Safety & Security Training for DV/SA Providers

The Rape Crisis Center of
Coastal Horizons Center, Inc.
&
The North Carolina Council on Developmental Disabilities

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Safety & Security Initiative Mission

- "To develop a meaningful, effective, and concise training for the providers of intellectual and/or developmental (I/DD) services and secondly, for providers of generic domestic and sexual violence prevention programs in the community. The purpose is to equip staff throughout the state with the tools to prevent domestic and sexual violence and to intervene effectively with victims with I/DD and those at risk." (NCCDD, 2013)

North Carolina Council on Developmental Disabilities

- The North Carolina Council on Developmental Disabilities (NCCDD) is part of a national network of 55 organizations that assist people with intellectual developmental disabilities (I/DD) and their families.
- Established by the Developmental Disabilities Bill of Rights Assistance Act (DD Act) PL 106-402
- Funded by the US Administration on Intellectual and Developmental Disabilities (AIDD).
- To conduct systems change, advocacy, and capacity building activities.
- The Council's sole purpose is to advance the quality of life for people with developmental disabilities

NCCDD Mission

- Mission is to ensure that people with developmental disabilities and their families participate in the design of and have access to culturally competent services and supports, as well as other assistance and opportunities, which promote inclusive communities.

The Rape Crisis Center of Coastal Horizons Center, Inc.

- The RCC staff provides victims of sexual assault with 24 hour crisis response, individual counseling, support groups, information and referrals, and law enforcement/court advocacy and accompaniment.
- The RCC of CHC, Inc. is a stand alone sexual assault service provider for New Hanover and Brunswick Counties.
- In July of 2011, the RCC received funding from GCC for a Victim Advocate to provide specialized outreach and direct services to individuals with developmental disabilities.
- In 2013, the RCC received a grant through OVW to enhance accessibility and capacity to serve survivors with disabilities.

Our mission is to provide support, education and advocacy to empower all individuals and families affected by sexual trauma, and engage and mobilize the community to prevent sexual violence.

Throughout This Presentation Please Take Care of Yourselves!

Did You Know?

- 56.7 million or 19% of Americans have a disability (US Census, 2010)
- Individuals with disabilities are the fastest growing minority group in the US

Developmental Disabilities

- Chronic disability that manifests before adulthood (age 21) and is likely to continue indefinitely.
- Results in substantial functional limitations in 3 or more of the following areas for major life activity:
  - 1. Self-care
  - 2. Receptive and expressive language
  - 3. Learning
  - 4. Mobility
  - 5. Self-direction
  - 6. Capacity for independent living and/or
  - 7. Economic self-sufficiency

Nervous System

- These disorders affect how the brain, spinal cord, and nervous system function, which can affect intelligence and learning.
- These conditions can also cause other problems such as behavioral disorders, speech or language difficulties, seizures, and trouble with movement.
- Cerebral palsy,5 Down syndrome, Fragile X syndrome, and autism spectrum disorders (ASDs) are examples of IDDs related to problems with the nervous system. (NIH 2012)

Sensory System

- These disorders affect the senses (sight, hearing, touch, taste, and smell) or how the brain processes or interprets information from the senses.
- Preterm infants and infants exposed to infections, such as cytomegalovirus, may have problems with their eyesight and/or hearing.
- In addition, being touched or held can be difficult for people with ASDs. (NIH 2012)

Metabolism

- These disorders affect how the body uses food and other materials for energy and growth.
- For example, how the body breaks down food during digestion is a metabolic process.
- Problems with these processes can upset the balance of materials available for the body to function properly. Too much of one thing, or too little of another can cause problems with overall body and brain function.
- Phenylketonuria (PKU) and congenital hypothyroidism are examples of metabolic conditions that can lead to IDDs. (NIH 2012)

Degenerative

- Individuals with degenerative disorders may seem or be typical at birth and may develop typically for a time, but then they begin to lose skills, abilities, and functions because of the condition.
- In some cases, the problem may not be detected until the child is an adolescent or adult and starts to show signs of loss of function.
- Some degenerative disorders result from other conditions, such as untreated problems of metabolism. (NIH 2012)
- Ex Include Alzheimers disease, Rett Syndrome, Pick's Disease

Intellectual/Cognitive Disability

- Formerly known as "MR" or "mentally retarded." (ouch!)
- The American Medical Association still uses "MR."
- IQ of 70 or below.

