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Learning Disabilities and Serious Crime – Sex Offences

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Learning Disability and Serious Crime - Sex Offences

Fiona Read & Elspeth Read

Abstract

This review paper follows on from two previous reviews of the literature with regard to, firstly, learning disability and murder and, secondly, learning disability and arson. This paper, in turn, examines the relationship, if any, between learning disability and sexual offence.

The approach taken in all these papers involves the concept of Disruptive Behaviour Disorder as being the group of behaviour and personality disorders most involved in the aetiology of these criminal and anti-social behaviours. Disruptive behaviour disorders (Read 2007) comprise:

Oppositional Defiant Disorder
Conduct Disorder
Anti-social Personality Disorder
Intermittent Explosive Disorder
(DSM IVR 2001)

The common characteristics of these disorders comprise aggression, irritability, over-activity, high arousal, and repetitive behaviour.

Key words: learning disability, intellectual disability, sexual offending, personality disorder, mental illness

Introduction

In this context, perhaps we can see there is a continuum of offences. As we will go on to show in this paper, the sexual offences most often carried out by individuals with an intellectual disability are those of a less serious nature (for example, exhibitionism or indecent assault), than compared to the more serious sexual offence of aggravated rape. If serious crime involving individuals with a learning disability can then be graded as to gravity along a continuum from sexual offence to arson, through to murder as the most serious, then the involvement of learning disabled people becomes less as the offence becomes more serious. Consequently, a conclusion of the paper concerning murder was that learning disabled people are not disproportionately involved.

This is not true of arson and sexual offences where learning disabled people are over-represented and particularly so in sexual offences (however, this over-representation should be treated with some caution as there may be methodological problems within studies that support this finding). This paper, as with the previous two papers concerned with murder and arson, shows that the predominant diagnoses of sex offenders are those in the group of Disruptive Behaviour Disorders. Mental illness is a minority diagnosis amongst those sex offenders who suffer from learning disability.

This accords well with the Review findings of Whitaker and Read (2007), who evidenced that there is little to support the notion that learning disabled people suffer disproportionately high levels of mental illness. However, behaviour, and personality disorders are over-represented. The aetiology of these conduct and

personality disorders is not so clear and the review papers regarding murder and arson relate the common occurrence of environmental factors in the developmental years as being of direct relevance to the offending behaviour as well as the association with learning disability which dates from birth or very early years.

Such observations are seen to have import with regard to treatment which is likely to be as much supervisory, educational and psychological as it is pharmacological. Medical treatment cannot be ignored as it represents the first step in psychiatric rehabilitation, involving as it does the drug treatment of conduct and personality disorders, and the use of anti-libidinals. However other treatment modalities, importantly individually tailored, are liable to be of great importance with regard to reducing risk of repeated offending.

In the past, intellectually disabled (ID) men seem to have gained a reputation as the group most likely to commit sexual offences. According to Goring (1913) cited in Lund (1990) 'the greatest single cause of delinquency and crime is low-grade mentality'. Research into the truth of this matter has produced conflicting results and opposing hypotheses, but no definitive answers.

With so many variables affecting the research conditions, and the differing criteria used for selecting sample groups and their sizes, comparing the validity and reliability of the findings of these studies is no mean feat. If intellectually disabled men are indeed more likely to commit sexual offences then it is essential (for their treatment and for the safety of the community) that we establish more firmly what the facts are.

However, if this is not the case, and ID males are in fact victims of their own circumstances and/or the limiting factors of the studies carried out, then this stigma needs to be removed and these individuals vindicated of the crimes they are likely to commit.

This is not the only issue. Attention needs to be drawn to characteristics of the behaviour and the meaning it has for offenders so that diagnosis and treatment can be tailored to individuals as well as groups.

