

sexuality is a complex construct, and goes far beyond sexual intercourse. It can, in fact, be seen as a fundamental aspect of who we are, encompassing our relationships (including familial, friendships, and intimate), our sense of self, and how we identify with various groups (including gender identity and sexual identity). It is in many ways a basic human right, and its healthy development and expression can be seen as a human rights issue. (Hingsburger, 1995) (Wortel, 2013)

Up to now, remarkably little research and clinical attention has been directed to the sexuality of adolescents and young adults with Asperger's Syndrome (AS) both in terms of their sexual profiles and their knowledge of sexuality. (Henault, 2016)



Most people with autism will express the desire to be in a relationship though many will find it difficult to meet partners due to anxiety, sensory, social and communication issues. The spaces where people often meet partners are often exclusionary spaces for those with ASD such as pubs and clubs as we have looked at previously. (Heffernan, 2016)

Sex can be a minefield for people with Asperger's Syndrome, as there are any number of problems that can occur: an inability to deal with the multitude of emotions that surround it, sensory issues that can be involved and the social rules that exist. (Jackson, 2017)



When the topic of sexuality has been addressed in the literature, it has usually been restricted to a discussion of problem behaviors (i.e., compulsive masturbation, inappropriate sexual interactions). Such a perspective is limited in that it fails to consider the complexity of sexuality in general. As in any other context, sexuality in AS consists of intimacy, friendship, pleasure, communication, love, masturbation, intercourse, dating, desire, identity and belonging in addition to problematic behaviors. (Henault, Healthy Sexuality: Adaptive Skills for Individuals with Asperger's Syndrome, 2016)

How do discussions of sexuality, gender identity, and relationships, make you feel?

- With other adults
- With students/clients/children
- With Individuals with Autism Spectrum Disorders

Incredible 5 Point Scale

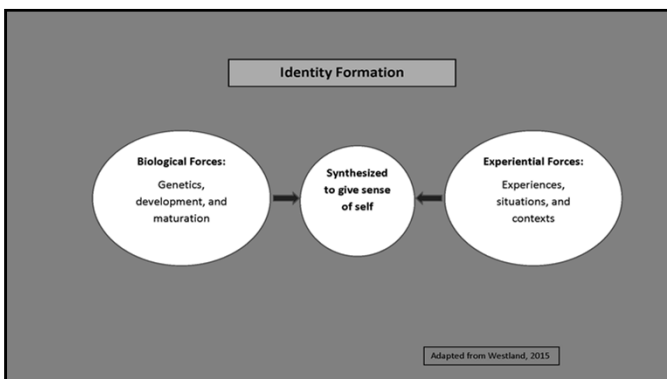
For the majority of Individuals with AS, sexual behaviors are perceived as any other behavior, free of social rules and convention. In contrast, parents and professionals often view sexuality in a much different manner. For them, sexuality may be taboo, value-laden and a source of conflict. The need to protect the adolescent may be so strong that the subject of sexuality is avoided or banned altogether. There is also a tendency to define everything with respect to AS. This perspective fails to consider that adolescence, as a developmental period, brings about a variety of changes, new behaviors, and a need for discovery.

Neurotypical Development of Sexuality, Relationships, and Gender Identity

- Develop through complex interactions between biology and the outside world
- Knowledge and behavior dependent on:
  - Age
  - Changes experienced in the body
  - What is observed
  - What is taught

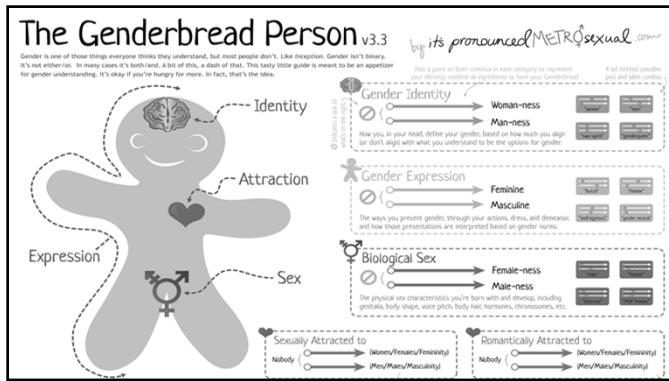
As you can see, many important lessons of a child's sexuality education are taught long before puberty. Parents and family members are the first, most influential and most important sex educators of young children. How parents regard each other and their children and how parents teach their children to enjoy and regard their bodies are important parts of early sexuality education. And the expectations and interactions parents and their children have "with others in their social world all contribute as well.

