

Community Services, Issues, and Service Gaps for Individuals With Developmental Disabilities Who Exhibit Inappropriate Sexual Behaviors

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Abstract

Inappropriate sexual behaviors represent the most challenging behaviors for community service providers. A national survey of 243 community agencies was conducted to describe services provided for individuals with developmental disabilities who exhibit high-risk sexual behaviors and to identify issues and service gaps. The most common types of offenses were sexual behavior (a) in public situations, (b) that inappropriately involved others, and (c) involved minors. Community agencies used multifaceted approaches to serve these individuals. The major issues and problems were systemic, specifically staff issues and service gaps, followed by funding. Implications of this study are that increased knowledge and skills related to sexuality and inappropriate sexual behavior and mental health resources are needed to build community capacity to serve this population.

Deinstitutionalization of all persons with developmental disabilities is predicated on addressing challenging behaviors in community settings (Sigafos, Reichle, & Light-Shriner, 1994). Inappropriate and offensive sexual behaviors represent the most challenging behaviors for community service providers. Sex offenders with developmental disabilities are an often overlooked and poorly understood population (Nezu, Nezu, & Dudeck, 1998; Swanson & Garwick, 1990) whose behaviors jeopardize community opportunities and quality of life.

The actual incidence of sex offending behaviors is unclear. Murphy, Coleman, and Haynes' (1983) comprehensive review concluded that the incidence rate of sex offenses by people with mental retardation is between 10% and 15%. If individuals with borderline intellectual functioning are included, Nezu et al. (1998) suggested the estimate could be as high as 40%. Day's (1997) review of the literature concluded that sex offenses accounted for 12% to 46% of convictions of people with mental retardation. On the other hand, Swanson and Garwick (1990) reported that as few as 3% of individuals who exhibit severe sexually aggressive behaviors receive community services. The most frequently reported sexual offenses by individuals with

mental retardation are indecent exposure and other minor offenses and sexual assault of young girls (Day, 1997).

Sex offending behavior among individuals with developmental disabilities is related in large part to impaired cognitive, affective, and behavioral skills. Although they present problems very similar to those of nondisabled offenders (Caparulo et al., 1988; Day, 1997; Murphy et al., 1983), there are substantial differences that make assessment and service delivery complicated. These include societal prejudice, limited sociosexual skills and knowledge, decreased opportunities for sociosexual behavior, sexual victimization, difficulty projecting consequences, difficulty recognizing and expressing emotions, low self-esteem, and significant others denying the behavior (Caparulo et al., 1988; Murphy et al., 1983; Nezu et al., 1998). Many people with developmental disabilities receive little or no sex education (Griffiths, Quinsey, & Hingsburger, 1989) and their attempts at sexual expression are either punished or ignored (McCabe, 1993; Swanson & Garwick, 1990).

The actual categorization of sexually deviant acts can become blurred depending on situational factors, degree of deviant activity, or the victim's

reaction (Schilling & Schinke, 1989). In fact, such behaviors may not “reflect deviant arousal, but arise from living in a system in which appropriate sexual knowledge and relationships are not supported” (Hingsburger, Griffiths, & Quinsey, 1991, p. 51). For people with developmental disabilities, inappropriate or offensive sexual behaviors may or may not lead to an encounter with the legal system, adjudication, or incarceration.

Little information exists about the treatment of sex offenders with cognitive disabilities (Haaven & Coleman, 2000; Nezu et al., 1998; Swanson & Garwick, 1990). Schilling and Schinke (1989) recommended that services should combine interventions designed for sex offenders in general with adaptations to accommodate people with cognitive disabilities and their limitations. Specifically, other authors have suggested that such services follow a multidimensional approach that includes decreasing inappropriate arousal, increasing appropriate arousal, increasing sociosexual skills and knowledge, and teaching self-management skills (Griffiths et al., 1989; Knopp, 1990; Pithers, Martin, & Cumming, 1989). In addition “post release monitoring, life skills training, and community supports must be tailored to fit the [person’s] unique risks and needs” (Schilling & Schinke, 1989, p. 42). Service planning for offenders with disabilities is complicated because it is unclear whether behaviors such as impulsivity, poor judgment, aggressive behavior, and a wide range of other inappropriate behaviors are associated with a propensity toward sexual offending (Schoen & Hoover, 1990).

