perspective, what is often overlooked or simply misunderstood, is the understanding that when one's identity begins to form somewhere along the developmental process the sequence is interrupted and an intact identity fails to emerge. The result of this interference may take several forms (i.e. psychosexual disorders), including sexual perversions among individuals with mental retardation. This understanding is critical, since it is during the developmental period that these disturbances must be identified and appropriately treated in order to reduce their prevalence among this particular population.

Limitations of the Study

The first limitation of this study was the composition of the sample pool. Due to the limited number of pedophiles available for group 1 the data pool was small. Consequently, it is difficult
to generalize these findings with any amount of reliability based on the size of the experimental population.

Secondly, the sex offenders were recruited from an in house group program developed specifically for treating sex offenders with mental retardation. Therefore, recruiting from this facility most assuredly contaminated the findings and skewed the resulting data.

Third, I felt that the SSKAT was an outdated instrument that did not adequately tap into the area of knowledge that should have been otherwise explored. This entire area of knowledge should have been more deeply probed to have revealed more information than a crude understanding of generalities associated with social-sexual functioning.

Lastly, although specific characteristics most often cited in the literature were the central focus of this study, I felt that I was tightly bound to explore these specific characteristics. Instead additional characteristics also should have been examined, particularly those commonly associated with sex offenders and specifically supported by empirical data (i.e. power, control, dominance).
Suggestions for Future Research

The above information suggests the need for additional research in this highly energized and often feverishly debated area replete with misunderstandings and misconceptions. Although the sexual identity and gender formulation among individuals with mental retardation has received a great deal of attention, little is known as to how intellectual deficits may impact upon sexual deviance. Thus, it is suggested that the following items be explored.

1. Adolescence is a particularly difficult period for all individuals even more so for those with limited intellectual abilities. Consequently, research aimed at the development of both normative as well as sexually aberrant behaviors must be conducted during this critical period of development. Early intervention seems to be an integral factor when attempting to eliminate the deviant behavior. Thus, it would be during the period of adolescence that these maladaptive behaviors need to be addressed.

2. Research studies should encompass all areas of sexual deviancy and not be limited to the areas which receive the most attention (usually the areas that individuals are most visible). In doing so specific predictors can be identified and early
interventions be employed while these individuals are still amenable to treatment protocols.

3. The etiology of the behavior itself should be explored, particularly its relative influences due to environmental-developmental circumstances. Are these learned behaviors passed along from generation to generation due to family dysfunction or are they instead produced by family and/or societal circumvention.

4. Lastly, a replication of this study would also be useful in an attempt to replicate these findings with other sample populations. However, the experimental population should also include an adolescent subject sample.
APPENDIX A

DEMOGRAPHICS
## Appendix A
*(Demographics)*

### Demographic

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APPENDIX B

RAW DATA
### APPENDIX B

**Raw Data (SSKAT)**

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APPENDIX C

DESCRIPTION OF THE STUDY
APPENDIX - C

Description of the Study

Few studies have attempted to identify observable behavioral characteristics associated with mentally retarded sex offenders. Clearly lacking from the literature is research using group comparison experimental designs that involve individuals diagnosed with both mental retardation and pedophilia. The purpose of this study is to examine three groups of adult males with mental retardation of which; the first group will also carry the diagnosis of pedophilia; the second group will have a documented history of criminal activity (excluding sex offenses); and the third group will have no history of criminal or sexually aberrant behavior. Each participant will be administered 4 assessment instruments in order to determine skill level and adaptive functioning in the areas of sexual knowledge and attitude, social judgement, impulse control, and aggressive tendencies. All the material will be identified by code and kept confidential. All participants will be informed that they will receive $5.00 for partaking in this study.
APPENDIX D

CONSENT FOR PARTICIPATION IN SOCIAL AND BEHAVIORAL RESEARCH
Appendix - D
Consent for Participation in Social and Behavioral Research

I consent to participate in (or my child's participation in) research entitled:

An Attempt To Identify Observable Behavioral Characteristics Associated With Mentally Retarded Sex Offenders.

_____________________________ or his/her authorized representative has explained the

(Principal Investigator)

purpose of the study, the procedures to be followed, and the expected duration of my (my child's) participation. Possible benefits of the study have been described as have alternative procedures, if such procedures are applicable and available.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Further, I understand that I am (my child is) free to withdraw consent at any time and to discontinue participation in the study without prejudice to me (my child).

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: __________________________ Signed: __________________________

(Participant)

Signed: __________________________

(Principal Investigator or his/
her Authorized Representative)

Signed: __________________________

(Person Authorized to Consent for Participant - If Required)

Witness: __________________________

HS-017 (Rev. 3/87) -- (To be used in connection with social and behavioral research.)
BIBLIOGRAPHY


