An Alternative Treatment Approach for Sex Offenders with Intellectual Disability

A Literature Review

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirement for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By

Steven T. Sturlaugson

Chair: Rachelle Reinisch, DMFT

Reader: Meghan Williams, MA, LMFT

July, 2018
An Alternative Treatment Approach for Sex Offenders with Intellectual Disability

Copyright © 2018

Steven T. Sturlaugson

All rights reserved
Abstract

There is a paucity of research on the treatment of sex offenders with intellectual disabilities. Current treatment approaches are often modified versions of mainstream programming and fail to take into account the specialized needs of the intellectually disabled population. If released into the community, these offenders face lifelong restrictions that limit their ability to find suitable housing and jobs, which can lead to increased rates of sexual reoffending. Individual Psychology can be utilized to provide sex offenders with intellectual disabilities the courage they need to increase social interest and obtain a sense of belonging within their communities.

*Keywords:* Individual Psychology, sex offender, intellectual disability
# Table of Contents

Sex Offenders ................................................................................................................................. 6  
  Civilly-Committed Sex Offenders ................................................................................................. 7  
  Sex Offenders with Intellectual Disabilities ............................................................................... 9  
The Impact of Sex Offending ......................................................................................................... 13  
  Financial .................................................................................................................................. 14  
  Social and Work ......................................................................................................................... 16  
  Relational .................................................................................................................................. 16  
Sex Offender Treatment Approach .............................................................................................. 18  
  Cognitive Behavioral Therapy ..................................................................................................... 20  
  Risk-Need-Responsivity ............................................................................................................. 21  
  Minnesota Sex Offender Program ............................................................................................... 21  
  Intellectual Disabilities ............................................................................................................... 22  
Individual Psychology .................................................................................................................. 27  
  Social Interest ............................................................................................................................. 29  
  Safety, Significance, and Belonging ............................................................................................. 32  
  Encouragement .......................................................................................................................... 33  
Discussion ................................................................................................................................... 34  
  Implications for Practice ............................................................................................................. 34  
  Recommendations for Future Research ...................................................................................... 39  
Conclusion .................................................................................................................................... 39  
References .................................................................................................................................... 41
An Alternative Treatment Approach for Sex Offenders with Intellectual Disability

Sex offenders with intellectual disabilities are an underserved population that require specialized approaches to treatment (Deming, 2008). Often, this population is treated using variations of conventional programming that do not fully take into account the cognitive functioning level of individuals with disabilities (Marshall & Hollin, 2015). Variations of conventional programming are frequently ineffective and can lead to an increase in the sexual offending recidivism rates for these individuals.

Current approaches to sex offender treatment include cognitive behavioral therapy, risk-need-responsivity models, and programs like the Minnesota Sex Offender Program that utilizes a comprehensive approach and combines a number of theories and models (Deming, 2008). While these approaches have varying levels of success, they are not typically designed to treat sex offenders with intellectual disabilities, which is a relatively new focus (Wilcox, 2004). The treatment of this population has suffered from inconsistencies in research (Hughes & Hebb, 2005; The Arc, 2015), and as such, current programs have simply adjusted existing models to meet treatment needs (Sakdalan & Collier, 2012).

An Individual Psychology approach for treating sex offenders with intellectual disabilities with a focus on the use of encouragement, social interest, safety, significance, and belonging could improve the mental health and treatment outcomes for sex offenders with intellectual disabilities (Ferguson, 2010; Gfroerer, Nelsen, & Kern, 2013; Taylor, 2009). An Adlerian approach can also reduce society’s ostracization of sex offenders with intellectual disabilities and foster full reintegration into society. An Individual Psychology approach provides sex offenders a better quality of life and increases the potential for social contribution and a safer community.
Sex Offenders

According to the sex offender tracking map developed by the National Center for Missing and Exploited Children (2017), there were 874,725 registered sex offenders in the United States as of November 28, 2017, and 17,689 sex offenders were registered in Minnesota (MN) at that time. The number of registered sex offenders included those that were incarcerated, in state-run treatment facilities, and offenders that had been released into the community. From 2014 to 2018, a review of the Minnesota Department of Corrections (MN DOC) adult inmate profiles revealed a yearly statewide average prison population of 9,930 inmates with an average of 1,669 inmates incarcerated for criminal sexual conduct offenses (MN DOC, 2014; MN DOC, 2015; MN DOC, 2016; MN DOC, 2017a; MN DOC, 2018).

According to the MN DOC (2017b), 17% of the inmate populace is serving a sentence for a criminal sexual conduct offense, and another 12% have been convicted of a prior sexual offense. The MN DOC (2017b) noted that over 90% of inmates serving time for a sexual offense will return to the community upon release from correctional facilities. As sex offenders are released from prison, there is a constant risk for reoffending or violating parole. From 2003 to 2012, Duwe (2015) found that an average of 130 sex offenders returned to prison each year because of probation violations. These offenders did not commit another criminal sexual conduct offense, but rather failed to register, could not find employment, or were unable to secure appropriate housing, which are common conditions after release.

*Sex offender* and *sexually violent predator* is used synonymously in the available literature; however, the actual definition of a sexually violent predator can change from state to state based on legislation (Deming, 2008). The common variables for identifying sex offenders are individuals who had been charged with, and/or convicted of, a violent sexual offense,
suffered from a personality disorder or “mental abnormality,” and the abnormality led to a sexual crime (McLawsen, Scalora, & Darrow, 2012; Miller, 2010). This common identification allowed states to categorize offenders with similar offenses, which led to large scale plans for change. Duwe (2015) noted that by the early 1990s many states tried to manage the number of sex offenders by extending prison sentences, requiring sex offenders to register, restricting housing options, and engaging in the civil commitment of sex offenders. These legislative shifts have fueled the growth of civil commitment programs nationwide and have led to an increasing number of individuals facing potential lifetime sentences.

**Civilly-Committed Sex Offenders**

When sex offenders are eligible for release, they may be subject to further evaluation and potential civil commitment based on individual assessments and evaluator recommendations. Miller (2010) noted that by 1911, independent state laws specifically identified individuals with violent sexual offenses, and through the process of legislation, violent sexual offenders were defined as *defective delinquents* and *criminal psychopaths*. According to McLawsen et al. (2012) civil-commitment programs were created specifically for sex offenders to identify, detain, and treat those that were most likely to reoffend and commit another sex crime. These sex offenders served most, if not all, of their prison sentences, and yet, once they are committed, they have no definitive release date. Roughly 4% of sex offenders released from the Minnesota DOC are identified in this subset and are committed to the Minnesota Sex Offender Program (MSOP) (MN DOC, 2017c). Schneider (2008) reported that almost half of civilly-committed sex offenders had four or more felonies with an overall average of three per offender (MN DOC, 2017d), and 8% of sex offenders that were not civilly committed had four or more felonies.
By the early 1990s, Duwe (2015) found that Minnesota legislators, in an effort to detain higher risk sex offenders, started applying civil commitments to those individuals categorized as violent sex offenders upon release from prison. Those individuals were civilly committed as either a sexually dangerous person, a sexual psychopathic personality, or both a sexually dangerous person and a sexual psychopathic personality (Office of the Ombudsman for Mental Health and Developmental Disabilities, 2017). After Dru Sjodin was murdered in November 2003 by a sex offender that had been recently released from prison, the number of civil commitments in Minnesota increased dramatically (Duwe, 2015). According to the Minnesota (MN) Department of Human Services (2018) there were 725 civilly-committed sex offenders in the MSOP as of April 1, 2018. Of those 725, 437 were in the Moose Lake facility, and the remaining 288 were in the Saint Peter facility. Duwe (2015) found that, per capita, Minnesota had more sex offenders under civil commitment than the other 19 states that operate similar programs.