Services for people with developmental disabilities exhibiting inappropriate or offensive sexual behaviors are virtually nonexistent, overly restrictive, or fragmented (Sundram, 1999; Swanson & Garwick, 1990). Demetral (1994) reported that only 13% of identified treatment programs for sex offenders serve offenders with cognitive disabilities and “rarely are these services adequately ‘adapted’ to meet the multidimensional needs of individuals with developmental disabilities, nor are they comprehensive with regard to modality of treatments necessary to impact relapse potential” (p. 57). Freeman-Longo, Bird, Stevenson, and Fiske (1995) found that only 1,514 service providers in the United States treated sex offenders with intellectual impairments. It is not clear, however, whether the total number of providers reported represents an unduplicated count. Because the data were reported by age categories (i.e., child, juvenile, and adult),

the actual number of service providers could be much lower.

Our purpose in this study was to describe the types of services and supports provided for people with developmental disabilities who exhibit high-risk sexual behaviors and to identify service issues and gaps in serving this population.

Method

We used a survey design to obtain quantitative and qualitative data from community service providers. For purposes here, we defined *inappropriate or offensive sexual behavior* as (a) sex acts involving nonconsenting partners, (b) sexual behavior that is public or intrusive, and/or (c) sexual behavior that presents a danger to the individual or others.

The Community Services Survey questionnaire developed for community agencies consisted of 14 questions. Questions included demographic information about the individuals served; living arrangements; adjudication; and open-ended questions to describe inappropriate and offensive sexual behavior problems, arrangements, and modifications to keep individuals and the community safe; problems and issues encountered in service delivery; interface with other service delivery systems; and service needs or gaps.

Respondents

A total of 689 surveys were mailed to members of the American Network of Community Options and Resources (ANCOR). Before we mailed the survey, ANCOR published an ad in its newsletter, LINKS, encouraging its membership to participate in an effort to increase the response rate. A follow-up mailing was sent to 538 respondents who had not returned surveys after 2 months. A total of 240 surveys was returned for a response rate of 34.8%.

Results

Table 1 shows the number of individuals identified as exhibiting inappropriate or offensive sexual behavior problems and where they were served. Over half of the community agencies reported serving this population. Our results indicated that about 5% of the total population represented in this study presented inappropriate or offensive sexual behavior problems. Only around 15% of these individuals were reported to have spent time in jail.

The demographics (age and type of residential

Table 1 Population Served by Community Agencies

Characteristic	Community agencies			
	No		Yes	
	<i>n</i>	%	<i>n</i>	%
Provide services for individuals with inappropriate/offensive sexual behaviors	90	37.5	150	62.5
Average number of all residents served	83.57		88.27	
Total number of residents served	5,850		11,917	
Total number of individuals with inappropriate/offensive sexual behaviors served			914	5.1
Total number of individuals with inappropriate/offensive sexual behaviors who had ever been incarcerated			139	15.2

placement) of the population with inappropriate or offensive sexual behavior problems receiving services are shown in Table 2. Forty-one percent of these individuals were over 36 years old. Group homes were the type of community living arrangement for almost half of these people.

Types of Inappropriate or Offensive Sexual Behaviors

We asked respondents to describe the types of inappropriate sexual behaviors that were exhibited by service recipients. Responses were sorted into nine categories as shown in Table 3. Because most respondents reported several types of behavior present, categories are not mutually exclusive.

As can be seen in Table 3, the most frequently reported type of behavior was inappropriate sexual behaviors in public situations. The behaviors in this category included sexual behaviors that are appropriate in private, but inappropriate or illegal in public situations. These behaviors included public exposure, public masturbation, public stripping, and consensual sexual behavior in public.

Sexual behaviors and stimulation that inappropriately involved others was the next most frequently reported type of behavior. This type of behavior is intrusive and violates social norms but does not include sexual intercourse nor involve children. These behaviors included inappropriate touching of others, grabbing others' genitals, rubbing against other people for sexual stimulation, writing letters to men asking them to strip and letters to woman indicating they would like to sleep with them, making sexually explicit phone calls, inappropriate staring and voyeurism, pinching breasts, offensive sexual comments, fondling and undressing others without permission, and stalking or grooming.