Traumatic Brain Injury (TBI)

- Can be caused by head injuries, overdoses, oxygen deprivation etc.
- Not technically a developmental disability but presents similarly.
- Can cause deficits in memory, inhibition, slow verbal or physical responses.

Inmates & TBI

- Due to PREA you may have more contact with incarcerated victims.
- 25%-87% of incarcerated people have a reported TBI compared to 8.5% of the general population. (CDC)

Intersection of TBI & DV

- Perpetrators seldom assault their partners only once, some victims suffer repeated head injuries. One study of women in three domestic violence shelters found that:
- 92% had been hit in the head by their partners, most more than once.
- 83% had been both hit in the head and severely shaken.
- 8% of them had been hit in the head over 20 times in the past year.
- The more times individuals had been hit in the head or shaken, the more severe, and the more frequent, were their symptoms.

(http://opdv.state.ny.us/professionals/tbi/intersection.html)

(d)Deaf Population

IPV in the (d)Deaf Community

- 54% of boys who are deaf have been sexually abused vs 10% of boys who are hearing.
- 50% of girls who are deaf have been sexually abused vs 25% of girls who are hearing. (Sullivan,Vernon & Scanlan, 1987)
- 50% of women in the deaf population will experience domestic violence vs 25% of hearing women.
- Deaf women are less likely to identify IPV as abuse (UMASS Medical School, 2014)

D vs d

- "We use the lowercase deaf when referring to the audiological condition of not hearing, and the uppercase Deaf when referring to a particular group of deaf people who share a language – American Sign Language (ASL) – and a culture. The members of this group have inherited their sign language, use it as a primary means of communication among themselves, and hold a set of beliefs about themselves and their connection to the larger society. We distinguish them from, for example, those who find themselves losing their hearing because of illness, trauma or age; although these people share the condition of not hearing, they do not have access to the knowledge, beliefs, and practices that make up the culture of Deaf people."

(http://nad.org/issues/american-sign-language/community-and-culture-faq)

Hard of Hearing (HOH)

- "Hard-of-hearing" can denote a person with a mild-to-moderate hearing loss. Or it can denote a deaf person who doesn't have/want any cultural affiliation with the Deaf community. Or both. The HOH dilemma: in some ways hearing, in some ways deaf, in others, neither.
- Can one be hard-of-hearing and ASL-Deaf? That's possible, too. Can one be hard-of-hearing and function as hearing? Of course. What about being hard-of-hearing and functioning as a member of both the hearing and Deaf communities? That's a delicate tightrope-balancing act, but it too is possible.
- As for the political dimension: HOH people can be allies of the Deaf community. They can choose to join or to ignore it. They can participate in the social, cultural, political, and legal life of the community along with culturally-Deaf or live their lives completely within the parameters of the "Hearing world." But they may have a more difficult time establishing a satisfying cultural/social identity."

(http://nad.org/issues/american-sign-language/community-and-culture-faq)

Keep in mind…

- All victims/survivors face difficulty when attempting to leave a violent person, situation or environment but individuals with disabilities face even more barriers when seeking services and increased risks for their safety.

AND!

- DV/SA services to survivors with disabilities is not an extension of our work, it is our work. (CALCASA 2010)

Unfortunately…

- In North Carolina, a person with a disability is 5 times more likely to be sexually assaulted than someone without a disability (National Center of Victims of Crime).
- 90% of people with developmental disabilities will be physically or sexually abused. (Reynolds, 2011)
- Half of people with developmental disabilities who are abused will experience 10 or more abusive incidents (WCASA)
- Abusers will typically abuse as many as 70 people before getting caught (Valenti-Hein & Schwarts, 1995)
- 3% of sexual abuse cases involving people with disabilities were ever reported to law enforcement (Valenti-Hein & Schwarts, 1995)

Unfortunately…

- People with disabilities experience abuse by a greater number of perpetrators (Baladerian 1991) & stay in dangerous conditions significantly longer
  - 11.3 years vs 7.1 years in situations of physical abuse
  - 8.3 years vs 4.1 years in situations of sexual abuse (Baylor University)

It is important to remember that it is not the disability itself that increases the risk of victimization, but the societal & situational factors.