According to Miller (2010) the civil commitment process has a purposeful role in society for the most mentally ill and violent sexual offenders; however, the treatment programs must balance the liberties of the offenders, without condemnation, with the safety of the public (Prescott & Levenson, 2010; The Arc, 2015; West, 2007). That is, Miller stated the goal of sex offender treatment is to keep the public safe and reduce recidivism, yet public safety tends to be more important than a reduction in recidivism when it comes to legislation and public opinion.

The goal of the civilly-committed sex offenders is to gain a provisional or full discharge from the MSOP (MN Department of Human Services, 2017). According to the MN Department of Human Services (2018), the MSOP released 16 sex offenders on a provisional discharge, which is only around 2% of the program’s population. Miller (2010) found that up to
approximately 4% of sex offenders are released from civil-commitment programs nationwide. This low release rate can lead to hopelessness and despair for offenders while in treatment if they do not believe release is possible.

**Sex Offenders with Intellectual Disabilities**

Another sex offender subset is the sex offenders with intellectual disabilities. The American Association on Intellectual and Developmental Disabilities (2018) defined an *intellectual disability* as significant limitations in an individual’s ability to adapt behavior and intellectual functioning in daily skills. Hollomotz (2014) found that when treatment programs consider an individual’s needs, they are better suited for sex offenders with intellectual disabilities. Within the current MSOP program, clients enter *conventional programming*, or they are treated in the *alternative programming*. Per the MN Department of Human Services (2017) MSOP treatment overview, alternative programming is for sex offenders with impairments in executive functioning such as learning difficulties, cognitive deficits, and brain injuries.

Wilson, Prescott, and Burns (2015) reported that incarcerating individuals with a mental illness has almost tripled over the past 30 years, and the number of available hospital beds for this population has decreased by 90% in the past 50 years. These shifts have occurred even though there is paucity of research about sex offenders with intellectual disabilities (Sex Offender Treatment Services Collaborative – Intellectual Disabilities, 2010). The fact that this population can be diverted from mainstream treatment programs due to their diagnosis, and that these offenders are rarely offered treatment, has an impact on the lack of research (Hollomotz, 2014; Sex Offender Treatment Services Collaborative – Intellectual Disabilities, 2010).

Wilcox (2004), Nezu, Fiore, and Nezu (2006), and West (2007) found that around 10 to 15% of sexual offenders have an intellectual disability, and Johnson (2012) cited the most
common offenses for these individuals as arson and sex offending. Lambrick and Glaser (2004) found that this population often resides in supervised residential settings or institutions where sexual relationships are discouraged or not allowed, which further hinders their ability to form appropriate relationships (Goodman, Leggett, Weston, Phillips, & Steward, 2008; Lindsay, 2002; Nezu et al., 2006; The Arc, 2015; Wilcox, Beech, Markall, & Blacker, 2009). Martinello (2014) added that this limited experience may increase the potential for an individual to engage in sex offending behavior (The Arc, 2015).

Lindsay, Steptoe, and Haut (2012) and Martinello (2014) noted how maltreatment during an individual’s childhood, which sex offenders with an intellectual disability have higher rates of, can lead to inappropriate behaviors and sexual abuse in adulthood; however, Wilson et al. (2015) cautioned that in many cases, these reports of childhood trauma were identified and used as an excuse by the offender rather than a treatment issue. Martinello (2014) found that it is important to be aware that these individuals are at risk of becoming victims and perpetrators of sexual abuse (The Arc, 2015), with as much as half of the offenders with an intellectual disability offending against another individual with an intellectual disability (Murphy, Powell, Guzman, & Hays, 2007; Nezu et al., 2006).

Murphy et al. (2007) noted how these at-risk individuals come from dysfunctional homes that can be chaotic and neglectful, with parents that often have criminal offenses (Lindsay, 2002; McGreevy, Newbauer, & Carich, 2001; West, 2007). Sex offenders with an intellectual disability reported feeling isolated from relationships with their parents, and yet, these offenders did not seek an emotional connection from their parents (Steptoe, Lindsay, Forrest, & Power, 2006). These offenders have conformed to this parental detachment and have either accepted it or believe that it will not improve (Steptoe et al., 2006).
This at-risk population has a lack of social competence and poor coping, problem solving, and interpersonal communication skills (Lindsay, 2002; Nezu et al., 2006; The Arc, 2015; West, 2007; Wilson et al., 2015), though Lambrick and Glaser (2004) saw a number of offenders that understood their sexuality issues and had excellent social skills. As a result of these deficits and limited access to services to remediate issues (Nezu et al., 2006), individuals with intellectual disabilities are at an increased risk of having sexual contact with a child, which depending on sentencing, will result in the individual becoming registered as a sex offender (The Arc, 2015). Along with offenses against minors, researchers found that sex offenders with an intellectual disability are more likely to have same gender interests, possibly due to the close contact in supervised residential settings during the developing years (Wilcox et al., 2009).

Offenders with lower intelligence are more likely to be arrested due to decreased freedom in residential settings and their limited ability to plan and hide behavior (Wilcox, 2004; Wilcox et al., 2009), which may result in a more transparent sexual offense history (Sex Offender Treatment Services Collaborative – Intellectual Disabilities, 2010). Goodman et al. (2008) and Lambrick and Glaser (2004) found documented evidence that suggested, at some level, these offenders planned situations to get themselves alone with a victim, which shows premeditation. Elisha, Idisis, and Ronel (2013) highlighted that, over time, these offenders will escalate and show a lack of self-control, which manifests as increases in the number of victims, age ranges of those victims, number of offenses, and levels of violence.

Wilson et al. (2015) found that prison sentences, and civil commitments for sex offenders with an intellectual disability, have increased along with the post-incarceration consequences of sex offender registration, public notification, and residential restrictions, although these consequences fail to consider the disability (The Arc, 2015). The legal precedent has been that
Sex offenders can be civilly committed regardless of an intellectual disability as long as the treatment program offers a variation of treatment for those that would not benefit from standard programming (The Arc, 2015). A major concern after civil commitment is the individual’s ability to fully participate in treatment (The Arc, 2015), and due to an inability to fully understand treatment, this could mean a life sentence in the program. Sex offenders without significant family, social support, and criminal pasts represent a greater treatment challenge and a higher risk of reoffending (Elisha et al., 2013).

