ASSESSMENT AND TREATMENT OF ADOLESCENT MALES WITH INTELLECTUAL DISABILITIES WHO EXHIBIT SEXUAL PROBLEMS OR SEXUALLY ABUSIVE BEHAVIORS

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ATSA Child & Adolescent Committee

The Association for the Treatment and Prevention of Sexual Abuse (ATSA) is an international, multidisciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning, ATSA promotes evidence-based practice, public policy, and community strategies that lead to the effective assessment, treatment, and management of individuals who have sexually abused or who are at risk to abuse.

ATSA is an association of individuals from around the world committed to achieving a high level of professional excellence. ATSA promotes the philosophy that empirically based assessment, practice, management, and policy strategies will enhance community safety, reduce sexual recidivism, protect victims and vulnerable populations, transform the lives of those caught in the web of sexual violence, and illuminate paths to prevent sexual abuse.

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Preface on Language

Our choice of language shapes perceptions and informs our understanding of issues. Great care was taken by the authors in selecting the terminology used in this document to accurately convey clinical implications.

The assessment, treatment, supervision, and case management of adolescents who have sexual problems or sexually abusive behaviors (SPSAB) are recognized as both complex and different from services provided to adults. This can be particularly challenging when adolescents also have intellectual disabilities (ID).

- ***Sexual problems or sexually abusive behaviors* are defined in this context as sexual behaviors that are or may be criminal offenses and/or abusive or harmful to others, that place the adolescent at odds with society's rules, and that may lead to legal sanctions.**
- **"Sexual problems" is incorporated into the term to avoid overpathologizing behavior, particularly when there is no adjudication.**

Estimates of the prevalence of adolescents with ID who have SPSAB varies from study to study, but the general view is that adolescents with ID are overrepresented in the juvenile justice system. Practitioners who provide assessment, treatment, and case management services to adolescents who have SPSAB therefore are likely to encounter adolescents with ID.

Overview

Adolescents who have ID and exhibit SPSAB are an important subpopulation of individuals involved with the juvenile justice system and require specialized attention. Each section of this paper therefore includes a review of the literature, whenever possible, in addition to elements that point to treatment and case management adaptations needed to accommodate an individual's cognitive abilities. Additionally, each section includes a discussion of limitations within the research literature and in the use of contemporary tools and approaches designed for mainstream adolescents who have engaged in sexually abusive behavior.

This paper summarizes much of what is known; however, much more is still unknown. Studies have noted problems when assessment measures that were originally designed for adolescents without ID were used with those who had ID. This paper provides suggestions regarding appropriate assessment strategies—including structured risk assessment instruments—and emphasizes the need to properly consider intellectual disability status.

Adolescents with ID most often receive community support services through local disability service agencies, but many professionals working with individuals who have ID do not possess knowledge or expertise related to SPSAB. Appropriate supervision and case management require cooperation and collaboration between families, the justice system, and disability service agencies. As definitive standards of care cannot be prescribed, this paper offers what are considered to be current, research-informed, and promising practices.

This paper provides information and practice guidelines for clinicians and evaluators working with adolescents with intellectual disabilities who have also engaged in sexually problematic behaviors. However, although readers will notice that this paper is, by its brevity, not all inclusive, many resources are noted that provide additional information for practitioners. It is beyond the scope of this paper to be exhaustive on any one topic, and this certainly may be said of each section herein. It is hoped that each section will pique readers' interest regarding issues relevant to working with adolescents with ID who exhibit SPSAB, in addition to providing references and resources that will help enrich their knowledge and practice repertoire.

Contents

Abbreviations

ATSA	Association for the Treatment and Prevention of Sexual Abuse
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*
ID	intellectual disabilities
PBS	positive behavioral support
PYD	positive youth development
RNR	risk, need, and responsivity
SPSAB	sexual problems or sexually abusive behaviors

Introduction

Male adolescents who have intellectual disabilities (ID) and who also exhibit sexual problems or sexually abusive behaviors (SPSAB) are a diverse group. Their cognitive and other neurodevelopmental conditions present as a broad spectrum of skills and abilities. They also exhibit a diverse range of sexual behaviors. The Association for the Treatment and Prevention of Sexual Abuse recognizes that female adolescents with ID may also exhibit harmful or problematic sexual behaviors; however, knowledge regarding this population is severely lacking. Much of the research and practice literature of the sexual abuse field focuses on the sexually harmful behavior of men, mostly adults and secondarily adolescents. This is in large part because sexually harmful behaviors and sexual offenses are committed primarily by men, who therefore constitute the largest and most feasible study group. In recent years, both empirical and clinical data on women who have engaged in sexually harmful behavior have increased; nonetheless, most research and resulting evidence-based guidelines are drawn from male studies. This lack of research on women who have engaged in sexually harmful behavior is even more prevalent on women with ID. Hence, the content of the paper is driven by research and clinical data drawn almost entirely from a male population.

The Nature of Intellectual Disabilities

Intellectual disabilities are complex conditions that often manifest themselves early in a child’s development and have lifelong effects (see the Assessment of Adolescents with ID section below for diagnostic criteria). These conditions are characterized by delays in achieving developmental milestones and by impairments in social, emotional, cognitive, and behavioral functioning. Some symptoms may be evident shortly after birth, but others may not be detected until the child enters school, where they experience greater academic or social demands. Although the long-term effects of cognitive functioning are relatively well understood, its effects on psychosocial development, processing of traumatic experiences, and sociosexual maturation are less so. These issues pose challenges to professionals who are working with families of children with ID and providing therapeutic services in outpatient and residential environments.

For the purpose of this document, *adolescents* are defined as individuals who have entered puberty and are aged 12 years and older (Herman-Giddens, 2006; Klein et al., 2017). It is difficult to precisely define the upper age limit of the developmental period of adolescence for persons with ID because social maturation and cultural adaptation can vary significantly from person to person. In the United States, for instance, federal regulations for educational funding allow individuals with ID to continue in the educational system through age 21; similar federal and provincial regulations exist in Canada and Australia. In England, additional supports and resources can be extended until age 25. This upper age limit clearly overlaps with early adulthood, which reflects the developmental immaturity within populations with intellectual and other developmental disabilities. As with other adolescents, those with ID may experience other conditions, such as autism spectrum disorder, attention-deficit/hyperactivity disorder, depressive or anxiety disorders, or other genetic conditions (American Psychiatric Association [APA], 2013; Fletcher et al., 2007). These co-occurring mental disorders often complicate the assessment and treatment processes for these individuals.