Intellectual Disability

Studies conducted by Allen (1969) and by Randell (1973) suggested that rapists tended to be of low intelligence, whilst studies by Karacan (1974) and Ruff et al (1976) proposed that the IQ of rapists did not in fact differ significantly from the IQ of individuals who were convicted of aggressive non-sexual crimes. In order to provide more evidence one way or the other Hernan, George & Barnard (1973) compared the IQs of violent sex offenders to those of non-violent sexual offenders, non-sexual offenders and non-violent non-sexual offenders. Their results showed that although the violent sexual offenders scored lower in the IQ tests, this difference did not appear to be significant in the pairwise χ^2 comparisons. Hernan et al concluded that their results held more to the opinions offered by Karacan and Ruff et al, that the IQs of rapists were not significantly lower than those convicted of non-sexual violent crimes, and that any over-representation of the intellectually disabled in this area was due to other variables.

Whilst Hernan et al's research provided evidence that implied individuals with ID were not more likely to commit violent sexual acts than those with average intelligence or greater, Day's (1994) research strongly stated otherwise. Day's

study of 47 ID sex offenders suggested that the over-representation of sex offending by the intellectually disabled was real, and that there was no support for the possible consideration that this over-representation was due to differential arrest or conviction rates.

Despite this difference in research findings, his study did report similarities with previous studies that found that although recidivism rates were common in the ID sex offenders group, violence and aggression were rare. When the ID sex offenders group was compared to the non-ID sex offenders group, serious offences were less common, and there was a higher percentage of minor or nuisance offences. Real sexual deviancy was rare.

Day took pains to highlight the difference between those who committed 'sex offences only', and those who committed 'sex and other offences'. Those who only committed sex offences tended to commit minor offences, and were rarely convicted. They tended to be less disabled. He suggested that a more enlightened approach to the education and treatment of these individuals would significantly reduce the number of these incidences.

However, those who committed violent as well as sex offences exhibited a high sociopathy, prevalence of psycho-social deprivation and brain damage. Their sex offending is part of a wider tapestry of offending, and this is indicative of 'under-socialisation, poor parental models and poor impulse control' (Day 1995). They are more likely to commit serious sex offences and become repeat offenders. In order to treat such individuals, specialist assessment and treatment services are required.

Psychiatric Disorder

Lindsay and Lees (2003) conducted a comparison of anxiety and depression in sex offenders with ID and a control group with ID, analysing any similarities and differences between their respective emotional levels. Results showed that the sex offenders reported significantly lower levels of anxiety and depression than the control group. Lindsay and Lees were unable to offer up why sex offenders should report lower levels of anxiety and depression, but did state that these results may lead to the hypothesis that sex offenders might show higher levels of measured psychopathy.

Dunsieth et al (2004) noted from their study of 113 men convicted of sexual offences, that persons who commit sexual crimes have high rates of sexual disorders and that paraphilias may correlate with a higher incidence of certain types of mental illnesses and personality disorders. They concluded that a greater appreciation of mental illness in persons who perform harmful sexual behaviour would help target more effective interventions, preventative strategies and risk management in these individuals.

Brown and Stein (1997) conducted a study that compared a group of ID sexual offenders to a group of non-ID sexual offenders to see what similarities and differences were evident between the two groups. They found that women predominated as the victims in both groups, but that there were slightly more men offended against by the ID sexual offenders. They also found that the abusive acts committed by the ID sex offenders were more likely to be less serious offences, such as masturbation or touch, rather than penetrative sex.

Brown and Stein commented that sexual offences committed by ID service-users should not be seen as different from and/or less serious than offences committed by non-ID offenders. They observed from their research that these matters tended to be dealt with 'in-house', without getting the expert input from other professionals or from the legal system. This lack of early input referred to here could be the source of the outcome regarding the disadvantaged state of the ID offender in the judicial courts, highlighted in a later paper by Lindsay.

Later research conducted by Doyle (2004) also ties in with Brown and Stein's study, research that looked at the intent behind sexual acts committed by individuals with intellectual disabilities.