The recidivism risk for sex offenders decreases with age, and longer prison sentences may have an indirect impact on future offenses because offenders will be much older when they are released. Researchers report a reduction in sexual recidivism as a result of an increase in civil commitments (Duwe, 2015). Researchers found varied sexual recidivism rates; 3% and 4% (Duwe, 2015); 16% (Lindsay, Steptoe, Wallace, Haut, & Brewster, 2013); 19% (Wilcox, 2004); 23.9% (Lindsay, Michie, Steptoe, Moore, & Haut, 2011); 30% (Elisha et al., 2013); and 40% (Lindsay, 2002); however, Heaton and Murphy (2013) stated that few studies have been conducted to determine recidivism rates, or the impact that treatment has on those rates, for sex offenders with intellectual disabilities.

Kleban and Jeglic (2012) stated treatment in community and correctional programs can decrease sexual recidivism rates. Minnesota sex offenders that require supervision after release from prison have a lower recidivism rate than offenders that are discharged into the community without supervision (Duwe, 2015), and this is contrary to the entrenched belief that this population cannot be treated (Elisha et al., 2013; Hollomotz, 2014). When offenders did not participate in treatment, recidivism rates were three times higher than those that did participate.
(Martinello, 2014). Wilcox (2004) reported recidivism rates are ultimately useful for treatment facilities to determine how well their programs work.

**The Impact of Sex Offending**

The true impact of sexual offenses is difficult to quantify. Consequences exist for the victims, the offender, the families of the victim and offender, the community, the state, and the country. There are financial costs as a result of sexual offenses that can be quantifiable, and there are social and relational impacts to consider.

Few topics ignite more public discussion and opposition than when sex offenders are released into the community (Kleban & Jeglic, 2012). When sex offenders are released from incarceration, they are faced with a number of challenges, especially if they are required to register, and these challenges can include the ability to follow the conditions of release, secure employment and appropriate housing, and reconnect with family and friends (Tolson & Klein, 2015).

As a result of the Jacob Wetterling Act, sex offender registries were required in every state (The Arc, 2015). The Jacob Wetterling Act was passed into law to maintain a record of the name, image, address, and identified sexual offenses of sex offenders across the country (MN DOC, 2017c). Two years later, Megan’s Law was an amendment to the Jacob Wetterling Act, which required that all information on the sex offender registries were accessible to the public (The Arc, 2015). The Sex Offender Registration and Notification Act of 2006 included stricter requirements for sex offenders, which included the elimination of the statute of limitations, an increase in the length of registrations, and minimum sentences for sexual offenses (The Arc, 2015). With these new requirements, some states enacted lifetime stipulations for some offenders. Levenson and Tewksbury (2009) found that the ability to access the sex offender
registries offers the public a sense of confidence that they can protect their families from potential sexual offenses; however, Kleban and Jeglic (2012) noted that community notification and sex offender registration have done little to reduce the sexual recidivism rates, and no empirical studies have been conducted to identify the impact on offenders with intellectual disabilities or their communities (Wilson et al., 2015).

**Financial**

Along with the requirements for sex offenders to be registered in national databases, Martinovic (2016) noted that over 30 states have made the use of global positioning satellite (GPS) monitoring a mandatory condition of release to track sex offenders. Bishop (2010) added that on a daily average, correctional programs across the country are responsible for 200,000 sex offenders, with 90,000 monitored within the community at any given time (Martinovic, 2016). The use of lifetime monitoring for specific offenders has been passed by legislation and is utilized in at least seven states. Bishop (2010) and Berenson and Appelbaum (2010) stated that lifetime GPS monitoring has the potential for substantial costs nationwide that could reach millions.

As with all technology, advances are constantly being made within the field of GPS, specifically with the development of the *Global Navigation Satellite System*, and in less than a decade, countries from North America, Europe, and Asia will combine efforts, share information, and share technology to improve the ability to track offenders (Martinovic, 2016). Martinovic reported that although the figures vary nationwide, the average annual cost of incarcerating an offender is around $30,000, yet the average cost of monitoring an offender with GPS technology is less than $6,000 per year. On the other hand, the MN Department of Human Services (2018) reported that the average cost for a civilly-committed sex offender is $372 per
day, or just over $135,000 a year, which for a population of 725 offenders can cost millions. The MN DOC has 419 available beds across five facilities for sex offender treatment, with a fiscal year 2018 budget of $4,740,000 (MN DOC, 2017b).

Due to the vast number of offenders with GPS devices, monitoring centers are staffed 24 hours a day to appropriately evaluate any issues that may arise and to notify the authorities if there is a serious violation (Martinovic, 2016). Bishop (2010) and Martinovic (2016) found the increasing number of offenders with GPS monitoring created an additional demand on law enforcement officers and those responsible for an offender’s supervision within the community. Additional responsibilities for law enforcement include (a) setting offenders up with the GPS equipment, (b) training the offender how to use and maintain the equipment, (c) monitoring the GPS information, (d) maintaining a stock of GPS equipment, and (e) responding to issues as they arise (Martinovic, 2016). Sixty percent of offenders are required to pay for a portion of the GPS equipment; however, this practice operates on a sliding scale due to the often-limited income of offenders and covers about 10% of the total cost (Martinovic, 2016).

Many family members of sex offenders identified a negative economic impact due to limited housing and employment options because of the registration requirement (Levenson & Tewksbury, 2009; The Arc, 2015). Securing suitable employment is critical for released offenders because it provides much needed income and is often one of the conditions of release. Tolson and Klein (2015) found that employment can be a difficult hurdle for sex offenders. Yu (2016) stated that sex offenders create direct costs to their families and victims, including the loss of an income, legal fees, and potential therapy expenses. In addition, offenders can have a negative impact on the price of homes in the neighborhood.
Social and Work

Tolson and Klein (2015) and Levenson and Tewksbury (2009) found that in order to comply with registration laws and remain set distances away from areas with children, up to 1,000-2,500 feet away, sex offenders are all but forced to live in areas of the community that do not always provide the assistance they need to succeed such as job opportunities, transportation, and mental health services (Duwe, 2015; Kleban & Jeglic, 2012; The Arc, 2015). Levenson and Tewksbury (2009) noted that sex offender registries and community notifications have a negative impact on sex offenders, with up to one half of all sex offenders experiencing limited employment options, especially offenders with an intellectual disability (The Arc, 2015). In addition, many offenders (i.e., 20-40%) reported having to move after a landlord, or someone in the neighborhood, was aware of the sex offenses. Levenson and Tewksbury (2009) and Hackett, Masson, Balfe, and Phillips (2015) stated many sex offenders have identified feelings of hopelessness, depression, and fear of personal harm, and some report assault or property damage.

The public has a sense of safety knowing that sex offenders do not live in their communities (Bishop, 2010), but the residency restrictions add undue stressors to the offenders, which increases the risk of reoffending, and ultimately, can decrease the safety of the community. Duwe (2015) found that residency restrictions have a limited impact on preventing sexual recidivism. Hackett et al. (2015) reported that approximately one third of the respondents in a nationwide survey believe it was reasonable to harass sex offenders, and 17% of the respondents believed it was reasonable to physically assault sex offenders.

