

## CASE REPORT

# The importance of multidisciplinary evaluation for differentiating between mental retardation and antisocial behavior in sex offenders: a case study

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## INTRODUCTION

The World Health Organization considers sexual abuse in childhood to be a growing public health problem worldwide.<sup>1</sup> The psychological and behavioral profile of sex offenders is a topic that has been widely investigated in the literature<sup>2-6</sup> because the appropriate treatment of such individuals can prevent them from becoming repeat sex offenders.

One important aspect of the aggressor profile is cognitive functioning.<sup>5,6</sup> In some cases, sexual assaults are committed by individuals with intellectual disabilities that impair their capacity to critically analyze their actions.<sup>2</sup> In other cases, sexual assaults can represent sadistic behavior related to antisocial personality disorder.<sup>2</sup>

The objective of this case report is to analyze the case of a teenager who was accused of sexually abusing a child and to determine whether the teenager should be diagnosed with mental retardation or early-onset antisocial behavior. This case exemplifies the need for multidisciplinary evaluation to establish a diagnosis and to develop appropriate treatments to prevent the recurrence of violence.

## CASE REPORT

The patient (W., a black male) was 16 years old and in the eighth grade. He had been a resident of a supervised shelter for two years due to inadequate family support after his father's death in a car accident and his mother's arrest for shoplifting. Before entering the shelter, W. often witnessed physical aggression between his parents and was neglected in terms of basic health care. He had seven siblings, of whom two had been adopted and five were living in shelters. He was in the process of being adopted, but he was not accepted because he sexually assaulted an 8-year-old girl who was living with the prospective parents. Sexual abuse was not substantiated by medical examination. Therefore, it was suspected that the assault involved fondling and sexual acts other than penetration.

The shelter team referred W. to the Equilibrium Program (Programa Equilíbrio), a multidisciplinary program that specializes in socially vulnerable children and at-risk adolescents.<sup>7</sup> One complaint was that W. had difficulty studying the materials because he could not read or write properly. Although he rarely exhibited behavioral difficulties at the shelter, once he inappropriately approached a female caregiver, attempting to grope her and using profane language regarding his body parts.

Before entering the Equilibrium Program, the teenager was followed at a health program, where his sexual misconduct was attributed to early-onset antisocial behavior. These types of adolescents should be referred to the Social and Educational Services for Adolescents Foundation Center (Fundação Casa), which focuses on implementing court-ordered educational measures for adolescent offenders between 12 and 21 years of age.

During the evaluation process, the shelter staff expressed uncertainty about how to handle W.'s case. They indicated that all possible interventions would be ineffective in improving his conduct. However, the multidisciplinary assessment differed from the assessment provided by the shelter staff. Table 1 presents the results of the multidisciplinary assessment.

## DISCUSSION

This report addresses a case of diagnostic uncertainty. In such cases, a careful multidisciplinary assessment should be performed to establish treatment strategies and approaches that improve quality of life and preserve the dignity of patients and other people within their social environment. Sexual abuse results in biopsychosocial damage to the victim, and treatment of the abuser is an important strategy for preventing such violence.

One study of sex offenders has suggested that sex offenders with an average or above-average intelligence quotient are more likely to have deviant sexual preferences and exhibit coercive behaviors, whereas those with intellectual disabilities choose children due to a cognitive lack of sexual knowledge and understanding of social rules.<sup>5</sup> Reviews of the literature support this hypothesis and classify sex offenders who suffer from some type of psychiatric disorder, including mental retardation, as "inadequate situational molesters". These individuals engage in nonaggressive sexual caressing and touching without perceiving the criminal nature of their acts.<sup>2</sup>

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**Table 1 - Results of psychiatric, speech therapy, and neuropsychological assessments.**

Type of evaluation	Main results
Psychiatric	<ul style="list-style-type: none"> <li>• Mild mental retardation (F70)</li> </ul>
Speech-related	<ul style="list-style-type: none"> <li>• Specific developmental disorders of speech and language (F80) (WHO, 1993)</li> <li>• Changes in expressive language capable of impairing the intelligibility of speech                             <ul style="list-style-type: none"> <li>• Change in receptive language</li> </ul> </li> <li>• Changes in pragmatic language (little ability to use linguistic and paralinguistic resources for troubleshooting)</li> </ul>
Audiologic	<ul style="list-style-type: none"> <li>• Hearing acuity within normal limits</li> </ul>
Neuropsychological	<ul style="list-style-type: none"> <li>• Changes in auditory processing moderate the following skills: figure-ground for linguistic and non-linguistic sounds, auditory closure, and sequence score for verbal and nonverbal sounds                             <ul style="list-style-type: none"> <li>• Estimated IQ = 62 (mild mental retardation)*</li> </ul> </li> <li>• Unsatisfactory performance on verbal test (Vocabulary Subtest - WISC-III) - Percentile = 0.1</li> <li>• Unsatisfactory performance on non-verbal test (Block Design - WISC-III) - Percentile = 9</li> <li>• Unsatisfactory performance on tests assessing executive function by <i>Frontal assessment battery</i>:<sup>8</sup> mental flexibility, planning, and selective attention</li> </ul>

\* IQ: estimated intelligence quotient obtained using Vocabulary and Block Design Subtests of Wechsler Intelligence Scale for Children, third edition (WISC III).

