Treatment Selection for Inappropriate Sexual Behavior

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(He/Him/His)
Objectives

• Define various types of inappropriate sexual behavior among ID/DD populations
• Review of a treatment selection model for ISB within a behavior analytic framework
• Determine possible evidence-based treatment options used in behavior analytic practice
Disclaimer!
How many of you currently work with someone who engages in Inappropriate Sexual Behavior?
Scope of Practice

• This is a primary concern for behavior analytic work in this arena
• Assuming this is “just behavior” can lead to:
  • Invasive assessment that does not allow for dignity
  • Victimization due to
  • Illegal activities
    • Example: Hand Made Love
  • Rights restrictions
• There are special considerations with this type of behavior that are not present with other types of challenging behavior
Rationale

- Inappropriate Sexual Behavior includes varied topographies that include:
  - Unique victimology
  - Legal considerations
  - Individual behavior change needs

- Like any behavior, ISB is functionally driven
  - And there are infinite functions
Who is Impacted?

- Intellectual and Developmental Disabilities
- Children
- Dementia
- Traumatic Brain Injury
- Neurotypical
- LBGT+
Ethical Challenges

- Social perceptions
- Functional assessment
- Effective treatment
- Treatment selection
- Scope of competence
- Cultural competencies
- Risk/benefit analysis
Stein & Dillenberger (2016)

• Historical precedence for assuming crime, poverty, and disease were linked to promiscuity, mental illness, and disability

• Individuals with ID/DD are at a higher risk for abuse, ranging from 44-83% of adults with disabilities being abused

• People have a RIGHT to sexual expression, and this is often a concern for the parent, not the learner

• Often, policies and procedures within an agency around sexuality are prohibitive or unnecessarily restrictive despite laws and guidelines that state otherwise
Stein & Dillenberger (2016)

• For assessment, are the procedures used intrusive? Is there a better way to gather the necessary information?
• For treatment, do we have the appropriate replacement skill so we are not simply attempting to suppress?
• For the targeted behavior, is there a replacement skill?
• For the caregivers, who’s problem is the issue? What is the impact of the behavior?
Assessment of Sexual Behavior

• First, identify WHY the behavior is inappropriate
  • I.e. Who’s problem is it?
• Next, determine the function
• Note: You might not have enough time to assess thoroughly if safety is an issue
1. Identify the behavior most in need of change
2. Describe all aspects of the behavior
3. Consider to what extent the client can control the behavior
4. Involve client in changing the behavior
5. Find alternatives and rewards that will help change the behavior
6. Maintain a consistent approach
7. Ensure that the message about the behavior is clearly communicated
8. Remember, you are treating the behavior, not the client
9. Be patient
Fyffe et al. (2004)

• Conducted FA for ISB occurring with 9-year old with TBI
• Originally treated for aggression and property destruction, but ISB was secondary concern
• Topography: attempts at touching or groping genitals, buttocks, breasts
• Designed treatment based on function (Social Positive Reinforcement)
Spiker (in draft)

- Describes offence types
- Assesses:
  - High risk items
  - Pre-Community Transition Skills
  - Current supports
  - Special considerations for the learner
  - Probes for skills
  - Static variables
  - Ongoing assessment post-transition
What works?  Treatment Selection
Instructional Revision

- Includes:
  - Antecedent manipulations
  - Environmental manipulations
  - Changes to tasks
- ISB maintained by escape?
  - Modify demands and provide auditory prompts (Cihak et al., 2007)
  - Model of task response and contingent assistance (Sprague & Horner, 1992)
Manipulation of Motivational Variables

- In general, UMOs are difficult to manage
- One consideration: Stalling
  - How can you delay long enough for the appropriate skill to occur?
- For attention?
  - Pre-session access to attention (O’Reilly et al., 2006)
Non-Contingent Reinforcement

- To work best, reinforcer should be functionally equivalent
- Serves as an abolishing operation (satiation)
- Hagopian et al. (2002) treated public masturbation using attention delivered as NCR
Differential Reinforcement of Alternative Behavior

• Cihak et al. (2007)
  • Token economy was implemented to treat inappropriate self-touching maintained by escape
  • FI30s/LH1s: So, super dense schedule
• Fisher et al. (2000)
  • Use of FCT where ISB was sensitive to tangible reinforcement
Differential Reinforcement of Other Behavior

• DRO alone might not be sufficient, so think DRO + ...
  • DRO + Restitution (Durana & Curvo, 1980)
• Used to treat sexual assault of minors (Polvinale & Lutzker, 1980)
• The problem? It doesn’t teach what to do instead
Extinction

- Function dependent
- Beware of self-stimulatory functions
  - You won’t be able to suppress a UMO for long
- Dozier et al. (2011)
  - Sensory extinction used to treat thrusting on floor near feet
  - Use of an athletic protector
  - Treatment package later included time-out and response interruption
Punishment

- Last resort (goes without saying)
  - Restitution
  - Time Out
  - Facial Screening
  - Physical Blocking
  - Restraint
- Facial Screening: used terrycloth bib over face for 30s and verbally reprimanded
  - The 80’s were a different time
- Careful: Some restraints might be reinforcing
Self-Management

- In the presence of evocative stimuli
- Prompted to inhibit arousal
  - Count backwards from 100
- Introduction of instructional control (prompts)
- May be used in the presence of varying stimuli (adults vs. children) with offenders
Where Do We Start?
Step 1: Determine your Scope of Competence

- What are your general assessment and treatment selection skills?
- What are these skills in context?
- Where do you need more support or consultation?
  - About the behavior/nature of the behavior?
  - About the process?
Step 2: Identify the Function

- FBA may not be feasible, but it IS possible
- Assessment may be topography and severity dependent
  - i.e. it’s too dangerous to let assessment occur for even short periods of time
- Ethical question:
  - How do we ensure we are providing the MOST effective treatment without doing an FA?
Step 3: Identify Potential Interventions

• Focus on function-based where possible
• Contextual fit matters
• Social appropriateness matters
• Caregiver buy-in DEFINITELY matters
• You might consider basic interventions until you gather more information
Step 4: Identify Stakeholders

- Who is involved and what is their involvement?
- Ballan (2012) identify common problems:
  - Misconceptions of Children’s Behavior
  - Challenges with Discussions
  - Communicating information to Children
  - Perception of Child’s Future
  - Differences among parents
Step 5: Identify Potential Replacement Skills

- Again, function based
- There might not be a functionally equivalent replacement skill
- There might be replacement skills that are not topographically related
  - See articles cited before
Step 6: Identify Contextual Fit

- For your intervention; will it match the context?
- Is it socially appropriate?
  - If not, what are the alternatives?
- Do we have time for gradual behavior change or do we need something more immediate?
Step 7: Identify Legal Rights

• Where is the line for your client’s bill of rights?
• Who provides consent to use the treatment?
• Have you provided the information to the stakeholders?
• Are there boundaries to:
  • Using your specific procedures (restraints)
  • Materials that might be necessary (i.e. Hand Made Love)
After careful consideration...

• Accounting for the previous steps, if you are ready to implement, then begin
• CLOSELY monitor the behavior changes
• Revise as necessary
• Continue consultation, even if you’re fairly sure you got it
  • Another perspective can’t hurt
Take Home Points

• Assessment is possible, with careful consideration
• Treatment packages tend to have more salient effects than singular intervention tools
• Inappropriate Sexual Behavior serves a function, just like any other response
  • And the function might not “match” the topography
• There is SOME literature to support behavior change procedures, but more is necessary
Thank you!

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