Relational

When children suffer from sexual abuse, the mothers are accused and shamed for the offenses committed by their partners (McClaren, 2013). McClaren stated mothers are shamed
because they were unable to protect their children, or they were unaware that the offending had occurred. McClaren found that common concerns for women included isolation and harassment by members of the community and family members. Typically, without much support, women are forced to deal with the abuse they suffered, or their child suffered (McClaren, 2013) and must come to terms with their new reality after the offenses are exposed. In instances when unsupervised custody may be granted to the offender, some women find themselves forced to stay with the offender to protect their child from additional abuse (McClaren, 2013).

According to Tewksbury and Connor (2012), sex offenders are often faced with families that harbor feelings of doubt, distrust, and uncertainty about the relationship. Most sex offenders stated they did not have family members visit while they were incarcerated (Tewksbury & Connor, 2012). For instance, family members blamed the distance to the facility, the intrusive nature of the facility’s security protocols, or the ominous feeling of the facility (i.e., the barbed-wire fences and series of locked doors). When family members decided to stay in contact with a registered sex offender, they reported that relationships with other relatives deteriorated as a result of that association (Levenson & Tewksbury, 2009; Tewksbury & Connor, 2012). Half of the family members disclosed losing a close relationship, and over 60% identified disengaging in social activities due to feelings of embarrassment and shame (Levenson & Tewksbury, 2009).

Levenson and Tewksbury (2009) stated family members frequently must agree to give law enforcement officials or supervisory agents access to their homes. This, coupled with the community’s awareness after an offender is registered and has a community notification, can lead to strong feelings of shame and scrutiny due to limited privacy. Over 80% of family members stated the registration of a sex offender caused additional stress, and almost half of the
family members felt fearful and had safety concerns after the community was notified of the offender’s release (Levenson & Tewksbury, 2009).

The children of sex offenders often find themselves the targets of bullying and abuse at school (Hackett et al., 2015). Over half of the sex offenders’ children stated they were unable to go to a friend’s house, friends were prohibited from coming to their house, and they believed that peers, teachers, and community members treated them differently because of their parent’s registration status (Levenson & Tewksbury, 2009). In these instances, children often exhibit signs of depression and anxiety while coping with strong feelings of isolation and fear.

Levenson and Tewksbury (2009) reported that even when family members do not reside with a registered sex offender, they experience a negative relational, social impact as a result of the offending. These extended family members experience threats of harm, property damage, harassment, and difficulty locating a home due to their association with a registered sex offender. Tewksbury and Connor (2012) found that school administrators can deny sex offenders access to school functions when legally possible, and 74% of offenders reported an inability to attend events, parties, and other functions involving children due to their registered status (Levenson & Tewksbury, 2009).

**Sex Offender Treatment Approach**

Initial approaches to sex offender treatment included a focus on single components such as arousal, deviance, or anger (Yates, 2013). As the multidimensional construct of sex offending became apparent, multiple approaches were utilized to address sexual offending behavior and risk (Wilson et al., 2015; Stirpe, Abracen, Stermac, & Wilson, 2006). Since sex offender treatment is a reactionary process, the interventions are directed at convicted sex offenders and focus on reducing deviant behavior and preventing future offenses (Collins & Nee, 2010).
According to Looman and Abracen (2013), correctional consequences alone (e.g., prison time) without a treatment approach did not have an impact on an offender’s recidivism rates. Evidence indicates that treatment programs contribute to a reduced recidivism rate, especially for those in the moderate to high-risk categories (Heseltine, Sarre, & Day, 2011); however, there is much less evidence regarding treatment of sex offenders with intellectual disabilities.

There are distinct populations within sex offender treatment programs and disadvantages to using blanket approaches (Collins & Nee, 2010). That is, the offenders need a varied treatment focus and will exhibit different levels of motivation. Mann, Webster, Wakeling, and Keylock (2013) noted that adequate and concise information given to potential treatment participants can reduce treatment refusal and dropouts. Collins and Nee (2010) also highlighted the importance of the therapeutic alliance between therapists and offenders and suggested a poor alliance can lead to higher treatment dropout rates and increased recidivism (Carich, Newbauer, & Stone, 2001; Grady, Swett, & Shields, 2016; Mozdzierz, Liseicki, Bitter, & Williams, 1986; Stein, 1988; Williams, 2005). Marshall and Hollin (2015) found that when treatment programs include strength-based methodologies for the assessment and treatment of offenders, they appear to offer more optimistic outcomes.

When civil-commitment treatment programs were created for sex offenders, the programs mirrored correctional settings and community-based programs—with some alterations (Deming, 2008; Moulden, Chaimowitz, Mamak, & Hawes, 2014). These treatment programs for sex offenders, and their varied interventions, are under legislative and societal pressure to be successful and prevent future sexual offenses (Collins & Nee, 2010). Political motivation can affect treatment programs, and when treatment programs require an offender to fully complete
the program, those programs have a near zero release rate and are in jeopardy of detaining offenders beyond the timeline of the civil commitment statute (Deming, 2008).

**Cognitive Behavioral Therapy**

During the 1960s and 1970s, a number of approaches were used to treat sex offenders in the United States (Marshall & Hollin, 2015) and by the 1980s, an increased cognitive behavioral approach was incorporated into the treatment plans (Moster, Wnuk, & Jeglic, 2008). With an ultimate goal of reducing recidivism rates, the *cognitive behavioral* approach includes a plan to change an offender’s cognition and behavior by utilizing skills-based techniques (Yates, 2013). Just as in other psychotherapeutic approaches, Collins and Nee (2010) found that the therapeutic alliance between the therapist and offender accounts for 25% of the success rate in the cognitive behavioral approach.

Kim, Benekos, and Merlo (2016) found that more than two thirds of over one thousand treatment programs in the United States and Canada utilize a cognitive behavioral therapy design. The cognitive behavioral therapy approach is currently the most empirically supported therapeutic approach (Yates, 2013) and is considered the most effective approach (Dreier & Wright, 2011; Heaton & Murphy, 2013; Murphy et al., 2007; Wilcox, 2004; Wilson et al., 2015). Schmucker and Losel (2015) argued that even though this approach has been supported over the years, the treatment effects are not as apparent as one would hope for. Collins and Nee (2010) stated cognitive behavioral treatment can be distributed on a large scale at a lower cost due to the heavy reliance on manuals and programming that can be facilitated by clinicians with little experience (Sandhu, Rose, Rostill-Brookes, & Thrift, 2012). As a result, the cognitive behavioral approach can limit the use of other therapeutic techniques. Recent studies show that a therapist’s treatment impact is limited when following a manualized treatment plan because
individual expertise can be hindered by the program’s structured design (Collins & Nee, 2010; Sandhu et al., 2012).

**Risk-Need-Responsivity**

The *risk-need-responsivity* concept was originally applied to sentencing and supervision of offenders (Yates, 2013), but its application to the treatment of sex offenders was realized soon thereafter. Treatment programs that addressed all three principles of risk, need, and responsivity were the most effective (Schmucker & Losel, 2015; Wilson et al., 2015) and had the greatest impact on recidivism rates (Looman & Abracen, 2013; Mann et al., 2013). The MN DOC (2017b) utilizes the risk-need-responsivity model for the treatment of sex offenders and this approach has been the prominent model for treating offenders in Canada, New Zealand, Australia, and the United Kingdom for over thirty years (Looman & Abracen, 2013).

