# Intellectual Disability and Problems in Sexual Behaviour

## Assessment, Treatment, and Promotion of Healthy Sexuality

A GUIDEBOOK BY

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*with a Foreword by*
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PEEL BEHAVIOURAL SERVICES
TRILLIUM HEALTH CENTRE

This resource is in dedication to the individuals we serve. Thank you for all you have taught us.



**Intellectual Disability and Problems in Sexual Behaviour:
Assessment, Treatment, and Promotion of Healthy Sexuality**

by Robin J. Wilson, Ph.D., ABPP and Michele Burns, B.Sc.



ISBN: 978-0-9869084-0-8

Publisher: Trillium Health Centre

Address: 5770 Hurontario St.
Suite 101
Mississauga, ON L5R 3G5

Printed and bound in Canada

1 2 3 4 5 13 12 11

Project Management and Editorial Services by Clarity Content Services

Design and Production by Pixel Hive Studio

Illustrations by Chris Reed

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# Preface

It has often been said that there is more art than science involved in the assessment and risk management of persons who sexually offend. There is some truth to this. As a field, we are really only just starting to progress in regard to science and evidence-based practice. However, that said, we appear to be pretty quick studies. What was "stone knives and bearskins" some 30 years ago is a much more refined process today. Of course, although we are much better at this than we used to be, we still have a long way to go. With the introduction of standardized assessment tools, actuarial risk assessment methods, and collaborative models of containment and risk management, we now have better tools to help our clients. Recent observations about declining rates of sexual abuse and reoffending would seem to suggest that our efforts are starting to pay off.

Of course, all of this is because of our shared goal—"No more victims."

We need to remember that this continues to be a pretty tall order. Sex and violence have gone together for a long time. But, in truth, it has only been in the last half century that human society has really paid much attention to sexual violence as a topic of popular discussion. It is good that this has changed—it needed to. Sexual abuse has a profound negative effect on the overall health of our society. Some groups and individuals have suggested that sexual abuse may be one of the most pressing public health concerns of our time. We agree, which is a good part of the reason we decided to write this guidebook and its accompanying quick reference guide.

Another big reason why we decided to write this guidebook is that we work with a group of clients who are generally misunderstood by the majority of society. Persons with intellectual disabilities have often been hidden away—essentially, kept out of sight and out of mind. However, because various governments have decided to deinstitutionalize such persons (and others, including those with mental disorders), ordinary citizens now encounter many more persons with intellectual disabilities, as well as their associated difficulties in managing everyday life.

Don't get us wrong. We are all for having persons with challenges being able to engage those challenges in the real world. Institutionalization of marginalized populations has likely done very little good for them or for us. Everyone has the right to make a go of it in the community. But, let us not kid ourselves. They also have the right to good service, which may include competent assessment, sensible treatment, and realistic risk management. That is where we come in. "We" are the counselors, case workers, behavioural associates/therapists/technicians, group home workers, mental health practitioners, law enforcement officers, and probation and parole supervisors who (among others) are charged with providing these services.

Deinstitutionalization raises another issue. As persons with intellectual disabilities move back out into the community, they will bring their "issues" with them. In truth, their issues are often not so different from those of other groups of people. The problem is the many preconceived ideas about persons

who experience intellectual and other cognitive processing difficulties, which means that having an intellectual disability and having sexuality difficulties amounts to something of a "double whammy."

Stigma abounds.

In order for those working with these clients to succeed, assessment and treatment professionals need good tools, but there are limited resources out there. Sometimes, it is even more difficult for front line workers who are the ultimate receivers of information about assessment and treatment. What does all that data and information mean, for us, as workers trying to provide support to persons in need? How do we make sense of it all?

In this guidebook, we hope to provide you with some useful knowledge and perspective that will ultimately increase your comfort and understanding of the major issues to be considered in working with persons with intellectual disabilities who sexually offend. In doing so, we want to be very clear that this is not a book about how to do assessment or treatment. There are other books on that topic, and we will refer to these throughout this guidebook. Our intent is to familiarize readers with the sorts of concepts and information that are given by assessment and treatment professionals, through consultation, clinical reports, and other media.

So, just to be clear … Reading this guidebook does not mean that you are now able to go out and conduct assessments or offer treatment; although, some readers may already be professionally trained to do so. Reading this guidebook will help you to better understand some of the complicated issues associated with working with persons with intellectual disabilities and sexual behaviour problems.

It is also important to note that the concepts and methods we describe in this guidebook are not necessarily the only ones of their kind. We have tried to be relatively comprehensive in our descriptions of methods and tools; however, we were also mindful that this guidebook is intended to serve a particular population of service providers—primarily, those in the Central West Region of Ontario. As such, we have made certain to focus on the methods and tools most frequently used in this region. In doing so, we do not mean to suggest that other methods or tools are not also useful or equally valid. Further, even though we had the Central West Region in mind, we expect that most sections will be helpful for workers in all locations who struggle to provide sensitive, evidence-based services to persons with intellectual disabilities.

Giving credit where credit is due…

In preparing this guidebook, we pulled together a variety of presentations, papers, and other materials we have amassed over our collective 50-plus years of working with this population. The Southern Ontario region has been very fortunate to have a tight knit group of professionals working in this field. The sharing of knowledge and expertise between those professionals has helped us all to do a little better in this important work.

We mentioned a close group of professionals, sharing information with one another. After a while, it gets hard to sort out whose perspective was whose, originally. But, we are very sensitive to the need to give credit. Throughout the chapters that follow, we have included references to a lot of manuscripts,

papers, book chapters, books, videos, presentations, personal communications, and other sources of knowledge. However, it is possible that we might have inadvertently overlooked an opportunity to give our colleagues credit for their hard work. This is certainly not our intention. In order to be sure that we acknowledge our primary sources, we wish to thank the following people for all the inspiration and influence they have exerted on our understanding and practice: Dave Hingsburger, Susan Tough, Dorothy Griffiths, Vern Quinsey, Brandie Stevenson, and the staffs of Peel Behavioural Services, Behaviour Management Services of York and Simcoe, Vita Community Living, Christian Horizons, and Prior, Linder & Associates. There are likely others we have forgotten to note.

We would also like to acknowledge the foundational work of Jim Haaven in Oregon. More recently, Gerry Blasingame in California has provided the field with cutting edge information on the current state of the science associated with working with persons with intellectual and other cognitive processing difficulties. Indeed, we were able to exploit our good relationship with Dr. Blasingame in having him provide critically helpful feedback on the final draft of this guidebook. He also graciously agreed to provide us with a Foreword.

Last, we are also thankful to the many persons who provided helpful feedback and critiques during round-table meetings focusing on early drafts of these documents. In particular, we owe a great debt of gratitude to Trevor Lumb, Regional Coordinator of the Central West Network of Specialized Care, as well as Peel Behavioural Services Manager Leanne Baldwin.

We hope you find this guidebook as energizing and informative in your practice as it was for us in its production.

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# Foreword

*Intellectual Disability and Problems in Sexual Behaviour: Assessment, Treatment, and Promotion of Healthy Sexuality* is full of practical, useful information for a range of persons who provide supports and services for individuals who have intellectual or other developmental disabilities who also have a history of sexual behavior problems. Not only do they bring together the important research about sexual offenders, authors Robin J. Wilson and Michele Burns effectively apply these concepts and guide the way for those who provide the supervision and management of individuals with intellectual disabilities.

This guidebook has important information for direct care staff, case managers, probation or parole officers, and others who are involved in developing service plans and ongoing supports for clients with these types of problems. Family members of these clients can also gain a tremendous amount of understanding and will appreciate the authors' sensitivity and common sense approaches to managing individuals who have sexual behavior problems. Therapists unfamiliar with these specialties will also find this to be a valuable resource. The guidebook is full of intelligent and well thought out principles that can enable support persons as well as the clients themselves make safe and sound decisions for better everyday living.

In my own work and writing, I've read a lot of material on developmental disabilities, sexual deviance, criminal justice strategies, etc. But it is rare to find all these perspectives well integrated. For example, chapter two covers a number of challenges that people with intellectual disabilities have. Chapter three brings sexual behavior problems into perspective with clarity and sensitivity. The chapters on assessment and treatment overview provide a wealth of information that will help support persons be better prepared to supervise these clients as well as lend support to the more formal treatment efforts. Each of the chapters offers many excellent points and recommendations that can help support persons better understand the clients whom they serve. Wilson and Burns have done a great job bringing this all together in such a practical way. I would be happy to recommend this guidebook to the many programs for whom I provide consultation and training.

Gerry D. Blasingame, Psy.D.
Redding, CA

# 1

# Defining the Problem

Sexual offending is clearly one of the most sensitive and upsetting social issues of our age. The immediate, visceral, upset emotional response that most of us have to sexual offending is mostly because of our awareness of who the likely victims are—women, children, and other vulnerable persons. In this guidebook, "vulnerable persons" will often refer to persons with intellectual disabilities or other difficulties associated with cognitive processing. In this introductory chapter, we will set the context and establish the working definition of the problem for our continuing discussion of sexual offending.

## Is Sexual Abuse Really That Big a Problem?

Statistics show that sexual abuse occurs at an alarming rate. According to various studies of child sexual abuse, as many as one in four girls and one in seven boys will be sexually abused at some point in their childhood (i.e., prior to age 18). Many researchers consider these figures to be underestimates (Badgley, 1984; Finkelhor, 1984—although we acknowledge that these are somewhat dated references, they are definitive on the matter and it appears that subsequent investigations have come to consistent conclusions). That means that if you are in a room with one hundred people, between 15 and 25 of those in the room might have been sexually abused in childhood. Those numbers are daunting, but when you add the numbers of persons who are sexually abused as adults, you start to get a sense of how truly pervasive a problem this is in our society.

Among persons with intellectual and other disabilities, sexual abuse is an even bigger problem. In fact, studies have shown that the rates of sexual abuse of people with disabilities are astronomically larger than they are among the mainstream population. For example, upwards of 70 percent of females with intellectual disabilities are sexually abused as children (Blasingame, 2005). Our comments in this chapter about sexual victimization of persons with intellectual disabilities are very brief. Chapter 10 features a much broader discussion of these issues.

## Sexual Offending

The past 25 years have seen a flurry of research into the nature and consequences of sexually offensive behaviour. However, we suggest that it is odd that the focus has come so late in the game. We have no doubt that people have committed sexual offenses at long as there have been people to be offenders and people to be victims—thousands and thousands of years. Why has the attention shifted to identifying causes only recently?

When a high-risk sexual offender is released to the community, the event often receives a great deal of media attention. Sometimes, this attention provokes fear in the community and leads people in the community to question why such people would be allowed to be free. The simple truth is that most persons who sexually offend receive determinate sentences—that means that they do not get "life." As a consequence, nearly all persons who sexually offend will be released back to the community at some point.

When that happens, there are several stakeholders:

| Stakeholders | |
|---|---|
| Victims (past, present, or future) | Person who has committed a sexual offense |
| Citizens | |
| Mental Health Personnel | |
| Legal and Correctional Personnel | |
| Law Enforcement | |
| The Media | |

*Stakeholders in the integration of a person who commits sexual offenses into the community*

In this list, you will notice that we separated the offenders from the other parties. In many respects, this is what actually happens in the community: an "us versus them" scenario. This polarization sometimes manifests in legislative and community responses to sexual offenders in the community. Some of you may know the acronym NIMBY—Not In My Back Yard. Persons who sexually offend become pariahs (people whom nobody likes and with whom nobody wants to spend time), for reasons that may be entirely understandable. However, some of the laws and rules regarding persons who sexually offend in the community may not actually help anybody to stay safe. Sometimes, these policies drive offenders underground and into hiding—an outcome that is not good for anyone. In the end, true community risk management will require us to be more involved in the lives of those sexual offenders we know about, if only to make sure that they never again engage in this harmful behaviour.

It is important to note that these issues also affect persons with intellectual disabilities. Keep in mind that many of our clients are already stigmatized because of their disabilities. Consider how much worse the stigma might be if they were suddenly identified as both disabled and a sexual offender.

As you read through this guidebook, we hope to provide you with some helpful information and tips regarding how you can be a part of a network of persons working to ensure effective risk management in the community.

## Victims and Offenders

One simple truth that we must keep in mind whenever we talk about sexual offending is that there are many more offenders and many more victims than we actually know about. Sexual offenses are crimes of secrecy. One of the most alarming statistics regarding sexual abuse is that as many as 80 to 90 percent of victims never tell anyone who is in position to help them (Finkelhor, 1984). This silence mostly occurs because of shame, guilt, and secrecy.

> *Sexual abuse is a very maddening problem—the offender does not want you to know and, tragically, neither do most of the victims. Worse still, many others in the community would rather not talk about such troubling issues and experiences.*

The end result of all this secrecy is that the police and courts cannot tell you about these "unknown" persons who sexually offend because they do not know who they are. However, the research tells us that they are often people we know in our families and in our community. Ironically, most are people we trust. It has been said that there is a dangerous person in every child's life. Parents and other caregivers need to be on guard and thoughtful with everyone, even with those they trust.

When we talk about sexual abuse, we know that we are able to talk about only the smallest part of the problem. Everything we say is subject to the qualifier "based on what we know." And, unfortunately, there is still a lot we do not know.

### Why Is Under-reporting Such a Problem?

There are many reasons that persons who are victimized choose not to report their experiences of sexual abuse. Generally, persons who are victimized as adults fail to report because they do not trust "the system" to take them seriously and to follow up with charges and punishment against the offender. This is likely the number one reason why women fail to report rapes or other sexual offenses committed against them.

Male persons who are victimized often under-report due to socialization (for example, the idea that "boys don't cry"). Also, boys in many cultures are still socialized to see any sexual experience as a positive thing, which complicates the reporting of offenses perpetrated by women. Sometimes, men who commit offenses against boys "groom" a boy to believe that what they do is a "special secret" that others will try to take away from them.

Female persons who are victimized often under-report because of the context in which they are victimized—typically in relationships. Reporting abuse that occurred in a family context can be quite complicated: loyalties may be distorted, and the victim may fear disbelief or negative consequences.

Children are likely the largest group of persons who are victimized, and, for a number of reasons, they may also be the ones least likely to report their abuse.

**Glossary**

**compliance training**
A method of training that introduces progressively more intrusive prompts (e.g., verbal instruction, modelling the desired behaviour, physically guiding the person to behave as required) depending on the degree of noncompliance the person demonstrates to the instruction.

First, because of their developmental status, many children don't understand that what is happening to them is abuse. Adults ask children to do many things they don't want to do (called **compliance training**)—like eat their vegetables—so, identifying inappropriate touching as abuse may not occur to them until later in life. Furthermore, even when children do understand that what is happening to them is wrong, the abuse is often occurring in a family setting that has so many other problems that the children feel that they do not have any way to report the abuse. Most children are abused in family settings, often at the hands of family members who say that they love them (and, indeed, who likely do love them). It is much harder to report abuse by a family member than by a stranger.

Perhaps one of the greatest social challenges facing modern society is how to help persons who are victimized to feel emotionally and psychologically strong enough to come forward, to tell us about their abuse, and to allow us to help them and their abusers. We must acknowledge that it will take a lot of effort if we are to meet our ultimate goal of "no more victims."

## Who Are the Abusers?

People who engage in sexually abusive behaviour are likely to be people we know. Most often, a person who engages in this behaviour is someone we care about. It would be easy to identify persons who sexually offend if they were like the ones we see in the media—strangers hanging around the edges of playgrounds or in the corners of video arcades. But persons who commit sexual offenses are hardly ever like that, in reality. In the vast majority of child sexual abuse cases, the child knows and probably trusts the person who commits the abuse. This is also true of rape cases and other offenses against victims who are adults. It is hard to face that someone we know—and maybe even love—could be sexually abusing a child or engaging in other sexually abusive behaviour.

Persons who sexually offend come from virtually every walk of life. Most are male, but females who engage in sexually abusive behaviour do exist (see Gannon & Cortoni, 2010). Offenders can be doctors, lawyers, construction workers, teachers, security guards, and even police officers. Tragically, they are often parents. As we will outline in the material that follows, there are certain features that many persons who sexually offend have in common, but these factors are not specific to any one culture, socioeconomic background, or other life circumstance. Caregivers, including family, friends, staff members, and volunteers, form a high proportion of those who sexually abuse persons with intellectual and other disabilities. Regrettably, when a person with a disability is abused, the abuser frequently is a staff member or a volunteer.

## Consequences of Abuse

On the surface, the easiest answers to the question "What are the consequences of abuse?" are:

- Emotional, social, and psychological complications for victims, and
- Prosecution and punishment/rehabilitation for offenders.

But the issue is a lot more complex than that.

Clearly, being sexually abused is a profound, life-changing experience. Some persons who are victimized deal with the aftermath much better than others. We know very little about what contributes to the resiliency (or, the ability to "bounce back") of some persons who are victimized, or why others seem so much more affected by the events. However, it stands to reason that being abused has some degree of influence on every person who is victimized.

Above, we reported that up to 90 percent of persons who are victimized never tell anyone who is in a position to assist them. That means that there is an awful lot that we do not know about the real effects and consequences of being sexually abused. The following is a brief list of some of the more commonly observed consequences for persons who are sexually abused:

- Maladaptive sexuality (either hyper-sexuality or hypo-sexuality)
  - Prostitution
  - Promiscuity
  - Inability to express one's own sexuality
  - Genital disfigurement
  - Sexual addiction
- Eating disorders
- Personality disorders (antisociality, borderline features)
- Dissociative disorders
- Anxiety, post-traumatic stress disorder, and depression
- Suicidal and self-harming behaviours
- Interpersonal problems (e.g., trust issues, loneliness, inability to link with others)
- Loss of relationships with significant others (either because of the abuse or because of secondary victimization)
- Substance abuse
- Violence and aggression
- Exacerbation of already existing conditions (e.g., mental health problems)

Several very good books have been written about the consequences of sexual abuse victimization. The *Courage to Heal* series by Bass and Davis is particularly good. So are Jan Hindman's *Just Before Dawn* and Mike Lew's *Victims No Longer*, the latter dealing with victimization of boys. However, these books are mostly about sexual abuse and persons without disabilities. There are not very many similar resources specifically for persons with intellectual disabilities. One good book, which is unfortunately difficult to find, is *Violence and Abuse in the Lives of People With Disabilities: The End of Silent Acceptance?* by Dick Sobsey (1994).

Overall, we cannot do justice to the literature on sexual victimization in this small section on victimology. We encourage those who wish to know more about persons who are victimized and their experiences to check out the aforementioned resources.

## Is Healing from Sexual Abuse Possible?

Yes, healing from sexual abuse is possible. The lives of persons who are victimized may be forever changed, but we have many wonderful examples of children and adults healing from the abuse and living out caring and productive lives. Some children want to talk about the abuse and deal with it soon after it happened; however, the literature tends to suggest that children who are victims do not report until they are older and have more understanding of their experience. These others choose to go on with their childhood and deal with it at a later time. Caregivers can help children the most by providing love as well as support from a counsellor with experience in counselling children who have experienced sexual abuse. Adults who experienced victimization as children also require love and support—from counsellors, family, and friends.

## Offenders as Victims

Offenders can also be victims. Indeed, the research literature suggests that as many as half—and possibly more than half—of those who victimize others were themselves victimized physically, emotionally, or sexually, often as children. However, when it comes to sexual abuse, it appears that there is no hard and fast relationship between being sexually abused and being a person who sexually abuses. It would appear that persons who suffer some sort of abuse—verbal, psychological, physical, emotional, or sexual—are at greater risk for maladaptive behaviour, some of which may be sexually oriented. Meta-analytic research (studies that look at the collected findings of a group of studies) suggests that, as a group, persons who are sexually victimized are more likely to engage in sexually offensive behaviour (see Jespersen, Lalumiere, & Seto, 2009), but there is no way to know for certain which persons will and which persons will not.

Traditionally, histories of personal victimization have not been principal clinical targets in treatment programs for persons who sexually offend; however, recent changes in the way we offer treatment (e.g., Pathways/Self-Regulation Model and the Good Lives formulation—see below, as well as Yates, Prescott, & Ward, 2010) have increased the level of focus on possible links between experience of abuse in those who are offenders and how this may have played a role in their own later abuse of others.

# 2

# Intellectual Disability: Effects on Behaviour and Self-Control

This chapter covers a lot of ground. We'll start by providing some definitions of intellectual disability, including a brief discussion of some of the causes and effects. We will end with a discussion of particular areas of concern in working with clients with these sorts of life challenges. Because persons with disabilities have traditionally experienced higher rates of sexual exploitation than those experienced in the general public, we will also focus on some of the victimology issues.

A good part of the focus of this guidebook is on a specific subset of persons with intellectual disabilities—those who also have sexual behaviour problems. This being the case, this chapter will also focus on issues such as the effects of stress on interpersonal violence, mental health conditions, and risk of harm to self or others.

## What is Intellectual Disability?

To be technical, "mental retardation" is the proper diagnostic terminology applied to what we in this guidebook call intellectual disability. However, while this may be the official diagnostic label in the Diagnostic and Statistical Manual of Mental Disorders (DSM), most workers in the field recognize that this label has taken on a lot of negative connotations. Indeed, saying that someone or something is "retarded" often has other meanings in everyday conversation. Nonetheless, readers should recognize that some books, magazines, or research articles will refer to our clients as being mentally retarded.

You may also notice that there have been many other attempts to label this group of individuals, including such terms as developmentally delayed, developmentally disabled, differently-abled, developmentally challenged, etc. The list of labels is pretty long.

In this guidebook, we will try to consistently use "intellectual disability," because we are told by learned colleagues that this term is the one currently most accepted in the field.

Intellectual disabilities are a group of lifelong disabilities attributable to physical or mental impairments. The most common areas affected by these disabilities include the following:

- Capacity for independent living
- Economic self-sufficiency
- Learning
- Mobility
- Receptive and expressive language
- Social interaction
- Self-care
- Self-direction

The Province of Ontario has identified Persons with Developmental Disabilities and listed the characteristics these individuals share in Bill 77.

**PROVINCE OF ONTARIO, BILL 77**
Services for Persons with Developmental Disabilities Act 2008

A person has a Developmental Disability for the purposes of this Act if the person has the prescribed significant limitations in cognitive functioning and adaptive functioning and those limitations;

**a)** Originated before the person reached 18 years of age

**b)** Are likely to be life long in nature; and

**c)** Affect areas of major life actively, such as personal care, language skills, learning abilities, the capacity to live independently as an adult, or any other prescribed activity

Adaptive functioning means a person's capacity to gain personal independence, based on the person's ability to learn and apply conceptual, social and practical skills in his or her everyday life.

Cognitive functioning means a person's intellectual capacity, including the capacity to reason, organize, plan, make judgements and identify consequences.

Intellectual disabilities affect between 2 and 3 percent of the population (Daily, Ardinger, & Holmes, 2000), and are twice as common in males as in females. Furthermore, the prevalence of mild intellectual disabilities is likely to be higher in areas of poverty and deprivation, and among people of certain ethnicities.

## Causes of Intellectual Disability

Common factors causing intellectual disabilities include:

- brain injury or infection before, during, or after birth,
- growth or nutrition problems,
- abnormalities of chromosomes and genes,
- extreme prematurity (i.e., babies born long before the expected birth date),

**Glossary**

**intelligence quotient (IQ)**
A term frequently associated with the numeric value assigned to intelligence by means of standardized testing. The average IQ level for all person is 100.

**concurrent diagnosis**
Two or more conditions with separate diagnoses, which may complicate or exacerbate each other, as when a client who has an intellectual disability also has mental health issues, substance abuse issues, sexual disorders, or other issues.

- poor diet and healthcare during pregnancy, and
- drug misuse during pregnancy, including excessive alcohol intake and smoking.

### Levels of Intellectual Disability

Generally, intellectual disability (or mental retardation) is classified according to **intelligence quotient** (**IQ**—a way to statistically categorize intelligence) levels. The average IQ score in the community at large is 100. Persons with scores over 140 are considered to be exceptionally intelligent. However, measuring intelligence is sometimes more complicated than a simple IQ test. For instance, you probably know some pretty smart people who have done some pretty stupid things. One of our colleagues, Dave Hingsburger, tells a story about a time when he was helping a client, using detailed and overly simplified instructions. Becoming frustrated, the client blurted out, "Geez, I'm retarded, Dave. I'm not stupid."

For this reason, we sometimes also need to look at levels of functioning in other areas. Recent literature in mental health is strongly suggestive that we always need to consider the whole person, by taking a comprehensive approach that considers all areas of the person's life, where lifestyle imbalance may cause difficulties. This same literature encourages us to remember that most problems are systemic in nature, meaning factors beyond the obvious ones are involved in determining how well an individual can function.

For information purposes, the table below presents the traditional way of classifying "mental retardation" according to IQ levels:

| Label | IQ levels |
|---|---|
| **Mild Mental Retardation**<br>About 85 percent of persons with intellectual disabilities fall into this group. | IQ level 50–55 up to approximately 70 |
| **Moderate Mental Retardation**<br>About 10 percent of persons with intellectual disabilities fall into this group. | IQ level 35–40 to 50–55 |
| **Severe Mental Retardation**<br>About 3 to 4 percent of persons with intellectual disabilities fall into this group. | IQ level 20–25 to 30–40 |
| **Profound Mental Retardation**<br>About 1 to 2 percent of persons with intellectual disabilities fall into this group. | IQ level below 20–25 |

*Traditional classification of intellectual disabilities according to IQ scores (APA, 2000)*

## Intellectual Disabilities and Behavioural Considerations

### Understanding Violence in Persons with Intellectual Disabilities

Individuals with **concurrent diagnoses** (e.g., diagnoses of both mental illness and intellectual disability) have complex needs and are difficult to service in the community. Sometimes, the frustration resulting from these difficulties

**Glossary**

**nature** In the nature versus nurture debate, factors that are related to biology and our physical make-up.

**nurture** In the nature versus nature debate, factors influenced by our environment and experience.

**functional** Pertaining to the ways in which a person's intrisic characteristics combine with experience to determine behaviour and perspective.

can spill over into aggression and violence. Severely aggressive clients who also have intellectual disabilities create unsafe and highly dysfunctional social and physical environments.

It is always important to assess the factors contributing to the physical acting-out behaviours—we need to determine the function of the behaviour, and to ask ourselves: What purpose is this behaviour serving? In this, we must consider:

- Illness
- Medications
- Environmental stimuli
- Social factors
- Access to meaningful activity (or, conversely, boredom)
- Co-morbid conditions (i.e., concurrent diagnoses)
- The individual's degree of control/decision making ability.

Generally, the causes of physical aggression are three-fold. Many of you have likely heard of the **nature** versus **nurture** argument. In most cases, we have found that a combination of the two factors can result in physical aggression. In this section, we outline some of the factors related to nature and to nurture. However, we also add into the mix "**functional**" factors. These are factors that dictate how a person's nature copes with certain environmental factors or how the environment will trigger certain aspects of a person's nature:

- Personal elements—characteristics that are often related to the person's physiological make-up
- Environmental factors—external elements that affect the individual
- Functional elements—factors that control interactions between the person's nature and the influence of the environment

| Personal Factors | Environmental Factors | Functional Factors |
|---|---|---|
| • physical condition<br>• mental health<br>• stress and/ or traumatic experiences<br>• use or abuse of mood-altering substances such as drugs and alcohol | • level of stimulation<br>• amount of interaction with others<br>• opportunities for choice<br>• availability of activities<br>• presence or absence of consistent routines | • coping skills<br>• the individual's desire for avoidance/escape<br>• the individual's desire for/access to attention/social interaction<br>• access to sensory input |

*Factors that may affect behaviour*

Essentially it is recognized that all behaviour has a communicative function.

## Understanding Behavioural Crises

The laws of behaviour suggest that the consequence of current behaviour will determine the course of future behaviour (Skinner, 1971). If a behaviour is followed by something positive, this increases the likelihood that it will

**Glossary**

**behavioural crisis** A situation in which a client's psychological, emotional, or physical distress is so heightened that the possibility of harm to self or others is inordinately increased.

re-occur. If it is followed by something neutral or negative, the likelihood of the behaviour occurring again will be decreased. Unfortunately, many people working with persons with intellectual disabilities fail to appreciate that simply giving in to avoid a scene or to quickly de-escalate a situation serves only to convey the message that inappropriate behaviour carries rewards for the client. Generally, it is better to attempt to teach a replacement skill that will achieve the same function, but with much less upset.

A **behavioural crisis** is an escalating episode of emotional upset involving anger, verbal threats, physical aggression, environmental aggression, and increased potential for self-harming behaviour. Behavioural crises can be either predictable or unpredictable. In general, we advocate that service providers pay attention to patterns of thought and behaviour that can assist in either avoiding situations known to be triggers or anticipating crises based on experiences in similar circumstances.

## Treatment and Intellectual Disability

Traditionally, persons with intellectual disabilities were placed in hospital-type settings and managed by nursing and medical staff. However, over the past several years, governments have sought to return persons with intellectual disabilities to community-based settings. This has led to a number of difficulties; particularly, where those clients have unique problems or clinical needs. One example might be clients with intellectual disabilities who are aggressive and engage in interpersonal violence. And, of course, there are always issues of funding and availability of services. Often, community members have not had the opportunity to learn about and understand the root causes of some of the inappropriate behaviour they may witness, and may not know how to respond.

> *While we would not necessarily want to "excuse" inappropriate behaviour in a person with an intellectual disability, it is important that we consider that the causes and manifestations of violence and aggression in special needs groups require a different approach.*

Our tendency to "let go" inappropriate behaviour by persons with intellectual disabilities may also require us to consider that some aggression can be reactive—it may come in response to issues in the client's environment, or as a consequence of difficulties in understanding his/her life circumstances.

### Community Management: Individuals Expressing Serious Aggression

Historically, community programs and staff have not been well equipped to manage individuals with severe behavioural problems (aggression toward self and others). This has resulted in many persons with disabilities being removed from the community and placed in institutional settings. Generally, resources for persons in such circumstances have been either entirely unavailable or too few to meet the level of need. There has also been a lack of appropriate staff training to safely manage individuals demonstrating severe aggression. Inappropriate staffing ratios and insufficient resources to safely manage an

**Glossary**

**Applied Behavioural Analysis (ABA)** The practice of examining a person's behaviour and the effect of that behaviour on both the person and his or her environment, in order to assess either the behaviour's utility or the need for changes in how to respond to the behaviour.

individual who is physically aggressive have led to frequent staff burnout, and long waitlists for the small number of facilities equipped to support these individuals—resulting in family burnout even before services can be obtained. Overall, this state of affairs has made it difficult to obtain and implement appropriate treatment and programming.

As a result of these barriers, police are sometimes called and individuals are hospitalized or, in the worst-case scenario, placed in traditional incarcerative settings (e.g., jail, prison, etc.). Placement in hospitals is difficult, as agencies are reluctant to support individuals with complex behavioural needs. Generally, management strategies and resources in hospital settings differ those in place in the community, the latter being where many governments want persons with intellectual disabilities to be. As for placement of persons with intellectual disabilities in jails or prisons, there are many social and moral factors that must be considered before such actions should take place. Traditionally, persons with intellectual disabilities have been abused in most of the institutional settings in which they have been housed. It is important to note that 80 to 90 percent of persons with disabilities are victims of some type of abuse at some point in their lives (Hingsburger, 1995).

## Behavioural Assessment and Applied Behavioural Analysis

**Applied Behavioural Analysis (ABA)** (see Baer, Wolf, & Risley, 1968 , Carr, Nicholson, Higbee, 2000, Cipani & Schock, 2007) dictates that we must examine an individual's interactions with the environments in which that individual exists. In ABA, overt behaviours are measured and events are translated into observable and objectively defined actions. Operationally, we need to understand what the behaviour looks like (its duration, frequency, intensity, etc.) before deciding how to best manage it. ABA also helps us to assess an individual's skill levels and provides a framework for acquiring new skills.

Crisis intervention planning and practice requires that we attend to issues of:

- environmental preventative planning,
- social-interactive considerations,
- behavioural management and treatment programming,
- crisis intervention training, and
- systemic/organizational consultation.

When putting together comprehensive programming for persons with intellectual disabilities and problems with aggression, it is important to integrate behavioural treatment and crisis intervention. On its own, behavioural treatment is often unsuccessful for those individuals who present a significant risk to others. Crisis intervention also does not fully attend to the need to teach new skills and modify violent behaviours. Therefore, integration is essential. Behavioural crises can be managed through programming that accounts for all elements of the situation, including the periodic need to physically intervene when all else is failing.

**Glossary**

**behavioural profile**
An outline of a client's behavioural tendencies.

In designing programming for persons with intellectual disabilities, it is important to recognize that this field is subject to considerable legislative direction. The Behaviour Programming Standards of the Ontario Ministry of Community and Social Services state that every individual is entitled to programming that incorporates:

- functional activity (i.e., things to do that are meaningful),
- regular access to attention (i.e., warm, positive regard),
- development and the reinforcement of alternative behaviours (i.e., assistance with making good decisions and choices for behaviour), and
- restraint/confinement according to strict guidelines (i.e., safety and preventive action).

Regarding the latter, the Canadian Charter of Rights and Freedoms, the Ontario Human Rights Code, the Ontario Mental Health Act, and the Ontario Developmental Services Act collectively note that individuals cannot be confined/restrained against their will except in situations in which their safety or the safety of others is at imminent risk. Such situations may include physical threats, self-harming behaviour, or overt acts of aggression towards staff or others. Furthermore, they can be restrained only until the period of potential harm is over.

In assessing the risk that a particular person with an intellectual disability poses for self- or other-directed harm, we must consider a variety of indicators:

- The client's behavioural repertoire and history of aggression
- The available aggression prevention protocols and interventions
- Injuries caused or sustained in prior events
- The number of staff required to manage the current situation
- The client's treatment history and any prior successes
- The generalization of treatment gains across environments
- The maintenance of treatment gains

Essentially, we must develop a **behavioural profile** but, first, we must determine the function of the behaviour in question. We must then turn our attention to developing a prevention plan, including an appreciation of the escalation continuum specific to the client.

A good behavioural profile will:

- identify early warning signs,
- attend to client learning styles,
- establish personalized teaching strategies for the client,
- identify opportunities for choice-making and power-sharing,
- convey the relationship between the client's style of communication and the corresponding violent episodes,
- establish personalized communication strategies with the client, and
- provide a framework for adjusting environmental factors, as required.

**Glossary**

**trigger** Person, place, thing, or situation that puts us at risk to engage in a behaviour we are trying to curb. For example, a person who is trying to quit smoking will be triggered by seeing another person smoking, or even by the smell of cigarette smoke.

The goal of a good behavioural program is to identify all antecedents to aggression and alter them, if possible, to reduce the likelihood of the client having another violent episode. In this, we need to both know and understand the typical antecedents/**triggers** and to develop appropriate de-escalation strategies for calming the client. Verbal de-escalation strategies should be attempted prior to any physical interventions.

However, there are times when physical interventions are required. For instance, behaviours that result in imminent or actual physical harm to the client or others need to be addressed quickly, but in the least intrusive manner possible. Legislation exists addressing how persons with disabilities may be physically restrained. Each client should have an individualized list of specific physical interventions that are approved use with that particular client during a behavioural crisis. It is important to remember that no intervention to manage physical aggression is without risk. Nonetheless, it is our responsibility as professional staff is to recognize and reduce the probability of harm , both to our clients and ourselves.

## Strategies for Avoiding the Development of Behaviour Problems

Problematic behaviours occur when an individual lacks understanding of a situation or because they do not possess certain skills because he/she has not learned them, or has difficulty in fully appreciating social and behavioural cues. Alternatively, an individual may have learned an inappropriate behaviour through inappropriate reinforcement of prior inappropriate behaviour.

Generally, the key to effective behaviour management lies in the reinforcement of making better choices. We want to change problematic behaviour because we want to decrease (and, ideally, eliminate) the potential for harm. For example, we want to decrease the number of times a client threatens to hit peers while increasing the frequency of alternative behaviours through encouragement and praise for engaging in pro-social behaviours/interactions with peers. As a side benefit, clients who are better able to manage their behaviours also gain greater social and personal freedoms—leading to increased quality of life. In the current literature on treatment for persons who sexually abuse, the focus has shifted away from treatments specific to sexual dysfunction and misbehaviour toward the development of balanced, self-determined lifestyles or "good lives."

## Persons with Disabilities Who Sexually Offend

In the following table, we address some of the important factors to consider when working with persons with intellectual disabilities who sexually offend. Specifically, there have been a number of misconceptions about this population. Here are some facts:

**Glossary**

**escalation continuum**
A graphical representation of a person's difficulty with a certain situation, from initial upset to eventual unmanageable consequences.

## PERSONS WITH INTELLECTUAL DISABILITIES WHO SEXUALLY OFFEND

Persons with intellectual disabilities who come into contact with the legal system have significant cognitive limitations and often experience 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

We also know that, on average, in comparison with the general population of persons who sexually offend, persons with intellectual disabilities who sexually offend:

- Have fewer victims
- Commit fewer "serious" sexual offences, but more minor or nuisance offences
- Have a smaller proportion of female victims (50 percent versus 89 percent among persons who sexually offend and do not have intellectual disabilities)
- Display significantly more social skills deficits
- Present as sexually naive, lack interpersonal skills, and have difficulties interacting with opposite sex
- Have higher incidence of family psychopathology
- Have higher incidence of psychiatric illnesses
- Have higher incidence of delinquent or other criminal behaviour
- Have a lower degree of specificity with respect to victim age, gender, and type of offense
- Are at greater risk to re-offend under certain circumstances.

## Escalation Continuum

In learning to manage violence and aggression in persons with special needs, we must understand the various stages an individual goes through when escalating a behaviour. This is known as an "**escalation continuum**," and we need to develop management strategies to address each stage in an individual's continuum. In particular, staff tasked with working with particular individuals known to be at risk must know when and how to intervene, at each level. Each escalation continuum is unique and requires a specific staff response for successful management. Sometimes it is also helpful to map out a client's responses to various stressors found in the home or other aspects of their daily experiences. We like to use a graphic tool called a "Stress Thermometer," because we find that our clients typically respond well to visual depictions.

Using the Stress Thermometer, we can make the process of identifying emotional triggers fun. Also, as workers, by identifying these stress-inducing factors, we can help clients to better manage their triggers and to avoid negative escalation (this, of course, requires a de-escalation plan for staff, which goes into effect the moment we identify an escalation continuum). Examples of a Stress

**Glossary**

**maladaptively** In an unhelpful, counter-productive manner.

Thermometer, Personalized Emotions Booklet, Guided Imagery and headings to use in an Individualized Escalation-De-escalation Cycle can be found in the Appendix.

A top priority in dealing with a client's escalation in risk for harm is developing an effective team. A good team must have the following components:

- A capable and well-respected team leader
- Trust in each other
- Confidence in the skill levels of the other team members
- Shared expectations
- An ability to engage in effective, client-centred communication
- An understanding that it is okay to request assistance
- An understanding that debriefing must occur following significant incidents

In conducting debriefings after incidents, it is often helpful to have a pre-set protocol for evaluating what happened, especially if there are internal or government policy documents that dictate what should happen in certain circumstances. Significant events can be very trying emotionally for both clients and staff, but they can also provide significant learning opportunities.

## Mental Health Issues

### Concurrent Diagnoses

It is common for persons with behavioural and other difficulties to have problems in more than one area. It seems that personal and lifestyle dysfunction is rarely confined to one particular issue. For example, we know that many persons with mental health difficulties also experience problems with drugs and alcohol, perhaps as a means to "self-medicate" or to **maladaptively** (inappropriately) manage the effects of their condition. Actually, the observation that persons with problems in one area often have problems in another is at the heart of recent trends in treatment programming pointing to the need to be comprehensive in attending to personal and lifestyle dysfunction.

The issue of concurrent diagnoses is also pertinent to persons with intellectual disabilities. Indeed, the total number of persons with intellectual disabilities who would be considered to have a concurrent diagnosis is as high as 70 percent (Campbell & Malone, 1991), although this figure is a source of some dispute in the field. These concomitant diagnoses may include Bi-Polar Affective Disorder, Depression, Borderline Personality Disorder, Obsessive-Compulsive Disorder, Attention Deficit/Hyperactivity Disorder, and Intermittent Explosive Disorder. Regarding sexually inappropriate behaviour, some of our clients with intellectual disabilities also suffer from Pedophilia, Voyeurism, Frotteurism, Exhibitionism, or other paraphilias as described in the DSM (APA, 2000).

### Suicide Protocol

Some of our clients may be suffering from depression or other mental health conditions and may have thoughts of hurting themselves.

**Glossary**

**parasuicidal** Behaviour that, on the surface, appears to be life-threatening, but that is really being used to achieve a secondary goal. For instance, cutting one's arm in a non-lethal way is a "cry for attention," not a true attempt at suicide.

*When our clients express thoughts of self-harming or suicidal behaviour, we need to take these statements seriously.*

Close and intensive observation is required in order to provide support and to prevent tragedy. Sometimes, it will be necessary to contact your local hospital or the client's family doctor to request additional aid in this area.

To reiterate, threats of self-harm or suicide should never be taken lightly, even when you believe that the threats are being made to achieve some secondary gain (i.e., "If you don't do ____, then I will cut myself/bang my head/etc." This is sometimes known as **parasuicidal** behaviour, which means that it looks like suicidal behaviour and may, indeed, include some very dangerous elements, but the goal is not actually death. Tragically, some persons engaging in parasuicidal behaviour for secondary gain end up causing themselves serious physical harm or, in some cases, killing themselves, even if that was not their original intent.

In order to manage threats of self-harm or suicide, it is important to set up a specific protocol with all involved with the care of the client, in advance. There should be a general list of phone numbers to use in all crisis situations, but it will also be important to include phone numbers that are relevant to specific clients.

## Early Warning Signs of Suicide

The following table may be helpful for staff to use when a client is acting differently from the client's usual behaviour (e.g., the client seems more lethargic and sad, or suddenly seems very happy when they have been sad for a period of time), is making threats of self-harm, or is otherwise indicating that something is not right.

If early warning signs are occurring, or the individual comes to you with a plan:

- keep the individual safe by addressing environmental factors (e.g., put knives and medications away), and
- link to mental health resources.

| Warning Signs | |
|---|---|
| **Feelings** | **Actions** |
| • Desperation<br>• Anger<br>• Guilt<br>• Worthlessness<br>• Loneliness<br>• Sadness<br>• Hopelessness<br>• Helplessness | • Giving away possessions<br>• Withdrawal from family, friends, school, work<br>• Loss of interest in hobbies<br>• Abuse of alcohol and/or drugs<br>• Reckless behaviour<br>• Extreme behaviour changes<br>• Impulsivity<br>• Self-mutilation |

| Physical Changes | Situational |
|---|---|
| • Lack of interest in appearance<br>• Change/loss in sex interest<br>• Disturbed sleep<br>• Change/loss of appetite and/or weight<br>• Physical health complaints | • Relationship problems<br>• Work problems<br>• Failing grades<br>• Trouble with the law<br>• Recent publicized suicide |
| **Thoughts** | **Behaviours** |
| • "I won't be needing these things anymore."<br>• "I can't do anything right."<br>• "I just can't keep my thoughts straight anymore."<br>• "I just can't take it anymore."<br>• "I wish I were dead."<br>• "Everyone would be better off without me."<br>• "All of my problems will end soon."<br>• "No one can do anything to help me now." | • Crying<br>• Emotional outbursts<br>• Drug and/or alcohol use<br>• Recklessness<br>• Fighting and/or law breaking<br>• Withdrawal<br>• Dropping out<br>• Putting affairs in order<br>• Prior suicidal behaviour |

*Things to look for when assessing risk for self-harm behaviour/suicide potential*

Mood charts can also be helpful in ensuring that all persons working with the individual have a full and consistent understanding of the issues the individual is presenting, in terms of mental health and personal safety. This information can then be brought to the psychiatrist or other mental health professional, to assist in determining if medication or specialized services are required. An example of a Daily Mood Chart is found in the Appendix.

## Mental Health Safety Plan

Mental Health Safety Plans can be completed with a client when there are suspicions that the client is considering self-harming behaviour or is experiencing other emotional upset. We suggest that caution be exercised when using this tool with a client. In particular, it will be important to be vigilant in monitoring the client in all situations, to observe any behavioural/emotional pattern changes. Let us note that this is a good example of where we are providing you with information that will be helpful in understanding what assessment and treatment professionals might do, but that you may not want to do yourself if you are a front-line worker. When client safety is at risk, it is always best to consult management staff or trained professionals.

A sample Mental Health Safety Plan is found in the Appendix.

# 3

# Sexual Deviance

**Glossary**

**offending behaviour**
Legalistically, the breaking of laws; however "offending" is a more complex term than it immediately seems. From a social sense, it can be any time one person engages in behaviour that is offensive to others.

**offensive behaviour**
Anything one does that causes others to be offended. This does not necessarily have to be something illegal.

In this chapter, we are going to cover a lot of material about sexual behaviour, specifically deviant sexual behaviour. One of the key messages we want you to get is that there is still a lot of controversy surrounding the question "What is sexual deviance?" It is also not known what causes some people to engage in this "deviant" behaviour while others do not. Some of the concepts in this chapter are highly theoretical. Please do not get the message that we are trying to claim that all of what we say is absolutely true. We are providing you with a range of perspectives, in the hopes that doing so might spur you to read further about the nature and consequences of this troubling class of human behaviour.

## What is Sexual Deviance?

In many respects, the answer to this question depends on the context in which it is asked. Who is asking the question also matters. Diagnosticians may have one idea about what sexual deviance is, but police officers or average citizens might have another. For example, many people believe that anyone who interacts sexually with a person under age 18 is a pedophile. Most sexual-offender professionals will want more information and may, indeed, consider some persons who sexually interact with some persons under age 18 to not be pedophiles.

Notwithstanding these potential differences in perspective, most of us can agree that sexual interaction between an adult and a prepubescent child is inappropriate, as is forcing a woman to engage in sexual intercourse against her will. However, there are many other circumstances in which the question of whether an action is appropriate or not is less clear. Indeed, one of the greatest hurdles to defining sexual deviance is a lack of clarity as to what actually constitutes offensive sexual behaviour. It is sometimes difficult to differentiate **offending** from **offensive behaviour**.

Consider the following example: Prior to 1983, it was impossible to rape your wife in Canada—at least according to the law. *"Rape," as defined in the law was forced sexual intercourse with a woman who was not your spouse. Interestingly,*

**Glossary**

**consent** Voluntary agreement or permission.

**informed consent** Consent or agreement that is given knowingly (with information), intelligently (with capacity), and freely (with no inducements).

*some research reports suggest that as many as 10 percent of women are sexually assaulted by their partner.*

In 1983, the Law Reform Commission of Canada released its findings on the crime of rape in Canadian laws and many laws were changed. Many of the former legal designations of sexual offenses were dropped in favour of broader classifications under the categories of Sexual Assault, Sexual Assault with a Weapon, and Aggravated Sexual Assault. Essentially, what happened was that the legal definitions went from being quite "exclusive" to rather "inclusive"; more actions against a greater variety of people became sexual crimes. In general, this has been a good thing; however, in some respects, we as a society are still having great difficulty in precisely defining what constitutes inappropriate sexual behaviour.

Consider the example of sexual harassment. What would be your working definition of sexual harassment? If you said, "It depends," you just made our point.

## Consent

A particularly important concept when looking at sexual offending is the question of **consent**. What constitutes consent? Most definitions suggest three main components to **informed consent**: it must be knowingly, intelligently, and freely given. This means that the person giving the consent must:

- have all the information they need in order to make the decision,
- have the intellectual ability to understand that information, and
- must be free of pressure, coercion, or other undue influence regarding the decision.

Another important question surrounds the matter of who can give informed consent. External factors certainly affect the first two points about information and intellectual ability noted above. Often, circumstantial elements—personal or situational variables such as an individual's age, or whether an individual has been consuming alcohol or other drugs—can impinge on consent. For instance, the age of consent for sexual activity in Canada is currently 16. From the late 1880s until very recently, however, it was 14. How does the age of consent in Canada match up to the age of consent in other jurisdictions? What about the United States?

A quick Web search will tell you that age of consent varies from country to country and even from jurisdiction to jurisdiction within a single country. Generally, most cultures or jurisdictions agree that prepubescent children cannot consent to sexual activity, but the same is not so clear when it comes to adolescents. The laws in some countries require sexual partners to be married, regardless of age.

