Chapter 13

Sexuality and Mental Health Issues

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Learning Objectives

Readers will be able to:

1. Compare the sexual wellness of persons with developmental disabilities to the sexual health of non-disabled persons.
2. Define sexual abuse of persons with developmental disabilities and apply the double-edged definition to the history and life experiences of persons labelled as disabled.
3. Identify the key mental health challenges that relate to the sexuality of persons with developmental disabilities and how the disability may create increased risks.
4. Identify appropriate treatment options for persons with developmental disabilities who present with sexual challenges.

Introduction

The sexuality of persons with developmental disabilities raises serious mental health issues. It is actually not the sexuality of persons with disabilities, but how society has misunderstood

and responded to their sexuality, that pose challenges for their mental health. Myths regarding the sexuality of persons with developmental disabilities have contributed to more than a century of abuse and repression for persons who have been labelled (Griffiths, 1999), and have created an increased risk that persons with developmental disabilities will develop sexuality related problems. In this chapter, the following topics related to persons labelled as developmentally disabled will be explored:

1. Sexuality as a normal part of mental well-being,
2. Sexuality as a mental health risk
3. Sexual abuse: Unwanted forced sexual contact
4. Sexual abuse: Restricted sexuality
5. Mental health risk factors associated with sexually inappropriate behaviour

1. Sexuality as a part of mental well-being

Healthy sexuality is essential to mental wellness. The necessary requirements for the development of healthy sexuality have been identified by the World Health Organization (1975). They are as follows: (i) the establishment of the capacity to enjoy and control sexual and reproductive behaviour in accordance with social and personal ethics; (ii) freedom from fear, shame, guilt, false beliefs, and other psychological factors that inhibit sexual response and the establishment of sexual relationships; and (iii) freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions.

In reality, the World Health Organization criteria for sexual health is not being met for most persons who are developmen-

tally disabled. Facts are as follow:

1. Persons with developmental disabilities are less likely to have control over their sexuality and reproduction.
2. They often experience restriction, punishment and recrimination regarding their sexuality, and are further denied privacy, opportunity, knowledge and choice regarding their sexual expression. They are more often the victims of sexual assault and abuse.
3. They are more likely to experience physical and medical challenges that interfere with their sexual experience and reproduction. As shown in Table 1: Syndromes and Effects on Sexuality, many conditions common among persons with developmental disabilities may have sexual implications.

Thus on all three levels, the sexual well-being of persons with developmental disabilities is jeopardized.

2. Sexuality as a mental health risk

One of the silent mental health challenges for persons with developmental disabilities is sexual abuse. For the purpose of this chapter, the following definition will be adopted.

> Sexual abuse is defined as including unwanted or forced sexual contact, unwanted touching or displays of sexual parts, threats of harm or coercion in connection with sexual activity; denial of sexuality, denial of sexual education and information, forced abortion or sterilisation (The Roeher Institute, 1994, p. vi).

Table 1: Syndromes* and their effects on sexuality

Syndrome*	Gender Affected	Effect(s) on Sexuality
Asperger's Syndrome	7:1 male to female ratio	Inappropriate sexual behaviour due to social skill deficits
Down Syndrome	Males and females	Males are generally sterile; Fertility rate in females is low
Fetal Alcohol Syndrome	Males and females	Inappropriate sexual behaviour related to impulsivity
Klinefelter Syndrome	Specific to males	Hypogonadism Gynecomastia Delayed development of secondary sexual characteristics Lack of sperm; usually sterile Elevated gonadotropic hormones Decreased libido
Noonan Syndrome	Males and females	Cryptorchidism Gonadal defects vary from severe deficiency to apparently normal sexual development
Prader-Willi Syndrome	Males and females	Hypogonadism; Small penis Underdevelopment of genitals and breasts Cryptorchidism
Rubinstein-Taybi Syndrome	Males and females	Cryptorchidism
Smith-Magenis Syndrome	Males and females	Polyembolokoilamania
Tourette's Syndrome	3-4 times more common in males	Inappropriate sexual activity due to impulsivity associated with comorbid ADHD Inappropriate touching due to complex motor tics
Turner's Syndrome	Specific to females	Infertility; Ovarian dysgenesis May lack secondary sexual characteristics
William's Syndrome	Males and females	Menstrual problems Inappropriate sexual behaviour due to increased sociability

*The syndromes on this table have been selected by the authors as samples only. Other syndromes may also have sexually related issues.

