Sexual Education for Adults with Disabilities

Tool 9

Handbooks
Appendices

Appendices

This booklet contains appendices to the instructional guide and toolkit. It includes interesting theoretical information, resources and references to sources and methods that stimulate educators of individuals with intellectual disabilities to look beyond the information provided in The Box.

Contents

Social Development Stages in Children

Social development in infancy (0-3 years)

One-and-a-half years:
Basic trust versus basic mistrust: the child develops trust or mistrust, depending on how the parents respond to his or her needs.

Autonomy versus shame: the child gains a sense of autonomy if he or she is encouraged to explore, whereas over protection or limitation of exploration foster feelings of shame.

During infancy, attachment between the child and a specific individual is formed. This is usually one of the parents, but may also be a different caregiver in other situations. There are various styles of attachment: secure attachment, anxious-avoidant attachment, or anxious-ambivalent attachment.

Attachment classification in infants

Category	Seeking nearness to caregiver	Maintaining contact with caregiver	Avoidance of closeness to caregiver	Refusal of contact with caregiver
Secure	High	High (in stressful situations)	Low	Low
Anxious-avoidant	Low	Low	High	Low
Anxious-ambivalent	High	High (often due to separation)	Low	High

(Attachment classification in infants, Feldman, 2009)

At the end of the first year, infants go through a phase known as stranger suspicion, where they become extra wary of people outside their immediate family. In a big and unfamiliar world, infants search for familiar things. Unfamiliar situations or objects elicit fear responses. When infants do not know how to respond to an unclear wsituation, they look at the facial expressions and behaviour that others display in order to obtain clarifying information (social referencing).

Around the age of two infants start to show empathy, an emotional response that corresponds to the feelings of other persons.

Social development in toddler and preschooler years (3-6 years)

Initiative versus guilt: the child is faced with conflicting feelings – the desire to act independently from his or her parents and guilt caused by unintentional consequences of his or her actions.

Moral development is a process through which children develop a sense of justice, right and wrong, and associated attitudes and behaviours. During this development, children go through a stage in which they start thinking in terms of heteronymous morality. They see the world as an unchangeable collection of rules that are beyond anyone's control.

Abstract modelling ensures that toddlers no longer directly copy the behaviour of others, but start to develop abstract principles about the behaviour they see around them.

Around the age of three children start to form real friendships. These friendships are based on the desire to have someone to play and have fun with. Older children also form friendships based on things such as trust, support and common interests.

Social development in school-age years (6-12 years)

Industry versus inferiority: during this phase the child learns to master competencies to cope with problems relating to parents, peers and environment.

Social comparison is self-evaluation through comparing own behaviour and skills with that of others. This may also have an effect on the development of self-esteem, i.e. how the child perceives himself or herself.

During school-age years, three stages of friendship can be distinguished:

1. **4-7 years:** Friendships are based on likeability and sharing toys and activities. Friends are often children who the child spends most of his or her time with. Personal traits are not yet that relevant.

2. **8-10 years:** Personal traits and characteristics come into play when forming friendships. The rewards of friendships also start to play a role. Friends are children who are there when you need them. Abused trust is not forgiven that easily.

3. **11-15 years:** Views on friendship are often maintained in adolescent years. Intimacy and loyalty are important factors. This stage is characterised by psychological closeness and mutual openness. Less emphasis on common interests and the psychological benefits of friendship.

Social development in adolescence (12-20 years)

Identity versus identity confusion: during this period the child, now an adolescent, learns how to answer 'Who am I' by identifying what makes him or her different from other people.

In the adolescent's social world, ties with people outside the family become increasingly important, while the relationship with family may change or become more difficult.

In school years, adolescents develop autonomy, become independent and gain control over their lives.

Adolescents often have a certain group of people who they identify themselves with. This reference group, or clique, exercises a lot of influence, which may lead to peer pressure.

During this stage of life the composition of groups of friends often changes. While children usually have same-sex friendships throughout their elementary school years, cross-sex friendships are much more common as they grow older and adolescence kicks in. Social pressure to engage in (heterosexual) relationships increases and sexual organs start to mature, creating a strong interest in the other sex. Peer pressure can also be a factor in friendship formation.

Puberty opens the door to a significant new stage in terms of relationships. For many teens, sexuality is a big issue. Masturbation and various forms of intimacy (kissing, massaging, oral sex) often precede one of life's major milestones: sexual intercourse.

