‘Counterfeit Deviance’ Revisited

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Twenty years ago, Hingsburger, Griffiths and Quinsey (1991) coined the term ‘counterfeit deviance,’ in a brief article, to define differing hypotheses explaining the sexually inappropriate behaviour of a subgroup of individuals with intellectual disabilities treated in the sexuality clinic at York Behaviour Management Services in Richmond Hill Canada. Within this subgroup, the behaviours appeared topographically as sexually deviant, but upon investigation alternate hypotheses explained the behaviour. These hypotheses altered the course of treatment for the individuals. The theory of ‘counterfeit deviance,’ though written years before, is consistent with the *DSM-IV-TR* (APA, 2000) cautions that persons with intellectual disabilities might have a "decrease in judgment, social skills, or impulse control that, in rare instances, leads to unusual sexual behavior" that is distinguishable from Paraphilia (p. 568)

Though the article is no longer readily available, there has been an increased interest in this concept as seen in various journal articles and presentations. Unfortunately because of the articles’s obscurity, the concept became misunderstood and simplified. Lindsay in his 2009 comprehensive review of the history and research literature in *The Treatment of Sex Offenders with Developmental* Disabilities outlines this misunderstanding providing clarification. The following article is written to i) revisit and expand the concept, ii) review research on the concept, and iii) explore what needs to be done to further investigate the concept of ‘counterfeit deviance’.

Introduction

Early on, Murphy, Coleman, & Abel (1983) urged for clinical treatment of individuals with intellectual disabilities who offended sexually noting a paucity of options. In 1985 Griffiths, Hingsburger and Christian described a community based programme in an article called, Treating Developmentally Handicapped Sexual Offenders. The programme gained considerable interest in a field that had left sexual problems of individuals untreated. A literature review conducted at the programme’s inception revealed that few sexual behaviours of persons with intellectual disabilities had been researched and treatment was universally intrusive (i.e., Foxx, 1976; Paul & Miller, 1971).

In their 1989 book “Changing Sexually Inappropriate Behaviour”, Griffiths, Hingsburger and Quinsey elaborated on the original article describing a community-based model for treatment and relapse prevention that was based on evaluation of the individual’s history and circumstances of the offence, the nature of the living and working/school environment, socio-sexual knowledge,

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social skills, coping skills, relationships, knowledge of responsibility, and assessment of sexual preference and arousal. After evaluation, each individual had a personalized programme to both enhance skills and provide coping strategies for deviant arousal or problematic behaviour patterns. These evaluations noted that some of the individuals presented with behaviours that were consistent with the Diagnostic and Statistical Criteria involving arousal to unusual or intrusive sexualized images and fantasies however some did not.

Using the data from more than 10 years of work with individuals referred for sexual offences (ranging from exposure to sexual assault and child molestation), the authors noted that **some** of the individuals presented differently than anticipated for someone with paraphilia. On examination of the case files it was noted that the presenting behaviours, although inappropriate were the product of different diagnostically significant factors. These factors were noted to influence the commission of sexually inappropriate behaviour. It was this observation that lead to the concept of 'counterfeit deviance'.

The theory of 'counterfeit deviance'

It must be clarified that the theory of 'counterfeit deviance' never denied paraphilia in persons with intellectual disabilities. The article noted that some with intellectual disabilities, as with the typical population, develop sexualized interests that meet the diagnostic criteria of paraphilia. However, the authors cautioned against the assumption of paraphilia based solely upon behaviour.

The authors described paraphilia as benign, offensive or hyper-sexualized.. Benign paraphilia included situations where the diagnostically-significant fetishes or images, although unusual, posed no danger. Often these behaviours were noticed in persons with intellectual disabilities because of clustered living environments where their behaviours were not privately conducted and easily observed by care-providers. These behaviours were therefore deemed problematic by care-providers, while typically developing individuals might have similar fetishes but also have the opportunity for private expression.

Offensive paraphilia, involved those forms of paraphilia where an individual may show arousal to children or situations involving violence. The offensive paraphilia presented as it does in the nondisabled population and requires similar treatment.

Lastly hyper-sexuality was noted in some individuals. In these cases the individuals were obsessed or controlled by sexual thoughts. As with the nondisabled this was often a manifestation of obsessive compulsive behaviour or even mania.