Sexual activity involving minors was also reported by almost half of the respondents and included behaviors that involved children—ranging from attempts to engage children in watching sexual behavior, solicitation of sex from children, infatuation with children, masturbation to pictures of children, inappropriate touching of children, and molestation of children.

Table 2 Living Arrangements of Individuals With High-Risk Sexual Behaviors by Age

Age	Foster		Group home		ICF/MR		Indep. living		Unknown		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Under 16	4	5	67	79	6	7	1	1	7	8	85	9
17–22	3	2	86	62	12	9	8	6	30	22	139	15
23–35	5	2	133	42	28	9	46	15	104	33	316	35
36+	1	0	141	38	22	6	41	11	169	45	374	41
Total	13	1	427	47	68	7	96	11	310	34	914	100

Table 3 Types of Inappropriate and/or Offensive Sexual Behaviors

Behavior	<i>n</i>	%
Inappropriate sexual behavior in public situations	92	62.2
Sexual behaviors and stimulation that inappropriately involved others	63	42.6
Sexual activity involving minors	63	42.6
Assaultive/nonconsensual sexual activity—not involving minors	51	34.5
Obsessive sexual behavior	14	9.5
High-risk sexual practices	14	9.5
Inappropriate self-stimulation	13	8.8
Homosexuality/cross-dressing	12	8.1
Contributory factors	10	6.8
Total	148	

Note: *n* represents the number of community agencies who reported serving individuals with inappropriate and/or offensive sexual behavior problems.

Assaultive and nonconsensual sexual behaviors not involving minors included nonconsensual intercourse with adults. This type of behavior included descriptions such as attempting to sexually assault others, abusive sexual behaviors, nonconsenting sex, forced sodomy, and rape.

Obsessive sexual behavior included behaviors described as fetishism, sexual addiction, wanting to have sex with pregnant women, cutting women’s hair to use as sexual stimulation, compulsion to collect used feminine hygiene products, and stealing women’s clothing for use during self-stimulation.

High-risk sexual practices included behaviors such as prostitution, solicitation, performance of sexual acts for money or other tangible things, sex with strangers, and unprotected sex.

Harmful self-stimulation were behaviors that could potentially cause harm such as dunking head in toilet after masturbation, self-mutilation, masturbating with objects that could easily cause bodily harm, inserting items into own rectum, tying strips of cloth around genitals tightly, and excessive or self-injurious masturbation. Homosexuality or cross-dressing were reported as inappropriate sexual behaviors by almost 10% of the respondents.

Contributory factors were behaviors that were not explicitly sexual in nature but possibly related to inappropriate sexual behavior problems, such as victim of incest, victim of sexual abuse, poor im-

Table 4 Types of Special Arrangements and Modifications

Arrangements and modifications	<i>n</i>	%
Supervision	107	73.8
Behavioral interventions	59	40.7
Mental health services	50	34.5
Environmental	47	32.4
Sex education	21	14.4
Legal sanctions	15	10.3
Pharmacology	7	4.8
Health	4	2.7
None	2	1.3
Total	145	

Note: *n* represents the number of community agencies who reported serving individuals with inappropriate and/or offensive sexual behavior problems.

pulse control, physically aggressive with peers over sexual issues, inability to discern feelings, anger management issues, and past history of drugs.

Arrangements or Modifications to Ensure Community Safety

We were interested in the approaches community agencies who served individuals with inappropriate or offensive sexual behavior problems used to keep the individuals or the community safe. Respondents were asked to describe any special arrangements or modifications they made to provide services. Responses were sorted into nine categories as shown in Table 4.

As can be seen from Table 4, the most frequently reported category was supervision, which included 24-hour supervision, one-to-one supervision, close monitoring, intense supervision, low client to staff ratios, and safety checks. Behavioral interventions included behavior management programs, training prompts and redirection, behavioral contacts, and level systems. Individual and group therapy, counseling, sex offender treatment, and consultation from mental health professionals were examples of mental health services.