Puberty usually occurs in girls between the ages of 10 and 14, while in boys it generally occurs later, between the ages of 12 and 16.



(Steensma, Kreukels, de Vries, & Cohen-Kettenis, 2013): The term identity comes from the Latin noun "identitas," which means the same. The term, referring to a person's mental image of him or herself thus implies some sameness with others in a particular way. Each individual may have a number of identities, such as an ethnic identity, a religious identity, or a national identity (Kroger, 2007).

Interest in Romantic Relationships: the majority of high-functioning individuals on the autistic spectrum are both interested in and engage in romantic relationships.



: Of our ASD sample, 10% reported being bisexual, 7% identified as homosexual, and 14% were not able to label their sexual orientation using the provided categories. Sexual identity is influenced by, and usually develops in the context of, societal expectations. (Strunz, et al., 2016)

The subjects diagnosed with ASD were 7.76 times more likely to report GV than the control sample (Janssen, Huang, & Duncan, 2016)  
20% will experience gender dysphoria (compared to 1% of the typical population) (Lawson W. B., 2017)

Social and Emotional Differences

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Faster biological development than social/emotional development

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Theory of Mind/Central Coherence and Naivete'

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"Hidden Curriculum" of Sexuality, Gender Identity and Relationships

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Social Competency and Sexuality, Gender Identity and Relationships

Sensory sensitivity in general and tactile sensitivity in particular can affect both every day and sexual relationships. (Attwood, 2012)

Regulation Differences

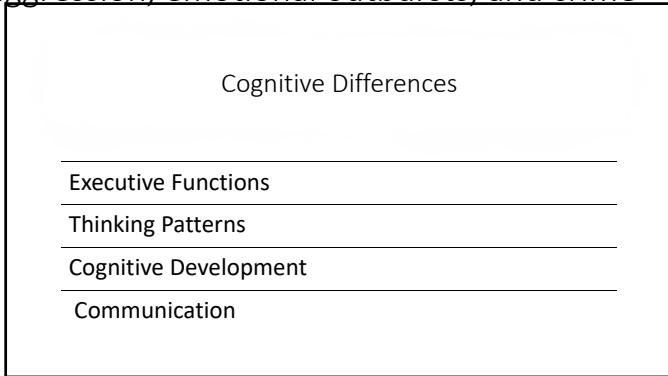
- Sensory Processing
- Emotion Regulation
- Interoception
- Fine and gross motor control

. The physical changes related to sexual maturation follow a typical course. Hormonal changes and fluctuating emotions are usual during adolescence. Puberty is a time of confusion in many ways. Sexual feelings and desires become more prominent. Social interactions become charged with sexual overtones.

Research has also shown that emotional processing can be difficult for some individuals with autism. (Edelson, 2010)

: Interoception is contemporarily defined as the sense of the internal state of the body.[1] It encompasses the brain's process of integrating signals relayed from the body into specific subregions. ] <https://en.wikipedia.org/wiki/Interoception>

Diamond 2016: EFs are important for marital harmony because people with poor EFs are more difficult to get along with, less dependable, and more likely to act on impulse (Eakin et al., 2004 ). Poor EFs can lead to social problems such as aggression, emotional outbursts, and crime



**Thinking Patterns**

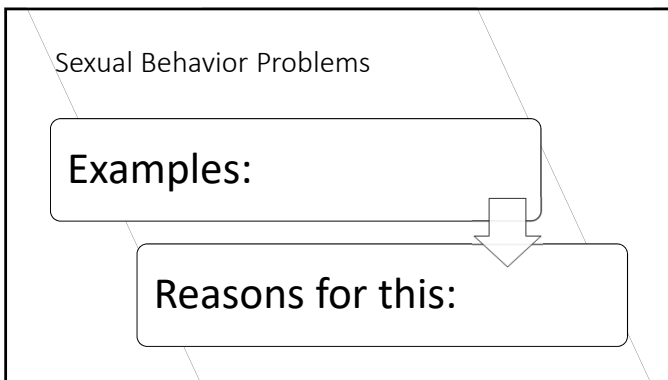
Black and White Thinking

Literal Thinking

Idealize concept of love

Rigid and fixated thinking

**Some youth with ASD conditions have severe learning or intellectual disabilities. Lower intellectual functioning complicates the sex education process, but does not make it any less important (Miller, Karam, & Rain, 2010).**