The Role of Intellectual Disabilities in Juvenile Justice Systems

Several meta-analytic reviews have supported the idea that having an intellectual disability is a minor but still significant factor in offending behavior, particularly juvenile offending (Andrews & Bonta, 2010; National Center for Injury Prevention and Control et al., 2001). It is difficult to know how many people with intellectual disabilities (ID) are incarcerated because the presence of ID is not well documented in arrest records. Nevertheless, studies have shown that when court appearances and police contacts are included with arrest records, individuals with ID make up roughly 10% of people who have criminal justice system involvement (Fogden et al., 2016; McBrien et al., 2003; Vanny et al., 2009). This would indicate that persons with ID are overrepresented in the criminal justice system, given that approximately 3% of the general population is diagnosed with ID (Blasingame, 2005). Men with ID are also much more likely to have criminal justice system contacts than women with ID, particularly for violent offenses (Fogden et al., 2016).

Several reports have indicated that adolescents with ID have characteristics that may place them at greater risk for problematic behavior. Asscher et al. (2012) reported that compared with neurotypically developing adolescents, those with ID have similar but more intense problems with goal setting, problem solving, accurate situational perception, interaction with others, difficult situations, feelings, and internal and external triggers. Asscher et al. also reported that adolescents with ID who have been involved with the justice system consistently have more difficulty with aggressive and violent behaviors than those without ID.

Reports have also shown that in addition to factors that predispose typically developing adolescents to delinquency, those with ID also have higher levels of impulsivity, exploitability, and desire to fit in with peers who may coax them to engage in delinquent or problematic behaviors (Douma et al., 2007). Additionally, the social information processing skills and related social deficits of adolescents with ID, such as poor emotion recognition and interpretation of social cues, have been associated with aggressive or submissive behavior when assertive behavior was called for (Jahoda et al., 2006; van Nieuwenhuijzen & Vriens, 2012). Failure to recognize the emotions expressed by others and failure to accurately interpret the nuances of social communication have been associated with aggressive responses due to hostile interpretations. Douma et al. (2007) reported that boys with ID were between one and two times more likely to exhibit problematic behaviors than their typically developing male peers. For these reasons, interventions to address specific behavior problems need to be multidimensional and applied early on to address such delinquent tendencies more broadly.

Sexual Development of Adolescents With Intellectual Disabilities

The onset of puberty for boys is typically between the ages 12 and 14 (Herman-Giddens, 2006; Klein et al., 2017). Puberty signals the beginning of the transition from childhood to adulthood and brings more than changes in secondary sex characteristics. The physiological changes also have a significant effect on mental, social, and behavioral aspects of the adolescent's life. This is further complicated when the adolescent has an intellectual or other developmental disability. Adaptive functioning deficits may impair an individual's ability to establish and maintain self-regulation, inhibitory controls, and general impulse control. These deficits can also contribute to significant social and sexual behavior problems.

Most adolescents with intellectual disabilities (ID) have typical and normal desires for intimate and sexual relationships. Although they may lack various interpersonal skills, there is no deficit in their desire for connection, acceptance, love, or affection (Blasingame, 2005). Many people with ID desire to have intimate relationships, to marry, and to have families of their own. However, for some youth, opportunities for age-typical exploration and experimentation in social and interpersonal relationships are limited or restricted due to family supervision constraints, out-of-home placements, or other factors that limit social engagement.

A significant number of adolescents with ID who have sexual problems or sexually abusive behaviors (SPSAB) have themselves been physically, sexually, and/or emotionally abused (Blasingame, 2005; Hudson et al., 2000). Although many of the perpetrators of that abuse are caretakers, many children and adolescents with ID have been abused by peers in school and group home settings. Overall, children, adolescents, and adults with ID experience victimization at a much higher rate than the typical population (Blasingame, 2010; Horner-Johnson & Drum, 2006; Reiter et al., 2007). People with ID are sexually abused at a higher frequency overall than the general population (Byrne, 2017), and children with a learning disability are more than twice as likely to be sexually abused than their peers without learning problems (Helton et al., 2018). As with other populations, childhood abuse and other adverse childhood experiences may interfere with healthy sexual development among adolescents with ID. Abuse can have long-lasting effects depending on the timing of the abuse and disclosure, response to the disclosure, coping skills of the victim, and the type of intervention provided in response to those experiences. Some adolescents with ID are unable to process the experience, disclose the abuse to a parent or supportive adult, or cope effectively with the emotional and psychological effects of being abused. This sometimes leads to maladaptive behavioral responses, including SPSAB.

Adolescents who have an autism spectrum disorder may also experience ID. Children and adolescents diagnosed with autism spectrum disorder both with and without ID have been shown to be at significantly greater risk for being abused and maltreated than their typically developing peers (McDonnell et al., 2019; Mandell et al., 2005). A variety of social communication difficulties are believed to contribute to their vulnerability for being abused (Blasingame, 2011; Sevlever et al., 2013). These include challenges with accurately interpreting other people’s verbal and nonverbal social cues, and thus detecting emotions, and impaired social perspective taking.

Adolescents with ID often have restricted or limited access to information about healthy sexual expression (Graff et al., 2018). Some adolescents with ID receive inaccurate or negatively framed information about sexual expression to dissuade them from such activity (Graff et al., 2018). Deprivation of accurate information about sexuality does not, however, do away with innate interest and developmental needs.

Sexual Problems or Sexually Abusive Behaviors Among Adolescents With Intellectual Disabilities

Lower full-scale IQs—more specifically, low verbal IQs—have been associated with greater sexual acting out (Blanchard et al., 1999; McCurry et al., 1998), including serious sexual problems or sexually abusive behaviors (SPSAB). Low verbal IQ scores may represent less than optimal executive functioning (Danielsson et al., 2012). *Executive functioning* refers to several cognitive and emotional tasks, including self-regulation, planning, decision making, problem solving, use of working memory, and attention shifting from one task to another. Executive functioning is often impaired or delayed in those with intellectual disabilities (ID). How these specific deficits influence sexual decision making is not fully understood, but recent research has begun to examine the connection between different types of executive functioning difficulties and adolescents’ engagement in SPSAB (Joyal et al., 2018; Yoder & Precht, 2020).

It is difficult to identify just how many adolescents with ID have committed sexual crimes (Fyson et al., 2003) as juvenile justice records do not consistently include ID as an identifier in case documentation. Further complicating the effort to calculate prevalence data is the fact that many adolescents in such circumstances are not adjudicated, particularly when the victim is another person with a developmental disability (Fyson et al., 2003). It is therefore likely that arrest records do not reflect the true frequency at which abusive sexual behaviors occur among adolescents with ID.