Some types of environmental modifications described were restrictions on community activities, restrictions on access to high-risk situations (e.g., children, public bathrooms, play grounds, schools), single or separate room assignments, home location to limit access to potential victims or high-risk sit-

uations, alarms on doors and windows, motion detectors, private transportation, blocking phone calls, removing inappropriate stimuli used for masturbation (i.e., pictures of children), and providing private time for masturbation.

Sociosexual education included human sexuality training, Planned Parenthood classes, training and education on appropriate sexual behaviors and expression, relationships and friendships, sex education, and teaching masturbation. Descriptions given of legal sanctions were probation and parole, court orders and restrictions, state registry for sex offenders, and instruction on legal issues. Pharmacology reflected use of medication (unspecified), medication to reduce sexual desire (e.g., Depo-Provera), and medication for an obsessive compulsive disorder.

Health-related interventions were, among others, AIDS testing, Hepatitis B immunization, precautions when giving first aid, gynecology examinations, providing condoms for protection, and health care monitoring. Only 1.3% reported that no special arrangements or modifications were made.

Problems Providing Services

We asked community agencies that served individuals with inappropriate sexual behaviors to describe any problems or concerns they encountered in service provision. Responses were sorted into 10 categories as shown on Table 5.

Table 5 Problems and Concerns in Service Provision

Problems and concerns	<i>n</i>	%
Staff issues	39	27.6
Service gaps	39	27.6
None	23	16.4
Safety	20	14.3
Quality of life/client rights	20	14.3
Funding	14	10
Parent/guardian issues	13	9.2
Teaching problems	13	9.2
Noncompliance	10	7.1
Other	3	2.1
Total	140	

Note: *n* represents the number of community agencies who reported serving individuals with inappropriate and/or offensive sexual behavior problems.

Staff issues and service gaps (e.g., staff attitudes and values toward the behaviors, lack of trained staff, limited availability of training, and staff turnover) were the most frequently reported problems. Service gaps included lack of expertise of mental health professionals to work with developmental disabilities, lack of treatment and sex education, lack of accurate diagnosis, lack of choice for mental health services, lack of employment opportunities, lack of police intervention and understanding, and lack of professional assistance. Responses about safety/risk reflected concerns about safeguarding others in the living environment and general concerns that community safety cannot be guaranteed.

Under the category quality of life/client rights, respondents mentioned concerns about maintaining choice, least restrictiveness and confidentiality while protecting community, and difficult community integration due to client reputation and community reactions. There were funding concerns and problems with inadequate financial resources to provide services. Parents and guardian issues were difficulty working with families or guardians, family nonacceptance of the problem, and lack of family support.

Included under teaching problems were descriptions about individuals not understanding consequences of their behavior and difficulty learning concepts (e.g., partner consent, appropriate/inappropriate touch, public/private). Client noncompliance included issues such as refusing program assistance, not accepting restrictions, leaving home or work without staff, and quitting or refusing mental health services. Situations under the category other nonspecified problems included transportation, being victimized, and impulse control problems. Of our respondents, 16.4% reported that they had no problems in providing services.

Other Service Delivery Systems

Respondents were asked to identify other service delivery systems they used to help to meet the needs of individuals with inappropriate or offensive sexual behavior problems. They were also asked to rate these services on a 1 (*completely dissatisfied*) to 5 (*very satisfied*) scale for the range of services provided, the quality of the service provided, and the effectiveness of communication with the providers. The mean ratings for these questions are shown in Table 6.

As can be seen from Table 6, community agencies primarily used mental health centers to help

Table 6 Mean Ratings of Service Delivery Systems by Community Service Providers

Service	<i>n</i>	Range of services	Quality of services	Communication
Mental health centers	110	3.26	3.40	3.48
Medical/pharmacology	35	3.86	3.97	3.97
Private therapists	27	3.89	3.93	3.96
Corrections/legal	24	2.96	3.08	3.08
Education	9	2.44	2.56	2.78
Case management	7	3.57	3.43	3.71
Day programming/vocational services	6	4.00	4.00	4.17
Residential services	5	3.60	2.80	3.20

Note. Ratings are on a scale from 1 to 5 (1 = *completely dissatisfied*; 5 = *very satisfied*).

meet the needs of their consumers but reported a moderate level of satisfaction with the range and quality of services provided and effectiveness of the communication. Community agencies reported working with medical/pharmacology services, private therapists, and corrections/legal to a much lesser extent. Satisfaction with the range and quality of services and effectiveness of communication for medical/pharmacology services and private therapists was somewhat higher than with mental health centers and lower for corrections and legal services.