The risk-need-responsivity approach is designed so that the offender’s level of risk determines the intensity of the treatment interventions used. For instance, the low-risk offenders receive little to no intervention while higher-risk offenders receive more intensive treatment (Willis & Ward, 2011; Yates, 2013). The risk-need-responsivity model relies on the offender’s awareness and avoidance of risky activities (Willis & Ward, 2011). At times, difficulties in the risk-need-responsivity approach include the singular focus of avoidance and the lack of consideration of the offender’s personal needs (Looman & Abracen, 2013).

**Minnesota Sex Offender Program**

Nearly all states with civil-commitment programs utilize a stage and/or phase system in their treatment design and focus on providing treatment through the use of cognitive behavioral therapy, group psychotherapy, relapse prevention, and risk-management plans (Deming, 2008). The MSOP compliments the aforementioned approaches with the added use of the *good lives*
model, risk-need-responsivity models, and individualized treatment plans that include defined and measurable goals (MN Department of Human Services, 2017). Despite the lack of empirical data to support the effectiveness of relapse prevention models when treating sex offenders (Yates, 2013), this approach continues to be utilized by almost two thirds of all treatment programs (Looman & Abracen, 2013). The relapse prevention model encourages a negative view of the offender by placing emphasis on criminal behavior and weaknesses, and evidence shows a strengths-based approach is a more effective approach (Marshall & Hollin, 2015).

As a result of identified limitations in the risk-need-responsivity model (Yates, 2013), the good lives model emerged as another approach to the treatment of sex offenders (The Arc, 2015; West, 2007; Wilson et al., 2015). Willis and Ward (2011) suggested that this strengths-based model equips offenders with the necessary skills to meet their needs in socially acceptable and meaningful ways rather than focusing on the suppression or avoidance of the negative behavior (Looman & Abracen, 2013). The good lives model helps offenders view themselves in a more positive light (Looman & Abracen, 2013) and encouragement is used as a means to assist offenders in identifying acceptable ways to live once they are released (Willis & Ward, 2011). On the other hand, Looman and Abracen (2013) stated when offenders were released, they were less aware of their risk factors. In a program that followed the good lives model, Willis and Ward (2011) found that offenders created treatment goals in conjunction with their therapist instead of the therapist dictating the goals (as in the risk-need-responsivity model). Yates (2013) added that treatment dropout rates decreased with the use of a good lives model program.

**Intellectual Disabilities**

Almost 90% of treatment programs identified the utilization of specialized programming for offenders with psychiatric impairments or intellectual disability (Deming, 2008), including
the MSOP, which utilizes the alternative programming for sex offenders with impairments in executive functioning such as learning difficulties, cognitive deficits, and brain injuries (MN Department of Human Services, 2017). Wilcox (2004) reported that treatment specific to sex offenders with intellectual disabilities is relatively new, which offers treatment providers unique challenges. With gaps and inconsistencies in the research, treatment for those with intellectual disabilities has lagged behind the treatment provided to non-intellectually disabled populations (The Arc, 2015). Sakdalan and Collier (2012) found that current programs in the United States, New Zealand, Australia, and the United Kingdom are versions of existing sex offender programs that have been adapted for this population. Hughes and Hebb (2005) noted the limited research conducted on this population was with individuals who resided in mental health facilities and these offenders required modified treatment that considers their level of intellectual disability, life experiences, and offending behavior (Lunsky, Frijters, Griffiths, Watson, & Williston, 2007; The Arc, 2015). Furthermore, individuals with intellectual disabilities will benefit from the simplification of language, content, and techniques within the treatment process (Goodman et al., 2008; Hollomotz, 2014; Johnson, 2012; Lambrick & Glaser, 2004; Lindsay, Whitefield, & Carson, 2007; Murphy et al., 2007; Sakdalan & Collier, 2012; Sandhu et al., 2012; The Arc, 2015; West, 2007; Wilcox, 2004; Wilson et al., 2015; Wilcox et al., 2009).

Modified treatment approaches must consider abstract reasoning abilities, impaired reading and verbal comprehension, limited insight, and an increased sensitivity to criticism (The Arc, 2015; Wilcox, 2004). Concrete concepts that the offender can relate to, and preferably those that originated with the offender, will be more meaningful and easily understood. As a result, the risk of reoffending decreases (Goodman et al., 2008; Lambrick & Glaser, 2004; Nezu et al., 2006; West, 2007). This approach to teaching allows for increased assimilation of
CONCEPTS, IMPROVEMENT IN CONCENTRATION, AND INCREASED INFORMATION RETENTION (WILCOX, 2004; WEST, 2007).


longer treatment timelines, for this population had an impact on reducing sexual offending recidivism. Murphy et al. (2007) noted that although knowledge of concepts and sexuality may reveal an improvement earlier in the process, offenders with an intellectual disability require longer periods of treatment to produce significant changes in cognitive distortions or level of victim empathy.

Duwe (2015) found that the management of most sex offenders can be done in the community, regardless of their risk of reoffending. Prescott and Levenson (2010) added that rather than basing treatment goals solely on avoiding consequences, relevant and meaningful consequences will be more beneficial, and there is an increased likelihood that offenders will embrace the meaningful consequences (The Arc, 2015). Wilson et al. (2015) reported that using experiential methods to present treatment activities has a greater impact on this population through an increased understanding of the meaning of the activities. Wilson et al. also found that offenders with an intellectual disability are aware of their differences and are more sensitive when misunderstood, so care must be taken to plan relevant treatment goals in order for increased investment and behavioral change to occur. Wilson et al. further noted additional education may be required for offenders with an intellectual disability to ensure treatment compliance because this population can be savvy and appear compliant to avoid consequences.

Lindsay et al. (2011) posited that sex offender treatment has a positive effect on offenders with an intellectual disability, and offenders that are under continuous supervision in the community have reduced opportunities to engage in sexually offending behavior and enlist readily available support. Goodman et al. (2008) found that a successful treatment plan must take into consideration a quality of life improvement plan for the offender, with a proposed plan for future employment, housing, and relationship development, while taking into account
restorative justice principles (Williams, 2005). Grady et al. (2016) noted that sex offenders with an intellectual disability are capable of change in their ability to develop and maintain healthy relationships, and through interpersonal skill development, offenders have the potential to reduce the risk of reoffending. Rose et al. (2002) added how this population tends to rely on an external locus of control, or direction from others, and need guidance to develop appropriate self-control techniques.

West (2007) identified the perceived notion that therapists in sex offender treatment programs felt cognitive distortions needed to be eliminated through confrontational challenges, but this process has caused criticism of those programs. Wilson et al. (2015) found that offenders with an intellectual disability are susceptible to influence and will present with an acquiescence bias, in which they will respond to questions in a way that they feel their questioner would want them to answer. Wilson et al. continued and stated that this population has issues with memory, which can put them at risk of admitting to crimes or additional victims, even those that do not exist, in order to appease an authority figure.