(Blasingame, 2011)

touching their own private parts in public

masturbation in public

masturbating with unusual objects

removing own clothing in public

touching children of the opposite sex inappropriately

indiscreet discussion of sexually inappropriate topics

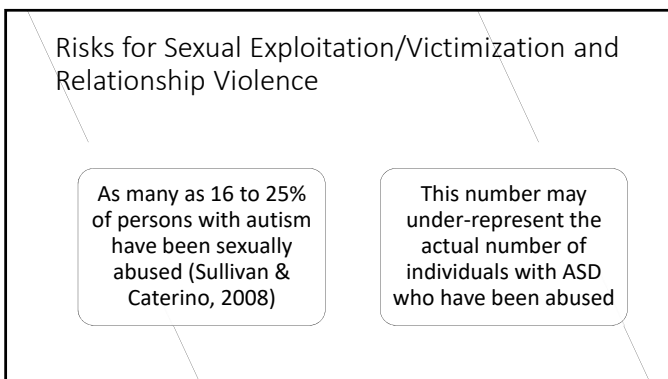
refusing to touch own penis while urinating

peeking behaviors

inappropriate sexual touching to parents

inappropriate touching of others (staff, parents, house guests, children)

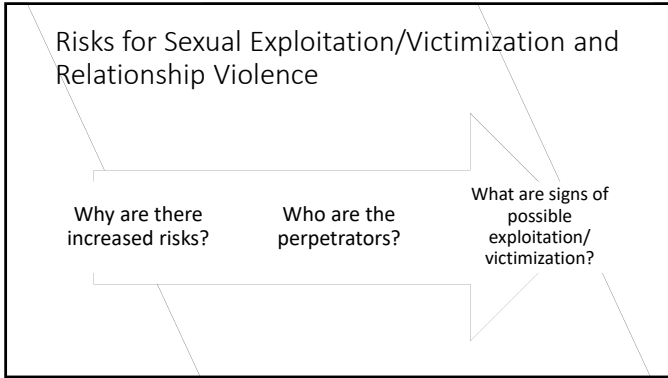
self-mutilation during masturbation for non-verbal individuals



It is estimated that between 61% and 83% of women and between 25% and 32% of men with an intellectual disability report having been victims of sexual abuse (McCarthy & Thompson 1997; Khemka & Hickson 2000). As for the population diagnosed with autism, an estimated 16–25% have been sexually abused (Mandell et al. 2005). (Normand & Sallafranque-St-Louis, 2015)

Individuals with ASD are at risk for more sexual solicitation on the INTERNET

Generally, society is not comfortable with people with disabilities having sexual desires, feelings and needs. Those same members of society are also likely to deny that people with disabilities are sexual or can be sexually abused or victimized.



Overprotection can also contribute to vulnerability. Hingburger, 1995 refers to the "Prison of Protection" in which in our effort to protect the individual, we tend to protect them from sexual information, decision making, society in general, and relationships. The prison of protection is built of kindness. When we service providers see someone as being 'vulnerable' because of who they are we become protectors. There are four walls to the prison. The walls are built to protect the person, who is seen as vulnerability encased in flesh. Unfortunately, this effort to protect the individual actually increases their risk of victimization and their ultimate vulnerability

evidence that over 50% of offenders of individuals with developmental disabilities had contact with their victims through some type of disability services with which they were involved. (Edelson, 2010)

Anxiety and depression may decrease the likelihood that individual will engage in relationships with others  
 May increase risk of excessive or inappropriate internet use  
 May experience social anxiety, particularly in unfamiliar situations with unfamiliar people

Medications used by individuals with ASD to ameliorate the symptoms of co-occurring disorders may impact sexual functioning


Ableism is a form of discrimination or prejudice against individuals with physical, mental, or developmental disabilities that is characterized by the belief that these individuals need to be fixed or cannot function as full members of society (Castañeda & Peters, 2000).