Myths about People with Disabilities

Myths like…

- People with disabilities are:
- Not sexual beings/overly sexual.
- Do not have intimate/romantic relationships.
- Are unable to consent to sex.
- Cannot communicate thoughts or feelings.
- Are unaffected by trauma
- Must have people make decisions for them in all areas of their lives

Society often depicts people with disabilities as being a source of pity or inspiration (Shapiro, 1993)

- "I can't help but wonder whether the source of this strange assumption that living our lives takes some particular kind of courage in the news media, an incredibly powerful tool in shaping the way we think about disability. Most journalists seem utterly incapable of writing or talking about a person with a disability without using phrases like 'overcoming disability', 'brave', 'suffers from', 'defying the odds', 'wheelchair bound', or my personal favorite, 'inspirational'."

  - Stella Young

The Media…

- Why do actors with out disabilities play people with disabilities?

Risk Factors

- Too frequently considered physically weak, emotionally unstable and/or intellectually incompetent, persons with disabilities may be viewed by perpetrators as easy targets for victimization.
- Perpetrators may trust that first responders won't believe these victims or know how to help them.
- Individuals with disabilities are taught values & beliefs that affect behavior and social etiquette making them more likely victims.
  - Obey the rules & those in charge
  - Don't be assertive or get angry
  - Agree with adults or authority figures
  - Honor other people's opinions
  - Taught to be obedient & dependent
  - Reluctance to express negative feelings or desire for change
  - Personal choices may not be possible
  - Refusal is not usually accepted

Risk Factors

- Social isolation
- Lack of accessible transportation
- Reliance on others for care & the use of multiple caregivers increases opportunities for abuse
- Communication barriers
- Lack of knowledge about healthy intimate relationships
- Lack of resources/lack of knowledge of existing resources.
- Poverty
- Lack of control of their personal affairs
- Perceived lack of credibility when they disclose sexual victimization
- Lack of support from caregiver
- Lack of privacy

People with disabilities often receive little or no sex education.

- Not educated in sex for fear it will "make" the individual sexually active.
- Denied a sense of sexuality- not viewed as a sexual being
- Believe, "what the don't know won't hurt them."

PCAR

ADA Compliance

- The Americans with Disabilities Act (ADA) (1990) and the ADA Amendments Act (ADAAA) (2008) require that the same full range of services be available to all people in the most integrated setting, regardless of any physical, sensory, cognitive, psychiatric, or other disability.
- All domestic violence and sexual assault agencies, regardless of size, are required by the ADA to provide accessible services to survivors with disabilities.

For DV/SA providers, examples of unlawful discrimination include...

- Excluding a person from services based on a disability.
- Providing lesser or fewer services because the person has a disability.
- Failing to modify policies (if necessary) or removing architectural barriers.
- Failing to provide auxiliary aids and services, such as ASL interpreters.
- Denying services because a child or any other member of an individual's network of family, friends and personal care attendants has a disability.

- It is generally the responsibility of the person with the disability to request the modifications/accommodations/auxiliary aids & services.
- Agencies may not screen for disability.
- But you can ask all clients across the board what accommodations they may need.
- Agencies may not charge for accommodations.
- Ex. a Deaf person has the right to an interpreter & is not required to pay for such services.

The ADA does not require nonprofits to provide a particular auxiliary aid or service or modification if it would result in an undue burden.

However!

Demonstrating undue burden does not exempt the agency from compliance with the ADA.

- For example: if installing an elevator in an old building is prohibitively expensive, a reasonable modification may be to hold meetings on the ground floor of the building or at an alternative accessible location.
- It may also be an undue burden for crisis center staff to provide personal care services for clients who require assistance.
- In that case, a reasonable modification might be setting up agreements with a local home health provider.

Examples of ways to promote agency accessibility to people with disabilities...

- Installing ramps or a wheelchair platform.
- Hiring qualified people with disabilities
- Designing an accessible website.
- Repositioning shelves so that someone using a wheelchair can reach materials.
- Adding flexibility in counseling sessions for people with cognitive disabilities who may need shorter sessions for a longer period of time or conversely may need slightly longer sessions.