Specific forms of SPSAB in which adolescents with ID engage vary in severity (Blasingame, 2005, 2014a; McCurry et al., 1998; Miccio-Fonseca & Rasmussen, 2013). Research on adults with ID has indicated that men who have offended sexually (or who have problematic sexual behaviors) engaged in a wide range of behaviors, including (but not limited to) sexually touching children, coercing or forcing sexual contact on same-age peers, inappropriately touching peers or staff members, exposing one’s genitals in public locations, masturbating in public, calling phone sex numbers, and engaging in voyeurism, paraphilias, bestiality, fetishism, and frottage (Blasingame et al., 2011). Similar sexual behaviors have been reported among adolescents with ID (Blasingame, 2018; McCurry et al., 1998; Miccio-Fonseca & Rasmussen, 2013). These types of SPSAB may bring adolescents with ID to the attention of disability service agencies, child protective service agencies, or the juvenile justice system.

Effects of Parenting Adolescents With Intellectual Disabilities

Neurodevelopmental disorders such as intellectual disabilities (ID) impact parents and siblings as well as the affected individual (Cavonius-Rintahaka et al., 2019). Numerous studies have identified that raising a child with ID significantly increases parents' levels of stress, depression, and anxiety (Cavonius-Rintahaka et al., 2019; Feldman et al., 2007; Khamis, 2007; White & Hastings, 2004). Importantly, these difficulties appear to intensify for parents when their child with ID also displays emotional and behavioral difficulties (Blacher & McIntyre, 2006; Einfeld et al., 2006; Lecavalier et al., 2006). Although most individuals with ID live with their parents, many have special care needs due to multisystemic health problems or other genetic disorders (Friedman et al., 2014). Additionally, the presence of comorbid mental health conditions increases the risk of out-of-home placement (Esbensen, 2011)—and faced with the decision to place their child into out-of-home care, parents often experience additional ongoing guilt and worry (Friedman et al., 2014).

Parental skills, resources, and parent–child engagement are critical in preventing or appropriately responding to delinquent behaviors in youth with and without ID. Dishion et al. (2012) reported that coercive discipline by parents and rejection by peers negatively contribute to youth seeking out individuals who will be more accepting and often simultaneously support disruptive or delinquent behaviors. Negative peers provide little reinforcement for prosocial behavior or school performance but do reinforce talk and behaviors that support delinquent activity. Youth with intellectual or other developmental disabilities also face the risk of being shunned and having no peers with whom to associate. In terms of healthy development, youth with ID have a heightened need for prosocial assets in their families, peers, schools, and neighborhoods (Blasingame, 2014a; Bowers et al., 2011; Jones, 2012). The dynamic interaction between the individual and their familial and social contexts can either support or undermine positive outcomes.

Parental well-being can also be impacted negatively by their child's comorbid conditions. The presence of both ID and a mental disorder impacts parents, siblings, and other care providers who, in turn, impact the affected individual. Facing increased demands, these parents may develop issues that affect their ability to parent as well as take care of their own well-being (Cavonius-Rintahaka et al., 2019; White & Hastings, 2004), including heightened levels of stress, anxiety, depression, and other psychopathologies.

Having positive coping strategies and supportive social outlets that are accepting of their child can improve the family's overall quality of life (Blacher et al., 2005). Active coping skills and teaching and training at the family level can help parents and families to positively adapt to the affected youth's intellectual or other developmental disability (Jones & Passey, 2004). Empowering parents with pragmatic skills and strategies for managing their child's behavior can be achieved by direct intervention, as well as through participation in support groups. Parent training programs should focus on supporting the parents' implementation of positive behavioral support strategies (discussed below), which enable parents to develop greater abilities to address their child's behavior (Blasingame, 2014a; Carr et al., 2002; Jones & Passey, 2004). These strategies help parents develop a greater sense of internal control and improved coping skills (Shogren et al., 2006). Many parents of youth with intellectual or other developmental disabilities report a range of needs—from a supportive, listening ear to formal counseling and skills training—needs that often are not addressed in community programs (Douma, Dekker, & Koot, et al., 2006).

Overarching Treatment Approaches for Adolescents With Intellectual Disabilities

Positive Psychology

Treatment approaches that embrace the principles of positive psychology are as important, relevant, and applicable in work with individuals with intellectual disabilities (ID) as they are in work with all other clients. Positive psychology involves recognizing and building upon the strengths, assets, natural resiliencies, and possibilities of individuals rather than focusing on deficits or limitations (Seligman, 2002). An important operating principle of positive psychology is that individuals are capable of, and want to, develop and lead positive, meaningful, and satisfying lives; therefore, focusing assessment and treatment only on disorders, deficits, or vulnerabilities may lead to deficit-based treatment rather than to rehabilitative treatment. As such, it is important to ensure that treatment for adolescents with ID includes a strong focus on desired and achievable *approach* goals (i.e., teaching and promoting desired behaviors) rather than *avoidance* goals (i.e., only teaching avoidance of problematic behaviors).

Models such as positive youth development are based on the principles of positive psychology in that they focus on strengths and are sensitive to the wide-ranging issues of child and adolescent development. PYD itself has been introduced in the juvenile justice system (Schwartz, 2007). The PYD model holds that treatment and developmental models can be directed toward achievement of desired (approach) goals rather than simply the prevention of undesirable behaviors (avoidance goals). The core *five Cs* of the PYD model reflect many of the treatment goals found in contemporary models of treatment for sexually abusive youth at all cognitive levels: competence, confidence, connection, character, and caring (Roth & Brooks-Gunn, 2003a).

Although not an empirically validated model of treatment for male adolescents with ID who exhibit sexual problems or sexually abusive behaviors, PYD serves as an example of contemporary treatment for behaviorally troubled adolescents. Like positive psychology, PYD seeks to build upon and strengthen assets already present within the individual and their ecological environment. According to PYD, youth are not broken and in need of repair but are resources to be developed (Lerner et al., 2005). PYD programs not only seek to prevent continued unhealthy behaviors and interactions but also to build abilities and competencies by exposing youth to supportive and empowering environments that provide multiple opportunities for growth and the development of social capacities (Roth & Brooks-Gunn, 2003b; Geldhof et al., 2014). Mutually supportive and beneficial interactions with others pave the way for youth to avoid difficulties as well as to contribute positively to self and others (Lerner et al., 2005).

