Promoting Healthy Sexuality in Persons with Special Needs and Sexual Violence Concerns

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Who are we talking about?

"Intellectual Disability" in the context of this presentation is a broad category that can include many different clinical presentations:

- Acquired Brain Injury
- Autism Spectrum Disorders (including Asperger's)
- Fetal Alcohol Spectrum Disorders
- Intellectual Development Disorder (re: DSM-5)
- Others with impaired cognitive ability due to a variety of reasons

Persons with ID and Sexual Behaviour Problems

Persons with intellectual disabilities may experience significant limitations leading to difficulties in many or all of the following domains:

- Communication
- Home living
- Community use
- Self-direction
- Functional academics
- Sexuality
- Self-care
- Social skills and relationships
- Health and safety
- Leisure and work

ID and Sexual Offending

One judge in Canada posited this theory:

Herein lies the problem relating to the commission of sexual offences. Having a mature body beyond his intellect, he has urges for sexual gratification which leads to impulsiveness and unpremeditated behaviour without using caution and with risk taking. This is followed by non-comprehension that the behaviour was inappropriate.

Judge Trueman

The cognitively challenged are before our courts in unknown numbers. We prosecute them again and again and again. We sentence them again and again and again. We imprison them again and again and again. They commit crimes again and again and again. We wonder why they do not change. The wonder of it all is that we do not change.

Assessment

Sexuality Assessment

- To determine the nature and scope of the sexual problems
- To determine the level of risk to community
- To determine the level of risk to individual
- What is the level of risk?
  - low, moderate, or high
- To determine therapy needs
- To determine educational needs
- Identify placement concerns

Dynamic Risk & ID

Clearly, persons with intellectual disabilities and sexual behaviour problems are at a disadvantage in regard to most, if not all, dynamic risk variables

- differential diagnosis and individualized case planning can be difficult

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Assessment of **R**isk and **M**anageability of **I**ntellectually **D**isabled **I**ndividua**L**s who **O**ffend **S**exually

Stable Client Items
1. Supervision Compliance
2. Treatment Compliance
3. Sexual Deviance
4. Sexual Preoccupation/Sexual Drive
5. Offence Management
6. Emotional Coping Ability
7. Relationships
8. Impulsivity
9. Substance Abuse
10. Mental Health
11. Unique Considerations - Personal and Lifestyle (e.g., neglect, physical or sexual abuse, antisocial tendencies)

Stable Environmental Items
1. Attitude Towards ID Client
2. Communication Among Support Persons
3. Client Specific Knowledge by Support Persons
4. Consistency of Supervision/Intervention
5. Unique Considerations (e.g., level of supervision, behaviour reinforced, staff modelling)

Acute Client Items
1. Changes in Compliance with Supervision or Treatment
2. Changes in Sexual Preoccupation/Sexual Drive
3. Changes in Victim-Related Behaviours
4. Changes in Emotional Coping Ability
5. Changes in Use of Coping Strategies
6. Changes to Unique Considerations (e.g., mental health symptoms, medication changes)

Acute Environmental Items
1. Changes in Social Relationships
2. Changes in Monitoring
3. Situational Changes
4. Changes in Victim Access
5. Unique Considerations (e.g., access to intoxicants, a new room-mate)

Treatment & Intervention

Sanction vs. Human Service

Several very large-scale meta-analyses

- Smith, Goggin, & Gendreau (2002)
- Aos, Miller, & Drake (2006)
- Lipsey & Cullen (2007)

All arrived at the same conclusion:

- Punishment alone will not reduce bad behaviour

An answered question?