- Rearranging furniture to prevent barriers through out the building.
- Installing flashing smoke alarms.
- Changing doorknobs to levers.
- Insulating pipes under sinks so that uncovered pipes do not burn the legs of people who use wheelchairs.
- Lowering paper towel dispensers.
- Providing low, flat carpet.

- Contract with a local certified ASL interpreter for intake and counseling sessions and as otherwise necessary.
- Offer agency rules, literature and materials in alternate formats (Braille, large print, simplified language, audio, video with interpretation in ASL)
- Ensure that a telephone is equipped with a TTY (telecommunication device for the Deaf) and that staff/volunteers receive adequate training on using the TTY and are familiar with relay services.

- You must allow service animals within the agency. They are not pets but are specifically trained to assist with mobility, tasks or alerts.
- Provide community outreach services targeted to people with disabilities.
- Include various aspects of disability & disability resources at staff/volunteer trainings.
- Agency events, fundraisers & volunteer opportunities are accessible to people with disabilities (material in accessible formats, held in accessible locations, accessible transportation is available.)

Values Embraced by the Disability Community

- Nothing about us with out us!
- Self advocacy
- Inclusion
- Self-Determination
- Diversity
- Person 1st language
- Wheel chair etiquette

Do's and Don'ts

DO:

- Look directly at the person so that they know you are speaking to and listening to them.
- Be aware that it is possible that this person has not had appropriate sex education or social skills training.
- Use short, simple, direct and concrete sentences & questions (but avoid patronization). It's possible that under pressure the person may regress to a lower level of understanding
- Observe for facial or non-verbal cues that a person may not understand a request or question.
  - Restate it using different words (speaking louder does not help if the person is not understanding the meaning of your words)
  - Be sure you are only asking one thing at a time in each question.

Do's and Don'ts

DO

- Gently guide the person back to the question or topic if they get off on tangents.
- Ask the person to repeat words or gestures if you do not understand.
- Let the person finish what they are saying.
- If possible, do not supply the ending.
- If necessary, use gestures or pictures that may help to express an idea or help the person to understand spoken words or gestures.
- Beware of the "echo effect." The person may repeat the last thing they heard.
- Try to limit distractions as much as possible.
- Go slow! Check for understanding by asking simple questions.
- Encourage questions!

Do's and Don'ts

DON'T

- Do not make assumptions that the person has understood you or previously understood what they were told. Always double & triple check.
- Do not pretend to understand what the person is saying. This will only frustrate you and the person. This is especially true for people with "atypical speech" (ie some people who have CP or Down Syndrome). If you are unsure of what someone says, ask for clarification!
- Do not guide the person toward the answer.
- Do not confuse a slow response with inability to think (i.e. many people with CP do not have any intellectual limitations).

ASL Interpreters

- Ensure interpreter is licensed and qualified (check on www.rid.org (Registry of Interpreters for the Deaf to find qualified, licensed interpreters in your area)
- Upon arrival interpreter seek out contact & (d)Deaf individual to discuss logistics
- Be aware of lighting and backgrounds
- Interpreter should be in (d)Deaf person's line of sight
- Understand interpreter will interpret all communication that occurs including environmental sounds (cell phones)
- Speak directly to the (d)Deaf individual not the interpreter
- Speak naturally
- One person speak/sign at a time
- Realize that the interpreted conversation may require more time
- Avoid asking the interpreter for opinions or comments on the content of the meeting or information about the (d)Deaf person
- ASL interpreting is physically and cognitively demanding and may require occasional breaks

Mandatory Reporting

- GS_108A-Article 6 Protection of the Abused, Neglected, or Exploited Disabled Adult Act
- GS-14 Article 7A Rape & Other Sex Offenses

Article 6

Protection of the Abused, Neglected or Exploited Disabled Adult Act

The words "disabled adult" shall mean any person 18 years of age or over or any lawfully emancipated minor who is present in the State of North Carolina and who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy or autism; organic brain damage caused by advanced age or other physical degeneration in connection therewith; or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances.