Literature on the efficacy of this approach specifically with youth with ID is limited but promising (Geldhof et al., 2014; Wozencroft et al., 2019). PYD approaches focus on developing positive, prosocial capacities by using the resources available within the adolescent's home and community (Blasingame, 2014a). In this regard, the core elements of the PYD model are consistent with adaptations of the good lives model (Ward & Mann, 2004) for adolescents (Wylie & Griffin, 2013).

A focus on the development of a prosocial peer culture also is important in developing treatment programs for juveniles with behavioral difficulties, particularly group programs or congregate care models such as residential treatment. The positive peer culture model, which also draws on the principles of positive psychology, emphasizes the potential benefits of mutual peer support and help. Although the positive peer culture model by itself is not adequate to address ID clients' range of needs (for instance, see Ryan, 2006), it is designed to develop social competence and increase self-worth, responsibility, and prosocial and caring connections with others (Laursen, 2010). Promoting positive peer relationships is but one aspect of positive psychology approaches.

Risk, Need, and Responsivity Principles

Many overarching research-informed strategies that apply to nondisabled adolescents who are involved with the justice system apply similarly to adolescents with ID. The use of research-informed treatment that follows the principles of the risk, need, and responsivity (RNR; Andrews & Bonta, 2010) model is well supported in the youth justice literature (Andrews & Bonta, 2010; Hoge & Andrews, 2011; Land et al., 2015; Latessa, 2006). This has been shown to facilitate a reduction in delinquency and crime, including sexual crimes (Hanson et al., 2009; Hoge & Andrews, 2011). The RNR principles, therefore, can help guide the overall assessment and intervention planning process.

The risk principle states that supervision and intervention strategies should be based on an individual's assessed level of risk for reoffense (Andrews & Bonta, 2010; Hoge & Andrews, 2011). The need principle states that interventions should focus on dynamic factors (i.e., criminogenic needs) that may contribute to an individual's antisocial and/or criminal behavior and that are changeable (Andrews & Bonta, 2010), as well as on individual and ecological protective factors (i.e., strengths that serve to buffer against risk). The responsivity principle states that interventions should be adapted to match the learning needs and style of each individual (Andrews & Bonta, 2010; Hoge & Andrews, 2011).

Based on RNR principles, assessment, treatment, and case planning recommendations should be based on the assessed risk for continued sexual problems or sexually abusive behaviors (SPSAB) and other nonsexual behavior problems. These recommendations should identify the primary treatment needs of the adolescent, including developmental and social needs. These recommendations also should identify the adolescent's likely responsiveness to treatment and any special issues that should be considered to ensure treatment services are best matched to the youth.

Positive Behavioral Support

Historically, people with developmental disabilities were often subjected to disrespectful, humiliating, and sometimes painful or abusive conditions in the name of "effective treatment" (Blasingame, 2010; Dykens, 2006). However, there is a growing body of research demonstrating that problematic behaviors can be improved with positive, nonaversive behavioral interventions and supports (Reid et al., 2004). Positive behavioral support (PBS) was developed in response to those aversive and harsh interventions of the past.

PBS is a set of research-informed strategies to increase quality of life and decrease problem behavior by teaching new skills to replace problem behaviors and by making changes in a person's environment (Association for Positive Behavior Support, 2021). PBS is not a specific practice or curriculum; rather, it is a general approach to preventing or changing problem behaviors.

The PBS schema assumes that:

- Behavior is learned.
- Problem behavior is linked to and reinforced by environmental factors.
- Behavior change occurs through manipulation of environmental factors and through direct intervention with the focus person.

PBS involves multidimensional interventions and supports, including:

- Implementing strategies to prevent antecedents and setting events (e.g., preventing precursors that create the environment in which the acting out occurs).
- Teaching replacement skills (e.g., teaching prosocial ways to get one's needs met).
- Using nonaversive consequence or response strategies.
- Using positive reinforcement and extinction (Moskowitz et al., 2011).

PBS calls for intervention strategies that:

- Fit the individual and the context where they are implemented.
- Prioritize the individual's needs, goals, and values.
- Consider the goals, values, skills, and resources of the family or other caregivers (Blasingame, 2014a; Carr et al., 2002; Moskowitz et al., 2011).

In PBS, the term "support" refers to using procedures and strategies that enhance personal competencies (e.g., developing social and self-calming skills) and making systemic changes to foster healthier environments where those competencies can be used to promote a good quality of life (Carr & Horner, 2007; Gagnon & Richards, 2008). Interventions must not only facilitate behavior change but also sustain those changes by ensuring that support continues once professional interventions are withdrawn. For youth with ID, the system changes usually need to occur in family, peer, and school contexts (Gagnon & Richards, 2008). It is critical to empower parents and families in their efforts to support behavior change and maintenance.

Collaboration Between Parents and Systems of Care

Adolescents with both ID and SPSAB and their families are often engaged with multiple systems of care. These include developmental disability service agencies, schools, mental health services, the probation system, medical service providers, social services, and juvenile justice agencies. Collaboration among the stakeholders in these systems supports both rehabilitation and public safety interests. Collaboration also has been associated with more effective treatment outcomes (Lipsey et al., 2010).

Better intervention outcomes are achieved when parents are involved in the process, particularly when the interventions promote positive, directive, parent–child interactions and the avoidance of inadvertent reinforcement of negative behaviors (Blacher et al., 2005). Empowering parents can be achieved through interactive psychoeducational groups or classes designed to improve parental attitudes toward supporting a child with ID (Blacher et al., 2005). Through engagement, education, and empowerment, parents can become more effective in carrying out their roles (Blasingame, 2014a).

Improved parental monitoring and engagement has been shown to have positive outcomes for adolescents with risky sexual behaviors (Dittus et al., 2015). Inviting collaboration increases the potential for positive outcomes in parenting, parental engagement in and support of treatment, and the youth’s participation in and response to treatment efforts.

Assessment of Adolescents With Intellectual Disabilities

Comprehensive assessment of adolescents with intellectual disabilities (ID) involves addressing a range of issues. Such multidimensional assessments attempt to capture all the various types of information needed in the development of a case plan for therapeutic intervention and supervision (Association for the Treatment of Sexual Abusers [ATSA], 2017; Blasingame, 2014b, 2018; Mussack, 2006a). As such, the assessment process needs to gather the following information about both risk and factors that protect against risk:

- Current cognitive and adaptive functioning.
- Individual strengths and assets, including support systems.
- Developmental and familial history.