Based on the aforementioned studies, we assumed that the sexual abuse committed by W. was associated with intellectual disability and an impaired perception of reality. The victim did not report coercion or aggression, nor was there any physical evidence of these types of behaviors.

The expression of sexuality in adolescents with mental disabilities is thought to be similar to that observed in adolescents with preserved intellectual ability: intense desire and curiosity.<sup>9</sup> For individuals with mental disabilities, the environment plays an extremely important role in providing models of healthy behavior. Communication must be adapted to the cognitive capacity of the individual, and it is necessary to provide concrete illustrations of social norms.<sup>9</sup>

W.'s biological family did not provide appropriate models of social behavior and dignity, which is a risk factor for the development of behavioral problems.<sup>10</sup> In addition, W. was not encouraged to exercise his capacity for empathy. His sexual misconduct appeared to be related to the models that he observed in his social and family environment.

Risk factors for the development of inappropriate behavior in people with intellectual disabilities include problems in language acquisition<sup>9</sup> and deficits in cognitive functioning and nonverbal executive functioning,<sup>11</sup> which were observed in the multidisciplinary assessment of W. Because language and cognition are important for adapting to reality, these deficits should be treated by specialists. After treatment, individuals such as W. will be able to properly analyze their social environment and plan their actions in a healthy manner.

The shelter team evaluated the episode of sexual abuse without considering W.'s environment or other aspects of his overall development (such as cognitive and communication deficits). This unilateral approach may result in hasty diagnoses that stigmatize patients and hinder their rehabilitation.<sup>12</sup>

**CONCLUSION**

A multidisciplinary assessment of the patient, which included an analysis of environmental factors and evidence from previous studies, indicated that the sexual abuse committed by W. was associated with mental retardation. A misdiagnosis (such as antisocial personality disorder) would have further victimized the patient, who might have been stigmatized and, more importantly, would have had little chance of receiving appropriate treatment and adapting to reality. In addition, without appropriate guidance and treatment, W. may have become a repeat sex offender,

which would have increased the number of individuals at risk for psychiatric and emotional problems.

This case exemplifies how a multidisciplinary approach can be helpful in the event of diagnostic uncertainty in complex psychiatric cases. Many patients can benefit from appropriate treatment of their symptoms after the underlying cause of those symptoms has been clarified.

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**REFERENCES**

1. Organização Mundial da Saúde (OMS). Classificação de Transtornos Mentais e Comportamentos da CID-10. Tradução de Dorgival Caetano, com a colaboração de Maria Lúcia Domingues e Marco Antônio Marcolin. Porto Alegre: Artes Médicas do Sul, 1993.
2. Serafim AP, Saffi F, Rigonatti SP, Casoy I, Barros DM. Perfil psicológico e comportamental de agressores sexuais de crianças. Rev psiquiatr clín. 2009;3:101-11, doi: 10.1590/S0101-60832009000300004.
3. Tan L, Grace RC. Social desirability and sexual offenders: a review. Sex Abuse. 2008;20:61-87, doi: 10.1177/1079063208314820.
4. Kocsis RN, Cooksey RW, Irwin HJ. Psychological profiling of offender characteristics from crime behaviors in serial rape offences. Int J Offender TherComp Criminol. 2002;46:144-69, doi: 10.1177/0306624X02462003.
5. Rice ME, Harris GT, Lang C, Chaplin TC. Sexual preferences and recidivism of sex offenders with mental retardation. Sex Abuse. 2008; 20:409-25, doi: 10.1177/1079063208324662.
6. O'Callaghan AC, Murphy GH. Sexual relationships in adults with intellectual disabilities: understanding the law. J Intellect Disabil Res. 2007;51:197-206, doi: 10.1111/j.1365-2788.2006.00857.x.
7. Scivoletto S, da Silva TF, Rosenheck RA. Child psychiatry takes to the streets: A developmental partnership between a university institute and children and adolescents from the streets of Sao Paulo, Brazil. Child Abuse Negl. 2011;35:89-9, doi: 10.1016/j.chiabu.2010.11.003.
8. Cunha PJ, Novaes M. Avaliação neurocognitiva no abuso e dependência do álcool: Implicações para o tratamento. Rev Bras Psiq. 2004;26:23-7, doi: 10.1590/S1516-44462004000500007.
9. Pratt HD, Greydanus DE. Intellectual disability (mental retardation) in children and adolescents. Prim Care. 2007;34:375-86.
10. Dickson K, Emerson E, Hatton C. Self-reported anti-social behaviour: prevalence and risk factors amongst adolescents with and without intellectual disability. J Intellect Disabil Res. 2005;49:820-6, doi: 10.1111/j.1365-2788.2005.00727.x.
11. Hartman E, Houwen S, Scherder E, Visscher C. On the relationship between motor performance and executive functioning in children with intellectual disabilities. J Intellect Disabil Res. 2010;54:468-77, doi: 10.1111/j.1365-2788.2010.01284.x.
12. Scivoletto S, Stivanin L, Ribeiro ST, Oliveira CCC. Avaliação diagnóstica de crianças e adolescentes em situação de vulnerabilidade e risco social: transtorno de conduta, transtornos de comunicação ou "transtornos do ambiente"? Rev Psiq Clín. 2009;36:206-7.