Further complicating the question of informed consent, what if one or more of the persons who wish to engage in sexual activity is intellectually disabled or has some other condition that might affect their ability to knowingly, intelligently, or freely give consent to that sexual activity?

You can see how this becomes a tricky subject.

For persons with intellectual disabilities, access to "normal" sexuality has been difficult. We will cover the nature of some of these difficulties in a later chapter; however, it is important to state that persons with disabilities are entitled to have the same range of human experience as persons who do not experience such challenges. Nonetheless, as professionals and others who work with persons with intellectual and other disabilities, we must make sure that our clients make good choices and that they engage in that range of human experience safely and with consideration of the what effects their choices and actions have on others.

*Often there is an emphasis on teaching persons with intellectual disabilities about being able to consent to sexual activity; however, it is also necessary to teach the individual the need to be able to hear "NO" to sexual activity.*

Both giving and receiving consent are equally important. Persons receiving support need to learn the age of consent in their jurisdiction, what consent to sexual activity means, that consent is voluntary, and that even if you have given consent you can still change your mind and that changing your mind needs to be heard. The individual also needs to understand what does not constitute consent, such as:

- when a person is threatened or bullied into sex,
- when a person has been drugged or has had too much to drink, or
- when someone who is in a position of power or control (e.g., a staff member, a family member, or a medical professional) touches the person in their control in a sexually inappropriate manner.

The individual must also realize that, in turn, all of these concepts apply to the individual with whom they want to engage in sexual behaviour. Consent must be mutual. This is sometimes a very difficult concept for our clients to grasp. Should our clients experience difficulties regarding issues of consent, it would be best for them to have strategies that they can use to help themselves, and they may rely on us to help them learn these strategies. These might include telling someone they trust, going to the hospital or a doctor, or calling the police.

## Theories of Sexual Deviance

Not only has inconsistency affected our ability to clearly define what constitutes sexual deviance, it has also clouded our perceptions of cause and effect in sexual offending. When we try to understand the causes and effects of sexually deviant behaviour, we find theories that appear to be both complementary and contradictory at the same time! These contradictions sometimes make understanding the origins and expressions of the sexual interests and behaviour of our clients very difficult.

Is there a single unifying theory of sexual deviance that will ever be satisfactory to the field?

At this point, our answer would have to be, "Wow, that's a difficult question!" In the following section, we will outline some of the current thinking about the causes and effects regarding sexual deviance. However, please remember

**Glossary**

**theory** The end product of working through many hypotheses. The theory is the best available answer to explain the phenomenon, for which there are no other reasonable possibilities.

**hypothesis** A working model of observed phenomena that attempts to make sense of what you observe.

that these are **theories** and **hypotheses**. At present, nobody can claim to know exactly *how* persons who sexually offend become involved in that behaviour, or specifically *why* they engage in this damaging behaviour. Unless we explicitly say so, we do not specifically endorse any one particular theory of sexual deviance. Indeed, as with many other complicated questions, we have found the most success by gleaning different ideas and approaches from different models.

## Types of Sexual Offenders

Before discussing the various types of sexual offenses, it is important to note that there are a variety of methods currently used to distinguish among different categories of persons who engage in sexually offensive behaviour. First, there is the distinction between those who offend and for whom the choice of target is the problem (e.g., those who commit child sexual abuse) versus those for whom the activity is problematic (e.g., those who commit rape, voyeurism, or exhibitionism). Another distinction has been made between paraphilic activities (i.e., activities that are motivated by a deviant sexual interest or preference, and that may overshadow any other sexual activities or interests,—see below and APA, 2000) and what are often referred to as opportunistic activities . The offenses that opportunistic offenders commit are very similar to those that paraphilic offenders commit, both in terms of the types of offenses and in terms of the harm these offenses cause. However, it appears opportunistic offenders commit offenses for reasons that do not stem from paraphilic interests or preferences. For example, it is widely believed that only 20 to 25 percent of persons who sexually offend against girls within family contexts—the so-called "classical incest constellation"—are actually pedophilic (Freund, Watson, & Dickey, 1991; Langevin & Lang, 1988; Langevin & Watson, 1991). Similarly, many persons who sexually assault persons in dating situations do not necessarily meet the formal criteria for a diagnosis of paraphilic rape-proneness (sometimes referred to as Paraphilia Not Otherwise Specified—Nonconsenting Victims, or Paraphilic Coercive Disorder).

## Paraphilias

Human sexual behaviour is varied both within and between cultures. When this behaviour becomes extremely divergent from the norm, and especially when it is harmful to others, we attempt to identify and classify the different behaviour in order to understand it. One of the major systems of classification is the Diagnostic and Statistical Manual of Mental Disorders (colloquially referred to as the "DSM" (APA, 2000)). The Paraphilias are sexual disorders described in the DSM. They include sexual interests and actions that generally result in the kinds of behaviours that lead some men and a smaller number of women to become involved with the criminal justice system and to be labeled "sexual offenders."

It is important to note that not all paraphilias are necessarily illegal or particularly harmful. For instance, cross-dressing (Transvestism), shoe fetishes (Fetishism), or working as an exotic dancer (Exhibitionism) only become illegal when another law is broken in the process of sexual fulfillment. A shoe fetishist who steals women's shoes from shops may come into contact with the law, but

this contact will not be because of his paraphilic interest in shoes. It is entirely possible to have a shoe fetish and not steal shoes.

## DSM-IV-TR

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders, Text Revision* (DSM-IV-TR; APA, 2000) defines the paraphilias as recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving:

- nonhuman objects,
- the suffering or humiliation of oneself or one's partner, or
- children or other nonconsenting persons.

DSM-IV-TR also specifies that these fantasies, urges, or behaviours have to be at least six months in duration, and that they must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specialists have identified a great many behavioural patterns as indicative of paraphilic interests. Although the most commonly known of these are Pedophilia, Exhibitionism, and Sexual Sadism, over 40 types of paraphilias have been identified and defined (Money, 1986). However, only a small number of these are listed in DSM-IV-TR (partially illustrating the occasional divergence between the DSM and clinical practice). The remainder of the paraphilias less frequently encountered are subsumed under the diagnostic category "Paraphilia—Not Otherwise Specified." Several of the more commonly observed paraphilias are listed in the table below.

| Object of Sexual Preference | Activity Preference |
|---|---|
| **Pedophilia** (pre-pubescent children) | **Voyeurism** (peeping) |
| **Hebephilia** (early adolescents) | **Exhibitionism** (flashing or exposing) |
| **Fetishism** (inanimate objects) | **Frotteurism** (touching or rubbing against another in a crowded place—e.g., bus, subway car, elevator; sometimes also called *Toucheurism*) |
| **Zoophilia/Bestiality** (animals) | **Telephone Scatalogia** (obscene phone calls) |
| **Necrophilia** (dead bodies) | **Paraphilic Rape** (forced, non-consenting intercourse) |
| **Urophilia** (urine) | **Sexual Sadism** (inflicting pain/humiliation) |
| **Coprophilia** (feces) | **Sexual Masochism** (receiving pain/humiliation) |
| **Transvestism** (cross-dressing) | |

*Paraphilias by sexual interest or activity preference*

## DSM Discontent

Although the DSM-IV-TR diagnostic criteria for the paraphilias are widely used in the mental health and legal domains, many sexual-offender specialists have expressed difficulties with the definitions. The principal question surrounds the intent of the DSM-IV-TR criteria—do they describe finite conditions (sometimes referred to as *taxons*), or do they assist clinicians in grouping together similar symptoms? Simply put: Do the diagnostic criteria constitute a diagnosis in and of themselves, or are they intended to aid clinicians in categorizing and classifying behaviour to assist in the diagnostic process?

It is also important to note that different mental health disciplines use the DSM criteria in different ways. Psychiatrists and psychologists are most likely to use DSM criteria to describe client symptoms and behaviour, while social workers have much less use for diagnostic labels.

At present, mental health professionals from across the world are in the process of revising many of the diagnostic frameworks in the DSM, including the paraphilias, as they prepare to release DSM-V. Within the next few years, we will likely see changes made to the way in which we understand and diagnose expressions of deviant sexuality.

A hallmark of the paraphilias is that the unusual or bizarre imagery or acts are insistently and seemingly involuntarily repetitive. This results in the essential distinction between paraphilia and the nonpathological use of sexual fantasies, behaviours, or objects as stimuli for sexual excitement in individuals without a paraphilia (that is to say, many people have "odd" sexual fantasies or practices without necessarily being diagnosable as paraphilic). From puberty through adulthood, all people experience erotic fantasies and dreams, mostly of the non-paraphilic type. However, some fantasies, behaviours, or objects become paraphilic when they lead to clinically significant distress or impairment. For example, behaviours, objects, or fantasies may be paraphilic if they:

- become compulsive,
- result in sexual dysfunction,
- require the participation of nonconsenting individuals,
- lead to legal complications, or
- interfere with social relationships.

It is also important to note that many persons with paraphilias will engage in paraphilic activities even though they have opportunities for "normal" expressions of sexuality.

Since the 1980s, the field has seen a considerable increase in the amount of literature on sexual deviation; however, it remains difficult to give a comprehensive overview of deviant behaviour. Because we know that men display deviant sexual behaviour more often than women, the deviations presented here are ascribed to men, with the understanding that a small number of females engage in incest, pedophilia, exhibitionism, or other forms of sexual aggression.

**Glossary**

**social learning theory** A proposed explanation for the ways in which people interact with each other. At its most basic, this theory states that people will act in whatever way they perceive will enhance their own condition. However, sometimes these behavioural choices can be maladaptive.

**law of behaviour** A principle that states that those activities which bring pleasurable outcomes will be repeated while those that bring unpleasant outcomes will be not be repeated.

## Social Learning Theory

**Social learning theory** dictates that human behaviour is the product of a number of learning processes that occur mostly in childhood, but can continue throughout the life cycle, including modelling, observation, repeated exposure to a stimulus object, and intermittent reinforcement. Social learning theorists examining sexual behaviour believe that cognitive processes mediate environmental and experiential events, such that certain entrenched thought patterns become supportive of sexually offending behaviours. Essentially, this appears to be about developing habits and is strongly related to the **law of behaviour**.

Consider this example: You see a music video on television in which scantily clad women are submissive to the male singer, and seem to be willing to do whatever he wants. The video makes you sexually aroused, which is a pleasurable experience. Some people believe that the more you pair such images with sexual arousal, the more you may wish to experience for yourself a situation similar to the one that you have seen.

Similarly, the relative contributions pornographic materials might make to sexually deviant behaviour is an ongoing topic of discussion in the fields of sexuality and gender relations. This topic is especially relevant right now because of the vast increase in availability of pornographic materials on the Internet. Some offenders have claimed that their abuse of others was "fuelled" by pornography. At present, there is no conclusive evidence to suggest that persons engage in sexually abusive behaviour against others because of what they saw in pornography; however, from a social learning perspective, this argument might be worth consideration. The case may be that people with certain interests create material to stimulate those interests and that others with similar interests seek those materials out. In general, many people believe that such materials are just plain bad for the moral health of our society but, honestly, the jury is still out as to the true effects of such media on the individual or social fabric of our civilization.

## An Evolutionary Perspective

The famed evolutionist Charles Darwin proposed that the principles of sexual selection apply whenever individuals of one gender (usually males) compete for mating opportunities, or when individuals of one gender (usually females) choose mating partners. This perspective suggests that among many species males tend to prefer multiple partners and that females who have greater parental effort and investment, tend to be more discriminatory. Essentially, in order to ensure successful competition, males must be able to demonstrate genetic superiority and ability to provide resources.

Some researchers (Thornhill & Palmer, 2000) have questioned whether there is a genetic cause for a tendency to rape that is "naturally selected." Essentially, the human species may face a problem of supply and demand. As we noted above, males tend to be indiscriminant when it comes to choosing sexual partners, while females tend to be more discriminating. In a sense, this makes women "sexual gatekeepers." Those males who "force" their genetic code on nonconsenting females may further the propensity to engage in "rape-like"

behaviour. In simple terms, according to Thornhill and Palmer, some men rape because rape helps to spread their genes. Once the "rape genes" have been spread, their offspring may have a higher likelihood of being rapists.

The evolutionary perspective has provided much controversy in discussions regarding the causes and manifestations of sexual violence. Indeed, the key may be found in those last two words, "sexual" and "violence." Traditional feminist theory, such as that of Susan Brownmiller (author of *Against Our Will: Men, Women and Rape*, published in 1975), tells us that sexual assault is about power and control, rather than about arousal—that rape is not a sexual act but a violent one. A strict evolutionary approach would suggest that rape is all about mating effort and passing on one's genetic code—essentially, about sex and reproduction. Most sexual offender specialists would likely suggest that rape is a complex act that contains elements of both violence and sexuality..

## Sex and Perversion

Freud suggested that it is "normal" to be interested in, or aroused by, something that has a sexual element to it. He characterized perversions as sexual activities or interests that extend beyond simple intercourse. From a Freudian perspective, therefore, many people engage in acts that could be labeled "perverse," but that would not necessarily constitute perversion in our current conceptualization of sexuality. Many people have observed that many adults include kinky elements in their sex lives; for example, there is a considerable market for handcuffs, riding crops, and other paraphernalia associated with what we colloquially refer to as S&M. Most of the people buying such "sex toys" are unlikely to be truly sadistic or masochistic; rather, they use such products to "spice up" their sexual experiences.

Indeed, many specialists working with persons who sexually offend have noted that most men harbour some tendency toward mild expressions of "deviant" behaviour patterns. These activities could be labeled as exhibitionism, aggressive sexuality, and voyeurism if we were sticklers for detail but, in reality, we are likely talking about behaviour and interests that are more fleeting than preferential.

Noted researcher Neil Malamuth (1981) conducted a study that suggested that an alarming percentage of male college students would commit a "rape" if there were no negative consequences, or that they had already done so. Other research (Corne, Briere, & Esses, 1992) has suggested that a significant percentage of women have fantasies of being taken by force.

If you find these statistics alarming, you are not alone. We suspect that some of the explanation for these troubling statistics relates to how the questions were asked. If you told a young heterosexual man that he could have sex with any woman he chose and that he would not have to ask for permission, he would probably jump at the chance. Similarly, if you asked a heterosexual woman if she would like to be ravished on the beach by some breathtakingly handsome fellow, she would likely give the fantasy some consideration. Early exposure to pornography, moreover, seems to influence answers in both cases.

However, these consequence-free scenarios involving imaginary (very attractive) people are not the realities of sexual abuse. The realities of sexual abuse are lack of consent and an individual being forced to do things they would

**Glossary**

**phallometric test** A test to measure male sexual arousal. An apparatus is placed on the subject's penis, and the subject is presented with audiovisual stimuli (pictures, videos, audiotaped scenarios). The apparatus measures changes in either volume or circumference.

**electroencephalography (EEG)** A brain imaging technique that measures electrical signals in the brain. It involves placing electrodes at various points on the scalp.

**endocrine function** The system of glands that is concerned with hormones. In male sexuality, the principal hormone involved is testosterone.

**neuroanatomy** The physical structure of the brain.

**preference** A markedly greater sexual interest in one type of sexual person, object or activity. For instance, someone who prefers children is someone who would rather engage in sexual activities with children.

not otherwise do. Sexual abuse is about self-gratification regardless of whether it causes harm to another person. Sexual abuse is, indeed, about really causing harm—often irreparable harm—to another person. It is not consequence-free or breathtakingly handsome. Nonetheless, context clearly plays an important role in determining what is and what is not sexually inappropriate.

## Neurophysiology and Neuropsychology

Researchers at the Centre for Addiction and Mental Health in Toronto (see Cantor, Blanchard, et al., 2004) have found that "neurodevelopmental perturbations" (prenatal or childhood brain injury) may increase an individual's risk for pedophilia and other conditions, including lower IQ and a greater incidence of being left-handed or ambidextrous. Cantor (2008) has shown that there are differences in structural aspects of the brains of men found to be pedophilic on the **phallometric test** (explained on page 28). In addition, Langevin (1993) noted that the brains of pedophiles and those of non-pedophilic control subjects are quite different, in regard to **electroencephalography (EEG)**, **endocrine function** (hormones), and **neuroanatomy** (brain structures). What these findings ultimately mean for regular folks who work with people who experience sexual deviance is not yet clear, but research of this sort helps us to better understand the potential causes of sexually deviant behaviour. Better understanding will ultimately assist us in devising better treatment options.

## Sexual Preference

In discussing sexual deviance, a natural companion to the medical model is the sexual preference model. Here, a distinction is made between **preference** and behaviour. In this distinction, preference is considered static (e.g., a leopard cannot change its spots), while behaviour is dynamic (e.g., a leopard can put on a different coat). The sexual preference model asks us to consider whether or not the person's behaviour represents paraphilic interest or opportunism. Remember that the DSM-IV-TR says that paraphilias are disorders that include "recurrent, intense sexually arousing fantasies, sexual urges, or behaviours of at least six months duration, and causing of some sort of psycho-social stress."

As we suggested above, most specialists working with persons who sexually offend concede that many (or most) persons who sexually offend are not paraphilic. Most appear to do so for reasons other than intense sexual interest or preference for the behaviour in which they engage. Thus, we sometimes need to look more closely at the underlying causes for the behaviour. Although a paraphilic and a nonparaphilic expression might result in exactly the same behaviour, the nature of the offender's interests might be quite different.

Let's take the example of date rape. Sadly, many people know of a situation in which a man has violently and insensitively forced a woman to engage in sexual behaviour against her will. That man, however, is not a paraphilic rapist. He may be antisocial; he may be a jerk; he may have little regard for women; but he might not be a paraphilic rapist. The key question in determining whether the man is a paraphilic rapist would be: "If she consented, would you have been equally satisfied?" The paraphilic guy would not want the woman to consent.

**Glossary**

**meta-analysis** A "study of studies." This statistical procedure allows us to compile data from individual studies of a phenomena into one larger study that is more representative of the population-at-large.

**counterfeit deviance** A hypothesis that suggests that some deviant behaviour in persons with intellectual disability is the result of dysfunctional attempts at sexual behaviour and not the result of paraphilic interests.

The opportunistic "jerk" has forced his desire on the woman, and does not appear to care about consent; he does not necessarily require a lack of consent in order to be sufficiently aroused or sexually stimulated.

Similarly, let's look at father-daughter incest. In many cases of father-daughter incest, the father engages in sexual behaviour with his daughter out of convenience or because of really inappropriate boundaries. However, the father does not have a true sexual interest in or preference for children. Indeed, it has been shown that many men in these situations cognitively distort the daughter's age and role to be that of an age-appropriate partner (like a kind of "replacement" for her mother, in family dynamics where there are sexual and other relationship problems between the parents).

Let's be clear: we are not saying that persons with paraphilic interests never appear among those who commit date rapes or incest offenses. Rather, we are saying that the statistics show that persons who commit date rape and incest are less likely to experience paraphilias than persons who assault or abuse strangers or non-family members.

## Phallometric Testing

In the sexual preference model, diagnosis of paraphilic preferences is often facilitated by the use of phallometric testing. Developed in the 1940s and 1950s by Czech psychiatrist Kurt Freund (1963), the phallometric test monitors changes in the shape of the subject's penis while the subject is given sexually arousing stimuli, in order to measure sexual arousal in males. Essentially, the male subject receives audio-visual stimuli, and his penile circumference (or volume) is measured. A higher relative response to an unacceptable category of stimuli, over responses to acceptable ones, would be indicative of paraphilic preference. By extension, we should be able to assume that a deviant sexual preference is highly correlated with a risk of engaging in behaviour related to that preference; however, this notion has been contested. Most importantly, the phallometric test is not a measure of guilt or innocence; it merely tells us what type of stimuli causes a man to be sexually aroused.

Dr. Karl Hanson of Public Safety Canada has done a lot of research into the factors related to sexual re-offending. In his two **meta-analyses**, he found that possession of deviant sexual interests, as measured by phallometric testing, was the single greatest predictor of sexual recidivism (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005).

## Counterfeit Deviance

Hingsburger, Griffiths, and Quinsey (1991), coined the term **counterfeit deviance** to describe a phenomenon observed in persons with intellectual disabilities. In some cases, the behaviour of persons with intellectual disabilities looks deviant; however, when all of the circumstances are considered, the behaviour turns out to be less deviant. Although this appears to make sense (and, thus, resonates with many practitioners), researchers have generally had difficulty empirically proving that counterfeit deviance exists. We will address this concept in greater detail in the next chapter when we talk about measures of sexual interest and preference.

In the table below, provided by Dr. Gerry Blasingame, we present preliminary data from sexual preference testing (the Abel-Blasingame protocol for intellectually disabled clients) completed on persons with intellectual disabilities who had engaged in sexual offending. What we see is that persons with intellectual disabilities often admit to a lot of sexually deviant activity over and above what is officially known to therapists. In many respects, this argues against the counterfeit deviance theory.

| Preliminary ABID Data | | | |
|---|---|---|---|
| | Therapist only | Therapist + Self-report | Increase |
| Public exposure | 89 | 108 | 21% |
| Public masturbation | 50 | 64 | 28% |
| Fetishism | 33 | 88 | 167% |
| Frottage | 31 | 51 | 65% |
| Voyeurism | 31 | 91 | 194% |
| Bestiality | 17 | 25 | 47% |
| Obscene calls | 29 | 47 | 62% |
| Masochism | 22 | 32 | 45% |
| Coprophilia | 8 | 17 | 113% |
| Child sexual abuse | 260 | 269 | 3% |
| Rape | 55 | 76 | 38% |
| Sadism | 24 | 36 | 50% |
| Transvestism | 21 | 33 | 57% |
| Phone sex | 26 | 61 | 135% |
| Pornography | 92 | 195 | 112% |
| Transsexualism | 9 | 31 | 244% |
| **Total (N = 350 males)** | **797** | **1224** | **54%** |

*Reporting of sexually deviant activity among persons with intellectual disabilities*

## Emotional Congruence

Of some importance in understanding some sexual interactions between persons with intellectual disabilities and children is Finkelhor's concept of "emotional congruence" (see Wilson, 1999). In his four-factor theory of pedophilia, Finkelhor (1984) postulated that four conditions would have to exist for a diagnosis of Pedophilia to apply:

- Sexual arousal
- Blockage
- Disinhibition
- Emotional congruence

**Glossary**

**emotional congruence** The tendency expressed by some persons who sexually abuse children to over-identify with the child role through their behaviour, views about children, or other choices in life.

**Courtship Disorder** A hypothesis that suggests that humans mirror animals in the various phases of courtship—partner location, getting attention, pre-coital tactile interaction, and sexual intercourse—and that these phases map onto the various paraphilias.

**Emotional congruence** is described as an over-identification with childhood or with the child role (Finkelhor, 1984; Wilson, 1999). It has been observed by some to be a strong diagnostic indicator of pedophilic interests. However, an over-identification with childhood or with a child's role is often difficult to differentially diagnose in persons with intellectual disabilities. This is because many people misunderstand what we mean when we describe persons with intellectual disabilities as having the "mind of a 10-year-old." We do not mean that the person is 10 years old, or that they are a 10-year-old in their interests or other elements of their development. What we really mean is that the person with the intellectual disability has cognitive capacities (e.g., problem solving, coping skills, social skills, etc.) similar to those of a 10-year-old child. Nonetheless, persons with intellectual disabilities are often treated like children and are also frequently left to engage socially with children. Unfortunately, for those persons with intellectual disabilities who are unable to understand the dynamics of adult-child sexual behaviour, this sometimes leads to inappropriate sexual exploration or outright sexual offending.

## Co-occurrence of Paraphilias

American sexologist Dr. Gene Abel (Abel et al., 1988) showed that wherever one paraphilia is found, it is likely that another will also be found. Other researchers have also tried to map the co-occurrences of many different paraphilia types. In this regard, the presence of a relatively benign paraphilia such as fetishism has been correlated with both exhibitionism and sexual sadism. The most prevalent grouping of paraphilias appears to occur within what has been referred to by Freund as **Courtship Disorder** (Freund & Watson, 1990). In this grouping, voyeurism, exhibitionism, frotteurism, and paraphilic rape are found to co-occur more often with one another than with other paraphilias. Wilson and Barrett (1997), taking Abel's finding one step further, noted that wherever you find one paraphilia, it is likely that the next paraphilia you find will be exhibitionism. The courtship disorder hypothesis is discussed in greater detail below.

Furthermore, with respect to co-occurrences, some sexual sadists employ rape as a means of inflicting fear and terror. Many persons who rape also have a history of exhibitionism, voyeurism, or frotteurism. One of the important aspects of exhibitionism, voyeurism, and frotteurism is that these actions may be the first steps in a progressive deterioration into more dangerous sexual offenses. In looking at the ABID data reported above, it would appear that there are many instances of cross-over offending in persons with intellectual disabilities, with the average person included in the table having engaged in three or more types of inappropriate conduct. Overall, it appears safe to say that it is unusual for persons to express only one type of inappropriate sexual activity, whether those persons are intellectually disabled or not.

## The Courtship Disorder Hypothesis

In sociobiological models, sexual aggression in the human male is seen as a mating behaviour. In many species, courtship involves behaviour designed to locate and attract a female, prepare her for mating by ensuring her exclusive

accessibility to the male, and finally to successfully copulate with the female. A common thread throughout the biological models is the suggestion that men's sexual attraction to women is instinctual and of genetic origins, and that such strong attraction provides the motivation for mating behaviour, ensuring the survival of the species.

Central among the sociobiological theories, evolutionary theory has been used to explain rape based on observations of forced intercourse in non-human species. There are two main evolutionary hypotheses about rape. First, the mate-deprivation hypothesis suggests that rape is a strategy used by unattractive, low-status, or poor men who are at a competitive disadvantage for attracting desirable mates. The second evolutionary hypothesis is that rape is simply a byproduct of persistent mating efforts even in the face of resistance offered by the female.

While evolutionary theory has viewed rape as a potentially successful strategy for mating by some men in some circumstances, other sociobiological theories have viewed rape as a distortion of the natural process of courtship and mating. A leading sexologist until his death in 1996, Dr. Kurt Freund referred to these as "courtship disorders." Freund described four stages of courtship in the human male:

1. The partner-location phase, in which the male locates a suitable partner;
2. The pre-tactile phase, wherein the male engages in interactions in which he looks, smiles, postures, talks with, and otherwise attempts to engage the female's attention in an attempt to attract her to him;
3. The tactile phase, in which the courting male touches, caresses, fondles, and kisses the female, preparing her for genital contact;
4. Genital union, in which the successful suitor engages in vaginal intercourse with the female.

Presumably, with the successful completion of phases one to three, the female will acquiesce (consent) to sexual intercourse in the fourth phase of courtship.

According to Freund, when any of these four phases of courtship becomes extremely intensified or distorted, the result is a Courtship Disorder. In the case of the distortion of the partner-location phase, the resulting disorder of courtship is voyeurism. Distortion of the pre-tactile phase is exhibitionism. Toucheurism or frotteurism would be the resulting courtship disorder of the tactile interaction phase. According to Freund, rape occurs as a disorder of the fourth phase of courtship, in which the male attempts genital union without appropriate preparation of the female and without securing her submission or participation, which would normally be achieved through the earlier phases of courtship.

For a moment, let us discuss courtship and persons with intellectual disabilities. For the most part, our clients are unlikely to experience the full range of courtship (or dating) opportunities enjoyed by persons without such disabilities. This is because of a variety of reasons, some of which are covered in the next chapter regarding healthy sexuality and sexual expression. Without going too far into that discussion here, it is important to note that factors that are client-based, other-based (e.g., owing to family, support persons, or the

community), and system-based (e.g., government policy or agency restrictions) conspire to limit the access of persons with intellectual disabilities to dating opportunities. All of these factors can potentially affect how our clients with intellectual disabilities meet their sexual needs. Sometimes, sexual expressions in persons with intellectual disabilities are deviant or paraphilic, and there is no reason to believe that courtship-disordered behaviour is not also found in our client group.

## Inconsistency Revisited

A common thread throughout this chapter has been "inconsistency." We have highlighted a number of different positions regarding the origins and manifestations of sexually offensive behaviour. Clearly, no one theory fits well enough to be descriptive of even a large percentage of offenders.

To recap:

- Overall, the DSM-IV-TR remains a controversial diagnostic framework when we consider the paraphilias. Sometimes, the diagnostic criteria appear to be at odds with some of what we know from the research literature. We also know that the DSM can be a very political document. Consider that homosexuality was only removed from the DSM in the 1970s, in spite of pre-existing research suggesting that this was not a mental disorder. Currently, there is great debate as to whether sexual addiction (Hypersexual Disorder) should be added to the DSM. Similarly, the field is polarized as to how to deal with the frequently used Paraphilia NOS diagnosis used to describe what others might refer to as rape or hebephilia (i.e., suggested for DSM-V as Paraphilic Coercive Disorder and Pedohebephilic Disorder, respectively).
- There is no general psychiatric profile for persons who sexually offend, that is, most persons who sexually offend are not "mentally ill." However, there do appear to be some group differences between certain categories of offenders and non-offenders, especially in regard to neuroanatomy and brain function. However, while the neuro-physiological and neuro-psychological findings may be interesting, they can be inconsistent and are not at the level where they could be used for individual diagnosis.
- The research literature is equivocal regarding the influence of media and other social influences. Specifically, there is no scientifically rigourous evidence to suggest that viewing child pornography or violent pornography will cause people to act in a similar manner, although most people who do view child pornography show sexual arousal to related stimuli during phallometric testing. Overall, the prevailing perspective on the effects of pornography on persons who view it and also engage in sexual offending is that most people in the market for these materials are persons who are already interested in such images.
- When we look at the evolutionary model, we find some promise for understanding some types of sexual violence, but this model does not easily explain child molestation, especially of boys. Generally, many people find the idea that sexually inappropriate behaviour may somehow be an outcome of natural selection to be uncomfortable (or even abhorrent) to consider.

**Glossary**

**incest** In a legalistic definition, sexual activity between relatives too close to marry. In sexological research, we have often extended this to include other persons in quasi-parental roles (e.g., a mother's boyfriend, a long-time babysitter, etc.).

- Regarding whether sexual offenses are about sex or violence, most researchers now appreciate the key role of sexuality in sexual abuse. We understand that power, control and sex play a role in sexually inappropriate behaviour. While we all clearly see the violence in sexual offending, we also know that the motivation for the offense(s) often has a sexual component.

## Characteristics of Persons Who Sexually Offend and of Their Crimes

In the sections above, we reviewed many different theories of sexual deviance and means by which to classify them. In this next section, we would like to describe some of the characteristics of persons who engage in these behaviours. As before, we would like to remind you that human behaviour is often very difficult to either describe or categorize, due to variations in how people behave.

### Child Molestation

*In attempting to determine an offender's risk for re-offense, it may be of critical importance that we be able to differentiate one type of child sexual abuser from another, particularly when issues of diagnosis, risk for recidivism, and treatment prognosis are considered.*

As discussed above, there are two categories of individuals who molest children. Some of those who sexually abuse children may do so out of preference for children as sexual objects while others may sexually abuse children due to more opportunistic reasons, as discussed below. Individuals who fall into the first group are considered pedophilic (having a sexual preference for children) while the latter are considered opportunistic (engaging in the same behaviour, but without the attendant sexual preference). Many of these persons who offend in opportunistic ways do so within the confines of family relationships, an offense sometimes referred to as **incest**.

As adults, persons engaging in incestuous offenses usually have poorly functioning marriages with a low level of sexual satisfaction with their spouses. Unlike pedophilic persons, however, their main sexual orientation is to female adults. Their victims are substitutes or surrogates. Often, the child victim comes to assume the wife's role in meeting the offender's sexual and emotional needs.

*In this regard, the typical person engaging in incestuous offenses differs from his pedophilic counterpart, in that he cognitively distorts the age of his victim so that he believes she is an age-appropriate sexual partner (essentially, the opposite of emotional congruence; see Wilson, 1999). Persons with pedophilic interests, on the other hand, are sexually attracted to children and do not distort the age of their victims.*

#### Characteristics of Pedophiles

***Pedophiles:***

- Are higher-risk child sexual abusers
- Have a preference for, or strong interest in, sexual activities with children

- Are most likely to target boys
- Are often kind to and indulgent of victims; overt violence is rare
- "Groom" their victims
- Target "needy" or vulnerable children
- May have experienced their own childhood trauma, and this may be a factor contributing to their deviant sexuality (however, the research on this point is still unclear)

Unlike rapes, instances of child sexual abuse are not necessarily precipitated by casual stressors. However, in a fashion similar to rapists, persons with pedophilic interests often deny or minimize their offenses, trying to justify the deviant behaviour and blame the victim. Many persons suffering from pedophilia are found to be shy, passive men who are lonely, immature, and often socially isolated. These men seem to relate more comfortably to children than to adults. Indeed, they appear to have an exaggerated identification with childhood and the role of the child. As we noted above, this has been labeled "emotional congruence" by Finkelhor (1984; see also Wilson, 1999), and is representative of (mainly homosexual) pedophiles' inability to establish relationships with adults.

Pedophiles often appear to genuinely care for their victims, but after the assault they usually fail to admit to, or accept, responsibility for having caused the victim any harm. Molestations are usually premeditated, often with a great deal of advance planning and lead-in time—often referred to as "grooming." For example, a man may become close to a single woman with a small child, or a middle-aged man may take a friend's child on casual outings. Both of these situations give the offender ample opportunity to molest. Recent media reports have focused much attention on the propriety of adult-child relationships, in particular, as they pertain to what kinds of behaviours are reasonable (e.g., sharing one's bed with a child). Some believe that grooming may not always occur in a devious way. Rather, it may be that an emotionally congruent pedophile is truly at ease around children, and that their adult sexual needs are inappropriately directed to children due to a lack of suitable adult companionship.

Pedophilia is seen by many to be a compulsive sexual orientation that can begin in teenage years or younger (Freund & Kuban, 1993). Many reports surface regarding teenaged male baby-sitters abusing children in their care. Indeed, it has frequently been said that the largest age-cohort of persons sexually offending against children is that of 14- to15-year-old boys. Persons with pedophilic interests may manifest their deviant interests in a number of ways, including emotional seduction, photographing or otherwise exploiting children, child prostitution, and child rape. In addition, they may commit long- and short-term molestation of anywhere from a few to several hundred children in a lifetime.

In our practice, we have seen many persons with intellectual disabilities who also have paraphilic interests in children. Sometimes those interests are not immediately apparent—they may be masked by other problematic behaviour or interests. For example, there appears to be an over-representation of interest in diapers in persons with intellectual disabilities with sexual behaviour problems

**Glossary**

**proxy** Something that acts as a "stand in" for something else. In this case, we are referring to sexual interest in diapers as being indicative of sexual interest in children. Diapers are the proxy for children.

(Wilson, Burns, Tough, Nethercott, Outhwaite, & Figliola, 2007). Often, the interest in diapers is a **proxy** for sexual interest in children. The same can sometimes be said of the inordinate interest shown by some clients in stuffed toys or other items that are suggestive of emotional congruence (as we discussed earlier in this chapter).

Pedophilic offenders usually *prefer* children of a specific gender and age group, for example, males 6 to 10 years old or females 9 to 11 years old. In actuality, however, victims can be of any age and from either gender. We know that a staggering number of sexual offenses are made against children. On any given day, a city newspaper will carry reports of several molestations, trials, or convictions. However, most cases of "extrafamilial" molestation are not reported. Remember that, generally speaking, as many as 90 percent of offenses are never reported to anyone in a position to offer assistance to the victim. Of those offenses reported, only a small percentage result in formal charges or in the incarceration of the person committing the offense.

Because of the superficial similarity of their sexual behaviour, we tend to group pedophiles with incest offenders. However, there are different dynamics in the two groups that may necessitate separate treatment aspects. It is generally accepted that persons with pedophilic interests are more difficult to treat than persons who engage in non-paraphilic incest offenses. This is thought to be a result of the pervasive, paraphilic aspect of these individuals' sexual interest in children, as opposed to many incest-type offenders who have developed inappropriate sexual outlets for other reasons.

### Incestuous and opportunistic offenders

***Opportunistic Offenders:***

- Are generally of lower risk
- Likely offend for reasons other than paraphilia
- Are not preferentially sexually interested in children
- Often offend in family or "friendly" contexts
- Are likely to target girls
- Often distort the child's role or age as being age-appropriate (i.e., a "spousal surrogate")

Incest has traditionally been defined by the legal community as sexual contact among family members related by blood, with some exceptions (e.g., adoption). In the sexual offender research literature, however, the definition of incest has been expanded to include those offenses in which a person in a position of quasi-parental authority (e.g., stepfather, grandfather, or even an older brother) offends against a child. Incest is believed to be a widespread problem that includes inappropriate sexual talk, exhibitionism, fondling, digital or penile penetration, oral-genital contact, and sodomy, among many varieties of inappropriate sexual activities. Molestation may occur only once, although this is uncommon. More frequently, it occurs over a period of years, beginning with behaviours that, on the surface, appear innocuous, but when put in context are only preliminary to the eventual overt acts of abuse. It is not uncommon for

incest offenders to offend against a number of children, primarily girls, within the same family unit, or over more than one generation.

There is definitely controversy as to whether or not incest offenders should be labeled pedophilic. According to a strict interpretation of the DSM-IV-TR criteria, any man who sexually interacts with a child for more than six months, or with more than one child where the total amount of time exceeds six months, would be considered pedophilic. However, others in the community of sexual-offense researchers would suggest that pedophilia is not just about behaviour, but also about preference. Engaging in a behaviour without necessarily having the attendant preference makes diagnosis more problematic. Some practitioners have attempted to address this by making a distinction between those who are exclusive pedophiles and those who are *non-exclusive*. The latter may be those persons who commit child sexual abuse and who are more opportunistic in nature.

***Characteristics of Incestuous Behaviour***

The most common form of incestuous behaviour is sexual contact between a father and daughter or a stepfather and stepdaughter. Incest is also committed by grandfathers, uncles, older brothers, and common-law spouses or partners. The majority of offenders are fathers and the majority of victims are daughters. As noted above, incestuous behaviour is strongly affected by the family situation. Dysfunctional marital relationships, substance abuse, sexual problems, social isolation, and other stressors may contribute to a situation in which incest can happen. Incest occurs because of combined individual and family processes, and the following patterns are common in families in which incest occurs:

- Higher rates of all forms of abuse, both physical and sexual, are present.
- The child victim often assumes excessive care-taking responsibilities.
- The father and mother abuse alcohol and other drugs.
- Larger percentages of separations and divorces occur among parents.
- Parents are estranged and were unable to cope with the demands of their roles and/or to satisfy each others' needs.

Research findings vary, but fathers engaging in incestuous behaviour are often found to be passive, dependent, isolated, suspicious, and lacking a core of masculine identity. Many of these characteristics are also found in men with paraphilic interests in children. Fathers engaging in incestuous behaviour may also have low impulse control, low frustration-tolerance, and a need for immediate gratification. They may have been mistreated as children, although the abuse was more likely physical than sexual. It has been hypothesized that much of their adult behaviour is based on displaced anger and on an identification with the person who abused them. Abused or not, a significant number of men engaging in incestuous behaviour report a cold, rejecting, and uncaring relationship with their own fathers.

The family dynamics of families in which incestuous behaviour occurs have been described as entangled, collusive, and accommodating. Some authorities have portrayed the wife as a *silent partner* in the circle of events, in which she

**Glossary**

**fixated** Obsessed with. In Groth's typology, "fixated pedophile" describes a pedophile whose principal interest was in children, and whose emotional state was fixated at an earlier developmental period. This is somewhat similar to emotional congruence.

**regressed** Literally, "to move backwards." In the context of paraphilias, a regressed pedophile prefers the sexual company of adults, but, under situations of stress or other blockage, will move his or her interest to sexual contact with children.

unconsciously or even consciously encourages the molestation. However, this situation is likely the exception, as the greater majority of wives and mothers are not aware of and do not consciously condone or contribute to the sexual assaults. Remember what we said above: Sexual abuse is the most maddening of dysfunctional interpersonal circumstances—the victim does not want you to know, the offender does not want you to know, and the majority of others would just as soon not talk about it.

*Occurrence of Incest*

Incest often begins with fondling of the oldest female child when the child is younger than five years. If the victim does not say anything, it is usually because she does not understand the nature of the situation or feels she will be disbelieved, blamed, or otherwise held responsible for the inevitable family disruption—most often because that is exactly what her abuser told her would happen. If this behaviour is not stopped by the mother or people outside the family, it often continues until intercourse occurs with the child when she is around the age of puberty. The victim may tell someone (usually outside the family) when she is a young adolescent and fears getting pregnant or is rebelling against her father's social restrictions. As is the case with most persons who sexually offend, fathers engaging in incestuous behaviour frequently deny or minimize their offenses.

## Typologies of Child Sexual Abusers

There have been numerous attempts made to develop typological systems that can accurately classify subtypes of persons who sexually offend against children. The two most often cited in the literature are those by Nick Groth (1978) and by Bob Prentky and Ray Knight of the Massachusetts Treatment Center (MTC-1990).

### The "Fixated" versus "Regressed" Typology

Groth (1978) presented a typology of persons who sexually assault children, which categorizes them as either "**fixated**" or "**regressed**" pedophiles. This typology is similar to others, except for some of the terminology. The DSM-IV-TR (APA, 2000) notes that the essential feature of pedophilia is "recurrent, intense, sexual urges and sexually arousing fantasies, of at least six months' duration, involving sexual activity with a prepubescent child." By this definition, a number of Groth's regressed pedophiles would not satisfy the DSM-IV-TR criteria for pedophilia as far as the "six months' duration" clause is concerned (see also Kingston, Firestone, Moulden, & Bradford, 2007; Wilson, Abracen, Looman, Picheca, & Ferguson, 2010). As such, many researchers (e.g., Krafft-Ebing, 1886/1950; Freund, Watson, & Dickey, 1991) have chosen to refer to these men as opportunistic child sexual abusers, rather than as pedophiles. Regardless of this distinction, Groth's typology is useful in many respects, and is explained in more detail below, with additions from other sources.

*Fixated Pedophiles*

Fixated pedophiles are persons who remain fixed at a pre-adolescent level of sexual interest and who fail to find comfort or confidence in sexual relationships with partners beyond puberty. Groth believes that fixated pedophiles become

so as a result of some trauma earlier in life, for example, pre-adolescent sexual abuse (see also Gebhard, Gagnon, Pomeroy, & Christenson, 1965). Most fixated pedophiles, according to Groth, are homosexual; however, a small minority may be heterosexual.

Groth described fixated pedophiles as being mostly kind to, and indulgent of, their victims, and as rarely resorting to any sort of overt or serious physical violence. Similarly, Schlesinger (1982) noted that, because adults have natural authority over children, force is rarely necessary in interactions between a fixated pedophile and a child victim. Fixated pedophiles may spend years developing affectionate and trusting relationships with the child and the child's parents, and are likely to have been previously unknown to the family (Groth & Birnbaum, 1978). The children on whom these men prey are often in need of attention and affection, and may be somewhat willing to accommodate the pedophile's sexual advances in return for having these needs met. The relationship, however, is time-limited and ends, or changes markedly, when the child grows beyond the pedophile's preferred age range.

***Regressed Pedophiles***

Groth defined the regressed pedophile as the *typical incest offender*; an individual who is not particularly interested sexually in children, but who opportunistically interacts with the child for some other reason (e.g., sociological factors, bad problem-solving, substance-abuse-fuelled disinhibition [Freund et al., 1991; Rada, Laws, & Kellner, 1976]). Pedophilia is diagnosed phallometrically in only 20 to 25 percent of such cases (Frenzel & Lang, 1989; Freund et al., 1991; Langevin & Lang, 1988), which means that, overall, the issue of sexual interactions between adult males and young girls is not as simple as just pedophilia. There are clearly other psychological and social factors at play.

The victims of regressed pedophiles are more frequently female than male. Most offenders of this nature tend to solicit victims from within family contexts, although extra-familial victims (strangers or friends of the offender's children) may also be present in a minority of cases. The relationship between offender and victim is also considerably different from that of the fixated pedophile. The offender does not interact with the child on the child's own level, but requires the child to function as an adult, often as a "surrogate" spouse (Freund et al., 1972; Groth, 1978; Wilson, 1999). As noted above, extended relationships between offender and victim seem to be more common in the intrafamilial offenders of this type.

***Persons with Intellectual Disabilities who Commit Sexual Offenses Against Children***

Research with persons with intellectual disability who also have committed sexual offenses against children suggests that many of these clients are also interacting with children because of sexual interest in or preference for children (Rice, Harris, Lang, & Chaplin, 2009). We will discuss this in more detail below, especially when we talk about counterfeit deviance. However, it is important to note that there is still a perspective that suggests that persons with intellectual disabilities may sexually interact with children because it is either more convenient or easy to do so.

## Homosexual versus Heterosexual Preference

Groth's typology, as well as the other typologies discussed in this chapter, implicitly leads us to differentiate the majority of persons who sexually offend against children into somewhat polar groups, for example, fixated versus regressed, preferential versus opportunistic, and ultimately homosexual versus heterosexual. Indeed, many differences have been observed between persons who commit sexual abuse against male children and persons who commit sexual offenses against female children. Howells (1981) noted the merits of a typological system of pedophilia based on sexual preference.

Frisbie and Dondis (1965) reported that male persons who sexually offend against male children were less likely to be married, tended to be younger, and were much more likely to recidivate than their heterosexual counterparts. Furthermore, many researchers have noted that persons who offend against boys tended to have significantly more victims. Meta-analytic reviews (i.e., Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005) have noted that the presence of even one male victim greatly increases the likelihood of future sexual offending.

Despite which distinction (fixated versus regressed, homosexual versus heterosexual, etc.) we employ, it is apparent that persons who sexually offend against children, and the behaviours which certain subgroups exhibit, share certain characteristics. Therefore, any attempt to categorize such offenders must address this issue.

## Rape (or Coercive Sexuality)

Since the nineteenth century, rape has been defined as "the having of carnal knowledge of a woman forcibly and against her will. Sexual intercourse with a child under the age of consent fixed by law, with an insane woman or a woman in a condition in which she cannot consciously consent, or when consent is extorted by fear, is rape, though no actual force is used" (Fishbank, 1896). Indeed, the definition of rape has not changed substantially since that time—forced sexual intercourse without consent is still defined as rape. However, in Canada, the crime of sexual assault now also includes male rape and rape within the context of matrimonial relationships.

At present, "rape" is not a diagnostic category under the paraphilias in the DSM-IV-TR. This reflects a considerable amount of controversy among sexological professionals as to whether this type of behaviour is truly paraphilic in nature. Some consider rape to be solely a crime of violence, mostly perpetrated by men against women. These researchers promote a sociological understanding of this behaviour. However, others have suggested that there is a discreet group of "rapists" who engage in this behaviour for paraphilic reasons. These researchers have suggested that a group of persons who commit sexual assault could conceivably be labeled as having a Paraphilic Coercive Disorder, distinguishable from Sexual Sadism and principally motivated by paraphilic interests. This debate continues to divide professionals.

**Glossary**

**progressive deterioration** In this case, we are talking about how some rapists started off by engaging in behaviour that was less offensive and damaging, but whose behaviour became progressively less acceptable and more damaging over time.

**recidivist** Someone who reoffends after having been previously caught, sanctioned (punished), and returned to the community supposedly with the knowledge that they should not do this again. The key point is the intervening sanction.

## Occurrence of Rape

Research tells us that while rapes are thought to occur every few minutes, the incidence of non-reporting is extremely high. A Canada-wide study found that using a conservative estimate, virtually two-thirds of persons subjected to Sexual Assault did not report the crime to the police. This means that very few persons engaging in rape are apprehended and even fewer are convicted. If they are convicted and incarcerated they usually serve less than five years and, even still, too many of them do not take advantage of treatment programs while in prison. When an offender is determined not to change, the treatment and reintegration process is jeopardized.

According to preliminary ABID data provided by Dr. Gerry Blasingame (see table, page 29), approximately one in five persons with an intellectual disability who engaged in sexually abusive behaviour had committed a rape.

