Thriving Relationships and Sexuality for People of All Abilities

Facilitated by Katy Park LSW

A Bit About Me & Acknowledgments:

- The foundation of these materials are drawn from the work of Katherine McLaughlin, an expert in the field of sexuality and developmental disabilities.
- Check out the curriculum she co-authored for Planned Parenthood of Northern New England: Sexuality Education for Adults with Developmental Disabilities as well as her extensive work with Self-advocate
- Also check out her great collection of on-line offerings at: disabilityworkshops.com

Why do people with disabilities need and want to learn about sexuality and intimacy?

"To get correct information!"

"To get resources and tools to make healthy sexual choices!"

"So that people know their rights!"

"So people with disabilities don't put themselves in bad situations!

"So we will know how to protect ourselves!"

"So we can feel good about ourselves and our bodies!"

"So we can be sexual self advocates, not just self advocates!"

Agenda

~Group Agreements & Creating a safe container for learning
~Why should we be talking about this?
~Trauma informed awareness, embodiment, and mindfulness practice integration
~Movement break
~Messages
~Barriers & Considerations
~Sexual development…(same…different?)
~Sexual Self-advocacy
~Stretch break
~Tips and Tools for Communicating about Sexuality
~Answering Questions and Keeping it simple
~Responding to behaviors and understanding communication
~Next Steps and Wrap-up

Learning Objectives:

My intention is to have you leave:

- With increased awareness of the internal and external barriers to supporting a generative culture of sex education for folks with intellectual disabilities across the developmental spectrum.
- Feeling empowered to hold space for adapted education for people of all abilities
- With curiosity about how to help people with disabilities become more empowered and thriving self and sexual advocates
- With a few new tools in your tool boxes!

What are you hoping to get out of this workshop?

The importance and practice of group agreements

- Creating an empowered learning environment
- What can we agree to during this time of learning together?
- The power of raising the bar of expectation and holding clear expectations

- Settling in exercise...landing here!

- Let's practice!

Group Agreement Brainstorm

Each go around and introduce yourself to you table mates!

1. Name and if you would like, what makes you curious about this particular workshop topic

2. Identify a note taker/reporter

3. Have a brief brainstorming period to come up with 2-3 potential group agreements that will facilitate the kind of safe learning community we want to be for each other this afternoon

4. Reporter share with group

What did you come up with?

Group Agreements (additional suggestions for class setting…)

~Confidentiality (unless someone is getting hurt)

~Respect differences of opinion

~Be respectful, don't interrupt or have side conversations

~You are welcome to ask questions, just not personal questions

~There are no stupid questions

~You have the right to pass

~To take care of yourself and your needs and communicate when you need help

~Take a risk

~Have fun

Why is this conversation and implementation so

- Let pause to pay close attention to our cultures (and our own assumptions) about the capacity of folks with cognitive differences have to live a thriving life including a thriving sexuality

- Chances are if you haven't had an opportunity to work closely with this population you may have some fears of broaching this subject…as it hard to know what such a wide range of folks are capable of understanding and integrating

- And if you have had the opportunity to work "in the field", often, the assumptions of what it truly means to support empowerment and fulfillment for people of all abilities exclude this topic, so it still quite taboo!

- The belief, that as providers, it is our job is "to protect"…well…let's think again about how we are "protecting":

The Numbers...

- Studies consistently demonstrate that people with intellectual disability are sexually victimized more often than others who do not have a disability (Furey, 1994).
- *According to research, more than 90% of people with intellectual disabilities will experience some form of sexual abuse at some time in their lives and 49% will experience 10 or more abusive incidents.*
- *Other studies suggest 68% of girls with intellectual disabilities and 30% of boys with intellectual disabilities will be sexually abused before their eighteenth birthday.*
- *Sullivan and Knutson found, in 2000, that children with intellectual disabilities are at a 3.14 times greater risk of experiencing sexual abuse than non-disabled children.*
- *Researchers have found that men with disabilities are twice as likely to become a victim of sexual violence compared to men without disabilities (The Roeher Institute, 1995).*

Some Theories on Why:

- Lack of knowledge and training in sex education!
- Lack of social awareness and training that would help identify and anticipate abusive situations. Ingrained reliance on the caregiver authority figure.
- Long-term dependence on services and personal care.
- Emotional and social insecurities.
- Lack of capacity to consent to sexual activity
- Powerless position in society.
- Not realizing that sexual abuse can cause harm
- Not being able to tell anyone about the abuse.
- Fear of not being believed, leading to non-reporting of about
- Feelings of guilt or shame that prevent reporting of abuse.
- Difficulty identifying an appropriate person to report the abuse to.
- Low risk of prosecution for perpetrators

Additional considerations for creating a safe and empowered space:

- Being aware of likely trauma in the room and implement practices that support and consider that awareness
- Create an invitation for folks to take responsibility for their learning and ask them if they agree to utilize coping skills (add to group agreements)
- Help folks identify what will best support their participation
- The importance of boundaries and private/public

The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma
~Bessel Van der Kolk MD 2014

Trauma considerations and Integrating mindfulness, music, and movement breaks:

Van der Kolk suggests that one of the first steps to recovery, is to restore the ability to sense, name and identify what is happening internally. We can train our arousal system by the way we breathe, chant, and move: "In contrast to the western reliance on drugs and verbal therapies, other traditions from around the world rely on mindfulness, movement, rhythms, and action"

Van der Kolk also suggests that self-efficacy is restored as movement addresses the traumatized feeling of being trapped and immobilized.

Self-efficacy, a feeling of agency, starts with introception, the awareness of subtle sensory, body-based feelings, and helps us develop trust and satisfying attachment."Recovery from trauma involves the restoration of executive functioning and, with it, self-confidence and the capacity for playfulness and creativity"

Messages, Messages, Messages:

- Let's take a moment to reflect and listen to our own lives…
- What messages did you receive about sexuality growing up and what messages do you receive now?
- Which ones were positive?
- Which ones were negative?

Barriers

With your small group, talk about this question for 10 minutes:

~When you think about talking about sexuality and delivering positive messages with people with disabilities and what internal and external barriers do you face?

~Spokesperson will tell us the barriers

What were some of the barriers discussed at your table?

Messages people with disabilities get:

- That they are not sexual beings
- They should not have sex
- They are innocent and childlike and need protection from sexuality
- They are not responsible or don't have the capacity to be
- That they cannot solve problems
- That they are unable to make good decisions about sexuality
- That they always make mistakes
- That they would not make good parents so should not have children
- That they are different than their non-disabled siblings and peers

Additional Potential Barriers or Concerns:

~Biological age v. cognitive age

~If we talk about it, they will do it, and they can't handle it

~That we are teaching them to have sex or creating desires that aren't there

~That they are too easily influenced and fear that we are giving them our values, which may be different from their parents or guardians

Working with Parents & Guardians

~Ask what their fears are…What worries you about that?

~Build trust

~It takes time

~They have the right and we also want to work with parents

~Reassure then that values are a parent's role and we are offering a wide range of opinions and facts to support their health and well-being.

Don’t panic!
Sexuality isn’t just about sex!

- Sexuality means more than intercourse or sex.
- It's about intimacy, connection, and belonging.
- It's about relationships. Friendships and sexual.
- It's about how we feel about being the gender we are.
- It's about how we feel about others and ourselves.
- It's about sexual expression and behavior.
- It's inseparable from we are, what we believe, what we feel, and how we respond to our world.
- “I just want to fall in love…”

How is a person with a developmental disability's experience of sexual development the same as someone without a disability?

Human Sexual Development Overview:

- Development of Biological Sex
- Gender Assignment
- Development of Gender Identity & Societal Gender Role
- Development of Values and Attitudes About Sexuality
- Physical and Emotional Changes of Puberty
- Development of Sexual Orientation (Affectional, Romantic, and Erotic attractions)
- Development of Sexual Behavior
- Development of Sexual Identity
- Development of Sexual Knowledge
- Development of Sexual Skills

Same Needs and Desires:

~Need same information, based on biological age

~Desire to establish and maintain intimate relationships that feel good and are healthy

~Need support navigating what a healthy relationship looks like

~Have sexual feelings, desires, and needs

~Have dreams like anyone else might, relationships, intimacy, babies

How is a person with a developmental disability's experience of sexual development different than someone without a disability?

Different

~People generally don't discuss it with them

~People may think there are oversexed

~Higher rate of abuse

~Behaviors are accepted or forgiven

~Lack friendships, privacy, or social opportunities

~Don't pick up on the social cues

~How you teach topics is different

~Often lack privacy to explore their sexuality

~Many parents let go of dreams for child related to sexuality or think of them as not sexual

Sexual Self Advocacy?
~Green Mountain Self-advocates

- Feeling good about yourself
- Feeling comfortable meeting people, flirting, and asking somebody to dance
- Being free about your sexuality
- Feeling free to speak with your partner and tell them what you want and don't want in a relationship
- Knowing your rights and responsibilities
- Privacy is important-so speak up for it
- Learn new things and decide with a is right and safe for you

Tips and Tools!

1. Be open, non-judgmental, and kind when you are answering questions or bringing up the topic. Remember, it can take a lot of courage to ask a question and many folks are starting from scratch…reassure the person that it is good to ask questions.