3. Sexual Abuse: Unwanted or forced sexual contact

The sexual abuse of persons with developmental disabilities will be explored relative to the incidence, causes, impact of abuse on mental health, and its consequences. The relationship between abuse as a serious mental health risk will be identified.

Incidence:

In the early 1990s, researchers increased the awareness among the developmental disability field as to the widespread sexual abuse and exploitation of persons with developmental disabilities. One study reported that 75-85% of women with developmental disabilities, living in community residential programmes, had experienced sexual assault (Davis, 1989). The majority of offences occurred in private homes (57.3%), or settings where services were being received, such as group homes (8.5%), institutions (7.7%), hospitals (1.7%), rehabilitation services (4.3%) (Mansell, Sobsey, & Calder, 1992).

The research by Mansell and her associates indicates that persons with developmental disabilities were abused at the hands of family members, neighbours, or babysitters, just as were non-handicapped persons. However, they were also at increased risk of abuse from other persons with disabilities, especially when clustered with potential offenders in residential programmes, and from persons in a care-giving role or those who gain access to the person through the disability services. The offenders were typically male, and were known to the victim (Sobsey, 1994; Mansell et al., 1992).

In a study involving 119 victims of sexual abuse, Mansell et al.

(1992) reported that abuse was generally repetitive (10.3%), or had occurred on many occasions (53.8%). Only 19.2% of the victims reported that the abuse had been singular, or had occurred 2-10 times (16.7%).

Cause:

The person's disability is not the direct cause of the increased vulnerability for abuse. The social conditions and systems, in which persons with developmental disabilities must interact as a result of their disability, create the increased risk (Griffiths et al., 1996, Roeher Institute, 1988, Sobsey, 1994). Several risk factors have been associated with the social conditions in which most persons with developmental disabilities find themselves. They include the following:

- social isolation and economic disadvantage;
- reliance on caregivers, who may lack training and support;
- lack of opportunity to gain socio-sexual knowledge, or to access social interactions;
- lack of empowerment and concurrent emphasis on compliance;
- limited communication or credibility;
- socialized tolerance for a breach of socio-sexual boundaries; and
- lack of credibility given to abuse reports.

Recent research and theory has suggested that the socially circumscribed world, within which persons with developmental disabilities usually live, and the nature of the roles and relationships in such settings, may result in confusion or distortion of interactions that can reduce the natural boundaries for abuse. When the healthy boundaries between support-

providers and support-recipients become blurred or breached, there is a potential for sexual abuse to be tolerated, or even worse, misinterpreted as appropriate social approach behaviour (Owen, Griffiths, Sales, Feldman & Richards, 2000). In some cases, persons with a developmental disability may be unaware of the expected limits of support-providers' behaviour beyond care-giving duties, and may not know or feel they have the right to defend themselves. Without clear policies and procedures with regard to appropriate boundaries, caregivers can rationalise inappropriate behaviour, and support-recipients will remain unclear as to appropriate and inappropriate caregiver behaviour (Owen, et al., 2000).

Impact of Abuse on Mental Health:

Myths exist that people with developmental disabilities, especially those who are more disabled, are insensitive to pain and are asexual (Sobsey & Mansell, 1990), and will not be affected by sexual abuse. However, Mansell et al. (1992) reported that most persons with developmental disabilities demonstrate negative effects following abuse. The experience of the negative effects following sexual abuse is idiosyncratic, and often related to pre-abuse history, the understanding of the abusive event, the nature of the abuse, the relationship with the abuser, and post abusive experience. Some individuals may experience the event as abusive and even traumatic; other individuals may experience the event with less negative overtones, or misinterpret it as love because of a lifetime of learned tolerance to an institutionalized abuse or misunderstood intentions (Owen et al, 2000)**.** In either case, the person with a disability is likely to demonstrate behavioural symptoms. These symptoms are often not understood, nor treated effectively as abuse reactions. Rather, symptoms can be poorly managed through behavioural

control and sedation and the reason for the symptoms may never be appropriately assessed or treated.