The Arc (2015) touched on how group therapy has been the traditional approach to treatment for sex offenders with an intellectual disability and it, along with supportive individual treatment, has been recognized as an effective format for this population (Carich et al., 2001; Carich & Stone, 2001; Lambrick & Glaser, 2004; Newbauer & Blanks, 2001); however, cognitive behavioral therapy may not always be a straightforward approach for these offenders (Wilson et al., 2015). Goodman et al. (2008) added that one advantage of this approach is that once an offender discloses in a group setting, which can carry a sense of relief, it is difficult for the offender to avoid challenges from peers if they attempt to return to previously held beliefs. In contrast, The Arc (2015) found that group therapy can be difficult for these offenders if their
intellectual disabilities are not considered. Newbauer and Blanks (2001) believed the group process allows offenders the opportunity to identify with others and see that they are not alone, which encourages the sharing of beliefs, attitudes, and behaviors with their peers. Sex offenders with an intellectual disability reported low self-esteem and feelings of isolation (Johnson, 2012; Martinello, 2014). The group therapy approach will challenge those feelings of loneliness, alienation, isolation, and inferiority through the connection with other offenders who feel the same way and have similar offenses, which can provide a level of comfort (Brough, 1994; Newbauer & Blanks, 2001). A cohesive group environment is conducive to creating healthy attachments because it offers a safe and secure place to seek intimate connections and foster relationships (Grady et al., 2016).

**Individual Psychology**

According to Crandall (1980) and Ferguson (2010), Alfred Adler believed the well-being of society and the individual were inseparable and interwoven. Newbauer and Blanks (2001) shared that the therapeutic goal of Individual Psychology is to promote one’s social interest while reducing inferiority feelings through an optimistic approach that inspires courage and engagement with other individuals (Main & Boughner, 2011). Brough (1994) stated that Individual Psychology is a theory of psychology that provides a theoretical explanation to address the relationship between an individual’s self-perception and his or her social interrelatedness. Carich (2001) noted that this Adlerian psychotherapy model assists the individual in addressing his or her negative perceptions in an effort to move toward more positive self-concepts through the use of identifying and challenging mistaken beliefs. In the early 1900s, Adler (1927) believed specialists would be needed to provide courage to criminals,
or offenders, who developed a neurosis, and that the causes of the neurosis, not the consequences, would need to be the focus of treatment and education.

McGreevy et al. (2001) highlighted how Adler believed that all behavior was purposeful and to that point, offenders freely choose their way of life in order to strive for superiority at the expense of others. McGreevy et al. also noted, that in order for an offender to change his or her faulty lifestyle, a sense of social interest must be fostered, and through this social interest, the offender will view the world and the self in a better light. Carich et al. (2001) added that Individual Psychology offers beneficial resources for working with sex offenders by fostering independence and courage (Adler, 1927) through a commitment of contribution to society (Ferguson, 2010).

Dutton and Newlon (1988) stated Adler proposed the following common factors for sexual deviance (a) emotional separation from the opposite sex, (b) a revolt from normal sexual roles, (c) behavior aimed at viewing the opposite sex as inferior, (d) deprecatory and aggressive behavior with a normal sex partner, and (e) a limited sense of social interest. McGreevy et al. (2001) added that Adler concluded offenders have limited concern for the well-being of others and their behavior is not conducted in a useful way, which reveals a lack of social interest (Crandall, 1980).

McGreevy et al. (2001) suggested that the act of sex during an offense is not for the purpose of sexual gratification, but rather, sex offenders use sex as a misguided and desperate effort to gain a sense of power and feel better about themselves. Saltzman, Matic, and Marsden (2013) added that these sexual boundary violations, through the use of power, are a form of *hierarchical infringement*. These offenders are often psychologically immature and utilize aggression to combat feelings of inferiority (McGreevy et al., 2001). McGreevy et al. believed
Sex offenders are poorly equipped to maintain intimate relationships because of their inadequate personalities, and that as a protective factor, offenders prefer to be in control of their environments to shield themselves from potential disappointment. Stirpe et al. (2006) added that insecure attachments may be a reason that sex offenders pursue their perception of intimacy through offending. Newbauer and Blanks (2001) noted that an Adlerian approach is beneficial for the treatment of sex offenders because offending behavior is a failed attempt to achieve a goal that is based on mistaken beliefs and perceptions.

Carich et al. (2001) found that Adler’s concepts and Individual Psychology are often not credited with influencing the treatment of sex offenders, but Adlerian theories and philosophies are apparent in contemporary interventions, especially the relapse prevention model, which is rooted in Adlerian theory (Carich & Stone, 2001). Ferguson (1989) added that striving for a sense of superiority has a direct correlation to the attempted removal of a feeling of inferiority, and this striving, coupled with a lack of courage, will shift behavior from useful to useless (Adler, 1927). Carich and Stone (2001) noted that sex offenders are self-determined, and offending is problem-focused. That is, offending utilizes a complex series of choices with the aim of meeting a need through learned behavior and creating a unique lifestyle pattern. Carich and Stone also found that sex offenders are responsible and accountable for their offending behavior, and they can reduce deviancy through effective treatment with the ideal aim to abstain from sexual offending behavior.

**Social Interest**

Hamm, Carlson, and Erguner-Tekinalp (2016) suggested social interest is an essential component of forgiveness, and Adler believed that offenders had a lower awareness of social interest that prevented them from succeeding in the areas of love, occupation, and community
Crandall (1980) noted that social interest can be defined as valuing things other than oneself, being a part of something more than any one individual, and as an essential element of a healthy personality. Additionally, social interest counteracts feelings of loneliness and helplessness. Steptoe et al. (2006) added that limited awareness of social interest in sex offenders meant less integration within society. Highland et al. (2010) established that offenses were preceded by established patterns of mistaken beliefs and offending behavior. La Voy, Brand, and McFadden (2013) promoted the concept of social interest as that of a community feeling where a sense of belonging is critical for an individual’s mental health.

Tewksbury and Connor (2012) found that sex offenders had limited social contacts outside of their family relationships, which is consistent with previous research and indicates that antisocial behavior is a predictor of recidivism and a risk factor for sex offenders (Hackett et al., 2015). Tewksbury and Connor (2012) noted that developing and maintaining positive social relationships, while incarcerated and upon release into the community, is necessary for sex offenders to resist reoffending. Steptoe et al. (2006) confirmed that a focus on quality of life, relationships, and a connection to society are important concepts within treatment. Steptoe et al. added that sex offenders with an intellectual disability will benefit from treatment that parallels mainstream approaches with the additional focus on increased social interest and attachment concerns within relationships and society. Mann et al. (2013) found that family and social factors are often discounted due to the focus on an offender’s behavior.