Adequacy of Community Services

All community agency respondents, whether serving individuals with inappropriate or offensive sexual behavior problems or not, were asked whether they believed that there were adequate community-based services available to this population in their service areas. Of the 198 responses to this question, 19% (*n*=38) answered that services were

adequate, whereas the remaining 81% (*n*=160) believed that services in their area were not adequate.

Respondents were also asked to describe the issues and problems related to the inadequacy of community services. The responses in rank order are displayed in Table 7. Expertise was the most frequently reported problem and included issues related to not enough professionals specializing in sexual deviance and developmental disabilities and not enough training. Systems issues were problems related to a general lack of services and need for collaboration between systems, such as mental health, corrections, and developmental disabilities. Funding comments were about the lack of financial resources to provide services or access specialized treatment. Access issues were concerns reported by rural providers that services were available but required traveling long distances to access. Liability issues and concerns were reported by only about 5% of the providers, and community acceptance (concerns about tolerance of neighbors, employers, and stereotyping) by even fewer.

Table 7 Issues Related to Lack of Adequate Services

Issue	<i>n</i>	%
Expertise	50	38.4
Systems issues	39	31.5
Funding	27	20.8
Access	14	10.8
Liability	7	5.4
Community acceptance	6	4.6
Total	143	

Note: *n* represents the total number of community agencies responding regardless of whether individuals with inappropriate and/or offensive sexual behaviors were served.

Discussion

The results of this survey generally confirm information reported in the literature. We found that the percentage of individuals exhibiting inappropriate or offensive sexual behaviors represented in this study to be less than the incidence rates reported in the literature. However, in the present study we did not account for individuals served within the correctional or mental health service systems.

An important finding was that the most common types of inappropriate sexual behaviors report-

ed were serious in nature and illegal. These data suggest that the community service delivery system is dealing with major challenges with respect to problematic sexual behaviors. On the other hand, the types of behaviors most frequently reported reflect the complicated nature of the problem. As Hingsburger et al. (1991) suggested, these problems are often related to a lack of skill and opportunity for appropriate sexual activity.

Community agencies addressed inappropriate sexual behavior issues using multifaceted approaches, specifically, increased supervision, behavioral interventions, mental health services, and environmental arrangements. However, sex education and supporting sexuality were not common strategies. The fact that 41% of the individuals who exhibited inappropriate or offensive sexual behaviors were over 36 years of age indicates the need for a more proactive approach (i.e., sociosexual skill development) to prevent the occurrence of sexual offenses by people with developmental disabilities. This age cohort reflects the consequences of a long history of social restrictions and segregation of people with developmental disabilities. Living arrangements, whether in an institution or a group home, typically have provided little or no opportunities for privacy (Griffiths et al., 1989; McCabe, 1993). Although attitudes are changing, society continues to react with discomfort to the recognition that people with disabilities are sexual beings with inherent needs for affection and intimacy as well as sexual gratification. These findings lend support to the conclusion that sex education and providing opportunities for appropriate sexual expression should be a higher priority for service delivery. Otherwise, the opportunity to live in the community will be compromised for a large number of individuals.

Interestingly, we found that systemic issues rather than funding were the major problems in service delivery. Although lack of financial resources was reported as a problem, it was not ranked as the primary issue. Although systemic issues are often related to lack of financial resources, these findings suggest that lack of knowledge and expertise are the primary barriers. Staff issues (i.e., attitudes and values toward the behaviors, lack of training, and staff turnover) and service gaps (i.e., lack of expertise of mental health professionals to work with individuals who have developmental disabilities, lack of treatment, diagnosis, and sex education) were reported as primary problems. These results have serious implications for the service delivery system.

