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FASD and Inappropriate Sexual Behaviour

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Issue:

The occurrence of inappropriate sexual behaviours (ISB) is an adverse life outcome that may be experienced by individuals with FASD. The purpose of this paper is to highlight an overview of the current existing research conducted in this area and offer implications for individuals, families, caregivers, and policy makers.

Background:

It is common for individuals with FASD to be involved in inappropriate sexual behaviours (ISB), as either a victim or a perpetrator. Individuals with FASD are more likely to be a victim of inappropriate sexual interactions, including crimes like sexual abuse, similar to trends seen for individuals with other intellectual and developmental disabilities.[1-3] This includes situations where individuals with FASD do not recognize the inappropriate nature or risk involved in certain encounters; for example, the giving and receiving of consent.[4] ISB generally refers to a wide-range of problematic behaviours of a sexual nature, including inappropriate sexual advances, sexual touching, promiscuous or dangerous sexual behaviour, prostitution, coercion, masturbation in inappropriate settings, exposing ones' self, voyeurism, and obscene or offensive language.[5,6] Individuals with FASD involved in inappropriate sexual behaviours can also come as a result of sexually inappropriate actions, use of sexual remarks, lack of physical boundary space, disrespect of privacy, and forced sexual intercourse.[7] In some situations, ISB can lead to trouble with the law and incarceration.[8,9]

Occurrence. Researchers estimate that ISB are displayed by 45%-52% of adults with FASD.[10,11] Rates of ISB associated with FASD appear to increase over the lifespan, with studies demonstrating the rates of ISB in children (ages 6-11) at 39%, 42% in adolescence (ages 12-20), and up to of 65% in adult males.[5,6] The average age when ISB initially present is approximately 10 years old, although the age of emergence can vary.[6] Between males and females, the prevalence of ISB is relatively consistent overall. However, in one study, researchers found that 22% of females displayed promiscuity, compared to only 11% of males. Those researchers also noted that amongst adolescents, 19% of males had trouble with the law because of ISB, which was over double the frequency seen in females (8%).[6] It is likely that the prevalence of ISB is

actually higher than currently reported, as many behaviours are underreported as a result of fear, embarrassment, and stigma.[6] Given recent trends in the developmental disability literature in general, it is also possible that specific situations with ISB are occurring online, although there is no specific research in this area yet pertaining to individuals with FASD.[12,13] Individuals with FASD who have been victims of violence themselves, including physical or sexual abuse, are more likely to display ISB.[5,7,8] Researchers have shown that 77% of individuals with FASD have experienced some form of violence; including 55% who have experienced sexual violence.[5] In one study, 94% of females displaying ISB reported having been victims of sexual or physical violence.[8] Additionally, a long history of research on the abuse of individuals with disabilities has indicated that children with disabilities experience all forms of abuse and neglect more often than other children, with the rates of abuse being approximately 3.4 times higher than the general population.

Understanding. The brain differences caused by prenatal alcohol exposure can result in challenges with executive functioning, comprehension, adaptive behaviour, social skills, linking consequences to actions, impulsivity, and response inhibition. These brain-based challenges can interfere with the regulation of appropriate sexual behaviour.[11,14] For individuals with FASD, there can be a gap between their chronological/biological maturation and their cognitive and social maturation which may lead to inappropriate responses to sexual urges emerging as they move through childhood and into adolescence and adulthood,[15] presenting a significant challenge for the individual with FASD and their caregivers. Individuals with FASD can be literal thinkers who struggle at times with interpersonal boundaries, especially those that are assumed or go unspoken, such as body language or personal space.[9] Impulsivity can also lead to less regulated reactions to sexual feelings, as well as sexual relationships being entered into more hastily.[16] In addition, due to unique brain-based challenges, as well as variations in environmental factors, there can be vast differences in developmental patterns between individuals with FASD. These variations in developmental trajectories can lead to unpredictable responses and unique issues underlying the ISB for different individuals with FASD.[17]

It is also important to understand that individuals with FASD may not have had healthy opportunities for learning about appropriate sexuality and discussing it openly. Because of stigma around sexuality and individuals with disabilities, as well as the lack of understanding, educators or caregivers may avoid the topic of sexuality, wrongly viewing individuals with disabilities as asexual or as sexuality being unnatural for individuals with disabilities.[18,19] These problematic perspectives can lead to the ignoring or avoidance of conversations about sexual needs, as well as overly harsh responses to expressions of sexuality.[8] Individuals with FASD may also live in situations which lack privacy and appropriate ways to express sexuality may not be present.[20] It is important to note that due to the aforementioned brain differences, even individuals with FASD who have received education and have conducive living situations are still vulnerable to ISB.

Implications:

It is essential that FASD-informed approaches towards adopting healthy sexuality and properly addressing ISB are implemented to help individuals with FASD as part of holistic support. Individuals with FASD are sexual beings like everyone else and need to understand their sexuality and sexual needs in a healthy way.

The presence of ISB seems to play a part in levels of care required, as one study demonstrated that lower level care needs (or even minimal care) were associated with fewer ISB.[10] Therefore, putting strategies and supports in place that facilitate development of positive understandings of sexuality and reduce ISB may be an important factor for decreasing the level of care required by individuals with FASD. The support required for each individual with FASD should be reflective of their unique needs and specifically for individuals demonstrating ISB, an approach that is tailored to the individual will likely be most effective. The understanding of the individual's environment and supports must also be kept in mind when seeking to address ISB appropriately with individuals with FASD. For example, there is a need to assess risk factors related to the individual (e.g., determination of level of sexual risk), agency (i.e., one's capacity to act independently and make their own free choices, such as the need for additional positive support), and environment (e.g., attitudes, perceptions, stimuli). It is critical to work towards changing the other modifiable factors, and not just the individual with FASD, to both reduce and prevent ISB.[7] Other areas for implications from the existing research that can be expanded on are highlighted below.