Another important topic on the agenda of many adolescents is sexual orientation. However, the threshold to give into same-sex attraction is often high due to prejudice and ignorance.

(Feldman, 2009)

The Hermeneutic Circle

The hermeneutic circle is a circular understanding process that gives a complete picture of a person by looking at various developments in his or her life, as well as the person's life history and ability to cope. There are two ways to complete the hermeneutic circle:

• Problem-focused: the circle is completed by listing skills and resources that the individual lacks, for example on a social or cognitive level.

• Solution-focused: the circle is completed by listing skills and resources that the individual possesses. This is done by taking his or her personal history into account and the challenges, if any, that were faced and overcome along the way. Crucial moments and their impact on the person's life can also be discussed here.

• The circle can be completed based on your experience with the individual, based on information from his or her file, or based on discussions where he or she explains the reasoning behind the decisions made. Note: good judgment is asked of the educator to ensure the individual is not overwhelmed by the process.
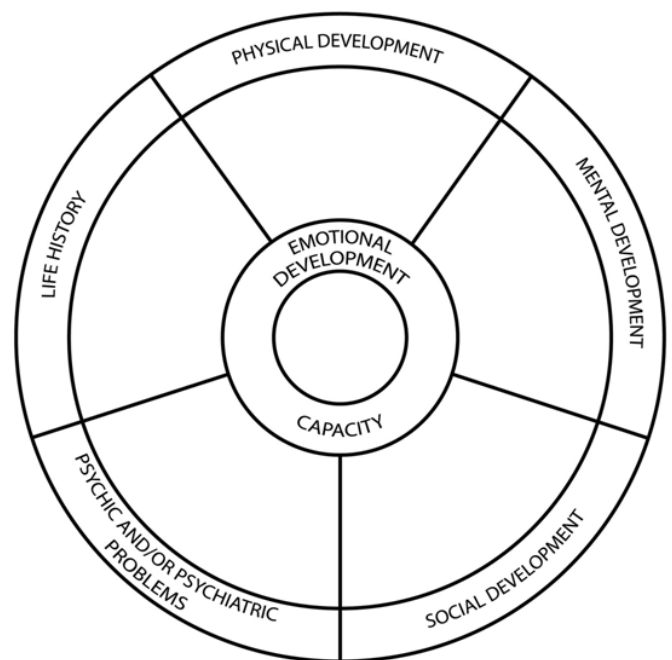
Recommended Methods and Sources for Training and Professional Development

To be completed by the country concerned.

Protocols for a Solution-focused Approach

The following pages contain protocols to help you get started with a methodological, solution-focused approach. The tools and tips provided can be used in teaching sexual education.

Appendix 1: Protocol for First Session

1 *Role clarification*
Information on the structure and duration of the session, whether there will be a break to reflect, and, if necessary, an explanation of the solution-focused approach.

2 *Matching your client's style/worldview*
The first step consists of building a positive working relationship with the client by going along with the client's worldview.

3 *Improvement prior to first session*
'What has changed since we last met or spoke with each other? The improvement question taps into the change process that may have already been initiated.

4 *Formulation/acknowledgement of problem*
'What brings you here?'
'How is that a problem for you?'
'What have you already tried and what has been useful?'
Acknowledgement is important: listening in a respectful manner, reflecting on feelings, giving compliments, defining the type of relationship between the professional and the client (customer, complainant, visitor), 'walking on two legs'.

5 *Goal formulation/miracle question (or related question)*
'You will go to sleep tonight, and in the middle of the night, a miracle happens and the problem that prompted you to talk to me (name specific problem) is solved or nearly solved. What has changed when you wake up tomorrow morning? What else?'

6 *Exceptions*
Are there any exceptions? When is the problem absent or less noticeable?
Together with the client, the professional looks for differences and exceptions, and the extent to which the client is able to control the occurrence of the exceptions.

7 *Scaling*
If 10 is: 'I have reached my goal' and 0 is: 'I have yet not reached my goal', where are you now on a scale of 10 to 0?

Scaling is often used to gain insight into the following areas:
• The client's progress during the sessions;
• The degree of hope the client has;
• The amount of energy the client is willing to invest in improving his or her life;
• The confidence the client has in terms of reaching his or her goal;
• The client's willingness to put the necessary effort into reaching his or her goal.

8 *Competency questions*
The professional compliments the client directly, asks competency questions (indirect compliments) and gives positive character interpretations:
• 'How brave of you to…'
• 'Where did you get that good idea to… ?'
• 'It takes a strong person to…' 'Please tell me more.'