## Characteristics of Rapists

Men who rape are found in all groups and levels of our society. They do not fit into one intelligence range or a specific socioeconomic level, but they do share certain behavioural and emotional characteristics:

- Rapists often lack feelings of empathy for their victims and the victims' families.
- They tend to regard people as objects and consequently may have few intimate relationships.
- Rapists often present as angry or inadequate individuals with low impulse control and generalized criminal tendencies.
- They may have anxieties about both heterosexual and homosexual relationships.

We often find that persons engaging in rape have very prudish views of sexual interaction and often have inadequate knowledge of human sexuality. They may also have very stereotyped views about women and carry strong feelings of aggression towards them. Some researchers have put forward a sociobiological or bioevolutionary perspective suggesting that rape is the result of maladaptive mating rituals (e.g., Thornhill & Palmer, 2000; Lalumiere & Quinsey, 1996). However, considerably more research needs to be done before we can conclude anything for sure in this area. One thing is certain: the emergence of bioevolutionary perspectives has reheated the debate over the nature and origins of rape, particularly in feminist circles, as this perspective has been characterized as providing a scientific excuse for such behaviour.

Rape is often precipitated by some form of stress and the phenomenon of **progressive deterioration** is sometimes observed. During the treatment process, some persons who committed rape report that they experienced a gradual escalation in the severity of their sexual offenses over time; for example, from obscene phone calls, to voyeurism, to rape. Many persons convicted of rape have prior convictions for rape, and over 50 percent of **recidivists** reportedly increased their use of force over time. A large number of persons convicted of rape committed prior, undetected sexual assaults (Mayer, 1988), and a significant proportion began to commit sexual offenses as juveniles. Some

researchers have also noted that many persons committing rape felt exploited or abused by their mothers or other female adults and experienced unloving, rejecting relationships with their fathers.

## Categories and Typologies of Rape

Researchers suggest that there are several categories of rape and that each category has its own underlying motivations. Modern conceptualizations of rape recognize that it involves both aggressive and sexual components. However, most conceptions emphasize one component while downplaying the other. For example, the feminist perspective has emphasized the aggression shown by men against women in rape and has regarded male sexual arousal as a coincidental by-product of rape. In contrast, the clinical perspective has focused on the sexual pathology of persons engaging in rape and has de-emphasized the hostility that these men show towards women. Another way of thinking of these two categories of rape is that some persons may engage in rape because of sexual desire while others may be expressing anger and hostility towards women through sexual aggression.

Theorists have long recognized that persons engaging in rape do not form a single homogeneous group—simply put, not all persons who engage in rape do so in the same way or for the same reason. Attempts have been made to divide these men into subgroups or subtypes. Raymond Knight and Robert Prentky (1990), both formerly of the Massachusetts Treatment Center, undertook to develop and empirically validate a typology of rapists. Their resulting typology divides rapists into five different groups depending on the underlying motivation of the person committing the offense (their typology is known as the Rapist Typology #3, or MTC:R3). These subtypes can be broadly divided into those for whom the motivation is sexual and those whose motivation is based on anger.

### *Sexual Motivation, Opportunistic Type*

These persons commit rapes that are unplanned, impulsive, predatory acts. Immediate contextual factors, rather than planning and fantasy, control their rapes. These rapists exploit an opportunity to satisfy their sexual urges and desires. Typically, these persons have a long history of diverse criminal behaviour and they seem to be quite callous and insensitive to the suffering they cause their victims.

### *Sexual Motivation, Non-sadistic Type.*

These persons are motivated by desire for sexual intercourse with the victim. Unlike the opportunistic rapists, these persons plan their assaults. Their planning is a mixture of intended strategy to locate and gain control over the victim. This includes sexual fantasy and distorted ideas concerning women and sex, including the idea that the victim will eventually come to enjoy the assault. This is combined with feelings of inadequacy about their own sexual prowess and masculinity. Persons fitting the description in this category of rape behaviour may stalk their victim(s) prior to the assault.

***Sexual Motivation, Sadistic Type***

When a person's sexual arousal is enhanced by the violence of the assault or when the individual becomes primarily aroused by the suffering of a victim, this is termed "sadism" and the person may be labeled a sexual sadist. Sadism may be seen as a need to cause suffering in the victim in order to produce or maintain sexual arousal, as would be the case in the "overt" sadist. Alternatively, sadism may be covert, as in "muted" sadism. In the muted instance, the sadism is not expressed through assaultive behaviour, but rather, is expressed through fantasy and verbal threats during the assault.

***Anger Motivation, Pervasively Angry Type***

Unlike persons engaging in rape who are sexually motivated, these offenders do not seem to be driven by fantasy or sexual desire. Rather, they rape as an expression of their anger. Their assaults often cause severe injury to their victims, up to and including death. The violence they show is gratuitous, in the sense that it is more than would be required to gain the sexual compliance of their victims. While these persons are angry, they do not harbor anger toward women but seem to be equally angry toward men. They may also have a history of problems with impulse control.

***Anger Motivation, Vindictive Type***

For these persons, their anger is focused exclusively on women—they degrade and humiliate their female victims. The extent of their assaults ranges from verbal abuse through to extreme brutality causing the death of their victims. While these offenders are similar to the Pervasively Angry Type, they do not seem to harbor anger towards persons other than women. They do not get into fights with men, nor do they have a general problem with impulse control. Persons meeting the criteria outlined in the two anger-motivated types usually cause more damage to the victim than the sexually motivated types, even when compared with persons expressing sadistic tendencies.

## Date Rape and Rape of the Elderly

There is a growing concern with respect to the incidence and prevalence of rape in North American society. Acquaintance or date rape is an increasingly common phenomenon. Statistics are hard to obtain, but it is believed that very few date rapes are reported. It is often difficult for persons raped by strangers to report the assault, and it is even more difficult for survivors of date rape to come forward. This may occur because of the complex issues related to consent and the nature of the relationship between victims and offenders.

In regard to persons with intellectual disabilities, cases of date rape can and do occur. For this reason, staff and other caregivers must be careful to ensure that clients who go on dates have been educated about consent and respect for the other person's wishes. In some cases, enhanced supervision may also be necessary.

A relatively recent development in rape behaviour has included the use of date-rape drugs. These chemicals either incapacitate the victim (so she cannot move or fight back but remains conscious) or cause unconsciousness. Persons who use these sorts of drugs in their offenses will often identify a potential

victim at a party or night club, slip the chemical into the victim's drink, and then wait for the opportunity to take advantage of the victim's vulnerability.

Reported rape of the elderly has also increased over the years, although it remains a rare phenomenom (Williams, Mallette, & Isaacs, 1994). This sort of offense is usually perpetrated by younger males, occurs during other criminal activities (such as a break and enter), and involves excessive violence. Lastly, the numbers of cases of gang rape have also increased. In these offenses, the leader is usually one of the subtypes mentioned above.

## Exhibitionism

Exhibitionism is one of the most common expressions of deviant sexual behaviour (Abel, Becker, Cunningham-Rathner, Mittelman, & Rouleau, 1988; Freund & Watson, 1990; Wilson & Barrett, 1997). Exhibitionism (or indecent exposure or public masturbation) involves the repeated exposure of the genitals or entire nude body to an adult or child stranger. Persons engaging in exhibitionism achieve sexual arousal from the act of exposing. In fact, many so-called exhibitionists prefer exposing themselves over regular sexual relations with a consenting partner, and may go out at night to expose themselves after having had sexual relations with their girlfriends or spouses.

Traditionally, persons who expose themselves have been seen as anxious, timid, and passive individuals with a poor self-image. They are often insecure, shy, and eager to please. However, they may also be quite responsible and able to maintain a high degree of functioning in employment and community settings. The majority of these men are of average intelligence, from all socioeconomic levels, and can be married or single. They have been described as psychosexually immature and in need of reassurance regarding their masculinity. Such persons may express ambivalence to women and may be (or have been) dominated by a wife or a mother. Some researchers have suggested that exhibitionism has its roots in anxiety, and that it may therefore be treated using anti-anxiety medications (Fedoroff, 1993).

Many believe that the act of exhibitionism itself is intended to cause fear in women, who are seen by the offender as powerful and intimidating. Sometimes, exhibitionism is an act of contempt with an added dimension of wanting to humiliate the victim. At other times, persons engaging in exhibitionistic behaviour believe or feel that the victim is sexually aroused by the display and that the victim will subsequently want to engage in sexual activity.

Persons with intellectual disabilities are also known to engage in exhibitionistic behaviour. According to the ABID table on page 29, more than one-third of such persons admit to having exposed themselves or engaged in public masturbation. For persons providing support or care, it is often important to get to the root cause of the behaviour. Sometimes, persons with intellectual disabilities will "self-stimulate" when presented with situations that are sexually interesting or arousing. Some clients will engage in true exhibitionism behaviour, while others may engage in self-stimulation more as a consequence of inappropriate social skills than because of paraphilic interest.

## Voyeurism

Voyeurism is the act of looking at people who are naked, disrobing, or engaging in sexual activities. People who engage in this behaviour are sexually excited by what they are looking at and often pair the behaviour with masturbation. Many persons who rape have a history of exhibitionism and voyeurism, and may use the latter as a method of locating potential victims. Similar to other types of persons who sexually offend, the voyeur may be seen as degrading women and viewing them as vulnerable and helpless. Voyeurism has often been called "visual rape."

The same caveat we noted above, under Exhibitionism, also applies here. There are clearly some persons with intellectual disabilities who engage in true voyeuristic behaviour. However, there are others who may stare or secretly attempt to view others because they do not understand that this behaviour is inappropriate. Again, we are attempting to make a distinction between paraphilic intent and bad social-skills development. In the ABID table on page 29, about 25 percent of Dr. Blasingame's sample of persons with intellectual disabilities admitted to engaging in voyeurism.

## Frotteurism

People who engage in Frotteurism rub their genital area against others, usually in cramped quarters such as a bus, subway car, or elevator. Frotteurism has also been called Toucheurism by some (e.g., Freund & Watson, 1990), and persons who exhibit this pattern of sexual deviance offend by touching others sexually without permission, or without the formation of a normal bond of relationship.

Frotteurs are compulsively oriented in the same fashion as exhibitionists and voyeurs and may engage in the behaviour for hours at a time, often ejaculating frequently into their underwear. Some frotteurs will even develop elaborate schemes (e.g., the use of plastic wrap) so that they can engage in the rubbing and ejaculation process many times without soiling their clothing.

The same caveats about paraphilia versus social-skills development also apply here, when considering these behaviours in persons with intellectual disabilities. According to the ABID data on page 29, this behaviour is somewhat more rare in persons with intellectual disabilities, with only about 15 percent of clients admitting to having engaged in it.

## Sexual Sadism and Sexual Masochism

Sexual sadism is the achievement of sexual pleasure through inflicting physical pain and other types of suffering on another person. Some persons suffering from sexual sadism may achieve the necessary satisfaction through observing, rather than causing, pain. For example, some afflicted persons engage in what has been colloquially referred to as "ambulance chasing"—a behaviour pattern in which the person shows up at accident sites in hopes of seeing injured, maimed, or otherwise tormented individuals. As noted above, there has been recent attention in the literature (mostly, by sexual offender treatment pioneer Dr. William Marshall) as to the existence of true paraphilic sadism. Dr. Marshall believes that such conditions do exist, but that they are vastly over-diagnosed

and that a more realistic differential diagnostic process is required (see Marshall, Kennedy, Yates, & Serran, 2002).

Masochism is essentially the opposite of sadism, in that the masochistic individual becomes sexually excited by being physically or emotionally abused. In the criminal justice field, we rarely see masochists because their paraphilic interests do not often bring them into contact with the law. An exception to this, however, would be if something about the individual's masochistic behaviour included activity that was illegal, for example, engaging in sexual acts in public. Approximately 10 percent of the persons with intellectual disabilities in the ABID sample admitted to either masochism or sadism.

## Summary

Throughout this chapter, we have presented a lot of sometimes complicated material about the nature of sexual deviance, the types of persons who engage in this behaviour, and some of the theories and hypotheses regarding why people engage in this behaviour. We have referred to the concept of "inconsistency"—primarily because we wanted to drive home the point that there is an awful lot about sexually inappropriate behaviour that we just don't understand. As a subdiscipline of the behavioural sciences, the field of working with persons engaging in inappropriate sexual conduct is quite young. As such, every year brings new scientific and practical discoveries that help us to better understand this particularly troubling and tragic social condition. We encourage each and every reader to continue reading long after you finish this guidebook. As professionals, we owe it to both our clients and the community to do everything we can to advance the "no more victims" agenda.

## Highlights

### CHAPTER 1

- According to various studies, one in four girls and one in seven boys will be sexually abused before the age of 18.
- Most of those abused are silent about their abuse because of shame, guilt, and secrecy.
- There is little trust in the "System."
- When a person with a disability is abused, the abuser is frequently someone they know.
- There is no hard evidence relating being sexually abused to being an abuser later in life.

### CHAPTER 2

- Intellectual disabilities affect between 2–3 percent of the population.
- Some studies show that persons with intellectual disabilities who have a concurrent diagnosis can be as high as 70 percent.
- We need to take statements of self harm and suicidal behaviour seriously.

### CHAPTER 3

- There are many theories and hypotheses as to why people offend.
- At this point no one can claim to know why persons who sexually offend engage in this damaging behaviour.

# 4

# Assessment: Theoretical Considerations

**Glossary**

**dangerousness** The capacity one individual possesses to cause harm to another.

## An Important Caveat

In the Preface to this guidebook, we noted that it was our intention to provide helpful information to persons working with clients with intellectual disabilities who engage in sexually inappropriate behaviour. Assessing the nature and extent of behavioural, intellectual, and other difficulties requires appropriate training and experience. In many cases, the persons conducting these assessments must be clinicians licensed in the jurisdiction where they practice. While we acknowledge that some readers will have expert knowledge about assessment procedures, we expect that most will not.

Furthermore, many tools are available to practitioners who conduct assessments. In this chapter and the one that follows, we will be presenting a lot of information about assessment processes, complete with examples from some of the frequently used tools of the trade. However, a thorough overview of all of the tools and practices used in assessments is beyond the scope of this book. Instead, we intend to focus on the tools used most often in the Central West Region. Please bear in mind that only those practitioners who are properly trained and who have the appropriate experience may use these tools for assessment purposes.

In situations where an individual has not conformed to societal expectations, and is therefore regarded as an offender—particularly in situations where the individual has engaged in violent behaviour, including sexual offenses—assessment is based on a need to evaluate the individual's **dangerousness**, or the potential the individual shows to harm another person. Assessment is also based on the need to design interventions that will reduce that potential (i.e., reduce the risk). Therefore, assessment forms the foundation upon which all subsequent intervention is built.

**Poor Assessment = Trouble**

**Glossary**

**demand situation** The natural tendency people have to modify responses or behaviour depending on the message they wish to convey or the outcome they wish to achieve.

**objective data** Pieces of information that are not subject to interference or interpretation on the part of the collector.

**subjective data** Information that reflects a degree of interpretation on the part of the collector, and may be in some way consistent with the collector's way of thinking.

At the end of the assessment process, we must be able to appropriately convey our findings to others. Consider the following two possible statements:

| BAD | GOOD |
|---|---|
| This person is dangerous. | If the following risk factors are present, then there is a high/medium/low probability that the person will engage in a specific behaviour within a specific period of time that may place specific victims at risk for a specific type and severity of harm. |

## Tenets of Good Assessment

In every assessment we conduct, for whatever purpose, we must always remember that every statement made by a person includes a certain degree of bias consistent with the individual's **demand situation** (Orne, 1962). Simply put, all the individuals involved in an event bring their own interpretations to the mix. Their recollections of the circumstances are influenced by the part they played in those events and the perceptions they have concerning the meaning of their participation in the greater scheme of things. We all filter our own memories, based on our understanding of the possible outcomes of a situation, and our awareness of how those outcomes will affect us. As a result, assessors need to beware of a number of factors when conducting evaluations.

Before we discuss the tools and procedures used to assess persons who sexually offend (next chapter), it is worthwhile to briefly discuss some of the basics of psychometric theory. While our intent is not to confuse readers with a thorough review of statistical theory and application, there are some basic concepts that must be understood by those who produce evaluation data, as well as by those who use it to develop or implement risk-management plans. This review will provide a framework with which to examine and establish the quality and usefulness of the data you may obtain through assessment or that you may receive if you are the person asking for the assessment to be done.

### Objective Versus Subjective Data

First, we need to make a distinction between **objective** and **subjective data**. Objective data are not susceptible to change due to individual influence. For example, the "truth" is objective, and would be characterized by hard facts, such as fingerprints, DNA evidence, or photographic materials. Subjective data, on the other hand, are subject to interpretation or can be altered by perception or memory. For instance, eyewitness testimony is subjective information, as are self-report data provided by persons interviewed during an assessment, including our clients.

In assessing persons who sexually offend, we often do not receive very much objective information. Most of the information we receive is in the form of verbal accounts from offenders, victims, or other involved parties. These

**Glossary**

**reliability** The level of consistency with which something is measured using a certain procedure.

**validity** The relationship between the findings of an investigation or test and the real-life truth.

accounts are excellent examples of subjective information. In reviewing these data, we must sift through the stories, claims, and counter-claims and attach a relative weight to each account. That is, we must somehow determine which subjective information is closest to the truth. In accomplishing this task, we must also establish the reliability and validity of the information before us. These are critical concepts that must be understood by all who either produce or use assessment information.

## Reliability and Validity

Data have two basic qualities that are important to consider when you are trying to establish how useful they are going to be in your assessment. **Reliability** refers to the consistency of your data. Reliable data will not be influenced factors that are unimportant to the assessment: a reliable test will yield the same information on different days, or even with different test administrators. As an example, your IQ should not vary by more than a few points even though the tests may be administered months apart. As another example: If five people witness an event and they all tell the same story, then the common account of the event in question is probably—but not certainly—a reliable account.

Interestingly, a test can be quite reliable, but have little **validity**. Validity refers to a test's ability to give an answer that has relevance to reality—i.e, to the truth. So, tests need to be both consistent and accurate in measuring whatever they are designed to measure. For example, when you administer a psychological test, like the Psychopathy Checklist—Revised (PCL-R, Hare, 2003), which has been designed to measure severe antisocial personality orientations, the result should actually be representative of this sort of personality profile (e.g., a high score should predict failure on conditional release). Using the example above, if five people witness an event, and all tell the same story, then we likely have a reliable account of the event in question, but if all of them interpreted the situation incorrectly, then we do not have a valid account.

In conducting thorough assessments, it is important to gather data from a variety of sources. In fact, it is almost always better to be redundant—to ask the same questions over and over again—to be sure that the answer is consistent. Many of you have likely taken psychological tests or filled out questionnaires in which it seemed that the same questions were being asked more than once. Sometimes, the question will be worded somewhat differently, but the general intent will be the same. This is done to establish how reliable you are in your answers (the consistency of your answers). Moreover, test constructors will also ask about things that are similar or related, but not exactly the same. This is often because research tells us that certain things go together with one another; like age and taste in music or clothing. How we answer in one area sometimes predicts how we will answer in another. When the answers in the two areas do not correspond, it suggests that the test administrator needs to do more investigation, principally because the validity of the answers is in question.

## Standardization

From the previous section, we saw that reliability and validity are two important concepts in the evaluation of data. Together, they are significantly influenced

**Glossary**

**standardization** An important means to ensure reliability, which requires that all persons performing a certain task do so in the same manner.

**mistake** Undesirable outcomes that occur when you knew the correct procedure but failed to follow it.

**error** An undesirable outcomes that occur when you followed the proper procedure, but the outcome was still not favourable, perhaps, as a consequence of factors of which you had no reasonable knowledge.

by test **standardization**. The concept of standardization refers to how you administer a test or assessment index. In order to ensure standardization, the test should be administered in the same fashion to every participant, regardless of who the administrator is or where the test is being given. This consistent approach allows researchers and clinicians to compare results across individuals and groups of individuals without unnecessary subjective interference by any individual test administrator. This last point is crucial. If we expect to make reliable and valid judgments about individuals based on test information, we must be able to say that the judgments are made only on the basis of the test's outcome and that they are not due to influences such as differences in instructions, preparation, or environmental conditions. In the assessment of persons who sexually offend, this is particularly critical because some tests (e.g., the phallometric test—see next chapter) may result in diagnoses, such as pedophilia, which can have dramatic implications. Therefore, it is important to guard against mistakes and errors, which can occur as a result of nonstandard testing procedures.

## Mistakes versus Errors

Mistakes and errors are not the same, particularly when we refer to assessment procedures. Essentially, a **mistake** is a negative outcome that occurs when we fail to pay attention to detail or when we fail to follow standard practice. As an example if a weather-person were to misread the data and give the wrong forecast, then the misreading of data would be the cause of the mistake.

**Errors**, on the other hand, are a largely uncontrollable aspect of testing. They are the result of statistical probability. They are not the result of administrator influence, but occur because of some element of the test or testing procedure. Using the same example above, an *error* occurs when the weather-person, assessing the probability of rain (based on available data), says that there is a strong chance that it will rain, but it actually turns out to be sunny. The test used was not sufficiently accurate to guarantee a perfect prediction, but this is not the fault of the weather-person.

*All behavioural assessment carries a chance of error. This is owing, in part, to the nature of behaviour.* As people, we all do the same things in different ways. An excellent example here is in regard to musicianship. Jimmy Hendrix and Eddie Van Halen are both regarded as top rock-and-roll guitar players, respected by most people who enjoy this sort of music. However, while they are both very talented and technically proficient on their instrument, they do not play in the same way. In fact, they do not even sound the same. The same can be said of baseball players, writers, and sexual-offender service providers—we do the same things differently. As a consequence, it becomes difficult to design a test that will measure that "same/difference" aspect with perfect reliability or validity.

Overall, it is fair to say that a perfect test has not yet been developed. Better standardization and more specific test methods will help, but we will still need to consider the tendency of most tests to give imperfect results.

**Glossary**

**true positive** When the test said "yes" and this is the true answer.

**false positive** When the test says "no," but the truth is "yes."

**true negative** When the test says "no" and this is the true answer.

**false negative** When the test says "no," but the truth is "yes."

**deception** In testing, any attempt to give false results. Interestingly, persons can either "fake-good" or "fake-bad," depending on what they are attempting to convey.

**malingering** The tendency some persons have to exaggerate symptoms or problems in order to achieve a secondary gain. For instance, a child might feign a stomach-ache in order to avoid going to school.

| | Pregnancy test = Yes | Pregnancy test = No |
|---|---|---|
| Subject is really pregnant | **True positive** | **False negative** |
| Subject is not really pregnant | **False positive** | **True negative** |

*Possible Outcomes: Pregnancy Testing*

There are four results a test can give: a **true positive**, a **false positive**, a **true negative**, and a **false negative**. A false positive is a result that indicates that the attribute you are supposedly measuring is present, when it actually is not. Consider the table above: In this example, if the subject receives a positive result from a pregnancy test, but is not actually pregnant, the subject has received a false positive. Conversely, a false negative is a result that states that the attribute you are attempting to measure is not there when it actually is. For example, the subject of our pregnancy test receives a result that indicates that she is not pregnant, when in actuality she is. If the test says she is pregnant, and she really is, then the subject has received is a true positive; while the opposite would indicate a true negative—the test returns a result of "not pregnant," and the subject is indeed not pregnant.

Generally, we try to guard against false positives. However, in working with persons at risk of engaging in sexual offenses, we tend to over-compensate to minimize the risk of false negatives. We may over-estimate risk, because we are trying to minimize the possibility that vulnerable persons will be harmed. In doing so, we must acknowledge that we will probably use measures (e.g., incarceration, reduction of freedom in the community) that are stronger than actually necessary. For instance, we frequently limit community access for our clients with intellectual disabilities who pose risk to certain vulnerable persons, in spite of the fact that our clients are not completely at risk all of the time. We "over-supervise" because we want to reduce the risk of the behaviour occurring and somebody potentially being harmed. We need to acknowledge that this is often done, however positive our intentions, at the expense of our clients' freedom of movement or of choice.

## Deception and Malingering

One last issue to consider before we end our discussion of psychometric theory is that of **deception** and **malingering**, both of which involve deliberate attempts to deceive examiners by "faking" test results. One of the important concepts in faking is "demand situation" (Orne, 1962), which we raised earlier in this chapter. At its most basic, the demand situation means that information is likely to be distorted in any testing situation, according to how the test subject feels that he or she should respond. For instance, the negative social stigma attached to being diagnosed as sexually deviant make it unsurprising that that a large number of persons who sexually offend attempt to fake sexual preference (e.g., phallometric) test results.

Malingering occurs when a person attempts to gain an advantage by feigning illness or some other negative situation. Individuals may also attempt to deceive

**Glossary**

**acquiescence** Providing answers or responses based on a perception of what the questioner wants to hear, rather than on the truth.

us by faking-good (look more normal than they ordinarily present), faking-bad (look worse than they really are), or may simply invalidate the test either by not answering all questions or by selecting answers at random. Many paper-and-pencil tests have built-in validity scales to assist evaluators in determining the presence of faking (remember the concept of asking the same question more than once that we discussed earlier). To revisit an earlier concept, increasing standardization is one good way to limit the effects of faking on a sample population.

The last point to make in discussing malingering and deception concerns the interpretation of tests where voluntary distortion of results is suspected. In some cases, it may still be useful to use tests that can be faked. For example, if the offender is highly motivated to look "normal" on a phallometric test, but comes out as abnormal despite attempts to "fake-good," he is likely to be abnormal, because the result is in opposition to the most likely "demand situation." In most other circumstances, a test result that scores high on the faking scale should be considered invalid and, therefore, should not be used to make diagnostic statements other than stating that the individual was non-compliant with the testing procedure.

## Testing and Persons with Intellectual Disabilities

There are several issues we need to discuss regarding the use of psychological testing and standardized assessment procedures with persons with intellectual disabilities. Although most of the concepts discussed in this chapter are equally applicable to procedures used with both disabled and non-disabled groups, we need to highlight some considerations, because they are potential sources of error, and to ignore them would be a mistake.

We discussed earlier the concept of demand situation—the manner in which a person approaches a testing situation; specifically, the way in which a subject attempts to perform in the way that will produce an outcome favourable to the subject, or help avoid an unfavourable outcome. The easiest example of the effect of the demand situation on individual behaviour is the way in which people are inclined to lie when telling the truth will result in a negative consequence.

Persons with intellectual disabilities have cognitive limitations that affect how well they are able to assess demand situations. Many persons with intellectual disabilities are unsophisticated in their approach to psychological testing and assessment; sometimes, to the extent that we have to be careful not to exploit their cognitive naïveté. For instance, some of our clients strongly desire attention from others. Sometimes, they admit to things that they actually did not do, because they believe that this is what the assessor wants. Many of our clients have a naturally trusting nature, and they will try to please anyone questioning them by telling their questioners what they think the other person wants to hear, even though the questioner may not necessarily be working in our clients' best interests (e.g., police officers). This is known as **acquiescence**.

Our clients are influenced by the world around them, often as it is displayed on television or in magazines or other media. These influences affect how they

**Glossary**

**social desirability** A form of bias related to acquiescence in which questions are answered based on what the person answering believes would be most socially acceptable.

**cognitive dissonance** The psychological conflict you experience when a situation has two opposing qualities. For example, a girl who is abused by her father will experience conflict because of these two things that she knows: "My dad loves me, but my dad does things that hurt."

respond to questions during assessment. This is referred to as **social desirability,** which means that clients will answer the way that they believe they should based on what they see and hear in others.

Our clients are also influenced by the things we (both those who work with them and support them, and their family members) say and do. We will discuss this in the chapter on healthy sexuality, but it bears noting here. Some staff have strong ideas about acceptable sexual behaviour for persons with intellectual disabilities. Unfortunately, sometimes these strong ideas produce conflict for our clients. This is known as **cognitive dissonance** and, in some extreme cases, it can lead to learned helplessness and depression. This is why we often need to "check our belief systems at the door" when working in social-service environments.

Consider the example of a client with an intellectual disability who is also gay, but whose worker has told him that homosexuality is a sin. Imagine the conflict that this potentially creates for the client who now has to find a way to manage his homosexual interests while also dealing with the shame of believing that he is being sinful and having thoughts that will potentially cause his worker to be mad at him. In regard to testing and assessment, if we are trying to assess the client's belief system or sexual preferences, how likely is it that we will get a truthful response?

## Highlights

### CHAPTER 4

- Persons conducting assessments must be properly trained and under the supervision of a clinician licensed in the jurisdiction in which they practice.
- Assessments form the foundation upon which all subsequent intervention is built.
- Those that support the individual may have strong beliefs about what is acceptable sexual behaviour for persons with intellectual disabilities.
- Sometimes these strong beliefs and ideas cause conflict for those we support.
- Staff working in the social system may need to "check their belief system at the door" when working in social-service environments.

# 5

# Assessment: Practical Applications

**Glossary**

**risk assessment** The process of evaluating the potential someone poses to engage in behaviour that places himself or others at risk for harm.

## Conducting Assessments

When designing **risk assessment** and management protocols for persons who sexually offend, we generally focus on North American men of European descent who are not intellectually disabled—largely, because the majority of offenders in Canada have these characteristics. But, clearly, not all persons who sexually offend fit this mould.

Special groups require special consideration.

Essentially, the most important thing to remember is that human sexual behaviour is very complex, and that there are many differences in how people meet their sexual needs. Most of us do so in acceptable ways (although, often quite differently from one another); however, there are those who do not. We must also acknowledge that not everything is always as it seems. Just as human sexual behaviour is complex in terms of its manifestations, sometimes the reasons for the behaviour can be equally complex.

A good example comes in the form of female persons who sexually offend. For the most part, it is safe to say that we drastically underestimate the true prevalence of sexual offending committed by females. There are many reasons for this, and it would also appear that sexual offenders who are female are categorically different from their male counterparts, on many levels. In some cases, this contributes to difficulties in appreciating the real extent of the problem. In reality, explanations for gender differences in the rates of sexual abuse perpetration range from cultural expectations to differential socialization strategies between male and female children. Suffice it to say, however, that the typical female offender is likely quite different from the typical male offender. Which means that we must use different assessment and treatment protocols with this offender population, if we truly hope to minimize risk.

### Intellectual Disability

Individuals with intellectual disabilities may lack certain social and relationship skills, but they all have the same desire for social comfort, personal relationships,

**Glossary**

**Risk/Needs/Responsivity (RNR) model** A model devised by Andrews and Bonta, and based on meta-analytic research, to set principles of effective interventions. Programs that adhere to these principles generally show much better outcomes.

**risk principle** A principle that decrees that the intensity of your interventions must match the level of risk posed by the individual. Mismatching can lead to increased chances of recidivism.

and meeting of sexual needs in appropriate ways. However, the way in which we manage persons with intellectual disabilities sometimes makes it particularly difficult for them to achieve their sexual goals in an acceptable manner. Assessment of sexual offending in this population then becomes as much about examining life circumstances as it does sexual deviance and propensity for harm to victims.

Overall, the important message we wish to convey is that all people are different. Just because we have a model that seems to work well with *some* people does not mean that we should expect it to work equally well with *all* people. Indeed, at times we may need to examine our own thoughts and feelings around what constitutes acceptable sexual behaviour. Consider that sexuality is likely a dynamic concept; it can change depending on time, space, and the person(s) involved. While there are some things that will probably never be considered okay (i.e., child molestation, rape), there are a lot of things that young people do today that their grandparents might find quite disturbing. This is also true of cross-cultural perspectives on sexuality. While no culture explicitly supports the sexual exploitation of one person by another, there are great differences in how it actually gets played out from one culture to another.

## The Principles of Effective Interventions

The **Risk/Needs/Responsivity (RNR) model** established by Andrews and Bonta (2010) has effectively revolutionized how we treat persons who offend, sexually or otherwise. Through meta-analytic research, these researchers and their associates have shown us that following a few relatively simple rules will assist us in getting the most "bang" for our treatment "buck," as it were. The model identifies three core principles, which form the Principles of Effective Interventions.

### The Risk Principle

Simply put, the **risk principle** decrees that the intensity of correctional interventions correspond with the level of risk posed by the person who commits an offense. Persons of higher risk potential should receive more intensive interventions, while persons who commit offenses who demonstrate lower risk potential should be offered lower-intensity programs, if they receive any programming at all.

> *Andrews and Bonta's research (2010, orig. 1994) showed that mismatching risk and intensity led to increased offending.*

Interestingly, this principle worked both ways. On the one hand, persons who committed offenses and who were at higher levels of risk for re-offending but received lower-intensity interventions showed a higher rate of recidivism. On the other hand, persons who committed offenses and were at lower levels of risk for re-offending who received too much programming also showed a higher rate of recidivism.

**Glossary**

**need principle** In the RNR model, the principle that states that you must assess the individual's criminogenic needs and focus on those, if you hope to truly reduce the risk to reoffend.

**criminogenic** Those areas of treatment and intervention focus that are most principally related to the reduction of risk; i.e., the factors that will contribute to an individual's likelihood to commit a crime. Focusing on these needs will substantially decrease the risk of recidivism.

**responsivity principle** A principle that decrees that interventions must consider the learning styles and capabilities of the participants, as well as attending to issues of motivation and treatment readiness.

## The Need Principle

The **need principle** states that treatment programming offered to persons who offend must principally target the problem areas most related to offending. Termed "**criminogenic** needs," these problem areas include those demonstrated by research to be linked to offending, particularly in regard to an individual case. Treatment must target these criminogenic needs in order to reduce risk for re-offending. Thus, for example, persons who sexually offend require treatment specific to sexual behaviour difficulties, while persons suffering alcoholism require substance-abuse treatment. Although persons who receive treatment in another problem area may receive some benefits from these treatments, recidivism is only decreased by specifically focusing on criminogenic need areas. This principle pointedly targets, the oft-observed tendency to offer general, insight-oriented counseling or psychotherapy to persons who engage in offending behaviour, without specifically focusing on those lifestyle areas that led to offending. In short, in order to be effective, treatment must clearly address criminogenic needs.

## The Responsivity Principle

The **responsivity principle** requires treatment providers to consider a participant's individual characteristics and idiosyncrasies when we design treatment plans and implement interventions. Specifically, acknowledging the participant's individual qualities is important in gaining the person's cooperation and engagement in the treatment process. Issues of cognitive ability, motivation, maturity, and the individual's personal and interpersonal circumstances are among the areas that we need to consider. For treatment plans and methods to be most effective, we must tailor them to these issues. Failure to ensure adequate client motivation for participation and for change more often than not results in programming that is less effective than it could be. (Barrett, Wilson, & Long, 2003).

We are reviewing this information, because it is critically important that all persons who develop and implement risk management plans and treatment services remember that effective risk management and treatment starts with a comprehensive risk assessment. When done correctly, such a comprehensive risk assessment will yield targets in need of attention and identify aspects of the client that may serve to either help or hinder the process of intervention.

## Background Information and Sources of Information

In conducting assessments—particularly risk assessments—we must gather as much information as we can about the individual who committed the offense, his or her circumstances, and any other relevant details that will help us to understand what happened, why it happened, and what the chances are that it might happen again. We can also use risk assessment data to compose risk-management plans. To properly assess risk, we need to gather information in the following domains:

- A structured interview between the person who has committed the offense and the individual performing the assessment

**Glossary**

**static variables** Historical, and therefore non-changeable, factors that can have an affect on a persons' behaviour.

**dynamic variable** Day-to-day, changeable factors that can have an affect on a persons' behaviour.

**stable dynamic** A set of risk factors that are amenable to change, but that require long-term and persistent attention to ensure change. In many cases, these are characterological (or personality) factors, in addition to patterns of behaviour (habits) and entrenched values and attitudes.

**acute dynamic** Risks that occur, for the most part, in the moment, and which are often subject to environmental changes or to an interaction between the client and his or her environment.

**actuarial risk assessment tools** Scales of items thought to be predictive of risk, prepared by researchers using meta-analysis. Using relative scores on the scale, practitioners can predict re-engagement in that behaviour over a certain time period, using the experiences of a large group of others already scored and followed (known as a normative sample).

- Self-reports, from both victims and offender—remember, however, that all self-reports include bias borne of different demand situations
- Collateral contacts (family, friends)
- Police reports, prior criminal justice reports, etc.
- Other official documents, such as court transcripts, judge's reasons for sentencing, pre-sentence reports, victim impact statements, etc.
- Any prior mental health reports, psychological tests, actuarial risk-assessment measures, results of sexual preference testing, etc.

## Static Versus Dynamic Factors

In order to assess the risk of re-offending for persons who have committed offenses we must consider both **static variables** (historical factors) and **dynamic variables** (day-to-day factors).

The research literature tells us that factors that are part of the history of the person who has committed an offense provide the basis for the largest part of any prediction we can make; however, it appears that information about changes in life circumstances of the person who has offended is quite helpful in evaluating the likelihood of impending failure. We will discuss in greater detail below some of the standardized tools for measuring static and dynamic risk.

Static risk factors do not change (on the whole) or, at least, they do not change as a result of any influence we can exert. These factors are mostly related to the person's history and they are helpful in predicting the long-term level of risk for sexual recidivism, in addition to suggesting an appropriate level of supervision and treatment for the individual.

In contrast, dynamic risk factors give us information about day-to-day variables that are subject to change via intervention. There are two broad types of dynamic risk factors—**stable dynamic**, which can change but do so over a relatively long period of time; and **acute dynamic**, which can change quite quickly. We need to pay great attention to both of these areas when we consider treatment and supervision. Generally, stable factors are the targets of treatment, while acute factors drive supervisory concerns.

## Actuarial Risk Assessment

Since the mid to late 1990s, risk assessment of persons who commit offenses has been greatly facilitated by the development of various **actuarial risk assessment tools**. Essentially, these are checklists consisting of robust (strong) predictors that, when scored together, give us a scientifically calculated estimate of risk. The process involved in putting together an actuarial risk assessment tool involves some complicated statistical practices, which we will not delve into in this guidebook. Those who are interested in the complicated elements of this process may wish to review the Hanson meta-analyses (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005) and the paper on the construction of the Static-99 (Hanson & Thornton, 1999; also see below).

The process of putting together an actuarial risk assessment scale requires a meta-analysis of the factors you might wish to include. A meta-analysis is essentially a "study of studies." This requires a review of all the literature on risk

**Glossary**

**standardization sample** A large population of test takers who represent the population for which the test is intended.

**Static-99R** A widely used actuarial risk assessment tool designed to measure the risk posed for sexual and violent reoffending in persons with known histories of sexual offending.

prediction, looking for trends—for example, if many studies find a particular factor to be a strong predictor, then the researcher will probably include that item in the resultant scale. After going through all the studies, and picking only the items that correlate most commonly with recidivism, the researcher can create a scale that might be helpful in deciding who is at greatest risk to reoffend. Then, of course, more research is needed to make sure that your scale actually measures what the researcher hoped it would.

Once we know that we have a scale with reasonable predictive ability, we can score individuals on whom we are conducting assessments to see what level of risk they pose. For instance, if we know that 30 percent of the group of offenders in the **standardization sample** who score 6 out of 10 reoffended within five years, and the person on whom you are performing the assessment also scores a 6, then that individual stands a 30 percent risk of reoffending in the same time period.

### Static-99R

The **Static-99R** (Hanson & Thornton, 1999; see also Helmus, 2009) is, in many ways, the Cadillac of sexual offender risk assessment indices. The result of exhaustive meta-analytic research, this scale is now one of the most widely used actuarial risk assessment tools in the world. This scale is the result of extensive research and professional collaboration.

| Static-99R Risk Factors |
|---|
| Age at release? |
| Single? (Ever lived with a lover for at least two years?) |
| Index non-sexual violence? |
| Prior non-sexual violence? |
| Prior sexual offences? |
| Prior sentencing dates? |
| Convictions for non-contact sexual offences? |
| Any unrelated victims? |
| Any stranger victims? |
| Any male victims? |

*The Static 99-R risk factors for predicting the risk that an individual will re-offend.*

As with any tool, the Static-99R has its strengths and weaknesses:

***Strengths***

- Uses empirically validated risk factors
- Gives explicit rules for combining factors
- Provides explicit probability estimates in the form of survival curves
- Makes robust predictions across settings and samples
- Is easily scored

*Weaknesses*

- In common with other actuarial scales, offers only moderate predictive accuracy—we always want to do better!
- Does not include reference to several factors we know to be important in evaluating risk; for instance:
  - Sexual deviance (as measured by phallometric testing)
  - All dynamic factors (which suggests that we use additional frameworks like VRS:SO [Olver, Wong, Nicholaichuk, & Gordon, 2007], Stable-2007 [Hanson, Harris, Scott, & Helmus, 2007], or SRA [Thornton, 2002]).
- Places a strong reliance on official records of inappropriate sexual behaviour, making it weak specifically in regard to persons with intellectual disabilities. Traditionally, persons with intellectual disabilities have not been held accountable for their behaviour in the same way as persons without disabilities. For instance, diversion methods (warnings, community service, placement in a group home) are often used instead of criminal prosecution. Many of the items on the Static-99R and other similar scales require a review of the client's official criminal history, which, for some of our clients, simply do not exist.

## Other Considerations

Standardized measures, including actuarial risk prediction scales, are standardized on a particular group of individuals. This means that they may not work quite as well when used on a different group of individuals. Some of the following factors can have dramatic implications for risk assessment, particularly as most tools of the trade are standardized using study populations consisting predominantly of white males who do not have intellectual disabilities or diagnosed mental illnesses. Consider what might occur if the person who has committed an offense and is now undergoing evaluation were:

- intellectually disabled
- hospitalized for a major mental disorder
- female, or
- Aboriginal.

Simply put, risk is risk, and those factors that robustly predict risk in the "white male" population typically also predict risk in other populations. However, in a business where inaccuracy potentially means that a child or other vulnerable person will be hurt, it is crucial that we pay attention to possible sources of error.

The Static-99R has a standardization sample of male adults. Therefore, we need always to exercise caution when attempting to use the scale with persons who fall outside of the limits of that standardization sample. For example, the Static-99R is not recommended for use with:

- females
- juveniles

**Glossary**

**statutory rape** When one person over the legal age of consent has sexual intercourse with someone under the legal age of consent. Where the two parties are of relatively similar age, there may be consent (leading to the term "Romeo and Juliet offenses"); however, the conduct is nonetheless illegal.

- individuals charged with **statutory rape**, or
- offenders who have committed only nuisance offenses.

The Static-99R is not as helpful in evaluating the risk of persons who have been sexual offense-free in the community for more than 10 years. In general, going 10 or more years in the community without reoffending is a risk prediction in and of itself, in that people doing well generally tend to continue to do well. Lastly, as with any psychological assessment tool, the Static-99R is not to be used for making statements about possible guilt. Decisions about guilt are the sole purview of the Court. The job of the assessor of risk is to provide information about risk assessment—whether or not a certain individual with certain traits and propensities who has engaged in certain behaviour is likely to engage in similar behaviour in the future.

There has been some controversy in the field regarding the relative utility of the Static-99R over other instruments in assessing reoffense risk for persons with intellectual disabilities. Susan Tough (2001) conducted research comparing the Static-99 to the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR; see Hanson, 1997) scale. She found that, at that time, the RRASOR better predicted risk for persons with intellectual disabilities. However, Static-99R co-author Karl Hanson has now publicly stated in various training sessions and international symposia that there is no longer a need to use the RRASOR since new normative data for the Static-99R include samples of persons with intellectual disabilities.

## Risk Assessment and Intellectual Disability

Risk assessment and risk management of clients who pose a risk for sexual offending has become one of the more significant social issues of our time. In order to develop appropriate treatments and programs, we need reliable and valid data regarding predictors of continued cognitive and behavioural difficulty. As we noted above, DSM-IV-TR (APA, 2000) has established diagnostic criteria for the Paraphilias (i.e., the sexual disorders, including Pedophilia, Exhibitionism, Sexual Sadism, etc.); however, the literature includes research suggesting that the diagnostic criteria are, at times, unclear or unreliable, or that they do not always match clinical experience (see Marshall, Kennedy, & Yates, 2002; Kingston, Firestone, Moulden, & Bradford, 2007; Wilson, Abracen, Looman, Picheca, & Ferguson, 2010). Of particular concern is the fact that the DSM-based diagnostic criteria for the Paraphilias have not been subjected to rigorous field trials. As such, diagnosticians have not always known how well these criteria apply to various client groups. This may be particularly true for intellectually disabled clients (see Fletcher, Loschen, Stavrakaki, & First, 2007).

The following table (adapted from Blasingame, in press) helpfully lays out some of the differences (and similarities) between persons who commit sexual offenses and who do or do not have intellectual disabilities:

| Persons who commit sexual offenses and *do not* have intellectual disabilities | Persons who commit sexual offenses and *have* intellectual disabilities or mild intellectual disabilities |
|---|---|
| Mid-Average IQ of 90–110<br>Low Average IQ of 80–89 | Cognitive impairments IQ of 70 or less<br>May also include Borderline IQ of 70-80 |
| | Severe impairments in adaptive functioning |
| Poor social support | Poor social support |
| Attitudes supportive of abuse; cognitive distortions that enable sexual aggression | Attitudes supportive of abuse; cognitive distortions that enable sexual aggression |
| Anti-social lifestyles and attitudes | Anti-social lifestyles and attitudes |
| Poor self-regulation and self-management | Poor self-regulation and self-management |
| Issues with supervision and treatment | Issues with supervision and treatment |
| Increased anger and stress prior to reoffending | Increased anger and stress prior to reoffending |
| Negative problem solving strategies | Negative problem solving strategies |
| | Greater inability to manage information; poor working memory |
| | Communication skills deficits; inadequate vocabularies; poor social interaction skills |
| | Slower information processing speed |
| | Memory recall deficits |
| | Early socialization constrictions; poor social training or socialization/boundary training |
| Significant frequency of prior sexual or physical traumatization | Very high frequency of prior sexual traumatization |
| Problematic coping skills | Poor and problematic coping skills |
| | High frequency of comorbid mental disorders; high percentage of dual diagnoses |
| | Low self esteem |
| | Significant frequency of personality disorder traits; antisociality |
| Small percentage has psychopathic traits | Small percentage has psychopathic traits |
| Special education in background; school grade failures | Special education in background; school grade failures |
| | Inconsistent application of sexual knowledge |
| | Lack of assertiveness |
| | Neurodevelopmental impairments undermine learning |
| | Allowances made by staff members; staff complacency |
| Significant crossover of areas of sexual interest | Significant crossover of areas of sexual interest; diverse victim selection |

*Characteristics of persons who commit sexual offenses (APA, 2000)*

### Dynamic Risk and Intellectual Disability

Clearly, persons with intellectual disabilities who commit sexual offenses are at a disadvantage in regard to most, if not all, dynamic risk variables. Remember that dynamic risk variables, often referred to as criminogenic needs, are that class of factors that can change, through targeted intervention, the passage of time, or some other process. These variables typically form the basis of our treatment and supervision plans.

Persons with intellectual disabilities simply do not have—or, at times, are not allowed to have—the same range of life experiences as those who are not intellectually disabled. These differences require differential diagnostics and risk assessment, which can present significant challenges for evaluators.

Evaluating clients who have intellectual disabilities requires a degree of creativity. As we noted above, one major problem is that most of the tools traditionally used in evaluating sexual offense risk were created for use with white, male, non-disabled adults. For this reason, traditional tools may not be very helpful with some clients, but may still be useful with others. Thankfully, the research and practice literatures are starting to grow regarding sexual offending and intellectual disabilities, and we are starting to see more tools designed specifically for this clientele.

## Assessment Tools

In this section, we are going to name and provide brief explanations of many of the assessment tools we typically use in the assessments that we conduct at Peel Behavioural Services. Because we work closely with other agencies providing assessments in the South-Central-West areas of Ontario, we are also aware that most of those sister agencies use largely the same tools. We are aware that other tools are available in the literature and in general practice. In listing some tools below and not others, our intention is not to suggest that the tools we use are somehow better or preferable to those other tools.

### Caveats and Limitations

Some of the tools noted below have not been scientifically validated. That is, we do not necessarily know their psychometric properties, such as their reliability or validity. Remember that we said in the last chapter that empirical validation and standardization are important aspects of "getting good data." We stand by this principle, in spite of the fact that we are going to tell you about some tools that are not yet validated. We are, however, in the process of evaluating many of these tools. Also, some of these "tools" are not so much tools as they are components of a structured interview process. For those readers who are concerned about such things, we will mark those measures that have been empirically validated with an asterisk (*).