A "disabled adult" shall be "in need of protective services" if that person, due to his physical or mental incapacity, is unable to perform or obtain for himself essential services and if that person is without able, responsible, and willing persons to perform or obtain for his essential services.

**This is the language used in the statute, not the preferable way to discuss persons with disabilities

Article 6 Continued…

- § 108A-102. Duty to report; content of report; immunity.
- (a) Any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the director.
- (b) The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information.
- (c) Anyone who makes a report pursuant to this statute, who testifies in any judicial proceeding arising from the report, or who participates in a required evaluation shall be immune from any civil or criminal liability on account of such report or testimony or participation, unless such person acted in bad faith or with a malicious purpose. (1973, c. 1378, s. 1; 1975, c. 797; 1981, c. 275, s. 1.)

Who Must Report?

- Any person who has reasonable cause to believe than a person with a disability is in need of protective services.

What Does That Mean?

- If there is suspicion that someone is being abused, neglected or exploited, you must make a DSS report.

What is…

Abuse?

- Willful infliction of physical pain, injury or mental anguish; unreasonable confinement; willful deprivation by a caretaker or services necessary for mental or physical health.

Neglect?

- Living alone and being unable to provide necessary care for physical and mental health; failure of caretaker to provide necessary services.

Beyond ADA Compliance

Tips & Tricks

- Making your office physically & attitudinally accessible!
- People with ASD are very sensitive to their surroundings. Try incandescent lights versus overhead fluorescent.
- Augmentative Communication Devices
- Fidgets are great for a wide variety of disabilities as well as PTSD & anxiety.
- Display:
  - Information about DV/SA and I/DD
  - Diverse images of people with disabilities
  - Information about local I/DD providers

Case Discussion

Split up into groups and discuss amongst yourselves what your 1st steps would be in responding to this client & how their disability will affect the services you provide. Ask yourselves the following questions & come up with a plan.

- What factors about the disability make this person vulnerable to violence?
- How is violence in this scenario similar to violence experienced by people without disabilities? How is it different?
- What are some special considerations/accommodations that may need to be made when providing services to this client?

Maddox

Maddox is a 28 year old man who has Cerebral Palsy. He utilizes a motorized wheelchair to get around and requires large print materials to read. Maddox lives with his aunt who physically and verbally abuses him. She also spends his monthly disability check on herself and does not give him his funds. She has also refused to get his chair fixed on several occasions when things went wrong with it. When Maddox disclosed to a family member, his aunt said he was "crazy" and "attention seeking." After Maddox disclosed, his aunt only fed him once a day. Maddox contacted your agency through a relay service to inquire about services that may be available to him. While talking with you, he also disclosed a history of sexual abuse at caretaker respite day program he used to attend for 2 years.

Vivienne

You are on call & receive a call that a victim has presented at the hospital. You arrive to meet Vivienne, a 36 year old woman with a cognitive disability who lives with her mother & father. Early that day, she was picked up on the side of the road by law enforcement who had been searching for her as missing person. LE took her to the local hospital where she disclosed being sexually abused by her father & brother. Her mother arrives & you notice Vivienne stops talking & withdraws every time her mother is near. Vivienne also seems to continuously lock eyes with you as if she's trying to communicate something. You also observe that Vivienne's mother keeps insisting that Vivienne tell the SANE & detectives that she is "fine." When the detectives inform mom about what Vivienne disclosed mom states that Vivienne is a "spoiled brat" & a "trouble maker." You step out of the room & leave to get Vivienne a blanket & when you walk back in you see Vivienne's mom crowding over Vivienne while Vivienne physically recoils. You begin to wonder if Vivienne's mom is a potential abuser & ask to speak with Vivienne alone. Vivienne informs you she is scared of her mom & her mom has also hurt her.

Shiloh

Shiloh is a 40 year old Deaf woman who stops by your agency to seek services. She uses ASL to communicate & usually relies on her husband as an interpreter. Her husband is also Deaf but has some hearing & speaks English. He physically, emotionally & sexually abuses her. She has called the police on several occasions but every time law enforcement arrives her husband insists she is just very emotional & irrational. Once she disclosed to a Deaf friend via her TTY machine. The friend minimized the issue & then gossipped about her to many other members of the local Deaf community who isolated her as a result. Her husband discovered her attempt to get help by reading the transcript of her TTY machine & broke it.