Consequences:

Crimes, including sexual crimes, against persons with developmental disabilities are rarely reported (Wilson & Brewer, 1992). Following abuse, persons are often removed from their home or programmes (Mansell et al., 1992).

In summary, the pervasive occurrence of sexual abuse, the nature of the abusive relationships, the lack of intervention following abuse, and the lack of natural consequences for abusers of persons with developmental disabilities, and the potential aftermath of disruption in their lives creates a severe mental health risk for persons with developmental disabilities.

4. Sexual Abuse: Restricted Sexuality

As stated earlier, abuse of the sexuality of persons with disabilities can involve restriction of sexuality through practice, policy, medication and denial of knowledge.

History:

At different times in history, persons with developmental disabilities were treated as “the sexually innocent”, who needed social protection. At other times in history, such as the beginning of the twentieth century, the Eugenics Movement branded persons with developmental disabilities as “sexually dangerous or promiscuous”, and in need of sanctioning. Persons with developmental disabilities were congregated with other populations typified by crime, sexual promiscuity, mental illness and

poverty. The professional community, armed with scientific data from hereditary studies, pursued most aggressively such restrictive measures as controlled marriage, sterilization, and segregation through institutionalization" (Scheerenberger, 1983). In the later part of the 20th century, forced sterilization eventually gave way to voluntary sterilization, and sex education was introduced. However, the facts about the sexuality of persons with disabilities have been slow to emerge from the myths (Griffiths 1992, 1999).

Despite the advent of massive deinstitutionalization and the expansion of community living for persons with developmental disabilities, most agencies that support persons with developmental disabilities do not teach about or permit sexual activity, appropriate or inappropriate. Today, many agencies still hold written or unwritten policies that fail to recognize the sexuality of the persons they serve. Age-appropriate, consensual and private sexual activity is often restricted or punished.

Hingsburger (1992) observed that the sexual experiences of individuals with developmental disabilities may have been so suppressed, controlled or punished that some individuals experience a negative reaction tendency to anything sexual. This is called erotophobia. Symptoms of this erotophobic behaviour include fear of one's own genitals, a negative reaction to any discussion, pictures or act involving sexual things, denial and anger over one's own developing sexuality, self-punishment following sexual behaviour, and a conspiracy of denial (Hingsburger, 1992).

Medication Use and Misuse:

Persons with developmental disabilities often receive a variety

of medications for conditions associated with their disability, for psychiatric treatment or behavioural control, and to control sexual behaviour.

Many of the medications prescribed to persons with developmental disabilities have sexual side effects. Additionally, the sexual side effects are more common as the dose and number of drugs increase, as often happens with persons with developmental disabilities. Too often, however, persons with developmental disabilities are not informed of the potential side effects that a medication can have on their sexual urges, fantasies or expression. Anti-convulsant medications, neuroleptics and antihypertensive medications are all associated with sexual dysfunction (Crenshaw and Goldberg, 1996). "Unwanted sexual activity", as defined by health-care providers was often "treated" with sedating neuroleptic medications (Mason & Granacher, 1980). In addition to causing tiredness and alterations in sexual desire, neuroleptics often cause erectile dysfunction, inhibited orgasm, and retrograde ejaculation in men (Lingjaerde, Ahlfors, Bech, Dencker, & Elgen, 1987). In women, neuroleptic medications have been associated with decreased vaginal lubrication, inhibited orgasm, and dysmennorhea (alteration in menstrual periods). Gallactorrhea (breast milk let-down) has been reported in both men and women (Lingjaerde et al., 1987). {See Table 2 for a partial list of such sexual active drugs. The medications in Table 2 have been selected based on the frequency with which they are prescribed for people who have a developmental disability.}

Most experts now agree that neuroleptic medications should never be prescribed for the purpose of controlling sexual behaviour (Fedoroff, 1995). This is because better pharmacological interventions are now available, and because of the poten-

tially lethal side effects of neuroleptic malignant syndrome (Levenson, 1985), and the disfiguring and incurable neuroleptic induced syndrome of tardive dyskinesia (American Psychiatric Association, 1992).

