Safer Options Manual:

A Road Map to Treatment and Community Safety

Developing Best Practices Treatment for People who have Intellectual Disabilities and Offending or Problematic Sexual Behavior

Pennsylvania’s Office of Developmental Programs

Revised, Developed and Written by Sharon Mahar Potter M.Ed. Nancy Nowell M.P.A. M.Ed. © 2010

Be Kind: Everyone is Fighting a Mighty Battle
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Thank You

Kevin T. Casey, Deputy Secretary for Pennsylvania’s Office of Developmental Programs and to Nancy Thaler, executive director of State National Association of MR Directors. The Safer Options process began under Mr. Casey’s tutelage in 1992 when he was Executive Director of Pennsylvania and Advocacy, Inc (Pennsylvania’s Disability Rights Network) and Nancy Thaler was the Deputy Secretary of ODP. They both encouraged the development of a statewide network of support for people who have intellectual disabilities as well as problematic sexual behavior. Three Training Institutes were conducted, a Best Practices handbook was produced and a cadre of resources was developed throughout the Commonwealth.

Currently, Mr. Casey, Deputy Secretary of the Office of Developmental Programs, continues to support the identification of therapists, therapeutic support groups and individuals who have expertise in testing and treatment of this unique population. There are countless success stories that are the direct result of this program and we thank Mr Casey for his unconditional support.

To Individuals who have intellectual disabilities and their families
A special thank you to those of you who are victims or offenders - and in many cases you are both. Together we help each other understand that life can get better and we can get stronger. To families who often seek help for their sons or daughters - we have failed you so often; hopefully, the continued work related to Safer Options will build bridges between the problems and the solutions.

The Safer Options Manual is a revision of the
Positive Approaches Handbook
(Prepared by Guy Legare, M.P.s 2003)
Introductions

Sharon Mahar Potter has thirty years experience working with children and adults who have disabilities. She is the Sexuality Consultant for Pennsylvania’s Office of Developmental Programs (2003-2010). She began working at Pennsylvania Protection & Advocacy (Disability Rights Network) in 1989 and was part of the development of the early intervention system in Pennsylvania. Deputy Director from 1995 – 2005, she started a statewide effort to address the needs of people who have intellectual disabilities as well as problematic or offending behaviors.

Nancy Nowell has worked with a wide range of children and adults who have Intellectual Disabilities and those on the Autism Spectrum since 1973. After completing a M.Ed. in Human Sexuality Education in 2002, she focused her career on sexuality issues that impact people with disabilities. Since 2001 she has provided supports and services to people with disabilities who need relationship / sexuality education, have Post Traumatic Stress Disorder (PTSD), have been sexually abused, exhibit problematic sexual behavior and/or sex offending behavior.

Between 2001 and 2007 Potter and Nowell coordinated three training Institutes sponsored by the Pennsylvania Office of Mental Retardation, now the Office of Developmental Programs (ODP). As part of this project they have written and developed training materials that are being used in Pennsylvania and have been shared with several other states. They have adapted existing material to meet the cognitive needs of people who have intellectual disabilities and developed a Train the Trainer curriculum that can be used in conjunction with this manual.

Guy Légaré developed the Positive Approaches: Learning about Best Practices in Supporting Individuals with Mental Retardation who also have Problematic Sexual Behaviors (2003). He was the Associate Clinical Director to the Office of Developmental Programs Statewide Training and Technical Assistance Initiative. Previously, Guy worked as a program consultant for Community Mental Health Services in Saint John, New Brunswick, Canada. Trained as a clinical psychologist, Guy has been involved in developing service options and communities for people with mental illness and other disabilities.
The contributions of the following are contained within the revised edition of the Safer Options Handbook.

Kathy Aiken coordinates Safe Choices, a program that offers innovative, individualized, community-based, comprehensive services to a wide range of clients with serious offending behaviors.

Saul Schoenberg is a licensed psychologist in Vermont where he began the Resolutions Program that works with adults, adolescents and special needs populations who have problematic sexual behaviors.

Safer Options was based on the philosophy of the Vermont programs and both Aiken and Schoenberg assisted our efforts in Pennsylvania to build a sustainable support system.

John Eirdosh and Cass Levin-Spaus also contributed their expertise in the development of the Best Practices manual. They developed many of the tools contained in the revised book.

James Haaven is consultant in private practice and trainer in the field of assessment, treatment and program development for people who have intellectual disabilities and sexual offending behaviors. He is the author of Treating Intellectually Disabled Sex Offenders and Seeing Things Differently. He also provided training for Safer Options and we include the ARMIDILLO, an assessment tool, in this handbook.
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A. Overview

Purpose

The purpose of this *Safer Options Manual* is to support the development and implementation of community based treatment programs for individuals with disabilities who have problematic and/or sex offending behavior. The manual provides information on ethics, sexuality, Pennsylvania statutes, risk assessment, treatment, supervision, treatment teams, as well as training and support for staff.

*Note:*

Problematic sexual behavior and sexual offending behavior are both serious problems and need to be addressed. A problematic sexual behavior might involve excessive or harmful masturbation and a sexual offence is one where an illegal activity has occurred, whether charges are pressed or not.

Assessing people with problematic sexual behavior and implementing appropriate supervision and treatment are skills that many agencies struggle with. This manual and the *Safer Options* Train-the-Trainer Curriculum can assist agencies in developing a process for supporting individuals with very serious, complex and at times dangerous sexual behavior.

Values and Agency Policy

Agencies using this manual and teaching the *Safer Options Curriculum* are encouraged to identify their values, policies, procedures, support for teams and decision-making process before implementing this type of program. Using this material with a predetermined set of rules and policies is important because when situations develop it is important for the team/staff to have a clear understanding of what they can and cannot do. For example, if a team determines that a restrictive procedure is a necessary part of treatment, there should be a procedure in place to support implementation.

Liability

Neither this nor any other training material will eliminate liability in these emotionally charged areas. However, not recognizing or responding to sexual concerns, victimization and/or predatory behavior can increase an agency’s liability. Struggling with difficult issues and providing training for staff can reduce liability.
Treatment

The *Safer Options Manual* is intended to provide a framework for agencies and staff and is best used in conjunction with the *Safer Options Train-the-Trainer Curriculum, and the Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend–Sexually / The ARMIDILLO-S.*

Further, it is important to work with a professional that have been trained in working with people who have developmental disabilities and problematic or sex offending behavior.

Natural consequences should be a normal part of a program for individuals who have intellectual disabilities. For people who also have problematic sexual behavior it is imperative that rights, responsibilities and consequences (used as a teaching tool) are parts of everyday life. When there are serious legal ramifications for behavior, it is important that treatment includes real consequences so that prison is not the first consequence experienced by the offender.

The content of any successful treatment program should include:

- An experienced therapist within the treatment team
- Coordination with the criminal justice system (if applicable)
- Regular on-going staff training
- Waiving confidentiality
- Knowledge of the Offending Cycle
- Supervision and Safety Plans
- No lies / No secrets
- Identifying and addressing red flag behaviors
- Understanding Thinking Errors / Cognitive Distortions / Triggers / Targets
- Disclosure

Treatment should be a combination of teaching internal controls, implementing real consequences, and helping the individual create a life that is fulfilling and safe as well as helping them understand and control problematic behaviors. Agencies and teams need to match supervision to risk, work closely with a therapist experienced in sex offender treatment, hold the person accountable for their behavior, and support the development of new and healthier personal goals.
B. History of Safer Options in Pennsylvania

This manual is the cumulative result of nine years of work and reflects national best practices when working with people with developmental disabilities who have illegal or problematic sexual behavior. The focus of this curriculum is to support government, agencies, and staff to learn how to manage problematic sexual behavior in community settings including residential programs, while maintaining community safety.

The *Safer Options* project worked with nationally known experts, trained approximately 100 people in three training institutes, developed two handbooks, wrote a curriculum with 12 lessons, presented at 2 national conferences, and continues to support agencies and treatment teams.

Pennsylvania’s Office of Developmental Programs has worked to increase access to community based quality clinical assessments, sex offender treatment, appropriate supervision, risk management, and on-going intensive training to teams working with this challenging population. The development and distribution of this manual is the next step in expanding these supports in Pennsylvania.

ODP’s *Safer Options* has expanded the resources available to government, therapists, families, and agencies. Our hope is that by using this manual in conjunction with the *Safer Options* Training Curriculum, professionals and agencies can provide the treatment, training, and support necessary for this population to live safely in the community. This manual and/or the *Safer Options* Curriculum will not provide answers to every question, but we hope it will provide a structure that can support agencies doing this work.
C. Who Are We Talking About?

People who offend are not all alike. There is no such thing as a profile of a sex offender; they vary significantly in age and represent all races, ethnicities, and socio-economic classes. Sex offenders engage in their abusive and criminal behavior for diverse and complex reasons, and they often create facades to conceal their crimes... disabled and not disabled. It is essential that the team and others working with the person understand all sexual abuse laws so that they are clear when someone is breaking the law and when they are not.

A non-disabled person can only be determined to be a sex offender if they have been convicted of a sexual crime. However, because many people with developmental disabilities are not competent to stand trial or are not charged with a crime (even though they have clearly broken the law), an alternative definition of a sex offender has been developed for people with developmental disabilities.

“If a person with a cognitive disability has moved (their residence), changed their work/work activity, and/or changed their school as a result of a documented sexual incident that is against the law; this behavior should be viewed as a sexual offence in terms of treatment and the seriousness of the behavior.”

Complex, legal situations develop because many people with cognitive disabilities and sex offending behavior are not charged with a crime. They can be grouped into three different types of situations. The chart that follows demonstrates how defining what type of person you are working with informs the type of treatment the person needs, what their treatment should include, and what treatment options are available to the team.
Person #1

**Problematic Sexual Behavior / Legal Behavior**
Problematic sexual behavior is legal, but it must be dealt with. The person may not have the cognitive ability to understand what they did, and/or the problematic sexual behavior is not sexually motivated.
Examples:
- If the person is masturbating in the living room, it is important to help them learn the difference between public and private, hence an educational approach.
- Is the person allowed to ‘body hug’ staff? If so, s/he may repeat this behavior with a stranger in the community and charges could occur.

**Questions you should ask yourself?**
Does the person understand what they are doing is wrong and possibility illegal? Is the behavior legal but not OK? Is the behavior motivated by its sexual impact on others?

Person #2

**Sex Offending Behavior / Illegal Behavior**  The person may not be competent to stand trial or is not being charged.
The ‘incident’ must be clearly documented and against the law. If both the perpetrator and the victim live or work together, the perpetrator, not the victim should be moved.
Example:
  • A man enters the women’s bathroom at a sheltered workshop and attempts to force a woman to have sex with him.
  • A person touches the breasts and buttocks of female housemates.

Criteria for this designation are:
  • The perpetrator has been moved to a different school, work situation or living arrangement because of the sex offending behavior.
  • This person will not be charged or stand trial because the police and/or district attorney do not think the charges will hold up in court (i.e. the victim is developmentally disabled and would not be a good witness).
  • The perpetrator has been determined to be not competent to stand trial

Questions you should ask yourself?
Were the police called? If not, why not?
Was the person moved out of a day or residential program because of the incident?
Were charges not pressed only because the person was not able to participate in their defense?
Have there been other incidents in the past?

Person #3

Illegal Sex Offending Behavior / The person is charged and convicted of a sexual offence
This is clear illegal behavior and the person is charged and convicted. The criminal justice system/probation/parole are usually involved, which can be very helpful because treatment may be a required component of their probation or parole.
Examples:
  • A person knows when the school bus arrives and he exposes himself and masturbates in the window when the children walk by his house.
  • A person waits until staff is distracted and then follows a woman into the dressing room and attempts to rape her.

Questions you should ask yourself?
Is there a history of this type of behavior?
Have charges been pressed in the past?
Is the person already on probation or parole?
How can probation/parole be used to help the person respond to treatment before his probation/parole is over?
Community Safety = Supervision + Treatment

Risk Management = Risk Control + Risk Reduction

Some offenders commit their crimes without any forethought or planning. For many offenders, the offense is planned hours, days, weeks, or even months before the actual sex crime is physically perpetrated. Other offenders may be impulsive or opportunistic which can make offences less predictable. It is important to determine the type of offender being supported so that appropriate supervision can be implemented.

The vast majority of sex offenders know that their abusive behavior is against the law and that it conflicts with the behavioral norms and ethics they have been exposed to and taught. Although most sex offenders do not believe sexually abusive behavior is acceptable, they manage to rationalize their behavior. These offenders are likely to have convinced themselves that they are not really committing a sex offense and that their behavior is "okay" and "acceptable" or it was “the victim's fault” (i.e. cognitive distortions).
D. Where to Start?

When working with individuals who have problematic sexual or offending behavior, Community Safety must always come first, even before the person’s individual rights. A failure to do so can result in victimization, incarceration for the offender and liability for the agency.

Problematic/sex offending behavior develops over a long period of time and is unlikely to go away with a sex education class or with casual treatment over a few months. These serious and complex problems call for responsive and intensive treatments and supports, involving a major commitment of time and energy from everyone. An effective and responsive program combines organizational and clinical elements to create a supportive treatment environment.

Agencies must take their responsibility seriously; unlike other types of behavior problems there must be zero incidents immediately, every day, forever. Agencies need to work cooperatively with the criminal justice system, and recognize that this is criminal behavior (when a law is broken) NOT a behavior problem.

A best practices treatment program can include; restrictive plans, Waiving confidentially rules, working with the criminal justice system, using medications to reduce libido, and understanding and experiencing natural consequences. Critical to this type of treatment program is the responsibility and accountability of:

- The person with sex offending behavior
- The Team
- The Agency / Organization

All aspects of a best practices treatment program require that the person be responsible for their actions. If any part of the treatment program is considered restrictive, a treatment plan should be written and submitted to a Human Rights Committee for approval. At times licensing, Human Rights Committees, regional and county offices, support coordinators and agency administration need to be educated about reasons for these requirements. A failure to restrict an ‘at risk’ individual’s activity may result in incarceration, the ultimate restriction.

The information in this manual should assist agencies in getting approval for a restrictive program. If the Human Rights Committee, licensing or other governmental bodies do not understand the need for a restrictive program, the agency should contact the ODP Regional Director.
E. What is Different?

Consequences for sexual offences are an appropriate and necessary part of any best practices model.

- Historically people with intellectual disabilities have had few consequences, therefore they do not get appropriate treatment and support or they are sent to prison, where they often have great difficulty participating in ‘typical’ treatment programs.
- Agency staff often under or over react to the sexual behaviors therefore they need to learn what is or is not a problem.
- There are many reasons for offending, but no excuses. It is important to identify the reasons.
- We need to help the person learn skills to manage their offending behavior in the community, outside of prison.

Core elements of a best practices treatment program are:

- It is NEVER appropriate to be punitive with the person with problematic sexual behaviors.

- Individuals who have offending or problematic sexual behaviors are, and can be, dangerous. These individuals are some of the most challenging individuals to treat and serve.

- It is to be expected that the person is engaging in illegal sexual behaviors and will behave in ways that are inherently covert, deceptive and secretive.

- Assessment, evaluation and risk management is an ongoing process. Progress in treatment and level of risk are not constant over time- as the individual learns to internalize controls, the supervision level will decrease.

- When working with individuals with intellectual disabilities who have problematic sexual behaviors, risk management replaces self determination and the dignity of risk.

- Individuals have the same rights as others to live in the community, and like their non-disabled peers they have total responsibility for their behaviors.
• Confidentiality must be waived since the staff or support systems need to know what specific issues are being addressed. It will most likely be direct care staff who will be responding ‘in the moment’ so it is imperative to give them the knowledge and tools they need to respond.

• Standards and guidelines for assessment, risk management, treatment and supervision will be most effective if there is cross systems collaboration with the criminal justice system, the mental health system, probation and parole, social services, and the treatment providers in the intellectual disability network.

• Successful management and treatment of individuals are enhanced by the positive cooperation of family, friends, employers and members of the community who have influence in the individuals’ lives.

• An effective and responsive team needs to have the flexibility to change and adapt supports, management and treatment options over time, to reflect the ongoing and dynamic process of managing and treating individuals.

• Management of individuals requires both clinical and organizational/administrative leadership and a coordinated team response.
The following Table of Contents details the comprehensive *Train – the – Trainer Curriculum* developed as part of the Safer Options Project in 2007.

All chapters in this *Safer Options Manual* have been cross walked with the *Train-the-Trainer Curriculum* so that these resources can be used together.

The Train-the-Trainer Curriculum can be found on the OPD Website
Train-the-Trainer Curriculum
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Safer Options

A Treatment Program for People with Developmental Disabilities who have Illegal/Problematic Sexual Behavior

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Introduction / Statement of the Problem

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4. Assessing, Measuring and Managing Risk
   ARMIDIGO-S Haaven 2010

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Four Ethical Standards
Positive Approaches as a Paradigm

Safer Options Train-the-Trainer Curriculum
Lesson 2  Four Ethical Standards

Four Ethical Standards

When providing treatment for people who have committed sexual offences or have problematic sexual behavior it is extremely important to talk about bad behavior, not a bad person. The ethical standards represent core values that all programs should maintain when providing best practices treatment. These standards are a framework to measure treatment decisions in a clear and concise manner.

The following four ethical standards were developed by Kathy Aiken and Saul Schoenberg (Vermont) to support people who have intellectual disabilities and have sexually offended.