Protecting Me

6 session educational/self advocacy program that focuses on educating individuals with disabilities about their right to be protected from exploitation & abuse.

- Touches heavily on preventing sexual abuse (technically tertiary prevention)
- Typically done with high school aged special education students in contained classrooms but is also regularly taught to young adults & adults of any age at local day programs.
- Has been modified for elementary aged children as well.

The Biggest Takeaway...

- Working with individuals with disabilities it not an extension of our work, it is our work.

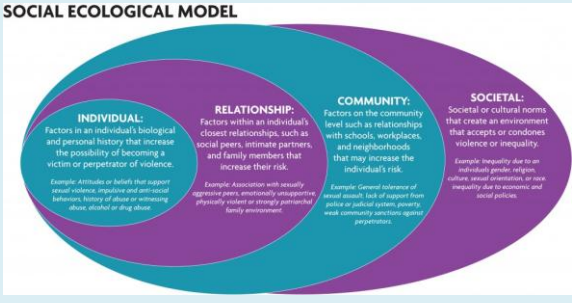
And!

- You're all already doing the work. You ask the hard questions & make accommodations for every client, clients with disabilities are no different.

Prevention of Sexual & Physical Violence

"We are still standing on the bank of the river, rescuing people who are drowning. We have not gone to the head of the river to keep them from falling in. That is the 21st century task."
– Gloria Steinem

SOCIAL ECOLOGICAL MODEL



Intersectionality of Oppression

Unpacking Privilege

- "As a white person, I realized I had been taught about racism as something which puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage."
- "I have come to see white privilege as an invisible package of unearned assets which I can count on cashing in each day…White privilege is like an invisible weightless backpack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks."
- "To redesign social systems we need first to acknowledge their colossal unseen dimensions. The silences and denials surrounding privilege are the key political tool here. They keep the thinking about equality or equity incomplete, protecting unearned advantage and conferred dominance by making these taboo subjects."
  - Peggy McIntosh, Unpacking the Invisible Backpack

Unpacking Privilege Activity

Widely Accepted Myths about Individuals with Disabilities:

- Individuals with I/DD are asexual.
- Individuals with I/DD have a child-like mentality and are dependent on others.
- Individuals with I/DD cannot control their sexual desires.
- Individuals with I/DD do not have boundaries.

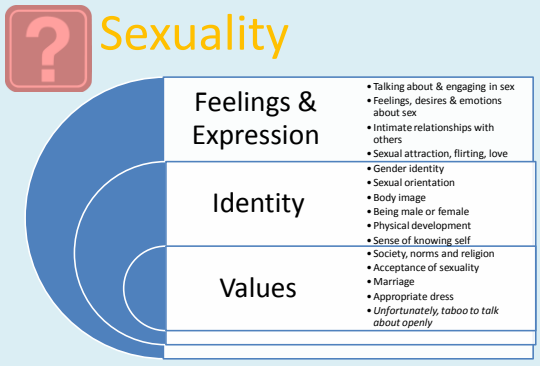
What factors specific to sexuality put this population so at-risk for sexual violence?

- Individuals with disabilities are systematically denied basic information about sexual health and relationships.
- Sex education is rarely provided in special education classrooms and, when it is, it is not tailored to the needs of children with disabilities.
- Many individuals with disabilities are never taught about their bodies or their rights to privacy and are never given a framework for healthy relationships. Without such fundamental lessons, individuals with disabilities have no way of recognizing sexual violence and no language to describe what has happened to them if they experience it.

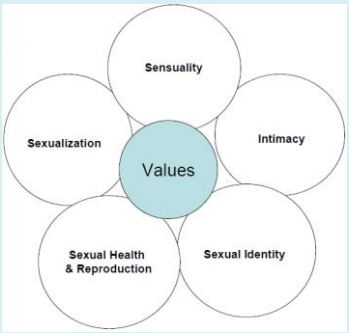
- Healthy sexuality education for individuals with disabilities is a key component of prevention. The more information someone has about healthy sexuality, the more likely they are to identify sexual violence when it occurs.
- Unfortunately, many parents and caregivers themselves have not received comprehensive sexuality education. This can impact their attitudes and comfort levels around sexuality.