Table 2: Sexual Side Effects in Commonly Prescribed Medications

Name	Primary Indication	Side Effect(s)
Cardiovascular		
Chlorothiazide	Blood pressure control	Sexual difficulties
Digoxin	Heart disease	Decreased sex drive; erectile dysfunction
Enalapril	Blood pressure control	Erectile dysfunction (rare)
Nadolol	Heart disease; blood pressure control	Decreased sex drive; erectile dysfunction
Propranolol	Heart disease; blood pressure control	Loss of sex drive (M & F); Erectile dysfunction
Verapamil	Heart disease	Erectile dysfunction (rare)
Central Nervous System		
Alprazolam	Anxiety	Decreased sex drive; trouble with ejaculation (M) & orgasm (F)
Amitriptyline	Depression	Decreased sex drive; erectile dysfunction; no ejaculation
Buproprion	Depression	Erectile dysfunction
Carbamazepine	Seizure disorder/ mood stabilizer	Erectile dysfunction
Chlorpromazine	Psychotic disorder	Decreased sex drive; erectile dysfunction; priapism; no ejaculation
Citalopram	Depression	Decreased sex drive; delayed ejaculation (M); problems with orgasm (F)
Diazepam	Sleeping difficulties/ anxiety disorder	Decreased sex drive; delayed ejaculation; delayed or no orgasm (F)

(table continues)

Name	Primary Indication(s)	Side Effect (s)
Doxepin	Depression	Lower sex drive; problems with orgasm (F) or ejaculation (M); erectile dysfunction (rare)
Fluoxetine	Depression	Decreased sex drive; delayed ejaculation
Fluvoxamine	Depression	Decreased sex drive; problems with orgasm (F); delayed ejaculation (M)
Haloperidol	Psychotic disorder	Erectile dysfunction; change in libido; painful ejaculation; priapism
Imipramine	Depression	Decreased sex drive; erectile dysfunction; Painful delayed ejaculation; delayed orgasm (F)
Levodopa	Parkinson's Disease	Increased sex drive
Lorazepam	Sleeping difficulties/ anxiety disorder	Decreased sex drive; delayed ejaculation; delayed or no orgasm (F)
Lithium	Bipolar disorder/ mood stabilizer	Erectile dysfunction
Mesoridazine	Psychotic disorders	Erectile dysfunction; ejaculation problems; priapism
Methadone	Pain control	Decreased sex drive; erectile dysfunction; no orgasm; delayed ejaculation
Nefazadone	Depression	Decreased sex drive; erectile dysfunction; delayed ejaculation; trouble with orgasm (F)
Nortripyline	Depression	Erectile dysfunction; decreased sex drive
Oxazepam	Sleep disorders/ anxiety	Decreased sex drive; delayed ejaculation; delayed or no orgasm (F)
Paroxetine	Depression	Decreased sex drive; erectile dysfunction; delayed ejaculation; trouble with orgasm (F)
Phenobarbital	Seizure disorder	Erectile dysfunction

(table continues)

Name	Primary Indication(s)	Side Effect (s)
Phenytoin	Seizure disorder	Decreased sex drive; erectile dysfunction; priapism
Primidone	Seizure disorder	Change in sex drive; Erectile dysfunction (uncommon)
Sertraline	Depression/ anxiety	Decreased sex drive; erectile dysfunction; delayed ejaculation; trouble with orgasm (F)
Tenazepam	Sleeping difficulties/ Anxiety disorder	Decreased sex drive; delayed ejaculation; delayed or no orgasm (F)
Thioridazine	Psychotic disorder	Change in sex drive; erectile dysfunction; delayed, painful, retrograde, or no ejaculation
Trazodone	Depression	Priapism; change in sex drive; retrograde ejaculation
Trifluoperazine	Psychotic disorder	Erectile dysfunction; painful or no ejaculation; spontaneous ejaculation; increase in sex drive for women
Chemo-therapeutic		
Methotrexate	Cancer treatment	Loss of sex drive; erectile dysfunction
Gastrointestinal		
Cimetidine	Ulcer therapy	Decreased sex drive (M & F); erectile dysfunction
Misoprostol	Ulcer therapy	Erectile dysfunction; decreased sex drive (both infrequent)
Ranitidine	Ulcer therapy	Decreased sex drive; erectile dysfunction (occasional)
Genitourinary		
Medroxyprogesterone	Contraception	Change in sex drive; trouble with orgasm
Oxybutyrin	Urinary incontinence	Erectile dysfunction
Musculoskeletal		
Naproxen	Arthritis	Erectile dysfunction; no ejaculation

In the previous two sections, we have shown that persons with developmental disabilities are (i) less likely to have sexual experiences that enhance their mental health, and (ii) more likely to experience abusive sexual events which may contribute to mental health challenges. These risk factors and others contribute to an increased vulnerability for persons with developmental disabilities to develop more sexually inappropriate behaviour.