In the above situations, individuals with intellectual disabilities presented behaviours that were consistent with the diagnostic criteria of paraphilia or real deviance. They cautioned that assessment was required to ensure that paraphilia was present not assumed. Behaviours could masquerade as paraphilia but lack the underlying urges. As such they posited eleven hypotheses to explain the inappropriate sexual behaviour in some individuals.

These hypotheses aimed at understanding both the individual and the system in which they lived.

People with intellectual disabilities often lived in atypical situations which could lead to atypical behaviour. ‘‘Counterfeit deviance’’ asked that the individual be understood in the context of the lives they lived as a result of attitudes, practices and protocols. Policies that denied appropriate sexual behaviours could possibly render any sexual behaviour as problematic, and deviant. The theory made it clear that people needed to have treatment adapted because of the cognitive disability and that the assessment needed to consider the environmental factors unique to people with intellectual disabilities.

What ‘‘counterfeit deviance’’ did not do, however, was suggest that any of the eleven hypotheses was predictive of individual behaviour or as a characteristic of ‘sex offenders with intellectual disabilities’. As an example, one hypothesis is ‘sexual knowledge’.

This hypothesis does not mean:

1) That all sex offenders with intellectual disabilities had poor sexual knowledge.
2) That someone with an intellectual disability with poor sexual knowledge will sexually offend.

It means:

1) A sexual offense by an individual with an intellectual disability possibly occurred because of poor sexual knowledge. Too, it was possible to have deviant arousal and good sexual knowledge. Hence, a lack of sexual knowledge is not a definitive path to sex offending, rather an area worth exploring when determining treatment.

It is important when reading the list of hypotheses, to understand that none imply that these are characteristics of *all* sex offenders with disabilities. Furthermore, that these hypotheses only assist a clinician in determining appropriate treatment regardless of the existence of paraphilia. It wass possible, according to ‘counterfeit deviance’, for an individual with a disability to have a paraphilia exacerbated by the presence of one of these hypotheses.

Eleven alternative hypotheses were the basis for ‘counterfeit deviance’ for which, any assessment needed to take into consideration:

The **structural hypothesis** suggested that some individuals with intellectual disabilities have lived or continue to live in environments where the policies and practice prohibited the expression of appropriate sexuality. Under restrictive conditions individuals exercised their sexuality in ways to avoided sanctioning, such as engaging in sex in a public place out of sight of care-providers.

The **modelling hypothesis** proposed that some in appropriate expressions were modelled on staff behaviour. In environments which did not model appropriate privacy when providing personal care then individuals may have replicated touching that failed to respect the personal space of others.

The **behavioural hypothesis** proposed that inappropriate sexual behaviour was rewarded. These

behaviours were highly functional in either garnering attention or allowing the individual to escape or delay an undesired situation.

The **partner selection hypothesis** proposed that many individuals with intellectual disabilities existed in a socio-sexual 'peer-void' because they lacked both opportunity and social skills to develop appropriate relationships. The relationship vacuum could produce situations where the individual attempted relationships with care-providers, children or others.

The **inappropriate courtship hypothesis** postulated that restricted living environments, often in same sexed wards, led to a lack of courtship skills resulting in blunt, often aggressive attempts at courtship.

Also a lack of appropriate and comprehensive sexual knowledge was sometimes the cause of inappropriate sexual behaviour, which led to the proposition of the **sexual knowledge hypothesis.**

Other individuals presented with a chronic state of sexual arousal, engaging in repeated masturbation. Assessment indicated an inability to masturbate to completion leading to the **hypothesis of perpetual arousal**. Causes varied from medication, lack of privacy, lack of stimulation available privately (i.e. erotica), a history of punishment, to a lack of physical ability.

The **learning history hypothesis** looked at the relationship between the experience of both sexual abuse and a lifetime of receiving harsh negative sexual messages. This was compounded by other life experiences that were often associated with disabilities such as life in multi-bed facilities being witness to a sexualized culture neither appropriate or legal.

The situation above led into the **moral vacuum hypothesis**. Given the experiences of many individuals with intellectual disabilities, the values held in society regarding sexuality may have never been learned. The individual may not have developed standards on which to judge their own behaviour or that of others.

The last two hypotheses were based on medical observations. The **medical hypothesis** was noted for individuals who were experiencing a medical problem such as touching genitals in public when experiencing a rash. The **medication side-effect hypothesis** was generated based on cases where individuals were reacting with frustration in an attempt to gain sexual satisfaction when a medication has altered their sexual functioning.