9 *Feedback*

Feedback to the client consists of three components:

• Compliments for what the client has accomplished and positive character interpretations. Compliments are a positive way of reinforcing past successes and competencies.

• A reason (rationale or bridge) for the task (preferably in the client's own words).
The bridge connects the compliments to the homework suggestions or tasks. The bridge often begins with 'and because...'

• A task or homework suggestions. This component consists of one or more behavioural or observational tasks.

The solution-focused professional can introduce a five-minute break before the feedback, allowing time to think about what feedback to give.

The feedback provided differs for 'visitors', 'complainants' and 'customers':

• Visitors are not given suggestions for homework assignments (they do get compliments).

• Complainants are only given suggestions for observational tasks.

• Customers are given observational tasks and/or behavioural tasks.

Appendix 2: Protocol for Goal Formulation

1 *Goal formulation (miracle question or another goal-oriented question)*
•'What is your goal?'
•'What would be a good result for you?'
•'What do you want to replace the problem with?'

2 *Elicit details*
• After the miracle: 'What is the first thing you notice? What else?'
'Who else will notice when the miracle happens?'
'What will you do differently? What else?'
• 'What will your day be like after the miracle?'
And so on.

3 *Towards solutions*
'What is needed to have (a small) part of the miracle happen?', 'How might that happen?', 'Who could help you with that?'

4 *Task*
• Visitors are not given tasks.
• Complainants are given suggestions for observational tasks.
• Customers are given suggestions for observational or behavioural tasks.

Appendix 2: Protocol for Finding Exceptions

1 *When the clients talks about the problem, ask:*
2 *'When was the problem absent?'*
Or
'When was the problem less intense or less frequent, even if the difference was small?'
Or
'What days were better?'
Or
'When was your last good day?'

3 *Ask for details and explore how the exception came to be*
'What did you do to make that happen?', 'What did you notice?', 'What did you say?', 'What happened?', 'What was different?', 'What did you find useful?', 'How did you manage that?', 'How did that feel?', 'What else?', 'Please, tell me more!'

4 *Reinforce/Pay compliments*
Nonverbal: lean forward, raise your eyebrows, make notes (do what you would naturally do when someone tells you something important).
Verbal: show interest. 'Was this new for you?', 'Did it surprise you that this happened?'
Pay compliments and ask competency questions: 'That must have been pretty difficult for you', 'It required courage for you to do that', 'Where did you get such a good idea?'

5 *Project exceptions on situations in the futur*e 'What is needed to make this happen again?'
'What should you do?'
'Who can help you with that?'

Appendix 4: Feedback and Task framework

Feedback: compliments; rationale or bridge (reason for the task); task suggestions for when client wants to do a task

No goal	Observational task	Discover more
Spontaneous exceptions		Register desired behaviour
Goal Exceptions	Observational task	When are things the way you want them to be for a moment?
Goal No exceptions	Observational task	Take note of when the problem is absent
No goal	Behavioural task	Do more of what works Or: Do the easiest thing that works
Deliberate exceptions	Observational task	Pay more attention to exceptions
Goal	Behavioural task	Do a small piece of what works Or: Pretend
No exceptions	Observational task	Pay attention to what brings you closer to your goal
Goal Exceptions	Observational task or	More tasks possible

Figure 10

Task Framework

Type of relation	Goal and exceptions	Type of task	Content-based task
Visitor	No goal No exceptions	No task	Not applicable
Complainant	No goal No exceptions	Observational task	What is going well and what do you want to keep the way it is? What gives you hope?
	No goal Spontaneous exceptions	Observational task	Discover more
Customer	No goal	Behavioural task	Do something different

Appendix 5: Protocol for Follow-up Sessions

EARS:
Eliciting (drawing out stories): 'What is or what is going better?'
Amplifying (asking for details): 'How does that work?', 'How exactly do you do that?', 'Is this new for you?', 'What effect does that have on…?', 'What is different between you and...?'
Reinforcing (confirming): Give compliments and positive character interpretations and ask competency questions.
Start again (start over): 'And what is or what else is going better?', 'What else?', 'What is needed to do that again or more often?'

If nothing has improved: 'How do you manage?', 'How do you survive that?', 'How come things aren't worse than they are?', 'How do you do that?'

Scaling progress: 'Where are you now on a scale from 10 to 0?', 'How did you manage that?', 'What would a higher rating look like?', 'What would be different?', 'What do you need to accomplish this?', 'Who will be the first to notice?', 'How would he or she notice this?', 'How would he or she respond?', 'What rating is your ultimate goal?'