1. Sexual Education

The Public Health Agency of Canada suggests that individuals with developmental disabilities should receive sexual health education which is specifically informed by the person's needs and disability. They recommend an approach which includes the following elements: "1) a deeper understanding that is relevant to their specific health needs and concerns; 2) the confidence, motivation and personal insight needed to act on that knowledge; 3) the skills necessary to enhance sexual health and to avoid negative sexual health outcomes; and 4) a safe, secure and inclusive environment that is conducive to promoting optimal sexual health".[21] By implementing education strategies that incorporate these elements, and are reflective of the specific needs and challenges being faced by those whom the education is targeting, educators and caregivers can approach conversations addressing sexuality with individuals with FASD in a more effective manner. Individuals with FASD who experience ISB should also be assessed regarding their social sexual knowledge and attitudes with a reliable tool, such as the Social Sexual Knowledge and Attitudes Tool (SSKAAT-R).[22,23] Additionally, the theory of *counterfeit deviance* should be considered for individuals with FASD, whereby ISB may be best explained by multiple hypotheses which recognizes individuals with intellectual and developmental disabilities may have decreased judgment, social skills, or impulse control.[24,25] The theory of counterfeit deviance means that a sexual offense committed by an individual with an intellectual disability possibly occurred because of poor sexual knowledge.[25] The authors outline eleven alternative hypotheses that are the basis of counterfeit deviance, which take

into account living situations, modelling behaviour, behavioural rewards, lack of opportunities for social skill development, lack of comprehensive sexual knowledge, perpetual arousal, experiences of sexual abuse, society's moral values regarding individuals with intellectual disabilities, and medical or medication side-effects.[25]

2. Considerations When Encountering ISBs

As ISB arise, specific considerations regarding vulnerabilities and risks should be kept in mind for individuals with FASD. For example, recognizing the vulnerability of individuals with FASD, and the risk for sexual exploitation, is extremely important. For some individuals with FASD, there is complexity to understanding capacity to "consent in meaningful, responsible decision-making about sexual activity" which can add to their vulnerability in these situations.[26] Furthermore, because of the link between ISB and victimization with regards to physical or sexual abuse, clinicians who come across ISB in individuals with FASD should consider the potential role of abuse and screen appropriately.[6] Also, when trying to determine the context under which events took place regarding ISB with individuals with FASD, there should be understanding around the higher likelihood of suggestibility (i.e., being inclined to accept something that is being suggested despite the truth) and confabulation (i.e., producing misinterpreted memories), as well as the potential for memory impairments.[14] Another area for awareness when approaching certain ISB with individuals with FASD, such as promiscuity or high risk sexual encounters, is the increased risk of unplanned pregnancies. Because individuals with FASD also have high rates of substance and alcohol use, attention should be paid by clinicians to the prevention of an unplanned pregnancy which may also expose the fetus to alcohol or other substances (e.g., monitoring of birth control; supervision of relationships).[6]

3. Trouble with the Law and ISB

Given the high prevalence of ISB amongst individuals with FASD, as well as the severe underdiagnosis of FASD, it is likely that there are many unrecognized individuals with FASD who have had trouble with the law with regards to sexual offending. Screening for FASD in sexual offending assessments would be valuable, given the fact that alternative programs or adaptations to standard sexual offending assessment and treatment are necessary to accommodate individuals with FASD appropriately.[11] Examples of beneficial alterations could include reviewing the problematic ISB and determining the specific cognitive deficits which may have played a role in the offending behaviour.

From there, determining the level of support required by the individual that is reflective of those deficits has a greater chance of success. Furthermore, understanding the individual's specific challenges will shed light on components of standard treatment that they will likely find difficult, such as asking someone with a memory deficit to recall all of their previous offenses, or expecting someone with executive functioning challenges to have a relapse prevention strategy focusing primarily on self-monitoring.[11] There are currently no research studies specifically evaluating FASD-informed sexual offending treatment or relapse prevention strategies, but beginning with an understanding of the individual, and tailoring treatment to

their specific strengths and needs, is likely to be more effective than putting an individual with FASD through a standardized program.[11,14] Researchers have recommended that "the use of strategies which address adaptive and executive functioning deficits, and sensory impairments aligned with attachment-based and trauma-informed approaches may be compelling, consistent and supported additions within traditional sex offender treatment for this population".[14] Expectations for the produced outcomes from treatment should also be adjusted accordingly for individuals with FASD.[11,14]

Conclusions:

ISB is frequently an adverse life outcome for individuals with FASD and although the existing research helps provide some understanding about the existence of ISB within this population, there is an obvious need for future research to address the significant gaps in this area. Future research should focus on investigations that better outline the cause of ISB in this population, as well as the assessment of FASD and ISB. Researchers also need to examine sex offender treatment programs for individuals with FASD and improve understanding about FASD amongst professionals addressing ISB, specifically those within legal settings contending with those experiencing trouble with the law as a result of ISB.[14]

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