As our knowledge base grows regarding comprehensive assessment of risk and need for persons with intellectual disabilities who engage in sexually abusive behaviour, we expect that our policies and procedures will need to be modified. With successive editions of this guide, you will be able to chart the evolution of our field, at least in regard to assessment procedures and practices.

Currently, we are aware of research conducted by similarly minded groups of professionals, who are also grappling with issues of how to conduct useful assessments. Specifically, Bill Lindsay and his group have developed the *Questionnaire on Attitudes Consistent with Sexual Offending* (QACSO—see Lindsay, Michie, et al., 2006; Lindsay, Whitefield, & Carson, 2007). The QACSO surveys the person who has committed a sexual offense's attitudes regarding rape, voyeurism, exhibitionism, dating abuse, stalking, homosexual assault, and sex with children. Additionally, Boer, Haaven, and associates have been working to establish the *Assessment of Risk Manageability of Intellectually Disabled Sex Offenders* (ARMIDILO—see Boer, McVilly, & Lambick, 2007; Boer, Tough, & Haaven, 2004) as a useful tool for measuring dynamic risk in persons with intellectual disabilities. The latter of these two scales includes a large number of the items from the Stable-2007 and Acute-2007. *The Treatment Intervention and Progress Scale for Sexual Abusers with Intellectual Disability* (TIPS-ID—see McGrath, Livingston, & Falk, 2007) is another structured approach to gathering dynamic variable information.

We think these are excellent tools, and we are exploring their usefulness in our practices but, for the time being, we have a set protocol for assessment that we have been using and researching for some time.

## Tools Used in the Central West Region

As we noted earlier, we are intentionally sharing the following information because, at the moment, if you request assessment services in the Central West Region, you are likely to receive a report that includes reference to these materials. However, that should not stop interested readers from researching other methods such as the QACSO, ARMIDILO, and TIPS-ID.

### * Socio-Sexual Knowledge & Attitude Test Revised (SSKAAT-R)

The SSKAAT-R (Griffiths & Lunsky, 2003) was developed for adults with developmental disabilities and sexuality concerns. The tool consists of a series of drawings and photographs of social and sexual activities, about which the examinee must answer questions. The SSKAAT-R assesses an individual's knowledge and attitudes in the areas of Anatomy, Men's Bodies, Intimacy, Pregnancy, Childbirth and Child Rearing, Birth Control and Sexually Transmitted Diseases, and Healthy Socio-Sexual Boundaries. The test provides standardized outcome data that assists in comparing the tested individual to normative samples of other individuals experiencing similar problems.

### * Card Sort Test

The Card Sort Test (CST) is an unpublished, ad hoc instrument designed to assist in determining age and gender preference. Because it is non-invasive in nature, it is often helpful in assessing these constructs where more invasive testing (i.e., phallometric testing, also known as the penile plethysmograph) might be unnecessary or even contraindicated. The CST requires an individual to sort a series of pictures by gender, age, age-appropriate friendships, partner choice, and self-identity. This test is described in much greater detail below, when we discuss measures of sexual interests and preference. Research assessing

the true utility of this methodology is currently under peer review (Hoath, Wilson, Burns, Figliola, & Tough, under review).

### Draw-a-Person Test

For the Draw-a-Person test the client is provided with two asexual outlines of a person. The client is requested to draw in and label the body parts of a naked male adult and a naked female adult. The test is designed to determine whether an individual understands the difference between males and females, and the differences between children and adults. Results of this test are often helpful in assessing the degree to which clients know where certain body parts are and what they are called. It can also assist in determining if the client has any preconceived ideas about sexuality (e.g., prudishness).

### * Susan Ludwig Boundary Assessment

The Boundary test helps to determine the client's understanding of the concepts of public, private, and the need to use caution in respect to places, body parts, clothing, and behaviours. As we have noted elsewhere, many instances of sexually inappropriate behaviour in persons with intellectual disabilities seem to be related to a failure to appreciate the nature of the situation in which the behaviour occurred. For example, clients who understand concepts such as public versus private, but who seem to frequently engage in private behaviour in public places, may present greater needs for intervention and treatment.

### Emotional Problem Scale

The Emotional Problem Scale consists of a self-report inventory and a behaviour rating scale. This scale was designed to measure the presence of psychological and emotional difficulties in individuals with an intellectual disability. This scale provides us with more information about how our clients experience and express emotions. When a person has emotional difficulties, we may need to include a component of emotions management training in their treatment plan.

### * YAI Verbal Consent Tool

The Young Adult Institute (YAI) Determining Sexual Consent questionnaire addresses issues regarding informed consent and sexual acts and asks questions regarding boundaries. When we are concerned about an individual's ability to fully understand consent or to verbally give informed consent, we use the YAI tool, which is specifically used to determine whether an individual understands behaviour that would be deemed illegal.

### * Adaptive Behaviour Assessment System II (ABAS II)

This assessment tool was designed for individuals with an intellectual disability. The intent is to provide a diagnostic assessment of persons who present difficulties with daily adaptive skills necessary to function effectively, given the typical personal and environmental demands placed on individuals of the same age.

### Sentence Completion

The Sentence Completion instrument probes for information related to sexual behaviour, experiences, attitudes, fantasies, and dysfunctions. Sentence completion tasks are popular in psychological assessments, as they often reveal interesting aspects of the client's value system, interests, and preferences.

**Glossary**

**sexological research**
The study of sex. Sexological research is conducted to help us better understand the cognitive, behavioural, and physiological aspects of sexuality.

### The Sexual Attitude Scale

The Sexual Attitude Scale evaluates a client's view of sexist attitudes and misconceptions. In the last chapter, we discussed socially desirable responding, acquiescence, and other influences on how a person may respond to certain questions. We know that attitudes regarding sexuality are greatly influenced by demand situation. This scale assists us in better understanding the specific sexual attitudes that the client being assessed holds.

### * Bumby Rape Scale

The Rape Scale assesses attitudes regarding rape, children, and sexual activity.

### * Bumby Molest Scale

The Molest Scale assesses attitudes regarding children and sexual activity.

### Sexuality Quizzes

The Sexuality Quizzes test the individual's knowledge with respect to Consent, Masturbation, Condoms, Sexually Transmitted Infections, and Healthy Sexuality. Please note that these quizzes test basic knowledge and do not address dynamic variables.

### * Sex Attitudes Questionnaire

This tool, based on the Hanson Sex Attitudes Questionnaire, assesses the subject's attitudes regarding children and sexual activity. Although this questionnaire was not originally designed for persons with intellectual disabilities, we have adapted it to use with our clients. Specifically, whereas the original method of completion was that the client would complete the questionnaire on his own, we have used it as a question-and-answer conversational tool.

### * Abel-Becker Cognitive Distortions Scale

The Cognitive Distortions Scale examines client attitudes regarding the appropriateness of sexual activity between children and adults.

### Ideal Fantasy

The Ideal Fantasy questionnaire investigates the type of fantasy material utilized by an individual during masturbation. This can often provide a starting point for assisting clients in developing more appropriate fantasy starters.

## Assessment of Sexual Interests and Preferences

In addition to the information that formal assessment tools provide, workers receive valuable information from psychologists and laboratory technicians concerning the deviant arousal and sexual preferences of the person who has committed an offense. Although the typical case manager does not conduct the tests that generate these data, case managers need to understand what is done, the relevant terminology, and how the information can help them manage the offender.

**Sexological research**, especially that conducted by Masters and Johnson (1966), has shown that the best way to judge a man's sexual interests is to see what happens to his penile physiology when he is presented with sexually provocative stimuli. This measurement is particularly useful in the diagnosis

**Glossary**

**penile plethysmography (PPG)** The process of measuring penile response to audiovisual stimuli. The phallometric test is synonymous with PPG.

**phallometry** The process of using phallometric testing.

of sexual deviance in persons who sexually offend. Deviant sexual arousal is measured in a behavioural laboratory setting, in a procedure is called **penile plethysmography (PPG)** or **phallometry**, which measures differential male erectile response to various audiovisual stimuli intended to affect sexual arousal.

## Phallometric Testing

Phallometric testing was pioneered by Czech psychiatrist Kurt Freund in the 1950s (Freund, 1963). It was initially used to screen homosexual men out of the military. However, Dr. Freund soon realized that phallometric testing could be used to diagnose other, more problematic, sexual interests. Specifically, he adapted the test to aid in the identification of paraphilic interests such as pedophilia. This adaptation of the test has proven the most useful to forensic researchers and correctional workers.

Measuring the erectile response is useful in both the assessment and the treatment of persons who sexually offend. In a phallometric assessment, the subject is fitted with an apparatus that measures his penile responses while he views or listens to materials intended to induce arousal. The measurement may be accomplished either by measuring changes in penile volume or in penile circumference; however, measurement of penile circumference is the most common method of assessing arousal. In this approach, the subject views or listens to materials that arouse him, resulting in increased penile circumference. Sophisticated electronic equipment can be used to measure the penile circumference . When the test session is over, the technician compares the subject's responses to "normal" stimuli (e.g., adults) with those generated by sexually deviant stimuli (e.g., children), allowing the evaluator to draw conclusions about whether the subject's sexual interests are deviant . For example, an individual who has committed an offense who shows consistently greater arousal to photographs of nude children than to photographs of nude adults would be diagnosed as pedophilic.

As was noted earlier, when we discussed psychometric theory, three important principles should be considered when evaluating phallometric procedures: standardization, reliability, and validity. To briefly restate, standard procedures use the same testing procedures or protocols for all subjects, thereby allowing us to compare the responses of one subject to those of all others. Reliability refers to the test's ability to give information that is consistent: an individual who tests positive for pedophilia on Tuesday should also test positive on Wednesday. Lastly, the validity of a test determines whether the test is accurately assessing sexual preference. For example, a test of pedophilia should be able to give you an answer regarding an individual's sexual preferences for children—the test must be measuring what you think it is measuring.

In order for case managers and clinicians to make sense of phallometric test reports, the test procedure must adhere to the three principles above. Unfortunately, not all test sites have evaluated the consistency of their own testing procedures; however, most agencies have instituted strict protocols for testing in order to attempt to ensure that tests are standard, reliable, and valid.

Each laboratory should have the same equipment, furniture, and recording devices. The offender sits in a comfortable reclining chair behind a curtained

partition and puts a strain gauge—a small mercury-filled rubber loop—around his penis. As the offender develops an erection, the strain gauge expands and sends a signal to a computer, which measures and records the amount of change between zero and one hundred percent of full erection. Before the test begins, a baseline is established for each individual and the computer compares the offender's arousal to the baseline and converts the subject's response to a percentage of the full erection possible. From an adjoining room, a lab technician operates the computer and audiovisual equipment. The computer printout of penile responses is later interpreted by a psychologist, who reports the findings to the case manager and places them in the client's file.

### Faking

Persons with histories of sexual offending who are asked to complete phallometric (and other) tests are strongly motivated to present themselves in the best light possible, since the tests will be incorporated in sexual offender assessments. Simply put, if an individual feels that the outcome of a test carries serious potential risks or benefits, he may try to make sure the test turns out favourably by faking or by deception. Persons who have committed an offense may lie in a self-reporting situation if they feel that lying will help their chance for release, or that it may keep them from getting in trouble. While phallometric testing may seem like a way to overcome the uncertainties created by the possibility of dishonest reporting, over-reliance on erectile information should not compensate for inadequate file information or self-report. It is, in fact, possible to fake erectile responses through digital manipulation (using the fingers to evoke a response where none would exist without physical stimulation), physical muscle control, controlling their thought processes, or simply not looking at the stimuli. Most of these behaviours will look contrived or suspicious, and skilled lab technicians are able to identify such attempts to interfere with the test's outcome.

Many studies suggest that phallometry is reliable and valid for age-gender preference (Freund & Blanchard, 1989; Freund & Watson, 1991; Blanchard, Klassen, Dickey, Kuban, & Blak, 2001). However, the findings regarding phallometry's reliability for establishing activity preferences are much more inconsistent. Recent research by Fernandez (2002) suggests that test-retest validity (i.e., measurements of whether a test will obtain the same result with the same person on multiple presentations) is inadequate in testing for pedophilia in persons who target female children. Actually, this can be a problem with phallometric research in general, as studies too often fail to report reliability and validity statistics. A bigger problem, however, is in regard to the reliability and validity of using such test measures with intellectually disabled clients (see discussion in Reyes, Vollmer, et al., 2006).

## Measures of Visual Reaction Time

In the 1990s, pioneering sexual abuse researcher Gene Abel designed the Abel Assessment of Sexual Interests (AASI, known colloquially as the Abel Screen; see Abel, Huffman, Warburg, & Holland, 1998; also www.abelscreening.com), a procedure in which clients view pictures of various persons and scenarios and the time they linger on each photo is measured. The Abel Screen is generally

**Glossary**

**goodness of fit** How well your working model truly represents an explanation of what you are seeing. Keep in mind that there are always exceptions to every working model, just as there are exeptions to almost every rule.

**normed** Standardized. In constructing tests and other measures, you must have a normative or standardization sample. This then becomes the reference point for comparing individuals to a larger group of persons thought to have the same features. However, the normative sample will be specified to a certain group, thus it is "normed" on that group.

known as a measure of visual reaction time (VRT). Although there has been a degree of criticism of this methodology (see Fischer & Smith, 1999), the AASI is, at present, the only validated alternative to PPG.

The Abel-Blasingame Assessment System for individuals with intellectual disabilities (ABID; www.abelscreening.com) is a modification of Abel's original AASI. It comprises a questionnaire (at a grade-2 comprehension level, which is read to the client as a semi-structured interview) and VRT protocol. The combined data provide information as to the sexual interests of persons with intellectual disabilities. It is suggested that this procedure is most effective with persons with IQs of 60 and above. Preliminary research on the procedure (Blasingame, 2006; 2011) found it to be moderately reliable in use with intellectually disabled clients. Furthermore, the VRT findings and answers to interview questions reflected what researches already knew, from the subjects' offense histories.

## Problems in Diagnosing Sexual Deviance in Clients with Intellectual Disabilities

Because our understanding of sexual offending as a problem for persons with intellectual disabilities is not as well developed as it is for persons without disabilities, clientele-specific testing protocols, treatment methods, and risk assessment procedures are generally lacking. To date, typical practice has been to adapt technology and procedure developed for general male adult clients to other groups (including women, juveniles, and persons with intellectual disabilities). However, it is clear that **goodness of fit** (how well the methods are truly suited to the population at hand) has affected overall client responsivity. There is a clear need for testing methods specifically designed for persons with intellectual disabilities, that take into account the particular characteristics of this group. The need is especially pressing with respect to diagnostic measures, principally because the needs and characteristics of this group of clients make mainstream methods unsuitable and inaccurate.

There are a number of possible problems inherent in doing sexual preference testing with clients with intellectual disabilities. First, the procedures can be invasive and unpleasant. Second, most test protocols are **normed** on non-disabled populations, which should cause us to question how applicable they may be to clients with intellectual disabilities. Another concern is that the presentation of explicit stimuli might spur anomalous fantasies or behaviour, which could affect test results. For this reason, some persons working with clients with intellectual disabilities have questioned whether other methods might be possible. At the very least, we may ask, is there a screening protocol that might eliminate the need for costly, invasive measures such as phallometry or the AASI or ABID?

### The Card Sort Test (CST)

We discussed the Card Sort Test (CST) methodology briefly in the last section, and we would like to expand on it here. The CST is a self-report measure used to explore sexual interests and preferences in persons with an intellectual disability. Research has shown that this measure is quite useful as a screening test and that,

in many situations, we may not require more invasive testing if we use the CST first (Hoath et al., under review).

The exact origins of the CST protocol are unknown; however, it is possible that the earliest versions of the test we now use originated at the Mental Health Centre in Penetanguishene, Ontario (Hingsburger, personal communication, July 23, 2010; see also Hingsburger, Chaplin, Hirstwood, Tough, Nethercott, & Roberts-Spence, 1999). Various versions of this procedure exist throughout the field, sometimes known by other names. The version of the procedure described here has been in use in a number of behaviour management services in South-Central Ontario (including those with which the authors are affiliated) for approximately 20 years. The procedure is quite simple: the test assesses for age discrimination, peer identification, and sexual age preference by having clients sort a variety of pictures and answer questions about their sorting habits.

The typical version of the CST used throughout South-Central Ontario consists of 24 cards with pictures of two of each of the following age groups for each gender: seniors, adults, young adults, teenagers, pre-teens, and children. To ensure that clients attend only to the important aspect of the stimuli, each picture shows only one person who has a neutral or pleasant presentation and is looking straight into the camera. The pictures show full body presentations, with models clothed in a mix of business and casual dress, including shoes.

Clients are presented with an array of picture cards, as described above, and are asked several questions, or given tasks, such as:

- Which of these persons looks most like you?
- Which of these persons looks most like me (the evaluator)?
- Sort these pictures according to male and female.
- Sort these pictures according to age groups (seniors, adults, young adults, teenagers, pre-teens, and children).
- Which of these persons would you like to be friends with?
- Which of these persons would you like to go on a date with?
- Which of these persons would you like to have sex with?

The answers we receive to these questions can tell us a lot about self-image, appreciation of difference in others, gender discrimination, age discrimination, and sexual interests and preferences. All of these are important variables when putting together a comprehensive treatment and risk-management plan.

Preliminary data regarding the utility of the CST shows that it is a useful tool in identifying sexually inappropriate interests in young persons. Our contention (e.g., Hoath et al., under review) is that if a client admits to sexually inappropriate interests on the CST (e.g., if in response to the question, "Which of these persons would you like to have sex with?" the client presents the picture cards showing female prepubescents), then we do not need to proceed to more costly and invasive testing like phallometry or ABID. In our research sample, all persons who completed both the CST and phallometric testing, and who showed inappropriate interests on the CST, also showed inappropriate interests in the phallometric test.

## Problems in Socialization

When discussing interests and preferences that may be indicative of sexual deviance, it is important to note that we know less about these concepts in persons with intellectual disabilities as we do in the population at large.

As we outlined in an earlier chapter, the DSM-IV-TR defines paraphilia as "recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least six months." (APA, 2000, p. 566). Many members of the diagnostic community have consistently expressed concerns regarding the application of DSM-based diagnoses of paraphilia. These concerns revolve around the fact that persons may be diagnosed based on behaviour alone, without necessarily demonstrating or admitting to "sexually arousing fantasies" or "sexual urges." As such, some clients may be diagnosed based on what they do more than based on what they feel and think. Although there is a conceptual link in the cognitive-behavioural world between thought and behaviour, we also know that people sometimes engage in behaviour that is not necessarily consistent with their attitudes.

As we mentioned in chapter 3, Hingsburger and associates (1991) first postulated the theory of counterfeit deviance, which explores the possibility that not all sexually inappropriate behaviour engaged in by persons with intellectual disabilities is synonymous with sexual deviance, as defined by either the DSM or other diagnostic schemes. At the heart of this proposition is the fact that this specific population faces social and environment challenges and influences that may contribute to sexually inappropriate behaviour without the obligatory presence of concomitant deviant interests or preferences. Although the concept has considerable face validity, the existence of counterfeit deviance has not been well supported in the empirical literature (e.g., Michie, Lindsay, Martin, & Grieve, 2006; Rice, Harris, Lang, & Chaplin, 2009), at least as it applies to persons with intellectual disabilities who ultimately engage in sexual offenses. It appears that persons with intellectual disabilities sexually offend for more or less then same reasons as persons without such disabilities.

In the last chapter we raised the issue that many people equate degree of developmental delay with a *mental age*, as in, "Client X has the mind of an eight-year-old." Accordingly, many people actually believe that persons with intellectual disabilities are "like" children and treat them as if they are. Consequently, persons with intellectual disabilities often do not have the same educational or other maturity-developing experiences as other children. They frequently have learning experiences that are game-based, and naturally gravitate to media and other materials that are easier to understand—typically those geared towards children. In some cases, these difficulties in regard to developing appropriate adult socialization may affect the choices a client with intellectual disabilities makes with respect to meeting sexual needs.

Furthermore, adults with intellectual disabilities often experience difficulties in social interactions with other adults and may, as a consequence, feel more at ease interacting with the children during family gatherings and other occasions. Indeed, during holiday feasts, family members with intellectual disabilities may

even be seated at the "children's table." While we accept that these practices may be well intentioned, we also submit that they dull the individual's experience of adult life, which necessarily contributes to an artificially high degree of over-identification with the child role, or faux emotional congruence. Unfortunately, for some persons with intellectual disabilities, expression of sexuality occurs with those persons with whom they have the greatest experience and opportunity—children. Our concern is that this expression of sexuality with children, as a possible consequence of limited opportunity for more appropriate outlets may, in some cases, be inappropriately equated with pedophilia.

## Summary

In this chapter and the one preceding it, we spent a lot of time going over some of the issues important in conducting comprehensive assessments of sexuality and risk potential in persons with intellectual disabilities. Concepts of importance in this chapter were standardization, reliability, and validity.

We also reviewed that many assessment procedures have been designed for use with clients who are non-disabled, white, and male, but that these are often difficult to adapt to other groups, including persons with intellectual disabilities. Evaluators have had to be a bit creative in their methods, while the field continues to develop measures specialized to persons with intellectual disabilities.

Our researchers continue to develop standardized methods of assessment for persons with intellectual disabilities who sexually abuse, but we are far from finished. Other research groups are also working on methods, including the QACSO and ARMIDILO.

At present, we believe that a comprehensive assessment should include consideration of the following domains:

- Personal and family history
- Educational history, including assessment of cognitive abilities
- Medical and psychiatric history and evaluations
- Psychological evaluations (including personality, emotions, self-esteem, etc.)
- Social skills and adaptive behaviour capacity
- Relationships and sexual history
- Sexual knowledge and education
- Sexual interests and preferences
- Sexual attitudes, thoughts, and fantasies
- Assessment of capacity to give informed consent.

There may be other domains in need of assessment, which will require individualized evaluation protocols. Remember that your best tool for a useful and effective treatment and risk management plan is a comprehensive assessment.

# 6

# Treatment Interventions: Philosophies and Models

**Glossary**

**evidence-based** Supported by research.

## An Important Caveat

In the last chapter, we noted that only trained and experienced professionals can provide assessment services for our clients. The same is true of treatment. Those who create treatment plans for clients must have professional expertise specifically in the field of providing treatment to persons with intellectual disabilities who experience problems with sexual behaviour.

We also want to reiterate that our knowledge of how best to treat sexually inappropriate interests and behaviours in persons with intellectual disabilities is continuing to adapt and grow. The methods we will explain in this chapter are **evidence-based** and supported by research; however, as with assessment methods, we do not mean to suggest that these are the only methods that might result in favourable outcomes for our clients.

## Treatment Methods—Trials, Tribulations, and Lessons Learned

A particularly important lesson as to why persons offering treatment must have training and experience is found in Martinson's groundbreaking study from the 1970s. Essentially, Martinson (1974) did a large-scale evaluation of the forensic rehabilitative literature and found that there was no evidence to show that our efforts at treating offenders were having any measurable impact. That is, the offenders who received treatment did not reoffend less often than the offenders who got no treatment at all. This discovery marked the beginning of the "Nothing Works" phase of the development of evidence-based correctional treatment.

Through the seminal work of Canadian researchers Don Andrews, Jim Bonta, Paul Gendreau, and others, we ultimately learned that we were focusing on the wrong things in treatment. For example, many program providers believed that offenders engaged in antisocial behaviour because they had low self-esteem. This may, indeed, have been true to a degree; however, we now know that offenders engage in offensive behaviour because of a complex mix

**Glossary**

**specific deterrence** In crime and punishment, an outcome whereby an individual appreciates that his or her actions resulted in a certain punishment, and the punishment decreases the likelihood of reoccurrence of the illegal behaviour.

**general deterrence** In crime and punishment, an outcome whereby the population at large is prevented from engaging in criminal behaviour because individuals are aware of what the punishment will be. For instance, when judges "make an example" of someone during sentencing, they are appealing to general deterrence.

**consequential learning** A style of learning that occurs when individuals can appreciate that certain outcomes are associated with their behaviour. In our context, we want our clients to understand that their actions have consequences.

of behavioural and cognitive factors, heavily influenced by their social learning experiences. Of greater importance for treatment were those criminogenic factors (treatment needs) that led these clients into trouble (e.g., poor problem-solving, substance abuse, poor emotional control, impulsivity, antisocial values and attitudes, etc.). We eventually learned that if we help our clients to develop lifestyle balance and self-determination, they engage in less criminal and other antisocial behaviour and, surprise, surprise, they feel better about themselves and have higher self-esteem as a natural consequence of leading much more profitable lives.

## Treatment and Intellectual Disability

Tough (2001) found that people with disabilities are often exempted from treatment because of their disability, yet treatment is possible with this population (of persons who received treatment, 15.8 percent of a sample of persons with intellectual disabilities recidivated, which is about the same rate as those persons who do not have intellectual disabilities). We feel very strongly that persons with intellectual disabilities *are* amenable to treatment. Indeed, we have witnessed a good many persons with intellectual disabilities who have ultimately learned to think and behave in ways that lead to their achieving more aspects of what treatment providers have termed "a good life."

It is certainly true that offering treatment services to persons with intellectual disabilities poses challenges. Indeed, as with conducting assessment procedures, offering treatment to this client population also requires a degree of creativity. Most importantly, it is crucial that we believe that our clients can get better. It is important that all those involved in the treatment of an individual are willing to support that individual in his or her participation in treatment.

## Consequential Learning

Our criminal justice system is built on the concept of "deterrence." There are two types of deterrence:

1. **Specific Deterrence**: This occurs when an individual, receives a punishment for engaging in bad behaviour. For example, a person who receives a ticket and a fine for failing to stop at a stop sign will likely be more aware of stop signs in the future. The idea is that someone who has been punished will want to avoid the punishment in the future, so will not engage in the bad behaviour.
2. **General Deterrence**: This occurs when an individual observes what happens to someone else who receives a punishment for engaging in bad behaviour. For example, the courts often assign harsh sentences in order to make an example of someone who has been convicted of a crime, in order to send the message that this type of crime will not be tolerated in society. The idea is that people will want to avoid receiving a similar punishment, so will not engage in the bad behaviour.

This system of deterrence is commonly referred to as **consequential learning**. Consequential learning can be very important for people who have poor problem-solving skills, or who are less able to develop appropriate means

of assessing and responding to situations. Clearly, unless the consequences of engaging in certain behaviours are not tolerable, the behaviours will not stop. Persons with intellectual disabilities have often received a "free pass" from the criminal justice system; police officers have been reluctant to lay charges against, and courts have been reluctant to convict, persons who may not understand the nature of their offenses. Consequently, many persons with intellectual disabilities who sexually offend never truly learn that their behaviour is unacceptable. This pattern is gradually changing as we educate all concerned that these behaviours cannot be tolerated, no matter what the individuals' diagnosis or personal circumstances may be. In the previous chapter, we suggested that there may be times when persons with intellectual disabilities may engage in behaviour that appears paraphilic, but might not be paraphilic. Regardless of the reason for the behaviour, we need to stress that our clients have a right to comprehensive assessment and sensitive and effective treatment. They also have the right to be held accountable for their actions, just as their non-disabled compatriots would be.

## Principles of Effective Interventions Revisited

Before we delve farther into the subject of treatments and interventions, it is worth revisiting the principles of effective interventions, or the Risk-Needs-Responsivity Model, discussed in chapter 5. Remember that interventions (treatment, supervision, etc.) are more likely to be effective and successful if they follow these simple guidelines:

- **Risk**: The level of intensity of an intervention should be matched to the level of risk posed by the individual. Remember that high-risk = high intensity, and that mismatching leads to higher rates of re-offending.
- **Need**: The goals of your intervention (treatment, supervision strategies) must be specifically tailored to the specific needs of your client. For example, clients with issues regarding children must either avoid children altogether or be strictly supervised when in the company of children.
- **Responsivity**: All interventions must be sensitive (responsive) to the individual characteristics of the client with whom they are being employed. This includes such important elements as learning style, cognitive ability, life circumstances, and motivation. You can imagine how critically important this particular principle is in working with persons with intellectual disabilities.

### Motivation to change

Probably one of the most crucial responsivity issues surrounds instilling and maintaining motivation to change in persons who offend. Pretty clearly, those persons who offend who are unmotivated will not benefit from programming—we will essentially be wasting both their time and money and ours, while doing nothing to increase public safety. From the research on motivation, we know the following:

- Motivation cannot be adequately measured by self-report (people tend not to tell the truth regarding levels of motivation).

- How people behave is a better source of information than what they say (actions speak louder than words).
- Motivation can be observed from the individual's degree of engagement (an engaged individual is very likely to be a motivated individual [Barrett, Wilson, & Long, 2003])

Regarding the last point, there are some key considerations when assessing a person's investment in the process of change. Foremost, does the person say that he or she wants to change? You would be surprised how often we forget to ask clients this important question before we put them into groups. Investment is a key component of treatment readiness, which we will discuss in a moment. Other questions that can provide indicators of motivation and engagement are:

- Does the individual attend?
- Is the individual listening?
- Does the individual contribute to the discussion?
- Does the individual give and receive feedback?

Positive answers to these question are all indicators of quality participation in the change process. Additionally, people who are working on their problems have goals, and are able to describe some sort of plan for reaching those goals. Therefore, it is important that clients participate in their own treatment planning and monitoring.

However, sometimes a client seems entrenched, resistant, and opposed to everything. These are the clients who make our lives difficult, and who often cause us the greatest concern. Why are these clients so problematic? Part of the answer to this lies in the client's demand situation. Remember that demand situation is a psychological concept related to how someone perceives the situation they are in.

We make subtler or greater changes to ourselves, our behaviour, or our appearances depending on what we perceive to be the relative outcome of this behaviour or presentation. Think of it this way: Do you wear jeans and a t-shirt to a wedding or funeral? Conversely, do you wear a sedate suit to a nightclub on a Friday evening? In both situations, you probably choose your clothing to meet the expectations of other people at the event. Similarly, we behave in different ways depending on what outcome we wish to promote. People who have engaged in bad behaviour know that their behaviour was bad and they are likely ashamed of it (at least on some level). So, when they are confronted with questions about their behaviour, they deny all involvement. What's the first thing a parent hears in response to the question, "Who left the milk out?" "Not me!"

Most people who break rules or engage in illegal behaviour were raised with the same basic societal and civic values as the rest of us—they know right from wrong. But, somehow, they were able to suspend those morals or values long enough to engage in the bad behaviour. Sometimes they use cognitive distortions—tricks our minds play on us to try to convince us that what we are doing is okay. For example, a person who has committed a sexual offense may think or say things like: "If she didn't want sex, why would she dress so

provocatively?" or "I only did it a little bit." Deep down, we all want others to think that we are nice people. We certainly do not want to be thought of as monsters. Yet, that is the public's perspective when it comes to those who sexually assault women, children, and other vulnerable people. Let's be honest—persons who sexually offend are hated, and our clients know it. This is why it is so difficult for them to come clean and start to be honest about their thoughts, feelings, attitudes, and behaviour.

### Why is it so difficult to disclose sexual violence?

The literature regarding sexual offending has tended to focus on issues of denial and minimization as important to risk assessment and treatment enterprises. However, it may surprise you to know that neither construct (denial or minimization) has strong empirical support in regard to reoffense risk or successful completion of treatment. Most people are offended when a person who has engaged in sexual offending denies having hurt the child or other vulnerable person. We want offenders to come completely clean and admit to all of the bad stuff they did. In fact, many people believe that persons who sexually offend cannot truly benefit from treatment, or be safe to release to the community, unless they take full responsibility for their harmful behaviour. However, as we stated above, there is little or no evidence to suggest that persons who sexually offend must admit to the offenses, or even take responsibility for the harm that occurred as a result of their behaviour.

Notwithstanding these research findings, most treatment programs require participants to disclose their offense histories, as a means to outline the extent of the problems in need of rehabilitative programming. Earlier, we said that there were psychological and social processes that contributed to secrecy regarding sexual abuse. We said that these processes were prominent for both victims and offenders. The following table suggests some of the reasons that persons who are either victims or offenders might not want others to know what happened.

| Reason | Persons Who Have Eexperienced Abuse | Persons Who Have Commited Abuse |
|---|---|---|
| Fear of not being believed | ✓ | ✓ |
| Fear of being blamed | ✓ | ✓ |
| Fear of being punished | ✓ | ✓ |
| Fear of physical harm | ✓ | ✓ |
| Fear of losing emotional, physical, and/or social supports or privilege | ✓ | ✓ |
| Fear of losing independence | ✓ | ✓ |
| Shame | ✓ | ✓ |
| Self-blame | ✓ | ✓ |

| | | |
|---|---|---|
| Not having the language to describe what has occurred | ✓ | ✓ |
| Not having access to a safe person to tell because everyone is somehow connected to the situation or people involved | ✓ | ✓ |

*Reasons that both persons who have experienced abuse and persons who commit offenses may have for not disclosing sexual offenses*

We can see that all of the reasons for wanting to maintain the secrecy are the same, whether a person has committed an offense or been hurt. Keeping in mind the aforementioned issues regarding denial and minimization, issues of victim understanding and victim harm are still important topics to assess and address in treatment. Most treatment programs incorporate special sections on understanding the harm to victims and developing victim empathy.

## Transtheoretical Stages of Change Model

Making lasting changes in one's personal life requires some sort of plan, with clearly defined steps and objectives, as well as ways to measure success. Most schemes include a rough approximation of the following steps:

1. Identify the problem (sometimes, this means simply acknowledging that a problem exists).
2. Outline the components of the problem.
3. Devise and engage alternatives.
4. Evaluate outcomes.
5. Make revisions as necessary.

The steps seem pretty simple, at least on paper. However, we know that some processes of the human psyche—such as denial and minimization—often serve to thwart this process. Indeed, even the seemingly simple task of acknowledging that we must change some part of ourselves or of our behaviour can prove daunting.

The Transtheoretical Stages of Change model originated with DiClemente and Prochaska (1998), who were interested in devising effective programs to treat clients with alcohol and substance abuse issues. As we will see throughout this chapter and others, there are some similarities and crossovers in the way we treat various impulse control problems (e.g., alcohol/substance abuse, gambling, overeating, sexual offending).

The Stages of Change model (we can leave off the unwieldy "Transtheoretical" for this discussion) is particularly helpful in that it helps us to "map out" where a client is in terms of the client's progress in treatment. Each stage of change brings with it certain challenges as we try to help clients to move ahead in the treatment process. The following table shows the clinical presentations and degree of motivation inherent in clients at each stage of change, as well as suggestions for intervention at each of the stages.

| Phase | Presentation | Level of Motivation | Tips for Clinicians |
|---|---|---|---|
| Precontemplation | No acknowledgement of problem's existence | Defensive/unmotivated | Create dissonance; raise doubts |
| Contemplation | Acknowledgement that problem "might" exist | Vacillation between minimization and acknowledgement of the problem | Tip the decisional balance; evoke reasons for change (pros/cons); support change |
| Preparation | Recognition of the problem | Appearance of motivation | Explore best course of action |
| Action | Active engagement with the process of change | Good motivation | Take steps toward change |
| Maintenance | Maintenance of change through application of effective coping strategies | Good motivation | Identify and use adaptive coping strategies |

*Stages of change, and tips for clinicians assisting clients in these stages*

**Glossary**

**motivational interviewing** A treatment technique in which facilitators attempt to engage clients in the process of treatment by using non-threatening, supportive, and empathic methods. Use of open-ended (Socratic) questioning encourages clients to disclose and discuss their problems in a collaborative dialogue.

## Interviewing Skills

Observing persons who have offended, during supervisory and treatment meetings, is one of the most important ways in which we gather information about these clients. Ironically, our success in achieving our supervision and rehabilitative goals is often more a result of our own conduct during the interview than of how the offender behaves. Skilled professionals who work with persons who have committed sexual offenses are adept at:

- Interpreting body language
- Attending to what the client says
- Asking questions in ways that solicit information, using such techniques as
  - Reflecting
  - Confronting
  - Referring

In recent years, much has been written about **motivational interviewing**—a clinical technique aimed at increasing client participation in the treatment and rehabilitation process. Although an extensive description of this method is beyond the scope of this publication, we strongly encourage all professionals working with persons with behaviour problems to learn more about how to "talk so clients will listen, and listen so clients will talk." Prescott (2009) has produced a good sourcebook on motivating clients in sexual offender treatment.

## Treatment Readiness and Focusing on Treatment-Interfering Factors

Even though the research is unclear as to how much we gain by focusing on such targets as denial, minimization, and victim empathy—at least as far as reduced recidivism is concerned—participants in treatment programming have to be "prepared" to discuss such things anyway. Discussion of "what you did," "who you did it to,", and "how often you did it" sometimes causes treatment

**Glossary**

**treatment-interfering factor** Factor that prevents successful advancement and completion of treatment. Examples might be cognitive distortions, low motivation, and poor cognitive problem-solving.

participants to "put up walls," which interfere with their ability to address aspects of their rehabilitation. Those psychological processes that prevent clients from attending to problem identification and personal change are often referred to as **treatment-interfering factors**, and virtually all persons in sexual offender treatment experience them to a degree. This is where the concept of treatment readiness programming comes into play (Marshall, Marshall, Fernandez, Malcolm, & Moulden, 2009; Wilson, 2009; Wilson & Pake, 2010).

The literature on effective interventions (remember the RNR model we outlined above?) stresses that all successful treatment endeavors must attend to issues of client responsivity. Simply put, all program components must take into account the personal attributes and skill levels of each participant in order to ensure maximum treatment efficacy. Programs also need to ensure that prospective participants understand why they must engage in treatment, and that they believe that such engagement will assist them in making the changes necessary to achieve the sort of balanced, self-determined lifestyle that we promise them will help them to live better lives.

Essentially, we need to be able to answer the question, "What's in it for me?" If we don't have a good answer, we should not expect our clients to put in the level of effort and determination that will be required for them to succeed in life without engaging in further sexual or other violence. We also need to remember that accomplishing all the changes we want them to—and that they want themselves to—is a tall order. Lasting change requires quite an investment and we need to help our clients understand that individuals slated for intensive psychotherapy must be ready for that experience.

So, the first part of treatment is the process of getting ready for treatment. In treating persons who sexually offend, this may be the most important thing we will accomplish. We also need to be mindful of the fact that some offenders will never get to a place where they can admit they did something wrong. This is a reality of sexual offender treatment. Nonetheless, we ask ourselves: What do you do with those clients in categorical denial? Do we badger them until they finally give in? Do we bang our heads against the proverbial wall until we are battered and bloody?

The research is pretty clear that offenders in categorical denial are usually more motivated to maintain that denial than we are to break it down. There is a point at which we just give up. But, this does not need to be the pattern. There are ways to treat people in categorical denial.

## Instead of giving up

Bill Marshall, formerly of Queen's University in Kingston, Ontario, is one of the "fathers" of modern sexual offender treatment. He used to see a lot of categorical deniers—most of whom were sent away from treatment on the belief that a person who commits an offense has to admit guilt in order to benefit from treatment. But Dr. Marshall had an ethical dilemma: he believed that it was unconscionable to do nothing. He believed that there had to be something we could do to reduce the risk posed by these "deniers." And he learned something really interesting.

Dr. Marshall decided to take denial off the table. He correctly ascertained that our abhorrence of their denial of guilt was entrenching his clients in denial against the process of change. Dr. Marshall turned the tables on these clients by stating (paraphrased), "Okay, let's say you didn't do it. Look at where you are. How did you get here? What went wrong? How are you going to make sure that this doesn't ever happen to you again?"

Dr. Marshall's clients could admit that their lives were not going very well and that they did not want to be in trouble all the time. Dr. Marshall then started working with his clients on the risk factors and lifestyle imbalances that put them at risk for "erroneously" getting in trouble again. Those risk factors and lifestyle imbalances were exactly the same ones we focus on with clients who admit their offenses. In the end, Dr. Marshall's clients could focus on treatment and personal change without being forced to admit guilt. Many of those clients, having had a chance to address their personal difficulties, ended up admitting to engaging in sexually abusive behaviour. All we needed to do was to take the shame and guilt (and, by extension, coerced responsibility-taking) off the table and focus on quality of life.

Because of Dr. Marshall's experience and that of others, we now know that people we expect to make changes have to buy into the process of change. We have learned that confrontation and shame-based approaches just do not work (Tangney, Wagner, Fletcher, & Gramzow, 1992). If we truly want our clients to change, we have to make sure that we prepare them properly for the process of change—that is what treatment readiness is all about. The step from precontemplation to contemplation can be a monumental accomplishment for both client and therapist.

## Responsivity Issues for Clients with Intellectual Disabilities

Programs for persons with intellectual disabilities who sexually offend must keenly address responsivity issues. That is, treatment programs must be presented in a form to which participants can respond. The following are common hindrances to effective programming with persons with intellectual disabilities who come into contact with the criminal justice system:

- Borderline intelligence
- Illiteracy
- Communication difficulties/disabilities (or other learning disabilities)
- Impulsivity
- Inadequate social skills

We must take care to rework complicated language, jargon, and other complex ideas and either present the material in simpler ways or, where appropriate, eliminate complicated material entirely. Many persons with intellectual disabilities who engage in sexually inappropriate behaviour may not have the cognitive ability to work through the complex situations that are the focus of traditional sexual offender treatment. For these clients, it may take years of treatment, cognitive rehearsal, and practice in real-life settings before skills are adequately generalized. For some individuals, understanding a basic

**Glossary**

**bio-psycho-social** An approach to behavioural analysis that proposes that most things we do as human beings are influenced by our physical makeup, our thought processes, and the affect our behaviour has on our relationships with others.

**id** According to Freud's psychoanalytic theory of personality, the personality component that works to satisfy basic urges, needs, and desires.

set of "safety rules" and the consequences of engaging in sexually offending behaviour is the core of treatment.

## Treatment Interventions

Treatment programming for persons who sexually offend continues to be a source of considerable controversy. On the one hand, many clinicians believe strongly that their efforts in helping clients change are having the desired effect. On the other hand, some have argued that we currently have no way to know for sure whether our efforts are *really* working. The most recent research (Hanson, Bourgon, Helmus, & Hodgson, 2009) suggests strongly that there is a significant treatment effect. In this section, we will discuss the history and current trends in treatment for persons who sexually offend.

### Treatment Philosophy

Sexual offending is a **bio-psycho-social** problem that results from a complex interaction of offender-specific and environmental factors that require competent assessment and, ultimately, long-term treatment and follow-up. For those readers unfamiliar with the bio-psycho-social perspective, let us explain a bit further. Almost all aspects of human behaviour include components of biology (how we are put together physiologically), psychology (how we think and behave), and social functioning (how we interact with others around us). These three components interact with one another to determine how we live our lives. In keeping with the "balanced, self-determined lifestyle" concept that underpins most of the material in this guidebook, those persons who learn to balance the biological, psychological, and social elements of their lives are most successful in life.

The history of sexual offender treatment has, in many ways, mirrored the history of psychological treatment in general. As our understanding of behaviour and cognition has advanced so, too, have our theoretical and practical perspectives on how to assist those who experience difficulty. Interested readers may wish to refer to two articles by Marshall and Laws (2003; Laws & Mashall, 2003), in which the authors provide an excellent summary of the progression of thinking by treatment theorists and providers, specifically in relation to understanding deviant sexual behaviour. In the following sections, we will outline many of the attempts that have been made over the years to treat persons who engage in sexually abusive behaviour.

### Psychodynamic Therapies

Freud has often been thought of as the "granddaddy" of sex research. Although this designation is probably not entirely true, it is certainly true that many early approaches to sexual offender treatment have their origins in work derived from or contemporary to Freud. Indeed, Freudian psychoanalysis was widely used with persons who sexually offended in the early part of the twentieth century. In these endeavours, therapists and their clients concentrated on early experiences and internal conflict derived from an uncontrolled **id**. Psychodynamic approaches still garner considerable favour in European circles. Older research

**Glossary**

**reinforcement** In learning and behaviour, whenever one event or outcome influences the likelihood that the antecedent cognition or behaviour will be repeated. There is both positive and negative reinforcement.

**conditioning** A process in which we attempt to modify a response to a certain situation or event by pairing the outcome with another process in the client's environment. These other processes become sources of reinforcement, positive or negative.

**systematic desensitization** A behaviour modification technique used to treat phobias and other extreme or erroneous fears.

**satiation and masturbatory reconditioning** A behaviour modification technique in which the client is encouraged to masturbate using a socially acceptable fantasy. Following orgasm, the client is instructed to continue masturbating using his or her desired deviant fantasy.

**orgasmic reconditioning** A behaviour modification technique in which the client is instructd to masturbate using his or her paraphilica fantasy and to switch to a more appropriate fantasy just at the moment of orgasm.

**aversive conditioning** A behaviour modification technique which involves exposing the client to unpleasant stimuli in response to the inappropriate or undesirable behaviour.

suggests that those approaches were counterproductive, or at least not ultimately helpful, in terms of recidivism.

### Behaviourism

The early work of John B. Watson formed the basis for early approaches to treating persons who sexually offend in North America, with a good deal of influence from concepts such as **reinforcement** (Thorndike) and **conditioning** (Pavlov). Behaviourism was also later influenced by Skinner's principles of operant conditioning. The following are some typical behavioual approaches:

- **Systematic desensitization**
- **Satiation and masturbatory reconditioning**
- **Orgasmic reconditioning**
- **Aversive conditioning**

Aversive conditioning, which was originally used in attempts to "treat" homosexuality, involves exposing the client to unpleasant stimuli, such as injected nauseants, foul odours, electric shock, or shame and embarrassment, while the client engages in the undesirable behaviour. Interestingly, however popular aversive conditioning methods might be with those who are unsympathetic to persons who sexually offend, the practice has never been conclusively shown to produce permanent changes in behaviour. Generally, such methods have been a bust.

### Cognitive-Behaviourism (CBT)

In the 1970s, behaviourism was broadened to include elements of cognition. This change represented, in many respects, a giant leap forward for psychotherapy, especially for treatment of impulse-control difficulties such as sexual offending. Methods and concepts emanating from the CBT school include:

- Covert methods, such as sensitization, reinforcement, extinction
- Cognitive restructuring
- Cognitive distortions

Two very important theoretical and practical models have come from the cognitive-behavioural tradition, as it relates to treatment of persons who sexually offend: the Relapse Prevention model, and the Pathways/Self-Regulation model.

## Relapse Prevention

Relapse Prevention (RP) was originally proposed as a treatment methodology for alcohol abuse. In the early 1980s, researchers and clinicians postulated that this method might also be helpful for other types of impulse control disorders (e.g., gambling, drug abuse, sexual offending). As such, the RP method was adapted for use with persons who sexually offend. Until recently, Relapse Prevention was the preferred model of sexual offender treatment in Canadian and American corrections.

**Glossary**

**problem of immediate gratification** In relapse prevention, a problem that occurs when clients become despondent about their poor cognitive and behavioural choices to the extent that they will do almost anything to feel better. They need for this to happen as soon as possible which, ultimately, leads to poor decision-making.

**internal self-management** In the relapse prevention model, the goal of the first part of treatment. During this phase, participants come to understand how their internal processes interact with the environment to increase the likelihood of offending. Learning to control those internal processes is the important first step.

In the Relapse Prevention framework, high-risk situations typically precede engagement in sexually abusive conduct. High-risk situations consist of both internal and external aspects.

*Environmental Elements + Personal Elements = High-Risk Situation*

## Basic Principles of Relapse Prevention (RP)

Participation in relapse prevention programming starts with a promise not to reoffend. However, in order to achieve this, persons who sexually offend need to understand and ultimately interrupt the chain of events leading to relapse. In this they need to learn to:

- Manage the **problem of immediate gratification** (PIG—see glossary of RP terminology on the following page)
- Address denial and minimization of damage
- Understand the specific precursors to their own offending behaviour
- Develop adaptive coping strategies for maintenance of an offense-free lifestyle.