- Community Safety First
- Victim Centered
- Respectful Treatment
- Safety for the Offender

It is critical that everyone working with a person with problematic/sex offending behavior understand how these standards support treatment by teaching people how to manage their behavior while holding them responsible and accountable for their behavior. The standards provide a best practices structure that agencies should use when making treatment decisions. This is important because supports for people who have serious problematic or offending sexual behaviors are quite different from supports for people who do not. The obvious difference is that failure to properly support a person can result in the victimization of another person.
Agencies and staff must have a justification for treatment decisions that at times can be restrictive. Agencies should understand, and agree to implement the Ethical Standards when treating people with problematic or offending sexual behavior.

**Ethical Standards**

**Community Safety First**
- Importance of appropriate disclosure
- Progress in treatment (content based) lowers level of risk

**Victim Centered**
- Protect and respect the victim(s), past and potential
- Safety needs of victims are paramount – appropriate disclosure
- Enlist a victim advocate for input into policies and assisting with training

**Assure Personal Safety of the Person With Problematic Sexual Behaviors**
- In the clinical environment – informed consent
- In the family or residential environment – trained to support, supervise and monitor
- In the community environment – the importance of appropriate *disclosure*?

**Provide Respectful Treatment for the Person with Problematic Sexual Behaviors**
- Supportive, not punitive
- Meet individualized needs
- Maximize individual strengths

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1 Developed and presented by Kathy Aiken and Saul Schoenberg at the Safe Options Institute, Halifax, PA, 2001-2002.
Respectfully Limiting Choices

The standards are a way to think about things that the person wants to do. Each of these standards needs to be met if a decision is to move to action. It is the responsibility of the team to determine how each of these standards could be met through the use of creative methods of supervision and supports. It is used systematically every time a decision is made about what the person wants to do. The decision-making process is clearly documented in a safety plan. A team trying to make informed judgments about the person with problematic sexual behaviors should understand the following points:

- A good intervention meets all the standards.
- If you can meet all standards, liability decreases.
- If any one standard cannot be met, then a decision to move to action cannot be made.
- If you cannot meet any one of the standards, you should not be doing what the person wants at that time.
- If you cannot meet standards, liability increases.

We know that people with disabilities are victims of sexual crimes at a significantly higher rate than people without disabilities; they suffer from undiagnosed Post Traumatic Stress Disorder (PTSD) and often do not have access to therapy. When both the perpetrator and the victim are people who have intellectual disabilities, agencies have a responsibility to provide supports to both individuals.
Positive Approaches as a Paradigm

Positive Approaches (adapted from Mental Retardation Bulletin, DPWPA, 1991) is a worldview, a movement, in which all individuals are treated with dignity and respect, in which all are entitled to Everyday Lives.

Central elements of Positive Approaches include:

- **Getting to know each person, his or her unique qualities as well as his or her personal history.**
- **Working in collaboration and in a spirit of openness, honesty and equality.**
- **An examination of all aspects of the person’s life including each person’s living environment, relationships, activities and personal dreams.**
- **Encouraging us to see the reasons and adaptive qualities of the most troubling behavior.**

The implementation of Positive Approaches for people who have problematic sexual behavior, have had contact with the criminal justice system or are sex offenders requires that the values of the team reflect the reality of the person’s life. This means that Community Safety must be first, and if a person has broken a law they need to accept, acknowledge, and respect the consequences of their behavior.

The priority of the team is to implement the ethical standards, which means supporting the person in changing their offending behavior, helping them stay out of jail, and ensuring that the person is taking responsibility for their actions. This may include court ordered restrictions or team agreed-upon restrictions such as:

- **Going to a playground (if they have offended with children)**
- **Relationships (they should not be in proximity of their victims)**
- **Watching pornographic films (depends on the person, the offence, where they are in treatment and the content of the film)**
- **Unsupervised time**
- **Participating in a therapeutic support group**
- **Adhering to their restrictive behavioral plan**
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- Deviant Sexual Arousal
- Sexuality Education for People with Intellectual Disabilities
- Sexuality Issues Specific to People with Intellectual Disabilities

Safer Options Train-the-Trainer Curriculum
Lesson 12 – Sexuality Education

Few people with developmental disabilities have had access to quality, developmentally appropriate sexuality education and many people with intellectual disabilities have been victims of repeated sexual abuse. As a result, it is not surprising that many people have limited or incorrect understanding of relationships, boundaries, and appropriate sexual behavior.

To address sexual offending behavior it is important to provide people in treatment with; role models of positive healthy relationships, clear boundaries, accurate information, as well as supporting good interactions in the relationships that they already have.

It is essential that agencies that work with people with problematic sexual behavior to first understand normal sexual arousal, and normal sexual behavior.

Normal Sexual Arousal\(^2\)
The sexual response cycle (Masters & Johnson)

- Excitement phase
- Plateau phase
- Orgasmic phase
- Resolution phase

**Excitement Phase**

- Increased muscle tension (movements are restless, forceful and swift).
- Engorgement of blood vessels (especially in the genitals).
- Maculopapular sex flush (more common in women a red coloration from the neck area extending as far as the facial area).
- Increased heart rate.
- Increased blood pressure.

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\(^2\) This was a presentation made by John Eirdosh and Cass Lavin-Spause from Mainstay Services at the Transforming Ourselves Institute in Camp Hebron, PA, 2002-2003.
**Plateau Phase**
Excitement phase reactions continue and intensify.
Increased muscle tension most pronounced in men.

**Orgasmic Phase**
The sudden discharge of accumulated sexual tension resulting in rhythmic muscular contraction in the pelvic region and producing intensely pleasurable sensations followed by rapid relation.
Physiologically, psychologically and subjectively similar in men and women.

**Resolution Phase**
Body function slowly returns to normal.
Anatomy returns to original size and color:
Slower in women than with men
Women capable of returning to orgasm phase
Men experience “refractory period”

**Deviant Sexual Arousal**
Identifying whether or not the person has deviant sexual arousal is important because it will determine risk levels and allocation of resources. Determination is part of the task of administrators, clinical personnel and support people. Specific knowledge about the person will inform the team about treatment direction, and how supports should best be provided to the person to ensure community safety. For example, the presence of deviant arousal will affect the length of treatment and how decisions about reducing levels of supervision over time will be made.

**So what exactly is deviant sexual arousal?**
The process of developing a deviant arousal has long been the focus of discussion among many practitioners. Genetic predisposition, constitutional, physiological, developmental, and environmental influences, reaction to sexual trauma, observation and imitation of deviant behavior, “accidents” of conditioning history based on actual life experiences or misapplication of sexual behavior because of lack of opportunity, are often mentioned. What perhaps can be found across all these possible factors is that someone who masturbates to the deviant fantasies (no matter what the original reason might be) can re-enforce the deviant arousal process and literally become conditioned over time.

The pairing of heightened sexual arousal and orgasm with some object, event, fantasy, activity, or person produces powerful conditioned associations,
attachments, emotions and potent reinforces. Sexual reinforcement is so powerful; it can be extremely difficult for the person to alter certain types of sexual behaviors.

Deviant arousal in this context may be defined as the sexual arousal of an individual to thoughts and fantasies of sexual contact with children, or sexual arousal to thoughts and fantasies of forced sexual contact with anyone. In this situation, force is not only restricted to physical violence, but can include sexual arousal to themes of humiliation, manipulation or sexual arousal to themes about inflicting of pain.

Note: An actual offence is taking action on the thought or fantasy, not the thought alone.

**Paraphilias:**
- Psychosexual disorders.
- Recurrent, intense, sexually arousing fantasies, urges, and/or thoughts that usually involve humans, but may also include non-human objects.
- Suffering of one’s self or sexual partner, children, or non-consenting persons is common.
- A deviation in normal sexual interests.

**Some Paraphilias Are Legal (If Consensual)**
- Coprophilia – sexual interest or arousal to feces.
- Fetishism – use of non-living objects (e.g. shoes, undergarments etc) for sexual arousal that often involves masturbation.
- Klismophilia – sexual arousal from enemas.
- Sexual Masochism – sexual arousal/excitement from being humiliated, beaten, bound or made to suffer.
- Sexual Sadism – sexual arousal/excitement from psychological or physical suffering of another.
- Transvestic fetishism – wearing of clothing (especially undergarments) of the opposite sex.

**Some Paraphilias Are Illegal**
It is not illegal to have fantasies about these paraphilias; it is illegal to act on them.
- Exhibitionism – exposing one’s genitals to others for purposes of sexual arousal.
- Bestiality – Acting on a sexual interest or arousal to animals.
- Pedophilia – Acting on urges or behavior involving sexual activity with pre-pubescent children (usually 13 years old or younger).
- Hebophilia – Acting on sexual interest/arousal to post-pubescent children or teens (illegal when child is under the age of consent - which varies by state).
- Fotteurism – Acting on touching or rubbing against a non-consenting person.
- Necrophilia – Acting on a sexual interest/arousal to corpses.
- Telephone Scatology – Acting on uninvited, sexually explicit talk with another person via the telephone.
- Voyeurism – Acting or observing unsuspecting individuals, usually strangers, who are naked, in the act of dressing or undressing, or engaging in sexual activities.

Sexuality Education for People with Intellectual Disabilities

Aside from deviant sexual arousal, people who have intellectual disabilities may develop problematic or offending sexual behaviors as a result of their life experiences. David Hingsburger’s work on Counterfeit Deviance is extensive.

Following are examples of life experience issues that can contribute to offending behaviors:

- Little or no access to sexuality education therefore they limited information about how their body functions
- Lack masturbatory skills due to a physical disability or to medication that lowers arousal
- Have a lack of privacy
- Lack of social skills and/or opportunities to practice
- Blurred boundaries, especially if they need help with personal hygiene
- Hyper sexuality may be the result of an additional diagnosis of mania

People with sexual offending behavior need to learn about positive sexuality as part of their therapeutic program. The therapist usually decides at what point sex education will be helpful and what the content of that education should be. The items listed below are topics that could be included in this type of sexuality education program.

Content of Sex Education Groups

- Confidentiality – themselves and others
- Boundaries – physical, personal, emotional
- Human Development / Bodies and how they work
- Relationships – Understanding all types of relationships
- Safety / Sexual Abuse Prevention
- Rules and Laws
- Sexual Health
- Sexual Behavior / Consent
- Communication and Decision Making in Relationships
Sexuality Issues Specific to People with Intellectual Disabilities

At times the way that people with Autism and Intellectual Disabilities experience relationships, puberty, and sexuality are different from their non-disabled peers. Their different life experiences can result in misunderstandings or social mistakes that have serious consequences, but are not necessarily sex offending behavior.

Some of these problem areas are:

- Hugging and talking to strangers
- Primary information about relationships, sex and sexuality from movies and on TV
- Not understanding what is public and what is private
- Stalking behavior that they view as trying to ‘get’ a girl/boy friend
- Depending on staff for personal hygiene, which at times means a complete stranger is physically touching them
- Going to a pornography site on the internet and accidently getting to a ‘kiddy’ porn site
- If people have been victims of sexual abuse they may have a confused understanding of sexual relationships and/or sexual behavior.
- Staring at women’s’ breasts (peers or staff) and becoming aroused.

To further complicate the issue many people do not know or understand the laws that relate to illegal sexual behavior. We can not expect the people we support to follow the laws if we do not know them. It is the responsibility of every team to understand the law as it relates to sexual behavior.
C. Pennsylvania Sexual Assault Laws

Topics
The Law
Legal Status of People with Intellectual Disabilities
Consent
Victims of Sexual Offences

Safer Options Train-the-Trainer Curriculum
Lessons 3 – Pennsylvania Law
Lesson 10 – Consent, Sexuality and People with Intellectual Disabilities
Lesson 11 – Victimization, PTSD and People with Intellectual Disabilities

Appendix # 1
Pennsylvania Sexual Offences Statutes

The Law

It is important for all people who work in the field of intellectual disabilities to have a clear understanding of Pennsylvania Law as it relates to sexuality. The Safer Options Manual has included a brief section on; Pennsylvania Laws, Consent, and Victims of Sexual Assault. This information is fundamental to a best practices treatment program. When working with people who problematic sexual behavior it is the responsibility of the team leader to teach Pennsylvania laws to the team so everyone is clear when a law is, or is not broken. In that way the person with disabilities, and the team are able to follow the laws and keep the community safe.

This knowledge is also a cornerstone of treatment for the person with problematic or offending sexual behavior because he or she may not know what is legal and illegal in any given situation.

Legal Status of People with Intellectual Disabilities

Some people with intellectual disabilities are “incompetent to stand trial and unable to participate in their defense” because of their cognitive impairments. This means that they can never be convicted of a sexual crime and never be on probation or parole, so it is critical that the people supporting these individuals are well informed and have the authority and ability to develop safety plans and assign appropriate supervision. It is difficult to mandate treatment for a person who has no 'legal' charges but it is also critical to supervise and educate the person so that they begin to learn control and experience consequences for their behaviors.
When people with developmental disabilities are charged and convicted of sexual crimes and are sentenced to prison, probation, and/or parole, it is essential for the system that supports them to understand the rules of the criminal justice system and work cooperatively with them towards similar treatment goals.

**Consent**

The issue of consent to sexual activity is a difficult one. On one hand we encourage and assist people so they can have fulfilling and respectful intimate relationships, but on the other hand we have a responsibility to protect vulnerable people.

Consent is important because it helps determine and define:

- **Safe respectful relationships**
- **Rights and Responsibilities**
- **When sexual abuse and victimization are occurring**
- **When a couple has the right to privacy and an intimate sexual relationship**

Consent is determined by the ability of a person to demonstrate knowledge, understanding, and voluntariness of sexual intimacy in a within a relationship.

**Knowledge** – Information about how their bodies work, pregnancy, sexuality, sexuality transmitted infections, and other information that is relevant to keeping them safe in a sexual relationship.

**Understanding** – The ability to understand boundaries, relationships, birth control, pregnancy, sexual health,

**Voluntariness** – The ability to listen, respect, and say YES and NO

**Note:** It is not necessary to do a Consent Evaluation on everyone. People who do not need a consent evaluation fall into two groups, those who clearly cannot give consent and those who clearly can give consent.

Who needs a consent determination?
- People who are in a relationship that is or could become sexual
- People who are developing a relationship that is or could become sexual
- People that you are not sure about their ability to give consent

Over the past few years a number of tools have been developed to clinically (not legally) determine if a person with developmental disabilities has the ability to give consent to sexual relationships. These tools can provide agencies and staff the structure they need to support the development of healthy, loving, intimate,
and safe sexual relationships. These tools can also help agencies protect people from harm. None of these tools can provide a legal determination of a person’s ability to give sexual consent.

**ABILITY TO GIVE CONSENT TO SEXUAL RELATIONS**

<table>
<thead>
<tr>
<th>Capability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capable of Giving Informed Consent – General</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Capable of Giving Informed Consent – Partner Specific</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Not currently capable - Education indicated</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Not Capable of Giving Informed Consent</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

**Confidentiality and consent** issues are raised when an agency completes a consent evaluation. It is important to be aware of these questions and be able to answer them.

- Who needs to know?
- Where is information filed?
- Are parents notified of the evaluation?
- Are parents notified of the results?
- What if another agency is involved?
- What if the person’s partner lives at home with their family?
- What if the person doesn’t want anyone to know the results?

**List of Consent Assessment Tools**

Tools that can help determine the ability of a person to give consent for a sexual relationship:

- **Young Adult Institute (YAI)**
- **AAMR – Consent for Professionals**
- **AAMR – Consent for Self-Advocates**
- **VISCAT – Verbal Informed Sexual Consent Assessment Tool**
- **SSKAAT-R - Socio-Sexual Knowledge and Attitudes Assessment Tool-Revised**
Victims of Sexual Offences

All treatment programs need to be Victim Centered. Many people with developmental disabilities have been victims of sexual assault; some studies document the numbers of victims with developmental disabilities to be as high as 90% for women and 60% for men. It is likely that many people with sex offending behavior have also been victims of sexual abuse. If this is true both their offending and their victimization need to be addressed.

It is important to understand the impact of sexual violence on victims and those close to them. In some cases victimization is a contributing factor to offending and it is our challenge to determine if the people with sex offending behavior in our treatment program also have Post Traumatic Stress Disorder (PTSD). This is not an excuse for sex offending behavior; however, it could help in treatment and in the development of empathy for their victims.
D. Treatment Team

Topics

The Team
Confidentiality
Responsibility and Accountability
Characteristics of an Effective Team
Other Ways of Knowing: A Team Process over Time
Stages of Group Development

Safer Options Train-the-Trainer Curriculum
Lesson 6 - The Treatment Team

The Team

A treatment team working with a person with sex offending behavior has significantly more responsibility than the traditional team. Over-supervision beyond what is necessary can result in the person giving up hope and losing motivation to change their behavior. If the team under-supervises, there can be more victims.

Offending behavior is unique in the amount of secrecy, manipulation, and compulsiveness presented by perpetrators; this can be very challenging for a treatment team. It is important to understand that not all people can or should work with people who have sexual offending behaviors. They will do more harm than good; therefore participation on these treatment teams is most effective if all of the team members have agreed to work with this complex population, and are not assigned.

Central to the development of a functioning, and effective team for a person with problematic/offending behavior are the items listed below:

- Understanding the role and responsibilities of the treatment team
- Confidentiality
- Understanding characteristics of an effective team
- Team management
- Understanding Group Dynamics
  - Forming, Storming, Norming, Performing
- No Team Splitting / Community Safety First
- No Lies, No secrets between anyone on the team
- A conflict resolution process must be in place
- Participation by the criminal justice system (if appropriate)
- Clinical leadership
Confidentiality

All members of the team managing and treating individuals with intellectual disabilities who have problematic sexual behaviors must have access to the same relevant information. Sexual offenses are committed in secret, and all forms of secrecy potentially undermine the rehabilitation of the person and threaten public safety. If confidentiality can not be waived, the effectiveness of the team will be compromised. In order to provide adequate support, all members must have the same information so communication is facilitated between team members and treatment or support providers.