In his paper, Doyle stated that sexual offending behaviour needed to be differentiated from challenging behaviour. The treatment of these two different types of behaviour requires the use of different models and therapies. A misdiagnosis could lead to the wrong treatment, resulting in non-beneficial outcomes. Individuals with an ID can perform both classes of behaviour, but this does not mean that the two should always be equivocated or that sexual offending behaviour can and should be treated with a challenging behaviour model.

The major difference between the two types of behaviour is the intent. With regards to challenging behaviour, the intent is communicative. However, in sexual offending behaviour, the intent is to be abusive in order to gain power and control.

Day commented on the factor of impulse control or the lack of it in ID sex offenders in his discussion of his research results. He also suggested that it was circumstance and opportunity rather than sexual preference or orientation that were the over-riding factors in the choice of victim and the type of crime committed.

This factor of impulsiveness was the subject of a later study conducted by Parry et al in 2003. They set out to prove the hypothesis that sexual offending behaviour in ID individuals is better explained by sexual deviancy than by impulsive behaviour. This theory, of course, goes against the previous proclamations by Day who stated a lack of impulse control is a foremost cause of offending.

The study conducted by Parry et al assessed the levels of impulsiveness in sex offenders and non-sexual offenders with mild ID. They found that the sex offenders were less impulsive than the non-sexual offenders. These results supported their hypothesis, and suggested that there could indeed be an ability within mild ID sex offenders to plan offences that are consistent with deviant sexual preferences. The results also offer up counter-evidence to Day's research that suggested that there was no true sexually deviant behaviour within the ID sex offending group.

Research findings such as these highlighted the importance of investigating the thought processes behind the sex offences committed by individuals with ID. In 2006, a qualitative study was conducted by Courtney et al in an attempt to explore the offence process of sex offenders with intellectual disabilities.

They concluded that the attitudes and beliefs held by the offending individual were central to the offence process. ID sex offenders 'tended to blame others, claim ignorance of social skills, deny their status as a sexual offender, and claim that they are the victims.' The only concept Courtney *et al* found that differentiated ID sex offenders from their non-ID counterparts was the concept of ignorance of

knowledge or skills. However, they did state that an individual's intellectual disability could also have an impact on their lack of awareness of wrongdoing.

In 2007, Lunsky et al compared a group of male ID sexual offenders to a matched group of males with ID who had committed no sexual offence. More specifically they looked at the sexual knowledge and attitudes of the two groups. A lack of socio-sexual knowledge is an often-discussed explanation of why sexual offence seems to be over-represented in the ID population. For the ID males who had committed a more minor offence of sexually inappropriate behaviour, they found no difference in sexual knowledge or attitudes compared to their non-offending counterparts. However, they found that the ID males who had committed more serious sexual offences demonstrated a greater sexual knowledge and more liberal sexual attitudes than those expressed by their non-offending counterparts.

Courtney et al (2006) stated that a thorough assessment of all the factors in an individual's situation would be crucial to deciding on the correct course of treatment and/or education for that individual. A thorough assessment would also be required to see whether any cognitive distortions were present. These would need to be addressed in order to increase the likelihood of treatment being successful.

Courtney et al's (2006) final conclusion with regards to the treatment of ID sex offenders was that they needed to be placed at the heart of a treatment package that was specifically created with them in mind. Using non-ID sex offender assessments, education and treatment models with areas adapted or altered to allow for the disabilities of ID sex offenders simply does not provide the best solution for these individuals. The fact that their disability can have an impact on their awareness of wrongdoing is a very important issue that needs to be considered, especially if harm is to be reduced.

Locus of Control

If, as Courtney et al's study suggested, all the factors in an individual's situation need to be considered when selecting the best possible course of treatment, then the locus of control also needs to be addressed. The locus of control 'is a construct that has been construed along the dimensions of external and internal' (Rotter 1966). Lefcourt (1976) described the internal locus of control as 'the perceptions of events, whether positive or negative, as being a consequence of one's own actions and thereby potentially under personal control' and the external as 'the perception of positive or negative events as being unrelated to one's own behaviour and thereby beyond personal control'.