Optional: scaling motivation and confidence

Feedback: compliments; rationale or bridge (reason for the task); task suggestions for when client wants to do a task.
Is it necessary or would it be useful for you to come back? If so: 'When would you like to come back?' Or:
Is it necessary for you to talk more about… If so: 'When shall we meet?'

Appendix 6: Guidelines for Crisis Situations

Acute care
Chevalier (1995), Berg and Szabó (2006), Gersons and Olff (2005) provide guidelines for initial therapeutic care for people in acute crisis situations. These guidelines mainly consist of natural responses given by the client's family and friends:
• Give comfort and hope.
• Listen to the client's story.
• Accept the client's view of the world.
• Relate to the client's language.
• Create a sense of calm and order in chaos.
• Inform significant others.
• Use important people from the client's immediate environment to cope with the crisis.
• Ensure the client drinks and eats enough.
• Make a follow-up appointment.

Solution-focused approach
Contrary to a general misconception, it is possible to deal with crisis situations in a solution-focused manner. Because a crisis takes care professionals by surprise, they are often inclined to take control of the situation in a problem-oriented way. However, most clients in a crisis situation stabilise quickly if they are encouraged to focus their attention on what they would like to be different (goal formulation) and make use of past successes and competencies. Solution-focused interventions include:
• Inquire about the client's competencies.
• Explore how the client is coping with the current crisis: 'How are you managing?', 'How are you taking care of yourself?'
• Pay compliments.
• How did the client solve a previous crisis?
• Focus on the client's strengths.
• Ask goal-oriented questions: 'What helps you the most?'

• Ask relationship questions.
• Ask scaling questions that focus on the goal.
• Ask scaling questions that focus on progress in terms of coping.

Please refer to chapter 18 for solution-focused questions for clients in a crisis situation.

Appendix 7: Guidelines for Involuntary Clients

Lans, Medema & Rakers (2003) give practical advice for working with clients who find ambulant care to be intrusive (involuntary clients). The following pointers and strategies may prove useful:
• Sit next to the client. Show that you are working from a position alongside the client, rather than confronting the client.
• Frequently use the word 'together'.
• 'Getting a foot in the door' is an expression that symbolises a personal approach: the professional who is often (literally) confronted with a closed door shows that he or she is involved by visiting the client more often, leaving an invitation, calling or by getting information from neighbours or housemates.
• Show respect for the client by asking questions without being dismissive or judgemental. This is essential for maintaining a good relationship.
• Find solutions that result in a win-win situation for all parties. In doing so, display a cooperative attitude. Explore, together with the client, how broken or distorted relationships with other persons or institutions can be restored within the context of common interest.
• Show an interest in the client. Generating trust, informing and building up a relationship is essential in times when the client is not under pressure of the problem. Make good use of these calm periods.

Clients with intellectual disabilities are considered involuntary clients if they do not acknowledge their part in the problem's creation and set goals to solve it, while others (e.g. parents or care workers) do acknowledge this. Involuntary clients include clients with uncontrollable anger issues who professionals don't know how to deal with, or ambulatory patients with financial or addiction problems who refuse help.

De Jong and Berg (2004) give a number of guidelines for conversations with involuntary clients:
• Approach the client from a visitor relationship perspective. Assume that the client has good reasons to think or act in the way that he or she does.
• Do not pass judgement and accept the client's viewpoints causing his or her cautious, defensive attitude.
• Listen to who or what is important to the client, especially when the client is angry or critical.
• When the client openly expresses anger or criticism, find out what the person or institution could have done differently to change the outcome.
• Ask the client what would be in his or her best interest. In other words, what would the client like to achieve?
• Listen to the client's terminology and parrot his or her language when summarising, paraphrasing or giving feedback.
• Make use of the client's context in the conversation by asking relationship questions.
• Provide information about non-negotiable conditions in a respectful way, and ask how the client feels about these conditions.
• Work from a not-knowing position.

For clients with intellectual disabilities, using people from the client's immediate environment can be a useful addition to the individual sessions. Stories of significant others may especially be of use to the solution-focused professional if the client refuses or is unable to articulate his or her problems. A combination of client stories and those of significant others form a good start for a solution-focused approach. Involving others in the sessions cannot be done without the client's consent. Chapter 16 contains a case study of cooperation with significant others in the case of an involuntary client. Solution-focused questions for visitors are listed in chapter 18.