Research Related to 'Counterfeit Deviance'

Research into the specific hypotheses that fall within 'counterfeit deviance' has been rare. Despite markedly differing living environments and social learning histories of people with intellectual disabilities, few researchers have explored the prospect of alternate motivations and causes of deviant sexual behaviour. However, research does exist examining the hypotheses in tangential ways. The following will discuss each of the hypotheses, alone or clustered, based on the existing literature. There may be methodological limitations or inconclusive results, which will be addressed.

Structural Hypothesis and Moral Vacuum Hypothesis:

As discussed, the living situations and culture of the intellectually disabled population is vastly different from the typical population. There are often sexually restrictive environments (Structural Hypothesis) and environments with different social norms and moralities (Moral Vacuum). Many individuals with intellectual disabilities grew up in institutions throughout Ontario. These settings often featured rows and rows of beds affording little or no privacy. Private activities such as changing, undressing and masturbation were made public by the constant presence of staff and co-residents. These boundary intrusions were typically done in the presence of female staff. As these institutions closed, residents were transferred to community settings with community norms.

Additionally, many of the agencies and homes within them had policies forbidding consenting relationships and enforcement of this policy could mean punishment or denied access. If appropriate sexual intercourse was forbidden, individuals might seek inappropriate sexual outlets.

In a study on Australian deinstitutionalization, Young, Sigafoos, Suttie and Ashman (1998) looked at 289 individuals with intellectual disability and found that of those that had lived in institutions most had lived in them from 8 to 9 years (p. 162). This amount of time, nearly a decade, was significant to make claims regarding the effects of institutionalization. In this paper, 13 studies were reviewed to determine the effects of deinstitutionalization across a variety of domains. While adaptive behaviour improved, none showed improvements in problematic behaviour when entering into community settings. Of particular interest, health and morality were reviewed in three studies, with no changes reported in any when individuals were transferred to community settings. The attempt to acclimatize and adopt individuals to community morays wa only partially successful. Behaviours such as aggression and attitudes like morality did not conclusively improve upon release, which indicated that old cultural norms may persist after deinstitutionalization

Institutional life had been studied based on the possible effects and increased risk associated with individuals in prison. Much like institutions, prisons have their own set of social mores and expectations, sex offenses being so common that that are "dismissed by prison administrators as behaviours that are unique to the prison environment or a result of deprivation and not indicative of risk in the community" (Heil, Harrison, English and Ahlmeyer, 2009, p. 893). Sex offenders who committed their crimes in prison were compared to other sex offenders on a variety of factors to assess risk upon release. Heil et al. (2009) studied rates of recidivism of sexual offending behaviour for those who offended in the community and within prison at 1-year and 5-year intervals. They found that at 1 year, all individuals who had been in prison were at least as likely, or even more likely, to commit a crime and had the most hands-off sex offenses. At 5 years, the same statistic held true and those offenders from prison were just as or more likely to reoffend. Those with sex crimes prior to prison were most likely to be charged after 5 years with another sex crime. Though there was insufficient data on new sex offenses for the prison only group, at 1 year only 33.3% of sex crimes were hands-on but at 5 year this jumped to 80% hands on offenses (Heil et al., 2009).

In the end, the prison and institutional setting does appear to have some impact on individuals and may generate new behaviours that were not present previously. Individuals without sex offenses engaged in sexual assault while in prison, and administrators tacitly condoned these assaults. A portion of these continued sexual offending when out of prison and the intensity of the behaviour grew dramatically over time. Drawing an analogy to similar environments and attitudes in institutions, it is reasonable to include structure and environment as a factor contributing to sexual offenses where deviance may not be the primary function.

Lindsay (2009) further noted based on his research (Lindsay, Steptoe & Beech, 2008) that a revision of the 'counterfeit deviance' theory on Moral Vacuum should be considered. He noted that individuals with intellectual disabilities, while not being "completely naïve about the fact that their behaviour is inappropriate, they have not internalized the extent to which it is against the conventions of society." He suggested that some individuals with intellectual disabilities have neither learned the appreciation for self-control with regard to their sexual behaviour nor of the importance of developing appropriate relationships that fit the mores of society. His research and observations would indicate a need to evaluate the understanding that the individual has to the laws and society rules as part of the assessment process.