First, community service agency staff need training and information related to issues of sexuality and inappropriate or offensive sexual behavior. This issue is complicated because there is a wide disparity of opinion expressed by staff regarding what constitutes appropriate sexual activities for people who experience different types of disability. A high percentage of staff believe sex education should be provided, and they accept masturbation. However, as the focus of sexuality shifts from education to interpersonal activities, the approval rate of staff members drops dramatically (Coleman & Murphy, 1980). Our finding that homosexuality and cross-dressing were reported as inappropriate sexual behavior problems by 8% of the respondents further illustrates the imposition of staff values on the sexuality of people with developmental disabilities. To address these issues, organizations should develop explicit value statements on supporting the sexuality of people with disabilities. Further, they must provide staff members with the necessary tools and resources to support people in learning about sexual issues and resolving problems. There are many excellent resource materials available (Brown, Carney, Cortis, Metz, & Petrie, 1994; Fegan, Rauch, & McCarthy, 1993; Haaven, Little, & Petre-Miller, 1990; Hingsburger et al., 1999; Kempton, 1988; Monathaller, 1992; Nezu et al., 1998). Finally, staff training must include values clarification around sexuality and sexual deviancy.

Second, there is a widespread lack of mental health services to meet the needs of this population. Further, community service providers reported only marginal satisfaction with the range and quality of the service provided and the effectiveness of communication. They reported slightly higher rates of satisfaction with private-practice therapists. The major barriers are that mental health service providers are not able or willing to meet the needs of individuals with developmental disabilities. Developing formal partnerships between community providers of developmental disabilities services and mental health service providers would begin to build capacity in the mental health system. These partnerships should be structured to increase the knowledge of mental health professionals about persons with developmental disabilities as well as increase the knowledge of developmental disabilities professionals about clinical issues. Strategies might include hiring mental health professionals as consultants for developmental disabilities service agencies, arranging situations to enable developmental

disabilities professionals to co-facilitate treatment groups for dually diagnosed individuals, or developing formal communication protocols between mental health providers and developmental disabilities agencies to bridge information on clinical issues and day-to-day behaviors.

Third, there are major service gaps between service delivery systems (i.e., developmental disabilities, mental health, and corrections) that create problems and barriers to meeting the needs of this population. Findings in the present study confirm that services for individuals with inappropriate or offensive sexual behaviors are still fragmented or nonexistent and, most important, not a priority for the service delivery system.

The results of this study are limited due to the sampling frame used to represent community agencies. Only those agencies that were members of ANCOR were surveyed. They may not be representative of the total population of community agencies. Further, the small, albeit respectable, response rate further limits generalization of the results.

Overall, the results of this study provide support that individuals with developmental disabilities who exhibit inappropriate or offensive sexual behaviors are not being adequately served. Future research is needed about prevention and effective service practices and interventions for this population. Further, broad dissemination about service needs and approaches across multiple systems (e.g., developmental disabilities, mental health, and corrections) is critical. The results of this survey reveal that a majority of community agency administrators are willing to serve this population, but increasing community capacity is dependent on expanding knowledge and skills as well as arranging resources to meet the unique needs of this very challenging, high-risk population.