Comprehensive Sex Education

- The National Survey of Family Growth found that teens who received comprehensive sex education were 50 % less likely to experience pregnancy than those who received abstinence-only education.
- https://www.youtube.com/watch?v=lvpLZ31iaj8 Parks & Rec



Circles of Sexuality



Sensuality

Physiological and psychological enjoyment of one's own body and the bodies of others

Intimacy

The ability and need to experience emotional closeness to another human being and have the feeling returned.

Sexual Identity

The sense of who one is as a sexual being, including sense of maleness femaleness or neither. To whom one is erotically and emotionally attracted.

Sexual Health & Reproduction

The facts of the sexual and reproductive systems. Includes the care of the organs, health consequences of sexual behaviors, and the biology of producing children, etc.

Sexualization

The use of sexuality to influence, manipulate, or control others

Healthy Sexuality

Knowledge & Empowerment

- Healthy sexuality means having the individual **knowledge** and **power** to express sexuality in ways that enrich one's life.

Respect

- This includes approaching sexual interactions and relationships from a perspective that is **consensual**, **respectful** and **informed**.

Healthy sexuality is free from coercion and violence.

Healthy Childhood Sexual Development

Sexuality is emotional, social, cultural and physical. Sexual development is one part of sexuality, and it begins much earlier in life than puberty.

Sexual Development in Infancy

Ages 0-2

- Experience erections (boys) and periods of vaginal lubrication (girls) starting at birth
- Enjoy being held, touched, kissed, hugged and tickled
- Experience positive sensations associated with being loved
- Curious about their bodies, including genitals
- Touch their genitals, including masturbation in public and private
- No inhibitions around nudity

Sexual Development in Early Childhood

Ages 2-5

- Start to develop a sense of being male or female (gender identity) and begin to associate certain behaviors with being male or female (gender roles)
- Continued lack of inhibition around nudity. Many children enjoy being naked and may take their diaper or clothes off
- Occasional masturbation. Usually occurs as a soothing behavior rather than for sexual pleasure. It may occur publicly or privately
- Begin to ask questions about sexuality and reproduction, such as "Where do babies come from?"
- Show curiosity in regard to adult bodies (e.g., wanting to go into the bathroom with parents, touching women's breasts)
- Consensual and playful exploration with children of the same age. This could include "playing house" or "playing doctor."

Sexual Development in Middle Childhood

Ages 5-8

- Hear and use slang terms for body parts and bodily functions
- Appreciate "potty humor" and make jokes describing body parts and functions
- Deeper understanding of gender roles. May act in a more "gendered" manner as expected behaviors and norms are reinforced.
- Sex play or activities that explore sexuality and bodies may occur with same- and opposite-sex friends
- Masturbation. Some children may touch their genitals for the purpose of pleasure. This happens more privately rather than in public.
- The word "gay" begins to surface in conversations (k-1), usually when adults are at a distance. Though the word becomes familiar, life experiences around the word and the idea that people *are* gay, vary enormously

Sexual Development in Late Childhood

Ages 9-12

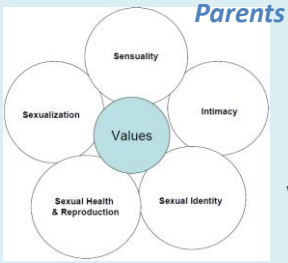
- As puberty begins (Ages 8-13 for girls/ 10-16 for boys) an increased need for privacy and independence is often expressed
- Around 3rd grade, interest in sexuality and playground banter containing sexual language increases exponentially. Children know that "sex talk" is taboo, so they most often confine it to when they won't be overheard by adults
- Interest in relationships. May want to have a girlfriend or boyfriend.
- May express curiosity about adult bodies. This could involve trying to see people naked or undressing or involve looking for media with sexual content
- As social norms around masturbation become clearer, it will likely occur in private

Statistics: Sexuality in Adolescence

High School

- Each year, about 40% of teens visit sexually explicit sites either deliberately or accidentally
- In the United States, 46% of all high school age students and 62% of high school seniors, have had sexual intercourse. Young people begin to have sex at about the same age in most industrialized countries.
- 1/3 of high school students who've had intercourse have had it with four or more different partners (regardless of what grade they are in)
- About half of 15- to 19-year-old males have received oral sex from a female, nearly 40% have performed oral sex on a female

Your Own Sexual Learning



Parents – Teachers – Friends

What messages did you receive growing up?