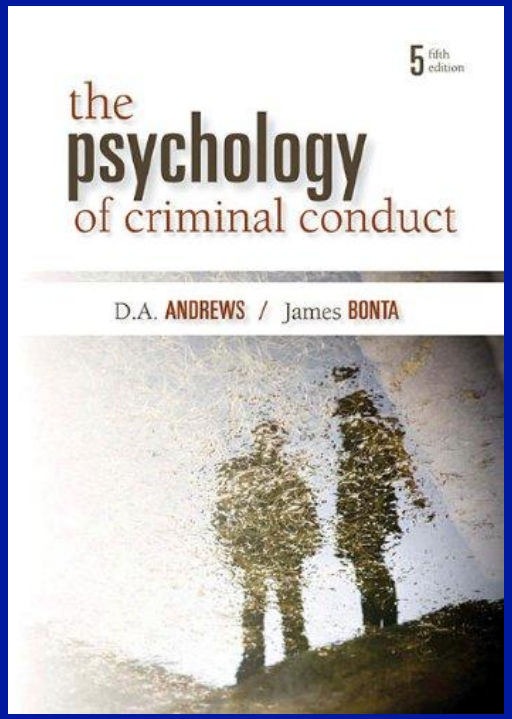
We are confident that, no matter how many studies are subsequently found, sanction studies will not produce results indicative of even modest suppression effects or results remotely approximating outcomes reported for certain types of treatment programs.

(Smith et al. 2002, p.19)

Andrews & Bonta (2010)

Three Principles:

- Risk
- Need
- Responsivity



From The Psychology of Criminal Conduct, 5th ed.

RNR Principles

(Andrews & Bonta, 2010)

Established risk factors for sexual offender recidivism

(Hanson & Yates, 2013)

Sexual deviance
- Any deviant sexual preference
  - Sexual preference for children
  - Sexualized violence
  - Multiple paraphilias
- Sexual preoccupations
- Attitudes tolerant of sexual assault

Lifestyle instability/criminality
- Childhood behaviour problems (e.g., running away, grade failure)
- Juvenile delinquency
- Any prior offences
- Lifestyle instability (reckless behaviour, employment instability)
- Personality disorder (antisocial, psychopathy)
- Grievance/hostility

Social problems/intimacy deficits
- Single (never married)
- Conflicts with intimate partners
- Hostility toward women
- Emotional congruence with children
- Negative social influences

Response to treatment/supervision
- Treatment drop-out
- Non-compliance with supervision
- Violation of conditional release

Poor cognitive problem-solving

Age (young)

Behavioural Difficulties

- Children with ID tend to be impulsive, uninhibited, overly friendly, inquisitive, demanding of affection and physical contact, intrusive, insensitive to social cues, and have poor social skills
- It's not hard to see how some of these could ultimately be precursory to problems in intimacy and sexuality later in life

Consequential Learning

- Persons with intellectual disabilities have often gotten a "free pass" from the criminal justice system
  - Officers have been reluctant to lay charges
  - Courts have been reluctant to convict
- Consequently, some persons with ID and sexual behaviour problems never truly learn that their conduct is unacceptable

Modifying Interventions

Treatment modifications include:

- Reduced reliance on verbal materials
- Increased use of visuals and modeling
- Increased use of practice
- Sexual education
- Increased supervision and structure
- Emphasis on predictability, clarity
- Use active teaching/explicit instruction
- Medication may be necessary
- Focus on rules and consequences

Treatment & Supervision

Responsivity

- Program materials must be presented in a manner that is simplified, concrete, and redundant
- Frequent review of topics covered is important, as is sufficient time for practice and repetition
- Given the increasingly multi-cultural nature of our clients, programs must be culturally relevant, holistic, and (where possible) community-based

Prevention – The other side

- We have focused on clients with ID who have become offenders
- We should not forget that an alarmingly high percentage of persons with intellectual disabilities are also victims
- Many of the traits that increase risk for **victimizing** also increase risk for **victimization**
- These two positions will interact with one another, especially regarding modeling

Promoting Healthy Sexuality

- Historically, society has reacted with fear and disgust when confronted with sexuality in persons with intellectual disabilities
- Even experienced professionals have shared negative feelings and beliefs about sexuality and intellectual disability
  - Commonly heard statements such as “Oh gross! Do you need to do that here?”, “Do you have to do that?”, “Stop that, it’s not normal.”

Healthy Sexuality Education

- Abuse Prevention
- Feelings About Sex
- Male & Female Anatomy
- Human Sexuality
- Birth Control
- STDs
- Health and Hygiene
- Dating
- Marriage
- Relationships
- Public and Private
- Consent
- Personal Space/ Boundaries

Challenges

What if your client's sexual practices are "abnormal" or "unusual"?

Contact

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