- Family strengths and assets.
- Mental health history and current diagnosis.
- Sexual history, including sexual behaviors that lead to the referral for assessment.
- Static and dynamic characteristics associated with risk for reoffense.
- Environmental characteristics associated with risk for reoffense.
- Protective factors that may reduce the effects of risk factors, including access to health care and social support services.

Many psychometric and nonpsychometric tests and inventories are available to assess the level of psychosocial functioning, adaptive skills, and general knowledge and awareness of individuals with ID. Each can be helpful in completing multidimensional evaluations. The following sections explore a range of topics associated with the assessment of adolescents with ID who have sexual problems or sexually abusive behaviors (SPSAB).

Diagnostic Criteria

Persons with ID have been described variously in the literature as individuals with mental retardation, learning disabilities, developmental delay, and ID. The present paper utilizes terminology from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013), which discontinued use of the term "mental retardation" and adopted the internationally accepted term "intellectual disability." The DSM-5 notes that *intellectual disability* is the "equivalent term for the ICD-10 [International Classification of Diseases 10th Revision] diagnosis of 'intellectual developmental disorders.'" Based in DSM-5, a person may be diagnosed with an intellectual disability if they meet three diagnostic criteria (APA, 2013, pp. 33–41):

- Criterion A: The person has "deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing" (p. 33). DSM-5 explains in detail how this criterion may be comprehensively assessed using IQ tests (p. 37).
- Criterion B: The person has "deficits in adaptive functioning that result in failure to meet developmental socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community" (pp. 33, 37–38).
- Criterion C: The person experiences the "onset of intellectual and adaptive deficits during the developmental period" (p. 33).

Historically, diagnostic manuals differentiated degrees of intellectual disability based on full-scale IQ ranges. In DSM-5, the coding level of severity of intellectual disability is “defined based on adaptive functioning and not IQ scores” because it is adaptive functioning that determines the “level of supports” that the individual will require (APA, 2013, p. 33). DSM-5 provides a three-page table describing at length how individuals in the mild, moderate, severe, or profound levels of intellectual disability differ from others in other levels in the conceptual, social, and practical domains, with clear examples for children, adolescents, and adults within each domain and across levels (APA, 2013, pp. 34–36). This section of the DSM-5 is helpful for differentiating levels within the new nomenclature of intellectual disability.

Special Considerations in the Assessment of Adolescents With Intellectual Disabilities

As cognitive and adaptive skills functioning has a significant effect on how interventions can be modified for the individual, it is imperative that assessors take it into consideration. Cognitive functioning is customarily assessed using a standardized instrument, such as the Wechsler Intelligence Scale for Children (5th ed.; Wechsler, 2014) or the Wechsler Adult Intelligence Scale (4th ed.; Wechsler, 2008). Adaptive skills are commonly assessed using the Vineland Adaptive Behavior Scales (2nd ed.; Sparrow et al., 2005) or the Adaptive Behavior Assessment System (3rd ed.; Harrison & Oakland, 2015).

Most adolescents with ID who are referred for assessment of their sexual behavior have had their ID diagnosed; records of these diagnoses can be accessed from their school or the developmental disabilities service agency. Some past functioning test results may be too old to consider representative of the individual’s current functioning. In this case, the adolescent should be referred for current testing. Assessors should note that index and individual-scale scores from IQ testing can be much more informative than only the full-scale IQ score (Blasingame, 2014a). Additionally, discrepancies between subscale scores can invalidate the full-scale IQ. As low verbal IQ scores have been associated with greater sexual acting out (Blanchard et al., 1999; McCurry et al., 1998), it is particularly important that assessors take these into consideration. The assessor should conduct direct and indirect engagement with sensitivity to the individual’s vocabulary and language skills, communication skills, and social comprehension. It is critical that the environment in which information is gathered about the adolescent with ID and the manner in which it is gathered are sensitive to the nuances of ID and the adolescents’ deficits in adaptive behavior skills.

In many ways, a comprehensive assessment of sexual risk for adolescents with ID is no different than a comprehensive assessment for any other youth with a history of sexually harmful or problematic behavior. It should include a thorough review of the individual’s developmental, social, behavioral, and psychosocial functioning, as well as family context and educational history. The assessor should gather information from multiple sources and through multiple methods whenever possible and should not rely on a sexual risk assessment instrument alone (ATSA, 2017; Blasingame, 2005; Colorado Sex Offender Management Board, 2002; Rich, 2011; Shaw & the members of the Work Group on Quality Issues, 1999; Righthand & Welch, 2001). The possibility of fetal alcohol exposure, trauma, and brain injury should also be explored. However, in the case of adolescents with ID, the assessment process should be sensitive to and consider factors in the individual's psychosocial environment, as well as intellectual and psychological functioning that are especially pertinent to those with ID.

The literature specifically addressing assessment and treatment of adolescents with ID who exhibit SPSAB remains underdeveloped at this time (Miccio-Fonseca & Rasmussen, 2013; O'Callaghan, 2004). To some degree, assessors must turn to the wider literature on ID in general and the better developed (but still sparse) literature on the assessment of individuals with ID who offend sexually and non-sexually, adult and adolescent. Assessors should take into special consideration the ability of the individual to recognize and accept responsibility for poor behaviors; factors that may destabilize the individual, such as impulse control and self-regulation difficulties; significant mental health issues and substance use; capacity to engage safely and appropriately in community settings; ability to make discriminating decisions; and persistent beliefs about sexual behavior (Blasingame, 2005; Lindsay, 2004; Mikkelsen, 2004). Each of these factors is relevant to adolescents with ID.

Social and interpersonal skills are also especially relevant in assessing adolescents with ID (Beail, 2004). Additionally, Lindsay and Taylor (2009) stressed the importance of being sensitive to and understanding the general cultural context of individuals with ID. This points to a special requirement in the assessment of adolescents with ID—the need for the assessor to recognize and understand differences that may exist between the social world, environment, and circumstances of disabled individuals without ID and those of adolescents with ID, and how those with ID experience their world and other people in it.

Assessment of Risk for Sexual Reoffense

Risk assessment is the process of projecting or estimating an individual's potential for continued SPSAB. However, despite advances in recent decades in the treatment and management of those who have engaged in sexually abusive behavior (ATSA, 2017), assessing sexual recidivism risk among adolescents who have engaged in SPSAB remains complex. Even when using the best methods available, the element of clinical judgment remains central to the process. Training and experience in assessment are therefore required, including understanding of the unique individuals being assessed and the special features that may be relevant to each individual. This is especially true in conducting risk assessments with adolescents with ID who have engaged in SPSAB. Equally necessary is consideration of cultural factors, such as race, ethnicity, and gender identity; these factors may further impact the individual being assessed and perhaps exacerbate the influence of ID.