Everyone does not need to know everything but the basic issues related to targets, red flags and goals need to be common knowledge for the support network, which can include therapist, family, direct care staff, probation or parole, employer, supports coordinator, and anyone who is providing direct support to the individual.
Responsibility and Accountability

The Following Should Be Understood, Accepted, Agreed Upon and Honored by Everyone on the Team

We as a group see the need for the person to be held responsible and accountable for his or her actions, and to assume the consequences of those actions. We should be clear that in order to effectively provide support we too need to be responsible and accountable. A double standard is not useful or helpful for either the person or for us. Looking at someone else’s need to be held accountable and responsible for his or her contribution to an event, or to a series of events, can be extremely counterproductive and potentially dangerous if we don’t first take responsibility for, and become accountable for, our contribution to the same event or series of events. Similarly, the same standards should apply to our organizations, administrations and various systems.
Characteristics of an Effective Team\textsuperscript{3}

Working with People Who also have Problematic Sexual Behaviors

- Mission must be: COMMUNITY SAFETY FIRST
- This must be a shared mission and all must agree
- The respect and dignity of team members are critical
- Climate of trust and openness
- Confidentiality must be waived
- Open honest communication
- Absolutely no secrets
- Team members are interdependent
- Team creativity is okay, but risk-taking is not
- ALWAYS ERR ON THE SIDE OF SAFETY
- Avoid splitting
- Shared and agreed upon conflict resolution and group processes are in place
- Team has good clinical and organizational leadership
- Team has well-established, ongoing supervision, mentoring, values clarification and training for team members
- Team culture is consistent and coherent with mission of the team

\textsuperscript{3} Adapted from the presentation done by Kathy Aiken and Saul Schoenberg at the Safe Options Institute, Halifax, PA, 2001-2002.
Other Ways of Knowing: A Team Process over Time

A good team recognizes the limits of assessment tools and realizes that getting to know the person well and really looking at the person they are supporting, both in terms of history and current actions can help them better assess or evaluate the person’s needs and how to make good decisions about risks.

Programs that provide support and treatment to people who have problematic sexual behaviors should have the ability to:

- Complete a thorough Biographical Timeline
- Create a history (across settings and systems) of sexual problems or issues
- Recognize the presence of questionable sexual problems or issues for the person
- Recognize the presence of patterns over time in the person’s history
- Recognize the presence of, and to list, the risk factors
- Recognize, document and monitor “red flag behaviors”
- Complete a thorough and detailed baseline
Stages of Group Development

Scott Peck conceptualizes the four stages of group development as Pseudo Community, Chaos, Emptiness, and Community. For the purposes of our work, they can be explained as follows:

**Pseudo Community** – (Forming): This is the first stage of working together as a group. Everyone is trying to be pleasant, sometimes faking it, and avoiding all disagreement.

**Chaos** – (Storming): The second stage reflects the raw emotions of members and can be emotional, noisy, and an expression of strong opinions that are in opposition to other group members.

**Emptiness** – (Norming): The third stage is where members have ‘let go’ and are now listening to each other. Opinions are expressed, feelings shared in a positive and helpful manner; emptying oneself of barriers to communication; i.e., expectations and preconceptions, prejudices, ideologies, and theology, and begin to move toward creating solutions.

**Community** – (Performing): The forth and last stage is where all teams should function – with honesty and with the ability to struggle through and resolve conflict.
E. Baseline Assessment, Supervision & Ongoing Risk Assessment

Topics
Baseline Assessment
   Recommended Background / Assessment Information
   Assessment: A Process Not an Event
   Static – 99 and RRASOR Scoring Sheet
   Vermont Assessment of Sex-Offender Risk
Supervision
   Risk Management and Supervision Protocol
   Safety Plan
   Protocol for Bathroom Use
Matching Supervision to Risk
   Plan for Supervision
   ARMADILLO –S Worksheet - James Haaven 2010
Safer Options Train-the-Trainer Curriculum
   Lesson 4 - Assuring, Measuring and Managing Risk
Appendix # 2
   ARMADILLO – Haaven 2010

Baseline Assessment

A psychosexual evaluation may represent the first formal opportunity to collect and organize information from diverse sources, organizations and service providers, into one document.

Risk Prediction is essential; however, most of these predictors are not normed for individuals who have intellectual disabilities therefore all materials should be adapted to meet the cognitive needs of this population. In addition, several approaches, never one, should be used (i.e. interviews, school records, incident reports, earlier evaluations, etc).

For a baseline risk assessment to be completed there must be at least one documented sexual offence. It cannot be used with people who have problematic sexual behavior – only with those who have documented offences, whether charges have been filed or not. There are a range of assessment tools used by trained professionals to assess risk to reoffend.
These assessments include:
- Psychosexual Evaluation
- ABEL Assessment for Sexual Interest
- Clinical Polygraph
- Phallometric Assessment / Penile Plethysmography
- Rapid Risk Assessment for Sex Offense Recidivism (RRASOR)
- Vermont Assessment of Sex-Offender Risk, Static 99, VASOR

Recommended Background Assessment Information

- Identifying and Referral Information
- Reason for Referral
- Sources of Information / Documents Reviewed
- Personal and Social History
- Sexual History / Sexual Knowledge
- History of Abuse / Victimization
- Previous Psychological Testing
- Mental Status
- Assessments Of Cognitive And Adaptive Functioning
- Social And Family Histories
- Data From Support Staff And Placement History
- Anecdotes
- Current Sexual Offence
- Prior Sexual Offences
- Police Affidavits
- Other Criminal Behavior
- Criminal Record Checks
- Victims And Witness Statements
- Previous Treatment And Assessment Reports
- Information About Prior Offense Behavior And Other Behaviors Contained In MH, MR And School Records
- Medical History
- Psychiatric History
- Test and Inventory Results
- Self-Report has some limited value, and no assessment should be based solely on the person’s self-report

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4 Presented by Saul Schoenberg at the Transforming Ourselves Institute, Camp Hebron, PA, November 2002.
ASSESSMENT: A PROCESS, NOT AN EVENT

Assessment Techniques and Tools

Cautionary Note:

No one single tool should be used to complete a good assessment, rather use a battery or combination of tools over time to get a better clinical picture of the issues. Assessments should be completed by well-trained and experienced professionals, clinicians with experience in assessing and treating individuals with problematic sexual behaviors.

Does this assessment contain/include more than one tool or modality?

☑ Yes
☐ No

If yes, which of the following does it include?

☑ PPG (only “tool” validated and not with folks who also have mental retardation)
☐ Abel Screen
☐ Card-sort
☐ Motivational Interviewing
☐ ARMADILLO

Actuarial Risk Predictors

☑ Static-99
☑ RRASOR
☑ VASOR
### Static - 99 and RRASOR Scoring Sheet

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Scoring Codes</th>
<th>Static-99 Score</th>
<th>RRASOR Score</th>
</tr>
</thead>
</table>
| 1. Prior Sex Offenses                             | None  
1 conviction or 1-2 charges  
2-3 convictions or 3-5 charges  
More than 5 convictions | 0  
1  
2  
3 | |
| 2. Prior Sentencing Dates (excluding index)       | 3 or less  
4 or more | 0  
1 | |
| 3. Any Convictions for Non-contact Sex Offenses   | No  
Yes | 0  
1 | |
| 4. Index Non-sexual Violence                      | No  
Yes | 0  
1 | |
| 5. Prior Non-sexual Violence                      | No  
Yes | 0  
1 | |
| 6. Any Unrelated Victims                          | No  
Yes | 0  
1 | |
| 7. Any Stranger Victims                           | No  
Yes | 0  
1 | |
| 8. Any Male Victims                               | No  
Yes | 0  
1 | |
| 9. Young                                         | Age 25 or older  
Age 18-24.99 | 0  
1 | |
| 10. Single                                       | Ever lived w/ lover for at least 2 years?  
Yes  
No | 0  
1 | |

**TOTAL SCORE**

---

Vermont Assessment of Sex-Offender Risk

Re-offense Risk Scale

1. Prior Sex Offense Convictions
   none=0    one=10    two or more=20

2. Prior Adult Convictions
   (Do not count items on #1 or #3)
   none=0    one=1    two or three=3
   four to six=5    seven or more=10

3. VOP's and Other Court Order Violations During Past Five Years
   none=0    one=2    two or more=5

4. Force Used During Current Offense
   hands-off offense=0    hands-on offense=5
   force greater than necessary to gain compliance
   or clear threats of physical harm to victim or others=8
   use of potentially deadly weapon=10

5. Relationship to Victims
   living with at time of offense=0
   nonresidential relative/acquaintance=5    stranger=10

6. Male Victim and/or History of Exhibitionism
   none=0    yes=10

7. Deviant Sexual Fixation
   Single victim and history of consenting, age appropriate
   sexual relationships=0    two to four victims and history
   of consenting, age-appropriate sexual relationships=5
   five or more victims and/or little or no history of
   consenting, age-appropriate sexual relationships=10

8. Alcohol Abuse during Past Five Years
   no problems=0    some legal or social problems=3
   serious life disruptions=5

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9. **Drug Abuse during Past Five Years**
   - no problems=0
   - some legal or social problems=3
   - serious life disruptions=5

10. **Address Changes during Past Year**
    - none=0
    - one=2
    - two or more=5

11. **Time Employed or in School during Past Year**
    - 60% or more=0
    - 40-59%=2
    - under 40%=5

12. **Reoffense During or After Treatment, or Terminated Unsuccessfully from Treatment**
    - none=0
    - yes=20

13. **Amenability to Treatment**
    - full or partial admission and willing to participate in treatment=0
    - denies offense or unwilling to participate in treatment=10

   **TOTAL**

**Violence Scale**

1. **Prior Convictions for Crimes Involving Violence**
   - (Count prior hands-on sex offense convictions)
   - none=0
   - one=5
   - two=10
   - three=15
   - four or more=20

2. **Prior Conviction for a Crime Involving a Potentially Deadly Weapon**
   - none=0
   - yes=15

3. **Force Used During Current Offense**
   - hands-off offense=0
   - hands-on offense=5
   - force greater than necessary to gain compliance or clear threats of physical harm to victim or others=15
   - use of potentially deadly weapon=30

4. **Sexual Intrusiveness of Current Offense**
   - hands-off=0
   - fondling=3
   - digital penetration, fellatio, or cunnilingus=5
   - actual or attempted penile penetration of vagina or anus=10
   - bizarre or ritualistic behavior=20
5. Physical Harm to Current Victim
no medical treatment required=0   injury not requiring formal medical attention=10   treated for injury and released=20   hospitalized=30

6. Victim Under Age 5, Over Age 55, or Mentally or Physically Disadvantaged
no=0   yes=10

TOTAL
SUPERVISION

Appropriate supervision requires that the team evaluate each person on a regular basis. Do their words match their behavior, are they attending therapy, have they been caught lying, and what is their overall mood? These and many other pieces of information are reviewed to determine what supervision is appropriate for a person with offending behavior.

A cornerstone of all supervision plans is the regular use of a Safety Plan. An example of a safety plan follows. Teams should be cautioned that safety plans can lose their effectiveness if the staff or person with offending behavior views completing the safety plan as routine and stops thinking about the content and purpose of each safety plan.
General Principles and Guidelines in Supervising and Monitoring Someone with Problematic Sexual Behaviors

Community Safety is defined by a combination of the supervision we provide to the person with problematic sexual behaviors and the treatment that person achieves over time. Each person with problematic sexual behaviors has an individualized “Plan for Supervision.” Each “Plan for Supervision” is a detailed description of the types of supervision that individual will receive in the various environments in which the person interacts.

The higher the risk, the more intense the level of supervision needs to be. The higher the risk, the more true the following principles and guidelines must be.

- The written plan for supervision provides the only statement of what minimum supervision requirements are for each person with problematic sexual behaviors.

- No one is permitted to decrease supervision of a person with problematic sexual behaviors to levels of greater independence than those set forth in this plan.

- Individual Safety Plans and a greater level of supervision may be initiated (at the support staff’s discretion) at specific times when risks are increased.

- Direct support staff can increase supervision as needed, but they can never decrease supervision on their own.

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7 Developed and presented by Saul Schoenberg, Director, Resolutions Program, Inc., Clinical Supervisor, Safe Choices Program, and Kathryn D. Aiken, Coordinator, Safe Choices Program.

8 This section of the document has been adapted from a policy statement presented by John Eirdosh and Cass Lavin-Spause from Mainstay Services at the Transforming Ourselves Institute in Camp Hebron, PA, 2002-2003.
When the support staff's discretion and judgment are used to increase supervision, an incident report describing the degree of increased supervision and the risks that supported that decision must not only be completed, but must also be reported immediately to the team leader.

Verbal authorization from one team member is never acceptable to decrease the levels of supervision. Any changes to the levels of supervision must be part of the team process and part of that person's “Plan for Supervision.” This does not include emergency circumstances. Emergencies are defined as sudden and/or unexpected situations in which proper staffing levels are not provided. During emergency circumstances, a supervisor or management staff may determine specific alternative supervision arrangements while the emergency is being resolved.

The times around “shift changes” are critical for direct support staff who are supervising a person with problematic sexual behaviors therefore it is critical that supervision levels are maintained during these periods. For example, direct support staff from the ending shift may not leave work until the full complement of incoming direct support staff has arrived. Failure to maintain staffing ratios during this time will be considered a violation of the expectations we have as a team and the critical role we have to play in ensuring Community Safety.

Everyone needs to understand how critical and essential supervising and monitoring can be when the individual presents a significant risk of engaging in problematic sexual behaviors. Following are examples of bathroom protocols and should demonstrate how thoughtful a team needs to be when supporting someone with problematic sexual behaviors.
Safety Plan

Name: __________________________

Date: ____________________

Where do you want to go?

What will you be doing?

What are the risks?

How will you stay safe?

Who will be with you?

How will you be supervised?

How long will you stay?

What would cause you to leave?

Other plans:

This plan is a request to go out. The therapy group and the Director must approve it. Be sure to hand this in to allow enough time for people to review it.

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9 This tool was adapted from a presentation made by John Eirdosh and Cass Lavin-Spause from Mainstay Services at the Transforming Ourselves Institute in Camp Hebron, PA, 2002-2003.
An Example: Protocol for Bathroom Use

This is an important topic because bathroom use is a unique situation that we cannot always control and that may result in the need for special circumstances to maintain supervision levels. Remember – the supervision levels specified in the Plan for Supervision are to be followed at all times.

This protocol will cover the following topics:

- Prevention of the need for special circumstances
- The staff’s use of the bathroom when in the residence
- The staff’s use of the bathroom when in the community
- The individual’s use of the bathroom when in the community

Public bathrooms may present special challenges to individuals with problematic sexual behaviors because of the unintentional or deliberate viewing of other people’s private body parts. This is especially true of young boys, who will often drop their pants when learning to use the urinals. In these ways, predatory as well as opportunistic offenders are at added risk when unsupervised in public bathrooms.

Prevention: The planned use of bathroom facilities is the best method to avoid situations in which supervision issues may be a concern. This means that team members should use the bathroom facilities before and after coming to work, during shift overlap times, or when other team members are present. Team members and the person with problematic sexual behaviors should always use the bathroom facilities prior to going out on a community outing. Whenever possible, staff that supervises the person with problematic sexual behaviors in the community should be the same sex as the individual. This will allow for more flexibility in the bathroom supervision.

Staff Use: It is important to highlight the need for team members to maintain their privacy when using the bathroom facilities. It is a boundary violation to allow a person with problematic sexual behaviors to observe you while you are using the bathroom. Visual contact is not desirable as the means of supervising the person with problematic sexual behaviors when team members are using the bathroom. Keep doors closed.

This section of the document has been adapted from a policy statement presented by John Eirdosh and Cass Lavin-Spause from Mainstay Services at the Transforming Ourselves Institute in Camp Hebron, PA, 2002-2003.

10
In The Residence: If you need to use the bathroom facilities during the course of your shift, please follow these precautions:

- Involve the person with problematic sexual behaviors in a specific activity while you are in the bathroom.
- Engage the person with problematic sexual behaviors in a conversation while you are in the bathroom and he or she is outside of the bathroom.
- Use the cell phone to call the person with problematic sexual behaviors on the house phone and engage in a conversation.
- Listen for the door/window alarms, responding immediately if they are activated.

In The Community with Same-Sex Client: If the need to use the bathroom facilities arises during the course of a community outing, please follow these precautions, if the person with problematic sexual behaviors is the same sex as the team member:

- Use a multi-user public bathroom when available.
- Have the person with problematic sexual behaviors in the bathroom with you (but not in the stall).
- If only single-user bathrooms are available, engage the person with problematic sexual behaviors in a phone conversation via the cell phone and a nearby public phone.
- Request assistance from an official person (owner/operator/employee of a store; police or security guard; or, lastly, a well-intentioned community member) to temporarily supervise the person with problematic sexual behaviors while you use the facilities. (Important: You must not disclose sexual information about the individual. Rather tell the helper that this is an emergency, and this individual needs to be watched all of the time.)