Traditional relapse prevention treatment consists of two components:

### 1. Internal Self-Management

The **internal self-management** phase is both time- and labour-intensive. It requires that offenders engage in a good deal of soul-searching. Essentially, they must learn to break down all of the thoughts and behaviours that have become patterns of maladaptive behaviour. This phase is heavy on knowledge acquisition and adaptation of concepts to behaviour. Because of the time and effort required, this phase is often best accomplished in an intensive group treatment program found in an institutional or group home setting (this is mostly because the intensity of treatment required to meet the targets at this level cannot be achieved if you have too many other responsibilities). Major areas of focus for treatment include the following:

- Offence disclosure
- Developing empathy for victims of sexual violence
- Understanding offence cycles
- Developing relapse prevention plans

### 2. External Supervision

Pithers (1990) suggested that, by the end of a successful internal self-management phase, treatment participants should have developed appropriate relapse prevention plans, and should now be ready to implement them in the community. Essentially, persons with sexual offense histories participating in treatment programming need real-life opportunities to test the skills they have developed in internal self-management. In the next phase of treatment—External Supervision—persons with a history of offense and their support teams focus on attempting to put new learning into action in the community; albeit, with a degree of supervision and mentoring. This is analogous to an internship or other process of supervised skills implementation. For persons in sexual offender treatment, effective external supervision processes require an appropriate relapse prevention plan, and a readiness to try it out in the community.

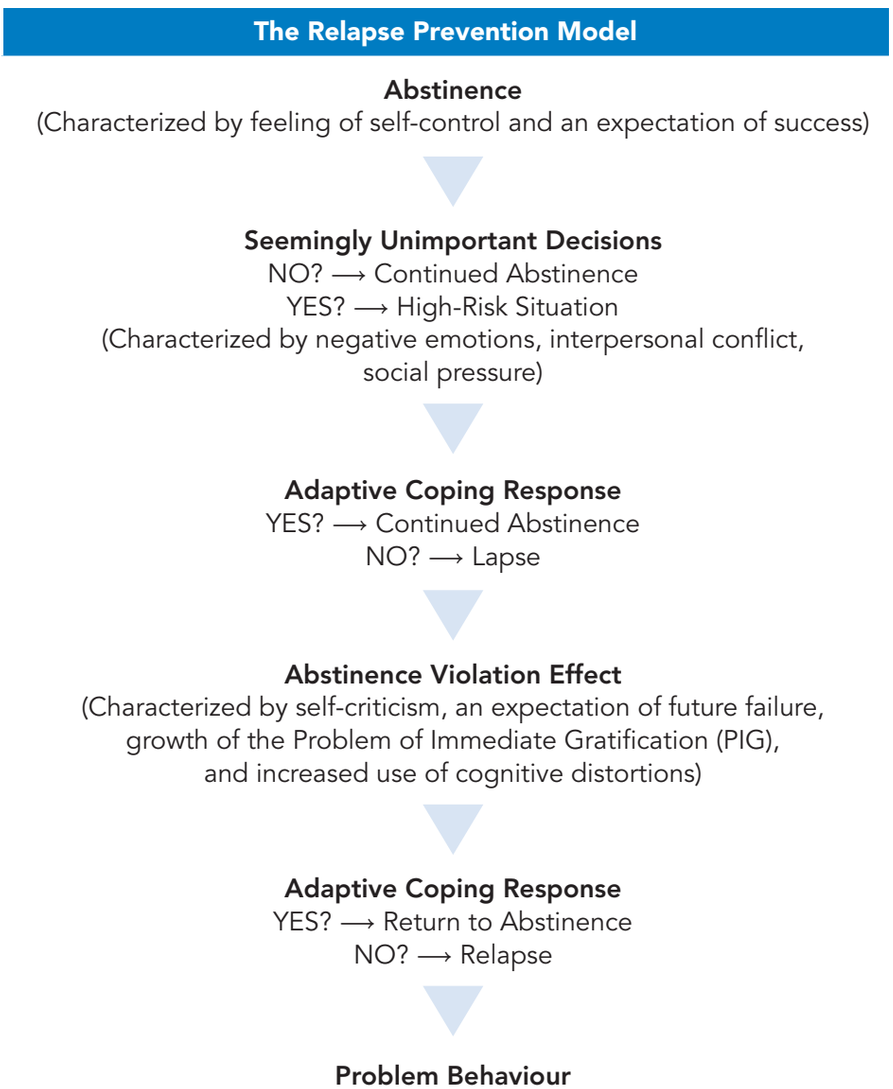
## Relapse Prevention Terminology

One criticism leveled at the RP model was that it was jargon-laden and that some of the concepts were difficult to grasp, especially for those with intellectual disabilities. The table below presents key terms used in the RP model.

| | |
|---|---|
| Abstinence | This does not mean abstinence from all sexual behaviour. Rather, this means abstinence from problematic sexual behaviour. |
| Seemingly Unimportant Decisions (SUDS) | These are decisions we make that, on the surface, appear to have nothing to do with offending but, in reality, actually contribute to high-risk situations. |
| High-Risk Situation | A high-risk situation is any scenario in which there is a heightened chance that the client will engage in problematic sexual behaviour (cognitive or behavioural). |
| Adaptive Coping Strategy/Skill | These are means by which clients avoid or escape high-risk situations, either by changing their lifestyles or by restructuring their thought patterns (e.g., challenging cognitive distortions). |
| Cognitive Distortions | At a basic level, these are ego defense mechanisms—cognitive processes that allow you to continue engaging in thought or behaviour that you know intrinsically will lead you into a high-risk situation. |
| Lapse | A lapse is a significant thought or action that approximates offending. For instance, active fantasizing about offending is a lapse. So is purchasing pornography. |
| Abstinence Violation Effect (AVE) | When people try to change their behaviour, most are relatively invested in the process—they want to succeed. However, if they find themselves in high-risk situations, and are not able to employ adaptive coping responses, they may become disillusioned and downtrodden. This is the "I'll never change" effect, and is tantamount to giving up. |
| Problem of Immediate Gratification (PIG) | The PIG is a very important component of the AVE. It is often a maladaptive attempt to manage the strong negative emotions that come from negative self-talk like "I'll never change." The PIG relates to the need to feel better, whatever the cost. Persons who sexually offend know that offending caused them a degree of sexual pleasure. Presented with a high-risk situation and a strong AVE, some persons who sexually offend will do anything to feel better—in this case offending. |

*Terminology used in the RP model*

The following is a graphic description of the Relapse Prevention Model.




In the late 1990s, many sexual offender specialists attempted to reformulate RP. In the approximately 20 years that the RP method was in use with persons who sexually offend, we learned a lot about its strengths and weaknesses. While the model helped many persons who sexually offend to remain offense-free, ultimately, some aspects required rethinking.

The RP method the model was seen as unnecessarily "negative," often leaving clients with little positive regard for their behaviour or ability to maintain the abstinence required by the model. Further, abstinence as the goal was difficult for some clients to understand. Treatment providers often had difficulties accepting that there was only one pathway to offending. Traditional RP conceptualizations stressed that reoffending behaviour flowed from experience of negative emotion leading to SUDS, HRSs, and the AVE. In a landmark publication entitled *Remaking Relapse Prevention*, Laws, Hudson, and Ward

(2000) outlined a new way of conceptualizing the social and psychological processes leading to increased risk for sexual offending. The model they outlined, referred to as the Pathways/Self-Regulation Model and colloquially known as the "Good Lives Model," is currently the more common approach to treatment for persons who sexually offend.

## Pathways/Self-Regulation Model

The Pathways Model suggests that offending can be seen as being the result of both positive and negative cognitions. Self-regulation theory holds that individuals engage in goal-directed behaviour based on internal and external circumstances and events that direct behaviour.

| Pathway | Dynamics |
|---|---|
| Avoidant Passive Pathway | Individuals following this pathway wish to refrain from offending, but do not actively attempt to do so, or simply attempts to deny urges or to distract themselves. |
| Avoidant Active Pathway | Individuals following this pathway select strategies and make active attempts to achieve this inhibitory goal. |
| Approach Automatic Pathway | Individuals following this pathway engage in behaviour that is ultimately related to offending, even if they do not actively intend to commit an offense. For example, an individual who gets into trouble when he or she goes out drinking might go out drinking late at night. This puts the individual at a greater risk of reoffending. |
| Approach Explicit Pathway | By contrast with individuals on the Approach Automatic Pathway, individuals on this pathway seeks explicitly to commit a particular offense. The dynamics of offending within this pathway are associated with goals that explicitly support sexual offending, such as attitudes supporting sexual activity with children or hostile attitudes toward women. |

### Good Lives Model (GLM)

A big component of the shift from RP to Pathways/Self-Regulation was in regard to general lifestyle issues. Whereas RP was focused on admission of guilt and identification of negative feeling states—often leaving offenders with not much to feel good about—the Good Lives Model suggests that offenders can (and, ultimately, must) have feelings of positive self-worth and self-esteem. This is quite similar to the Life Skills concept of a "balanced, self-determined lifestyle," in which offenders strive to lead lives that are healthy, productive, and free of risk as a natural consequence of stability and balance (see Curtiss & Warren, 1973).

**Glossary**

**prosociality** Behaviour that is characterized by a concern for the well-being of others.

The literature regarding effective treatment of offenders has continued to grow as our understanding has expanded regarding the dynamics of interpersonal conflict and offender rehabilitation. Over the years, professionals in the field have made many attempts to get this right, but we have generally failed to maximize treatment potential. In looking back at the RNR model, we emphasized the need for treatment and interventions to consider the specific personal elements of persons who engage in offending behaviour, and to make sure that the interventions were specifically tailored to them, in order to ensure greatest success.

The Good Lives Model (GLM—see Ward & Stewart, 2003; Wilson & Yates, 2009; Yates, Prescott, & Ward, 2010) has recently been put forward as a major revisiting of what works with persons who sexually offend, although there is little reason to believe that this approach would not also work with other types of offenders, including violent offenders. In comparison to the Relapse Prevention Model, the GLM regards individuals as active, goal-seeking beings who seek to acquire fundamental primary human goods—actions, experiences, and activities that are intrinsically beneficial to their individual well-being and that are sought for their own sake. All human beings see examples of primary human goods such as relatedness/intimacy, agency/autonomy, and emotional equilibrium, and all humans seek to attain these.

Among most persons who engage in offending behaviour, risk factors and criminogenic needs can be seen as symptoms of ineffective or inappropriate strategies employed to achieve primary or secondary goods or goals. For example, an offender may desire intimacy, but turn to children to meet this need.

> *Essentially, criminal behaviour results from problematic methods used to achieve goals, and not from the goals themselves. The aim in treatment is, therefore, not to change the goal (intimacy), but to target the methods the individual uses to achieve the goal (achieving "intimacy" with children).*

All in all, the GLM emphasizes looking at persons who commit offenses as "whole beings," and not just as the sum of individual parts. Doing so reminds us that most persons, including offenders, should not be evaluated as human beings based solely on "the worst thing they ever did." When we emphasize lifestyle elements that lead to greater **prosociality**, and teach ways to minimize antisocial peer affiliation, cognitions, and behaviour, clients learn to lead a balanced, self-determined lifestyle. They strive to lead lives that are healthy, productive, and free of risk, as a natural consequence of stability. A balanced, self-determined lifestyle is antithetical to offending.

## Applying Current Best Practice Treatment Principles to Treating Clients with Intellectual Disabilities

It is all well and good to spend most of a chapter talking about treatment of persons who sexually abuse, but who do not have concurrent problems with intellectual disability. At this point, many readers will likely be asking, "But

what about my clients? How do I take all of this complex theory and put it into practice with the people with whom I work?" These are fair questions.

Dr. Gerry Blasingame has written several books (2005; 2006; 2011) on working with persons with intellectual disabilities and sexual behaviour problems. There are also other good books out there dealing with these issues (e.g., *Footprints* by Hansen and Kahn [2006] and *Healthy Choices* by Horton and Frugoli [2001]). Interestingly, most people who propose models of treatment for our clients do not suggest that we need to do things markedly differently. Rather, they contend that the models of treatment that we use with persons who are not intellectually disabled are conceptually sound for using with our clients who are intellectually disabled. However, in order to making sure that our treatment endeavours make sense and work as well as possible for persons with intellectual disabilities and sexual behaviour problems we need to adjust our practices, somewhat. Specifically, we need to address the specific challenges that our clients face:

- Borderline intelligence
- Illiteracy
- Communication difficulties/disabilities (or other learning disabilities)
- Impulsivity
- Inadequate social skills

## Treatment Group Programming with Clients with Intellectual Disabilities

As we discussed in the preceding sections, treatment programming for persons who sexually offend is relatively new. In keeping with comments we have made elsewhere, it is important to note that applications of methods to persons who sexually offend who also have intellectual disabilities are usually even newer. In this section, we will share with you some of the treatment processes we have found useful in our work with this client group.

### Weekly Group

Group counselling programs can be very effective in assisting individuals with intellectual disabilities. In such programming, a number of individuals with similar needs and issues come together to discuss their common experiences and issues. In order to promote group cohesion and the ultimate "group process," the facilitator(s) should screen potential participants for age and functioning level, and some determination should be made as to whether the group should be co-ed or gender specific. Overall, it is important to ensure that participants have similar treatment needs, so that they can work on these issues collaboratively.

Group counsellors need to be very proactive and creative in their leadership style when working with groups of persons with intellectual disabilities. Our clients have a variety of different skill levels and learning styles. With this in mind, group counsellors must be open to trying several different strategies to teach a single concept. Otherwise, the usual benefits of group counselling may

**Glossary**

**wrap-around care** An approach to providing care in which a person in need is provided with comprehensive attention to all facets of life that might impinge on risk. Many such programs have been referred to as "Circles of Support."

be lost. Furthermore people with intellectual disabilites do not always track what peers are saying and therefore cannot give feedback even if called on.

### Duration of sessions

In working with clients with intellectual disabilities (and, actually, in other types of groups), it has typically been found that eight participants is an optimal number in a group with two facilitators. The length of each group session may be flexible, but 90 minutes appears to be a good duration for clients with mild intellectual disabilities—long enough that something can be accomplished, but not so long that participants will become restless or otherwise distracted. The duration of the group session may also need to be flexible, depending on the topic being addressed, the amount of material being covered, the availability of the participants, and the purpose of the group.

### External support

Group work with clients with intellectual disabilities often requires collateral support from others important in the clients' lives. Hosting an information session for the people who support your clients can help these members of your clients' communities understand how they can reinforce topics you discuss in the group, and help clients apply the skills they learn in everyday settings. In these sessions with support persons, you can review the curriculum being addressed and the strategies used for learning.

Holding periodic sessions with collateral support persons at intervals during the clients' participation in programming provides a good opportunity to reiterate program goals, review any challenges that specific participants may encounter, and to obtain any feedback. Feedback from support persons is a particularly important aspect of successful interventions with clients with intellectual disabilities, because collateral support workers have the opportunity to observe and report on how well clients are generalizing the skills they learn in group and applying them in real-life situations. Research regarding **wrap-around care** has suggested that having a strong and highly invested social support network increases the likelihood of success in behavioural change (see Wilson, McWhinnie, & Wilson, 2009). However, it is important that information provided by either the group's facilitators or the clients' support persons be shared in a manner sensitive to privacy and with the client's consent to share this information.

### Establishing the group

When beginning a group it is very important to establish rules to make each group environment a comfortable and safe place where individuals can participate and work out their issues. It is important to begin by having the group come up with rules and guidelines for participation; however, the group's facilitators may wish to guide participants to make sure important rules (such as non-judgmental attitudes, confidentiality, active listening, respect, and the modelling and use of appropriate social skills) are included. A few sessions can be dedicated to establishing good rapport within the group, in addition to setting rules and boundaries and building a feeling of community and teamwork.

### Begin with a warm-up exercise

Warm-up exercises promote team building and common experience. They are usually designed to encourage all members to actively participate in the group session. In some groups, the warm-up is embodied as a "check-in," at the beginning of each session—giving individuals an opportunity to discuss important things that have occurred in the previous week gives them a sense of community and of belonging. In the weekly check-in, each individual may have a chance to present something that is important to them (at times this may need to be approved by the facilitators). A schedule can be created at the very beginning of group to make sure everyone has an opportunity to share with the group (e.g., one individual per week).

### Activities and discussions

Each session should have a particular focus on a specific topic or strategy—some topics and strategies require more than one session, and others need to be reviewed often. Before presenting each topic or strategy, facilitators may wish to give participants a pre-test, written at a grade-2 or grade-3 reading level, to assess each participant's baseline knowledge of the topic at hand. At the end of the unit, consider giving the test again, to gauge how much the individuals have learned. If participants have difficulties reading and writing, the facilitators can work with them on a one-on-one basis to ascertain their knowledge of the subject.

As facilitators plan group activities, they should take pains to plan a balance of oral, written, and interactive (moving) activities, in addition to having the participants work in pairs, small groups, and as a whole group. Activities could include, but are not limited to, paper-and-pen worksheets, oral discussions, role playing, scenarios, drawing concepts, and games. The facilitators will likely also need to provide extra guidance or encouragement, depending on each participant's strengths and limitations. In addition, every session should have handouts, worksheets, or homework that can be reviewed further with each individual's support person. Note that most individuals with intellectual disabilities require repetition in order to retain the information provided during group. Further, reviewing with others the concepts and issues processed in treatment increases the likelihood that those new concepts or skills will be generalized to other situations and settings.

Social skills are a natural part of any group dynamic, because each individual is learning to respect others' thoughts and feelings, as well as practising certain skills such as listening, waiting, responding appropriately to others, and so on. Thus, as a general rule, facilitators should monitor all discussions are monitored to ensure that the ideas shared are appropriate and on topic.

### Cool-down activity

Cool-down activities are often a fun way to close a group session while assisting participants to review what they learned that day. They represent an important means by which to keep the activities positive and engaging, while ensuring that participants leave for the day on a positive note. Cool-down activities can include the following:

- Word games
- Trivia games
- Charades
- Picture charades (win, lose, or draw)
- Discussing scenarios and alternatives
- 20-questions
- Other creative ways to integrate learning with a positive experience.

### Examples of topics covered

- Social Skills
  – Boundaries in relationships, behaviours, and communication.
- Healthy Sexuality
  – Developing relationships, promoting generalization to various kinds of relationships, establishing appropriate behaviours in each relationship, managing urges and fantasies, promoting abuse prevention, emphasizing self-esteem.
- Emotions Management
  – Recognizing signs of emotions dysregulation in both self and others; identifying strategies for managing strong and dysfunctional emotions.

## Specific Programming Offered in Group Home Environments

In group-home environments, residents may have access to specific skills-based program options that specifically address residents' social skills and management of ongoing issues encountered within the home. The group meets for one hour each week and addresses topics and situations that the residents have identified that they would like to learn more about. These may include issues in the home that residents would like to discuss, as well as suggestions for how to improve social functioning and other aspects of their home environment.

The following are some examples of group-home programming topics:

- Communication
- Sharing
- Appropriate dress
- Personal goals
- Understanding another's point of view
- Hygiene
- Money management
- Relaxation techniques
- Healthy living
- Boundaries,
- Etiquette

(see Antonello [1996] for additional information on social skills training).

In addition, during these sessions, staff and support workers may spend time with the residents on playing board games, cards, bingo, cooking, baking,

and video games to increase the sense of community within the home and to increase the amount of positive interaction the individuals have with one another.

## Emotions Management

Anger, frustration, depression and even extreme happiness are all emotions that could potentially lead to offending behaviour. The individuals we support need to be able to recognize and express these emotions in an appropriate manner, and we need to assist them in learning how to do so. Often, we target only anger management; however, we all need *all* of the emotions that we experience. Many of the individuals we support are typically black-and-white thinkers (they experience things as either good or bad, with nothing in between). They may have difficulty understanding how the reactions of others to events are different from their own. They may take a victim stance when dealing with their inappropriate behaviours. Often, they misinterpret the reactions others have to their behaviour. For example, if someone shows kindness towards one of our clients, then clients may believe that the person is interested in them; whereas, if the person shows a lack of interest in them, then clients may feel that the person is mad at them.

Thus, it is important to educate our clients on the variety of emotions that we experience and how these emotions affect us. People may feel emotions of all types as sensations in their bodies. For example, our hearts race, our palms get sweaty, our stomachs feel as though they were tied in knots, or we experience "butterflies" in our bellies. We need to discuss with our clients how they experience the many different types of emotions, as well as how to put in place appropriate strategies for dealing with these emotions. We must assist them in understanding that it is okay to feel the wide variety of emotions, including both the positive and negative ones; it is how we express these emotions that can sometimes get us into trouble. So, when we see something or someone that excites us sexually and we feel all tingly *inside*, this feeling is not an issue. But, if we run up to the individual and try to touch their breasts or penis, this behaviour then becomes an issue. Furthermore, it is understandable that our clients may get frustrated with a co-resident who will not change the television channel to allow them to watch a favourite television program; however, swearing and hitting that co-resident is unacceptable.

There are many ways to assist the individuals we support in learning to recognize their own emotions and those of others. Watching television programs with clients and discussing what they are viewing in terms of the emotions is effective. Conducting role plays, developing individualized emotions booklets, and using a visual stress thermometer may also be helpful. Relaxation training is another effective strategy to teach individuals to help them in controlling their emotions. This can be done in a variety of ways such as through the use of auditory relaxation tapes, positive visual imagery, and progressive muscle relaxation. Presenting the individual with a variety of options is the best way to determine what modality they enjoy best or is most effective for them. Examples of tools that can be used when working on emotions management can be found in the Appendix.

## Ensuring Treatment Success

Following the completion of a risk assessment including a functional behavioural analysis (see section below on the ABC model), a number of recommendations specific to the needs of the individual will be brought forward. Generally, individuals with intellectual disabilities lack education in a variety of areas, typically including healthy sexuality, boundaries and relationships, appropriate social skills, assertiveness training, abuse prevention, age discrimination, and self-esteem, to name a few.

### Information Sharing

Agencies that have identified concerns regarding someone's behaviour do not necessarily have to wait for the completion of an assessment before they implement education sessions to assist the individual in learning necessary skills. Agencies can seek out assistance to provide the individual with education in specific areas. If the agency feels they have the ability to effectively engage the individual in educational sessions, they may find some of the strategies in the following chapters helpful.

Most new research regarding management of problematic behaviour suggests that collaborative approaches work best. In a collaborative approach, team work—especially across agencies and stakeholders—is critical. A variety of groups in the field of working with clients with intellectual disabilities who sexually abuse have important information, perspective, and service to provide. These groups include Behaviour Management Services, Community Living Services, agencies providing residential services, Police Risk Management Panels, and Probation and Parole. In addition, there are many ways in which we can all take advantage of opportunities for consultation and sharing of expertise, through workshops, symposia, panel discussions, and putting together workbooks and publications like this one.

In general, our clients must understand that we work together. As we noted above, sexual abuse is a crime of secrecy—neither the offenders nor the victims want us to know. The only way we will ever overcome this secrecy is to make sure that we establish clear information-sharing protocols and that we ensure a free flow of information. In the end, such policies will result in less secrecy and overt manipulation by clients, as well as in the swift identification and management of problems or risk situations. These concepts are of paramount concern in the work we do. Further, in acknowledging that secrecy is "bad" for good risk management, and in establishing a culture of openness and honesty, we also make it easier for victims to come forward. This is especially true when our offender clients have been victimized. Essentially, if secrecy was not "good" for them, then it is not "good" for their abuser either.

# 7

# Treatment Interventions: Behavioural Considerations

In the last chapter, we briefly outlined some of the treatment methods and philosophies that have been applied to persons who engage in sexually abusive behaviour. In working with persons with intellectual disabilities, we have learned that traditional treatment methods sometimes do not work as well. Our clients' cognitive limitations can make it difficult for them to understand the concepts in certain treatment models. As such, we often have to emphasize the *behavioural* aspect of the cognitive-behavioural model.

## Behavioural Considerations

When seeking to change any behaviour, we need to understand behavioural principles. Knowing what behaviour you want to change, what functions that behaviour serves for the individual, and how to identify an appropriate replacement behaviour is fundamental to any behavioural program, for individuals who engage in sexually inappropriate or offending behaviour as with any other individuals. For example, when an individual has a difficulty with "fetish" behaviour, we need to attempt to determine what function this behaviour serves for the individual. Why the individual grabs at himself/herself while in public, and why the individual targets young children to touch in an inappropriate manner are other examples for which we need to determine the function of the behaviour.

### Functional Behavioural Analysis

Not all sexual behaviours are driven by an inappropriate sexual arousal. Some behaviours are a result of circumstances. There are a number of factors that may hypothetically account for an individual engaging in inappropriate sexual behaviour, including:

- Lack of sexual/social education
- Modelling or re-enactments of behaviour they have witnessed or been a part of, either positively or negatively

**Glossary**

**Functional Behavioural Assessment** Like applied behavioural analysis, a process in which we seek to understand the underlying motivational factors for clients behaving in certain ways. Understanding what function these behaviours support allows us to contemplate and put in place alternatives that will be ultimately for effective and healthy for our client.

- Behaviours that are the result of a medical condition (for example, an infection in the genital area that results in excessive scratching, regardless of the setting).

To implement behavioural techniques to determine if one of these hypothetical scenarios applies to the individual you support, you must do a **Functional Behavioural Assessment** (Cipiani & Schock, 2007). These assessments focus on three main areas:

- Bio-psycho-social
- Functional
- Reinforcement

### The Bio-psycho-social assessment

First, let's look at the Bio-psycho-social assessment (remember that we introduced this concept in chapter 6). This assessment consists of three components—Biological, Psychological, and Social.

In the *Biological* component, it is important to summarize known medical conditions. Include all possible medical concerns that may influence the target behaviour, and the impacts of any medications that the individual may be taking. Behaviours such as inappropriate touching or exposure may be the result of side-effects from medication, or possibly of a sexually transmitted or other genital infection. It is always important to first rule out any underlying medical conditions.

The *Psychological* aspect considers conditions and associated cognitive or behavioural characteristics and/or deficits that may influence the behaviour. For example, a known diagnosis of Autism may account for a lack of understanding regarding social-personal boundaries.

The *Social* component summarizes details of the person's social environment (e.g., opportunities to engage in age-appropriate social activities, family life, and integration). For example, in cases where an individual may be targeting younger individuals, but has not had an opportunity to socialize with age-appropriate peers, the behaviour may not be deviant. Rather, the behaviour may indicate a lack of opportunity to access age-appropriate peers.

### The Functional assessment

The Functional aspect consists of two components: indirect and direct assessment methods. In the indirect assessment, we conduct behavioural interviews with all pertinent parties. Standardized assessment tools, such as the Question About Behavioural Functioning (QABF), Motivational Analysis Rating Scale (MARS), or the Functional Analysis Screening Tool (FAST) may be useful in structuring this assessment.

Direct assessment methods include:

- Determining a baseline
- Creating scatter plots, and conducting functional analysis/analogue assessment and observations
- Assessing ABC data (antecedents-behaviour-consequences, see next section).

**Glossary**

**baseline** In behaviourism, the natural state of cognition or behaviour.

**scatter plot** A way of graphically representing a person's behaviour in regard to particular areas of treatment or risk management interest. These plots allow us to look for patterns in behaviour and to formulate plans for behavioural change or risk management.

**Functional Analysis/ Analogue Assessment** The process of determining what outcome a client is attempting to achieve by engaging in a certain behaviour.

**ABC data** Descriptive data (antecedent, behaviour, consequence) that is evaluated to tell us why a behaviour occurs as oppose to how often a behaviour occurs.

**antecedent** In the ABC model, the precursory thought or event that results in a behaviour leading to a consequence.

**behaviour** In the ABC model, the action or response one makes to the antecedent.

**consequence** In the ABC model, the result of the behaviour one chooses to engage in as a response to the antecedent.

A **baseline** is a measure of the target behaviour before intervention, which usually includes either frequency or duration data. **Scatter plots** are charts used to plot occurrences of behaviour in relation to time. These plots help to gain an understanding of when the behaviour occurs at its highest or lowest frequency. This can assist in generating hypotheses related to the function of the behaviour (e.g., high rates of behaviours may be found to be associated with certain environments or activities).

**Functional Analysis/Analogue Assessment** is an experimental analysis of behaviour functions under contrived test conditions that typically include attention, demand, and being alone. These contrived conditions are used to mimic contingencies occurring in the natural environment that are hypothesized to be controlling the behaviour.

**ABC data** provides a descriptive analysis (e.g., antecedents, behaviour, consequences). When looking at a number of descriptive examples, patterns often become clear and show us which antecedent conditions precede the target behaviour as well as which consequences serve to reinforce the behaviour.

## The ABC Model

All behaviours have a purpose and a function. That is, the behaviour happens for a reason. The reason could be to gain access to something or someone needed or wanted (e.g., attention, control, activities, items), or to avoid or escape something (e.g., a task or a demand). Identifying the ABCs—Antecedents, Behaviours, and Consequences—can assist in determining appropriate replacement behaviour.

- An **antecedent** or trigger is what happens immediately before the behaviour occurs. This may include instructions, boredom, being told "no," loud noises, being "touched" in uncomfortable ways, or physical conditions (being tired/ hungry), to name a few.
- A **behaviour** is what we can see or hear a person do. A behaviour is measurable.
- A **consequence** is what happens immediately after the behaviour occurs. The consequence can be positive, negative, or neutral. Consequences are important, because they strengthen or weaken the behaviour. Also, consequences often become the next antecedent in a cycle of behaviour.

Determining the antecedents to a behaviour can be difficult. There are times, such as when an individual sexually targets a young child, that the only acceptable immediate replacement behaviour is to keep both the potential victim and the individual safe by severely limiting or precluding the client's access to children.

There are many ways to change an antecedent (using antecedent control strategies) that will assist in increasing the positive behaviour. Some of these include establishing a routine, changing how instructions are given, providing advanced warning, offering redirection, changing aspects of the environment, and providing choices. It is important for staff to know how to provide instructions and education, particularly with an individual who has an

intellectual disability. Facilitators will need to establish good rapport with the individuals they support and know how the individual learns best.

If the consequence of a behaviour is pleasant, the behaviour is likely to increase; if the consequence of a behaviour is unpleasant, the behaviour is likely to decrease. However, sometimes a consequence that we might think is negative, such as yelling or assigning a time out or a punishment, may in fact be reinforcing to the individual.

There are a variety of reinforcers that may assist in maintaining the appropriate replacement behaviour. Reinforcers include social reinforcers, such as praise, high-fives, or smiles; activity reinforcers, such as going to the movies, going for a walk, or playing a game; material reinforcers, such as a small tangible item (like a gift certificate); and food reinforcers, such as going out for ice cream (please note that these should be used sparingly and with awareness of health concerns such as diabetes).

The many ways to teach a new behaviour include shaping, task analysis, chaining, modelling, prompting, using visual strategies, engaging in role plays, employing a token system, and practising the new behaviour. To maintain a newly taught behaviour, the individual must continue to use the strategies that successfully helped the individual to change the behaviour in the first place. The goal, then, is to have the individual generalize the appropriate behaviour to other settings and use the appropriate behaviour with other mediators.

Should we find that the desired behaviour changes are not occurring, we want to troubleshoot with the team by asking some of the following questions:

- Are you hoping to decrease too many behaviours at once?
- Is the reinforcer really motivating for the individual?
- Are all staff being consistent?
- Is the expectation realistic?

Bear in mind that all individuals learn differently, and the type of disability that the individual has will determine how we provide education. The facilitator will obviously have to make modifications if the individual also has a hearing, visual, or mobility impairment.

When implementing a new behavioural strategy, it is important for those involved to keep data. When working to change a behaviour, such as hitting, all persons involved must clearly identify the behaviour that they want to decrease and define the appropriate replacement behaviour. Staff then set up a data sheet to accurately measure if the behaviour is decreasing (and the replacement is increasing). It is extremely important that all those working with the individual record data accurately and consistently (remember standardization, reliability, and validity—they're important here, too!). The data recorded will assist the team in making critical decisions, such as whether the client may go on future outings or is ready for a decrease in supervision.

An ABC Data Chart can be found in the Appendix.

## Social Skills Training

In the recent literature on working with persons who offend, we have tried to de-emphasize the prior tendency towards confrontational approaches. Indeed, we have learned that most persons who offend, when confronted, simply entrench in their denial and shut down. It is always in our best interests for our clients to engage in the treatment options we present, in the hope that they might learn to better manage their community behaviour.

### Communication

Appropriate and effective communication skills are an important learning goal for our clients, as many clients lack these skills and may run into difficulties while attempting to converse and interact with others. When individuals are non-verbal we need to make every attempt to assist them in developing communication skills and tools that assist them, including picture boards, sign language, gestures, or a combination of a variety of strategies.

In chapter 6, we discussed motivational interviewing. The skills we develop in practising this technique apply to working with persons with intellectual disabilities just as much as they do to any other client group: the goal is always to learn how to "talk so clients will listen, and listen so clients will talk." Following are some tools and approaches to communications training for our clients:

- Boundaries
  - Appropriate topics of conversation
  - When it is appropriate to speak
  - How to approach someone
  - Touching someone during conversations
- Scripts for common interactions with others
  - How to introduce oneself
  - Asking questions (e.g., showing interest in another person)
  - Telephone conversations
  - Dealing with community professionals
  - Interacting with co-workers
- Alternative means of expressing oneself (letter writing, personal journals, code words)
- Making good impressions (in interviews, with new people, on the job)
- Social expectations (handshakes, eye contact, waiting for a turn to speak)
- Communication (verbal and non-verbal)
- Internet (safety, chat rooms, dating services)

More than any other skill set, communication skills benefit from a variety of teaching approaches. While clients are learning and practising, they may need tools to help them establish new, more acceptable communications patterns. Some helpful resources or intervention strategies are:

- Scripts for common interactions
- Journal writing (can be written or drawn depending on the level)

- Social stories (scripts written by the client, with assistance from staff, that outline how certain social interactions or situations might progress)
- Role playing.

The following is a possible card that a client who wants to engage in conversation with others can use as a reminder. As with many of our sample resources, this card should be modified to meet the needs of the individual.

**MY CONVERSATION STARTER WALLET CARD**

Hi, how are you? My name is _____. What is your name?
What are you doing today?
What do you like to do in your free time?
Where is your favourite place to eat?
What kind of music do you like to listen to?
What is you favourite television program?
I like the _____ you are wearing. Where did you get it?

*A conversational resource for clients to use*

The Appendix includes a helpful framework for "Making Friends" as well as an example of a social story.

## Self-Esteem

For a variety of reasons, many of our clients suffer from low self-esteem. Addressing self-esteem issues can help the client with respect to both moving forward in life and complying with treatment. Activities focusing on self-esteem need to be fun and lighthearted; otherwise, we risk frustrating our clients. In addition, the topics and areas addressed must be personally meaningful to the client. Important parts to address are:

- Things you like about yourself
- Things you can or can't change (accepting and making plans)
- Setting realistic goals for the future
- Changing negative thoughts into positive thoughts
- Drug and alcohol use
- Abuse
- Emotions (recognizing one's own emotions and dealing with them appropriately).

Helpful resources or intervention strategies are:

- Goal Setting Plans (daily, weekly, monthly, yearly)
- A script of positive attributes ("letter to myself")
- A list of positive self characteristics
- A scrapbook of accomplishments.

## Relationship Skills

Persons with intellectual disabilities often receive a skewed perspective of who it is appropriate to talk to, touch, and trust. As mentioned previously, when a person is born with a disability often many more stakeholders become involved in their lives. Depending on the disability, the individual talks to, is touched by, and must trust many different people. The list varies considerably from client to client but may include caregivers, support workers, doctors, nurses, family members, and others. Often, this is done for all the right reasons, yet the message that the individual receives is that they can talk to, touch, and trust most people.

Developing relationships with others is a main part of reintegrating into society. Many of our clients demonstrate a desire for these relationships, but either do not have the necessary skill set or have developed inappropriate ways of developing relationships. There are a number of important concepts to address when educating individuals in this area.

The individual needs to:

- Learn appropriate ways to develop relationships
- Learn where to appropriately meet others
- Learn to respect the opinions and wishes of others (accepting "No" and being able to say "No.")
- Learn how to make a good friend (someone who is trustworthy, likes them for who they are, and whom they have known for a long time)
- Find common interests (understanding and accepting that everyone likes different things)
- Engage in appropriate conversation.

Once a relationship has been established, persons with intellectual disabilities often have difficulty maintaining the relationship. The individual needs support in learning the skills necessary to be a good friend (listening, empathizing, doing things both friends like to do), make plans, live/cohabitate with others, and to resolve conflicts (recognizing when they have been wronged or have wronged another, working through differences to maintain the relationship).

### Romantic relationships

When developing romantic relationships, our clients need further education and support. They need to learn how to start as friends, proceed through the dating process and, then, if both consent, move into a more romantic relationship. It is important to stress that developing these relationships should take time if the relationships are to be healthy.

Individuals need to:

- Plan their dates
- Make appropriate partner choices (someone in the same age group, who likes the same things, and whom they have known for a long time)
- Learn how to resolve conflicts they may encounter
- Learn healthy sexual behavour

**Glossary**

**teachable moment**
Situations in which we have the opportunity to reflect on antecedents, behaviours, and consequences in a fashion that assists our client in better understanding these dynamics. These are also sometimes referred to as "a-ha!" moments, due their powerful potential for supporting change.

- Learn options in regards to avoiding sexually transmitted infections (STIs)
- Learn how to use birth control
- Learn what to do in the event of pregnancy.

The concepts of respecting each other, trusting each other and engaging in activities that are based on mutual consent also need to be addressed with the individual.

### Tools for teaching

It is important for persons with intellectual disabilities to receive education regarding the boundaries within each type of relationship. The *Circles* Program was developed specifically for persons with intellectual disabilities to address the various types of relationships they may encounter in their lives and to teach how to establish boundaries around the type of talk, touch, and trust that is appropriate within each relationship. The program is visual and, culminates in the individual's development of a unique "circles board." When the *Circles* Program is undertaken in conjunction with a support person or others our clients know, one of the natural outcomes is that they learn that each person is different and has a unique set of relationships.

Relationship and boundaries education can be accomplished in a variety of ways, using a number of different tools. **Teachable moments** provide real-life opportunities to put skills and ideas into practice. These can occur when the support person is out with the client, and the pair encounters opportunities to discuss boundaries within different relationships as they experience them. For example, when the individual is at work, the support person can discuss the appropriate boundaries at work. If the support person is a paid staff person, the support person and the client can discuss what type of relationship is or is not appropriate with a paid staff person. In this context, it is important to emphasize that paid support staff are not friends, since friends do not get paid to be with their friends. Watching television provides further opportunities to discuss whether the relationships depicted in the program are appropriate or inappropriate. Staff members need to be well trained and be ready to take advantage of these windows of opportunity.

### Avoiding expensive mistakes: Internet and media awareness

When seeking out and developing relationships, the individuals we support need to learn about the benefits and difficulties posed by Internet chat rooms, Internet dating, telephone dating services, and advertisements for "friendships" that they may find in newspapers and magazines. Persons with intellectual disabilities often seek out relationships in these sources and have fallen prey to the kind voice they find on the other end of the phone line. Tragically, some of our clients have received expensive phone bills as a consequence of talking to the person on the other end of the phone, whom they truly believed to be their girlfriend.

It is wonderful when individuals have meaningful relationships with one another. However, some relationships are not always positive. For this reason, it is important to teach the persons we support about some of the possible behaviours that may indicate that a relationship is turning negative. We need to

discuss what should happen if the other person in their relationship becomes controlling or makes all the decisions as to what to do, where to go, and whom to see; becomes jealous of a client's possessions or of the other people with whom they have relationships; or engages in put-downs, such as making negative comments about what a partner wears, decisions a partner makes, or about a partner's achievements. We need to teach the persons we support techniques for identifying warning signs of such inappropriate behaviour, as well as strategies for self-assertion, should this occur. In addition, our clients require strategies on how to deal with the situation and ensure that they get the help they need for themselves.

Helpful resources or intervention strategies are for teaching about conflict resolution and self-assertion are:

- Social rules for touch and talk in a visual form
- Scripts/role-playing conversations.

## Appropriate Touch

Many clients have issues understanding boundaries in regards to appropriately touching others. The social rules can be confusing for many, so setting concrete guidelines are important. Following are some important concepts to address:

- Where and when it is appropriate/inappropriate to touch other people
- Touching yourself in private (set rules around when, where, and privacy)
- Abuse (defining, recognizing, reporting, and avoiding dangerous situations)
- Saying "No" and hearing "No"
- Protecting your boundaries
- Emotions management (hitting, kicking, self-injurious behaviours)

Some helpful resources or intervention strategies are as follows:

- Creating a contract for appropriate touch
- Establishing rules for self-touch
- Creating scripts and role-playing for how to deal with inappropriate situations

## Hygiene

Some of our clients suffer from hygiene issues. The best way to address this is to teach the skills the client may be lacking, then follow through with a visual schedule and reinforcement program for completing a hygiene routine. Important topics to address are:

- Cleanliness
- Personal care
- Hygiene routines
- Making good impressions
- Appropriate dress (clean clothes everyday, what to wear in different situations)
- Washing hands
- Cleaning your house/room.

Helpful resources or intervention strategies are:

- Visual schedule for hygiene routine
- Teaching step-by-step hygiene routines (visuals, role-playing, prompting).

An example of a visual schedule can be found in the Appendix.

### Age Discrimination

Through the Card Sort Test, performed during the Sexuality Assessment, it may become apparent that the client cannot identify age accurately. This difficulty in deciphering age can prove to be very problematic with many of our clients.

It is not uncommon for persons who have developmental disabilities to be confused about who is of the appropriate age to have friendships or intimate relationships with. In society and through the media, it is increasingly common that young people are portrayed as older than they are. In today's society, some girls are wearing makeup at quite a young age and may dress to appear older than they are. Sometimes, the clothing that young girls wear appears provocative and quite "sex-oriented" (for example, a pair of shorts or sweatpants may feature the word "juicy" on the backside). With all these factors blurring the distinctions between age groups, people without disabilities often confuse people's ages. Imagine how confusing it must be for persons who have difficulties in age discrimination.

Simply put, we can assume that our clients with intellectual disabilities sometimes have a difficult time knowing what is right or what is the correct thing. Indeed, some of our clients have such difficulty in distinguishing adults from non-adults, that they experience attraction to people who are of an inappropriate age. Sometimes, they truly believe that a person is older than the age they are. In treatment, rather than simply assuming that such clients have deviant preferences, it is important to assist such clients in knowing how to accurately determine other peoples' ages. In assisting individuals in determining the age of an individual, the support person can identify characteristics of a specific age group (e.g., body types, hair growth, height, facial features, muscle changes, secondary sexual features, etc.). They can do this together with the client by reviewing pictures and identifying the appropriate age group. When out in the community or while watching television the support person can ask questions and have discussions as to what age they think someone is and why. Furthermore, they can discuss how the media portrays people as older/younger, and the importance of knowing and asking someone's age.

Helpful resources or intervention strategies are:

- Educational books on changing bodies
- Magazines and pictures of different people.

## Is Treatment Effective?

In Canada, the costs of sexual assault are enormous. This situation is certainly paralleled in the USA and other major western nations. The cost associated with each person who sexually offends is considerable, when you consider expenses such as law enforcement, criminal prosecution, treatment and risk management

services for those who offend, and counseling and prevention services regarding victimization. Therefore, a reduction in recidivism of merely 1 percent—even though this does not sound like a lot—is certainly significant in terms of cost and harm reduction. A recent review (Nafekh, Allegri, Stys, & Jensen, 2009) suggested that for every dollar spent on correctional programming in Canada (including programs for persons who sexually offend), taxpayers and victims save as much as $5.00 to $7.00 in costs associated with reoffending.

## Assessment of In-Treatment Change with Persons Who Sexually Offend

Hanson (1997; 2000) suggested that while long-term outcome studies are useful, they do not tell us anything about the effectiveness of current interventions. A study published in 2005 that tells us the treatment outcome of offenders followed for 15 years is actually telling us about the effectiveness of methods used in 1990. It is therefore important that we find a way to measure within-treatment change, as a more immediate measure of treatment effectiveness. However, as sensible as this may seem, few studies have examined relationships between change on measured treatment targets and outcome.

Measurement of status on dynamic factors can do a lot to tell us whether or not an intervention is effective. Dynamic factors (like those tapped by the Stable-2007 and Acute-2007) should be those criminogenic needs identified for the population of interest, in our case persons who sexually offend.

Remember that a useful treatment plan is only as good as the criminogenic needs it targets. Therefore, we need to:

- Make sure that the treatment targets addressed are actually related to recidivism (thus, we need to complete dynamic risk assessments)
- Make sure that targets are actually being addressed
- Make sure that higher-risk clients actually receive more treatment programs than lower risk clients.

The question of whether or not treatment for persons who sexually offend works is still unanswered; although, several meta-analytic reviews suggest that there is a clear difference in rates of reoffending between those who finish treatment and those who do not (Hanson, Harris, Scott, & Helmus, 2009). Some question the available research, pointing to a need for randomized clinical trials (like those employed in the SOTEP study from California—Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). However, the consistency of the outcome studies to date highlights the need to move beyond simple questions of whether treatment works or not. A number of other significant questions about sexual offender treatment still need to be answered, for example, do higher risk clients receive more treatment programs than lower risk clients? Perhaps, instead of asking whether treatment works at all, we should be asking, "What treatment works best?" (Abracen & Looman, 2005).

## Highlights

### CHAPTER 5

- Individuals with intellectual disabilities may lack certain social and relationship skills, but they have a desire for social comfort, personal relationships, and meeting of sexual needs in appropriate ways.
- The field continues to develop standardized methods of assessment for persons with intellectual disabilities who sexually abuse.
- The best tool for effective risk management is a comprehensive assessment.

### CHAPTER 6

- Individuals with intellectual disabilities have a right to comprehensive assessment and sensitive and effective treatment.
- It is important that the individual participates in their own treatment planning and monitoring.
- Group counselling programs can be very effective in assisting individuals with intellectual disabilities.

### CHAPTER 7

- Not all sexual behaviours are driven by an inappropriate sexual arousal. Some behaviours are a result of circumstance.
- Developing relationships with others is a main part of integrating into society. Persons with intellectual disabilities often require assistance in establishing and maintaining healthy relationships.

# 8

# Risk Management

In this guidebook, we have consistently argued for a team approach that is evidence-based and that takes into account all of the important stakeholders and variables necessary for best practice in risk management. This does not mean that we are oblivious to the fact that risk management with respect to persons who sexually offend in community settings is perhaps the most controversial of all contemporary correctional issues. Silverman and Wilson (2002) have likened the community's abhorrence of and, sometimes, morbid fascination with these offenders to a "moral panic." The typical release of a "high-risk" sexual offender goes something like this: Offender released ... police conduct community notification ... media frenzy ... community panic ... offender driven out of said community or into hiding. This pattern of events appears to be universal, and there are countless examples throughout Canada and other similar nations. However, despite repeated experience of this progression, few have ever seriously investigated whether such practices are actually effective in managing the risk of persons who sexually offend when released into the community.

The latter part of the 20th century witnessed several legislative attempts at increasing offender accountability. Legislators assumed that increased sentences and stronger punitive measures would translate to increased community safety. However, some have questioned whether those practices have really either made offenders more accountable for their actions or made communities safer (Levenson & D'Amora, 2007). Typical examples of increased offender accountability are found in "three strikes" laws, civil commitment, lifetime probation, and offender registries, the latter being particularly popular of late in Canada. California started registering sexual offenders in 1947, but public notification only came about in the mid-1990s after Megan Kanka (for whom all of the US Megan's Laws were named) was kidnapped and killed. The first Canadian sexual offender registry was instituted in the province of Ontario in 2001, with a national registry being proclaimed in December 2004. The Ontario registry was heralded as a "bold measure in community safety"; however, some have questioned whether the community is really any safer since the establishment of the registry (John Howard Society of Alberta, 2001).

## Community Integration

Risk management of persons accused of sexually inappropriate behaviour generally requires that the individual in question be appropriately supervised and effectively treated. Appropriate supervision is sensitive to patterns in the client's behaviour and is based on a dynamic appraisal of the client's current life circumstances. At the beginning of chapter 5, we outlined some principles of intervention: effective interventions match treatment and supervision intensity to level of risk, while ensuring that assessed needs are targeted in a manner that considers client capabilities and overall motivation to change. Treatment targets are generally established during an evaluation phase at the beginning of treatment; however, it is important to note that those targets may change depending on changes in client circumstances while the client is under supervision or in treatment.

### Stakeholders

Remember the listing of stakeholders from Chapter 1? Here they are again. What is different about this version of the list?

- Victims
- Citizens
- Law enforcement
- Legal and correctional personnel
- Mental health personnel
- The media
- Offenders

If you noticed that we now have one list, that combines the individual who has committed an offense and the rest of the community, then you are correct. Persons who are released into the community become part of the communities into which they are released.