Statistics on Sexually Inappropriate Behaviour:

Gilby, Wolf and Goldberg (1989) reported that persons with developmental disabilities often engage in more inappropriate behaviours such as public masturbation, exhibitionism and voyeurism, but less serious sexual violations, than do nondisabled persons. Edgerton (1973) suggested that persons with developmental disabilities do not tend to demonstrate any more sexually inappropriate behaviour than do non-disabled persons *if* they are provided a normative learning experience. However, the sexual learning experience of many persons with developmental disabilities is anything but normative.

Offence Statistics:

Studies on population statistics have shown that individuals with developmental disabilities are over-represented in the population of convicted sexual offenders (Shapiro, 1986; Steiner, 1984, Langevin, 1992). However, these statistics have been debated. Some argue that they are overestimated because the data is based on the number of people convicted, and people with developmental disabilities are more likely to get caught, to confess and unable to mount a suitable defence (Santamour & West, 1978; Murphy et al., 1983).

Although the rate of serious sexual assaults may be overestimated among this population, it is likely that the rate of "sexually inappropriate behaviour" may not be. It is likely that persons who commit such violations are often diverted into residential programmes rather than correctional facilities, or the charges are dropped (Day, 1994).

Nature of Sexually Offensive and Inappropriate Behaviour:

Sexual behaviour, defined as offensive or inappropriate, can take many forms. According to the the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV; APA, 1994), there are a number of diagnostic codes under the rubric of *paraphilia*, meaning love of the unusual. *Paraphilia* is described as: "recurrent sexually arousing fantasies, sexual urges or behaviours generally involving (1) non human objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other non-consenting persons, that occur over a period of at least six months" (p. 522).

Day (1994) suggested that *paraphilia* does occur, but rarely among persons with developmental disabilities. It is, however, often misdiagnosed. Among this population, there is a higher experience of abuse (Griffiths, Quinsey & Hingsburger, 1989; Gilby et al., 1989), poor self-esteem (Lackey & Knopp, 1989), lack of sociosexual knowledge and experience (Hingsburger, 1987), and poor social problem-solving skills (Hingsburger, 1987). The DSM-IV states that in persons with developmental disabilities there may be a "decrease in judgement, social skills, or impulse control that, in rare cases, leads to unusual sexual behavior" distinguishable from *paraphilia* (APA,1994, p. 525).

The latter behaviours can be differentiated from *paraphilia*

since these acts do not represent a person's preferred and recurring sexual behaviour (APA, 1994). This non-paraphilic sexual behaviour usually occurs at a later stage in development, and is often sporadic. The DSM-IV description, while accurate in some cases, does not provide diagnostic criteria for differentiating between *paraphilia* and what some authors have called "counterfeit deviance".

The term "counterfeit deviance" was used in an article by Hingsburger, Griffiths, and Quinsey in 1991. They provided case examples to demonstrate that often, the sexual misbehaviour of persons with developmental disabilities is the product of experiential, environmental, or medical factors, rather than a *paraphilia*. Such misbehaviour can result from a lack of privacy (structural), modeling, inappropriate partner selection or courtship, lack of sexual knowledge or moral training, or a maladaptive learning history, or medical or medication effects (Hingsburger et al., 1991).