In The Community with Opposite-Sex Client: If the need to use the bathroom facilities arises during the course of a community outing and if the team member is the opposite sex of the person with problematic sexual behaviors, please follow these precautions:

- Engage the person with problematic sexual behaviors in a phone conversation via the cell phone and a nearby public phone.
- Request assistance from an official person (owner/operator/employee of a store; police or security guard; or, lastly, a well-intentioned community member) to temporarily supervise the person with problematic sexual behaviors while you use the facilities. (Important: You must not disclose sexual information about the individual. Rather tell the helper that this is an emergency, and this individual needs to be watched all of the time.)
Use by Person with Problematic Sexual Behaviors, In the Community with Same-Sex Staff: The person with problematic sexual behaviors is to be supervised in the use of bathroom facilities at all times when in the community. This does not mean the individual is to be observed while eliminating; rather, the person is to be supervised to the point at which the individual is in a safe situation to use the facilities. Team members need to follow these precautions:

- Use single-user bathrooms whenever available (not handicapped-only accessible bathrooms).
- Accompany the person with problematic sexual behaviors to the single-user bathroom; assure the bathroom is vacant when the person enters and wait outside of the single-user bathroom until the individual is finished.
- Accompany the person with problematic sexual behaviors into multi-user bathrooms; check first for children in the bathroom and wait until children leave.
- The person with problematic sexual behaviors should use the stall for added privacy in multi-user bathrooms.
- Remain inside the multi-user bathroom until the person with problematic sexual behaviors is finished.

Use by Person with Problematic Sexual Behavior, In the Community with Opposite-Sex Staff:

- Use single-user bathrooms whenever possible (even handicapped-only accessible bathrooms).
- Accompany the person with problematic sexual behaviors to the single-user bathroom; assure the bathroom is vacant when the person enters and wait outside of the single-user bathroom until the individual is finished.
- When only multi-user bathrooms are available, wait immediately outside of the bathroom entrance; ask an exiting bathroom patron if the bathroom is empty – try to wait until the bathroom is empty.
- Request that children (with or without parents) wait to enter until the person with problematic sexual behaviors exits.
- Request assistance from an official person (owner/operator/employee of a store. police or security guard; or, lastly, a well-intentioned community member) to temporarily supervise the person with problematic sexual behaviors while the person uses the facilities. (Important: You must not disclose sexual information about the individual. Rather tell the helper that this is an emergency, and this individual needs to be watched all of the time.)
Every team member is responsible for and must be knowledgeable of the Plan for Supervision for the individuals with problematic sexual behaviors with whom they work.

Failure to be knowledgeable is dangerous and irresponsible. It places both the person with problematic sexual behaviors and the team in a very dangerous position. In this work and in this team, willful disregard of the “Plan for Supervision” for any individual with problematic sexual behaviors will result in the immediate termination of the team member. Other failures to follow the “Plan for Supervision” will result in disciplinary actions up to, and including termination.
MATCHING SUPERVISION TO RISK

The first step in treatment is to measure the risk to re-offend. This process will enable the treatment team to determine the beginning level of supervision and treatment.

The evaluation of a persons risk to re-offend consists reviewing the persons past history of offences, their biographical history, as many relevant records as possible, reports from the criminal justice system, a baseline assessment of risk at the start of treatment, and ongoing risk assessments throughout treatment. A good risk assessment is based on the review of past and current information from numerous sources over time. No one source of information should ever be used to evaluate risk.

Participants will learn how risk is assessed initially and measured over time. Risk to re-offend is determined by compiling comprehensive data that includes the persons history of offences, current or past involvement with the criminal justice system, the current environment (access to targets), evaluations/assessment tools that measure the risk to re-offend, current life stressors, family/staffing issues and direct staff input, etc.

All members of the team should be involved in evaluating/ reevaluating risk to re-offend. The team should discuss information such as; how has the person been interacting with family/staff, has the person been actively participating in therapy? What do assessment tool(s) conclude? Has the person been demonstrating internal controls?

Risk should be discussed at every team meeting, although frequent changes in supervision do not need to be made. Probation/parole and the therapist have significant input in determining the level of risk and supervision.

The two instruments that follow 1) Plan for Supervision and 2) ARMIDILLO-S Worksheet are examples of ways to measure a person’s risk to reoffend. The ARMIDILLO has been used effectively for a number of years as a way to match the supervision required to a person’s risk to reoffend.
Plan for Supervision

Name: ___________________________ Date: ______________________

The staffing ratio will be: ______ staff assigned to ____________ person

☐ This ratio will be in effect at all times except as noted below.
☐ There will be no exceptions to this staffing ratio.

Other supervision requirements:

_______ staff assigned to ____________ person in the following setting:
________________________________________________________________

_______ staff assigned to ____________ person in the following setting:
________________________________________________________________

_______ staff assigned to ____________ person in the following setting:
________________________________________________________________

In the home, the person requires the following level of supervision:

☐ Arm's length contact
☐ Maintain a distance of not more than 15 feet
☐ Maintain in field of vision
☐ Know precise whereabouts at all times
☐ Unsupervised time is allowed as described below:
________________________________________________________________

Does the supervision change when the person is in the home bathroom?

☐ NO
☐ YES, specify: ____________________________________________

Does the supervision change when the person is sleeping?

☐ NO
☐ YES, specify: ____________________________________________

---

11 This tool was adapted from a presentation made by John Eidosh and Cass Lavin-Spause from Mainstay Services at the Transforming Ourselves Institute in Camp Hebron, PA, 2002-2003.
Does the supervision change in any other situation?

☐ NO
☐ YES, specify: ____________________________________________

In the **community**, the person requires the following level of supervision:

☐ Arms length contact
☐ Maintain a distance of not more than 15 ft.
☐ Maintain in field of vision
☐ Know precise whereabouts at all times
☐ Unsupervised time is allowed as described below:
________________________________________________________________________________________

On the **job**, the person requires the following level of supervision:

☐ Arms length contact
☐ Maintain a distance of not more than 15 ft.
☐ Maintain in field of vision
☐ Know precise whereabouts at all times
☐ Unsupervised time is allowed as described below:
________________________________________________________________________________________

Approved supervisors include:

☐ All staff of the team
☐ Specially-trained staff of the team, specify: _________________________________
☐ Probation officer
☐ Case manager
☐ Therapeutic staff of the program
☐ Family members, specify: _________________________________________
☐ Others, specify: _____________________________________________________

Is special technology required for the supervision of this person?

☐ NO
☐ YES, specify: _______________________________________________________

This Plan for Supervision has been reviewed by the Director.

_________________________________________  ___________________________
Signature                                      Date
ARMIDILO-S Worksheet
(Haaven, 2010)

Client_______________         DOB___________             Date______________

Referral purpose ____________________________________________________________

Current residence (where/type) ______________________________________________

Vulnerable others (relationship, age, sex, vulnerability) __________________________

___________________________________________________________________________

Current level of supervision (home, community, other) __________________________

___________________________________________________________________________

Restrictions-_______________________________________________________________

___________________________________________________________________________

Sexual History:

**Offenses:** Chronological order/Details/ Age/Gender of victim/Supervision at
time

Sanction
## STATIC RISK BASELINE

<table>
<thead>
<tr>
<th>Static-99</th>
<th>Total Score ________</th>
</tr>
</thead>
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### RRASOR

<table>
<thead>
<tr>
<th>Prior sexual offenses</th>
<th>Any unrelated victims</th>
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<tr>
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<table>
<thead>
<tr>
<th>Any male victims</th>
<th>Young offender (18-25)</th>
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<tr>
<td>______</td>
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</table>

<table>
<thead>
<tr>
<th>Total Score ________</th>
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</table>

### STABLE CLIENT ITEMS

<table>
<thead>
<tr>
<th>Compliance with supervision and treatment</th>
<th>Risk - Protective (Y, S, N)</th>
</tr>
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<tbody>
<tr>
<td>_______</td>
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<table>
<thead>
<tr>
<th>Sexual deviance</th>
<th>Risk - Protective (Y, S, N)</th>
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<td>_______</td>
<td>_______</td>
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</table>

<table>
<thead>
<tr>
<th>Sexual preoccupation/sexual drive:</th>
<th>Risk - Protective (Y, S, N)</th>
</tr>
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<tbody>
<tr>
<td>_______</td>
<td>_______</td>
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<table>
<thead>
<tr>
<th>Preoccupation</th>
<th>Risk - Protective (Y, S, N)</th>
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### Sexual drive

<table>
<thead>
<tr>
<th>Masturbation frequency</th>
<th>Risk - Protective (Y, S, N)</th>
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</thead>
<tbody>
<tr>
<td>________</td>
<td>Where? ________________</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Masturbation boundaries</th>
<th>Risk - Protective (Y, S, N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Masturbation Problems</th>
<th>Risk - Protective (Y, S, N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td></td>
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</table>

### Offense management

<table>
<thead>
<tr>
<th>Risk - Protective (Y, S, N)</th>
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<tbody>
<tr>
<td>_______</td>
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</table>

### Emotional coping ability

<table>
<thead>
<tr>
<th>Risk - Protective (Y, S, N)</th>
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<tbody>
<tr>
<td>_______</td>
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</table>

### Relationships

<table>
<thead>
<tr>
<th>Risk - Protective (Y, S, N)</th>
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<tbody>
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<td>_______</td>
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### Impulsivity

<table>
<thead>
<tr>
<th>Risk - Protective (Y, S, N)</th>
</tr>
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<tbody>
<tr>
<td>_______</td>
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</tbody>
</table>
Mental health______________________________  ____  ____  __

Unique personal and lifestyle considerations  ____  ____  ____

____________________________________________

Substance abuse_________________________ Antisocial________________________

Problematic peers________________________

Protective (supervision level, etc.) ________________________________

**ACUTE CLIENT ITEMS**

Change in compliance with supervision or treatment  ____  ____  ____

______________________________________________

Change in sexual preoccupation/sexual drive  ____  ____  ____

______________________________________________

Changes in victim related behavior  ____  ____  ____

______________________________________________

Changes in emotional coping  ____  ____  ____

Changes in use of coping skills  ____  ____  ____

______________________________________________

Unique considerations  ____  ____  ____

______________________________________________

**STABLE ENVIRONMENTAL ITEMS**

Attitudes towards client  ____  ____  ____

______________________________________________
<table>
<thead>
<tr>
<th>Topic</th>
<th>Row</th>
</tr>
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<tbody>
<tr>
<td>Communication among support persons</td>
<td>_____ _____</td>
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<tr>
<td>Client specific knowledge by support persons</td>
<td>_____ _____</td>
</tr>
<tr>
<td>Consistency of supervision</td>
<td>_____ _____</td>
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<tr>
<td>Unique considerations</td>
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<tr>
<td>Situational consistency</td>
<td>_____</td>
</tr>
<tr>
<td>Staff modeling</td>
<td>____________</td>
</tr>
<tr>
<td>Sexual opportunity</td>
<td>______</td>
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<tr>
<td>Behavior reinforced</td>
<td>____________</td>
</tr>
<tr>
<td><strong>ACUTE ENVIRONMENTAL ITEMS</strong></td>
<td></td>
</tr>
<tr>
<td>Change in social relationships</td>
<td>_____ _____</td>
</tr>
<tr>
<td>Changes in monitoring</td>
<td>_____ _____</td>
</tr>
<tr>
<td>Situational changes</td>
<td>_____ _____</td>
</tr>
<tr>
<td>Changes in victim access</td>
<td>_____ _____</td>
</tr>
<tr>
<td>Unique considerations</td>
<td>_____ _____</td>
</tr>
</tbody>
</table>
F. Treatment and Therapy

Topics
Treatment and Therapy
  Providing Responsive Supports and Supervision
  Treatment and Supports Principals
  Good Lives Model
  Daily Journal - Old Me / New Me
  Anger Management Log
Monitoring Risk
  Risk Management and Supervision Protocol
  Best Practices: Having a Well Developed Support Plan
  Accountability of the Person with Problematic Sexual Behaviors
  Relapse Prevention: An Integrative Approach
Disclosure
  Disclosure Exercise

Safer Options Train-the-Trainer Curriculum
  Lesson 8 – Biological Timeline / Who is this Person?
  Lesson 9 – Essential Components of Treatment and Therapy

________________________________________________________________________

Treatment and Therapy

PROVIDING RESPONSIVE SUPPORTS & SUPERVISION
  Increasing the Effectiveness of Relapse Prevention

The relapse prevention model helps the person develop internal self-
management strategies. Supervision consists of monitoring and supporting
the person through the change process and requires verifying that what
the person says in groups or treatment is consistent with what other
members of the team or support network hear and see. Collectively, the
supervision and support network members will observe and interact with
the person almost constantly creating opportunities for team members to
see how well the person is actually integrating or incorporating real
changes in his life.
The support and supervision network should consist of the most important people in the person’s life, such as family members, friends, neighbors, and co-workers who help with a transition back to an everyday life in the community. The network should help the person work toward a healthy lifestyle and in developing and engaging in appropriate leisure or community activities and healthy friendships.

It is critical to understand and appreciate is Community safety comes first therefore we should always err on the side of safety and if a choice must be made, provide too much supervision rather than too little. As we move through the treatment process, we get to know and understand the person and their particular pattern and cycle. The treatment process is always content-based and not time-based therefore, the risk and supervision levels should be re-evaluated on a regular basis.

Any person with problematic sexual behavior, regardless of the original risk assessment, who begins to evidence an increase in risk, needs to be returned to a higher level of supervision.
TREATMENT AND SUPPORTS PRINCIPLES
A Practical Checklist

People with problematic sexual behaviors who also have a developmental disability usually develop their problematic sexual behaviors over a long period of time. These problematic sexual behaviors are unlikely to go away with casual treatment over a few months. These serious and complex problems call for responsive and intensive treatments and supports, involving a major commitment of time and energy.

Long before a single person is supported and treated, an organizational structure, as well as a clinical framework, needs to be in place for the direct support staff to help them accomplish clinical goals. An effective and responsive program for people with problematic sexual behaviors and intellectual disabilities:

- Must be a cooperative venture among all the agencies, organizations and systems that will be involved with the person.

- Must have confidentiality addressed so communication is facilitated between team members and treatment or support providers.

- Will need to develop a meaningful way to integrate very conflicting value systems, such as balancing and integrating community safety first with being person centered.

- Building in direct support staff training and supervision from the very beginning is necessary to develop an effective and responsive therapeutic program.

- Must be as voluntary as possible; being voluntary engages the person with problematic behaviors in working toward change.

- Will make sure that the person lives in a community setting that protects and respects the victim, expects accountability and responsibility, assures the safety of the community as well as the safety of the person, meets the individualized needs of the person maximizing the person’ strengths.

- Will explain that treatment is designed to help them recognize, change and control their problematic sexual behavior.
Will accommodate to the person who has limited reading, writing or verbal abilities. Direct support staff can become extremely useful (this doesn’t mean taking over, or ‘doing it’ for the person) in helping the person become accountable and take responsibility for his or her own behaviors.

Cognitive restructuring is an effective approach as long as what we are offering the person is adapted to that person’s learning style or processing limitations.

Using group and group process is a preferred approach in an effective and responsive program.

Will focus its initial interventions to assist the person in accepting at least some responsibility for the problematic sexual behaviors.

Since cognitive distortions serve to maintain problematic sexual behaviors, an effective and responsive program will help people to modify their cognitive distortions.

Will confront denial and cognitive distortions as well as educate the person about the role he or she plays in maintaining the problematic sexual behavior.

Problematic sexual behaviors are usually preceded by sexual fantasy and sexual arousal. An effective and responsive program will use treatment strategies designed to reduce a person’s deviant sexual arousal.

Will teach the person relapse prevention and develop with the person a variety of strategies to identify and interrupt these patterns and reduce the risk of re-offense.

Will help the person in establishing supervision networks and community supports to maximize the effectiveness of the relapse prevention work.

Many people with problematic sexual behaviors will ignore or minimize the consequences of their behaviors towards their victim. This inability to appropriately empathize with their victims may be causative and may help maintain their problematic sexual behaviors.

The process is more important than the task, for example, any safe activity is an opportunity for the person to work closely with direct
support staff, to develop a better understanding of him or herself ‘in the moment’ and also is an opportunity to practice doing something different than past behaviors.

☐ Open communication between direct support staff, other team members and the person in treatment is absolutely essential.

☐ Significant treatment and supervision violations (lapse behaviors) will be reported to the appropriate team member in a timely manner.

☐ Treatment progress will be evaluated using multiple sources of information. Self-reporting is useful but of limited value if other sources of information is unavailable.

☐ Safely using and organizing the environment is a powerful way to engage in and practice the use of what is being learned in treatment and therapy.

☐ Appropriate supervision networks, community supports and careful attention to program location are essential working toward community safety.
Good Lives Model

The following is an excerpt from Rehabilitation, etiology and self regulation: The comprehensive good lives model of treatment for sexual offenders. (Tony Ward & Theresa Gannon 2005)

The Good Lives Model (GLM) has its roots in positive psychology and humanistic traditions. By preserving the strengths of the Relapse Prevention model and providing offenders with the necessary conditions (e.g. skills, values, opportunities and social supports) for meeting human needs in more adaptive ways, the assumption is that they will be less likely to harm others or themselves. (Ward & Stewart. 2003). The treatment approach is deeply ecological (includes environment, cultural and social factors), multi-systemic, developmental, concerned with risk management and humanistic and scientific values, and it is clear on how and why relationship factors are critical aspects of treatment.

The Good Lives Model formulates a theory of rehabilitation and contains three related components: (a) an overarching set of rehabilitation values and principles. (b) A set of etiological assumptions and (c) a set of treatment principles and strategies. The GLM should help clinicians to develop a treatment plan that focuses on capability/strength enhancement and risk management. Using standard cognitive behavioral interventions, where appropriate, the GLM should result in clinical practice that that is deeply respectful of offender’s status as human beings, but mindful of the fact that they have committed harmful actions against children and adults. The integration of therapeutic and moral values is a necessary treatment task and cannot be avoided.
Daily Journal - Old Me / New Me

The OLD ME behavior I did today was

________________________________________________________________
________________________________________________________________
________________________________________________________________

The NEW ME behavior I did today was

________________________________________________________________
________________________________________________________________
________________________________________________________________

STAFF Comments

Please comment on how the client participated in the journal writing activity. At a minimum, sign your name if you helped with today's journal.
Anger Management Log

Name: __________________________________________________________
Date: ____________ Time: _______________ Staff initials: ____________

Briefly describe the event(s) that preceded the person's becoming angry.