If an individual with an intellectual disability believes, as Courtney et al's research findings suggest, that they are the victims and are not to blame for their own actions, then they would be deemed to have an external locus of control, i.e. no personal control over the sexual offences they committed. If this is indeed their belief, then this perception could potentially have an impact on the type of treatment they would receive and, just as crucially, on the success of that treatment.

In 2006, Langdon conducted a study to look at the locus of control of ID offenders. 41 individuals with ID were categorised into three groups; ID sex offenders who had received treatment, ID sex offenders who had not received treatment, and ID non-offenders. Langdon wanted to see how useful locus of control was as a construct for predicting treatment outcome amongst ID sex offenders. If the locus

of control was related to the outcome of treatment, then one would expect the sex offenders who had received treatment and the non-sex offender groups to have more internal locus of control than the sex offender group who had not received treatment. This was not the case in Langdon's study. His results showed that there was no overall difference in the locus of control – all three groups had a similar level of external locus of control.

An issue (highlighted by Timms et al 2002) that needs to be addressed is why ID individuals have a tendency towards an external, rather than internal, locus of control. They studied research on adolescent sex offenders with intellectual disability, and found two factors that may contribute to their way of thinking. The first was that their cognitive limitations meant there is a high risk of them 'locking into' inappropriate arousal and sexual interest – this 'offender thinking' becomes ingrained and automatic.

The second was that this group of individuals is judged to be particularly vulnerable to all forms of abuse. They found that 'the significant prevalence of victimisation within this group contributed to an external locus of control'. By definition, ID individuals suffer from varying degrees of social deficits, and assessors cannot disregard the culture in which these individuals exist, nor can they ignore the additional emotional and behavioural difficulties that these individuals often experience.

Abuse in Childhood

Adams et al (1995) looked at sexually inappropriate behaviour in seriously mentally ill children and adolescents and found that youths with inappropriate sexual behaviours have increased rates of abuse histories (especially sexual abuse).

In a later study by McCurry et al (1998), an association between sexual abuse and sexual offences was established in youths with low verbal IQs and mental illnesses. McCurry et al state that because children and adults with intellectual disabilities are particularly vulnerable to both physical and sexual abuse, this association alone might place them at greater statistical risk of committing offences. Studies on the association between sexual abuse and sexual offences have been conducted by Knutson (1995), Day (1994) and Wachtel (1992).

In their study, Lindsay et al's (2001) results indicated that abuse in childhood might be a significant variable in the development of sexual offending tendencies in adulthood. Their findings supported the hypothesis that the type of abuse suffered in childhood may be related to the type of offence committed in adulthood.

Lindsay et al went on to surmise that individuals with developmental delay might be more likely to replicate their experiences (such as adult-child sexual contact, exposing themselves etc.), and may be less able to apply abstract concepts to understand that what happened to them was abusive and therefore not to be replicated with others.

The issue of gender also needs to be addressed. There is a marked difference between the offending rates of the two sexes. Even though a far higher percentage of female offenders were sexually abused than male offenders, men commit the overwhelming majority of sexual and violent crimes. The large majority of ID sex offenders are male.

Lewis and Stanley (2000) conducted a study of retrospective chart reviews of women who were referred for forensic evaluation on charges of sexual offence between 1987 and 1997. In that period, 15 women were referred, in comparison to 905 men. The diagnoses of offenders supported previous observations that female offenders are likely to be intellectually disabled. Depression and psychosis were found to be more prevalent than personality disorder, and nine out of the 15 women suffered sexual abuse with penetration in childhood.

According to Lindsay (2004), the low percentage of female referrals (only 9%) leads to the hypothesis that women with ID do not show the same levels of sexually abusive behaviour or aggressive behaviour. Also, a higher percentage of ID women were identified as having a mental illness than ID men. This, however, could be due to different assessment methods and/or diagnostic criteria being implemented for the different sexes.

