Sexologies (2014) 23, e99—e102

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ORIGINAL ARTICLE

Sexual behavioural disorders and intellectual disability: A case study of counterfeit deviance☆

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Available online 23 September 2014

KEYWORDS
Intellectual disability;
Counterfeit deviance;
Sexual education;
Holistic sexuality;
Sexual health;
Intervention

Summary This article aims, firstly, to explain counterfeit deviance from a current point of view. That is to say, explaining the scope of this concept in the psychosexual development of an individual with an intellectual disability. Secondly, the analysis of a specific case study supports this process in order to demonstrate its progress. It is described how socio-environmental factors can lead to an intellectually deficient individual to a deviant sexuality. Based on a holistic view of sexual health, clinical guidelines are proposed. The goal is to raise awareness among professionals to help them distinguish between genuine paraphilic disorders and counterfeit deviance in order to apply appropriate interventions to patients with their specifics sexual needs.

Individuals with intellectual disabilities (ID) have problematic behaviour, including aggressive behaviour towards others and destructive acts (Lowe et al., 2007). The incidence of problematic behaviours in individuals with ID is higher than among individuals without ID (Dekker et al., 2002). Intellectual functioning limitations and adaptive behaviour of individual with ID can bring them to do actions that deviate from social and cultural norms. These problematic behaviours affect the lives of people with disabilities and their families.

Some problematic behaviours include a sexual component. The incidence of sexual offending is four to six times higher among offenders living with an ID than in the general population (Barron et al., 2002). Especially since the risk of recurrence is statistically higher for offenders living with an ID (Craig and Hutchinson, 2005). However, they go through the same psychosexual development stages as any other citizen and they have the same rights regarding sexual health (Faucher, 2012). Therefore, diagnostic assessments and interventions concerning the sexuality of individuals with an ID need to be carried out by a specialized and collaborative multidisciplinary team (Claveau, 2014). Several factors other than biomedical and psychological must be taken into account before the development of treatment (Claveau

DOI of original article:
http://dx.doi.org/10.1016/j.sexol.2014.07.007.
☆ La version en français de cet article, publiée dans l'édition imprimée de la revue, est également disponible en ligne: http://dx.doi.org/10.1016/j.sexol.2014.07.007.
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http://dx.doi.org/10.1016/j.sexol.2014.07.008
1158-1360/

and Bouche, 2012). Certain adverse socio-environmental variables are more present among adults with ID, which increases their risk of developing inappropriate or abusive sexual behaviours. Examples include repressive and restrictive social attitudes, a different sexual conditioning, sustained punishment for normal and acceptable behaviour, minimizing problematic sexual behaviours, the scarcity or lack of social or legal consequences and ignorance of socio-sexual laws and standards (Faucher, 2012; Claveau and Boucher, 2012; Langevin and Curnoe, 2002). According to Claveau and Boucher (2012), problematic sexual behaviours are often denied, minimized or even reinforced by the attitude of the environment. It is under this social constructivist paradigm that counterfeit deviance is defined. This article presents the process of counterfeit deviance from sex education for people living with an ID. This process will then be illustrated with a case study. Finally, clinical recommendations including educational strategies related to counterfeit deviance are provided.

Intellectual disabilities and sexual education

Individuals with intellectual disabilities often lack sexual knowledge. The study by Galea et al. (2004) reports that lack of knowledge is related to STIs, sexual health, safe practices, legal issues and contraception. Adequate sex education regarding these issues is needed to promote greater independence and reduce risky behaviours. Educational interventions can increase sexual knowledge of individuals with an ID (Garwood and McCabe, 2000). Sex education has enabled them to increase their ability to give sexual consent, which makes their sexual behaviour less problematic (Faucher, 2012; Dukes and McGuire, 2009).

Although many organizations are trying to compensate for this shortcoming, many individuals with intellectual disabilities (ID) receive little or no sex education. Various factors inhibit sexual education among professionals, such as protective attitudes, lack of education, poverty, educational resources and cultural prohibitions (Lafferty et al., 2012). Erroneous deductions put forward that people with ID are unable to assume the responsibilities of an active and fulfilled sex life, given their vulnerability. It is feared that sex education creates an unhealthy sexual interest in people with ID, which would effectively encourage them to take action. No scientific data is available to demonstrate a positive correlation between knowledge about sexuality and sexual interest (Claveau, 2014). This author also points out that although this myth is widespread, it appears that an individual with more knowledge about sexuality has less irresponsible sexual behaviour. On the other hand, Faucher (2012) states that learning basic knowledge about sexuality (knowledge) and training in decision making (know-how) are essential for accountability and autonomy with respect to sexuality of people with ID (skills). A lack of adequate sex education can therefore lead not only to a lack of knowledge, but also a lack of socio-sexual skills.

Counterfeit deviance

Counterfeit deviance is defined as a false assessment of deviant behaviour resulting from influential factors. According to Hingsburger et al. (1991), counterfeit deviance may come from different sources, such as inappropriate and unpunished sexual experiences, lack of adequate support from the environment or inadequate education rather than actual deviant sexual interests. The same authors state that inappropriate sexual behaviour can be specifically attributed to a lack of intimacy, inadequate learning, low socio-sexual skills or even side effects from medication. For Claveau and Boucher (2012), counterfeit deviance is not the effect of a genuine psychiatric disorder or inappropriate sexual arousal. According to them, counterfeit deviance results from a lack of socio-sexual skills, since an individual with an ID has little opportunities to develop a healthy sexual life. In addition, the absence of appropriate and positive support about affection and sexuality leads to an important lack of essential tools in the construction of an adequate sex life. Thus, the concept of counterfeit deviance refers to deviant sexual behaviours in form but not in their basis. It is essential to provide appropriate services to prevent inappropriate sexual behaviour before it take the form of a structured and pathogenic paraphilia.

Case study

This story relates the case of Mr. M., 57 years old, institutionalized since childhood because of his moderate impairment and his inability to take care of his aging mother. Mr. M.'s unit of care has been changed several times due to his inappropriate sexual behaviour. Indeed, on four occasions he was found in another patient's room. On each occasion, he had a sexual relationship with another man. These patients were classified non-verbal because they did not have the ability to express their agreement or disagreement. Those sexual encounters were considered non-consenting. Therefore, it was sexual abuse.

A sexological intervention was requested to put an end to this problematic sexual behaviour. At first, a caregiver analyzed Mr. M.'s case, which included his medical and neuropsychological evaluations, daily records and a history of institutional living. Then, Mr. M.'s entire healthcare team; his psychiatrist, his nurses, his social worker and psychoeducator, met to exchange their point of view. Finally, the first two meetings were held with the patient to assess his own knowledge about sexuality and romantic relationships.

Several findings emerged from these preliminary steps. Firstly, the failure from the measures undertaken before had to be acknowledged. Indeed, the pharmacological approach to decrease Mr. M.'s libido did not bring the expected results as problematic behaviours were repeated. Isolating the patient and placing him under surveillance was not successful either, his sexual urge persisted and more importantly remained unmet. On the other hand, the patient's interpretation of sexuality was problematic and erroneous. Mr. M. confessed that the sexology specialist was the first person to talk about sex with him without reprimand (let's remember that he is 57 years old). According to Mr. M., masturbation represents the act of the devil. This is what he remembers about his sexual education during kindergarten, which could probably be explained by the generation gap. Mr. M. could only say one thing about