Day (1994) identified two types of sexual offenders among those with developmental disabilities. They were (a) those who committed sex offences only, and (b) those who committed a range of offences, including those of a sexual nature. He observed that the latter group demonstrated a higher incidence of sociopathic personality disorder, brain damage, family dysfunction, and other inappropriate behaviour. This group was less sexually naïve, and more specific and persistent in sexual offending. In contrast, those who committed only sexual offences were generally mildly disabled and without associated psychopathology, brain damage or generalized problem behaviours. This latter group committed less serious offences and was less specific in choice of offence behaviour or victim. Offenders in this group were typically shy, lacking sexual knowl-

edge or experience, and often were from sexually repressive environments (Day, 1997). In contrast to non-disabled offenders who target mostly females, offenders with developmental disabilities offend equally against males and females (Gilby et al., 1989; Griffiths, et al., 1989). In addition, offenders with developmental disabilities appear to have far fewer victims.

The presence of various biomedical, psychological and socio-environmental variables that are more likely to be present in the lives of persons with developmental disabilities, can create increased risk for the development of sexually offending or inappropriate behaviours (Griffiths, 2002). These variables are discussed in depth in Griffiths (2002); however, they are discussed briefly below.

Biomedical Factors:

Neurological challenges and mental illness are more often witnessed in the population of persons who commit sexually offensive or inappropriate behaviours; these conditions are more likely to coexist in persons with developmental disabilities (Nezu, Nezu, & Gill-Weiss, 1992). Persons with developmental disabilities experience the same range of mental health challenges as persons without disabilities. As such, they are vulnerable to the same range of mental health challenges that may present as non-specific sexual symptoms (i.e., mania or obsessive compulsive disorder).

Psychological Factors:

Psychological factors such as lack of attachment bonds, lack of prosocial inhibition, childhood sexual trauma, and deficits in skills and empathy, are risk factors for development and occur-

rence of sexual challenges in the nondisabled population. Persons with developmental disabilities have been found to be as likely or more likely to experience these psychological vulnerabilities (Griffiths, 2002).

*A*lthough the experience of abuse does not predict that an individual will commit a similar sexual crime, among persons with developmental disabilities who have engaged in sexually offensive behaviour, there is a high percentage of persons who have experienced childhood abuse (Griffiths, as cited in The Roeher Institute, 1988; Hingsburger, 1987). If early sexual abuse may condition some individuals to respond sexually to the presence of certain individuals, or when confronted with specific situations reminiscent of early experiences of abuse, then the increased sexual abuse may represent a risk for future sexual problems. Moreover, because persons with developmental disabilities are denied education, counselling or opportunity to develop healthy sexual experiences to countercondition the early abuse, they may be more likely to be influenced by that experience of abuse. For example, one man who had been abused repeatedly as a young boy within his family, then went on to abuse young boys when he became older because was unaware that his behaviour was unacceptable. For the young man, age-inappropriate sexual contact was the only standard of conduct he had been taught. This man had neither cognitively nor experientially encountered any instruction or moral view contrary to his experience.

Socio-Environmental Factors:

Day (1997) suggested that the high rates of sexually inappropriate behaviour attributed to persons with developmental disabilities reflect the generally repressive and restrictive attitudes toward the sexuality of persons with disabilities. Individuals

with developmental disabilities may experience a differential conditioning to sexuality. Persons with developmental disabilities have often been punished for normal sexual behaviour. The environments in which many persons with developmental disabilities live may reverse the natural contingencies of reinforcement and punishment for sexual behaviour. Appropriate and consenting sexual behaviours are often punished at the same or greater rates than an inappropriate and perhaps non-consenting sexual encounter.

Additionally, for many persons with developmental disabilities, sexually inappropriate behaviour has failed to bring about natural aversive consequences. Persons with developmental disabilities may lack knowledge of the law, or the relevance of the law to their sexual misbehaviour. If persons with developmental disabilities are charged with sexually inappropriate behaviour, the charges are often dismissed and the person is placed in settings other than correctional facilities. Thus, the natural consequences are often not taught nor experienced.

Risk Assessment:

An important challenge for mental health professionals, charged with the assessment and treatment of people with developmental delay, is the accurate assessment of risk of violent or sexual offences. Typical interviewing and testing procedures require adaptation and caution when used with this population (i.e., phallometric testing) (Murphy, Coleman, & Haynes, 1983).