Modelling Hypothesis and Learning History Hypothesis:

Hingsburger in 1989 published a case study of coprophilic behaviour in a person with an intellectual disability who had been institutionalized and whose learning history led unusual ways to achieve sexual pleasure. This predated and presaged the development of Counterfeit Deviance as a theory. An earlier paper (Hingsburger, 1985) also suggested that the restrictions and experiences of institutionalization was an alternative explanation for inappropriate behaviour. Also, the cycle of abuse theory posits that history of abuse may serve as a model to later offending (Modelling Hypothesis) which is compounded by the lack of normative sexual experiences and opportunities (Learning History).

Individuals with intellectual disabilities are frequently the targets of sexual abuse. Statistics vary but it has been reported that 61% of women and 25% of men have been sexually abused in their lifetimes (McCarthy & Thompson, 1997). An almost uniform finding is that sexual abuse is overrepresented in this population. In drawing a correlation between abuse history and later offending Lindsay, Law, Quinn, Smart and Smith (2001) compared the sexual abuse histories of sexual and non-sexual offenders with intellectual disabilities There were 46 sexual offending participants and 48 non-sexual offending participants; the authors theorized that the sexual offending participants would have sexual abuse histories while the non-sexual offending participants would have histories of physical abuse. The results showed a significant difference in sexual abuse histories between the two groups, with 38% of the sexual offenders being abused and 12.7% of the non-sexual offenders being abused. The authors concluded that an abuse history may lead to a replication of abusive behaviour.

Though only one study directly analyzed the abuse histories of sexually disabled offenders, the results lend credit to the theory proposed by 'counterfeit deviance'. Given the sexual abuse rates within the intellectually disabled population, their exposure to and experience with deviant

sexual behaviour is significantly greater than in the typical population. In light of this increased abuse, the study by Lindsay et al. (2001) demonstrates a correlation between sexual abuse and nature of offense. Evidence suggests that previous experience with sexual abuse could serve as a model influencing future behaviour.

Behavioural:

There are numerous potential functions for problematic behaviour. 'Counterfeit deviance' posits the possibility of alternate behavioural functions for deviant behaviour. For the purposes of this paper, only attention and sensory functions will be discussed.

The use of Applied Behavioural Analysis for sexually offending behaviour is still in its infancy. As such, studies applying the ABA method to sexual offending behaviour and the intellectually disabled population are rare. However, there are studies that have used behaviour analysis for sexual offending behaviour in other populations and findings will be extrapolated with caution.

In 2009, a study by Alderman et al. looked at the current technology available on sexually offending behaviour, notably with individuals with Acquired Brain Injuries (ABI). They developed the St. Andrew's Sexual Behaviour Assessment (SASBA) to record and track what they described as inappropriate sexual behaviour (ISB). They included details such as setting events, antecedents and interventions. Using this tool, they looked at 91 individuals with ABI and assessed their ISB over a period of three months.

They found that ISBs were less likely to occur when the environment was noisy and when individuals were involved in formal rehabilitation. A significant portion of the time (64%) behaviours occurred with no obvious antecedent but the authors theorized that less structured activities played a role. The most common intervention utilized was ignoring or playing down the behaviour, which occurred 70.4% of the time, and while talking to individuals, which occurred after 21% of the behaviours. Tthe authors discussed the potential functions of the ISB. Since behaviours typically occurred during low demand times, escape was ruled out. However, they felt that "ISB may provide...contact with staff at times when reduced opportunities for social engagement increase the likelihood of expression of sexual needs" (Alderman et al., 2009, p. 217). Additionally, they highlighted the stark difference between ignoring as a response and attending to behaviours suggesting that attention was intermittently reinforcing ISBs.

Though it is difficult to make conclusive statements, there is ample evidence to suggest the possibility that some or part of the sexually offending behaviour documented in the study was mitigated by non-deviant factors and served alternate functions. In this case, attention from staff is a likely motivating factor for some of the ISB seen in this study.

Partner Selection and Inappropriate Courtship:

Many individuals with intellectual disabilities lack the opportunity and skills to develop normative relationships. In a 1999 study, McCabe found that individuals with intellectual disabilities had less sexual experience than either those with physical disabilities and the typical population. While the desire for sexual experience and relationships may be appropriate, the

object (partner selection) and means (inappropriate courtship) are not. This romantic or sexual pursuit is in and of itself not a deviant goal but it is the means by which this population attempts to gain it that is inappropriate.