Effective risk management requires that we allow persons with histories of offending an opportunity to reintegrate safely into society. Simply stigmatizing offenders and forcing them to adhere to often ill-conceived standards does not necessarily increase public safety. Some argue that many current official control measures (e.g., prohibition from being near any place where children might reasonably be expected to be, the 1000-foot rules enforced in the USA, offender registries, etc.) actually increase risk, as persons who have committed offenses are forced out of one community and into another, so that they never have the chance to integrate properly or achieve any sort of personal stability. Without personal stability, the individual has a far lower chance of leading a stable or productive life, and the individual's risk of recidivism increases.

It is important to recognize that some of our clients with intellectual disabilities who come into contact with the police because of sexually inappropriate behaviour will have legally enforced risk-management plans (e.g., probation orders, peace bonds, or other formal or informal agreements). In many respects, the police are a great resource for workers supporting persons with intellectual disabilities and sexual behaviour problems. Most police

services will have an officer designated for community liaison with the sorts of organizations in which we all work. We recommend that workers and agencies identify that officer and work closely with him/her to establish an understanding of the needs of our clients, along with any risk they may pose. In the Appendix, you will find a sample Protocol for Police/Agency interactions.

### Comprehensive and Collaborative Approach

In most human endeavours, two heads are better than one. This is no less true when it comes to managing offender risk—particularly, sexual offender risk. We must work as a team. We must consider information and perspective from a variety of sources, and we must be sure to look for objective corroboration of any information we find. Surprising as it may be, what appears to be the truth, or what many will tell you is the truth, often is not the truth. For instance, offenders often do not tell the whole truth about their offense histories.

## Risk Management

Remember that effective risk management in the community involves the collaboration of many different service providers. When we vary the modes of contact, we allow for greater community monitoring of activities and attitudes. This is not only good psychology, it also promotes public safety, as well as balance and good lifestyle health for our clients. Simply put, greater community contact and monitoring increases the reliability of information leading to case management, treatment decisions and initiatives. However, we cannot stress enough that we need to have good information to make good decisions. Obtaining quality information will require working with our community partners.

Gerry Blasingame (in press) presents a useful graphic that clearly demonstrates the collaborative and integrated nature of community-based risk management for persons with intellectual disabilities who sexually offend.


*The Risk-management Circle for individuals with intellectual disabilities*

## Challenges

The principal challenge in establishing good community-based risk-management protocols is to promote healthy sexuality for our clients while maintaining their own safety and that of others. When working with a challenging or challenged population, we walk an ethical tightrope. We need to advocate on the behalf of the individual with an intellectual disability; yet, at the same time we need to protect the community. Hingsburger is fond of asking, "Who do we serve?" a variation on the age-old question, "Who is the client?" and a restating of the stakeholder issue above. The following is a suggested list of people we need to consider when answering these questions:

- The community-at-large
- The community immediately around (i.e., the neighbourhood)
- All potential victims
- All people with disabilities (in answer to the unfortunate misperception that if one individual offends, then all individuals with disabilities are offenders)
- Our own agencies
- Court personnel
- Probation and parole officers and the terms of probation and parole
- The client

Typically when treatment is provided to someone they are identified as the top priority. When providing treatment to an individual who sexually offends, potential victims and community safety becomes the top priority.

## Additional Challenges

Many persons with intellectual disabilities who sexually offend receive support from community-based programs. Residential staff are not always trained in dealing with issues such as sexual expression, especially when that sexual expression becomes problematic or offensive. For the client, this sometimes reinforces the notion that any sexual activity is wrong—creating confusion in which individuals are often not taught the differences between appropriate and inappropriate sexual behaviour.

Many agencies institute policies prohibiting any sexual expression in the intellectually disabled individuals residing within their programs. This can lead to repressed sexual urges and a belief that all sexual behaviour is wrong. Or, it can lead to the client seeking clandestine opportunities for sexual expression, like in the agency van, day program bathroom, or sneaking "quickies" at the group home.

## Consideration of Static and Dynamic Factors

As we noted in chapters 4 and 5 on assessment, risk assessment of persons with intellectual disabilities is an area of emerging understanding. That is, there is much research left to be completed in predicting future criminal or socially inappropriate behaviour in this client group. As such, it important to note that caveats must be made when providing risk assessment information regarding persons with intellectual disabilities.

**Glossary**

**active supervision** A style of supervision in which individuals working with clients are not just observers and documenters of client activities, but also seek to provide ongoing support and instruction as the client encounters various life events.

Primarily, it is important to recognize that many of the tools used to predict risk were composed and standardized with a population who do not have intellectual disablities in mind. Many persons might be tempted to take those tools and simply apply them to our clients who have intellectual disabilities; however, the assessments would be inappropriate and, likely, inaccurate. Although some research has been conducted to explore the utility of these tools with persons outside of the standardization sample, such studies are far from comprehensive. As we discussed earlier, there are tools that have been specifically devised for persons who are intellectually disabled (e.g., QACSO, ARMIDILO, TIPS-ID) and research continues as to the applicability and utility of others (e.g., Stable-2007, Acute-2007).

The caution noted above regarding application of methods for non-disabled persons to disabled persons is also true of some of the risk-management protocols typically used with persons who sexually offend. Accordingly, risk managers are encouraged to exercise caution in interpreting risk assessment information and applying it to their work with persons with intellectual disabilities; particularly, if it does not appear that the methods or outcome data have been specifically tailored to persons with intellectual disabilities.

## Safety Plans

When we work with clients with problems that potentially place themselves or others at risk for harm, we need to be sure that appropriate intervention strategies are put in place. In essence, we need to create a "safety plan" that will help ensure that risks to these persons will be addressed and that appropriate interventions will be effective.

### Support and Supervision

One of the main components of supporting our clients is implementing adequate surveillance and **active supervision**. On all levels, individuals should have the ability to initiate certain tasks, and to work as independently as possible; however, to optimize client-centred support we also need to maintain diligent supervision. Being eyes-on and ears-on at all times is one of the best ways we can support the individuals with whom we work.

Here are some useful tips:

- Create and implement effective protocols and procedures for management and supervision of the individuals you support. Ensure that each protocol is specific to each individual's needs, behaviour, and overall status.
- Review and update protocols and procedures on an ongoing basis to ensure appropriate and effective supervision. The goal is to ensure that staff are consistent when supervising and implementing protocols. A protocol binder will serve as a quick reference tool to ensure consistency among the staff, which will in turn assist the client by providing them with a clear, consistent structured approach.
- Be vigilant and active in supervision, and get to know the individuals you support. Active supervision consists of eyes-on and ears-on supervision at all times. This allows you to detect when there is a change in need of attention.

It is essential for staff to be "present" while working with the individual. Staff need to have keen observational skills to detect changes in the individual's mood or behaviour, which may indicate a possible issue.

- Foster both a positive and interactive environment with the individual you support. Providing a structured daily routine that allows the individual to actively participate in daily activities provides them healthy outlets that will, ultimately, assist the individual in learning new skills.
- Keep good records. Effective supervision also involves proper documentation of that supervision. Remember the need to keep data—this is how we further the behavioural analysis agenda. Staff need to ensure that appropriate documentation is completed each day, which assists in keeping all staff "in the loop" while ensuring the safety of the individual supported.
- Pre-plan every event as a team and ensure that all parties involved are aware of the event and the details involved. Pre-planning allows structure since the individual, along with the mediator, can establish a protocol as to what is expected and devise contingency plan(s) of alternative solutions in the event of an unexpected situation or other emergency.

## What is a Safety Plan?

A safety plan is a written description of what a supported individual needs to do to stay safe in designated areas (e.g., in the general community, on home visits, at the group home).

*A safety plan is an effective tool that can keep the community safe. It also provides an opportunity for the supported individual to self-regulate his/her safety strategies while generalizing the skills necessary to ensure safety.*

Making a safety plan involves identifying the steps that the individual you support needs to take to increase his or her safety in various settings. A safety plan presents clear and direct guidelines as to what the supported individual would need to do to remain safe and appropriate in an environment that may become dangerous. It also helps alleviate a potential risk situation in which the client may have difficulty maintaining self-control. Not only does it help the supported individual, it also prepares support staff in advance for any possibilities when encountering a potentially dangerous situation.

## Who Should Receive a Safety Plan?

Persons with intellectual disabilities receiving behavioural support should have and must keep a copy of their safety plan. Having a safety plan promotes a sense of responsibility by ensuring that the supported individual actively uses the safety plan.

In order to make sure that the individual receiving support receives consistent support and that all parties who work with the individual know what the appropriate support measures are, all staff should have access to the safety plan. In addition to the above, staff are better able to support the individual in a potentially dangerous situation (a higher-risk situation or "danger zone"), as the safety plan provides clear understanding as to the steps involved in keeping the

individual safe. In group-home and other communal environments, copies of all client safety plans should be kept in a common area for staff to have easy access at any given time. It is also advised that both staff and clients consistently review their individualized safety plans before an outing so as to keep the information fresh.

Family members, friends, and external organizations involved in providing support should also have access to the parts of the safety plan that are relevant to their involvement with the individual receiving support. For example, if the individual has a safety plan for when she or he goes home, the family should receive a copy as well. If the individual has a community safety plan, all of the support persons should be kept abreast of the individual's safety plan and have a copy. Furthermore, family and support persons should receive training about the client's needs and the necessity of the safety plan.

## Individualized Safety Plans

Not all persons who sexually offend are alike. Other than the common denominator of committing sexually inappropriate acts, individuals experiencing such difficulties differ in personality, triggers, and their overall behaviour pattern(s). Although some safety plans can be generalized, in order to be effective, each safety plan should be comprehensive, relevant, and individualized—designed and tailored specifically for the particular individual being supported. Several key issues should be considered when developing a safety plan.

### The client's risk and needs

First, a general assessment of the risk level and the needs of the supported individual is required. Remember what we discussed in the chapter on Assessment. For some individuals, a safety plan may need to specify restrictions for specific activities, such as certain employment opportunities or extra curricular activities that may increase the risk for them. At the same time, the same activities may not be problematic or potentially dangerous for other supported individuals. Based on the various types of needs they have, some individuals may require different types of support strategies. Hence, it is important for staff to have a full understanding of the needs of the individual with whom they work. To create a safety plan that is relevant to the client and his or her prioritized needs, it is first necessary to review the available assessment reports, prior treatment records, behaviour patterns, and individual tendencies.

Identifying the supported individual's strengths and assets is important in identifying the individual's capabilities to excel in a certain area and, furthermore, provide a clear indication of the type of safety plan that is best suited for each individual.

### Safety of potential victims

Next, it is important to take into account the needs and safety of (potential) victims. This is a sensitive issue and can become particularly challenging where the individual offends against a family member. In such cases, the safety plan must clearly state the specifics of what is restricted and what is allowed. For instance, if an individual receiving support has sexually offended against

a family member who is a minor, the safety plan should clearly indicate the restrictions involved in a home visit, if applicable. This may include adult supervision or no contact with minors (including the victim), among other considerations.

## The Safety Person

Safety persons are important in helping persons with intellectual disabilities to manage any risk they may experience. In typical daily living, most people have family and friends on whom they can rely to assist them in attending to personal goals and issues. Often, persons in care or under supervision, do not have access to the same sort of family or friendly support, and they receive the bulk of their supervision from persons who are paid to do so. However, whenever possible, it is quite helpful to involve other persons important in the client's life. As such, other than staff, family members (both immediate and extended) or a friend can also be a safety person. It is important that safety persons go through a process of standardized training sessions before they are considered to be potential safety persons. It is highly recommended that all external contacts be identified as a "safety person" before independent supervision (i.e., without front-line staff accompanying them) is established.

Below are the necessary requirements for an external contact to become a safety person:

- The supported individual should establish rapport and feel a sense of comfort with the person.
- Safety persons must be committed to safety for both the community and the supported individual.
- The supported individual must consent to the proposed safety person, who will be added to the supported individual's safety plan (a meeting/session is usually set up to go over the requirement and conditions of a support individual).
- A safety person must have solid background knowledge of the supported individual's issues and the strategies needed to best support them.
- The potential safety person must undergo training—this may be going out with front-line staff and the supported individual on numerous occasions to ensure consistent implementation of the safety plan.
- The person should be responsible and conscientious (i.e., they must be knowledgeable of the plan, believe in the plan, and do their best to further the intent of the plan).
- The person should be willing to undergo a police background check.

## How to Create a Safety Plan

First, ensure that the text is clear and concise. Language should be written at a level that the supported person can understand. Avoid jargon and technical terms. Second, the supported person should be actively involved in creating the safety plan(s). This provides a sense of accountability in following through with the steps required to keep the individual safe. Be sure to consider both time and place when creating a safety plan. For example, an individual who becomes

**Glossary**

**potentially vulnerable person (PVP)/thing**
The objects of our clients inappropriate desire or interest. For clients with histories of abusing children, PVPs are children. Analogously, for clients with fetishistic interests, the fetish object is the potentially vulnerable thing.

hyper-aroused around children may want to consider the time of day and the places to which he or she can go. It is also important to consider the relevance of the plan; that is, how significant the safety plan is to the individual's current status and situation. Consider the replacement behaviour (the behaviour that the client will engage in instead of the problematic behaviour you are trying to prevent), and identify the most appropriate response to a potentially dangerous situation.

There are several issues and conditions that need to be considered when creating a safety plan. Specifically, it is important to consider:

- **Time:** Curfew restrictions
- **Time period:** Consider the time when the individual is going out, as this may be a key component in considering appropriate areas.
- **Place:** Restrictions on encountering **potentially vulnerable persons (PVPs)/things** are necessary, but it is important to understand that safety plans are designed to provide a safer option for the supported individual. The goal is to integrate the supported individual into society while providing safety strategies for them to regulate their skills. For example, an individual who is attracted to children can go to the mall (within reason); however, an amusement park should be prohibited due the high volume of potentially vulnerable persons who might be present. Also, an individual who engages in inappropriate sexuality with pets or other animals should not go to a pet store/animal shelter; a walk in the park may be an acceptable alternative. A client-specific list of danger zones, prohibited locations, or activities should be developed in advance, so that risky locations are already precluded by the time the safety plan is being developed.
- **Safety person:** Other than staff, it is important for external support persons (e.g., family members) to have a clear understanding of the individual's issues and what is required to keep him or her safe—before considering support. Individuals who are not on the safety plan should not be allowed to take a supported individual into the community.
- **Media:** The supported individual's access to the Internet, television, and movies in the community should be consistent with the viewing allowed in a more supported environment.
- **Emotional readiness:** The individual and the support team should be aware of the individual's level of negativity and anger, as strong emotional reactions and states are suggested in the literature on risk management as strong dynamic predictors of potential reengagement in problematic behaviour.
- **Triggers and Antecedents:** What sets the individual off?

It is strongly recommended that every individual with the potential of engaging in inappropriate sexual behaviour when out in the community have a safety plan specific to his/her needs. Because not all persons who sexually offend are alike, not all safety plans should be alike. Conditions should be imposed and implemented selectively, based on the individual's circumstances and risk profile.

A sample Individualized Safety Plan is found in the Appendix.

**Glossary**

**outing journal** A written record of a client's interaction with the community, which forms a powerful tool for evaluating client progress and success in managing situations in which they encounter risk or other difficulties.

## Danger Zones

Most persons with intellectual disabilities and sexual behaviour difficulties have individualized treatment and risk-management needs. A comprehensive assessment of the nature of the individual's issues allows us to create and implement a personalized risk-management plan. Clients with intellectual disabilities often need complex concepts to be simplified and put in easily understood terms. For example, risk factors may be called "danger zones." Essentially, danger zones are cognitive, behavioural, or environmental variables or factors whose high-risk nature both the client and the support team acknowledge. In the Appendix you will find an example of how to use this "danger zone" concept to assist clients in being better informed about the risks they may encounter and how to manage them when they do.

Generalized safety plans can be used in a group home for supported individuals who share similar issues. If the supported individuals vary in their backgrounds in terms of triggers, danger zones, and behavioural tendencies, an individualized community safety plan is the most effective option. It is highly recommended that the supported individual read this type of plan each time he or she goes into the community. This serves as a prompt to remind the individual of his or her responsibility to use their safety strategies. The individual is also thereby held accountable for her actions. These generalized safety plans are reviewed with the individual by the supervising adult prior to going into the community. An example of a Generalized Safety Plan can be found in the Appendix.

To provide an additional prompt for the individual when in the community, a wallet-sized Safety Plan can be developed that is void of any descriptors so that, if the wallet or card should be lost, the individual's confidentiality will not be compromised. This wallet card serves as a critical reminder that can be used at any time, especially in emergency situations. It is also recommended that important contact numbers (e.g., police, group home safety person, and any additional number that may be necessary) be kept on this type of safety card. A sample Wallet Card can be found in the Appendix.

When individuals go home for family visits, it is important that they take with them all of the necessary tools to ensure that the visit will be safe. If an individual is going home or engaging in any sort of visitation (e.g., an overnight or a one-day visit) where staff will not be present, it is recommended that staff provide a package outlining all of the strategies/items that the supported individual will need to ensure safety. This package should include relevant safety plans, **outing journals**, and daily journals, as necessary. Whenever possible, working as a team and having consistent contact to ensure that all are working with the same information can greatly increase the potential for a safe and successful outing.

## Outing Journals

Outing journals are designed to provide the necessary guidelines for remaining safe in the community and an overall structure for the supported individual to follow. Outing journals provide clients with a sense of accountability for their

actions, as clients are encouraged to take appropriate measures to remain safe and stick to their plans.

## Important Items to Consider When Creating an Outing Journal

**Safety Plan Review:** The safety plan does not have to be on the outing journal; however, it is strongly advised that the supported individual review her or his safety plan before each outing.

**Safety Checklist:** The outing journal should have an outline of all of the safety rules that the supported individual should follow while on an outing. The individual should review the checklist to ensure that he or she has followed it. The checklist should cover areas that the supported individual is required to work on in his or her daily routine. Consider areas such as: behaviour in the community, appropriate conversations, social/physical boundaries, and hygiene when creating a checklist.

**Name/Signature:** Including names and signatures of both the client and the safety person is important for record keeping. It is also equally important for supported individuals to sign their outing journals, as doing so provides a sense of ownership as they take the time to plan their outing.

**Date and Time:** Day, Month, and Year is recommended; particularly, if you wish to pursue data tabulation.

**Place:** The journal should list where the outing will take place, and the type of outing it will be.

**Pre-planning Section:** In this section, the individual must answer questions around pre-planning and premeditating safety strategies for the outing (see the sample Outing Journal in the Appendix).

**Post-Review:** It is recommended that a post-review section be provided, to reinforce what went well on the outing and to problem-solve any situations that could be improved. In this section, the support worker can ask two or three core questions about the outcome of the outing and how the client feels as a result.

**Potentially Vulnerable Person (PVPs):** In order to properly assess whether or not the individual is able to independently utilize his or her strategies, the outings journal should include a section that covers possible strategies that a supported individual can use if he/she or she encounters one or more PVP(s).

**Prompt versus Independent:** The supported individual's ultimate goal is to self-regulate safety strategies by using them independently. In the post-review, it is best to include a note of whether or not the individual utilized his/her skills independently, or if a support person needed to prompt the individual. This record-keeping will help both the safety person and the supported individual to get a sense of what area(s) require more work and support.

Sample Outing Journal and Outing Checklist forms are found in the Appendix.

## Highlights

### CHAPTER 8

- The first Canadian sexual offender registry was instituted in the province of Ontario in 2001.
- A national registry was proclaimed in December 2004.
- Risk management of persons accused of sexually inappropriate behaviour generally requires appropriate supervision and effective treatment for the individual.
- Effective risk management in the community involves the collaboration of many different service providers.
- Active supervision consists of eyes-on and ears-on supervision at all times.
- A safety plan is a written description of what a supported individual needs to do to stay safe in designated areas.
- Safety plans must be tailored to meet the specific needs of the individual.
- Outing journals are designed to provide guidelines for remaining safe in the community.
- Outing journals require the individual to plan effectively in advance to ensure a safe outing.

# 9

# Promoting Healthy Sexuality

## The Sexual Needs of Persons with Intellectual Disabilities

Persons with an intellectual disability may lack certain social and relationship skills. However, they have the same needs as anyone else with respect to social comfort, personal relationships, and fulfilling sexual needs in appropriate ways (Blasingame, 2005).

## How We Fail to Promote Healthy Sexuality

Historically, people in Western society have reacted with fear and disgust when disabled persons engage in sexual activities. Persons with intellectual disabilities often have very limited access to privacy, which means their sexuality often gets played out in "public." Even experienced professionals have shared negative feelings and beliefs about sexuality with respect to persons with intellectual disabilities. Some commonly heard statements include:

- "Oh gross, do you need to do that here?"
- "Do you have to do that?"
- "Stop that, it's not normal."

Attitudes demonstrated by professionals working with persons with intellectual disabilities can greatly influence how the clients feel about themselves. Insensitive comments such as those noted above may lead clients to have unhealthy ideas and beliefs about sexuality and their bodies. And while harsh words and consequences are common forms of overt pressures from staff, subtle expressions of disapproval—such as facial expressions or body posture—are also noticed by clients. These subtle gestures can further influence clients' understanding of their sexuality.

As professionals working with persons with intellectual disabilities, we actively promote and advocate for many of our clients' needs in terms of health care, nutrition, exercise, academic training, and so on. However, when it comes to promoting and supporting normal sexual needs and expression, many of us put up all kinds of barriers. How confusing must this be for our clients?

Societal attitudes also often shape policies affecting disabled persons and sexuality. In some respects, we might need to consider that, in a sense, we are intruders in their homes.

## Healthy Sexuality Education

Over the years it has not been uncommon for persons with intellectual disabilities to be excluded from sex education classes/programs. This may occur for a variety of reasons, such as a belief that persons with disabilities are non-sexual or are incapable of learning, and that if they are excluded from education then they will not engage in inappropriate sexual behaviour. Nothing could be further from the truth, however. All people are sexual beings, regardless of disabilities. And, we know that knowledge is power. It is the lack of knowledge that often leads to behaviours that are inappropriate.

There are many aspects of sexuality that should be taught to the individual. Persons with intellectual disabilities often do not even know the appropriate words that identify the various body parts, particularly those areas that are associated with sex. Often, they know only a variety of slang terms.

Education regarding the various types of sexual activities must include discussion of the strategies that can be use to prevent sexually transmitted infections and unwanted pregnancies. The appropriate use of condoms and birth control options must be taught. It is also important to address sexual orientation and define lesbian, gay, bisexual, transgender, and questioning (LGBTQ). Specifically, it is important to debunk some of the sexual myths that the individual may have been subjected to so that they would not engage in certain behaviours, such as: *When you masturbate you will go blind or grow hair on the palms of your hands.* In his 2005 book, Blasingame provides suggested policies that agencies should develop to aid in the promotion of healthy sexuality.

### Challenges

Persons with intellectual disabilities have few opportunities for privacy and even fewer opportunities for obtaining a meaningful intimate relationship. Their interactions with peers and potential partners are limited and scrutinized by staff, with many staff and professionals failing to recognize that consenting sexual activity in the confines of a private space should be viewed as normal and healthy. Stigmatizing sexuality reinforces the notion that any sexual activity is wrong, which subsequently creates confusion in individuals who are often not taught the difference between appropriate and inappropriate sexual behaviour.

Many agencies institute policies prohibiting the sexual expression of individuals with intellectual disabilities residing within their program. However, establishing strict policies and procedures regarding sexual expression can have some unwanted consequences, for instance:

- Individuals engage in public masturbation when a lack of privacy and/or clear social-sexual boundaries is an inherent part of their living environment
- Individuals report that they no longer engage in masturbation because they are "tired" of negative comments from staff and because of the knowledge that everyone is aware of what they are doing.

**Glossary**

**harm reduction** A concept in which we attempt to measure successful outcomes in gradients, rather than with a simple yes or no. Harm reduction techniques seek to account for the lessened degree of harm sustained by parties involved in a certain practice. For instance, needle-exchange programs for intravenous drug users reduce the potential for secondary harm that may result from such practices (e.g., transmission of disease).

What if your client's sexual practices are "abnormal" or "unusual"? How will you change the treatment plan or the behaviour management protocol? Just as there are persons in the non-disabled population who have sexual interests that may be a bit "off the beaten path," there are likely to be persons with intellectual disabilities who also like to engage in sexual practices that others may find unusual. When confronted by such challenging situations, the first question we need to ask is: *What is the chance that this might hurt somebody?* We also have to ask ourselves, "Is there consent?" and "Are any laws being broken?"

As practitioners working with persons with sexuality concerns, one thing we need to consider is that there are many different ways to express personal sexuality, and that not all of them will be socially palatable.

> *Some of the sexual practices of our clients with intellectual disabilities may even be quite troubling to staff with strong moral or religious values. However, it is our job to support clients in their reasonable expression of sexuality, not to impose our value and belief systems on our clients.*

The *observer effect* makes some things seem unnatural because it is unnatural for us to be observing. A question we may need to ask ourselves is: *Would it be a problem behaviour if we didn't know about it?* Similarly, we might have to ask:

- If one of our clients wishes to dress up in the clothes of the other gender, and he/she does so in the privacy of his/her own room and does not make a spectacle of him/herself, why should we care?
- If one of our clients has a penchant for inserting objects into his/her anus during masturbation, and those objects are resulting in physical or other damage, why would we not consider prescribing a butt plug?
- If one of our clients decides that she/he is gay and that she/he wishes to lead a gay lifestyle, who are we to judge or condemn that choice?

These are but three examples of challenging sexual situations that we might encounter as professionals working with clients with intellectual disabilities. It is important to keep in mind that determining healthy sexual expression in clients who have engaged in sexually abusive behaviour requires additional thought and consideration. While we certainly want to promote a range of sexual experience for all our clients, sometimes there are triggers and high-risk situations inherently associated with seemingly harmless practices. The ultimate goal is to ensure that our clients have avenues for expressing their sexual interests and preferences *without causing harm* to themselves or others—this is referred to as **harm reduction**.

## Specific Approach

In short, we need to ensure that staff have the education required to support their clients in healthy sexual activities and relationships. As discussed in previous chapters, it is important that individuals receive the knowledge they need to have a healthy relationship with others, including understanding issues of consent, age appropriateness, private versus public behaviour, how to use a condom, and healthy masturbation.

A number of DVDs (e.g., "Handmade Love," "Fingertips," "Undercover Dick") have been developed to assist individuals with intellectual disabilities in the use of condoms and to provide instruction on how to masturbate in a safe and appropriate manner. These DVDs illustrate key points clients must remember when masturbating, particularly regarding privacy, hygiene, and safe practices. Additional information on these DVDs can be found in the References. In assisting individuals with respect to masturbation, it may also be helpful to establish a Healthy Masturbation Protocol. A masturbation kit can then be developed with the individual that suits her/his specific needs (e.g., a kit may include: appropriate fantasy material, lubricant, wipes, appropriate sexual aides etc.). We must review the key points made in the DVDs with the individual prior to providing the kit, so as to ensure the individual has sufficient education. An example of a Healthy Masturbation Protocol is found in the Appendix.

## Media

Like persons without intellectual disabilities, our clients are susceptible to influences in media—television, video, newspapers, magazines, the Internet, and other sources of images. Many persons view "pornography" as being "all bad;" however, we believe that a distinction needs to be drawn between pornography and erotica. Like pornography, erotica consists of sexually explicit media. However, erotica materials are presented in a less obscene or overtly sexually deviant manner. Even materials labelled "pornography" may not necessarily be "bad" for our clients, if they can be used appropriately and without potential harm to our clients or to others. We may need to make distinctions between "good" and "bad" pornography, accepting that what is okay/safe for one person might not be okay/safe for another.

Essentially, professionals working with persons with intellectual disabilities need to assess how sexually explicit materials will affect those clients. We need to assess the distinction between appropriate versus inappropriate imagery. We noted above that our clients have a right to safe and healthy sexual expression. As also noted above, this may sometimes require that we provide them with masturbatory aids, which may include pictures, videos, or stories, in addition to tools or "toys" that will facilitate the mechanical aspects of masturbation.

### Media Contracts

In order to ensure safety and consistency within a treatment protocol, all forms of media must be reviewed for appropriate content, depending on the needs of the client. This will include TV, Internet, video games, video game systems (e.g., PlayStation and Wii), books, magazines, newspapers, catalogues, iPods, MP3 players, and other means of storing and presenting sexually explicit media. All TV programs need to be monitored for the presence of type of individuals (e.g., children, women), amount of nudity, and amount of violence. It is important to remember that what is permissible for one person may not be for another—for example, diaper commercials are no big deal for most people, but clients with sexual interests in babies or who possess a diaper fetish may be inappropriately stimulated.

**Glossary**

**media** Any method of audiovisual representation of real-life persons or objects. These may include video, DVD, CD, tape, photography, or electronic storage devices (jump drive, SD cards, computer hard drives).

Whenever a media protocol or contract has been established, all team members must act consistently. Team members must ensure that family members and other collateral support persons are on board with the plan when a client is at home for a visit. Gifts must also comply with the contract or protocol. Family members sometimes forget or lack full understanding of the contract and give clients materials that are detrimental to their treatment or behaviour management. For this reason, it is important to conduct a search of the client's bags whenever they return from visits. This will help to ensure that any media content is appropriate, and to recognize that when clients are living together in group home environments, media rules must be in place that will ensure the safety of all. One example of a Media Screening Protocol is detailed below.

## MEDIA SCREENING PROTOCOL

Individuals who engage in sexually inappropriate behaviours present unique challenges. The media that they are allowed to view present one such challenge. One person's appropriate media may be another's pornography. Therefore, all media must be screened for appropriate content with consideration to the specific needs of the individual. Inappropriate content may include representation of children, fetish material, violence, language, etc.

For the purpose of the Media Screening Protocol, the term **media** is defined as the "means or channels of general communication, information, or entertainment in society." Specifically, this policy targets:

- Television programming
- Radio programming
- Movies/productions in theatres, on video, DVD, and Blu-Ray discs
- Music/Audio programming on CDs, cassette tapes, records, and in MP3 files (including those on iPods)
- Computer files—Games, text-based files, videos and audio files, all other programming
- Internet—Web pages, email, messaging programs, networking
- Video games on PSPs, Wii, Nintendo, Xbox, and other systems
- Literature—Newspapers, books, magazines, advertisements, and any other form of written material
- Live entertainment—Sports, concerts, stage productions, and all other forms of live production
- Visual—Art, photography, audio and video recordings

### Media content containing Potentially Vulnerable Persons

Potentially Vulnerable Persons (PVPs) are defined by the treatment program as persons or other animate objects targeted by the supported individual to satisfy inappropriate sexual urges in their fantasies or through illegal sexual acts.

No content that contains any representation of a PVP is to be in the possession of the individual being supported.

No content that has themes or plotlines involving PVPs is to be viewed or read by residents in the group home of the supported individual without the supervision of a trained safe person.

## Keeping the Environment Safe

### Conducting Room Checks

It is important to ensure that clients do not have inappropriate material in their room, in their possession, or somewhere easily accessible to them. We often think that keeping people safe only applies to when they are out in the community. We often forget that they must also be kept safe when at home. This means that their environment must be free of pornography or items that are potentially inappropriate. Inappropriate or "bad" pornography can be anything that potentially increases the client's sexual arousal towards a deviant act. This could be media of any kind depicting children, animals, acts of violence, or inappropriate fetish material such as diapers, children's clothing, stockings, and so on.

When looking for things that might present a problem, we really need to think outside of the box. In our experience, to name just a few examples, items have been found stored on the Wii system, in laptops, and in video tape or DVD cases; pictures have been stapled together to hide the inappropriate picture inside; and items have been hidden in the vents of the room. Those persons who support the individual should also consider the artwork within the home, as well as the programs that are watched on television. Even some types of music increase the individuals' sexual arousal since the lyrics may contain sexual and violent content. Items that are confiscated should be recorded, either by documenting in writing or by taking pictures of the items. The items should then be appropriately disposed of by the team.

### Phone Calls

It may be necessary to screen phone calls, as some clients may use the phone to contact others and engage in inappropriate conversations with them. This is not about them calling advertised sex phone lines; this is when they ask others they know to tell them inappropriate stories in order to satisfy their own sexual needs. Where necessary, phone calls can be put on speakerphone or the support person can monitor the client's dialogue and reaction to it for clues as to whether the conversation is of an appropriate nature. However, one should be aware that clients often run up expensive telephone bills calling phone sex lines because they truly believe that the person on the other end of the line is their friend and really cares about them.

### Protocols

We have provided a number of examples of helpful media and sexual behaviour protocols in the Appendix, including:

- Healthy Masturbation Protocol
- Computer, Laptop, and Wireless Device Safety Agreement
- Rules for Keeping My Pictures
- Camera Contract
- Media Screening Protocols
- Personal Computer Protocol

# 10

# Our Clients as Victims

Although this guidebook deals mostly with how to manage risk for sexual abuse by persons with intellectual disabilities, we need to remember that these clients are also often victims of sexual abuse by others. It is not uncommon for individuals who have intellectual disabilities to have experienced some type of abuse. In fact, the risk of being physically or sexually assaulted for adults with intellectual disabilities is likely 4 to 10 times greater than it is for other adults (Sobsey, 1994). Virtually half of the perpetrators of sexual abuse against people with disabilities had gained access to their victims through disability services (Sobsey, 1994). The fact that individuals with intellectual disabilities often require more frequent, long-term support from a caregiver makes them much more vulnerable to some type of abuse.

## Abuse Prevention

Statistics show that sexual abuse occurs at an alarming rate. Remember in chapter 1 we stated that studies show one in four girls and one in seven boys will experience some form of sexual abuse before the age of 18. With these types of statistics it is important that all of us play an active role in attempting to prevent abuse and as a result decrease these numbers.

There are several types of abuse other than sexual abuse. These include physical, emotional, financial, and spiritual abuse:

- Physical abuse may include hitting, pushing, kicking, and punching.
- Emotional abuse may include yelling, making inappropriate comments about the person being victimized, and not involving the person in activities.
- Financial abuse may include taking away money, not allowing a person to make choices on how to spend money, and other forms of financial exploitation.
- Spiritual abuse may include not allowing an individual's spiritual practices, selectively using scriptures to justify abusive behaviour, and ridiculing another person's spiritual beliefs.

**Glossary**

**abuse** An action or behaviour that causes or is likely to cause physical injury or psychological harm to the recipient. This includes neglect.

**neglect** When a caregiver fails to provide certain necessary aspects of healthy living. These can include food and shelter, warm positive regard, or attention to healthcare issues.

In Ontario the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008 Ontario Regulation 299/10 defines **abuse** as follows:

> *Abuse* means action or behaviour that causes or is likely to cause physical injury or psychological harm or both to a person with a developmental disability, or results or is likely to result in significant loss or destruction of their property, and includes neglect.

Abuse includes any and all kinds of physical, sexual, emotional, verbal and financial abuse. **Neglect** means the failure to provide a person with an intellectual disability with the support and assistance that is required for their health, safety, or well-being and includes inaction or a pattern of inaction that jeopardizes the health or safety of the person.

All those supporting individuals with intellectual disabilities must be educated—as indicated previously, in the Quality Assurance Measures—and must follow the guidelines regarding abuse as indicated in this document. Legislation requires that all agencies establish a clear protocol as to how staff deal with issues of alleged, suspected, or witnessed abuse, and make sure they are in compliance with the Quality Assurance Measures set forth in the Ontario Regulation 299/10.

## Educating About Abuse

When we educate persons with intellectual disabilities about abuse, it is important to assist them in being able to recognize, report, and avoid potentially abusive situations. Individuals need to know that most abuse is not committed by a "dirty old man" in the park, or by strangers who ask you to get into their car. Abuse can take place in any type of situation or relationship—it can happen at home, at work, or at the mall, as well as among family or friends, with a sexual partner, or with staff. It is important to teach the individual to be assertive and to be able to say "NO." However, it is also important for the individual to be able to hear and respect any statement or gesture from others indicating "NO."

When addressing issues of abuse, many clients will experience difficulties in understanding boundaries regarding appropriate touch of others. Social rules can be confusing for many—even for those without disabilities—so setting concrete guidelines is important. Many of the strategies we outlined in the sections on teaching boundaries (see chapters 6 and 7) can be utilized to address the importance of abuse prevention. Important concepts to address are where and when it is appropriate/inappropriate to touch other people (or have them touch you), protecting your and others' boundaries, and knowing your rights.

## Indications of Abuse

Individuals supporting clients with disabilities should be aware of some of the possible indicators of abuse. It is important to note that these are just some of the possible indicators; the list is not comprehensive. Furthermore, we should refrain from jumping to conclusions. Whenever you see the following warning signs, it is best to be observant and to investigate further:

- A marked change in adaptive skills

- Withdrawal
- Fear of touch/intimacy
- Fear or avoidance of certain people/places
- Weight loss
- Sleep disturbance
- Medical issues

Whenever a staff member suspects that abuse has occurred, there are established agency protocols that must be followed. Some of these policies are legislated, meaning that you have little or no choice but to follow through, such as those contained in the *Child and Family Services Act* regarding the duty to warn, protect, or report with respect to suspected child abuse.

## Self-Esteem

Many individuals with intellectual disabilities suffer from low self-esteem, due to a variety of reasons. This may be one of the factors that makes them more susceptible to being abused. Addressing these issues can help, not only in moving the client forward in their lives, but also in helping to decrease the possibility of them becoming a victim of abuse. At times, clients may try to hide their feelings of inadequacy by overcompensating. They may do this by acting as though they are better than others, or by trying to do everything for themselves without help.

Assisting someone to heighten their self-esteem requires that you discuss with them what they like about themselves, help them to accept the things they can and cannot change, help them to set realistic goals for the future, and help them to change negative thoughts they have about themselves into positive thoughts.

Here are some other tips:

- Have them develop a list of positive self-statements (this may require additional support, since many clients have difficulty seeing the things that they do well, often because they lack self-awareness).
- Have them look into a mirror and give themselves compliments.
- Help them to learn how to truly accept compliments.
- Have them develop a "positive me" box into which they can put items that represent the things they like about themselves.

A scrapbook activity that we call "*All About Me*" is also sometimes quite helpful in building and sustaining self-esteem. This is essentially a scrapbook depicting all the various things that are important in the person's life, such as where the person was born, the members of his/her family, school, vacations, different places he/she has lived, and things that person enjoys doing. It is a wonderful tool to reinforce all of the positive things in a person's life.

The group component discussed in chapter 6 is a wonderful opportunity to teach the concept of self-esteem in a variety of ways. It is very moving to observe group members tell each other what they like and admire about each

**Glossary**

**disclosure** A process in which a person gives clear details of an event, either cognitive or behavioural. Persons who are victimized will "disclose" their experiences of abuse, while clients who offend in treatment will "disclose" their actions as a way to identify problems in thinking and behaviour.

other. Having members of their own peer group provide them with these types of compliments has greatly assisted the individuals to gain insight in what others like about them and think that they do well.

When teaching individuals about abuse prevention, rights education, and privacy awareness, educators are often faced with the potential disclosure of an act of abuse that has already occurred. This sometimes happens when the individual suddenly comes to the realization that what happened was actually abuse. Disclosures can occur at any time, not just when in a teaching situation, and it is imperative that those working with individuals in such circumstances know how to handle these situations appropriately.

## Dealing with Disclosures

**Disclosure** occurs when an individual tells you, or lets you know in some other way, that she or he has been or is being abused.

### Staff/Support Person

When a support person is working closely with an individual, it is not uncommon for that individual to disclose some type of abuse. Disclosure can be *direct*, *indirect*, or a *third-party* disclosure. It is important that all disclosures of abuse be reported, no matter where or when they happened.

### Responding to Disclosure

*Upping the Anti* (Hingsburger, 2009b) and *Black Ink* (Hingsburger, 2009a) are two helpful booklets dealing with situations of abuse in clients with intellectual disabilities. These publications provide advice as to what one should do when faced with a disclosure of abuse.

In compliance with Quality Assurance Measures as outlined by the Ministry of Community and Social Services, there are certain actions a service agency must take. When a service agency suspects any alleged, suspected or witnessed incidents of abuse of a person with an intellectual disability that may constitute a criminal offence, a report must be made immediately to police. The service agency shall not initiate an internal investigation before the police have completed their investigation.

# 11

# Staff Strategies

## Staff Support

Clients with intellectual disabilities and sexual behaviour problems require many resources. Because of their unique clinical and interpersonal presentations, clients require assistance from trained professionals to ensure that their needs are met regarding housing, safety, treatment, and other clinical interventions, supervision, and community risk management. Staff who work with persons with intellectual disabilities often find this work very rewarding, but most will also tell you that it is quite challenging and emotionally exhausting. For this reason, it is important that staff who work with these clients receive sufficient training and support, while working as part of an organizational structure that is attentive to the needs of both its clients and its staff.

### Skill Sets

Agencies seeking staff who will be effective in working with persons with intellectual disabilities and sexual behaviour problems need to be careful about whom they select. Preconceived ideas can signal that a candidate will have a hard time being open to new ideas, or will experience difficulty maintaining boundaries. The following are some issues to consider:

- What is the candidate's understanding of normative behaviours?
- What prior understanding does the candidate have regarding theoretical models of sexual deviance?
- Does the candidate have experience in the effective use of behavioural techniques, such as reinforcement, extinction, and modelling?
- Will the candidate be able to teach generalization of behaviours outside of the treatment environment?
- Does the candidate appear to be a team player?
- Does the candidate have good communication skills, both oral and written?
- Will the candidate be able to follow through with program goals?

- Does the candidate appear to have any negative feelings about working with persons who have engaged in behaviours that many find distasteful?

## Staff Communication

Effective communication is vital in any organization. It is important to ensure that the process of transmitting information (e.g., ideas, thoughts, plans, etc.) is shared among the entire team so they can create a united front. Unity among staff members and pertinent others ensures that the vision of the organization is applied effectively. Furthermore, supported individuals are better able to adapt to a structured plan.

A clear understanding of the agency's goals and objectives for its clients are necessary to encourage understanding and ensure commitment from all staff of the organization. Clear communication among all staff creates an environment with clear goals and direction, and helps staff members identify ways to work as a team that can best support the clients and themselves.

Research has suggested that staff members work harder and are less susceptible to burnout when they better understand the goals and aspirations of the agency. Often, workers, even those on the front line, are simply told what to do, without explanation of the philosophy behind the task or of the intended outcome. These staff members tend to not have much investment in their jobs, because they feel as though they are simply following orders. By comparison, staff members who have been trained and instructed with respect to the agency's mission and goals tend to feel part of a team. Consequently, they are more motivated because they can see and understand the importance their personal role and actions will have in achieving the organization's goals.

### Importance of Written Communication

For situations in which more than one clinician, practitioner, or support person is involved in supporting an individual, many agencies have established a communication book, support notes, diary, or similar record to ensure the continuous transfer of vital information between all pertinent staff. A sample Client Profile form can be found in the Appendix.

Staff are accountable to each other in maintaining the programs, protocols, and policies that have been set in place. Constant communication among staff is a must. Verbal communication alone is not good enough. Written communication must be detailed, clear, purposeful, and concise, using correct words, to avoid misinterpretation of message. This is essential so that others can properly support the individual and foster a strong team unit. In fact, it is usually a good practice to have specific training for staff in producing reports, so that all staff understand the need for clear and appropriate information.

Written communication provides a permanent record and may be critical in determining patterns of the client's behaviour, for future reference. It is vital that staff document every significant piece of information that may assist other staff working with the individual they are supporting. When documenting information it is important to think of the five Ws: who, what, when, where, and why. Below are some examples of what should be included in documentation:

**Glossary**

**debrief** To meet after an event, project, or incident to discuss what happened, what went wrong, what went right, and what you can learn from the experience.

- Date/Time
- Who is involved
- What happened
- Possible triggers (what triggered the behaviour of the client—antecedent)
- Consequence (were there any consequences applied to the behaviour?)
- Person(s) involved in the issue
- The facts (avoid personal opinions.)
- Future action

## Staff Meetings

Regular feedback on the progress of the individual supported by a team is recommended for creating team cohesion. Meetings are necessary because they allow all persons involved with the individual to provide a picture of how well the programs are working. Such meetings also allow for problem-solving and finding alternative programs or tools that may be more effective. While some meetings may require the entire team, others may only require those directly involved in a particular situation. No matter who is involved, prompt communication about specific incidents that occur each week is necessary in order for the team to problem-solve and find a resolution.

Meetings should also provide a safe environment in which staff can **debrief**. This creates an outlet for staff to talk about a stressful event and receive support. Meeting soon after a situation has been resolved or a project has been completed gives staff members a chance to examine which approaches worked, as well as which were less successful; to solve problems with the tools and programs in place; and, to come up with new tools and programs to use in the future. In an ideal world, debriefing would happen immediately after the situation has occurred. However, given the multiple tasks that each staff member performs, immediate debriefing is not always possible. We recommend that time be set aside for team debriefing as soon as possible following an incident.

The frequency of meetings among all staff needs to be determined by those involved. Short, regular meetings, once per week, have typically proven to be most effective. All staff must be present, if possible, so that the entire team is aware of the issues and the action plans involved to bring about a positive change in the client(s). When everyone is informed and has input in determining plans, staff are better able to operate as a unified body. There should be written documentation (minutes) from each meeting which all staff can reference in the future. Assignments should be made as to who will be responsible for tasks in need of completion. If no one is assigned to the task or no deadline is given for its completion, a task will not get done.

For those caregivers who are working with the individual in the community, the supporting agency must recognize that isolation can readily lead to burnout. The care provider must be able to connect with a supervisor/manager on a regular basis to ensure an avenue for debriefing. Staff need to be able to discuss issues in a timely and efficient manner, as well as receive support as needed.

Several care providers may be working with an individual in the community at different times. Here again, the use of a communication book (typically

housed at the home of the individual being supported) has been effective. Consistency for all will be assisted by maintaining a binder with anecdotal notes, data sheets, mood charts, and whatever other pertinent documentation is required to effectively meet the individual's needs.

## Supporting Staff

Staff members who work daily with clients are critical resources in clients' treatment and integration into their communities. Because working with persons who have intellectual disabilties requires constant vigilance, creativity, and empathy, the work, while rewarding, can also be very taxing.

### Team Building

As suggested above, workers need to feel that they are valued members of a team with a common purpose and goal. Periodic team-building activities, when implemented effectively, can increase team spirit as well as reinforce commitment and foster awareness of the team's shared goals and objectives. Activities such as warm-ups and cool-downs at meetings, social outings, and peer feedback workshops, can develop strong interpersonal relationships, which help to bond the team, bringing them closer together as a unit.

### External Support

It is equally important to maintain strong lines of communication with any external support persons, such as family members, friends, probation officers, and other social-service agents, who may be associated with the individual. Teamwork is vital not only to those who are directly involved with the agency the mediator works for, but also to everyone involved in supporting the individual. In keeping with a client-centered focus, it is important to pull in or provide any additional support that is needed. Sharing information with the "whole support team," with the client's consent, is helpful in ensuring consistency and will assist in keeping the client and community safe. Here are some examples of information that needs to be shared amongst the entire team, including ancillary contacts:

- Significant incidents (accidents of physical outburst)
- Incidental (non-behavioural occurrences that may be significant)
- Medication changes
- Program/protocol changes
- Safety plan
- Consequences for behaviours
- Client progress
- Success stories

### Training

Ongoing training and job-specific education not only gives treatment and supervision providers a refresher of what may already be established, but also keeps everyone abreast of new ideas and tools that can be utilized to enhance

the support provided to clients—and each other. Annual in-service training and specialized workshops can increase skill levels as well as understanding of the "bigger picture." Training opportunities also help convey a sense of being valued by the organization. Well-trained staff, motivated by an understanding of the agency's goals and purpose, do better work, and are generally happier doing it.

## Challenges

Staff working daily with clients who have intellectual disabilities face some unusual on-the-job challenges. Being aware of these challenges can help us to anticipate problems that may arise, and provide training and support to help our valuable staff members avoid and deal with the difficulties they face.

### Clinical/Professional Boundaries

When working with individuals in clinical, mental health, or social service settings, professional boundaries must be maintained at all times.