Research findings by Lindsay et al also show that the rate of re-offending in women is much lower than in men. Lindsay et al state that this could be due to their greater receptiveness to psychological and social treatment interventions.

Re-Offending

With regards to recidivism in ID sex offenders, Lund's (1990) study of ID criminal offenders in Denmark looked at their characteristics and compared them to an ID non-offending control group. He found that the prevalence of behaviour disorders was much higher in the offender group, and the frequency of recidivism was significantly increased in the persons with a behaviour disorder. He also found that recidivism of violent and sexual offences was found only in the behaviour disorder group.

Lund observed from his results that the majority of ID offenders have a behaviour disorder as well as their developmental disability. Behaviour disorders should not be confused with mental illness, as an ID individual may have neither, either, or both.

Lindsay et al (2004) conducted a study that compared the re-offending rate of two cohorts of offenders with intellectual disabilities: sexual offenders and non-sexual offenders. He found that a significantly greater number of non-sexual offenders re-offended than sexual offenders. Indeed, only 19% of the sex offender group re-offended. Lindsay highlighted the importance of harm reduction rate. He noted that there was a huge reduction in the number of crimes, significant up to five years after initial referral, and that this indicated the considerable success of programmes targeted at ID offenders, despite the numbers who did re-offend at some point.

He also found that the average age of offenders was higher than that in previous studies. Lindsay believes this could be the result of the loss of parental control (the death of parents who previously would have prevented such actions from occurring) or the fact that individuals who had previously been confined to large hospitals were now able to re-offend due to the shift within society from institutions to community care. The switch to community settings may have provided these offenders with opportunities to commit crimes and may also permit certain behaviour to occur that would not have been tolerated in prior, more controlled, environments.

When comparing the rates of recidivism in ID individuals to those of average intelligence found by other researchers, with results varying from 42% recidivism rate (Brownlee 1995) to 63% (Klimecki et al 1994), a recidivism rate of 52% is not too alarming. However, Lindsay noted that some concern should be shown to this figure when taking into consideration the amount of targeted treatment, intervention, and management given to this current group of offenders.

Like Lund, Lindsay noted that some (but not all) sex offenders with ID also suffer from a mental illness or behaviour disorder in adulthood. Lindsay (2006) concluded that treating mental illness appears to be an important factor to address, as his findings showed a marked level of improvement in ID individuals' recidivism rates, having been successfully diagnosed and subsequently treated.

Another important point highlighted by Brown and Stein's study is that one third of service-user perpetrators abused several victims. Brown and Stein comment that ID service-users who abuse other ID service-users need to be dealt with accordingly in order to prevent them continuing to do so. The fact that several victims were abused by one offender is an indication that the system is failing to protect those who are most vulnerable, i.e. other service-users, and that this in turn implies that the offenders are not getting the correct assessment or treatment.

According to Cooper (1995), 10-15% of all sexual offences are committed by individuals with intellectual disability, which is only slightly higher than what might be expected from general population statistics (around 9%). The majority of these offenders do not have severe intellectual disability. This finding was supported by Su et al's (2000) study on the characteristics of intellectually disabled criminal offenders in Northern Taiwan, which noted that a considerable majority of the cases studied fell into the mild ID range, with representation declining the more severe the disability.

Treatment

The issue that now needs to be addressed is the successful treatment of ID sex offenders. According to Cooper (1995) the current treatment for ID sex offenders consists of two major components: drugs and counselling (although the usefulness of the latter will depend upon the level of cognitive and personality deficits).

Pharmacological treatment is divided into two categories (Lindsay 2002):

1. Direct hormonal intervention which attempts to reduce the effect of sex hormones in parts of the brain associated with creation and maintenance of sexual urges.
2. Indirect intervention with pharmacological regimes directed at comorbid conditions which might influence sexual inhibitions.

With regards to the first category, Cooper (1995) looked at the role of two anti-libidinal drugs in the treatment of sex offenders with intellectual disability. He noted that previous research by Clarke indicated that there were no reasons why the outcome of pharmacotherapy should differ for individuals with or without ID, so treating ID sex offenders with these drugs should provide similar results.