Steptoe et al. (2006) noted that in order to assist offenders with their reintegration into society, the following factors should be addressed (a) attachment to the values of positive relationships in society, (b) understanding the consequences of offending behavior, (c) pro-social involvement in vocational, educational, and occupational activities, and (d) acceptance and
adherence to laws. Steptoe et al. (2006) and Lindsay (2002) added that engagement with society is an essential component of treatment for sex offenders and the use of adaptive activities and pro-social influences are beneficial approaches to accomplish this goal. Williams (2005) noted that social and leisure experiences are a significant component of an improved quality of life for individuals, yet sex offenders have difficulties functioning in those activities. Williams (2005) also found that community support is integral for improving the quality of life for sex offenders as they transition into the community, and this support must be considered and fostered by treatment programs that are committed to offender rehabilitation. The Arc (2015) reported that limitations placed on released offenders, such as the housing restrictions previously mentioned, have a negative impact on the offender’s ability to maintain community involvement, which researchers show has the potential to reduce recidivism.

Martinello (2014) found that a key component of reducing recidivism for offenders with an intellectual disability was building social skills. Adler (1927) believed that an individual without a true social feeling will be hesitant and resistant in new or unfamiliar situations. Brough (1994) added that Adlerian theory identifies the concept of social interest as the primary indicator of a sense of belonging. Carich et al. (2001) found that when a sexual offense occurs, the offender’s level of social interest is minimal to non-existent, victim empathy is a critical component of a sex offender’s treatment, along with remorse, and all can be utilized as obstacles to prevent reoffending. Carich et al. also posited that victim empathy and social interest are similar concepts comprised of similar elements. For example, both victim empathy and social interest include the requirement of identifying with others and experiencing a feeling of connectedness. Carich et al. added that remorse and victim empathy can be identified as components of social interest as well due to the need to understand the experiences and emotions
of others. Deficits in social interest prevent sex offenders from feeling the same levels of remorse or guilt as most individuals do, which allows offenders to commit the offenses. Carich et al. found that the development of social interest, remorse, and victim empathy is not an easy, nor immediate, process for the offender.

Due to a history of difficult interactions within the community and within prison, typical sex offenders lack the ability to interact with others as equals, some of this can be a result of a lack of confidence and antisocial behavior components (McGreevy et al., 2001). Early sexual abuse can hinder or restrict the development of social interest (Saltzman et al., 2013). Saltzman et al. (2013) stated cooperation and encouragement are the keys to developing social interest, which is inextricably tied to a sense of belonging (Ferguson, 2010; Shoenaker, 1985).

**Safety, Significance, and Belonging**

Adler was one of the first in the field of psychology, with Maslow following later, to identify the need to belong as a primary human goal and fundamental motivation critical for positive mental health and life satisfaction (Ferguson, 2010; Gfroerer et al., 2013; Taylor, 2009). Mental health improves when a strong feeling of belonging is present in both the individual and the community (Ferguson, 2010) and psychological disturbances can manifest when an individual does not feel a sense of belonging. A provision of the Americans with Disabilities Act identifies belonging as a major life activity and the need to belong can be a motivating and encouraging factor for offenders with an intellectual disability (Taylor, 2009).

As with social interest, only by contributing to the community and the betterment of others can an individual truly identify with a sense of belonging (Ferguson, 2010), and the greater the sense of belonging, the more likely the individual will seek out others. Gfroerer et al. (2013) identified the perception of social support and a sense of belonging as protective factors
that add to an individual’s resilience. A sense of belonging also means that an individual will feel connected in all areas of living, without the need for offensive or defensive mechanisms to interfere with socially useful behavior (Shoenaker, 1985).

**Encouragement**

Adler considered *encouragement* a foundation of psychotherapy from which a sense of belonging and social interest could be developed, but it is not easily defined because based on the level of encouragement, individuals make choices that may or may not encourage striving on the useful side of life (Azoulay, 1999; Main & Boughner, 2011). One focus of Adlerian therapy is to assist in the discovery of an individual’s strengths and to encourage the attainment of goals in a pro-social and healthy way (Hamm et al., 2016). Encouragement is a valuable component of many major theories of psychotherapy (Dinkmeyer, 1972) and the therapist’s goal is to instill courage and inspire active engagement in the community through the use of verbal and nonverbal approaches to increase awareness of self-worth (Main & Boughner, 2011). The irreducible role of the therapist is that of the encourager, through which the individual becomes more independent, self-aware, and confident to deal with the tasks of life (Abramson, 1994; Carich et al., 2001; Mozdzierz et al., 1986; Slavik, 1999).

Elisha et al. (2013) highlighted the effectiveness of interpersonal components in treatment, such as encouragement and humor, rather than the confrontational approach typically associated with sex offender treatment. This shift utilizes a strengths-based approach to help the offender identify that a perceived deficit could also be an asset (Marshall & Hollin, 2015; Mozdzierz et al., 1986). Adler (1927) noted that individuals who develop a neurosis require a psychotherapist to increase their courage, and empowerment can help individuals believe in themselves even if they see evidence to the contrary (Mozdzierz et al., 1986).
Dinkmeyer (1972) found that motivating an individual, especially an offender with a long
criminal history, is a major therapeutic undertaking, but as the individual feels accepted and
takes responsibility for the course of action, a change in motivation will occur. Thus, an integral
part of the therapist’s role is to encourage an internal desire to change while being mindful of
external components (e.g., early parole) that may be motivating an individual’s participation in
treatment (Collins & Nee, 2010). As individuals identify and foster their strengths and skills,
they become more resilient and empowered (Hamm et al., 2016), which can lead to a more pro-

Discussion

Sex offenders with an intellectual disability are an underrepresented and undertreated
population within the criminal justice system and local communities. Rather than approaches
designed for this unique population, current treatment approaches for these offenders have been
modified from mainstream treatment programs. If treatment of this population is not conducted
in a multi-faceted approach that considers individual, intellectual disabilities, treatment providers
run the risk of doing more harm than good. An Adlerian approach that utilizes encouragement to
increase social interest and foster a sense of belonging can help these offenders reduce
recidivism and become a part of the community.

Implications for Practice

Theory knitting is the process of integrating the best parts of current theories and
practices into a new treatment framework in order to create a more comprehensive all-
embracing theory (Keeling, Rose, & Beech, 2009). Offenders require an all-inclusive
approach to treatment where appropriate social activities, work skills, and regular employment
are addressed, and much like mainstream approaches, treatment staff utilize strengths-based
approaches in both individual and group therapy venues to identify an offender’s talents (Newbauer & Blanks, 2001; Stone & Thompson, 2001). Acknowledgment of positive movement is beneficial, especially for sex offenders with intellectual disabilities, but self-respect is developed from goal attainment and not from compliments alone (Newbauer & Blanks, 2001).

Mental health practitioners understand that supervision of sex offenders is a key component to their treatment, particularly when they do not reside in an institutional setting (Carich & Stone, 2001). In addition, an aftercare treatment model serves to transition offenders back into society once they have been released from a correctional or institutional setting (Carich & Stone, 2001). This concept can successfully be applied to sex offenders with intellectual disabilities as it offers varying levels of support and is customizable to the needs of the individual offender. The individual and society are equally responsible for the well-being and development of the other and contributions from both are mutually beneficial (La Voy et al., 2013). The greatest measurement of a community is the ability to nurture the development of individuals with resources that support training and education for the betterment of society (La Voy et al., 2013).