2. Find out what the person thinks/is really asking.

3. Decide what message you want to give and remember to give positive messages. Being positive and non-judgmental helps people develop personal values, self-esteem, effective communication, and good decision-making skills.

4. Answer the question simply, using correct and graphic vocabulary. Give facts and a range of opinions. Stick to facts. When you just give the facts you aren't imposing your values. You can also add a range of opinions to your answer. You could say, "some people think this and others think this, what do you think?".

5. Encourage the person to give feedback, do they have more questions?

Types of Questions about Sexuality

Factual, how to

- What is a boner?
- How are babies made?
- How do I meet people?

Values, Opinions

- Should I have sex?
- What contraception should I use?

Personal

- When did you start having sex?

Values

Common values that we can all agree upon are OKAY:

- It is important to respect others by treating them well and listening to them
- It is important to get consent from a partner for being sexual
- It is important to be responsible in a romantic relationship
- Relationships should be equal and positive without violence or abuse
- Sex should be safe and pleasurable for both

Scarborough Method-Winifred Kempton

- Physical-what it is, physical aspects
- Social-private, responsibility, laws
- Emotional-feelings connected to it

Example: What is a condom?

~Physical: a rubber sock that covers a man's penis

~Social: using a condom is private; it protects you and your partner

~Emotional: Many people feel good when they use them because they are being responsible

The 4 P's-Keep it Simple!
~Terri Couwenhoven

- Permission
- Privacy
- Pleasure
- Protection

Responding to Behaviors (or rather, unconventional communication)…

In order to support integrated and thriving connectedness and understanding:

1. Decide first if it is better to ignore the situation. If ignoring the situation is inappropriate, then continue with the following steps…
2. Name the behavior/communication to the persons as you see or hear it; praise if appropriate.
3. Find out the meaning of the behavior/communication to the person).
4. Decide what "messages" you want to give.
5. Give the messages by responding simply.
6. Encourage the persons to give you feedback.

Dave Hingsburger

- ✓ 1. Structural
- ✓ 2. Modeling
- ✓ 3. Partner Selection
- ✓ 4. Inappropriate Courtships
- ✓ 5. Sexual Knowledge
- ✓ 6. Learning History
- ✓ 7. Perpetual Arousal
- ✓ 8. Medical
- ✓ 9. Medications
- ✓ 10. Moral Vacuum

(ADDED FROM HANDOUT)

Assessing and Responding to “Behaviors”

DAVE HINGSBURGER HYPOTHEIS FOR FINDING OUT THE MEANING AND COMMUNICATION OF THE BEHAVIOR:

*A good place to start with opening up our ideas of what could be going on for the person, not necessarily what we might think at first glance.

1. Structural:

Consider the environment. If a person with a disability is not given privacy they will do typical things in the wrong place. If a person shares a bedroom with a roommate, they will find a "private" place in the bushes outside the grocery store. We also have to teach public and private as well, but in order to do that we have to give, support, and facilitate privacy.

(Continued)

2. **Modeling:** If caregivers are violating an individual's boundaries, they may be modeling that behavior. When we want to get a person's attention we may put our faces in their faces. They may do this to a store clerk and be accused of assault.

3. **Partner Selection:** Who is in their partner pool? Sometimes people don't quite feel they "fit in" with their assumed "peer group" and don't want a partner who is disabled. Have they come to see other people with disabilities as potential partners? They may be asking a provider out because who else do they feel close to?

4. **Inappropriate Courtships**:If you had limited social skills around asking someone out or telling someone you like them, you may just grab the body part you're most interested in. Can this person show affection any other way besides flashing or touching? If no, need to teach these skills.

5. **Sexual Knowledge:** Person who masturbates with feces, was using because he needed lubricant and never knew about it. Once they got some lubrication, he never did it again.

More for Hinsburger…

6. **Learning History:**Where did they learn about sexuality, if at all? What do they know? Would they be able to have safe sex just because we gave them privacy? May need more information.

7. **Perpetual Arousal:** May be masturbating all the time and aren't releasing. May have misinformation, i.e. someone told them that if you let the white stuff come out, you'll get sick.

8. **Medical:** May have infection and that's why they are masturbating aggressively.

9. **Medications:** May be causing the behavior. Have the doses been adjusted lately that may cause a change?

10. **Moral Vacuum:**Where have they learned what's right and wrong? Consumer touching people's private parts over and over, no one told them they were angry-he was surprised when all of a sudden everyone was upset by his behavior. Moral decisions are learned not innate.

Thank you so much!!

Please do not hesitate to be in touch!

Check out our Website and Relate with Katy Park Facebook page for on-going offerings!

- Park@momentumme.com
- Momentumme.com/relate.html
- Katherine McLaughlin has skillfully created a wonderful set of resources at:
- http://disabilityworkshops.com/