As noted above, although literature addressing the assessment and treatment of individuals with ID who have engaged in SPSAB has grown over the past decade, it remains relatively sparse.

To be most useful, the overall process should identify the unique factors or circumstances that may increase or decrease the possibility of further SPSAB. Accordingly, it may be more helpful to conceptualize the assessment of risk as a way of identifying the preponderance of factors that continue to represent risk for that individual. Risk factors frequently point to underlying developmental and social needs, which may then be addressed in treatment and case planning.

Contemporary risk assessment also evaluates the presence and influence of factors that protect against risk and decrease the potential for harmful behavior. These include stable and supportive relationships and environments, prosocial beliefs, moral reasoning, and supervision and monitoring. From this perspective, an assessment of risk is not based upon a single factor or even a group of factors. Instead, it is an effort to understand how certain factors influence the adolescent's engagement in problematic sexual behavior; as such, it identifies treatment areas that, if addressed, would promote positive development while diminishing future risk.

Assessment of Risks in the Environment

Assessments of adolescent behavior should focus on risk factors that reside and operate both within the individual and within their social and physical environment. Risk must be understood, at least in part, as contextual (Casey et al., 2009; Fanniff & Letourneau, 2012; Graham et al., 1997; Rich, 2009, 2011).

Adolescents with ID who have histories of SPSAB are at risk of being placed in supervised care, such as group home facilities. These placements can expose them to other individuals who may have challenging behaviors or other destabilizing effects. As exposure to antisocial peers or companions can increase risk, residential placement may in and of itself be iatrogenic (Blasingame, 2014b). This further supports the importance of considering environmental factors when completing risk and needs assessments of adolescents with ID.

Most of the instruments available for adolescent sexual risk assessment include a strong focus on environmental conditions and the adolescent's relationships in their environment. Indeed, assessing environmental conditions as well as interactions and relationships—with family members, peers, and caregivers, for instance—may be particularly important in the assessment of individuals with ID as these individuals may be especially sensitive to environmental stimuli (Hurley et al., 2007). Because of this, environments that may provide opportunities or inducements for behavioral acting out, access to potential victims, little supervision, or significant emotional demands or stressors should be considered when assessing risk for continued SPSAB.

Use of Structured Risk Assessment Instruments

It is widely recognized that risk assessments should be structured and anchored in the findings of empirical research. It is also recognized that structured and empirically guided risk assessments are more reliable and valid than unstructured risk assessment processes (for instance, Doren, 2002; Hart et al., 2003, Borum et al., 2002; Rich, 2009). Thus, structured assessments are strongly preferred. Additionally, use of an *evidence-based risk assessment instrument* (i.e., an instrument that includes factors that have been identified in research as relevant to risk for sexual re-offense) is considered best practice (ATSA, 2017).

However, the capacity of current risk assessment instruments to accurately predict sexual recidivism among adolescents has not been established (Caldwell et al., 2008; Fanniff & Letourneau, 2012; Knight et al., 2009; Viljoen et al., 2009; Viljoen et al., 2012; Vitacco et al., 2009). Further, no instrument alone is sufficient to complete the task of risk assessment (Bonta, 2002; Conroy & Murrie, 2007). Given this context and the relatively low rates of sexual recidivism in adolescents who complete treatment (Reitzel & Carbonell, 2006; Fanniff & Letourneau, 2012), using risk assessment instruments to identify the presence and amount of risk, need, and protective factors in the life and environment of each individual in order to shape and guide treatment may have greater value than using them to predict future behavior (Bengis et al., 2012). Additionally, an empirically based risk assessment instrument may not always be available or appropriate. Risk assessment instruments for adolescents with intellectual or other developmental disabilities that are informed by research on risk and protective factors specifically for adolescents with ID have yet to be fully developed. Consequently, the application of risk assessment instruments that are designed for adolescents with average or higher intellectual functioning to youth with ID must be considered carefully.

Assessment of Sexual Attitudes and Interests

Given the range of SPSAB that lead to referral for evaluation, the assessment of sexual awareness, knowledge, and interests is of great importance. Several studies have shown that persons with ID have low levels of knowledge about sexuality (Lunsky et al., 2007) and experience greater problems negotiating socially acceptable sexual interactions than persons without ID, although these issues can improve with appropriate interventions (Dukes & McGuire, 2009).

Hingsburger et al. (1991), proposed the notion of “counterfeit deviance” as one of several hypotheses that attempt to explain the demonstration of questionable sexual behaviors in persons with ID. The counterfeit deviance hypothesis posits that sexual behavior in some persons with ID may seem at first to be driven by deviant interests (which may also be unlawful) or arousal, but when all circumstances are considered, the reason for the behavior may be less concerning. For example, an adolescent with ID might not excuse himself to a bathroom when he feels a need to scratch his groin due to itching from a rash. Although several studies have questioned the validity of the counterfeit deviance hypothesis (Lunsky et al., 2007; Michie et al., 2006; Talbot &

Langdon, 2006), it does bring attention to two important points. First, persons with ID may lack awareness of the extent to which their behaviors are socially unacceptable (Lindsay & Taylor, 2009). Second, it is important to address environmental factors, especially the degree to which they may increase risk for sexual offending (Blasingame, 2018; Blasingame et al., 2014).

A number of instruments are available to assess sexual attitudes, knowledge, and interests:

- Self-report measures such as sexual history forms and questionnaires are commonly used to gather information about the onset of sexual awareness, types of sexual behaviors in which an individual may have been involved, sexual orientation, and general sexual knowledge. Although not validated, self-report is the oldest form of information gathering, and it is commonly used with adolescents with ID.
- The LifeFacts: Sexuality (Stanfield, 2021) sexual knowledge screening estimates an individual's basic factual knowledge about human anatomy and functions, feminine hygiene and menstruation, human reproductive process, various birth control issues, sexually transmitted diseases, and the interpersonal and social aspects of sexuality and sexual relationships. The Stanfield materials also include a structured curriculum designed for the developmentally disabled population. The LifeFacts screening is clinically oriented: The evaluator makes a clinical judgment as to whether the individual has a sufficient knowledge base or whether training is needed. This tool can be used with adolescents with ID.
- The Socio-Sexual Knowledge and Attitudes Assessment Tool–Revised (Griffiths & Lunsky, 2003; Lunsky et al., 2007) is normalized for individuals aged 15 and older and is designed specifically for individuals with ID. The tool measures basic sexual knowledge and attitudes regarding domains such as anatomy, sexual functioning, relationship issues of dating and marriage, pregnancy, and sexually transmitted diseases.
- Combining unobtrusively measured visual reaction time with a self-report questionnaire is a method for assessing sexual history, fantasies, and interests. This approach has been shown to be useful in both adolescents and adults who have engaged in sexually abusive behavior. The Abel-Blasingame Assessment System for individuals with intellectual disabilities (Blasingame 2018; Blasingame, et al., 2011) is one such measure. It was specifically designed for individuals with full-scale IQs from approximately 60 to the borderline intellectual functioning range. Preliminary data regarding use of the Abel-Blasingame Assessment System with adolescents have been similar to findings regarding its use with adults with ID (Blasingame, 2018). Although the value of visual reaction time used alone in assessing sexual interests has not been fully established and its capacity to be any more accurate than self-report has been questioned (Worling, 2006), the combination of visual reaction time with the questionnaire features in instruments such as the Abel-

Blasingame Assessment System may prove to be a useful in the assessment of sexual behaviors, interests, and fantasies.

Time Limitations on Juvenile Assessment

Contemporary research has recommended that adolescent sexual risk assessments be considered operative for only short time periods, although an exact period has not been specified (Caldwell & Dickinson, 2009; Fanniff & Letourneau, 2012). Adolescents are going through a period of significant developmental change; factors that may be influential in their behavior at one time can noticeably alter over a brief period. Therefore, any assessment of risk for adolescents is necessarily time limited and needs to be reconsidered when there are notable changes in the circumstances surrounding an adolescent's life (Worling et al., 2012)—for example, a family relocating, or parents being separated or incarcerated. This recommendation can be applied equally to assessments of both adolescents with ID and without ID.

Impact of Childhood Adversity on Adolescents With Intellectual Disabilities

A wide range of neurodevelopmental research has established that early life stress and maltreatment can confer substantial and lasting risk for developing cognitive, social, and emotional problems (De Bellis et al., 2009; McLaughlin & Sheridan, 2016; Middlebrooks & Audage, 2008; Perry, 2001; Teicher & Samson, 2016; VanTieghem & Tottenham, 2018). A significant number of adolescents with ID, with or without SPSAB, have themselves been physically, sexually, and/or emotionally abused. De Bellis and colleagues (2009) found that experiences of maltreatment can lead to a range of learning disabilities, including lower IQ and specific problems in reading, mathematics, complex visual attention, visual memory, language, verbal memory and learning, and effective planning and problem solving. There is a clear overlap between these processing difficulties and the characteristics that are inherent in having an intellectual disability. Frequently, the increased incidence of victimization of youth with ID is considered to be a reflection of their increased vulnerability to be harmed or manipulated by others. However, neurodevelopmental research has highlighted the possibility that, for many youths identified to have ID, their history of adversity and maltreatment may also be the causal basis of their ongoing learning problems (Blasingame, 2018).

In conjunction with specific learning problems, broad developmental issues have been associated with a child's experience of persistent stressors. These include attachment difficulties, significant deficits in self-regulatory functioning and inhibitory control, sensory integration problems, poor peer relationships, mental health problems, and involvement in the juvenile justice system (Aguilar et al., 2000; Creeden, 2017; McLaughlin et al., 2015; Ogden & Fisher, 2016; Raine et al., 2003; Scheeringa, 2011; Sebastian, 2015). Through their ongoing study of adverse childhood experiences, the Centers for Disease Control and Prevention has shown that repeated or pervasive exposure to these experiences can result in broader, cumulative harm beyond the impact that a single, specific adverse childhood experience may have on development (Middlebrooks & Audage, 2008). Along with a range of health-related problems and the developmental and learning issues already noted, the adverse childhood experiences study has identified an increased risk for specific behaviors that are related to child and adolescent sexual behavior problems. These include early initiation of sexual behavior, having multiple sexual partners, and risk for intimate partner violence. These problems were shown to increase incrementally with the addition of each identified adverse childhood experience (Song & Quian, 2020). Unfortunately, to date, no research compares adverse childhood experiences among adolescents with and without ID who have SPSAB.

In addition to the cumulative impact that adverse childhood experiences can have on structural and functional neurodevelopment, other factors may influence the nature and extent of difficulties that youth face as a result of childhood adversity and maltreatment. The developmental timing of these experiences, the type of adversity experienced, the severity of the particular event(s), and the availability of engaged and supportive caregivers are all factors that can exacerbate harm or promote resilience (Cohodes et al., 2021; Teicher & Samson, 2016; Weems et al., 2019).

Implications of Identifying Childhood Adversity

Perhaps the most immediate issue for attention when addressing emotional and behavioral problems associated with the experience of trauma is differentiating the type and severity of the problems from the characteristics of the learning difficulties or intellectual disability that the adolescent may experience. An exclusive focus on behavioral issues may obscure or minimize the importance of identifying a cognitive disability or of appreciating how that disability may contribute to serious behavioral problems.

Research on the neurodevelopmental impact of trauma has identified that a range of learning issues is associated with early adverse experiences. Prominent in a number of studies has been problems associated with language-based learning, including reading, receptive and expressive language processing, and verbal memory challenges (De Bellis et al., 2009; McLaughlin & Sheridan, 2016; Snow, 2009; Teicher & Samson, 2016). These issues create assessment difficulties on a variety of levels; in particular, those with receptive and expressive language difficulties and auditory processing problems often also have difficulties with attention, hyperactivity, and anxiety. These issues may make it difficult to engage these adolescents in the assessment process. By the time they have reached adolescence, many of these youth can present as disengaged, unmotivated, distractible, or openly oppositional as a means to cover up language and communication difficulties.

In addition to language-based learning problems, many studies have indicated that deficits in executive functioning skills often result from early, persistent stressors such as neglect and abuse (De Bellis, 2005; Nadeau et al., 2013; Perna & Kiefner, 2013; Schore, 2002; Weller & Fisher, 2013). As noted above, executive functioning refers to a wide range of cognitive and perceptual skills, including attention, concentration, anticipation, planning, abstract reasoning, concept formation, cognitive flexibility, and the ability to control impulsive, unsuccessful, and inappropriate behavior. Studies focusing on individuals with delinquent and conduct-disordered behavior have frequently identified executive functioning difficulties (Hughes, 2015; Morgan & Lilienfield, 2000; Pinsonneault et al., 2015; Raine et al., 2003; Scheeringa, 2011), particularly in individuals who engage in problematic sexual behavior (Burton et al., 2014; Stone & Thompson, 2001). These compromises in executive functioning only further compound the effects of having an intellectual disability.