> *Individuals who are paid to support and/or teach another person, for whatever reason, are not that person's friend. They are paid professionals.*

However, this does not mean that paid professionals do not care about their clients. Rather, it means that they must adhere to a defined boundary. This is particularly important when working with or supporting individuals with intellectual disabilities.

Boundaries between a person with an intellectual disability and their staff members must be respected, but it is often apparent that the boundaries have become very blurred. The concepts of "private" and "public" may have become skewed for the supported individual for numerous reasons:

- The individual may have lived in an institution where bathing or dressing was done habitually in front of others.
- The individual may have required hands-on assistance to complete hygiene routines and therefore they think having someone touch them in their private areas is acceptable.
- Families and staff may have been very physical when providing gestures of affection or discipline. As such, the individual may have developed a belief that it is acceptable to hug, touch, kiss, grab, or slap others without consent.

When working with an individual who may be new and unfamiliar to the person offering support, you need to gain as much information about the prior nature of their living conditions, their interactions with others, and the exceptions that may have been made for certain behaviours. For example, rules are traditionally different for exclusively male or female environments in comparison to those that are co-ed.

Even though many of our clients, as persons with intellectual disabilities, live and work in collective environments where they have close contact and a lot of interaction with peers, we must remember that they still have a right to privacy. We may be tempted to speak about an individual's most private issues, perhaps in a group with the client present. However, we must remember that

this can happen only with the client's consent and awareness as to why the discussion is happening. Unfortunately, we often model inappropriate ways of communicating information, especially in public or social environments. When facilitators and other support workers inappropriately manage public disclosures of personal information, we should expect that the clients will model these practices and also make private disclosures in public settings.

As concerned clinicians and supervisors, we need to teach the concepts of Private, Public, and "Be Careful" boundaries to the individuals with whom we work. In order to ensure that clients fully understand these concepts, we employ "over-learning" techniques—giving the same message over and over again, re-teaching important constructs, intervening when clients demonstrate poor understanding of boundaries.

We also need to respect the need for private time as a mental health coping strategy. All people—staff and clients—need time to detach, decompress, and regroup when things are overwhelming or stressful. We often forget that individuals with an intellectual disability may not be as able to communicate these needs or desires. We need to respect that "checking out" for a period of time is okay.

## Touch

Traditionally, individuals with intellectual disabilities have been omitted from sex education classes, for a variety of reasons. Although the education is getting better, the instruction an individual often receives around "private body parts" is that breasts, genitals, and the buttocks are private, when in fact most areas of the body are private. We need to teach that touch is contextual and that there must be a reason for the touch. As counsellors and supervisors, we need to get consent to touch the individual. We should request permission to assist them with their hygiene, dressing, lifting, and so on. At the very least, we need to tell the individual what we are doing and why we are touching him/her. We also need to be aware that these acts should be done in private, providing as little assistance as possible for the client to complete the task. Additionally, we need to be aware that acts of personal care must be completed with discretion and respect for the privacy of the individual.

## Dealing with Disclosures

As indicated in chapter 10, there are certain strategies that staff should use when faced with a client who discloses current or historical abuse:

### Stay calm

A person who is reporting abuse or neglect needs to know that you are available and there to help. Reactions of shock, outrage, or fear may make them feel anxious or ashamed. A calm response reassures them that what has happened can be worked through.

### Go slowly and be reassuring

It is normal to feel inadequate or unsure about what to do or say when an individual tells you about their abuse. It is important to:

- Proceed slowly.

- Reassure the individual that they have not done anything wrong.
- Use gentle and open-ended questions, such as, "Tell me more about what happened."
- Avoid questions that begin with *why*?

### Be supportive

Be sure to let the individual know:

- They are not in trouble.
- They are safe with you.
- You are glad that they have chosen to tell you about this.
- They have done the right thing by telling you about this.
- You are sorry that they have been hurt or that this has happened to them.
- You will do everything you can to make sure they are not hurt again.
- You know others who can be trusted to help solve this problem.

### Get only the essential facts

Be brief and limit your discussion to finding out what took place. When you have sufficient information and reason to believe that abuse and/or neglect has occurred, gently stop gathering facts and provide support.

At this point the authorities (e.g., the police) must be called. It is important that you not jeopardize the investigation by asking too many questions. While it is necessary to provide support to the individual, do not ask further questions. Unskilled investigators often ask leading questions that may unduly influence the abused person's reports to police or later testimony in court (if it gets to that level). Once the authorities have been called, you must complete written documentation. Do not make promises to the individual about what may or may not happen next. Provide only reassurance that is realistic and achievable.

### Make notes

Make notes of all comments. Use the individual's exact words if possible. You will need to share these notes with the police and other legal professionals, if appropriate. Documentation must consist of only the facts and must avoid any emotional aspects on the part of the staff reporting the incident.

Supervisors receiving the report need to be careful not to interview staff or discuss the report, beyond the documentation. The witnesses (the victim and the staff who received and wrote the report) need to be kept uncontaminated by conversations with others or questions from supervisors. Debriefing can occur after the authorities (most often the police) have taken the witness's statements.

When it comes to issues regarding abuse, most people see successful prosecution leading to a conviction as the only acceptable success. Hingsburger suggests that we need to see success much differently:

> *Really, success is anything that reduces the likelihood of future abuse; it is anything that makes the world safer for those in care. Prevention of abuse is a much more worthy goal than mere successful prosecution after someone has already been abused.*

Indeed, even if there was no successful prosecution after an abuse event, this should not be seen as failure. The openness of the organization to making the report, giving the person in care the opportunity to tell their story to the authorities, and the fact that a police report was made are all part of a successful agency approach. Fear is created in perpetrators when they recognize that there is a real possibility of being caught. Making it difficult for abusers to hurt others is the ultimate success!

## Staff Conduct

Staff need to be aware of the concepts of private versus public when working with individuals with intellectual disabilities, especially individuals with offending behaviours. Most agencies should establish a staff code of conduct, which will typically include a dress code. All staff need to be mindful of the possibility that how they dress may contribute to confusion on the part of clients, which may lead to inappropriate behaviour. Tight or revealing clothing is not appropriate. We must remember that, even in a group home environment, this is a professional place of business for support staff.

Establishing professional boundaries (physical, verbal, and emotional) with the individuals we support is essential. We are fond of the Stanfield *Circles* program, which is a useful tool in this area. When following the *Circles* curriculum, staff are advised to remain in the "yellow handshake circle," and to not move any closer to a client as long as they are a paid professional. Contact among staff should be limited to handshakes, high fives, and so on.

Although the individuals we serve and support may express frustration at the apparent "one-way street" regarding sharing of personal details, staff must maintain appropriate boundaries and not discuss their personal situations with the individuals they support. The clients should be made aware that staff are there to assist them in their lives, not to be "friends." Staff are encouraged to discuss life situations in general with persons they support, rather than getting into the specifics of their own lives.

Ensuring that appropriate boundaries are maintained also means that we must be cognizant of what clients may overhear. For instance, staff need to be mindful of the conversations they have with one another and discussions that may be overheard while talking on the phone. When discussing personal issues, staff should be aware of the content of the conversation and what supported individuals may become privy to. Staff need to also be aware of the family photos that they may post in their offices or keep in their wallets, as well as information that the client may be able to access regarding where the staff person lives. As such, staff phone numbers and addresses should be kept in a secure place.

When an individual that you support has an issue with inappropriate sexual behaviour, all staff who work with the individual need to be aware that personal discussions they have (e.g., regarding their children) could prove arousing for the supported individual. Some individuals we serve have learned to be manipulative in getting their needs met. For instance, some are very skilful in getting their staff to discuss things that, on the surface, may seem benign, but are actually fulfilling aspects of the client's deviant fantasies.

### Vicarious Trauma/Stress Management

Given the challenges that caregivers experience when working in this field, it is understandable that workers commonly suffer from compassion fatigue or vicarious trauma. Staff are often privy to stories of offending behaviour that may evoke a visceral response. It is difficult to listen to the stories of arousal from children or interest in diapers, urine, feces, and so on. It is challenging to always have to be one step ahead of the client, supervising them in the community, and enforcing safety plans. Staff are not immune to being sworn at, having physical threats made against them, or having threats made against their property or the people they care about.

Therefore, it is important for frontline care providers and managers to determine which support services and mechanisms are necessary for all involved to remain healthy. Researchers have identified circumstances associated with increased work-related distress. Some of these factors include being less than 25 years old, living alone, having experienced a traumatic event in the last six months, and having experienced sexual abuse. Personal characteristics of staff associated with increased distress include the following:

- Use of emotional or avoidance coping
- A tendency to ruminate on events
- High emotional inhibition
- High empathic concern for others
- An inability to detach from situations or persons
- Poor coping skills

When developing staff training curricula, we must consider including sessions that deal with coping strategies and emotional expression. Staff must feel that they can express their concerns, struggles, and emotions in a safe, supportive, and non-judgemental environment. The agency is responsible for ensuring that this is provided for all staff.

## Why Do We Keep Doing This Work?

For most of us, we work with difficult clients because we recognize we can have a dramatic effect on reducing the number of potential victims. Research suggests that an individual who is actively offending in the community can have five or more victims per year. Therefore, if we are able to successfully manage the risk of even a handful of potential offenders, we are making significant contributions to public safety. We firmly believe in the "no more victims" goal.

However, we also do this work because we have a fundamental belief that our clients have the right to receive appropriate treatment and care. They have the right to engage the community safely, but they require our assistance to do so. We want our clients to have the "good life" that our treatment models tell us is possible, given appropriate treatment and ongoing risk management. This work can also be extremely rewarding. Making a difference in someone's life, even in a small way, can be very gratifying.

### However ...

No matter how socially benevolent our reasons for doing this work may be, some key self-care elements are very important:

- We need to take care of ourselves and each other.
- We need to be able to leave our issues at the door and pick them up when we go out—to work on a two-way street.
- We need to celebrate the small victories.
- We need to be able to take the time to debrief with our team.
- We need to attempt to have balance in our life.
- We need to be able to laugh.

## Highlights

### CHAPTER 9

- Agencies must ensure that staff have the education required to support the individuals in healthy sexual activities and relationships.
- Like persons without intellectual disabilities, our clients are susceptible to influences in the media.

### CHAPTER 10

- There are several types of abuse: physical, emotional, sexual, financial, and spiritual.
- When we educate individuals with intellectual disabilities about abuse, it is important to assist them in being able to recognize, report, and avoid potentially abusive situations.

### CHAPTER 11

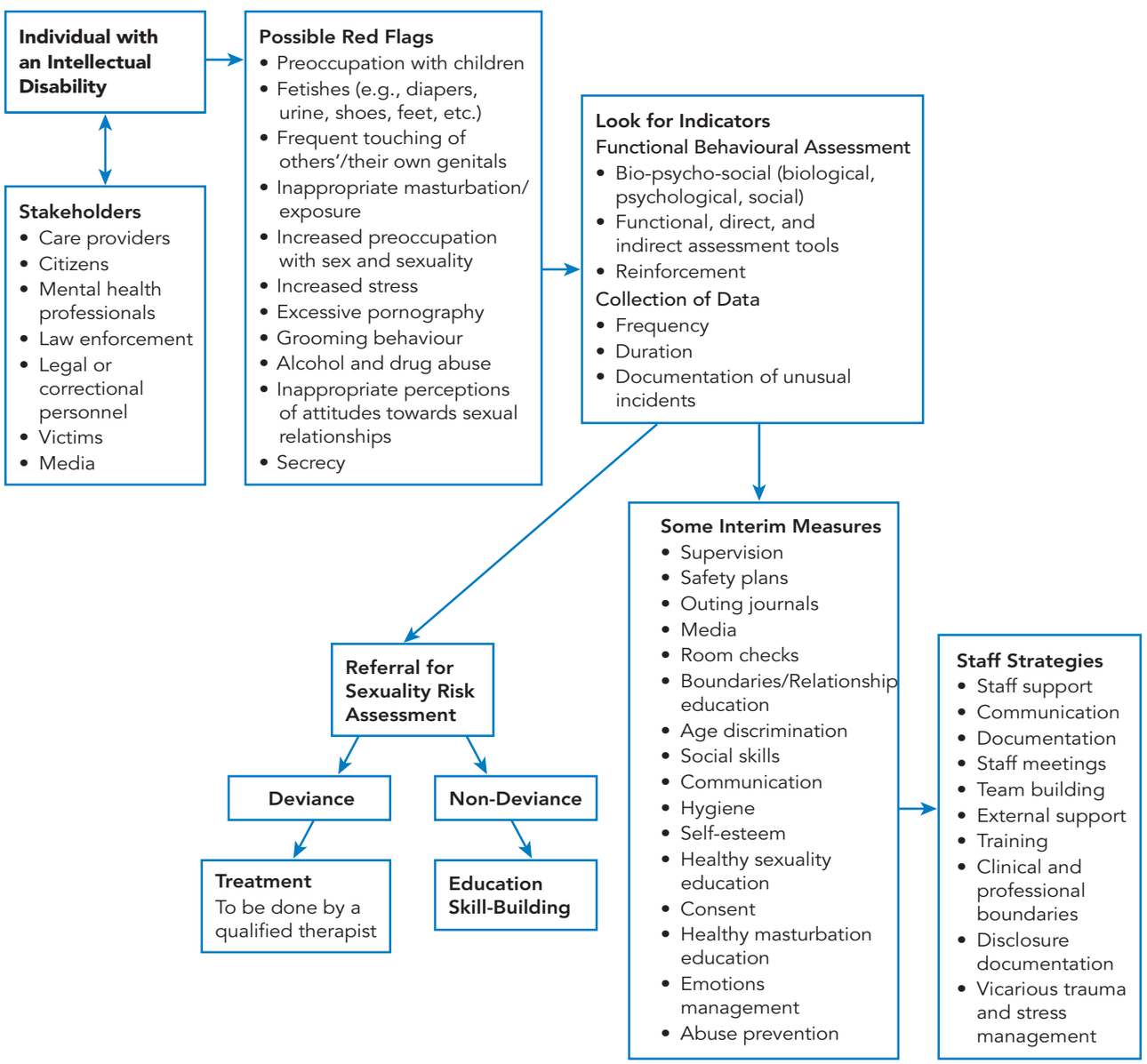
- Research suggests that staff work harder and are less susceptible to burnout when they understand the goals and aspirations of the agency they work for.
- Staff are accountable to each other in maintaining the programs, protocols, and policies that have been set in place.
- When working with individuals in clinical, mental health, or social service settings, professional boundaries must be maintained at all times.

# 12 Service Flow Chart

The flow chart on the next page is an example of how a network of professionals and agencies may support individuals with intellectual disabilities who may also present inappropriate sexual behaviours. It is an attempt to provide support persons with a simple yet clear course of action to take when faced with such a situation. The flow chart shows various avenues of service delivery depending on case-specific elements. Starting with a person with an intellectual disability, the chart shows what might happen when a stakeholder identifies possible inappropriate sexual behaviour (see chapter 3). This then leads to assessment (see chapters 4 and 5), treatment interventions (see chapter 7), and risk management strategies (see chapter 8).

## Service Flow Chart

The following is a service flow chart for persons supporting an individual with an intellectual disability who presents issues of concern regarding sexually inappropriate behaviour.



# 13 Closing Thoughts

In putting together this guidebook, it was not our intent to provide the absolutely most comprehensive information that you will ever come across. Of course, that would be nearly impossible. Indeed, this guidebook may start to be outdated the moment it is released. As such, we encourage you to continually read more about your field. As our understanding increases with respect to the connection between intellectual disability and sexual abuse, new publications will provide perspective, understanding, and guidance regarding policy and practice. That is a certainty. We hope to be able to update this guidebook and to make sure that it grows along with the field.

We leave you with the following thoughts:

*Research has clearly shown that a collaborative approach that includes representation from all stakeholders can assist considerably in enhancing public safety and offender accountability. Working together, we can manage the risk.*

*Teamwork is the key!!*

# About the Authors

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Dr. Robin J. Wilson, ABPP, is a researcher, educator, and board certified clinical psychologist with more than 25 years' experience working with sexual and other offenders in hospital, correctional, and private practice settings. He has worked as a consultant with Peel Behavioural Services and similar organizations for more than 10 years, in addition to maintaining an international practice in consulting and clinical psychology. Wilson's current focus is on developing collaborative models of risk management and restoration as persons of risk are transitioned from institutional to community settings. He has published over 75 scientific articles, book chapters, and monographs and has presented internationally on the diagnosis and treatment of social and sexual psychopathology. Wilson is the elected Southern Regional Representative on the Board of the Association for the Treatment of Sexual Abusers (ATSA) and is President of Florida's ATSA Chapter. He is presently Editor of the *ATSA Forum* and *sajrt.blogspot.com*, in addition to being a member of the editorial boards of *Sexual Abuse: A Journal of Research & Treatment*, the *Journal of Sexual Aggression*, and the *Howard Journal of Criminal Justice*.

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Michele Burns has been working for Peel Behavioural Services for the past 25 years. During this time, she has worked with a variety of individuals along with their mediators in addressing the behavioural challenges that they face. For the past 18 years, she has focused on working with individuals with intellectual disabilities who engage in sexually offending behaviour. Twelve years ago she assisted in developing a partnership with a residential provider to support individuals moving from an institution to a community setting. With the success of the first home, two additional houses have been opened which provide 24/7 residential treatment-specific programs. Michele has developed and presented materials at The Association for Treatment of Sexual Abusers (ATSA) conferences. Michele presently works as a therapist as well as supervises the three treatment homes and a community-based treatment program.

# Useful Resources

The following is a list of resources that you may find helpful when working with the individuals that you support. Remember that no resource is perfect, and that we need to screen resources to make sure that the content is appropriate for the individual who is receiving support. Some resources depict children or other potentially vunerable persons/things. As with any teaching tool, we must bring a certain amount of discretion to our choices.

| Life Skills | | |
|---|---|---|
| Title | Description | Contact |
| *JobSmart-1* (Video and Reading Material) | Teaches students the bottom-line behaviors and basics of getting a job, getting along with co-workers, and satisfying the boss. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *JobSmart-2* (Video and Reading Material) | Focuses on job safety and productive attitudes that lead to advancement. | |
| *First Impressions: Attitude* (Video and Reading Material) | Body language, tone of voice, mannerisms, conduct, and demeanor: those hard-to-pin-down personal strategies that make the crucial difference between a successful social contact or job interview and a failure. | |
| *SafetySmart-1* (Video and Reading Material) | Teaches students NotSmart and SafetySmart ways to avoid life's daily hazards and pitfalls—at home, on the job, and on the streets. | |
| *SafetySmart-2* (Video and Reading Material) | Teaches students to recognize what to do if an accident does occur; when it's an emergency; what community agency to contact; and how to explain their immediate situation to authorities. | |

| Life Skills | | |
|---|---|---|
| Title | Description | Contact |
| *In Search Of Character*<br>*Trustworthy*<br>*Responsibility*<br>*Fairness*<br>*Caring*<br>*Citizenship*<br>*Honesty*<br>*Courage*<br>*Diligence*<br>*Integrity*<br>(Video and Reading Material) | *In Search of Character*™ spotlights 10 core virtues that help teens develop into caring, respectful, responsible people who make choices based on what's right, rather than what's easy. In this series, viewers take a fun, behind-the-scenes peek at the Dr. Mike Radio Show, where callers explore different aspects of character with "Dr. Mike" (Michael Thomson, Ph.D.). | Live Wire Media<br>Phone: (800) 359- 5437<br>Fax: (415) 552-4087<br>Mail:<br>Live Wire Media<br>273 Ninth Street<br>San Francisco, CA 94103<br>Hours of Operation:<br>Monday–Friday,<br>8:30 am–5: 30 pm PST |
| *Home of Your Own: Cooperative Living*<br>(Video and Reading Material) | *Home of Your Own* is part of the three-part Living With Others library. After meeting "The Housemates from Hell," your students will learn the cooperative living skills needed to successfully live with others. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *LifeFacts: Managing Illness & Injury*<br>*Basic Wellness Education*<br>(Video and Reading Material) | This program teaches students 22 important lessons about health so they can live self-sufficiently and safely. Designed especially for people with learning difficulties who need preparation against the dangers of illnesses and injury so they may have a successful independent lifestyle. | |
| *ASSET*<br>*A Social Skills Program for Adolescents*<br>2nd Edition<br>(Video and Reading Material) | A social skills program for adolescents that focuses on 8 areas.<br>Tape 1: Giving Positive Feedback<br>Tape 2: Giving Negative Feedback<br>Tape 3: Accepting Negative Feedback<br>Tape 4: Resisting Peer Pressure<br>Tape 5: Problem Solving<br>Tape 6: Negotiation<br>Tape 7: Following Instructions<br>Tape 8: Conversations | Research Press<br>Phone: (217) 352-3273<br>(800) 519-2707<br>Fax: (217) 352-1221<br>Email: orders@researchpress.com<br>Mail:<br>Dept. 10W<br>P.O. Box 9177<br>Champaign, IL 61826<br>www.researchpress.com |

| Relaxation | | |
|---|---|---|
| Title | Description | Contact |
| *Autogenic Relaxation*—Audio (Eli Bay, 21 minutes). | Imagery-based | Eli Bay—The Relaxation Response Institute<br>Tel: (416) 932-2784<br>Toll-Free: (877) 435-4229<br>Fax: (416) 932-2971<br>Mail:<br>1352 Bathurst St.<br>Suite 201<br>Toronto, Ontario, Canada<br>M5R 3H7 |
| The Healing Light Audio (26 minutes) | Imagery-based | |

| Social Skills: Hygiene | | |
|---|---|---|
| Title | Description | Contact |
| *First Impressions: Hygiene* (Video and Reading Material) | Detailed demonstrations of showering, bathing, shampooing, bathroom clean-up, hand washing, and good hygiene associated with elimination. | James Stanfield<br>Contact Information<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *First Impressions: Grooming* (Video and Reading Material) | Hair and nail care, skin protection, shaving, and dental care basics are covered in the two Grooming modules, both tailored specifically for males and females. | |
| *First Impressions: Dress* (Video and Reading Material) | The basic pieces of "mistake-proof" wardrobes are illustrated, as well as fit, coordination, condition, appropriateness, and accessories. | |

| Social Skills: Money Management | | |
|---|---|---|
| Title | Description | Contact |
| *MoneySmart-1* (Video and Reading Material) | Focuses on careful budgeting, smart shopping, and wise spending. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *MoneySmart-2* (Video and Reading Material) | Teaches students how to keep their hard-earned dollars by avoiding the most common budget busters. | |

| Social Skills: Manners | | |
|---|---|---|
| Title | Description | Contact |
| *Manners for the Real World* by Dan Coulter (DVD and Reading Material) | The DVD covers how people should act during their most common interactions with one another. There is a helpful section on how to use this DVD with persons who have Asperger's Syndrome or High-functioning Autism. This DVD also comes with subtitles for viewers who are deaf or hearing impaired. | Coulter Videos<br>Phone: (336) 608-4224<br>Fax: (336) 608-4224<br>E-mail: info@coultervideo.com<br>Mail: 1428 Pinecroft Drive,<br>Winston Salem, NC 27104<br>www.coultervideo.com |
| *Mind Your Manners* (Video and Reading Material) | Encourage social success and acceptance through proper social behavior with the everyday situations portrayed in the *Mind Your Manners* program. *Mind Your Manners* is part of the three-part Living With Others library. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |

| Coping With Conflict/Problem Solving | | |
|---|---|---|
| Title | Description | Contact |
| *Be Cool* series (Video and Reading Material) | The *Be Cool* series is composed of several modules. The modules show various situations where conflict may arise. It provides three general ways in which people commonly respond to conflict: hot (angry), cold (withdrawn) or cool (calm and collected). There are a variety of programs offered for different grade levels and for those with intellectual disabilities. The curriculum is further broken down into concepts such as dealing with anger, teasing, criticism; give and take verses threats, demands, and intimidation. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *Imagery Procedures for People with Special Needs: Breaking the Barriers II* by Dr. June Groden and Dr. Joseph R. Cautela (Video) | This video features training sessions in which clinicians use and demonstrate imagery-based procedures to help individuals with intellectual disabilities learn to cope with stress and develop self-control. | Research Press Publishers<br>Phone: (800) 519-2707<br>Fax: (217) 352-1221<br>Email: orders@researchpress.com<br>Mail:<br>Research Press Dept. 11W<br>P.O. Box 9177<br>Champaign, IL 61826<br>www.researchpress.com |

| Workbooks (Emotion Focused) | | |
|---|---|---|
| Title | Description | Contact |
| *Strategies for Anger Management: Reproducible Worksheets for Teens and Adults*<br>by Kerry Mole | This workbook is a good tool for professionals to help teens and adults learn how to cope with anger in healthier ways. This workbook is divided into three sections: Understanding Anger, Interventions for Anger Management and Conflict Resolution, and The Differences between Anger & Abuse. Each of the 34 topics covered has one or more reproducible worksheets and a facilitator's information sheet outlining the purpose, background information, and guidelines for leading an individual/group activity. This package includes a CD with reproducible activities. | Currently, there are no sellers for this item, but it can still be purchased on amazon.com. |
| *The Self-Esteem Workbook*<br>by Glenn R. Schiraldi | Provides effective and practical strategies for raising ones self-esteem: liking oneself, conquering self doubt, rational thinking, affirming thoughts, body appreciation, etc. | Currently, there are no sellers for this item, but it can still be purchased on amazon.com. |
| *Anxiety Workbook for Teens: Activities to Help You Deal with Anxiety and Worry*<br>by Lisa M. Schab | Provides a collection of tools to help control anxiety and face day-to-day challenges. This workbook both gives anxious teens insight into their problems and offers practical guidance for overcoming them. | Currently, there are no sellers for this item, but it can still be purchased on amazon.com. |
| *Breaking Down the Wall of Anger: Interactive Games and Activities*<br>by Esther Williams | This book consists of seven units. Each unit contains activities that provide for group bonding, self analysis, personal goal setting, and practice. Each unit can be taught independently or the seven units can be used as a complete anger management program. | YouthLight, Inc.<br>Phone: (800) 209-9774<br>Fax: (803) 345-0888<br>Email: YL@youthlightbooks.com<br>www.youthlightbooks.com<br>Mail: P.O. Box 115<br>Chapin, South Carolina 29036 |
| *141 Creative Strategies for Reaching Adolescents with Anger Problems*<br>by Tom Carr | This book provides the reader with some of the common causes of anger in our young people, but the bulk of the book is filled with 141 strategies that are divided in to five categories (levels of anger). Included are over 25 reproducible skill sheets to assist staff when working with the individual they support. | YouthLight, Inc.<br>Phone: (800) 209-9774<br>Fax: (803) 345-0888<br>Email: YL@youthlightbooks.com<br>www.youthlightbooks.com<br>Mail: P.O. Box 115<br>Chapin, South Carolina 29036 |

| Workbooks (Emotion Focused) | | |
|---|---|---|
| Title | Description | Contact |
| *Stress Management for Adolescents: A Cognitive-Behavioral Program* by Diane de Anda | The aim of this book is to affect both cognitive and behavioural changes. It offers both knowledge and specific coping techniques to expand the individual's behavioural repertoires. The program includes information and activities to help the individual achieve a variety of goals. | Research Press<br>Phone: (800) 519-2707<br>www.researchpress.com<br>Mail: 2612 North Mattis Avenue<br>Champaign, Illinois 61822 |

| Relationships: Communication and Boundaries | | |
|---|---|---|
| Title | Description | Contact |
| *Circles* Curriculum | The *Circles* Curriculum teaches relationship boundaries and relationship-specific behaviors, using a simple multi-layer circle diagram to demonstrate the different relationship levels students will encounter in daily life. This will help your supported individuals generalize the skills they learn in their home and community. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *Intimacy & Relationships, Level 1* (Video and Reading Material) | Teaches relationship boundaries and relationship-specific behaviors. For example, it's okay to hug your mother, but it's not okay to hug the mail carrier. | |
| *Intimacy & Relationships, Level 2* (Video and Reading Material) | Shows how to apply the rules of social intimacy in more complex settings. | |
| *DateSmart-1* (Video and Reading Material) | Teaches students how to control their emotions and avoid impulsive reactions to intimate situations. | |
| *DateSmart-2* (Video and Reading Material) | Teaches students how to control their emotions and avoid impulsive reactions to intimate situations. | |
| *Safer Ways* (Video and Reading Material) | Provides current information on avoiding and treating communicable diseases and ways to protect against sexually transmitted diseases. | |

| Relationships: Communication and Boundaries | | |
|---|---|---|
| Title | Description | Contact |
| *PeopleSmart-1* (Video and Reading Material) | Teaches basic friendship skills and is the first video program to focus on the specific skills needed to make a "real" friend. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *PeopleSmart-2* (Video and Reading Material) | Helps students learn the difference between trust and gullibility and that "niceness" does not always mean "goodness." | |
| *Relationship* Series by the Young Adult Institute (YAI). (Video) | A comprehensive three-part video series for (young) adults with intellectual disabilities. It includes the following:<br>1) Friendship Series: focuses on the differences between strangers, acquaintances, and friends, becoming acquaintances and friends, and being a friend.<br>2) Boyfriend/Girlfriend Series: Focuses on starting a special relationship, building a relationship, and having a good relationship.<br>3) Sexual Relationship Series: Focuses on enjoying your sexual life, working out problems, and sexual acts that are against the law. | YAI<br>Phone: (212) 263-7474<br>Mail:<br>Central Office<br>YAI Network<br>460 West 34th St.<br>NY, NY 10001-2382<br>www.yai.org |

| Healthy Sexuality | | |
|---|---|---|
| Title | Description | Contact |
| *Life Horizons 1* (Video and Reading Material) | Physiological and emotional aspects of being male and female. (I.e., Parts of the Body, Sexual Life Cycle, Human reproduction, Sexually Transmitted Diseases, and AIDS) | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *Life Horizons 2* (Video and Reading Material) | The moral, social, and legal aspects of sexuality. (I.e., Moral, Legal & Social Aspects of Sexual Behavior (both male and female), Dating Skills, and Learning to Love). This module covers additional areas that may or may not be helpful for the supported individual (i.e., parenting), however, it is suggested to consider the areas that may be effective in attributing to generalizing their skills. | |
| *LifeFacts: Sexuality* (Video and Reading Material) | Basic sex education in a teacher-friendly format This program is designed to provide the essential materials and information necessary to teach human sexuality to adolescents and adults with intellectual and learning disabilities. With the help of two sets of explicit and non-explicit teaching illustrations and 35-mm slides, you determine the appropriate level of presentation suitable for student needs and community attitudes. Includes pre-test and post-tests. | |
| *LifeFacts: The Teacher-Friendly Life Skills Series* (Video and Reading Material) | This series teaches sexuality, abuse prevention, AIDS avoidance, managing emotions, trust issues, substance abuse prevention, and wellness. | |
| *Hand Made Love: A Guide For Teaching About Male Masturbation* by Dave Hingsburger (Video and Reading Material) | This book and video set discusses privacy, pleasure, and the realities of sharing living spaces with others. The narrator of the video talks about myths and suggests that masturbation can be a way of learning about sex, while the book discusses masturbation from the point of view of both health and pleasure. | Diverse City Press Inc.<br>Phone/Fax: (877) 246 5226<br>Email:<br>diversecitypress@bellnet.ca<br>(or latourdcp@hotmail.com)<br>Mail:<br>7654 Fifth Line,<br>Angus, Ontario L0M 1B1<br>www.diverse-city.com/display.htm |

| Healthy Sexuality | | |
|---|---|---|
| Title | Description | Contact |
| *Under Cover Dick: A Guide For Teaching About Condom Use Through Video and Understanding* by Dave Hingsburger (Video and Reading Material) | This book and video set provides clear direction regarding condom use. The video discusses disease transmission and demonstrates how to wear a condom, plus the book includes photographs of each step involved. | Diverse City Press Inc.<br>Phone/Fax: (877) 246 5226<br>Email:<br>diversecitypress@bellnet.ca<br>(or latourdcp@hotmail.com)<br>Mail:<br>7654 Fifth Line,<br>Angus, Ontario L0M 1B1<br>www.diverse-city.com/display.htm |
| *Finger Tips: A Guide for Teaching about Female Masturbation* by Dave Hingsburger and Sandra Haar (Video and Reading Material) | This book and video set is aimed at teaching women with developmental disabilities about masturbation. It also confronts typical myths about female sexuality. The book includes a step-by-step photographic essay about masturbation, and the joy of private time. | |
| *It's Perfectly Normal: Changing Bodies, Growing Up, Sex and Sexual Health* written by Robie H. Harris; illustrated by Michael Emberley | This universally acclaimed classic by Robie H. Harris and Michael Emberley is a cutting-edge resource for kids, parents, teachers, librarians, and anyone else who cares about the well-being of "tweens" and teens. Providing accurate and up-to-date answers to nearly every imaginable question, from conception and puberty to birth control and AIDS, *It's Perfectly Normal* offers young people the information they need—now more than ever—to make responsible decisions and stay healthy. | Candlewick Press<br>Phone: (800) 733-3000<br>Fax: (800) 659-2436<br>Mail: 99 Dover Street<br>Somerville, MA 02144<br>www.candlewick.com/default.asp |
| Able to Live, Able to Love: A sexuality education resource guide for persons with intellectual disabilities and those who live and work with them by Anne Escrader with Elizabeth Moore; illustrations by Srividy Natarajan | This sexuality education resource has been planned, designed, and developed because the authors believe in taking a proactive approach towards disability and human sexuality. The authors understand sexual self-expression to be an important aspect of being human. The guide provides basic information on sexuality and relationships that persons with disabilities can work through on their own or with the support and assistance of parents, teachers, and others who live with them. | The Relationship, Sexuality and Safety Education Network of Wellington and Dufferin Counties<br>Contact:<br>Christine Rickards<br>Phone: (519) 824-5544 ext. 776<br>Email: crickards@trellis.on.ca |

| Healthy Sexuality: Abuse Recognition | | |
|---|---|---|
| Title | Description | Contact |
| *Circles* Curriculum: *Stop Abuse* (Video and Reading Material) | Teaches students how to recognize and avoid sexually threatening or abusive situations. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *Circles* Curriculum: *AIDS: Safer Ways* (Video and Reading Material) | Part 1: Focuses on communicable disease and casual contact<br>Part 2: Focuses on STDs, AIDS and intimate contact | |
| *LifeFacts: Sexual Abuse Prevention Teach Essential Self-Protection Skills* (Video and Reading Material) | This program contains all the essential materials and information necessary to teach sexual-abuse recognition, prevention, and protection strategies for adolescents and adults. The program provides concepts that are presented in simple terms and materials that are logically sequenced and paced for ease of presentation. Pre-tests and post-tests for each of the instructional areas assess entry-level needs and allow evaluation of student understanding of this critical material. | |
| *Life Facts: Substance Abuse Refusal Training* (Video and Reading Material) | This program provides lessons about drugs in daily living situations at home, in school, or in the community. The program teaches the facts of life about the dangers of substance abuse and chemical dependency, emphasizing how students can avoid drugs, by empowering them with refusal skills. | James Stanfield<br>Phone: (800) 421-6534<br>Fax: (805) 897-1187<br>Email: orderdesk@stanfield.com<br>Mail:<br>James Stanfield Co., Inc.<br>Drawer: WEB<br>P.O. Box 41058<br>Santa Barbara, CA 93140<br>www.stanfield.com |
| *No! How!!!* co-written by Dave Hingsburger (Video) | This video involved people with disabilities in acting, writing, producing, and directing a film aimed at others with disabilities. From discussing disability to teaching boundaries and body parts, people with disabilities take the lead. | Diverse City Press Inc.<br>Phone/Fax: (877) 246-5226<br>Email:<br>diversecitypress@bellnet.ca<br>(or latourdcp@hotmail.com)<br>Mail:<br>7654 Fifth Line,<br>Angus, Ontario L0M 1B1<br>www.diverse-city.com/display.htm |

| Staff Education | | |
|---|---|---|
| Title | Description | Contact |
| *Who Do We Serve?* with David Hingsburger (Video) | This lecture deals with supporting people with intellectual disabilities who have committed sexual crimes. Who do we serve first in a community setting? Do we serve the individual first or do we serve the community? | Diverse City Press Inc.<br>Phone/Fax: (877) 246-5226<br>Email:<br>diversecitypress@bellnet.ca<br>(or latourdcp@hotmail.com)<br>Mail:<br>7654 Fifth Line,<br>Angus, Ontario L0M 1B1<br>www.diverse-city.com/display.htm |
| *Behaviour Self!* by Dave Hingsburger. (Book) | Dave writes about the importance of understanding behaviour messages from people with intellectual disabilities in a straightforward yet humorous fashion. This book gives insight to parents and staff with new ways on how to get the message right. | |
| *The Ethics of Touch* (Video and Reading Material) | This training package looks at the delicate issue of touch. Those who provide direct care to people with intellectual disabilities are often asked to be in private places performing intimate services. From bathing to toileting to dressing, we are necessarily in close proximity to those we serve. Given this situation, it is imperative that staff be aware of how to provide these services while maintaining appropriate professional boundaries. How do we appropriately express affection toward those we serve? This video suggests new and healthy ways of helping people with disabilities fulfill their deepest needs. | Diverse City Press Inc.<br>Phone/Fax: (877) 246-5226<br>Email:<br>diversecitypress@bellnet.ca<br>(or latourdcp@hotmail.com)<br>Mail:<br>7654 Fifth Line,<br>Angus, Ontario L0M 1B1<br>www.diverse-city.com/display.htm |
| *Power Tools: Thoughts About Power and Control in Service to People with Developmental Disabilities* by Dave Hingsburge. (Book) | This book addresses the delicate issue of power within human services. Power is one of the most important issues that front-line care providers need to consider. *Power Tools* gets you thinking about who we are and the power that we have. The process of change involves three steps and two skills. *Power Tools* is written with humour, wit, and warmth. Please note that there is some language used in this book that may offend some readers. | Diverse City Press Inc.<br>Phone/Fax: (877) 246-5226<br>Email:<br>diversecitypress@bellnet.ca<br>(or latourdcp@hotmail.com)<br>Mail:<br>7654 Fifth Line,<br>Angus, Ontario L0M 1B1<br>www.diverse-city.com/display.htm |

| Staff Education | | |
|---|---|---|
| Title | Description | Contact |
| *Ethical Dilemmas: Sexuality and Developmental Disability*<br>edited by<br>Dorothy M. Griffiths, Ph.D.; Debbie Richards;<br>Paul Fedoroff, M.D.; and<br>Shelley L. Watson, M.Ed. | Unique in its approach, *Ethical Dilemmas: Sexuality and Developmental Disability* addresses critical issues and questions. It also provides recommendations and suggestions through extensively documented, researched, and expert consensus. Numerous case studies are used throughout to identify the issues and build the foundations for the many situations that occur within the lives of individuals who have disabilities. | NADD Press<br>Phone: (800) 331-5362<br>Fax: (845) 331-4569<br>Email: info@thenadd.org<br>Mail:<br>132 Fair Street<br>Kingston, New York 12401<br>www.thenadd.org/index.shtml |
| *Sexuality and the Developmentally Handicapped: A Guidebook for Health Care Professionals*<br>by William Rowe and Sandra Savage with Mark Ragg and Kay Wigle | Presents the knowledge, attitudes, and skills pertinent to responding to the sexual problems of intellectually handicapped persons, their families, and communities. Details fully documented cases, issues concerning the law, and resource materials available. | The Edwin Mellen Press<br>Phone: (716) 754-2266<br>Fax: (716) 754-4056<br>Email: imiller@mellenpress.com<br>Mail:<br>P.O. Box 450<br>Lewiston, New York, 14092<br>mellenpress.com/index.cfm |
| *Stress Management* | A workbook to use with individuals with a developmental disability but could be a good tool for staff to use themselves in working through the management of stress. | Christine Rickards<br>Behavioural Consultant<br>Trellis Mental Health and Developmental Services<br>Phone: (519) 824-5544 ext. 776<br>crickards@trellis.on.ca |
| *Practical Treatment Strategies for Persons with Intellectual Disabilities*<br>by Dr. G. Blasingame | This book is a result of a collaborative effort of several professionals in the field with their goal being to bring practical training to the professionals working with these issues and to change the lives of the individuals they support. | Wood 'N' Barnes Publishing<br>Phone: (405) 942-6812<br>WOODBARNES.COM<br>Mail: 2717 NW 50th<br>Oklahoma City, OK 73112 |

# Appendix: Protocols

Throughout this guidebook, we made reference to a variety of forms, protocols, or other scales that you might find useful in trying to work with your clients. In this section, we have collected all of those items together. Feel free to use them to assist you in your work. However, in some cases, you may wish to consult with an assessment or treatment professional to make sure that you are using them properly or in a way that will best assist you. It is also important to remember that these tools are to be used as a guideline. For a tool to be effective it must meet the individual needs of the person being supported. Therefore, these tools can be used as they are, if they are specific enough to meet the individual's requirements, or they can be used as a template to be modified accordingly.

## ABC Data Chart

The following is a chart that may be used to map out ABC data when doing Functional Behavioural Analysis.

| Date | Time | Those Involved | Antecedent/ Trigger | Behaviour | Consequence | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
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## Daily Mood Chart

The chart below gives examples of what to look for in the way of behavioural and affective cues.

| Hrs./ Day of Sleep | Time | Anxiety Level | Irritability Level | Depressive Symptoms | | | | Manic Symptoms | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Severe | Moderate | Mild | None | Severe | Moderate | Mild | None |
| | Morning | Low<br>Med.<br>High | Low<br>Med.<br>High | | | | | | | | |
| | Afternoon | Low<br>Med.<br>High | Low<br>Med.<br>High | | | | | | | | |
| | Evening | Low<br>Med.<br>High | Low<br>Med.<br>High | | | | | | | | |

| | Mild | Moderate | Severe |
|---|---|---|---|
| **Depressive** | • Consistently antisocial<br>• Will not engage<br>• Keeps to self<br>• Seems quiet | • Displays flat affect<br>• Seems groggy<br>• Stays in room<br>• Does not greet people | • Does not come out of room<br>• Appears completely withdrawn |
| **Manic** | • Overly talkative<br>• Uses moderate volume<br>• Performs excessive mimicking<br>• Shows some impulsivity<br>• Performs rhythmic tapping<br>• Invades personal space<br>• Wanders | • Cannot regulate emotions<br>• Excessive laughing, crying, etc.<br>• Disregards boundaries<br>• Uses high volume, sweats, wanders excessively, shows increased impulsivity | • Hits, kicks, bites, threatens<br>• Holds head, cannot self-regulate, talks about head hurting<br>• Uses extreme volume<br>• Threatens harm |

The introduction section of the Individualized Safety Plan can be deleted should it not be required.

## Individualized Safety Plan

**Introduction:**

Individuals who engage in sexually deviant behaviours generally do not realize how much harm an offense causes. The victims often suffer extensive, long-lasting problems. They may have difficulty controlling their thinking and behaviour, lose their self-confidence, have problems with their sexuality, and experience sleep disturbances and actual physical illness. When the victim of abuse is a family member of the offender the problems are even worse.

For these reasons, all who support an individual at risk of offending must work together to be constantly vigilant. Although the individual is responsible for learning how to keep himself or herself safe, all must assist and support the individual so further offenses are not committed. This is the only way to keep both the individual and the community safe.

**Plan and Agreement**

A meeting was held with the individual and _____ (list parties) on _____ (date). The importance of ensuring that _____ (name of client) is provided with the appropriate levels of support and supervision when he or she is in the community, visits his or her family, etc. was discussed. It is recommended that _____ (name of client) be supervised by a responsible adult over the age of 18 [here one may adjust the age in keeping with the age of the client—an older client should have a safe person whose age is closer to his or hers] who is aware of their Safety Plan, and the sorts of issues he/she might face in the community. This person is referred to as a "*safe person*" and can help to prompt _____ (name of client) to use safety strategies in the community. These strategies may include but are not limited to looking away, walking away, thought switching, and/or talking to a safe person.

The safe person agrees to abide by the agreement detailed below as indicated by signing the plan.

1. It is recommended that _____ (name of client) not be provided with the opportunity to exchange physical or close contact with any children under the age of 18, including family members. When appropriate, _____ (name of client) may give "props" or "knuckles" to teenage family members.
2. _____ (name of client) may not to be in the company of anyone under the age of 18 unless supervised by a safe person over the age of 18 who is aware of his or her issues.
3. _____ (name of client) is to be within eye- and earshot of a safe person at all times. This is not necessary when _____ (name of client) is in the washroom or in the privacy of his/her bedroom. _____ (name of client) should not have a television or computer in his/her room.
4. When _____ (name of client) is with family, he/she will not go into the community unless a accompanied by a safe person. _____ (name of client) is to review the plans prior to going out and determine if the outing is an appropriate one. Part 1 of the Outing Journal must be completed prior to the outing and Part 2 must be completed upon returning from the outing. The Outing Journal will be returned to those recording the data.

5. When _____ (name of client) is visiting people (i.e., family members), _____ (name of client) will never be left alone in the home.
6. _____ (name of client) will never be left alone with children, or be requested to interact with children who may be visiting the home or in the community. _____ (name of client) is to be encouraged to use his or her Supported Self-Regulation Techniques when children may be in the area, and the safe person must respect _____ (name of client)'s decision to leave the environment should he or she report feeling uncomfortable. Should _____ (name of client) experience a Lapse and not leave the area, the safe person must prompt _____ (name of client) to either leave or move to a safer place.
7. Should _____ (name of client) need to use the washroom when in public, it would be preferable to find a single-stall washroom. If one is not available, the safe person must ask _____ (name of client) to make sure the washroom is safe prior to using the facilities. If _____ (name of client) is with a same-sex safe person, the safe person must go in the washroom with _____ (name of client).
8. When _____ (name of client) is at home, all media must be screened for appropriate content. Magazines, books, television programs, newspapers, catalogues, movies, DVDs , digital cameras, etc., should be monitored. Although all forms of media contain some level of child content, _____ (name of client) is to have limited exposure to children. Therefore, the types of television programs, movies, books, etc. that _____ (name of client) is exposed to when with the safe person should not be centered on children.
9. When _____ (name of client) is at home he or she is not to have access to the Internet. Should she or he be using the computer to play a game, he or she must be monitored so that she or he does not access inappropriate material on the computer.
10. (If applicable) Should the safe person feel that _____ (name of client)'s safety is an issue at home or something unexpected comes up, and the appropriate level of supervision cannot be provided, the safe person will immediately contact the agency that directly supports the individual and arrangements will be made to drop off or pick up _____ (name of client).
11. (If applicable) The safe person is responsible in ensuring that _____ (name of client) receives his or her medication at the appropriate times.

Please sign below to indicate that you have been fully informed of _____ (name of client)'s risk issues and that you intend to adhere to the Safety Plan in all aspects.

Signatures:

_____ _____

(Name of individual) Safe Person, (Name of safe person)

Dated: _____

# Danger Zone

| My Danger Zone Feelings are: |
|---|
| • Angry<br>• Scared<br>• Sad<br>• Lonely<br>• Bored |
| **My Danger Zone Thoughts/Fantasies are:** |
| • Thinking about children<br>• Having sexual fantasies about children |
| **My Danger Zone Behaviours are:** |
| • Looking at pictures of children (in flyers or in magazines)<br>• Being around children<br>• Touching children<br>• Staring at children<br>• Talking to children<br>• Taking pictures of children<br>• Masturbating while looking at children or thinking about them<br>• Writing notes about children<br>• Taking brochures about children's programs or services<br>• Taking items that belong to children |
| **My Danger Zone Places are:** |
| • Schools<br>• Parks/playgrounds<br>• Malls<br>• Kids' stores<br>• My neighbourhood<br>• The Internet |
| **My Danger Zone Times are:** |
| • School Times<br>• 8:00 – 9:00<br>• 3:00 – 4:00<br>• School holidays |

## Generalized Safety Plan

1. Before every outing in the community, I will read, understand, and accept the details of my Safety Plan. I will do this in front of the staff or other support person(s).
2. Before I go into the community, I will make sure that I am in a good/positive mood. If I am not in a good mood I will do something relaxing and calming before I go out.