Read each of the following statements and responses to the person. Check all responses that the person indicates. A person may have more than one response to each question.

1. It seems to me that you are angry. Is it because:
   - 🔵 You feel teased?
   - 🔵 You feel picked on?
   - 🔵 You feel you are not being respected?
   - 🔵 You feel no one is listening to you?
   - 🔵 You feel staff is talking about you?
   - 🔵 You feel another person is talking about you?
   - 🔵 Other ________________________________

2. When you are angry
   - 🔵 Do you raise your voice?
   - 🔵 Do you lower your voice?
   - 🔵 Does your face get red?
   - 🔵 Does your face feel tight?
   - 🔵 Do you breathe faster?
   - 🔵 Do you walk back and forth?
   - 🔵 Other ________________________________

3. What would you like to do to help you get rid of your anger?
   - 🔵 Talk to staff
   - 🔵 Write in your journal
   - 🔵 Go for a walk
   - 🔵 Play basketball, or other sport
   - 🔵 Be by yourself
   - 🔵 Go to your bedroom
   - 🔵 Other ________________________________

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12 This tool was adapted from a presentation made by John Eirdosh and Cass Lavin-Spouse from Mainstay Services at the Transforming Ourselves Institute in Camp Hebron, PA, 2002-2003.
Monitoring Risk

Best Practices: Having a Well Developed Support Plan

☐ The plan is developed by the team in collaboration with the person with problematic sexual behavior.

☐ No formula works for any one person and assessments and plans all need to be individualized.

☐ Look closely at information provided - it’s not always what it seems.

☐ The person with problematic sexual behaviors is aware of the plan, and how team members will respond in any given situations.

☐ A good support plan should address all the needs of the person with problematic sexual behaviors.

☐ The whole team needs to know how to use the plan, how to make decisions ‘in the moment’ according to the support plan, or the plan is worthless.

☐ Liability goes down when best practices go up - provided you document best practices.

Example: A proactive support plan will not only describe what team members should do if the person wants to run away, but it would also be addressing the reasons the person may be running away: fear, anger, control, etc.
Accountability of the Person with Problematic Sexual Behaviors

Relapse prevention provides a context for assessing areas that the person with problematic sexual behaviors must actively control or be in the process of changing, if risk is to be controlled. It is usually a set of self-directed interventions used to assist the person with problematic sexual behaviors in learning a framework to change and develop plans to cope with risk situations. It will always focus around three levels of risk management:

1. **Environmental** (organize the environment/setting to minimize risk)
2. **Interpersonal** (use of people supports to minimize risk)
3. **Internal** (risk management comes from the person)

The program or support system will help and support the person in doing the following:

- The person ultimately accepts responsibility for offending behaviors
- The person identifies and modifies cognitive distortions
- The person understands and controls deviant arousal
- The person acquires and practices relapse prevention skills
- The person establishes supervision networks and community supports and sensitivity
- The person improves social competencies through communication
- The person develops victim empathy
Relapse Prevention: An Integrative Approach\textsuperscript{13}

Internal, self-management dimension

- Identify triggers – situations that lead to offending behaviors
- Identify dangerous decision–making that can lead to offending behaviors
- Develop strategies to avoid or cope, before a lapse occurs that could permit fantasies to turn into behaviors

External dimension

- Create collaborative relationships with the broader community
- Create a network of additional supports

Interpersonal dimension

- Teach the person with problematic behaviors about the high-risk factor of fragile self-esteem
- Teach the person with problematic behaviors how his sexually exploitative behavior is an extortion of intimacy
- Teach new strategies to build and sustain self-esteem
- Teach the person to develop skills and talents from which a sense of accomplishment can be derived
- Teach the person to experience the enhancement of self-esteem through meaningful connections

\textsuperscript{13} Marlatt’s model (1982), Pithers, Marques, Gibat & Marlatt (1983).
Disclosure

Disclosure Exercise

Disclosure begins by making a full and frank presentation of your problematic sexual behaviors to the group. This needs to be completed within the first four weeks of treatment. The purpose of this disclosure is to break through some of the denial surrounding your problematic sexual behaviors. Additionally, it provides a basic statement from which all other disclosures can be made.

Disclosure should include:

1) What have you done – including grooming behaviors? How did you get your victims to trust you? What sexual acts did you commit? How did you keep your victims from telling? Did you use force?

2) To whom – This does not mean names, but describe your victims. How old were they? What was their relationship to you? Are there physical characteristics you look for? Male or female?

3) How often – How many times did you offend each victim? Daily? Weekly? For years?

4) How long – When did you start having these problematic sexual behaviors? When was it worse? How many years has it gone on?

5) Current functioning – What is happening now? How often do you have deviant fantasies? How often do you masturbate to those fantasies? What about power and control issues? Manipulation? What puts you at risk of engaging in the same problematic sexual behaviors in the future?

The next step in the disclosure process is to inform your significant others, be they parents, spouses, siblings, or partners, of the full nature of your problem. This disclosure does not usually need to be as detailed as the first. It should help those closest to you to protect themselves and others, while at the same time helping you, as you learn how to live life without engaging in your problematic sexual behaviors and offending or victimizing other people. It should make clear:

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Developed and presented by Saul Schoenberg, Director, Resolutions Program, Inc., Clinical Supervisor, Safe Choices Program, and Kathryn D. Aiken, Coordinator, Safe Choices Program.
1) What you have done and how your problem is an ongoing one.

2) What the series of behaviors are (risk factors and red flag behaviors), which precede your actual problematic sexual behavior.

3) What situations, including emotional states, put you at risk of engaging in your problematic sexual behaviors?

4) How significant others can intervene, to help prevent you from engaging in your problematic sexual behaviors (it is important to let them know this is something you want them to help you with and act on).

You may only be in treatment for an hour or so each week. Therefore, it is important that what you learn supports you in the rest of your life. This is difficult, if those around you do not understand what is happening and how they can help. This is an opportunity for you to give them that understanding.

Another type of disclosure needs to be made to those people outside your immediate and closest support network, such as teachers, bosses, friends, fellow employees, neighbors, etc. The purpose of this exercise is once again build protection for the community, but it is also an opportunity for you to develop support networks and for you to gain personal power by acknowledging responsibility for your problematic sexual behaviors and claiming credit for being in treatment. It should:

1) Inform and educate the community about the nature of your problematic sexual behaviors, your target population and the fact that your problem is ongoing.

2) Explain the process of denial or distortion and how you might manipulate support people to excuse your behaviors.

3) Let them know that it would be helpful for them to intervene and also how and when they might best do that.

It is sometimes the case that the person with problematic sexual behaviors has been able to manipulate his audience into feeling sorry for him, because he needed to make this disclosure. This usually is an indication that the person has utilized one of his own distortion strategies to his own advantage.

*Note:* It is the responsibility of the person with problematic sexual behaviors to continually work on refining his or her disclosure exercises. Disclosure work is a priority in community-based programming and supports for people with problematic sexual behaviors.
G. System Support and Staff Training

Topics
Agency / Systems and Support
Agency Relationship and Sexuality Policies
Liability
Staff Training

Safer Options Train-the-Trainer Curriculum
Lesson 1 - Overview working with People with Problematic Sexual Behavior and Sex Offenders (new staff orientation)
Lesson 5 - Agency Relationship and Sexuality Policies
Lesson 7 - Staff/Team Training and Support

Agency / Systems and Support

Agency administrations, support coordinators, county and state governments need to understand that treatment programs and the best practices treatment standards are different for individuals who have problematic or offending sexual behaviors than those for people with developmental disabilities who do not have problematic sexual behaviors.

Agency Relationship and Sexuality Policies

Sexuality and Relationship policies can reduce provider liability.

The development of relationship and sexuality policies for agencies that are supporting people with intellectual disabilities is critical. These policies provide the structure and rules for providing services. For those who have problematic sexual behaviors, the provision of these services can involve restrictive procedures, arms length supervision, contact with the criminal justice system and complex sexuality issues, therefore, clear guidelines within the agency are helpful for staff as well as reducing liability for the agency.

Agencies and their staff who are working with a person with sex offending behavior have significantly more responsibility than the average provider agency. It is important for the agency, the staff and the person receiving services that everyone knows the rules. An offence can happen in minutes and how to handle situations must be discussed and agreed upon before a situation occurs.
Some Thoughts on Liability

What policies are needed?

- General – Identifying differences in philosophy
- Specific
  - A. Informed consent
  - B. Limited waivers of confidentiality

1. Policies and Guidelines

- To ensure safe service delivery, create agency policies wherever possible.
- Create network of providers to establish guidelines where policies are not an option.

2. Careful Wording

- *Make no guarantees:* Say, “We will deliver services designed to provide John with the opportunity to learn and to manage risk,” instead of “We will ensure John does not re-offend.”
- Use respectful language to assign appropriate responsibility to the person.
- Contracts with other providers need to contain clear expectations about safety and collaboration.

3. Training and Supervision

- Ongoing formal trainings and in-services for all team members
- Regular, frequent and ongoing supervision
  - A. General practices
  - B. Specific to each person being served

4. Accurate, Immediate and Complete Documentation

- All supervision
- All trainings
- Outcome measures for overall program
- Critical incidents
- Person-specific status in treatment (monthly summary)

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15 Developed and presented by Saul Schoenberg, Director, Resolutions Program, Inc., Clinical Supervisor, Safe Choices Program, and Kathryn D. Aiken, Coordinator, Safe Choices Program.
Staff Training

Staff is the glue that keeps the community and the person with sex offending behavior safe. The importance of staff training when providing services to this population can not be underestimated. It is critical that staff have the information and support they need to implement a complex and comprehensive treatment program. Training and support must be a priority when providing services to this population and financial stress can not result in cutbacks that reduce the quality of supervision and treatment. When support and on-going training for staff are reduced the likelihood of an offence goes up.

Teams have been making decisions for many years, however, the treatment team working with a person with sex offending behavior has significantly more responsibility. If the team underestimates the persons risk to re-offend someone is victimized and the offender could go to jail.

The treatment team must function well at all times if they are going to maintain community safety, and appropriately support the person. Cultural and religious differences should be discussed so that everyone has a basic understanding of personal issues that might conflict with treatment goals. (I.e. masturbation or same sex relationships) Participation on this treatment team is most effective if all of the team members volunteer to work with this complex population. Not all people can or should work with people who have sexual offending behavior. They will do more harm than good.
There are times when staff must be trained quickly; for example, new staff hired or a new person coming into an existing treatment program. They must be trained on the basic components of *Safer Options* that will ensure community safety -consistent, constant supervision by all staff, no matter where, no matter when. Decisions need to be made about where it is safe to take a person and where it is not safe, whether a person needs arms length supervision, or field of vision supervision. Teams must discuss and decide if the criteria changes depending on where the person is in their treatment (recently started therapy), what are their targets (pedophiles should not go to places where children congregate), and environmental changes (during summer people wear less clothes).
Appendix 1

Pennsylvania
Sexual Offences Statutes*

Additional Statutes That May Apply
Confidentiality of HIV Related Information Act
Sodomy Law
Kidnapping
Offences against the Family
Public Indecency
Minors
Indecent Exposure
Harassment and Stalking
Sexual Harassment (Federal Civil Rights Law)
Megan’s Law
Public Indecency
Video Voyeurism
Neglect of Care of Dependent Persons
Assault

*Laws vary from state to state
CHAPTER 31. SEXUAL OFFENSES

§ 3101. Definitions
Subject to additional definitions contained in subsequent provisions of this chapter which are applicable to specific provisions of this chapter, the following words and phrases when used in this chapter shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Complainant." An alleged victim of a crime under this chapter.

"Deviate sexual intercourse."
Sexual intercourse per os or per anus between human beings and any form of sexual intercourse with an animal. The term also includes penetration, however slight, of the genitals or anus of another person with a foreign object for any purpose other than good faith medical, hygienic or law enforcement procedures.
"Forcible compulsion."
Compulsion by use of physical, intellectual, moral, emotional or psychological force, either express or implied. The term includes, but is not limited to, compulsion resulting in another person's death, whether the death occurred before, during or after sexual intercourse.

"Foreign object."
Includes any physical object not a part of the actor's body.

"Indecent contact."
Any touching of the sexual or other intimate parts of the person for the purpose of arousing or gratifying sexual desire, in either person.

"Sexual intercourse."
In addition to its ordinary meaning, includes intercourse per os or per anus, with some penetration however slight; emission is not required.

§ 3102. Mistake as to age
Except as otherwise provided, whenever in this chapter the criminality of conduct depends on a child being below the age of 14 years, it is no defense that the defendant did not know the age of the child or reasonably believed the child to be the age of 14 years or older. When criminality depends on the child's being below a critical age older than 14 years, it is a defense for the defendant to prove by a preponderance of the evidence that he or she reasonably believed the child to be above the critical age.

§ 3104. Evidence of victim's sexual conduct
(a) General rule.--Evidence of specific instances of the alleged victim's past sexual conduct, opinion evidence of the alleged victim's past sexual conduct, and reputation evidence of the alleged victim's past sexual conduct shall not be admissible in prosecutions under this chapter except evidence of the alleged victim's past sexual conduct with the defendant where consent of the alleged victim is at issue and such evidence is otherwise admissible pursuant to the rules of evidence.
(b) Evidentiary proceedings.--A defendant who proposes to offer evidence of the alleged victim's past sexual conduct pursuant to subsection (a) shall file a written motion and offer of proof at the time of trial. If, at the time of trial, the court determines that the motion and offer of proof are sufficient on their faces, the court shall order an in camera hearing and shall make findings on the record as to the relevance and admissibility of the proposed evidence pursuant to the standards set forth in subsection (a).

§ 3105. Prompt complaint
Prompt reporting to public authority is not required in a prosecution under this chapter: Provided, however, that nothing in this section shall be construed to prohibit a defendant from introducing evidence of the complainant's failure to promptly report the crime if such evidence would be admissible pursuant to the rules of evidence.
§ 3106. Testimony of complainants
The credibility of a complainant of an offense under this chapter shall be determined by
the same standard as is the credibility of a complainant of any other crime. The testimony
of a complainant need not be corroborated in prosecutions under this chapter. No
instructions shall be given cautioning the jury to view the complainant's testimony in any
other way than that in which all complainants' testimony is viewed.

§ 3107. Resistance not required
The alleged victim need not resist the actor in prosecutions under this chapter: Provided,
however, that nothing in this section shall be construed to prohibit a defendant from
introducing evidence that the alleged victim consented to the conduct in question.

§ 3121. Rape
(a) Offense defined.--A person commits a felony of the first degree when he or she
engages in sexual intercourse with a complainant:
1. By forcible compulsion.
2. By threat of forcible compulsion that would prevent resistance by a person of
reasonable resolution.
3. Who is unconscious or where the person knows that the complainant is unaware that
the sexual intercourse is occurring.
4. Where the person has substantially impaired the complainant's power to appraise or
control his or her conduct by administering or employing, without the knowledge of the
complainant, drugs, intoxicants or other means for the purpose of preventing resistance.
5. Who suffers from a mental disability which renders the complainant incapable of
consent.
6. Who is less than 13 years of age.
(b) Additional penalties.--In addition to the penalty provided for by subsection (a), a
person may be sentenced to an additional term not to exceed ten years' confinement and
an additional amount not to exceed $100,000 where the person engages in sexual
intercourse with a complainant and has substantially impaired the complainant's power to
appraise or control his or her conduct by administering or employing, without the
knowledge of the complainant, any substance for the purpose of preventing resistance
through the inducement of euphoria, memory loss and any other effect of
this substance.

§ 3122.1. Statutory sexual assault
Except as provided in section 3121 (relating to rape), a person commits a felony of the
second degree when that person engages in sexual intercourse with a complainant under
the age of 16 years and that person is four or more years older than the complainant and
the complainant and the person are not married to each other.

§ 3123. Involuntary deviate sexual intercourse
(a) Offense defined.--A person commits a felony of the first degree when he or she
engages in deviate sexual intercourse with a complainant:
1. by forcible compulsion;
2. by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution;
3. who is unconscious or where the person knows that the complainant is unaware that the sexual intercourse is occurring;
4. where the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing, without the knowledge of the complainant, drugs, intoxicants or other means for the purpose of preventing resistance;
5. who suffers from a mental disability which renders him or her incapable of consent;
6. who is less than 13 years of age; or
7. who is less than 16 years of age and the person is four or more years older than the complainant and the complainant and person are not married to each other.
(b) Definition.--As used in this section, the term "forcible compulsion" includes, but is not limited to, compulsion resulting in another person's death, whether the death occurred before, during or after the sexual intercourse.

§ 3124.1. Sexual assault
Except as provided in section 3121 (relating to rape) or 3123 (relating to involuntary deviate sexual intercourse), a person commits a felony of the second degree when that person engages in sexual intercourse or deviate sexual intercourse with a complainant without the complainant's consent.