The Good Lives Model of sexual offender treatment lists nine primary goals that most humans try to achieve including life, friendship and happiness. The theory behind the Good Lives Model is that these goals are not deviant but their pursuit can lead to deviant methods of attainment (Ward & Stewart, 2003).

There is literature supporting the theory that unmet sexual and intimacy needs area contributes to sexual offending. Lockhart, Guerin, Shanahan, Coyle (2010) measured the sexual knowledge, experience and needs of a cohort of 600 adults and youth with intellectual disabilities. They were divided into one of three groups: sexualized challenging behaviour, non-sexualized challenging behaviour, and no challenging behaviour. The sexualized challenging behaviour group showed greater needs in the areas of dating and intimacy than the non-sexualized challenging behaviour group which "lends some empirical support to opinion in the literature that the problematic sexual behaviour of individuals with ID represents an effort to meet these needs in inappropriate way" (Lockhart et al., 2010, p. 128). This difference was not seen with the non- challenging behaviour group, which makes it difficult to establish strong conclusions.

In 1989, Marshall concluded: "treatment and assessment programs should include as targets, attachment and intimacy as well as the experience of loneliness" (p. 497). Similarly, in his discussion on the role of intimacy needs and loneliness he argued for "the inclusion of these issues in the functional analysis of sexual offending [which] will expand behavioral theories and treatments of these problems to the greater benefit of patients and to the proper protection of society" (Marshall, 1989, p. 500).

Based on current treatment practice and research, inappropriate courtship and partner selection are valid contributors to sexual offending behaviour. Sexual needs are a fundamental aspect of humanity and fulfilling them in appropriate ways are a primary goal according to the Good Lives Model of assessment and treatment. Individuals with IDs that sexually offend appear to have greater unmet sexual needs than individuals with other problematic behaviours. Though there is no direct evidence that these needs lead to sexual offending, there is some research to suggest that unmet sexual interests can lead to behaviour that appears deviant.

Sexual Knowledge:

Sex education can come from formal and informal sources but it appears that, in both cases, there is an overall reluctance to provide this education to those with intellectually disabilities. This deficit was noted by Mcabe in 1999, who found that "In all areas of sexuality assessed in this study, people with intellectual disability demonstrated lower levels of knowledge than people with physical disability, who in turn demonstrated lower levels of knowledge than people from the general population." (p. 166). Sexual knowledge is the most researched and possibly least understood factor of 'counterfeit deviance'.

In 2006, Talbot and Langdon assessed the relationship between sexual knowledge and sexual offending behavior and concluded that there was no significant difference in sexual knowledge. between sex offenders with intellectual disability who had received treatment and those who had not received treatment. They also found that the offenders who had received treatment displayed greater sexual knowledge than a control group of non-offenders but that sex offenders who had not received treatment did not display less knowledge than non-offenders. There sample size was small and they cautioned that it was difficult to find offenders without prior sex education because that is typically the first option for intervention. Despite this they questioned the assumption that sex offenders with intellectual disabilities commit sexual offences because of a lack of sexual knowledge.

Similarly Michie, Lindsay, Martin, and Grieve (2006) examined the socio-sexual knowledge of offenders with ID by comparing a group of 17 male sex offenders with an ID against a matched control group of 20 males with ID but who had no history of sexually inappropriate behavior or abuse. Previous sexual education and IQs were controlled for. Employing the Socio-Sexual Knowledge and Attitude Test (SSKAAT) to measure sexual knowledge, the authors found that the sexual offending group demonstrated significantly more sexual knowledge than the control group. They argued that the sex offenders did not offend because of a lack of sexual knowledge and therefore were not displaying 'counterfeit deviance'.

Lunsky, Frijters, Griffiths, Watson and Williston (2007) found similar results when they measured the knowledge and attitudes of 48 male individuals with an intellectual disability who also had sexual offense histories to a matched control sample group. The study split the sex offending participants into one of two groups: Type 1 – who were described as, "paedophiles, rapists or as having engaged in repeated or forced sexual assaults" (Lunsky et al., 2007, p. 76) and Type 2 – who had engaged in "inappropriate touching, public exhibitionism or public masturbation" (p. 76). The authors found that not only did Type 1 offenders have more sexual knowledge than non-offenders but also that Type 2 offenders showed no significant difference in knowledge compared to the non-offender group. Lockhart et al. (2010) whose study found similar results concluded that "in relation to sexual knowledge, the current study did not uphold the hypothesis that individuals with sexualized challenging behaviour would have the lowest levels of sexual knowledge" (p. 127). However, given the dynamic relationship between knowledge and offending it's important to note that while lack of knowledge does not necessary lead directly to offending it may be a contributing factor in the Type 2 sub-group whose behaviours are inappropriate rather than offending.