One of the most well established actuarial assessment instruments for the prediction of sex offences is the Sex Offender Risk Appraisal Guide (SORAG) (Quinsey, Harris, Rice, &

Cormier, 1998). Recent research by Fedoroff, Smolewska, Selhi, Ng, and Bradford (2001) demonstrated that persons with developmental disabilities are more likely to score significantly higher overall when compared to other offenders with an equal number of victims. On two subscales, they rated significantly higher on two scores when compared to a matched sample of nondisabled offenders. The subscales were related to marriage and living with natural parents up to age 16. Fedoroff et al. (2001) suggest it is likely that the factors that may contribute to a man being unable to establish a romantic relationship, or to hold a job, have a different developmental path for a man who has developmental delay than in a man without cognitive handicaps. As we have stated before, the opportunity for appropriate sociosexual interaction have been denied in the population of persons with disabilities. Thus, the increased risk may be the result of the life experience afforded persons with disabilities in our society, such as limited options for meaningful work, lack of opportunity to develop relationships and marry, isolation from family and community.

Treatment Programmes:

In the early part of the century, sexual behaviour (appropriate or inappropriate) resulted in castration or incarceration in segregated facilities (Pringle, 1997). In the 1970's, behavioural control techniques were adopted to stop sexual behaviour such as masturbation. Approaches included the use of time-out, omission training, or punishments like response cost, overcorrection, or squirts of contingent lemon juice in the mouth following this behaviour (Griffiths, Quinsey & Hingsburger, 1989). Informally, persons with developmental disabilities were ridiculed, sanctioned or denied privileges.

In the early 1980's, few programmes offered treatment for persons with developmental disabilities who demonstrated sexually offensive behaviour (Coleman and Murphy, 1980). In the past two decades, however, an increasingly rich body of clinical literature on intervention programmes for sex offenders with developmental disabilities has emerged (Murphy et al., 1983; Griffiths, Hingsburger & Christian, 1985, Griffiths et al., 1989; Haaven, Little, & Petre-Miller, 1990; Lund, 1992; Ward et al., 1992). More recently, the treatment focus has shifted toward promotion of the development of adaptive sexual behaviours (Griffiths, et al., 1989; Haaven, et al., 1990; Lindsay, et al., 1998; Nezu, Nezu & Dudeck, 1998; Ward et al, 1992).

Based on a growing body of clinical experience, specialized treatment providers have reported that sex offenders with developmental disabilities, particularly those individuals who were mild and moderately disabled, have been surprisingly responsive to treatment (Lackey & Knopp, 1989). However, to date there is minimal empirical demonstration of the treatment effectiveness with this population (Griffiths, Watson, Lewis, & Stoner, in press).

The recidivism rates for persons with developmental disabilities who commit sexual offences present contradictory data for persons in community and institutional settings. Demetral (1989, as cited in Nolley, Muccigrosso & Zigman, 1996) reported a recidivism rate of less than 2% within a community programme; Haaven et al. (1990) indicated a rate of recidivism of 23% for their population of institutionalized offenders. Nolley et al. (1996) suggested that treatment outcome in the community is enhanced by the use of qualified facilitators, increased social opportunities for persons with developmental disabilities, the enlistment of natural support systems, and

teaching about culturally acceptable ways of sexual expression.

Treatment strategies should involve:

1. *Teaching and reinforcing alternative replacement behaviours that will serve the same or similar function as the sexually aggressive behaviour by:*
   - Providing an appropriate means for the individual to achieve the desired interaction and sensory state, which the person is now receiving through an inappropriate means, both acted out and in fantasy;
   - Overcoming barriers to the development of appropriate socio-sexual outlets currently unavailable because of such vulnerabilities as a lack of social skills; and/or
   - Providing an alternative and appropriate means for the individual to reduce, remove or alter the aversive internal state the person is currently escaping through the sexually aggressive behaviour or fantasies.

2. *Altering the maintaining consequences that have been sustaining the behaviour:*
   - For many persons with developmental disabilities, this often means teaching the legal consequences of sexual aggression, and that as a citizen, they will be held responsible for such behaviour, and
   - Teaching individuals to use the naturally punitive consequences (legal, social and moral) of the behaviour, to inhibit sexual aggressive behaviour and/or fantasies through cognitive self-management methods such as covert sensitization or masturbatory reconditioning (Griffiths et al., 1989).