§ 3124.2. Institutional sexual assault
(a) General rule. Except as provided in sections 3121 (relating to rape), 3122.1 (relating to statutory sexual assault), 3123 (relating to involuntary deviate sexual intercourse), 3124.1 (relating to sexual assault) and 3125 (relating to aggravated indecent assault), a person who is an employee or agent of the Department of Corrections or a county correctional authority, youth development center, youth forestry camp, State or county juvenile detention facility, other licensed residential facility serving children and youth, or mental health or mental retardation facility or institution commits a felony of the third degree when that person engages in sexual intercourse, deviate sexual intercourse or indecent contact with an inmate, detainee, patient or resident.
(b) Definition.--As used in this section, the term "agent" means a person who is assigned to work in a State or county correctional or juvenile detention facility, a youth development center, youth forestry camp, other licensed residential facility serving children and youth, or mental health or mental retardation facility or institution who is employed by any State or county agency or any person employed by an entity providing contract services to the agency.

§ 3125. Aggravated indecent assault
Except as provided in sections 3121 (relating to rape), 3122.1 (relating to statutory sexual assault), 3123 (relating to involuntary deviate sexual intercourse) and 3124.1 (relating to sexual assault), a person who engages in penetration, however slight, of the genitals or anus of a complainant with a part of the person's body for any purpose other than good faith medical, hygienic or law enforcement procedures commits aggravated indecent assault, a felony of the second degree, if:
1. the person does so without the complainant's consent;
2. the person does so by forcible compulsion;
3. the person does so by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution;
4. the complainant is unconscious or the person knows that the complainant is unaware that the penetration is occurring;
5. the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing, without the knowledge of the complainant, drugs, intoxicants or other means for the purpose of preventing resistance;
6. the complainant suffers from a mental disability which renders him or her incapable of consent;
7. the complainant is less than 13 years of age; or
8. the complainant is less than 16 years of age and the person is four or more years older than the complainant and the complainant and the person are not married to each other.

§ 3126. Indecent assault
(a) Offense defined.--A person who has indecent contact with the complainant or causes the complainant to have indecent contact with the person is guilty of indecent assault if:
1. the person does so without the complainant's consent;
2. the person does so by forcible compulsion;
3. the person does so by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution;
4. the complainant is unconscious or the person knows that the complainant is unaware that the indecent contact is occurring;
5. the person has substantially impaired the complainant's power to appraise or control his or her conduct by administering or employing, without the knowledge of the complainant, drugs, intoxicants or other means for the purpose of preventing resistance;
6. the complainant suffers from a mental disability which renders him or her incapable of consent;
7. the complainant is less than 13 years of age; or
8. the complainant is less than 16 years of age and the person is four or more years older than the complainant and the complainant and the person are not married to each other.
(b) Grading.--Indecent assault under subsection (a)(7) is a misdemeanor of the first degree. Otherwise, indecent assault is a misdemeanor of the second degree.
Appendix 2

Manual - *Assessment of Risk and Manageability of Intellectually Disabled Individuals who Offend—Sexually*

*The ARMIDILLO-S*

(Boer, Haaven, Lambrick, Lindsey, McVilly, and Sakdalan)

Adobe File

ARMIDILLO-S Scoring Sheet
Adobe File

ARMIDILLO-S Worksheet
(Haaven, 2010)
Word File
ARMIDILO-S Worksheet
(Haaven, 2010)

Client_____________         DOB___________
Date____________________

Referral purpose______________________________________________________

Current residence (where/type)
____________________________________________________

Vulnerable others (relationship, age, sex, vulnerability)_____________________

_____________________________________________________________________

Current level of supervision (home, community, other)_____________________

_____________________________________________________________________

Restrictions-___________________________________________________________

Sexual History:

Offenses – chronological order/details, age/gender of victim, supervision at time - Sanction

STATIC RISK BASELINE

Static-99   Total Score ________

RRASOR

Prior sexual offenses _______ Any unrelated victims _______
Any male victims _______ Young offender (18-25) _______

Total Score ________
<table>
<thead>
<tr>
<th>STABLE CLIENT ITEMS</th>
<th>Risk - Protective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Y, S, N)</td>
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<tr>
<td>Compliance with supervision and treatment</td>
<td>___  _____</td>
</tr>
<tr>
<td>Sexual deviance</td>
<td>___  _____</td>
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<tr>
<td>Sexual preoccupation/sexual drive:</td>
<td>___</td>
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<tr>
<td>Preoccupation</td>
<td></td>
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<tr>
<td>Sexual drive</td>
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<tr>
<td>Masturbation frequency Where</td>
<td></td>
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<tr>
<td>Mast. boundaries</td>
<td></td>
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<tr>
<td>Mast. problems</td>
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<tr>
<td>Offense management</td>
<td>___  _____</td>
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<tr>
<td>Emotional coping ability</td>
<td>___</td>
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<tr>
<td>Relationships</td>
<td>___</td>
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<tr>
<td>Impulsivity</td>
<td>___</td>
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<tr>
<td>Mental health</td>
<td>___</td>
</tr>
</tbody>
</table>
Unique personal and lifestyle considerations

Substance abuse Antisocial

Problematic peers

Protective (supervision level, etc.)

ACUTE CLIENT ITEMS

Change in compliance with supervision or treatment

Change in sexual preoccupation/sexual drive

Changes in victim related behavior

Changes in emotional coping

Changes in use of coping skills

Unique considerations

STABLE ENVIRONMENTAL ITEMS

Attitudes towards client

Communication among support persons
Client specific knowledge by support persons

Consistency of supervision

Unique considerations

Situational consistency  Staff modeling

Sexual opportunity  Behavior reinforced

ACUTE ENVIRONMENTAL ITEMS

Change in social relationships

Changes in monitoring

Situational changes

Changes in victim access

Unique considerations
Terminology used by professionals in any field can be difficult to understand. Furthermore, there are often multiple terms used for similar subjects within a given discipline. The field of person with problematic sexual behaviors is no exception. The purpose of this document is to provide a listing of terms with definitions that reflect conventionally accepted language in the domain of supporting people with problematic sexual behaviors.

Abel Assessment for Sexual Interest: A psychological test giving an objective measurement of deviant sexual interests. This is a computer-driven test that gives the operator an objective reaction time measure of deviant sexual interests. People who participate in an Abel Assessment complete a 30-minute computerized test showing 160 slides of clothed adults, teens, and children. Objective reaction time measuring 22 sexual areas are compared using “z scores” and self report. A 60-minute paper and pencil questionnaire is coupled with the computerized test to provide extensive details of the person with problematic sexual behaviors' history of interest, degree of control, accusations, and other information.

Access to the Community: Refers to a person with problematic sexual behaviors’ ability to leave the physical confines of a residential program (with or without permission) and enter the community for any purpose and under any level of supervision or under no supervision.

Access to Potential Victims: Any time a person with problematic sexual behaviors is alone with a potential victim, the person is considered to have access to a potential victim, and the potential victim is considered at risk.

Actuarial Risk Assessment: A risk assessment based upon risk factors which have been researched and demonstrated to be statistically significant in the prediction of re-offense or dangerousness.

Adaptive Coping Response (ACR): A change in thoughts, feelings, and/or behaviors that helps people deal with risk factors and reduces the risk of lapse. Adaptive coping responses help the person avoid re-offending (relapse), and may be general in nature (e.g., talking with a friend who is upset, hurt, or angry)

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16 This glossary has been adapted from a document available from the Center for Sex Offender Management (June 1999). 8403 Colesville Road, Suite 720, Silver Spring, Maryland 20910. Phone: (301) 589-9383. Fax: (301) 589-3505. Internet: www.csom.org
or specific to certain situations (e.g., avoiding children or refraining from masturbation to deviant fantasies).

**General coping responses improve the quality of life. These responses include:**
- Effectively managing stress and anger;
- Improving skill and ability to relate with others;
- Changing life in ways which do not support sexually abusive behavior;
- Learning to relax;
- And increasing knowledge, skills and ability to solve problems.

**Adjudication:** The process of rendering a judicial decision as to whether the facts alleged in a petition or other pleading are true; an adjudicatory hearing is a court procedure where it is determined whether the allegations of the petition are supported by legally-admissible evidence.

**Aggravating Circumstances:** Conditions that intensify the seriousness of the sex offense. Conditions may include age, gender, reduced physical and/or mental capacity of the victim, the level of cruelty used to perpetrate the offense, the presence of a weapon during the commission of the offense, denial of responsibility, multiple victims, degree of planning before the offense, history of related conduct and/or the use of a position of status or trust to perpetrate the offense.

**Anaphrodisiac:** A drug or medicine that reduces sexual desire.

**Aphrodisiac:** Anything that stimulates sexual desire or arousal.

**Assault Cycle:** The person with problematic sexual behaviors’ pattern of abusing that includes triggers, feelings, behaviors, cognitive distortions, planning, etc. Methods of addressing the assault cycle may include charting, the use of a psycho-educational curriculum, individual teaching/therapy, etc.

**Assessment:** An assessment is the process of collecting and analyzing information about a person so that appropriate decisions can be made regarding sentencing, supervision, and treatment. An assessment does not and cannot determine guilt or innocence, and it cannot be used to determine whether an individual will commit future offenses. Assessments lay the groundwork for conducting an evaluation. There are several phases and types of assessments. These include the following:

- **Investigative Assessment** is generally completed by a team that includes law enforcement personnel, a prosecuting attorney, and a child protective services staff member. The purpose of this assessment is to gather as much information as possible regarding the modus operandi of a sexual abuser and to corroborate evidence regarding the crime scene and how the abuse occurred.
- **Risk Assessment**: considers the nature, extent, and seriousness of a person’s sexually abusive behavior; the degree of threat the person presents to the community or victim; and the general dangerousness in any particular settings. It determines appropriate settings, intensity of intervention, and level of supervision needed by a particular person. A risk assessment is required prior to admission to any program for people with problematic sexual behaviors, and is conducted on an ongoing basis after admission.

- **Treatment Planning Assessment** identifies problem areas, strengths and weaknesses, skills, knowledge, and the precedents and antecedents of the sexually abusive behavior. The assessment includes consideration of thinking, affect, and behavior, organicity of behavioral and cognitive issues, psychiatric disorders, addictions, and family functioning.

- **Clinical Assessment**: is necessary for treatment planning. It helps determine the problem areas that need to be addressed in treatment, as well as the types and modalities of treatment most suitable to treat the person with problematic sexual behaviors.

- **Formal and Informal Assessments** are used to determine the progress of the individual in treatment. They are typically done using pre-post testing of information learned, direct observation of the skills the person has acquired, and the extent of his/her behavioral change.

- **Graduation or Discharge Readiness Assessment** is used to determine if a person has successfully completed treatment. The person’s behaviors, skills, knowledge, and abilities are evaluated based upon the treatment plan and other factors that were identified to determine progress.

- **Classification Assessment**: is conducted to determine the supervision classification status of a person on probation or parolee.

- **Outcome Evaluations** are conducted after discharge from a program, typically by tracking people with problematic sexual behaviors to determine rates of recidivism/re-offense.

**Autoerotic**: Self-stimulation; frequently equated with masturbation.

**Aversive Conditioning**: A behavioral technique designed to reduce deviant sexual arousal by exposing the people with problematic sexual behaviors to a stimulus which arouses him/her and then introducing an unpleasant smell or physical sensation.

**Castration**: Removal of sex glands—the testicles in men and the ovaries in women. Chemical castration refers to the use of medications to inhibit the production of hormones in the sex glands.

**Child Pornography**: Any audio, visual, or written material that depicts children engaging in sexual activities or behaviors, or images that emphasize genitalia and suggest sexual interest or availability.
Civil Commitment: The confinement and treatment of people with problematic sexual behaviors who are especially likely to reoffend in sexually violent ways following the completion of their prison sentence. Commitment is court-ordered and indeterminate.

Cognition: Refers to the mental processes such as thinking, visualizing, and memory functions that are created over time based on experience, value development and education.

Cognitive Distortion (CD): A thinking error or irrational thought that people with problematic sexual behaviors use to justify their behavior or to allow themselves to experience abusive emotions without attempting to change them. Cognitive distortions are ways people with problematic sexual behaviors go about making excuses for justifying and minimizing their sexually abusive behavior. In essence, these are self-generated excuses for taking part in one's relapse patterns. These thoughts distort reality.

Cognitive Restructuring: A treatment technique wherein the person with problematic sexual behaviors is made aware of distorted thinking styles and attitudes that support sexual offending and/or other problem behaviors and is encouraged to change those cognitions through confrontation and rebuttal.

Collaboration: A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. This type of relationship developed between supervising officers, treatment providers, polygraph examiners, victim advocates, prosecution and the defense bar has been credited with the success of effectively supporting people with problematic sexual behaviors. This type of relationship includes a commitment to:

- Mutual relationships and goals;
- A jointly developed structure and shared responsibility;
- Mutual authority and accountability; and
- Sharing of resources and rewards.

Community Supervision: Casework by a supervision officer that centers around monitoring people with problematic sexual behaviors and their compliance to conditions of supervision, including the person's relationship and/or status with his/her family, employers, friends and treatment provider. The officer obtains information from these sources regarding compliance with conditions of supervision, participation in treatment and assists the person with behavior modification and restoration to the victim and community. Types of community supervision include:
• **Bond supervision** (also called “Pre-Trial Supervision”): Supervision of an accused person who has been taken into custody and is allowed to be free with conditions of release before and during formal trial proceedings.

• **Parole supervision**: The monitoring of parolees’ compliance with the conditions of his/her parole.

• **Probation supervision**: The monitoring of the probationer’s compliance with the conditions of probation (community supervision) and providing of services to people with problematic sexual behaviors to promote law abiding behavior.

**General goals of community supervision include (American Probation and Parole Association, 1995):**

- Protection of the community and enhancement of public safety through supervision of people with problematic sexual behaviors and enforcement of the conditions of community supervision;
- Provision of opportunities to people with problematic sexual behaviors which can assist them in becoming and remaining law-abiding citizens; and
- Provision of accurate and relevant information to the courts to improve the ability to arrive at rational sentencing decisions.

**Conditions of Community Supervision:** Requirements prescribed by the court as part of the sentence to assist people with problematic sexual behaviors to lead a law-abiding life. Failure to observe these rules may lead to a revocation of community supervision, or graduated sanctions by the court. Examples of special conditions of community supervision for people with problematic sexual behaviors are noted below:

- Enter, actively participate, and successfully complete a court recognized treatment program as directed by your supervising officer, within 30 days of the date of this order;
- No contact with the victim (or victim’s family) without written permission from your supervising officer;
- Pay for victim counseling costs as directed by the supervising officer;
- Submit, at your expense, to polygraph and plethysmograph testing as directed by your supervising officer; and
- Do not possess any sexually explicit materials.

**Containment Approach:** A model approach for the management and supervision of people with problematic sexual behaviors (English, et al., 1996). This is conceptualized as having five parts:

1. A philosophy that values public safety, victim protection, and reparation for victims as the paramount objectives of the treatment and management program;
2. Implementation strategies that rely on agency coordination, multi-disciplinary partnerships, and job specialization;
3. A containment approach that seeks to hold the person accountable through the combined use of both the person’s internal controls and external criminal justice control measures, and the use of the polygraph to monitor internal controls and compliance with external controls;
4. Development and implementation of informed public policies to create and support consistent practices; and
5. Quality control mechanisms, including program monitoring and evaluation, that ensure prescribed policies and practices are delivered as planned.

**Conviction:** The judgment of a court based on the verdict of guilty, the verdict of a judicial officer, or the guilty plea of the defendant that the defendant is guilty of the offense.

**Covert Sensitization:** A behavioral technique in which a deviant fantasy is paired with an unpleasant one.

**Cruising:** The active seeking out of a victim for purposes of engaging in deviant sexual activity.

**Culpability:** While the term guilty implies responsibility for a crime or at the least, grave error or misdoing, culpability implies a lower threshold of guilt. Culpability connotes malfeasance or errors of ignorance, omission, or negligence. Criminal justice practitioners and treatment providers use an assessment that includes a detailed examination of abusive behavior and criminal histories to determine culpability in sex offenses.

**Denial:** A psychological defense mechanism in which the person with problematic sexual behaviors may act shocked or indignant over the allegations of sexual abuse. Seven types of denial have been identified (Freeman-Longo and Blanchard, 1998):
1. **Denial of facts:** The person with problematic sexual behaviors may claim that the victim is lying or remembering incorrectly;
2. **Denial of awareness:** The person with problematic sexual behaviors may claim that s/he experienced a blackout caused by alcohol or drugs and cannot remember;
3. **Denial of impact:** Refers to the minimization of harm to the victim;
4. **Denial of responsibility:** The person with problematic sexual behaviors may blame the victim or a medical condition in order to reduce or avoid accepting responsibility;
5. **Denial of grooming:** The person with problematic sexual behaviors may claim that he did not plan for the offense to occur;
6. **Denial of sexual intent:** The person with problematic sexual behaviors may claim that s/he was attempting to educate the victim about his/her body, or that the victim bumped into the person with problematic sexual behaviors. In this type of denial, the person with problematic sexual behaviors tries to make the offense appear non-sexual; and
Denial of denial: The person with problematic sexual behaviors appears to be disgusted by what has occurred in hopes others would believe s/he was not capable of committing such a crime.

Detumescence: The process of a fully or partially erect penis losing erection and becoming flaccid resulting from drainage of blood from the erectile tissue in the penis. This usually occurs because the man is no longer aroused by the erotic stimulus that previously caused the man’s penis to become erect.

Deviant Arousal: The sexual arousal to paraphilic behaviors. Deviant arousal is a pattern of being sexually aroused to deviant sexual themes. Not all people with problematic sexual behaviors have deviant arousal patterns. The most common method of assessing deviant arousal is through phallometric assessment conducted by a trained and qualified sexual abuse treatment specialist.