References

- Brown, G. T., Carney, P., Cortis, J. M., Metz, L. L., & Petrie, A. M. (1994). *Human sexuality handbook: Guiding people toward positive expressions of sexuality*. Springfield, MA: Association for Community Living.
- Caparulo, F., Comte, M., Gafgen, J., Haaven, J., Kaufman, K., Kempton, W., Sissala, L., Whitaker, J. M., & Wilson, R. (1988, March 25–27). *A summary of selected notes from the working sessions of the First National Training Conference on the Assessment and Treatment of Intellectually Disabled Juvenile and Adult Sexual Offenders*. Columbus, Ohio.
- Coleman, E. M., & Murphy, W. D. (1980). A survey of sexual attitudes and sex education programs among facilities for the mentally retarded. *Applied Research in Mental Retardation*, *1*, 269–276.
- Day, K. (1997). Clinical features and offense behavior of mentally retarded sex offenders: A review of research. *The NADD Newsletter*, *14*, 86–89.
- Demetral, G. D. (1994). A training methodology for establishing reliable self-monitoring with the sex offender who is developmentally disabled. *Habilitative Mental Health Newsletter*, *13*, 57–60.
- Fegan, L., Rauch, A., & McCarthy, W. (1993). *Sexuality and people with intellectual disability* (2nd ed.). Baltimore: Brookes.
- Freeman-Longo, R. E., Bird, S., Stevenson, W. F., & Fiske, J. A. (1995). *1994 nationwide survey of treatment programs and models serving abuse-reactive children and adolescent and adult sexual offenders*. Brandon, VT: Safer Society Program and Press.
- Griffiths, D., Quinsey, V., & Hingsburger, D. (1989). *Changing inappropriate sexual behavior: A community based approach for persons with developmental disabilities*. Baltimore: Brookes.
- Haaven, J. L., & Coleman, E. M. (2000). Treatment of the developmentally disabled sex offender. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 369–388). Thousand Oaks, CA: Sage.
- Haaven, J., Little, R., & Petre-Miller, D. (1990). *Treating intellectually disabled sex offenders*. Orwell, VT: Safer Society Press.
- Hingsburger, D., Chaplin, T., Hirstwood, K., Tough, S., Nethercott, A., & Roberts-Spence, D. (1999). Intervening with sexually problematic behavior in community environments. In J. R. Scotti & L. H. Meyer (Eds.), *Behavioral intervention: Principles, models, and practices* (pp. 213–236). Baltimore: Brookes.
- Hingsburger, D., Griffiths, D., & Quinsey, V. (1991). Detecting counterfeit deviance. *Habilitative Mental Health Newsletter*, *10*, 51–56.
- Kempton, W. (1988). *Life horizons I: The physiological and emotional aspects of being male and female*. Santa Barbara, CA: Stanfield.

- Knopp, F. H. (1990). Introduction. In J. Haaven, R. Little, & D. Petre-Miller (Eds.), *Treating intellectually disabled sex offenders*. Orwell, VT: Safer Society Press.
- McCabe, M. P. (1993). Sex education programs for people with mental retardation. *Mental Retardation*, 31, 377–387.
- Monat-Haller, K. (1992). *Understanding and expressing sexuality: Responsible choices for individuals with developmental disabilities*. Baltimore: Brookes.
- Murphy, W. D., Coleman, E. M., & Haynes, M. R. (1983). Treatment and evaluation issues with the mentally retarded sex offender. In J. G. Greer & I. R. Stuart (Eds.), *The sexual aggressor: Current perspectives on treatment* (pp. 22–41). New York: Van Nostrand Reinhold.
- Nezu, C. M., Nezu, A. M., & Dudek, J. A. (1998). A cognitive behavioral model of assessment and treatment for intellectually disabled sex offenders. *Cognitive and Behavioral Practice*, 5, 25–64.
- Pithers, W. D., Martin, G. R., & Cumming, G. F. (1989). Vermont treatment program for sexual aggressors. In R. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 313–325). New York: Guildford.
- Schilling, R. F., & Schinke, S. P. (1989). Mentally retarded sex offenders: Fact, fiction, and treatment. In C. Hanson, J. Snow, & C. Smallwood (Eds.), *Treatment of sex offenders in social work and mental health settings* (pp. 33–47). New York: Haworth.
- Schoen, J., & Hoover, J. H. (1990). Mentally retarded sex offenders. *Journal of Offender Rehabilitation*, 16(1/2), 81–91.
- Sigafoos, J., Reichle, J., & Light-Shriner, C. (1994). Distinguishing between socially and nonsocially motivated challenging behavior: Implications for the selection of intervention strategies. In M. F. Hayden & B. H. Abery (Eds.), *Challenges for a service system in transition: Ensuring quality community experiences for persons with developmental disabilities* (pp. 147–169). Baltimore: Brookes.
- Sundram, C. J. (1999). Pitfalls in the pursuit of life, liberty, and happiness. *Mental Retardation*, 37, 62–67.
- Swanson, C. K., & Garwick, G. B. (1990). Treatment for low-functioning sex offenders: Group therapy and interagency coordination. *Mental Retardation*, 28, 155–161.

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