: Our finding that the individuals with ASD obtain less of their knowledge from social sources is in line with previous research. (Brown-Lavoie, Viecili, & Weiss, 2014)

The lack of these social sources means that individuals with ASD are left to obtain the majority of their sexual knowledge from non-social and often unmonitored sources, and in the current study, were more likely than peers to obtain knowledge from television/radio, pornography, and the internet (depending on the type of sexual knowledge). (Brown-Lavoie, Viecili, & Weiss, 2014)

General Principles for Intervention (Blasingame, 2011)

- Early, and ongoing, intervention
- Be specific, clear, and explicit
- Be consistent about relationship and sexual health and safety
- Address social aspects of relationships and sexual health
- Teach in real-life contexts




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Evidence-Based Practices for Use in Sexuality Education

- Direct Teaching/Training
- National Standards Project, Phase 2
  - Behavioral Interventions
  - Cognitive Behavioral Interventions
  - Modeling
  - Scripting
  - Self-Management
  - Social Skills Package
  - Story-based Interventions
- National Professional Development Center on Autism Spectrum Disorders
  - Visual Supports




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(Travers & Tincani, 2010)

Who Teaches Sexuality Skills to Individuals with ASD? Decision Making Guidelines

Deciding who will be responsible for teaching sexuality should also be determined during the IEP team meeting. Traditionally, parents and caregivers have been the primary providers of sexuality education (Fegan et al., 1993). Parents and caregivers provide the foundation for sexual development by demonstrating and modeling appropriate relationships within the home

Interventions

- Assessing Individual's, Parents', and Other Professionals' readiness to intervene with differences and difficulties



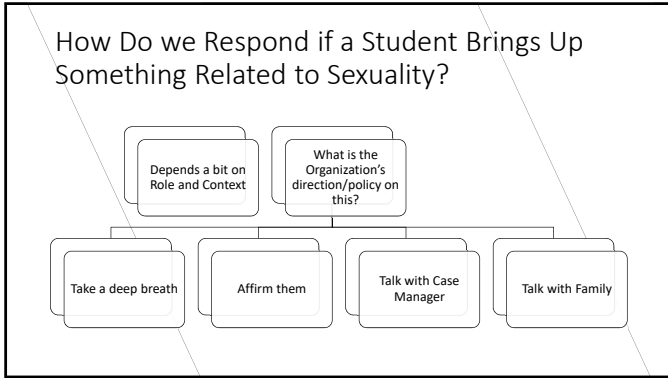
A Collaborative Effort: Collaboration is the ideal context to provide sexuality education to individuals with ASD. Parents and professionals may find comfort in working together to provide quality sexuality education. Through collaboration parents can be designated as the responsible party for providing explicit sexuality education that is consistent with their family's culture, religion, and/or other beliefs, while professionals are responsible for teaching skills for social development in the school and community settings. In combining efforts, maintaining communication, and building relationships with the family, positive outcomes are more likely.

Qualities for Professional providing training:

(a) feel confident and at ease, (b) be open and direct about the topic, (c) be aware of your own attitudes to reduce bias, (d) learn and understand current information so that it can be presented accurately, (e) maintain open relationships and communicate frequently with parents, (f) ask for help from a qualified individual (e.g., sex therapist) when needed, (g) repeat, reinforce, and generalize instruction, and (h) use multi-sensory tools (e.g., videos, pictures, models, charts, etc.) (pp. 15-16).

Parental capacities and needs also affect decision making regarding which form of intervention to use. Factors to consider include: (Blasingame, 2011)

- parents' level of motivation and desire to participate
- parental stress and depression
- level of social support
- parents' time availability
- parents' ability to maintain a consistent implementation strategy
- parents' own communication or social capacities or deficits
- parental substance use or history of violence
- parental access to resources, such as transportation




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Barriers to Parent Involvement (Hartman, 2014)

- 1) Skills, 2) Information, 3) Resources, 4) Desire to Protect, 5) Beliefs, 6) Grief, 7) Personal History, 8) Understanding, 9) worry that SRE could lead to perseveration of a particular behaviour, 10) Time/Stress/Money, 11) Negative experiences with professionals or schools, 12) Privacy




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