Disinhibitors: Internal or external motivators (stimuli) decrease prohibitions against engaging in sexual activities. An internal disinhibitor may be a cognitive distortion such as “that 8-year-old is coming on to me”. Alcohol and drug use are examples of external disinhibitors.

Electronic Monitoring: An automated method of determining compliance with community supervision restrictions through the use of electronic devices. There are three main types of electronic monitoring utilizing different technologies (Crowe, 1998):

1. Continuous Signaling Technology: The person wears a transmitting device that emits a continuous coded radio signal. A receiver-dialer is located in the person’s home and is attached to the telephone. The receiver detects the transmitter’s signals and conveys a message via telephone report to the central computer when it either stops receiving the message or the signal resumes again.

2. Programmed Contact Technology: This form of monitoring uses a computer to generate either random or scheduled telephone calls to the person during the hours when he or she should be at his/her residence. The person must answer the phone, and verify their presence at home by either transmitting a special beeping code from a watch attached to the person’s wrist, or through the use of voice or visual verification technology.

3. Global Positioning Technology (GPS): This technology monitors an individual’s whereabouts at any time and place. A computer is programmed with the places where the person should be at specific times as well as areas that are off limits (e.g., playgrounds and parks). The person wears a transmitting device that sends signals through a satellite to a computer, indicating their whereabouts.

Evaluation: The application of criteria and the forming of judgments; an examination of psychological, behavioral, and/or social information and
documentation produced by an assessment (assessments precede people with problematic sexual behaviors’ evaluations). The purpose of an evaluation is to formulate an opinion regarding a person’s amenability to treatment, risk/dangerousness, and other factors in order to facilitate case management.

**False Remorse:** An insincere attempt by the person with problematic sexual behaviors to show s/he feels sorry for the abuse s/he has committed. The false remorse is usually self-pity or self-disgust.

**False Resolve:** An insincere effort on the part of a person with problematic sexual behaviors to make promises to him/her self never to abuse again.

**Family Reconciliation:** The therapeutic process that ends with a resolution of problems and conflict areas that prevent a family from having a healthy, non-abusive relationship. Family reconciliation must take place before family reunification can occur. Reconciliation may take place without reunification, although reunification should not occur without reconciliation.

**Family Reunification:** This is the joining again of the family unit as part of a person with problematic sexual behaviors’ treatment plan. It is a step-by-step process with achievable goals and objectives.

**Grooming:** The process of manipulation often utilized by child molesters, intended to reduce a victim’s or potential victim’s resistance to sexual abuse. Typical grooming activities include gaining the child victim’s trust or gradually escalating boundary violations of the child’s body in order to desensitize the victim to further abuse.

**High Risk Factors (HRF):** A set of internal motivations or external situations/events that threaten a person with problematic sexual behaviors’ sense of self-control and increase the risk of having a lapse or relapse. High risk factors usually follow seemingly unimportant decisions (SUDs).

**Incest:** Sexual relations between close relatives, such as father and daughter, mother and son, sister and brother. This also includes other relatives, stepchildren, and children of common-law marriages.

**Index Offense:** The most recent offense known to authorities.

**Individual Treatment Plan:** A document outlining the essential treatment issues which must be addressed by the person with problematic sexual behaviors. Treatment plans often consist of core problem areas to be addressed in treatment such as cognitive restructuring, emotional development, social and interpersonal skills enhancement, lowering of deviant sexual arousal, anger management, empathy development, understanding of the sexual abuse cycle,
and the formulation and implementation of a relapse prevention plan. These plans include the:

- Problem to be addressed;
- Proposed treatment;
- Treatment goal;
- Responsible staff; and
- Time frame to meet goals.

**Lapse**: An emotion, fantasy, thought, or behavior that is part of an offending cycle and relapse pattern. Lapses are not sex offenses. They are precursors or risk factors for sex offenses. Lapses are not failures and are often considered as valuable learning experiences.

**Informed Consent Statement**: A clinical document that is signed by a person with problematic sexual behaviors which becomes part of the treatment record and may be admissible in court. It implies that the person understands the benefits and risks of a particular treatment procedure and may voluntarily withdraw from the procedure without consequence.

**Less Restrictive**: Changing the environment in which a person lives by decreasing the level of intensity in supervision, allowing greater access to unsupervised leisure time activities, and permitting community or family visits. A less restrictive environment is usually the result of significant treatment progress or compliance with the treatment program and environment.

**Level of Risk**: The degree of dangerousness a person with problematic sexual behaviors is believed to pose to potential victims or the community at large. The likelihood or potential for a person with problematic sexual behaviors to re-offend is determined by a professional who is trained or qualified to assess people with problematic sexual behaviors’ risk.

**Masochism**: A sexual deviation in which an individual derives sexual gratification from having pain, suffering and/or humiliation inflicted on him/her.

**Masturbation**: Self-stimulation of the genitals; autoeroticism.

**Megan’s Law**: Passed in October, 1996 it requires states to provide notification to the public the whereabouts of convicted sex offenders. The public can search on a website that lists offenders by name, age, address, photograph, license plate number and a description of the offense including if the victim was a minor.

**Minimization**: An attempt by the person with problematic sexual behaviors to downplay the extent of abuse.
**Mitigating Circumstances:** Conditions that may modify the seriousness of a sex offense. Conditions may include that the person participating in the offense was under coercion or duress; had a lack of judgment due to physical or mental impairment; or has sincere remorse and has begun to demonstrate restitution, responsibility, and culpability.

**Multi-Cultural Issues:** Any difference that exists between the language, customs, beliefs, and values among various racial, ethnic, or religious groups.

**Obscene:** A legal finding that a specific depiction, typically sexually explicit, is so abhorrent to a community’s standards of acceptability that it is an exception to the First Amendment’s free speech protections and is therefore illegal to possess or distribute. Examples of obscene materials include depictions of children engaged in sexual behavior.

**Obsession:** A neurosis characterized by the persistent recurrence of some irrational thought or idea or by an attachment to or fixation on a particular individual or objects.

**Orgasmic Reconditioning:** A behavioral technique designed to reduce inappropriate sexual arousal by having the person masturbate to deviant sexual fantasies until the moment of ejaculation, at which time the deviant sexual theme is switched to a more appropriate sexual fantasy.

**Paraphilias:** Psychosexual disorders, recurrent, intense, sexually-arousing fantasies, urges, and/or thoughts that usually involve humans, but may also include non-human objects. There are legal and illegal paraphilies:

**Legal Paraphilias (If Consensual):**

- Coprophilia – sexual interest or arousal to feces.
- Fetishism – use of non-living objects (e.g. shoes, undergarments etc) for sexual arousal that often involves masturbation.
- Klismophilia – sexual arousal from enemas.
- Sexual Masochism – sexual arousal/excitement from being humiliated, beaten, bound or made to suffer.
- Sexual Sadism – sexual arousal/excitement from psychological or physical suffering of another.
- Transexualism – surgical sexual/gender change.
- Transvestic fetishism – wearing of clothing articles (especially undergarments) of person of the opposite sex.
Illegal Paraphilias:

- Exhibitionism – exposing one’s genitals to others for purposes of sexual arousal (illegal when recipient is non-consenting).
- Bestiality – sexual interest or arousal to animals.
- Pedophilia – sexually arousing fantasies, urges or behavior involving sexual activity with pre-pubescent children (usually 13 years old or younger).
- Hebophilia – sexual interest/arousal to post-pubescent children or teens (illegal when child is under the age of consent which varies by state).
- Frotteurism – touching or rubbing against a non-consenting person.
- Necrophilia – sexual interest/arousal to corpses.
- Telephone Scatology – engaging in uninvited, sexually explicit talk with another person via the telephone.
- Voyeurism – observing unsuspecting individuals, usually strangers, who are naked, in the act of dressing or undressing, or engaging in sexual activities.

- Bestiality (Zoophobia): Sexual interest or arousal to animals.
- Coprophilia: Sexual interest or arousal to feces.
- Exhibitionism: Exposing one’s genitalia to others for purposes of sexual arousal.
- Frotteurism: Touching or rubbing against a non-consenting person.
- Fetishism: Use of nonliving objects (e.g., shoes, undergarments, etc.) for sexual arousal that often involves masturbation.
- Hebophilia: Sexual interest in, or arousal to, teens/post-pubescent children.
- Klismophobia: Sexual arousal from enemas.
- Necrophilia: Sexual interest in, or arousal to, corpses.
- Pedophilia: Sexual interest and arousal to prepubescent children
- Pederast: Sexual interest in, or arousal to, adolescents.
- Sexual Masochism: Sexual arousal/excitement from being humiliated, beaten, bound, or made to suffer.
- Sexual Sadism: Sexual arousal/excitement from psychological or physical suffering of another.
- Telephone Scatology: Engaging in uninvited, sexually explicit talk with another person via the telephone. This is often referred to as “obscene phone calling.”
- Transsexual: A person who has undergone a surgical sexual/gender change.
- Voyeurism: Observing unsuspecting individuals, usually strangers, who are naked, in the act of dressing or undressing, or engaging in sexual activities.
Parole:
A method of prisoner release on the basis of individual response and progress within the correction institution, providing the necessary controls and guidance while serving the remainder of their sentences within the free community.

Both Pennsylvania sexual assault laws and the definition of consent are important to understand because consent to sexual activity determinates if a law has or has not been broken.

Consent to Sexual Relationships
Many people with developmental disabilities can give consent to a sexual relationship, while others can not. The ability to give consent determines if two adults are engaging in a respectful, sexual relationship. If consent can not be established, one person may become a victim and the other an offender.

“The most widely accepted legal criteria for valid sexual consent are:
1. knowledge (information)
2. understanding (rationality),
3. voluntariness (lack of coercion)

Although there is some variation among these three criteria, they generally encompass the necessary considerations that the law requires...Professionals should include these three legal criteria in their evaluation of the capacity of a person with mental retardation or other developmental disability to participate in sexual activity for which the law requires consent...”17

1 AAMR – A Guide to Consent, 1999
Published By - American Association on Mental Retardation
Edited by Robert Dinerstein JD, Stanley S. Herr JD, D. Phil,
Joan L. O’Sullivan JD
Chapter 4 – Consent to Sexual Activity, p. 62
Pennsylvania State Laws – See Appendix for complete information on relevant laws

**Aggravated Indecent Assault** law states: penetration, however, slight of the genitals or anus of a complainant with a part of the persons body if:

1. The person does so without the complainant’s consent
2. By forcible compulsion
3. By threat of forcible compulsion
4. Who is Unconscious / unaware
5. Who is Impaired by drugs, intoxicants preventing resistance
6. Has a mental disability which renders the person incapable of giving consent
7. Less than 13 years of age
8. Less than 16 and the person is four or more years older and the two are not married to each other

**Involuntary Deviant Sexual Intercourse:** Sexual Intercourse, oral or anal between human beings and any form of sexual intercourse with an animal. Also includes penetration, however slight, of the genitals or anus of another person with foreign object.

**Indecent Contact** – Touching intimate parts of a person for purpose of arousing or gratifying sexual desire in either person

**Rape:** Forcible sexual penetration of a child or an adult (vaginal, oral, or anal) with a penis, finger, or object.

**Phallometric Assessment or Penile Plethysmograph:** A procedure where a device that is attached to the penis and is used to measure sexual arousal to both appropriate (age appropriate and consenting) and deviant sexual stimulus material. Stimuli can be audio, visual, or a combination.

**Plethysmograph:** A devise that measures erectile responses in males to both appropriate and inappropriate stimulus material (see Phalometry).

**Polygraph:** A diagnostic instrument and procedure designed to assist in the treatment and supervision of people with problematic sexual behaviors by detecting deception or verifying truth of statements by persons under supervision or treatment. The polygraph can assess reports relating to behavior. The three
types of polygraph examinations that are typically administered to person with problematic sexual behaviors are:

- **Sexual History Disclosure Test**: Refers to verification of completeness of the person's disclosure of his/her entire sexual history, generally through the completion of a comprehensive sexual history questionnaire.
- **Instant Offense Disclosure Test**: Refers to testing the accuracy of the people with problematic sexual behaviors' report of his/her behavior in a particular sex offense, usually the most recent offense related to his/her being criminally charged.
- **Maintenance/Monitoring Test**: Refers to testing the verification of the person's report of compliance with supervision rules and restrictions.

**Pornography**: The presentation of sexually arousing material in literature, art, motion pictures, or other means of communication or expression.

**Precursors**: A general term used to describe seemingly unimportant decisions (SUDs), maladaptive coping responses, risk factors and lapses. Precursors are events that occur prior to a sex offense.

- **Perpetuating Precursors** are thoughts, feelings, and behaviors which are generally ongoing problems in the person's life and often help maintain him/her in a 'pretend-normal' phase of the cycle. They can trigger the relapse process (e.g., unresolved angers, alcohol and drug abuse, and low self-esteem). This is the phase in which the person attempts to cover up his/her behavior by engaging in "normal daily routines" that do not include sexually deviant behavior.
- **Precipitating Precursors** are thoughts, feelings, and events which generally began during the person's childhood and which influence the way he/she thinks, feels, and behaves.
- **Predisposing Precursors** are thoughts, feelings, and events which occur in the person's life that can trigger both the deviant cycle and relapse process. These precursors are usually high risk factors and triggers which precede acting out (e.g., arguments with others, isolation, etc.).

**Presentence Investigation Report**: A court-ordered report prepared by a supervision officer which includes information about the person's index offense, criminal record, family and personal history, employment and financial history, substance abuse history, and prior periods of community supervision or incarceration. At the conclusion of the report, the officer assesses the information and often makes a dispositional recommendation to the court.

**Probation**: A court-ordered disposition through which an adjudicated person is placed under the control, supervision, and care of a probation field staff member in lieu of imprisonment, so long as the probationer (person with problematic sexual behaviors) meets certain standards of conduct.
**Progress in Treatment:** Observable and measurable changes in behavior, thoughts, and attitudes which support treatment goals and healthy, non-abusive sexuality.

**Promiscuous:** Engaging in sexual intercourse with many persons.

**Psychopathology** is often characterized by grandiosity; excessive need for stimulation, prone to boredom; pathological lying; cunning, manipulative; with a lack of remorse or guilt; parasitic lifestyle; poor behavior controls; promiscuous sexual behavior and many short-term relationships; early behavioral problems; lack of realistic, long-term goals; impulsivity; irresponsibility; history of juvenile delinquency; likelihood of revocation on conditional release; and criminal versatility.

**Psychosexual Evaluation:** A comprehensive evaluation of an alleged or convicted person to determine the risk of recidivism, dangerousness, and necessary treatment. A psychosexual evaluation usually includes psychological testing and detailed history with a focus on criminal, sexual, and family history.

**Puberty (or Pre-Pubescence):** The stage in life at which a child’s reproductive organs become functionally operative and secondary sexual characteristics develop.

**Rapid Risk Assessment for Sex Offense Recidivism (RRASOR):** A risk assessment tool that assesses sexual re-offense risk among adult people with problematic sexual behaviors at five-and ten-year follow-up periods. In this tool, four items are scored by clinical staff or case managers using a weighted scoring key (Hanson, 1997).

**Recidivism** refers to reoffending

**Reintegration:** Gradual re-acclimation or adjustment to a non-supervised, less structured environment featuring opportunities to demonstrate new social skills and responsible decision-making in support of community and personal safety.

**Relapse:** A re-occurring abusive behavior or offense.

**Relapse Prevention:** A multidimensional model incorporating cognitive and behavioral techniques to treat sexually abusive/aggressive behavior.

**Release of Information** is a signed document that allows the sharing of information, such as legal and treatment records between individuals involved in managing the person’s behaviors and is necessary for effective treatment, monitoring and supervision.
**Restrictive**: The degree to which a program places limitations or external controls on a person’s physical freedom, movement within a treatment facility, access to the community, or other basic privileges.

**Restitution**: A requirement by the court as a condition of community supervision that the person with problematic sexual behaviors replaces the loss caused by his/her offense through payment of damages in some form.

**Reunification**: A gradual and well-supervised procedure in which a person with problematic sexual behaviors (generally incest) is allowed to re-integrate back into the home where children are present. This takes place after the clarification process, through a major part of treatment, and provides a detailed plan for relapse prevention.

**Risk Controls**: External conditions placed on a person with problematic sexual behaviors to inhibit re-offense. Conditions may include levels of supervision, surveillance, custody, or security. In a community setting, conditions are a part of supervision and are developed by the team or individual charged with overseeing the person with problematic sexual behaviors' placement in the community.

**Risk Factors**: A set of internal stimuli or external circumstances that threaten a person’s self-control, therefore increasing the likelihood of recidivism. Risk factors are typically identified through risk assessment instruments.

**Risk Level** is the determination of a person’s likelihood to offend, and the extent to which the offense is likely to be traumatic. Based on these determinations, the person is assigned a risk level consistent with his/her relative threat to others. Risk level is changeable, depending on behaviors exhibited within a treatment program. Disclosures of additional, previously unknown offenses or behaviors may also alter the person's assessed level of risk.

**Risk Management** is used to describe services provided by corrections personnel, treatment providers, community members, and others to manage risk presented by people. Risk management includes supervision and surveillance in a community setting (risk control) and requirements that people with problematic sexual behaviors to participate in rehabilitative activities (risk reduction).

**Risk Reduction** refers to activities designed to address the risk factors contributing to the person’s sexually deviant behaviors. These activities are rehabilitative in nature and provide the person with the necessary knowledge, skills, and attitudes to reduce his/her likelihood of re-offense.