Cooper found that treatment with an anti-androgen drug plus some type of counselling would generally be more effective than treatment with the drug alone. The medication will likely reduce the intensity of the sex drive, but not the

direction. Continuous monitoring and adjunctive counselling is essential to ensure optimal compliance, thereby reducing the likelihood of re-offending. Compliance on behalf of the individual increases the long-term likelihood of successful treatment.

With regards to the second category, Lindsay et al (2004) found that recidivism and harm reduction rates were lowered significantly when the issues of mental illness and other index problems (such as aggression) were treated. In a later study Lindsay (2006) noted that the classification of a behavioural disorder as separate from a mental illness needed to be highlighted, as whether it was included as a mental illness or stood on its own as a variable, would affect inclusion criteria for future studies.

Besides the administration of drugs, there are several other treatments available. Langdon's (2006) study appears to show that cognitive group treatment of ID sex offenders reduced cognitive distortions of rape, exhibitionism, homosexual assault, paedophilia and stalking and sexual harassment, even though the locus of control was external. Successful treatment of ID sex offenders should focus less on altering the locus of control of each individual, and focus more on addressing the cognitive distortions regarding sexual deviancy held by the offending individuals. Research into the success of treatment of ID sex offenders by Lindsay (2002) and Murphy (2004) has shown positive results in reducing recidivism and harm reduction rates, even though the individuals were exhibiting external locus of control.

Lindsay and Smith (1998) compared the results of group treatment given to ID sexual offenders with a one or two year probationary sentence for either indecent exposure or offences against children. The subjects with two years probation showed greater improvement compared to the subjects with only one year probation (who still showed denial and minimisation of their offence). As a result, Lindsay recommended a period of at least two years probation with treatment, believing a one year probation period to be of little value. So, when looking at the efficacy of group treatment, it would seem the length of the treatment programme itself is very important.

Lindsay et al (1998) looked at cognitive treatment for a group of men with ID convicted of exhibitionism or indecent exposure. All the men responded positively to treatment. Lindsay et al found that beliefs such as indecent exposure being fun and not causing harm to women were the most open to change, whereas beliefs such as that of the victim sharing responsibility for the incident were the most difficult to alter.

Bearing in mind the type of treatment that should be offered to ID sex offenders depending on the motivations behind their acts, Steptoe et al (2006) looked at the quality of life and relationships in sex offenders with intellectual disability. It was hypothesised that sex offenders would show poorer relationships and poorer engagements with society than the control group. The sex offender group respondents' use of relationships and leisure was significantly lower than that of the non-offender group.

This study's data provides some tentative indication that sex offenders may have lower integration with the community, and poorer attachments to some significant relationships (such as parental relationships) than the control group. Steptoe et al (2006) suggest that according to their findings, the treatment for ID sex offenders should parallel that of non-ID sex offenders and deal not only with deviant sexual

preference, attitudes and cognitions associated with offending and relapse prevention, but also with relationships and society.

Educational and occupational opportunities do exist to promote increased identification with society and pro-social influences, without increasing access to or skills in dealing with, potential victims.

There are problems, however, with using the same assessment and treatment methods for ID sex offenders that are used for non-ID sex offenders. Few assessments have been developed to be appropriate for ID individuals. Factors like language complications, social skills deficits and cognitive distortions need to be tackled and overcome.

An insightful research project was conducted by Dowrick and Ward (1997). Their study was on the support of a man with intellectual disability who had inappropriate sexual behaviour. The study developed a series of self-modelling interventions in which the self-control elements were displayed on video. Pilot video interventions were first used to enhance participation in a support program at supervised apartments. Video feedforward was then implemented in a multiple baseline design, resulting in the rapid acquisition of self-control behaviours.