What was helpful? What was not?

What would you like to have been different?

"The Talk" is Outdated

Information about healthy sexuality shouldn't be given all at once when a child reaches a certain age.

Instead, incorporate healthy sexuality into everyday conversations, answering questions as they arise

Laci Green's Take on "The Talk"

Correct Terminology & Sexual Abuse

- Unfortunately youth with disabilities are far more vulnerable to sexual abuse than their peers. Sex education must, therefore, encompass skills to prevent sexual abuse **and encouragement to report and seek treatment for unwanted sexual activity.**
- Research has shown that a child who has accurate language for private body parts is **more likely** to report abuse than a child who lacks appropriate language.

Discussing Sexual Abuse

- Children with disabilities may need lots of repetition for messaging to sink in and therefore "good touch/bad touch" programs implemented in schools are not effective on their own at preventing childhood sexual abuse.
- It is important for messages about sexual abuse to be discussed and reinforced at home, within the context of overall healthy sexuality.
- Good touch/bad touch can be confusing, as caregivers and medical personnel may touch in ways that feel "bad" (for example a shot) and the physical sensations accompanied by certain types of sexual abuse may feel "good".
- Instead, advocates recommend using concrete concepts like "green flag" and "red flag" to help children understand situations that are ok (green) versus situations that are not okay (red).

Discussing Sexual Abuse

- Use the situations involving touch that children experience regularly to define specific touches that would be considered "green flag" as well as those that would be "red flag."
  - For example, a "green" touch would be when a caregiver helps a child to wipe his bottom after using the toilet and a "red" touch would be the caregiver touching the child's bottom when he is not using the toilet.
- Once you've helped a child define specific touches as "green" or "red", look for opportunities to practice determining whether touches are "green" or "red" and how to respond to "red" touches.
- Make sure that children understand that touching rules are for everyone. Just as it is not okay for someone to give them a "red" touch, they should not be touching others with "red" touches.

Personal Boundaries & Consent

- Sometimes we inadvertently teach children (especially those with disabilities) to be passive or compliant by doing things and making decisions for them.
- Model respect for their personal space and physical boundaries by asking children for permission or declaring what you are going to do before touching them.
- Saying "no" is an important safety skill. Teach children with disabilities to say "no" in lots of different ways.
  - Help them communicate "no" through speaking, shouting, shaking their head, stamping feet, making faces, etc.
  - Share the child's way of communicating "no" with his/her care team. Ask them to respect the child's "no".

Start a Conversation about Healthy Sexuality

- **Why?**
  - We are all sexual beings.
  - Sexuality is a lifelong process
  - Children are already learning about sexuality from their peers and the media
  - Sexuality carries responsibilities and consequences
  - Sexuality is an important and complex topic

  (PreventConnect.org)

Tips for Talking

- Use correct terms and start early.
- Keep it simple and accurate.
- Only answer what they are specifically asking and let the knowledge build over time.
- Look for natural "teaching moments" to explain key concepts and instill values.
- If a question catches you off guard, remain calm and stick to the facts. It's important that you *appear* comfortable discussing these topics.
- If you do not know the answer (or just need time to compose yourself), you can always say "That is a good question. Let me find out and I'll get back to you."

  And then actually get back to them!

Putting Health Sexuality Education into Practice

- Model appropriate boundaries in your professional relationship with clients.
- Talk with parents/caregivers of individuals with disabilities about how they can start an ongoing conversation about healthy sexuality.
- If your agency already hosts groups, incorporate discussions on healthy sexuality.
- If your agency has the opportunity to work with young individuals with I/DD in an educational capacity, discuss ways they can increase their protective factors.

- "In a rape culture, both men and women assume that sexual violence is a fact of life, inevitable as death or taxes. This violence, however, is neither biologically nor divinely ordained. Much of what we accept as inevitable is in fact the expression of values and attitudes that can **change**."

  -American College Health Association

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