The distinctions between offenders raised by Hingsburger, Griffiths and Quinsey (1991) and supported by Lunsky et al. (2007) are consistent with Day's (1994) suggestion that there are two types of offenders with intellectual disabilities. Day (1994) noted that sexual offences committed by persons with intellectual disabilities are typically more "minor or nuisance offences" (p. 279). He suggests that many of the offences, such as indecent exposure, represent an inappropriate expression of sexual feelings rather than a sexual deviance (Day, 1994). Day similarly does not deny the existence of paraphilia within the population of intellectual disabilities rather cautions for differentiation.

However, each of these studies' authors identify a limitation to their own studies, namely that,

those with sexual offending histories may have been exposed to formal or informal sexual education after their offenses or that the offending behaviour is, itself, educational. In addressing this issue, Lunsky et al. (2007) state that, "Type 1 offenders...were also more likely to have received past sex education than their non-offending counterparts" (p. 79). In fact, when sexual education was controlled for, they found no differences in the knowledge between offenders and non-offenders. When discussing their results, Michie et al. (2006) state that, "all of the sex offender cohort have some experience of sexual interaction...one might therefore conclude that these sex offenders have given some thought and attention to sexuality" (p. 277). In conclusion, there is neither evidence to prove nor disprove the effects of sexual knowledge on inappropriate sexual behaviour.

Even with all this research, according to the ideas behind 'counterfeit deviance' the wrong question has been asked. Since the theory never stated that people who sexually offend have poor sexual knowledge studies that look at the population of offenders can not prove or disprove the hypothesis. The question would have to be reframed from the larger population to individuals on a case by case basis. 'Counterfeit deviance' only posits that some individuals, due to poor knowledge, make sexual mistakes or engage in behaviours that appear deviant.

There is some research that suggests this may be true. Cortoni and Marshall (2001) explored the possibility that sex was used to alleviate negative emotional states. Looking at a group of general offenders, violent offenders, rapists and child molesters they measured intimacy, loneliness and social desirability. They found increased intimacy problems with the sex offender population along with decreased intimacy and concluded that "sexual activity provides a powerfully pleasurable experience that can temporarily relieve...negative emotional states. In unskilled people, sex may easily come to serve as a coping mechanism to deal with loneliness and intimacy problems" (Cortoni & Marshall, 2001, p. 38).

Medical, Medication and Perpetual Arousal:

Another hypothesis put forth under 'counterfeit deviance' was the existence of medical or medication side effects that may influence inappropriate sexual behaviour. The prevalence of mental health issues within the intellectually disabled population is dramatically overrepresented. It is difficult to pinpoint an exact rate however approximately 30% of individuals with an intellectual disability with have a mental health concern (Ministry of Health and Long-Term Care and Ministry of Community and Social Services, 2008). Based on this prevalence, it can be assumed that a disproportionate amount of medications will be prescribed.

Among the most commonly prescribed medications for the intellectual disability population are Selective Serotonin Reuptake Inhibitors (SSRIs) (Matson, Rivet, Fodstad, 2008). These drugs, used for a variety of concerns, increase the amount of serotonin left in the system. If this medication and medical side effects are a potential contributing factor of sexually offending behaviour, it would be assumed that any medications commonly prescribed would lead to hypersexuality. However, sexual dysfunction is one of the most prevalent side effects associated with the class of drugs. For example, Montejo-gonzàlez found that 200 of 344 (or 58%) patients reported sexual dysfunction after using SSRIs. Additionally, a wide difference (43.94%) was found between using spontaneous reporting and questionnaire as data collection methods. As a

result, sexual dysfunction in many studies may be underreported. In line with Kafka's (2003) theory that serotonin plays a factor in suppressing testosterone, common current treatment practice recommends prescribing SSRIs to reduce sexually offending behaviour (Adi, Ashcroft, Browne, Beech, Fry-Smith, Hyde, 2004). In conclusion, commonly prescribed medications, notably SSRIs, likely play a role in reducing sexual arousal patterns and not increasing them. Given their usage to treat sexual offending behaviour, it is unlikely that they increase libido or sexual desire.