**Sadism**: The act of sexual gratification by inflicting physical or psychological pain and/or humiliation upon another.
Seemingly Unimportant Decisions (SUDs) are decisions a person makes that seem to him or her to have little bearing on whether a lapse or relapse will occur. SUDs actually allow a person to get closer to high risk factors that increase the probability of another offense (e.g., a pedophile who decides to go to a Walt Disney movie on a Saturday afternoon is making a Seemingly Unimportant Decision—the presence of children at the theater creates a high-risk factor that may lead to lapse or relapse).

Sex Offender: The term most commonly used to define an individual who has been charged and convicted of illegal sexual behavior.

Sexting: Sending nude or semi nude photos from a cell phone. Both senders and receivers can be charged with distribution of pornography.

Sexual Abuse Cycle: The pattern of specific thoughts, feelings, and behaviors which often lead up to and immediately follow the acting out of sexual deviance. This is also referred to as “offense cycle” or “cycle of offending.”

Sexual Abuser: The term most commonly used to describe persons who engage in sexual behavior that is considered to be illegal (this term refers to individuals who may have been charged with a sex crime but have not been convicted).

Sexual Assault: Forced or manipulated unwanted sexual contact between two or more persons.

Sexual Contact: Physical or visual contact involving the genitals, language, or behaviors of a seductive or sexually provocative nature.

Sexual Deviancy: Sexual thoughts or behaviors that are considered abnormal, atypical or unusual. These can include non-criminal sexual thoughts and activities such as fetishes (sexual arousal to shoes) or criminal behaviors, such as pedophilia.

Sexual Predator: A highly dangerous person with problematic sexual behaviors who is likely to engage in a predatory sexually violent offense.

Statement of Informed Consent is a clinical document that is signed by a person with problematic sexual behaviors which becomes part of the treatment record and may be admissible in court. It implies that the person with problematic sexual behaviors understands the benefits and risks of a particular treatment procedure and may voluntarily withdraw from the procedure without consequence. Informed consent is used with treatments such as behavioral therapy, odor aversion, aversive conditioning techniques and chemotherapy treatments that may generate physical discomfort or be intrusive to the human
body. Informed consent is not used with sex offense specific treatments such as group and individual therapy, and educational classes.

**Thinking Error:** See Cognitive Distortion.

**Treatment Contracts:** A document explained to and signed by a person with problematic sexual behaviors, his/her therapist, his/her probation/parole officer, and others that include:

- Program goals
- Program progress expectations
- Understanding and acceptance of program and facility (if applicable) rules
- Agreement by the person with problematic sexual behaviors to take full responsibility for his/her offenses within a specific time frame
- Acknowledgment of the need for future stipulations as more risks and needs are identified (e.g., triggers, patterns, etc.) and that privileges or restrictions may be adjusted as progress or risk factors change
- Parental/family requirements to participate in sexual abuse specific family treatment and be financially responsible when necessary
- Acknowledgment of consequences for breaking the treatment contract
- Incentives

**Treatment Models:** Various treatment models are employed with people with problematic sexual behaviors.

- **Bio-Medical Treatment Model:** The primary emphasis is on the medical model, and disease process, with a major focus on treatment with medication.
- **Central Treatment Model:** A multi-disciplinary approach to people with problematic sexual behaviors and sexual abuser treatment that includes all program components (e.g., clinical, residential, educational, etc.).
- **Cognitive/Behavioral Treatment Model:** A comprehensive, structured treatment approach based on sexual learning theory using cognitive restructuring methods and behavioral techniques. Behavioral methods are primarily directed at reducing arousal and increasing pro-social skills. The cognitive behavioral approach employs peer groups and educational classes, and uses a variety of counseling theories.
- **Family Systems Treatment Model:** The primary emphasis is on family therapy and the inclusion of family members in the treatment process. The approach employs a variety of counseling theories.
- **Psychoanalytic Treatment Model:** The primary emphasis is on client understanding of the psychodynamics of sexual offending, usually through individual treatment sessions using psychoanalytic principles.
- **Psycho-Socio Educational Treatment Model:** A structured program utilizing peer groups, educational classes, and social skills development.
Although the approach does not use behavioral methods, it employs a variety of counseling theories.

- **Psychotherapeutic (Sexual Trauma) Treatment Model**: The primary emphasis is on individual and/or group therapy sessions addressing the person with problematic sexual behaviors' own history as a sexual abuse victim and the relationship of this abuse to the subsequent perpetration of others. The approach draws from a variety of counseling theories.

- **Relapse Prevention (RP) Treatment Model**: A three-dimensional, multimodal approach specifically designed to help people with problematic sexual behaviors maintain behavioral changes by anticipating and coping with the problem of relapse. Relapse Prevention:

- **Sexual Addiction Treatment Model**: A structured program using peer groups and an addiction model. This approach often includes 12-Step and sexual addiction groups.

**Treatment Planning**: A face-to-face gathering of a multi-disciplinary team to discuss the results of initial evaluations and outline the individual treatment plan for problematic sexual behaviors. The meeting generally focuses on developmental, vocational, educational, treatment needs; and housing and recreational placement.

**Treatment Progress**: Gauges the person with problematic sexual behaviors’ success in achieving the specific goals set out in the individual treatment plan. This includes, but is not limited to: demonstrating the ability to learn and use skills specific to controlling abusive behavior; identifying and confronting distorted thinking; understanding the assault cycle; accepting responsibility for abuse; and dealing with past trauma and/or concomitant psychological issues, including substance abuse/addiction.

**Triggers**: An external event that begins the abuse or acting out cycle (i.e., seeing a young child, watching people argue, etc.).

**Victim Impact Statement**: A statement taken while interviewing the victim during the course of the presentence investigation report, or at the time of pre-release. Its purpose is to discuss the impact of the sexual offense on the victim.
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2006
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Safer Society Foundation, Inc.
Has many books and resources for the treatment of of sex offenders
P.O. Box 340 Brandon, Vermont 05733-0340
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www.saftersociety.org
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A Model Residential Program
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www.safersociety.org

An Introduction to the Assessment and Treatment of
Intellectually Disabled Sexual Offenders
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Ph: (802) 247-3132; Fax: (802) 247-4233
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Sexuality Curriculum
Toni Cavanaugh Johnson PhD
1101 Fremont Ave., Suite 101
South Pasadena, CA  91030
List of materials numerous
Phone – 626-799-4522
Fax- 818-790-0139
www.tcavjohn.com
email – TcavJohn@aol.com

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608-257-1516  fax 608-257-2150

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Creating Opportunities
To prevent victimization and discrimination
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ARCIL, Inc. & back to life
Consumer prevention curriculum
The Administration on DD
1300 Bluff Drive
Voice 512-255-1465
Fax 512-255-1746

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The Four Scenarios
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For sexual assault service with in Pennsylvania call
888-772-7227
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www.cavnet2.org

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One Carando Drive, Springfield Mass 01104-3211
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Phone 413-732-0531
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Establishing and Maintaining Appropriate Boundaries in Service to People with Developmental Disabilities (Video)
Two videotapes and a workbook
2 Videotapes; Each 1-hour long
David Hingsburger and Mary Harber
1998
Diverse City Press
$110.00 US

Families

Sexuality: Your sons and daughters with intellectual disabilities
David Hingsburger
Karin Melberg Schwier
Paul Brooks Publishing: Baltimore
2000

An Easy Guide for Caring Parents: Sexuality and Socialization – A Book for Parents of People with Mental Handicaps
Lynn McKee and Virginia Blacklidge
1986, 56 pages, $7.25
Planned Parenthood Shasta-Diablo
Concord, CA
510-676-0505
Sexuality Curriculum for Abused Children and Young Adolescents and Their Parents (Sexuality Curriculum)
Toni Cavanaugh Johnson PhD
1101 Fremont Ave., Suite 101
South Pasadena, CA 91030
List of materials numerous
Phone – 626-799-4522
Fax – 818-790-0139
www.tcavjohn.com
email – TcavJohn@aol.com

All of Us Talking Together (Video for Parents)
Planned Parenthood of Santa Barbara
Lucaswrites Educational Video Productions
www.lucaswrites.com

Sex Education for Children/Adolescents/Adults with Developmental Disabilities

Children

It’s Not the Stork!: A Book about Girls, Boys, Babies, Bodies, Families, and Friends
Robie H. Harris
Illustrated by Michael Emberley
Candlewick Press
(Great Book for everyone 4 years and up, wonderful illustrations)

It’s So Amazing!: A Book about Eggs, Sperm, Babies, and Families
Robie H. Harris
Illustrated by Michael Emberley
Candlewick Press
(Great Book for everyone Children and Older, wonderful illustrations)

“Where Did I Come From?”
The facts of life without any nonsense and with illustrations
By Peter Mayle
Illustrated by Arthur Robins
Mommy Laid an Egg or Where Do Babies Come From?
By Babette Cole
Winner of LA Parent Magazine Book Award

Before You Were Born
By Jennifer Davis
Illustrated By Laura Cornell

Your Body Belongs to You
Cornelia Spelman
Illustrated by Teri Weidner

Developing Personal Safety Skill in Children with Disabilities
Freda Briggs
1991
Paul H Brooks Publishing Co
Baltimore

Adolescents

The Care and Keeping of YOU: Body Book for Girls
American Girl Library
By Valoried Lee Schaefer
Illustrated by Norm Bendell

It’s Perfectly Normal: Changing Bodies, Growing Up, Sex and Sexual Health
Robie H. Harris
Illustrated by Michael Emberley
Candlewick Press
(Great Book for everyone Teenage and Older, wonderful illustrations)

F.L.A.S.H. - Family Life and Sexual Health
Developmental Disabilities sex education Curriculum for Grades 7-12
Jane Stangle, MEd
Seattle-King County Department of Public Health Family Planning Program & Seattle Public Schools
www.metrokc.gov/health/famplan/flash
1-800-325-6165 X64970

Period.
By JoAnn Gardner-Loulan
Bonnie Lopez
Marcia Quackenbush
Illustrated By Marcia Quackenbush
Volcano Press, Inc.

“What’s Happening To Me?” An Illustrated Guide to Puberty
Written by bestselling author Peter Mayle
Illustrated by Arthur Robins
Kensington Publishing Corp.
www.kensington.com

Preventing Sexual Abuse
Activities and strategies for those working with children and adolescents
Curriculum guides for k-6, 7-12 and special populations; 1997, 1984
Carol Plummer / Learning Publications, Inc.
5351 Gulf Drive / PO Box 1338
Holmes Beach, Florida

Changes in You: A Clearly Illustrate, Simply Worded Explanation of the Changes of Puberty for Boys

Changes in You: A Clearly Illustrate, Simply Worded Explanation of the Changes of Puberty for Girls
Peggy C. Siegel
1994, 47 pages each, $8.95
Family Life Education Associates
Richmond VA
804-262-0531

Asperger Syndrome and Adolescence: Helping Preteens and Teens Get Ready for the Real World
Teresa Bolick PhD
Fair Winds Press  2001

Asperger's Syndrome and Sexuality: From Adolescence through Adulthood
By Isabelle Henault
Forward by Tony Attwood

Autism-Asperger’s & Sexuality: Puberty and Beyond
Jerry and Mary Newport (A Married Couple with Aspergers)
Future Horizons 2002

All Together Now: Teaching about Contraception and Safer Sex
Planned Parenthood Federation of America, Inc (2006)
  An Evaluated Curriculum for Teens without disabilities

Adults

Young Adult Institute (YAI)
Relationship Series – Videos and Curriculum About $900.00 total / $300 each
Series I - Friends, Acquaintances, Strangers
Series II - Boyfriends and Girlfriends
Series III – Sexuality
By Arsenio Hall and Magic Johnson
42 Minutes
Free at Video stores / $7.00 when bought online

Learn About Life: Sexuality and Social Skills
Available on National ARC Website
Attainment Company
1-800-327-4269

Let’s Talk about Health
What Every Women Should Know: Workbook and Video
The Arc of New Jersey - Video of an actual gynecological exam
Caryl Heaton, DO, Beverly Schenkman Roberts
Leone Murphy, Mary Megher, Doreen Randall
1996, The Arc of New Jersey, North Brunswick, NJ
Prepared by the Arc of New Jersey for production and distribution by The Arc of the United States

The Sexual Assault Survivor’s Handbook for People with Developmental Disabilities and Their Advocates
Norma J. Baladerian
1991, 34 pages, $11.95
San Jose CA
408-866-6303

Your Safety…. Your Rights
A personal safety training video for persons with developmental, physical, and sensory disabilities
17 minutes, Caption with Video description
Produced by the Network of Victim Assistance
16 N. Franklin Street
Doylestown, PA  18901
215- 348-5664

Person to Person (Video)
Program Development Associates
800-543-2119
www.DisabilityTraining.com

No How! (9:30 minutes)
Self Advocate Video to stop sexual abuse
This film is dedicated to the self advocacy movement
Diverse City Press
David Hingsburger - 1996

Hand Made Love
Video - to teach male masturbation
Diverse City Press
David Hingsburger

**Fingertips**
Video – to teach female masturbation
Diverse City Press
David Hingsburger

**Under Cover Dick**
Video – to teach how to use a condom
Diverse City Press
David Hingsburger
Sexuality Therapists / Educators / Consultants:

Bill Allenbaugh
170 McCracken Run Rd.
DuBois, PA 15801
814- 371- 5565
Wga2@psu.edu

Michele Angelo PhD
Sexuality Therapist
610-917-8561

Ann Bernstein
Chester Co ARC
Sex Education Groups
610-696-8090 x 217
ABernstein@arcofchestercounty.org

Cathy Clover PhD, therapist
cathyclover@cloverpsychological.com

Grafton Eilson, therapist
862- 266-4021

Beverly Frantz, PhD Educator
Temple; Institute on Disabilities
215 -721-9550

Ann Gaulin, MA
Trauma Informed Therapy / Family Therapy
Treatment for Post Traumatic Stress Disorder (PTSD)
Extensive experience with people with disabilities
Accepts Medical Assistance
610-246-0679
agaulin@trauma-counseling.org

Tom Graves PhD
Therapist
Sex Offender Therapy Groups for people with Developmental Disabilities
Lancaster County
1-717-392-4322
gravestom@comcast.net

Susan Kaye, Ph.D.
Sexuality Therapist
610-517-8276
susankayek@aol.com
www.yourrelationshipsdocs.com
Carol Nettleton, DSW
Associate Professor Widener University Human Sexuality Program
Family therapist, sexuality education, people with problematic sexual behavior/offenders, victims,
610-971-9771
cnettleton@wayne-counseling.com

Nancy Nowell MPA M.Ed. Sexuality Educator
Education for adults and students who have problematic sexual behavior, are victims or offenders
or people who have PTSD. Assessment referral and assistance with policy development.
215-836-1111
nknowell@yahoo.com

Sharon Mahar Potter, M.Ed.,
Sexuality Consultant; Specializing in Intellectual Disabilities
717 -238-7062 smapotter@comcast.net

Catherine Surbeck, PhD Therapist
610 -525- 6451

Veronique Valliere, PhD, Therapist
610 -530-8392

David Smith, PhD Therapist
717 -238-3660

Larry Sutton, PhD Therapist
Expertise in autism
lasutton@state.pa.us

Robin VanEerdon., therapist
717 4139159

Specialized Services

Carelink, Inc.
John Benedict
Director of Forensic Services
1201 Stanbridge Street, Building 13
Norristown, PA 19401
610- 270-9120
Assessment and treatment for people with developmental disabilities and sex offending behavior

Chester Co ARC
Ann Bernstein
Sex Education Groups
610-696-8090 x 217
ABernstein@arcofchestercounty.org
Community Interactions
321 N. Woodland Avenue
Springfield, PA 19064
Contact: Marian Salino

Community Living and Learning
574 Philadelphia Street
Indiana Pa 15701

Community Services Group
Mountville PA 17554
717 2857121

Devereux Foundation
The Whitlock Center
139 Leopard Road
Bereogn, PA 19312

Erie Special Probation
32 W. 8th Street
514 Masonic Building
Erie, PA

Evergreen Homes
101 Ross Avenue
P.O. 471
Ford City, Pa 16226
724 763 3125

Friendship Community
1149 East Oregon Road
Lititz, PA 17543
717 6562466

Human Services, Inc.
Sex Offender Group for people with developmental disabilities
Groups meet every Tuesday afternoon
610-873-1005

Impact Systems
4 Beryl Road
Paoli, PA19301
4843204831

Lifestyles Support Services
PO Box 303
Elmora, PA 15737
814 9486708
Donna Caruso
donna@lifestylessupport.net

NHS (Northwest Human Services)
4391 Sturbridge Drive
Harrisburg, PA 17110
717- 441-3700 (Astrid Berry)
Reading Specialists
Family and Children's Problems
220 North 5th Street
Reading, PA 10601
Contact: Bruno Andracchio, PhD
610 372-7960

Resource for Human Development (Mainstay)
4700 Wissahickon Avenue, Suite 126
Philadelphia, PA 19144-4248
215-438-6379

Sharp Visions (Signals)
Ruth Siegfried
1425 Forbes Avenue
Pittsburgh, Pa 15219
412 456-1444
INFO@SHARPVISIONS.ORG

Special Offenders Programs
Lancaster
Mark Wilson
717-299-8184
Erie
Stacy Babay
Sbabay@eriecountygov.org
Chris DeLuca
cdeluca@eriecountygov.org

Spectrum Community Services,
1655 Valley Center
Bethlehem, PA 18017
484-893-5050

Supportive Concepts for Families
200 Penn Street
Reading, PA 19602
610 372-7712

Step by Step
Brenda Cicchinelli
bcicchinelli@stepbystep.com

Valley Community Services
Mount Pleasant, PA 15666
724-547-0980
Ford City, Pa 16226