3. *Judicious use of medication or hormonal therapy:*
   - Medication and hormonal therapy may be an important *addition* to treatment plans for individuals whose sexual interests pose a risk to themselves or others. Table 3 describes a lists of common medications used to treat sexual deviations. Apparent from the table, the potential side-effects of the medications can be significant.
   - When considering medication or hormonal therapy for the treatment of sexual problems in people with developmental delay, the practice guidelines should be followed:

Box 1: **Practice Guidelines for Medications or Hormonal Therapy for Sexual Offending Behaviour**

(i) Medication or hormonal therapy should only be prescribed to patients who understand the risk and benefits of treatment with these medications, and who are able to give voluntary consent.

(ii) Medication or hormonal therapy should be used as part of a comprehensive treatment plan which includes healthy sex education and psychotherapy.

(iii) Medication or hormonal therapy should only be prescribed in cases in which their efficacy can be monitored (e.g., there is no point in prescribing medication or hormonal therapy to a person with sexual interests in children if that person has no contact with children, and is not otherwise distressed by their interests in children (paedophilia).

(iv) Medication or hormonal therapy should only be prescribed by physicians who are able to assess their efficacy

and diagnose medical contraindications to their use.

(v) Other treatment options should always be considered.

Table 3– Class of Medications for Sexually Inappropriate Behaviour

Class of Medication	**How they work**	**Effects and side-effects**
Antiandrogens	Decrease testosterone	Decrease sex drive Decrease fertility Glucose intolerance Increase risk of thromboembolic disorders Alter liver function
Luteinizing Hormone Releasing Hormone (LH RH) Analogues	Supress gonadotropin production	Decrease sex drive Decrease fertility Osteoporosis Glucose intolerance Increase risk of thromboembolic disorders Alter liver function
Selective Serotonergic Reuptake Inhibitors (SSRI's)	Increase post-synapatic serotonin availability	Antidepressant Decrease impulsivity Alter sex interest Alter sleep and appetite

Summary

There is a complex interplay of biomedical, social and psycho-

logical factors, related to the experience of being a sexual person with a developmental disability in our society.

A) Although sexuality is considered an important factor in mental health and wellness (World Health Organization, 1975), the sexuality of persons with developmental disabilities is often negatively affected because of the following:
   a) denial of opportunity to enjoy and control sexual and reproductive behaviour in accordance with social and personal ethics;
   b) the experience of fear, shame, guilt, false beliefs, and other psychological factors that inhibit sexual response and the establishment of sexual relationships; and
   c) the co-existence of organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions.

B) Persons with developmental disabilities are more likely to be sexually abused, and to have their sexual expression repressed and punished. They are also less likely to receive treatment for their sexual abuse experiences. These abusive and repressive experiences represent serious behavioural and mental health risks for persons with developmental disabilities.

C) The statistics show that individuals with developmental disabilities are more likely to engage in sexually inappropriate behaviour as a result of conditioning, and are more likely to be involved in less serious sexual crimes, because they will likely get caught, confess, and not negotiate a plea bargain, or gain appropriate defence. Moreover, they are less likely to receive appropriate treatment for their challenging sexual behaviour.

The sexuality of persons with developmental disabilities poses significant mental health risks, not because of the disability, but because of the societal response to the sexuality of those who are labelled in our society. The World Health Organization has proclaimed that we are all sexual beings, and that includes those with a disability. Failure to recognize this reality poses a great threat to the mental health integrity of individual with disabilities.

Resources

Sexuality and Persons with Developmental Disabilities

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Do You Know?

1. What are some of the key mental health risks that face people with developmental disabilities regarding their sexuality?
2. Why are people with developmental disabilities over-represented in correctional facilities regarding sexual crimes?
3. What factors could contribute to the development of sexual problems in persons with developmental disabilities?
4. Can individuals with developmental disabilities benefit from sex offender treatment programmes? What should be the focus of treatment?

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Disabled Woman's Network Canada
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National Clearninghouse on Family Violence www.hc-sc.gc.ca/nccn

SIECCAN (Sex Information and Education Council of Canada) www.sieccan.org

SIECUS (Sex Information and Education Council of the US) www.siecus.org

Safer Society www.safersociety.org

Sexual Health Network: Sexuality and Disability or Illness Information Help Therapy www.sexualhealth.com

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