At present there is little research or validation supporting the medical/medication hypothesis of counterfeit deviance and more structured research needs to be done on the topic.

Expansion of the Theory of 'Counterfeit Deviance'

The theory of 'counterfeit deviance' was updated in "The Key: A community approach to assessment, treatment and support for people with intellectual disabilities" (Hingsburger, Dalla Nora & Tough, 2010) in which the hypotheses were added to and grouped into four differing types. Several new hypotheses were added under the following categories: Historical and Environmental; Abuse Related; Medical and Psychiatric, and Deviance. The hypotheses were grouped thusly to ensure that readers understood that 'counterfeit deviance' did not mean that deviance was not possible, this new means of presenting the theory aimed at ensuring that the existence of one did not preclude the existence of the other. The grouping was to help clinicians in their assessment process, to ensure that questions be asked that covered all four possible areas from which 'counterfeit deviance' might arise.

The difference between the updated list of possible hypotheses and the original shows growing understanding of the lives of people with disabilities. Since the original article there has been significant research into the abuse of people with intellectual disabilities, therefore most of the new hypotheses are abuse related. With new research comes new areas of questioning. Further, as people with disabilities return home to the community from institutions and as young people with disabilities are not institutionalized, there are hypotheses that are linked to community living – and indeed there are.

Here are two examples of new hypotheses:

The Behavioural Reporting of Abuse hypothesis proposes that people with disabilities re-enact their abusive history as an attempt to display what happened to them. Historically, people with disabilities who verbally reported abuse received little in the way of support or counselling, let alone belief that their stories were true

The Malicious Peer Pressure hypothesis proposes that people will be used as dupes by their non-disabled peers as a joke. Desperate for 'friends' and 'approval' and without ability to recognize manipulation, people with disabilities are vulnerable to engaging in behaviour for social acceptance and find that instead they've been used and that peers are laughing at their folly.

Others have also developed theories, for example the Sexual Coping hypothesis by authors such as Wulfert et al. (1996) posit the existence of 'situational pedophiles' a term which suggests that

pedophilic behaviour can occur because of reasons other than attraction, and their studies show that this type of pedophile, because of lack of access to typical expression, receives reinforcement through stress reduction when they engage in pedophilic behaviour. Again they found that topographically the behaviour appears to indicate deviant interest but other factors are at play. Another possible hypothesis is based on the hypothesis of Power and Control. This is especially notable with the persons with intellectual disabilities, who may lack autonomy in a system where virtually every decision is made for them by others. For this population, any chance to exercise control is valuable and incredibly reinforcing. Marshall and Marshall (2000) suggest that deviant sexual behaviour may be "driven by or associated with a need to exercise power and control over another person" (p. 256). This power and control would serve as a replacement to something that they have lacked for most of their lives.

The Medical Hypothesis was expanded by Griffiths (2002) and Griffiths et al. (2009) who noted that syndromic behaviours and psychiatric behaviours can serve as the etiology for an apparent sexually inappropriate behaviour. Some individuals with specific genetic syndromes might be at risk to display an inappropriate behaviour that is viewed as sexual. One syndrome related example provided was polyembolokoilamania (the insertion of objects into orifices, including the vagina or anus) associated with Smith Magenis syndrome which is often diagnosed as a paraphilia although there is no evidence that the behaviour serves a sexual function.

Additionally, psychiatric conditions such as mania can present as over-sexualized behaviour. APA suggests that differential diagnosis should be conducted to examine whether the identified behavior is a preferred and recurrent sexual pattern, if it is associated with another active mental disorder, and the age of onset. These cautions were elaborated more fully in the Diagnostic Manual- Intellectual Disability (DM-ID) (Fletcher, Loschen, Stavrakaki, and First, 2007); the DM-ID is the companion diagnostic manual designed specifically to provide guidelines for the diagnoses of persons with intellectual disabilities.