Dowrick and Ward's study was an effort to develop skills training approaches to expand the development methods that address private events (if the offending individual sees themselves as the subject they may find it easier to relate their thoughts to their actions) without using any strong dependence on language. By reducing dependency on language skills, interventions using the positive self-image can more equally address cognitive diversity.

Crucial to providing the correct form of treatment, the motivation behind the offences needs to be comprehended accurately by the professional assessors. Sexually deviant behaviour needs to be stopped, and emotional and social problems need to be dealt with more constructively.

Lindsay et al (2002) commented that when it comes to the judicial process, people with ID might be disadvantaged due to their lack of understanding of the gravity of the situation, lack of support and lack of appropriate representation from early stages in the criminal judicial process.

Lindsay et al found that although some studies have suggested an increased incidence, there is no over- or under-representation of people with intellectual disabilities amongst sex offenders. They stated that sexual abuse in childhood has been associated with sexual offences in adulthood, although this is not a determining factor, as there are many ID sex offenders who have not been abused, and many ID individuals who were abused but have not become sex offenders.

Having assessed results from their 12-year follow-up study of referrals, analysis of referral patterns and assessment of harm reduction, Lindsay et al (2006) concluded that community assessment, treatment and management of ID sex offenders had an impact on reducing the number of offences committed over the follow-up period. The treatment of mental illness and behaviour disorders appears to be an important factor, as the study's findings suggest a marked level of improvement in ID individuals' recidivism rates.

Cantor et al (2005) conducted a quantitative reanalysis of aggregate data on IQ in sexual offenders, in an attempt to clear up once and for all whether or not the IQ of sex offenders is lower than that of non-sexual offenders. Their reanalyses confirmed that adult males who commit sexual offences score lower in IQ than do adult males who commit non-sexual offences.

There are possible explanations for these scores. The first is that sexual offenders do not actually score lower in IQ than non-sexual offenders, but only appear to because the ID sex offenders are more likely to get caught and less likely to have the financial resources to avoid conviction.

The second explanation is that the IQ differences are indeed genuine and reflect an underlying deficiency of brain function. This could lead to a direct association with sexual offending, i.e. poor cognitive functioning reflects disinhibited decision making or a failure to comprehend consequences, yielding sexual behaviour (however, this now seems less likely due to the findings of Parry et al), or there could be an indirect association, i.e. intellectual disability correlates significantly with paedophilia, but it does not cause it.

Cantor et al's (2005) analysis of results suggest that IQ relates primarily to the presence of paedophilia among sexual offenders, and that previous studies that merged paedophiles and non-paedophilic offenders together into one group (not two distinct categories) were at risk of obscuring any underlying patterns.

In their conclusion, Cantor et al (2005) are hopeful that future research into this issue will attempt to further ascertain whether sexual offenders demonstrate general or more selective cognitive differences.

Conclusion

Having taken into account the results and conclusions of varying studies conducted over the past decades, it is fairly safe to say that there is an association between intellectual disability and sexual offences. In order to more fully understand the relationship, future research needs to focus on the different sub-groups of sex offenders to see if intellectual disability correlates with any particular factors, such as victim age and gender, or the type of sexual offence. It is also important to establish whether or not other precipitating factors, such as mental illness, an individual's abuse history and their social circumstances are of greater import than their IQ level with regards to the likelihood of them sexually offending.

Finally, it is of the utmost importance that the motivation behind such acts of sexual offence is properly realised, because only in wisdom can we help those who commit such acts and prevent them from occurring. In order to provide successful treatment to offenders and adequate protection of those most vulnerable to assault, the correct diagnoses must be made from the outset. Discovering the motivation behind sexual crimes would lead to the most appropriate course of treatment for that particular individual.

Treatment modalities that offer effectiveness include pharmacotherapy and various psychotherapies, with most success achieved when both are used together. Multiple approaches may be the way forward, but management of recidivist behaviour will always be an issue. Further research should focus on the analysis of the recidivist behaviour of sexual offenders in order to discover which types and combinations of treatment are the most successful at reducing re-offending and decreasing harm.

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