Incorporating the use of halfway houses would be most ideal and a common residential placement for post-incarcerated sex offenders in the United States because of the ability to provide supervision, aftercare treatment, behavioral consequences, and risk monitoring (Carich & Stone, 2001). These residential settings provide the primary components of care for released sex offenders, including housing, supervision, and treatment, and can also provide necessary assistance in seeking employment and establishing healthy peer support (Carich & Stone, 2001).

When treating sex offenders with intellectual disabilities, a single care coordinator needs to be responsible for all areas of the offender’s treatment to ensure that communication between
service providers continues and to prevent the offender from potentially manipulating the system (Carich & Stone, 2001). With supervision in mind, the goals for the offender are centered on enhancing reintegration into the community, with specific goals tailored to the offender’s current treatment, social, vocational, familial, and recidivism risk needs (Carich & Stone, 2001). An aftercare program provides a safety net and encourages sex offenders to acclimate into the community with readily available support. Since there is no cure for sexual offending, there will always be the risk of a sex offender reoffending, regardless of the progress made in treatment or the use of relapse prevention techniques (Carich & Stone, 2001).

Mental health practitioners could engage in the practice of shared confidentiality as a necessary component of an offender’s treatment, as it requires the sharing of information among all involved in the offender’s successful reintegration, including significant others and pertinent members of the community (Carich & Stone, 2001). Currently, MSOP does not have the ability to share information with other treatment providers. Sharing of information is key with sex offenders since sexual offending is a secretive behavior, so traditional confidentiality practices do not work with this population. This level of transparency is critical to the offender’s success and encourages transparency to eliminate the secret-keeping behavior that prolonged the offending behavior and allowed manipulation of the system.

In addition to sex offender treatment programs, treatment staff would benefit from the adoption of strategies and techniques utilized in the rehabilitation fields (Stone & Thompson, 2001). These strategies and techniques allow for the continued practice and real-world application of new skills in an environment that can provide real-time feedback. Treatment providers should be mindful of, and challenge, an offender’s acquiescence bias to ensure that the skills and concepts are not just acknowledged but are demonstrated and mastered within the
offender’s capability (Wilson et al, 2015). Depending on the offender’s degree of intellectual

disability, it can be beneficial for residential staff and significant others to attend group therapy

in order to assist the offender with homework or new skill practice within the community (Rose

et al., 2002). A safety plan for offenders with intellectual disabilities should include offending

history as a guide to control environmental and social risk factors, and this population must

understand that the offending behavior did not just occur, but it was a culmination of multiple

thoughts and processes that led to sexual offending (The Arc, 2015; Goodman et al., 2008).

Group therapy is the treatment representation of social interest and is ideal for sex offenders with

the goal of community reintegration, to provide social support and combat feelings of loneliness

(Brough, 1994).

Public safety increases as a result of treatment for sex offenders with intellectual
disabilities. With public support and changes to sex offender legislation, such as reducing or
removing housing and proximity restrictions, can increase treatment success and increase safety
within the community (Kleban & Jeglic, 2012; Lindsay et al., 2013). Adler proposed the need to
identify and develop an individual’s strengths instead of pathology, and the current research
supports this approach, especially when the focus is on community involvement and employment
(The Arc, 2015; Hamm et al., 2016). Programs that utilize this Adlerian approach have had
success in the reduction of recidivism rates for released sex offenders and have higher levels of
satisfaction among treated offenders (Elisha et al., 2013; Levenson & Prescott, 2009).

As a result of social interest, individuals will focus less on personal needs once they are
committed to contributing to society, but first, they must be allowed to contribute (Ferguson,
2010). So, it is critical that the implementation of an offender’s reintegration plan is not impeded
by the uninformed decisions of community members and law makers (Willis & Ward, 2011).

When developing social skills, treatment providers must also be mindful of the potential for the offender’s perpetrating behavior to increase as well, which may make it easier access to possible victims (Steptoe et al., 2006).

Sex offenders with intellectual disabilities have spent years of their lives either incarcerated or in secure residential facilities, which can lead to institutionalization. The deinstitutionalization of these offenders can be a long and difficult task, but it is more successful when the community takes a responsibility to maintain and care for these individuals (Wilson et al., 2015). Sex offenders with intellectual disabilities require support to negotiate and interpret the post-incarceration world, especially when it comes to their conditions of release and registration requirements (The Arc, 2015). With registration laws as they are now, some of these offenders will be required to register for life, which only compounds their issues. The risk of a registration violation is always a possibility that could ultimately lead to reincarceration.

Employment options for sex offenders are limited, mainly due to the label they have been given and the registration restrictions placed on them, and employment opportunities for those with intellectual disabilities are even more difficult when cognitive ability further limits vocational opportunities (The Arc, 2015).

Residency restrictions limit potential residential options, even eliminating the possibility of living with supportive family, and most of the available housing options are not structured to assist sex offenders with intellectual disabilities with the registration requirements (The Arc, 2015). Furthermore, federally subsidized housing and apartment complexes may not be a consideration due to an existing set of restrictions placed on offenders as residents within proximity to parks or schools. Those sex offenders with intellectual disabilities that currently live independently and grasp the ramifications of registration requirements report high levels of
anxiety (The Arc, 2015). They understand that due to the community notification, society members know who they are, or at least they perceive that others are aware of who they are. This constant anxiety not only affects their mental health, but it can have an impact on their ability to work and live. Improved reintegration planning, which requires cooperation from the community, will contribute to a reduction in recidivism rates for sexual offenders (Willis & Ward, 2011).

**Recommendations for Future Research**

Sex offenders with intellectual disabilities require approaches that are more concrete and less abstract, which discourages treatment providers from utilizing certain techniques. Research to determine how to use *Socratic questioning* and *as if* techniques could apply to this population and would be beneficial for practitioners. The variations in disabilities among this population are vast and may confound research if all individual disabilities are not considered. Researchers could study the MN DOC Circles of Support and Accountability program (Duwe, 2015) to determine the effectiveness with sex offenders with intellectual disabilities. In addition, MSOP could incorporate Adlerian concepts and techniques when working with sex offenders. Researchers could study the effectiveness of an Adlerian approach to working with MN sex offenders with intellectual disabilities.

**Conclusion**

Adler’s philosophies on inclusion and social interest had an impact on the 1954 Supreme Court’s decision in the case of Brown vs. the Board of Education, which ruled that racial segregation in schools was unconstitutional, and this monumental decision went on to inspire a growing civil rights movement (Taylor, 2009; Ferguson, 2010). Just as the Adlerian philosophy paved the way for racial equality in this country, so too it can help influence the current
treatment milieu and society’s ostracization of sexual offenders, especially those with intellectual disabilities. Without community support, this population cannot fully reintegrate into society, and offenders will not have an opportunity to become socially useful individuals. Adlerian theories can be utilized to encourage social interest in sex offenders with intellectual disabilities so that they can become active and accepted members of society.
References