It becomes clear, then, that there will probably never be a finite list of hypotheses, people with disabilities live very different lives in very different circumstances. The only constant is that 'disability' itself places each person at risk to make mistakes because of the environment or because of the decisions or manipulations of others. It is probably best to view 'counterfeit deviance' as an idea and the list of hypotheses as a guide, but not a static list. The more clinicians pay attention to 'counterfeit deviance' as a possibility, the more the concept of 'person centered approaches' enters into the mind set of service providers, there will be more and different examples of the phenomenon.

Future Directions

With this article, we hope that the term 'counterfeit deviance', including what it is and what it is not, is now current in the literature in a way that will clarify previous misunderstandings. The hypotheses were not meant to be a diagnostic tool, rather areas of investigation to persuade assessors to ask questions. 'Counterfeit deviance' was not just about sexual knowledge. The original article stated 10 other hypotheses that encompass 'counterfeit deviance', and since then others have been added by both the original author's and other researchers.

The theory of 'counterfeit deviance' was designed to encourage clinicians, many of whom may

not be cognisant of the experiences of those with intellectual disabilities, to think outside the box and inside the life of a person with a disability and to show caution in making diagnoses based on the offence behaviour alone. To delve into the history and context of the situation to provide the explanation and hence, make treatment decisions for inappropriate behaviour. It is important for those who work with sex offenders with an intellectual disability to look beyond topography. However, by thinking critically about seemingly deviant behaviour, it is possible to come up with a variety of other explanations. The theory of 'counterfeit deviance' provides some of these other possible explanations.

'Counterfeit deviance' determines the underlying motives behind offending behaviour. It provides direction for individualized treatment programmes rather than the 'one size fits all' approach to treatment. An important first step is to determine whether the offender has a paraphilia. Differentiating between true deviance and 'counterfeit deviance' is a very crucial initial step to take in order to guide appropriate treatment programmes. Determining whether an individual has a paraphilia versus behaviour that appears as paraphilic marks the beginning of developing individualized treatment approaches that target the outcomes of the initial assessment.

No one variable that can adequately explain sex offending behaviour across the board. Understanding the etiology and primary motivations behind sex offending by people with intellectual disabilities can lead to effective prevention and treatment. This alone highlights the need for a bio-psycho-social model for people with intellectual disabilities who sexually offend (Griffiths, 2002). We need a comprehensive model that encompasses all these factors, to provide a solid framework to help clinicians target primary motivations that individualize treatment programmes.

With the concept of 'counterfeit deviance' being revisited future research should aim to expand on the concept by focusing on differential diagnosis and designing evaluative treatment strategies that differentially treat paraphilia and those with 'counterfeit deviance'. The efficacy of various treatment programmes should also be evaluated and critiqued so people in this field can work further towards protecting the community and effectively serving the needs of people with disabilities. In addition, the theory streamlines treatment to provide appropriate treatment for the appropriate etiology, thereby ensuring that individuals are not unduly labeled and that resources are targeting the correct areas of risk for the offense. Logic, efficiency and human interest dictate that careful diagnostic evaluation informs treatment. The theory of 'counterfeit deviance' suggests only that clinicians provide such a comprehensive assessment.

Conclusions

The primary concept involved in 'counterfeit deviance,' then, is that people with intellectual disabilities, because of their unique histories and unique living situations may engage in deviant behaviour for reasons other than deviance. Hingsburger (2012) has posited that the theory can, and should, be expanded to the concept of "Counterfeit Criminality." He suggests that people with disabilities may be involved in crimes for reasons other than criminal enterprise. Social acceptance, social manipulation, social victimization being some of the hypotheses. He points to literature as early as Dicken's Barnaby Rudge (2003) originally published in 1840 and as recent

as Picoult's House Rules (2010) wherein popular culture has come to recognize that sometimes people with disabilities behave differently and that different can be mistaken for criminal. Perhaps, then the biggest contribution by 'counterfeit deviance' will be that people with disabilities will be better understood, in the context of both their disability and the society in which they live, by those who serve them.

The original counterfeit deviance article was a motivator for service providers and clinicians to reflect carefully on the type of service provided to the individuals they served. The ideas presented in the original article in regards to thinking critically about behaviour were a driving force behind agencies advocating for larger changes that positively affected service. In the region in which we started, there are now no agencies that have negative policies; rather they provide the opportunity to participate in anti-abuse training and sex education. The hypotheses presented in 'counterfeit deviance' make way for change in the lives of all people with disabilities, change that can have a profound impact on the enrichment of their lives.

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