   I MUST BE CALM AND POSITIVE BEFORE I GO OUT!
3. I have already completed the first part of my outing journal for this outing and have discussed my plans with staff. I will complete the rest when I get back.
4. An adult who is aware of my safety strategies will accompany me in the community to help me practice my SRT (Self-Regulation Therapy) and to help me stay safe.
5. When I go into the community, I will choose appropriate and safe places where there will be very few or no PVPs (Potentially Vulnerable Persons).
6. It is **my responsibility** to use as many of the following strategies as I can to stay safe in the community:
   - Stay focused on my task.
   - Choose places that are safe for me to attend.
   - Discuss my feelings or strategies with staff when it is safe to do so.
   - Keep a safe distance from PVPs.
   - Make sure the environment is safe before entering.
   - Walk away from any problem area(s).
   - Look away from area(s) where there are PVPs.
   - Leave the environment altogether if I am feeling uncomfortable or if there are too many PVPs to stay safe.
7. It is **my job** to remember to use my SRT (Self-Regulation Therapy) strategies in the community without being reminded.
8. Staff are there to help me stay safe, so it is best for me to follow their direction when on an outing.

By following the items above, I will make sure that I have a safe and fun outing. With practice, I will get even better at making safe choices by using my SRT strategies in the community.

_____ _____

Signature Date

This is an example of a Wallet Card that clients can keep on their person, to assist them in remembering what to do when they encounter a Danger Zone or other problematic situation. Different Wallet Cards can be created to meet various needs.

## Individualized Safety Plan

**Wallet-Sized Safety Card for the Community**

I have a responsibility to:

**a)** Think safe and healthy thoughts

**b)** Stay focused, aware, and alert

**c)** Keep potentially vulnerable persons safe at all times

**d)** Respect everyone's personal boundaries

**e)** Speak appropriately

**f)** Plan only safe outings

**g)** Stay with safe person at all times

**h)** Stay with peer group my own age

**i)** Buy only items that are suitable

**j)** If I feel uncomfortable—leave

**Emergency contact number:** _____

The following is an example of a Mental Health Safety Plan you might put together to assist your client in managing mental health symptoms and their consequences.

## Mental Health Safety Plan

**Am I experiencing the following?**

| Am I feeling: | Have I been thinking: | Have I been experiencing: |
|---|---|---|
| • Desperate<br>• Angry<br>• Guilty<br>• Worthless<br>• Lonely<br>• Sad<br>• Hopeless<br>• Helpless<br>• _____<br>• _____<br>• _____ | • "I won't be needing these things anymore."<br>• "I can't do anything right."<br>• "I just can't take it anymore."<br>• "I wish I were dead."<br>• "Everyone would be better off without me."<br>• "All of my problems will end soon."<br>• "No one can do anything to help me now."<br>• _____<br>• _____<br>• _____ | • Crying<br>• Emotional outbursts<br>• Drug and/or alcohol use<br>• Recklessness<br>• Fighting and/or law breaking<br>• Withdrawal from family/friends<br>• Dropping out<br>• Putting affairs in order<br>• Prior suicidal behaviour<br>• _____<br>• _____<br>• _____ |

**What to do:**

1) Contact a friend or family member who I trust:
   If I am experiencing feelings, thoughts or behaviours as above, I can call:

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   - I can talk about how I have been feeling.
   - I can discuss the behaviours or thoughts that I have been experiencing.

2) Contact my formal resources:

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

This is a template for an Outing Journal. We have found Outing Journals to be particularly helpful for both planning outings and debriefing them after the fact. Outing Journals provide valuable data for both treatment planning and research purposes.

## Outing Journal

### Part 1

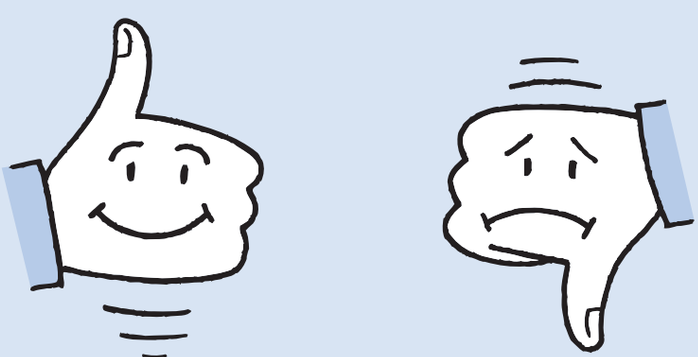
**To be completed before going on the outing:**

1. What are your plans for today? What will you do? Where will you go?
2. What are the risks? Will there be any dangerous situations?
3. How will you use SRT (Self-Regulation Techniques) to make sure everyone is safe?

### Part 2

**To be completed upon return from the outing:**

4. How did your day go? Did you follow your Safety Plan? Did you use any SRT strategies, and if yes, which ones?
5. Circle the picture that best represents your outing today.



Individual's signature: _____

Safe Person's signature: _____

Outing Checklists are valuable in debriefing after an outing; particularly, regarding pertinent issues and situations that may have come up, along with ratings as to how well those issues and situations were managed.

## Outing Checklist

Safe person: _____ Outing: _____

Safe person signature: _____ Date & time: _____

**SECTION A — To be completed by the mediator with the individual present**

| | | | |
|---|---|---|---|
| • REVIEWED SAFETY PLAN BEFORE OUTING (if no, no outing) | | Yes | No |
| • Did the client behave appropriately with people he/she met? | N/A | Yes | No |
| • Did the client respect staff directions? | | Yes | No |
| • Did client stay with staff? | | Yes | No |
| • Did the client use appropriate touch & respect personal space? | | Yes | No |
| • Did the client speak appropriately to staff? | | Yes | No |
| • Was the client's hygiene acceptable? (if no, no outing) | | Yes | No |
| • Potential victims present on outing? (Potential Victims = anyone under the age of 18) | | Yes | No |
| • Was the client aware of potential victims? | N/A | Yes | No |

**If no potential victims present on outing — Proceed to Section B**

Circle the SRT strategies used by the client (if potential victims present):

| | | |
|---|---|---|
| a) Self initiate safety strategies (without staff prompting) | Yes | No |
| b) Stay focused on task (avoidance) | Yes | No |
| c) Discuss safety strategies/feelings with staff | Yes | No |
| d) Keep safe distance from potential victims (avoidance) | Yes | No |
| e) Make sure environment is safe before entering (avoidance) | Yes | No |
| f) Walked away (escape) | Yes | No |
| g) Looked away (avoidance) | Yes | No |
| h) Left environment altogether (escape) | Yes | No |

**SECTION B — to be completed only by safe person**

Age of potential victims: _____

| | | |
|---|---|---|
| Gender of potential victims | Male | Female |
| Did the client appear to be comfortable on outing? | Yes | No |

Number of potential victims: _____

ADDITIONAL COMMENTS:

_____

_____

## Media Screening Protocols

One aspect of treatment is for the individuals to learn to control their inappropriate sexual urges and learn to engage in healthy sexual behaviours. During treatment, the behavioural team has determined that each of the persons supported, also have identifiable inappropriate anger/aggression challenges that must be addressed in treatment. Due to the above treatment concerns, it is necessary to screen all media content that enters your program for inappropriate viewing or listening content. The following content may trigger inappropriate urges or behaviours that counter treatment efforts being learned by the person supported.

For the purposes of the Media Screening Protocol, the term "media" is defined as "the means, or channels of general communication, information or entertainment in society." More specifically, these are the forms of media targeted by this policy:

- Television Programming
- Radio Programming
- Movies/Productions in Theatres, on Video, DVD and Blu-Ray
- Music/Audio Programming on CDs, Cassette Tapes, 8-Tracks, Records, MP3 files
- Computer Files – Games, Text Base Files, Video and Audio Files, All Other Programming
- Internet – Web Pages, Email, Messengers, Networking
- Video Games – PSP, Wii, Nintendo, and Other Video Gaming Systems
- Literature – Newspapers, Books, Magazines, Advertisements
- Live Entertainment – Sports, Concerts, Stage Productions, and Other Forms of Live Production
- Art, Photography, Audio and Video Recordings

**Media content containing Potential Vulnerable Persons.**

Potentially vulnerable persons/objects ( PVP) is defined as individuals or objects that elicit inappropriate sexual arousal or deviant urges in the individual being supported. Please refer to each rindividual's safety plan to determine relevant PVPs for that person.

**No content that contains any PVP is to be in the possession of the individuals.**

**No content that has themes or plotlines involving PVPs is to be viewed or read by the individuals.** This includes animated cartoons or movies. (i.e., Disney films, The Simpsons)

**No content that has primary and/or major secondary characters that represent characters who are PVPs is to be viewed or read by the individuals.**

**No content that has actors/actresses cast in primary or major secondary roles who are PVPs is to be viewed by the individuals.**

*Using proper filtering procedures, some media containing PVPs may be viewed or read by the individuals, but only under the careful supervision of staff. (Please view Screening Procedures for specific details on Media Filtering Strategies.)*

The following pages give examples of protocols and agreements that can be useful in assisting clients with access to computers, media, and other materials that may increase client access to sexually explicit or inappropriate materials. Clients may need help understanding these protocols, and you may wish to change the language or requirements of this worksheet to reflect the needs of the individual you are supporting.

## Computer, Laptop, and Wireless Device Safety Agreement

The following is a contract, which outlines _____ (individual's name)'s obligation to use his/her computer (laptop) and all wireless-capable devices in a safe and responsible manner. This agreement also applies to the Wii wireless game system and any other wireless- or Internet-capable device in any location. This includes all gaming devices, watches with memory storage, cell phones, MP3 players, cameras and digital picture frames.

1. Administrative changes to the computer are limited to _____ (designated safe persons) who have a special password, which is required to add, remove, or change programs. The administrator has disabled capacities to burn CDs and connect to the Internet.
2. Any removable data storage devices such as memory cards, memory-sticks, CDs, DVDs, CDRWs, including rewritable game cartridges, are not permitted.
3. _____ (the user) is expected to use the computer in a safe and responsible manner and must have all viewable (non-recordable) media i.e., VCDs, CDs, or DVDs screened by _____ (designated safe person) before purchasing and/or viewing. The user is also accountable for all content that they have written in word processing programs to be of an appropriate nature.
4. _____ has agreed that it is not safe to take her/his computer or any wireless-capable device on home visits or anywhere outside the home unless special permission is obtained from _____ (designated safe person).
5. _____ (designated safe person) reserves the opportunity to do a computer or wireless device spot check and view the device's contents to ensure that it contains appropriate content and that it has been used appropriately and safely.
6. (If applicable) All provisions set forth in the media agreement for the house also apply to computers and wireless devices. This means that the lending, borrowing, trading, giving, selling, or acquiring any data or data storage device from anyone is **not permitted**. This includes all data files such as pictures, video, music, etc. Purchasing music/data from online stores or approved sources will be supervised by a designated safe person.
7. The individual is aware that any violation of this contract will result in the suspension of computer/device privileges for an amount of time determined by the safe person/ support team.

_____ _____

Individual Safe Person

Dated: _____

## Rules for Keeping My Pictures

1. All of my pictures must be legal. I cannot have pictures that are against the law.
2. I cannot have pictures that:
   a. objectify the body (make the person non-human),
   b. show pain or hurting,
   c. show rape, sex with children, or any other illegal behaviour,
   d. resemble staff or others that I work with, or
   e. have more than one person in them.
3. All of my pictures will be of age-appropriate men or women.
4. I will not show my pictures to anyone. I will not show my pictures to anyone in my home or to guests. I will not show my pictures to anyone at work. If I have questions about my pictures, I will speak only to _____ [support person].
5. _____ [support person] must approve my pictures.
6. My pictures are private. They are only for me. I will not talk about them to anyone. I must keep my pictures private.
7. I will keep my pictures in the following safe place: _____, where nobody else can find them. I will put my pictures back in the safe place after I finish using them, so that nobody coming into my room will see them.
8. If I show my pictures to anyone, I will lose them for a period of time to be determined by _____ [support person]. If I show them a second time, they may be removed altogether.
9. If I am practising inappropriate masturbation in my bedroom with my pictures (for example, if I am urinating or harming myself), I will lose them for a period of time to be determined by _____ [support person]. If I inappropriately masturbate a second time, I may lose my pictures altogether.
10. I will fantasize about the individuals in the pictures only while I am masturbating.
11. If I want different pictures in the future, I will speak to _____ [support person].

_____ Client

_____ Support Person

_____ Date

_____ Support Person

## Camera Contract

The following is a contract outlining _____'s duty to use her/his camera in a safe and responsible manner.

1. The camera is to be stored in the filing cabinet in the office.
2. A staff person or designated supervising individual must be with me while I am taking pictures.
3. I am not to take my camera with me while on home visits.
4. I will not bring my camera into work, the washroom, or my bedroom.
5. I will only take appropriate pictures such as scenery, wildlife, and nature.
6. I will only take pictures. I will not take any video footage.
7. I will not take pictures of strangers even if they are just in the background.
8. If I take a picture of a person they must be age appropriate (over 25 years old) and the person must give their consent.
9. I will return my camera (with media card) to the office immediately upon my return from my outing.
10. Staff will review all stored pictures before I can look at them, print them, copy them, or download them onto my computer.
11. I will not give copies of pictures to anyone unless approved by Staff.
12. I am aware that any violation of these guidelines will result in the loss of camera privileges for an amount of time determined by Staff.

Client: _____ _____
Signature Date

Manager: _____ _____
Signature Date

Support Staff: _____ _____
Signature Date

## Personal Computer Protocol

This protocol will outline the use of personal computers by individuals within the group home.

- No Internet access will be allowed on laptops or computers. Wireless Internet devices will be disabled by staff through software or disconnecting the wireless components of the computer physically.
- Sharing files may spread viruses or allow for transfer of inappropriate materials. Sharing files is not permitted.
- The use of memory sticks / flash drives are for personal back-up use only. No one should share a flash/thumb drive with another person unless directed to do so by staff and under supervision. A flash drive should not leave an individual's personal room unless such is requested by staff.
- Laptop computers may be used outside an individual's personal bedroom only if a staff person is present and observing. A personal computer should be used where no other individual, except staff, may see the screen.
- All media to be used with or on a personal computer is subject to the *Media Protocol.*
- Staff may request to perform a search of files on any personal computer to identify, if any, inappropriate media.
- Files (i.e., .zip), thumb drives, or diskettes, that have been locked or password protected will be removed and/or deleted immediately.
- Printers with scanners are permitted if used appropriately.
- No one other than the owner of a personal computer is permitted to use it, unless they are staff.

### Other Devices:

Nintendo Wii, Playstation 3, Xbox 360, Playstation Portable (PSP), Nintendo Gameboy, iPod Touch, and a large variety of devices are equipped with both Internet browsers and wireless Internet receivers. In light of this information, it is necessary to ensure that either:

- The device does not support internet capabilities; or
- The device's parental controls have been enabled and locked as per the user manual; or
- Wireless signals are not available (this must be checked on a weekly basis); or
- Use of the device is directly monitored during the period of use and the device is stored in a secure location not accessible to individuals other than staff.

### Public Computers:

Public computers with Internet access are available in many locations within every community. Individuals shall not be permitted to use such computers unless directed to do so by staff. Individuals in educational settings are likely to be required to use a computer; these individuals should be monitored closely.

## Morning Routine — Visual Schedule

The following is an example of a morning routine — visual schedule. Visual schedules must be modified to address the specific needs of the individual being supported.

Week Of : _____

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| Wake Up (6:45 am)   | | | | | |
| Take Meds  | | | | | |
| Take Shower  | | | | | |
| Eat Breakfast  | | | | | |
| Use Washroom  | | | | | |
| Brush Teeth  | | | | | |
| Get Dressed for work  | | | | | |
| Go to Work  | | | | | |
| *REWARD EARNED?* | | | | | |

## Making Friends 1

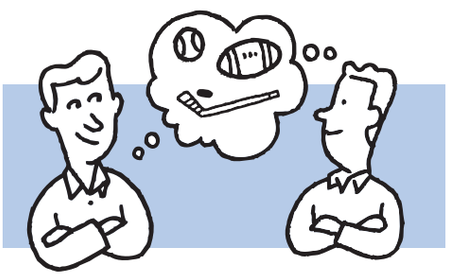
Often a social story is helpful in teaching an individual how to make friends. The story can be very general, like the one below, or as detailed as necessary to suit the needs of the individual being supported.

1. I introduce myself to the person and ask them their name.

   We are now acquaintances.

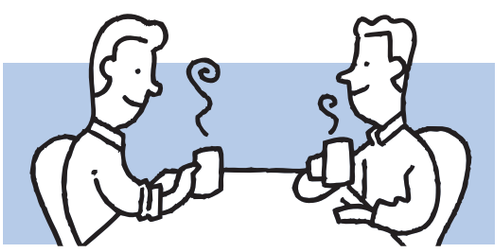
2. We talk about our interests and hobbies.

   We are getting to know each other but are still acquaintances.



3. We continue to see each other in public and get to know each other better by talking more.

   We are still acquaintances.

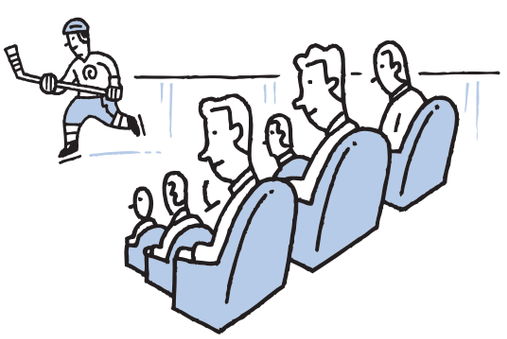


4. We exchange phone numbers and call each other sometimes.

   We are becoming friends.

5. We make plans to go out together.

   We are now friends.



## Making Friends 2

Often a social story is helpful in teaching an individual how to make friends. The story can be very general, like the one below, or as detailed as necessary to suit the needs of the individual being supported.

**1.** I introduce myself to the person and ask them their name.

We are now acquaintances.

**2.** We talk about our interests and hobbies.

We are getting to know each other but are still acquaintances.

**3.** We continue to see each other in public and get to know each other better by talking more.

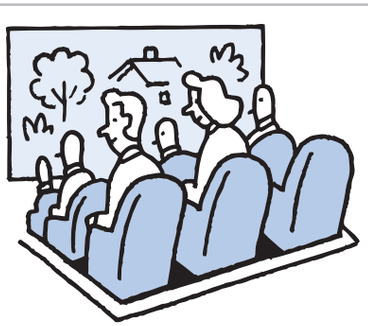
We are still acquaintances.

**4.** We exchange phone numbers and call each other sometimes.

We are becoming friends.

**5.** We make plans to go out together.

We are now friends.



The following social story is an example outlining the stages of how a romantic relationship starts and then builds. The story follows the colours and concepts addressed in the *Circles* program, which teaches boundaries and relationships.

## How a Romantic Relationship Starts and Builds: A Social Story

One day I will meet someone who may become my sweetheart.

**Red** One day I will see someone in the community that I am attracted to. This is okay if this person is of an age close to mine. This person is a stranger at this point and it is inappropriate for me to act on these feelings. I do not touch, talk to, or trust strangers.

▼

**Yellow** Should I continue to see this person through a community activity such as work, church, the recreation centre, etc., I can be introduced or introduce myself to them. This person then becomes an acquaintance. I have casual conversation with them, but I do not touch, trust, or engage in personal talk with them.

▼

**Green** If I continue to see this person through our mutual activity for a long time I may ask them to go out for a coffee. We may go out, enjoy each others' company, and feel comfortable enough to talk on the phone, email each other, and go to the movies. We may feel comfortable as friends and talk about general things in our lives. We may feel comfortable giving each other a hug when we greet each other. We do not have sexual/romantic touch, because we are only friends. I do not tell this person my private personal things. I have some trust, but not full trust, in this person.

Sometimes it is normal for me to have sexual and loving feelings for someone. If this happens, I will not act out in a sexual way with this person. I can talk to them about their feelings and about my feelings.

If they do not feel the same way, I will respect their feelings and respect their decision.

▼

**Blue** If this person is feeling the same way, then the relationship can start to move towards a more romantic relationship.

If they do feel the same way, we may spend more time together, have closer hugs, hold hands, and kiss.

Touch happens only when both people in the relationship consent to the touching.

I must remember that consent is true and real when both people understand what is happening, are honest with each other, understand the consequences, have a choice to say "yes" or "no," and are not forced into giving consent.

▼

**Pink** If we both agree and give consent then we might agree to become each other's boyfriend/girlfriend. We can be sweethearts.

As sweethearts we will have full trust with each other, talk with each other, and may have loving, gentle, consensual, romantic touch with each other in a private appropriate place.

The following healthy masturbation protocol can be shared with clients who are developing safer practices for expressing their sexuality.

## Healthy Masturbation Protocol

1. All of my pictures must be legal. I cannot have pictures that are against the law.
2. My pictures are provided by (*Name of Agency or therapist*) and they meet the following rules. They do not contain any of the following:
   a. Objectifying the body (makes the person non-human)
   b. Violence of any kind
   c. Rape, sex with children, or any other illegal behaviour
   d. Anybody who looks like safe persons or others that I work with
   e. More than one person
3. All of my pictures will be of age-appropriate men or women.
4. I will not show my pictures to anyone. I will not show the pictures to anyone in my home, or to guests. If I have any questions about the pictures, I will only speak to (*name those who have provided the pictures*).
5. My pictures are private. They are only for me. I will not talk about them to anyone. I must keep my pictures private. They are to remain in my room and to never be taken out of the home.
6. I will keep my pictures in an envelope/folder. I will keep all my supplies (pictures, Healthy Masturbation Protocol, lubrication, Fantasy Starter [optional], data sheets, and wet wipes) in a safe place where no one else can find them. They will be put safely away after I use them, so that no one coming into my room can see them.
7. If I show my pictures to anyone I will lose them for a period of time, which will be determined by *(name of person setting up protocol*). If I share them a second time, then they may be removed altogether.
8. I will only fantasize to the individuals on the pictures (or to my Fantasy Starter) while I am masturbating.
9. Should I want different pictures in the future, I will speak to (*name of person setting up protocol*).
10. I will be very careful with my hygiene:
    a. I will make sure that I wash my hands before I masturbate.
    b. I will use wet wipes or tissues to clean my hands.
    c. I will clean off the pictures with a fresh wet wipe.
    d. I will use sanitizing wipes to clean any part of my room that I have touched.
    e. I will use sanitizer for my hands before leaving my room, and then I will go and wash my hands thoroughly in the washroom.
    f. Should I feel that a shower would be best to clean myself thoroughly, I will do so.
11. If I abuse my genital area in any way or violate any of the above agreements, my kit may be removed.
12. Self-reporting—it is a good idea to write about masturbation activity on a calendar. I will try to write about 1) Successful Ejaculation, and 2) Type of thoughts and fantasies involved. I will keep this data private in my kit. Being honest and open with those directly involved in my treatment about my fantasies and masturbation practices is an important part of my ongoing treatment.

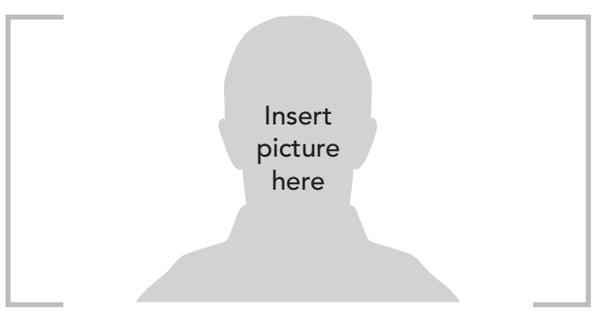
_____ (*Client*) _____ (*Person establishing protocol*) _____ Date

## Sometimes I Get Angry

The following example of a personal emotions book outline can be used to assist clients in better managing their anger. It is helpful to insert a picture of the client engaging in one of the suggested scenarios beside each of the statements below.

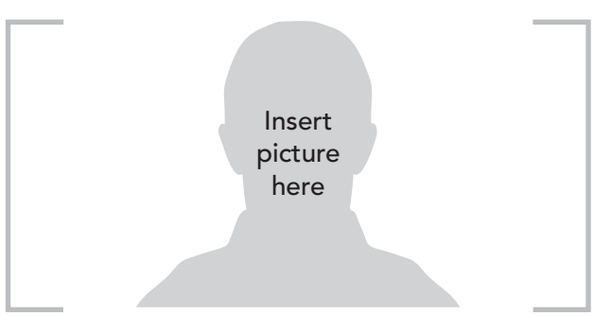
Some things that make me angry are …

1. someone getting mad at me.
2. someone talking too much.
3. when I make a mistake.
4. when I don't win.



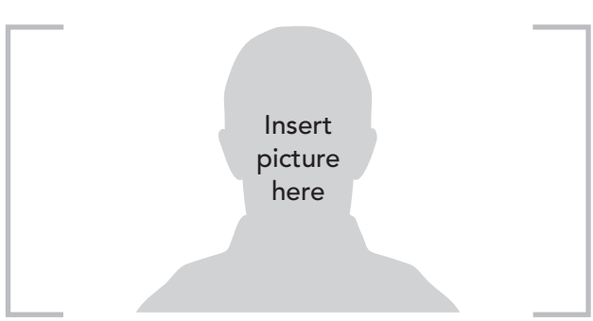

I know I am angry when …

1. my stomach gets tight.
2. my mind goes to another world.
3. my breathing gets stronger.
4. I make fists.




Things I can do when I get angry are …

1. go for a walk.
2. rest in my room, thinking positive thoughts.
3. talk to staff when I am calm.
4. take deep breaths.




I will reward myself for following my plan by getting a treat or an extra coffee.

## Stress Thermometer

The following example is a visual stress thermometer that those who support the individual can develop specific to the individual. This tool provides an engaging visual way to discuss emotions and triggers.

| Signs | | What I Should Do |
|---|---|---|
| • Violent behaviour towards self<br>• Violent behaviour towards others<br>• Verbal aggression<br>• Verbal threats | **4 Lost It** | • Seek first aid<br>• Ask yourself, "Was it worth it?"<br>• Debrief with support person<br>• Review consequences |
| • Feel like hurting myself<br>• Feel like hurting someone else<br>• Feel like running away<br>• Hitting things<br>• Kicking things<br>• Throwing things | **3 Really Hot** | • Get help ASAP<br>• Let it out in private<br>• Talk to a trusted person<br>• Listen to my relaxation CDs<br>• Complete my anger log |
| • Yelling<br>• Hitting my head<br>• Rubbing or pulling my hair<br>• Stomping my feet<br>• Heart beating fast | **2 Getting Hot** | • Call my family or a friend<br>• Talk to a support person<br>• Complete an anger log<br>• Review my anger plan<br>• Have a drink of water |
| • Swearing<br>• Raising my voice<br>• Feeling funny in stomach<br>• Sighing<br>• Feeling overwhelmed | **1 Getting Warm** | • Listen to music<br>• Watch a movie/television<br>• Read a book<br>• Count to 10<br>• Take a deep breath |
| • Positive attitude<br>• Engaging in conversation | **0 Cool and calm** | • Be with people<br>• Community outings |

## Escalation/De-escalation Patterns

It is important to have a good understanding of the escalation patterns of the individual you support. Once you know the patterns, you can problem solve in advance how to diffuse a situation before an outburst/action occurs. Below please find some headings you may want to follow in developing your plan.

| Escalation Cycle |
| --- |
| • Anger triggers<br>• Early warning signs<br>• Possible targets<br>• Patterns of outburst behaviour |
| **De-escalation Cycle** |
| • Ignore<br>• Talk-down procedures<br>• Removal<br>• Possible PRN (medication) |
| **Debriefing Cycle** |
| • With individual<br>• With service providers<br>• Documentation |

Liaison and consultation with local law enforcement can often prove invaluable for clients in community settings (e.g., group homes). In order to ensure the safety of both clients and the community, it is helpful to draft a "police protocol" to ensure proper handling of elopements and other unapproved absences. This can only be done with the individual's consent.

## Police Protocol with _____ and _____

**(individual's name)** **(organization's name)**

At a meeting on _____, a response protocol was established with
(date)
_____. The following outlines the procedures to
(insert name of individual and name of regional police department)
be followed in the event of requested police intervention by _____'s 24 hours a day, 7 days a week residential treatment home.
(your organization)

- In the event that a resident of this group home leaves the premises against staff advice, a search will be conducted internally and externally of the property and the surrounding area. This search will take a maximum of 30 minutes and if the resident is not found within that time staff will contact the _____ at the appropriate _____
(insert job title) (insert region)
Regional Police department _____ and advise them of the situation.
(phone number)
Staff will re-inform the _____, regarding the nature of the
(insert job title)
individual supported, and that all pertinent information is located in the folder at their office. Staff will provide any relevant information requested regarding the particulars of the current situation.
- In the event that the _____ is unavailable, staff will request to be
(insert job title)
connected with the Communications Department where a folder of the resident's profile is also maintained. Staff will re-inform the contact, regarding the nature of the person supported, and that all pertinent information is located in the folder at their office. Staff will provide any relevant information requested regarding the particulars of the current situation.
- When this type of non-emergency call is made an officer will be dispatched at the first available opportunity to specific _____ residence. Upon arrival, the office will be
(your organization)
updated with the most recent available information on the occurrence.
- In the event of an elopement, from staff, while in the community (e.g., mall, park, etc.), a maximum 5-minute search of the area will be conducted. If the resident cannot be located within the 5 minutes, an immediate 911 call will be made.
- In the event of an occurrence of a more serious nature, either on or off the premises, (e.g., the physical safety of staff, residents, or members of the community has been compromised) staff will make a 911 call. Staff will then follow all emergency procedures as directed by the responding authority.

Please attach any necessary contact information.

## Positive Guided Imagery

In this technique, the goal is for the individual to visualize himself or herself in a peaceful setting. What works will be unique to each individual, so before beginning, you will need to discuss some options with the individual that you support. The following resource lists some suggested images.

**Some Peaceful Places**

Lying on a quiet beach, listening to the waves, and feeling the soft breeze

Slowly swinging back and forth in a hammock

Lying on your bed listening to relaxing music

Floating on an air mattress in a pool

Rocking in a rocking chair

### Steps in the Guided Relaxation Process

Ask the person to get comfortable and visualize herself or himself in this peaceful, safe environment.

Ask the person to slowly breathe in and out as he or she pictures himself or herself in the peaceful, safe place.

Ask the person to relax and enjoy the experience.

Encourage the person to use this type of positive guided imagery when she or he is feeling stressed.

## Progressive Muscle Relaxation

Progressive Muscle Relaxation is a strategy that helps you to figure out where you hold the tension and stress in your body so that you can release the stress and feel calm and relaxed.

This is a strategy that helps to decrease anxiety and tension.

It helps you to be more focused and, as a result, to make better decisions.

It helps your mind to relax so you can think clearly and make good choices.

Progressive Muscle Relaxation (PMR) is a tension-reducing technique that involves the systematic tension and relaxing of specific muscle groups. Starting with the muscles in the face, the individual completely tenses all muscles and holds the tension for several seconds (usually to the count of ten), completely relaxes for the same period of time, then repeats the process with the next set of muscles (the neck, the shoulders, etc.) until every area of the body has been relaxed. With practice, the individual learns to completely relax the body within seconds and keep from storing up tension and stress in the body, a practice known as Deep Muscle Relaxation.

Try it—it is a lot of FUN!

**Some helpful websites are:**

1. http://www.umm.edu/sleep/relax_tech.htm
2. https://www.helpguide.org/mental/stress_relief_meditation_yoga_relaxation.htm

The following is an example of a client profile that is important to produce for every person receiving support. This important information should be readily available to treatment and group home staff, to ensure consistency of service and access to personal data in the event of an emergency.

PEEL BEHAVIOURAL SERVICES

**CLIENT PROFILE**

| PERSONAL INFORMATION | | Photo to be Inserted | |
|---|---|---|---|
| Name: | | | |
| Birthday: | | | |
| Address: | | | |
| Phone No.: | | | |
| Diagnosis: | | | |
| Medical: | | | |
| Medications: | | | |
| CLIENT DESCRIPTION | | | |
| Status: | | Personality: | |
| Ethnicity: | | Education: | |
| Eye Colour: | | Employment: | |
| Height: | | Income: | |
| Weight: | | Transportation: | |
| Hair Colour: | | Has Children: | |
| Style of Dress: | | Religion: | |
| Smoking Habits: | | Diet Habits: | |
| Drinking Habits: | | | |
| MEDICAL INFORMATION | | | |
| Family Doctor: | | Health Card #: | |
| Optometrist: | | Social Insurance #: | |
| Dentist: | | ODSP Member ID: | |
| Psychiatrist: | | ODSP Case File #: | |

| FAMILY INFORMATION | | | |
|---|---|---|---|
| Mother: | | Father: | |
| Sister: | | Brother: | |
| Address/Phone No.: | | Address/Phone No.: | |
| SPECIAL INSTRUCTIONS | | | |

| FAVOURITES | | |
|---|---|---|
| Favourite Colour: | | Favourite Outdoor Activity: |
| Favourite Indoor Activity: | | Favourite Type of Movie: |
| Favourite Reading: | | Video Games: |
| Favourite Music: | | Concerts: |
| SPECIAL NOTES | | |
| SPECIAL INSTRUCTIONS | | |
| CAUTIONS | | |

# Glossary

## A

**ABC data** Descriptive data (antecedent, behaviour, consequence) that is evaluated to tell us why a behaviour occurs as oppose to how often a behaviour occurs.

**abuse** An action or behaviour that causes or is likely to cause physical injury or psychological harm to the recipient. This includes neglect.

**acquiesence** Providing answers or responses based on a perception of what the questioner wants to hear, rather than on the truth.

**active supervision** A style of supervision in which individuals working with clients are not just observers and documenters of client activities, but also seek to provide ongoing support and instruction as the client encounters various life events.

**actuarial risk assessment tool** Scales of items thought to be predictive of risk, prepared by researchers using meta-analysis. Using relative scores on the scale, practitioners can predict re-engagement in that behaviour over a certain time period, using the experiences of a large group of others already scored and followed (known as a normative sample).

**acute dynamic** Risks that occur, for the most part, in the moment, and which are often subject to environmental changes or to an interaction between the client and his or her environment.

**antecedent** In the ABC model, the precursory thought or event that results in a behaviour leading to a consequence.

**Applied Behavioural Analysis (ABA)** The practice of examining a person's behaviour and the effect of that behaviour on both the person and his or her environment, in order to assess either the behaviour's utility or the need for changes in how to respond to the behaviour.

**aversive conditioning** A behaviour modification technique which involves exposing the client to unpleasant stimuli in response to the inappropriate or undesirable behaviour.

## B

**baseline** In behaviourism, the natural state of cognition or behaviour.

**behaviour** In the ABC model, the action or response one makes to the antecedent.

**behavioural crisis** A situation in which a client's psychological, emotional, or physical distress is so heightened that the possibility of harm to self or others is inordinately increased.

**behavioural profile** An outline of a client's behavioural tendencies.

**bio-psycho-social** An approach to behavioural analysis that proposes that most things we do as human beings are influenced by our physical makeup, our thought processes, and the affect our behaviour has on our relationships with others.

## C

**cognitive dissonance** The psychological conflict you experience when a situation has two opposing qualities. For example, a girl who is abused by her father will experience conflict because of these two things that she knows: "My dad loves me, but my dad does things that hurt."

**compliance training** A method of training that introduces progressively more intrusive prompts (e.g., verbal instruction, modelling the desired behaviour, physically guiding the person to behave as required) depending on the degree of noncompliance the person demonstrates to the instruction.

**concurrent diagnosis** Two or more conditions with separate diagnoses, which may complicate or exacerbate each other, as when a client who has an intellectual disability also has mental health issues, substance abuse issues, sexual disorders, or other issues.

**conditioning** A process in which we attempt to modify a response to a certain situation or event by pairing the outcome with another process in the client's environment. These other processes become sources of reinforcement, positive or negative.

**consent** Voluntary agreement or permission.

**consequence** In the ABC model, the result of the behaviour one chooses to engage in as a response to the antecedent.

**consequential learning** A style of learning that occurs when individuals can appreciate that certain outcomes are associated with their behaviour. In our context, we want our clients to understand that their actions have consequences.

**counterfeit deviance** A hypothesis that suggests that some deviant behaviour in persons with intellectual disability is the result of dysfunctional attempts at sexual behaviour and not the result of paraphilic interests.

**Courtship Disorder** A hypothesis that suggests that humans mirror animals in the various phases of courtship—partner location, getting attention, pre-coital tactile interaction, and sexual intercourse—and that these phases map onto the various paraphilias.

**criminogenic** Those areas of treatment and intervention focus that are most principally related to the reduction of risk; i.e., the factors that will contribute to an individual's

likelihood to commit a crime. Focusing on these needs will substantially decrease the risk of recidivism.

## D

**dangerousness** The capacity one individual possesses to cause harm to another.

**debrief** To meet after an event, project, or incident to discuss what happened, what went wrong, what went right, and what you can learn from the experience.

**deception** In testing, any attempt to give false results. Interestingly, persons can either "fake-good" or "fake-bad," depending on what they are attempting to convey.

**demand situation** The natural tendency people have to modify responses or behaviour depending on the message they wish to convey or the outcome they wish to achieve.

**disclosure** A process in which a person gives clear details of an event, either cognitive or behavioural. Persons who are victimized will "disclose" their experiences of abuse, while clients who offend in treatment will "disclose" their actions as a way to identify problems in thinking and behaviour.

**dynamic variable** Day-to-day, changeable factors that can have an affect on a persons' behaviour.

## E

**electroencephalography (EEG)** A brain imaging technique that measures electrical signals in the brain. It involves placing electrodes at various points on the scalp.

**emotional congruence** The tendency expressed by some persons who sexually abuse children to overidentify with the child role through their behaviour, views about children, or other choices in life.

**endocrine function** The system of glands that is concerned with hormones. In male sexuality, the principal hormone involved is testosterone.

**error** An undesirable outcomes that occurs when you followed the proper procedure, but the outcome was still not favourable, perhaps, as a consequence of factors of which you had no reasonable knowledge.

**escalation continuum** A graphical representation of a person's difficulty with a certain situation, from initial upset to eventual unmanageable consequences.

**evidence-based** Supported by research.

## F

**false negative** When the test says "no," but the truth is "yes."

**false positive** When the test says "no," but the truth is "yes."

**fixated** Obsessed with. In Groth's typology, "fixated pedophile" describes a pedophile whose principal interest was in children, and whose emotional state was fixated at an earlier developmental period. This is somewhat similar to emotional congruence.

**functional** Pertaining to the ways in which a person's intrisic characteristics combine with experience to determine behaviour and perspective.

**Functional Analysis/Analogue Assessment** The process of determining what outcome a client is attempting to achieve by engaging in a certain behaviour.

## G

**general deterrence** In crime and punishment, an outcome whereby the population at large is prevented from engaging in criminal behaviour because individuals are aware of what the punishment will be. For instance, when judges "make an example" of someone during sentencing, they are appealing to general deterrence.

**goodness of fit** How well your working model truly represents an explanation of what you are seeing. Keep in mind that there are always exceptions to every working model, just as there are exeptions to almost every rule.

## H

**harm reduction** A concept in which we attempt to measure successful outcomes in gradients, rather than with a simple yes or no. Harm reduction techniques seek to account for the lessened degree of harm sustained by parties involved in a certain practice. For instance, needle-exchange programs for intravenous drug users reduce the potential for secondary harm that may result from such practices (e.g., transmission of disease).

**hypothesis** A working model of observed phenomena that attempts to make sense of what you observe.

## I

**id** According to Freud's psychoanalytic theory of personality, the personality component that works to satisfy basic urges, needs, and desires.

**incest** In a legalistic definition, sexual activity between relatives too close to marry. In sexological research, we have often extended this to include other persons in quasiparental roles (e.g., a mother's boyfriend, a longtime babysitter, etc.).

**informed consent** Consent or agreement that is given knowingly (with information), intelligently (with capacity), and freely (with no inducements).

**intelligence quotient (IQ)** A term frequently associated with the numeric value assigned to intelligence by means of standardized testing. The average IQ level for all person is 100.

**internal self-management** In the relapse prevention model, the goal of the first part of treatment. During this phase, participants come to understand how their internal processes interact with the environment to increase the likelihood of offending. Learning to control those internal processes is the important first step.

## L

**law of behaviour** A principle that states that those activities which bring pleasurable outcomes will be repeated while those that bring unpleasant outcomes will be not be repeated.

## M

**maladaptively** In an unhelpful, counter-productive manner.

**malingering** The tendency some persons have to exaggerate symptoms or problems in order to achieve a secondary gain. For instance, a child might feign a stomach-ache in order to avoid going to school.

**media** Any method of audiovisual representation of real-life persons or objects. These may include video, DVD, CD, tape, photography, or electronic storage devices (jump drive, SD cards, computer hard drives).

**meta-analysis** A "study of studies." This statistical procedure allows us to compile data from individual studies of a phenomena into one larger study that is more representative of the population-at-large.

**mistake** Undesirable outcomes that occur when you knew the correct procedure but failed to follow it.

**motivational interviewing** A treatment technique in which facilitators attempt to engage clients in the process of treatment by using non-threatening, supportive, and empathic methods. Use of open-ended (Socratic) questioning encourages clients to disclose and discuss their problems in a collaborative dialogue.

## N

**nature** In the nature versus nurture debate, factors that are related to biology and our physical make-up.

**need principle** In the RNR model, the principle that states that you must assess the individual's criminogenic needs and focus on those, if you hope to truly reduce the risk to reoffend.

**neglect** When a caregiver fails to provide certain necessary aspects of healthy living. These can include food and shelter, warm positive regard, or attention to healthcare issues.

**neuroanatomy** The physical structure of the brain.

**normed** Standardized. In constructing tests and other measures, you must have a normative or standardization sample. This then becomes the reference point for comparing individuals to a larger group of persons thought to have the same features. However, the normative sample will be specified to a certain group, thus it is "normed" on that group.

**nurture** In the nature versus nature debate, factors influenced by our environment and experience.

## O

**objective data** Pieces of information that are not subject to interference o interpretation on the part of the collector.

**offending behaviour** Legalistically, the breaking of laws; however "offending" is a more complex term than it immediately seems. From a social sense, it can be any time one person engages in behaviour that is offensive to others.

**offensive behaviour** Anything one does that causes others to be offended. This does not necessarily have to be something illegal.

**orgasmic reconditioning** A behaviour modification technique in which the client is instructd to masturbate using his or her paraphilica fantasy and to switch to a more appropriate fantasy just at the moment of orgasm.

**outing journal** A written record of a client's interaction with the community, which forms a powerful tool for evaluating client progress and success in managing situations in which they encounter risk or other difficulties.

## P

**parasuicidal** Behaviour that, on the surface, appears to be life-threatening, but that is really being used to achieve a secondary goal. For instance, cutting one's arm in a non-lethal way is a "cry for attention," not a true attempt at suicide.

**penile plethysmography (PPG)** The process of measuring penile response to audiovisual stimuli. The phallometric test is synonymous with PPG.

**phallometric test** A test to measure male sexual arousal. An apparatus is placed on the subject's penis, and the subject is presented with audiovisual stimuli (pictures, videos, audiotaped scenarios). The apparatus measures changes in either volume or circumference.

**phallometry** The process of using phallometric testing.

**potentially vulnerable person (PVP)/thing** The objects of our clients inappropriate desire or interest. For clients with histories of abusing children, PVPs are children. Analogously, for clients with fetishistic interests, the fetish object is the potentially vulnerable thing.

**preference** A markedly greater sexual interest in one type of sexual person, object or activity. For instance, someone who prefers children is someone who would rather engage in sexual activities with children.

**problem of immediate gratification** In relapse prevention, a problem that occurs when clients become despondent about their poor cognitive and behavioural choices to the extent that they will do almost anything to feel better. They need for this to happen as soon as possible which, ultimately, leads to poor decisionmaking.

**progressive deterioration** In this case, we are talking about how some rapists started off by engaging in behaviour that was less offensive and damaging, but whose behaviour became progressively less acceptable and more damaging over time.

**prosociality** Behaviour that is characterized by a concern for the well-being of others.

**proxy** Something that acts as a "stand in" for something else. In this case, we are referring to sexual interest in diapers as being indicative of sexual interest in children. Diapers are the proxy for children.

## R

**recidivist** Someone who reoffends after having been previously caught, sanctioned (punished), and returned to the community supposedly with the knowledge that they should not do this again. The key point is the intervening sanction.

**regressed** Literally, "to move backwards." In the context of paraphilias, a regressed pedophile prefers the sexual company of adults, but, under situations of stress or other blockage, will move his or her interest to sexual contact with children.

**reinforcement** In learning and behaviour, whenever one event or outcome influences the likelihood that the antecedent cognition or behaviour will be repeated. There is both positive and negative reinforcement.

**reliability** The level of consistency with which something is measured using a certain procedure.

**responsivity principle** A principle that decrees that interventions must consider the learning styles and capabilities of the participants, as well as attending to issues of motivation and treatment readiness.

**risk assessment** The process of evaluating the potential someone poses to engage in behaviour that places himself or others at risk for harm.

**risk principle** A principle that decrees that the intensity of your interventions must match the level of risk posed by the individual. Mismatching can lead to increased chances of recidivism.

**Risk/Needs/Responsivity (RNR) model** A model devised by Andrews and Bonta, and based on meta-analytic research, to set principles of effective interventions. Programs that adhere to these principles generally show much better outcomes.

## S

**satiation and masturbatory reconditioning** A behaviour modification technique in which the client is encouraged to masturbate using a socially acceptable fantasy. Following orgasm, the client is instructed to continue masturbating using his or her desired deviant fantasy.

**scatter plot** A way of graphically representing a person's behaviour in regard to particular areas of treatment or risk management interest. These plots allow us to look for patterns in behaviour and to formulate plans for behavioural change or risk management.

**sexological research** The study of sex. Sexological research is conducted to help us better understand the cognitive, behavioural, and physiological aspects of sexuality.

**social desirability** A form of bias related to acquiescence in which questions are answered based on what the person answering believes would be most socially acceptable.

**social learning theory** A proposed explanation for the ways in which people interact with each other. At its most basic, this theory states that people will act in whatever way they perceive will enhance their own condition. However, sometimes these behavioural choices can be maladaptive.

**specific deterrence** In crime and punishment, an outcome whereby an individual appreciates that his or her actions resulted in a certain punishment, and the punishment decreases the likelihood of reoccurrence of the illegal behaviour.

**stable dynamic** A set of risk factors that are amenable to change, but that require long-term and persistent attention to ensure change. In many cases, these are characterological (or personality) factors, in addition to patterns of behaviour (habits) and entrenched values and attitudes.

**standardization** An important means to ensure reliability, which requires that all persons performing a certain task do so in the same manner.

**standardization sample** A large population of test takers who represent the population for which the test is intended.

**static variable** Historical, and therefore non-changeable, factors that can have an affect on a persons' behaviour.

**Static-99R** A widely used actuarial risk assessment tool designed to measure the risk posed for sexual and violent reoffending in persons with known histories of sexual offending.

**statutory rape** When one person over the legal age of consent has sexual intercourse with someone under the legal age of consent. Where the two parties are of relatively similar age, there may be consent (leading to the term "Romeo and Juliet offenses"); however, the conduct is nonetheless illegal.

**subjective data** Information that reflects a degree of interpretation on the part of the collector, and may be in some way consistent with the collector's way of thinking.

**systematic desensitization** A behaviour modification technique used to treat phobias and other extreme or erroneous fears.

## T

**teachable moment** Situations in which we have the opportunity to reflect on antecedents, behaviours, and consequences in a fashion that assists our client in better understanding these dynamics. These are also sometimes referred to as "a-ha!" moments, due their powerful potential for supporting change.

**theory** The end product of working through many hypotheses. The theory is the best available answer to explain the phenomenon, for which there are no other reasonable possibilities.

**treatment-interfering factor** A factor that prevents successful advancement and completion of treatment. Examples might be cognitive distortions, low motivation, and poor cognitive problemsolving.

**trigger** Person, place, thing, or situation that puts us at risk to engage in a behaviour we are trying to curb. For example, a person who is trying to quit smoking will be triggered by seeing another person smoking, or even by the smell of cigarette smoke.

**true negative** When the test says "no" and this is the true answer.

**true positive** When the test said "yes" and this is the true answer.

## V

**validity** The relationship between the findings of an investigation or test and the real-life truth.

## W

**wrap-around care** An approach to providing care in which a person in need is provided with comprehensive attention to all facets of life that might impinge on risk. Many such programs have been referred to as "Circles of Support."

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