The clear connection between neurodevelopmental difficulties and childhood adversity/maltreatment, coupled with the greater likelihood that youth with ID will experience adversity and maltreatment, indicates that attention to neurological and neuropsychological factors is important for understanding and assessing youth with ID and sexually problematic behavior. De Bellis et al. (2013) have argued—though some may disagree—that every child who has been involved in child protective services should have a full neuropsychological assessment as part of their systemic treatment intervention. This would also be a reasonable response for any adolescent involved in the juvenile justice system (Creeden, 2017).

In the absence of a full neuropsychological battery, gathering information on the adolescent's executive functioning skills through prior assessments or the use of instruments—such as the Delis-Kaplan Executive Function System (Delis et al., 2001), Behavior Rating Inventory of Executive Function (2nd ed.; Giola et al., 2015), the Conners Continuous Performance Test (Conners, 2004), and the 64 card version of the Wisconsin Card Sorting Test (Berg, 1948)—might start to be considered as necessary elements in any assessment protocol (Creeden, 2017).

Trauma-Informed Treatment

Key developmental concerns need to be assessed when considering treatment interventions and strategies. These concerns, to a great degree, frame what is commonly known as trauma-informed treatment.

The high incidence of trauma experiences in adolescents with ID who have engaged in SPSAB (Blasingame, 2010, 2018; Burton et al., 2011) calls for trauma-informed treatment approaches. This includes adapting specific trauma-informed approaches, such as trauma-focused cognitive behavioral therapy (Grosso, 2016), and addressing the issues identified in the neurodevelopmental research involving arousal regulation, language deficits, and executive functioning. It also includes incorporating aspects of trauma-informed care, such as attachment theory, mindfulness, sensory integration, and adapted dialectical behavior therapy approaches.

- Arousal regulation: Several authors have noted that the core of traumatic stress involves the breakdown of the capacity to regulate internal states such as fear, anger, and sexual impulses (Schore, 2002; van der Kolk, 2005). Treatment of SPSAB has historically focused on increasing an individual's capacity to modulate sexual impulses. However, research on the problems associated with persistent childhood stressors has identified broad difficulties in regulating physiological, emotional, and behavioral responses due to increased activation of complex networks within the brain (Bales & Carter, 2009; Porges, 2011; Teicher et al., 2002). These findings suggest the need for body-based treatment interventions that focus on bottom-up, as well as top-down, capacities to self-regulate (Ogden & Fisher, 2016).

    - *Bottom-up interventions* focus on helping adolescents accurately attend to and identify physiological cues that accompany dysregulation, as well as actions that can help regulate their responses to anxiety, distress, and trauma triggers. Some interventions include the use of movement, sensory integration and modulation, breathing techniques, and other body-based interventions. Initially, it may be helpful to pair these new skills with simple biofeedback mechanisms like heart rate and coherence monitoring and galvanic skin response. These biofeedback measures reinforce a sense of client control and effectiveness while encouraging the regular practice and use of these skills (Champagne, 2011; Hammond, 2005).

    - *Top-down cognitive approaches and interventions* are typically used in most treatment programs for individuals who have engaged in abusive sexual behavior. These approaches and interventions often include an understanding of triggers, recognition of high-risk activities or environments, an understanding of the negative consequences for oneself and others of engaging in certain behaviors, and the development of plans that address identified issues and needs in a more adaptive, prosocial manner. Top-down processing and planning should be done in a multimodal manner to accommodate the learning styles and difficulties of adolescents with ID that have been noted above. Top-down interventions with these adolescents should utilize clear and direct language, visual organization, and reminders. They also should provide the opportunity for practice and role plays that allow the client to learn, organize, retain, and integrate new ways of coping and problem solving (Craig & Hutchinson, 2005; Rose et al., 2002; Sakdalan & Gupta, 2014).

- Language deficits: Most clinicians are trained to engage people in a heavily language-loaded therapy process. However, research has pointed to deficits in language processing and language-based learning in youth with histories of abuse and neglect, and in delinquent populations in general (Perkins et al., 2011). This is further heightened for individuals with ID. Consequently, multimodal approaches to treatment that regularly utilize sensory-based, movement-based, and other types of experiential interventions are recommended. Jensen (2000, 2005) points out that children and adolescents are likely to be more engaged in the learning process and better able to integrate information when information is presented in a variety of modalities and attention is paid to the factors that influence neurological processing.

- Executive functioning: As noted above, research has identified significant executive functioning deficits in adolescents who have experienced trauma (Garrett et al., 2012; Lanius et al., 2003). Executive functioning difficulties have been associated with conduct disorders, behavioral impulsivity, and aggressive behavior (Brower & Price, 2001; Craig et al., 2004; White et al., 1994). Executive functioning skills impact self-regulation, effective problem solving, attention, and other areas that allow individuals to adapt and function every day. The educational field has increasingly focused on identifying executive functioning difficulties and enhancing executive functioning skills (Riccio & Gomes, 2013). Executive skill development should likewise be included in the assessment and treatment planning process for adolescents with ID.

Treatment for Adolescents With Sexual Behaviors and Intellectual Disabilities

Treatment developed for clients whose intellectual capacity ranges from low average to above average is not likely to be as effective with cognitively lower-functioning individuals. To be most effective, as with any treatment established within the risk, need, and responsivity (RNR) schema (discussed above), treatment for individuals with intellectual disabilities (ID) should be tailored to their particular needs and level of cognitive capacity. The treatment also should be developed and presented in a manner sensitive to the unique learning needs of individuals with ID. However, treatment for those with ID should not merely be a simplified or modified version of other treatments. Instead, it should be an intervention designed for adolescents with cognitive issues, with an emphasis on the individual’s strengths and weaknesses.

Diminished intellectual capacity significantly limits one’s ability to form abstract ideas and a set of related, highly developed, and age-typical formulations about the world and its operations. Diminished intellectual capacity clearly affects the ability to process, understand, and work with complex ideas that are more typical and expected of adolescents and adults. It also reflects diminished capacity to develop higher orders of abstract thinking, perspective taking, and empathy; to understand moral expectations; and to internalize a higher order of moral decision-making skills (Blasingame, 2014a). Neurological impairments further limit the development of these cognitive skills and capacities. As noted earlier, the sequelae of traumatic experiences may also inhibit progression toward development of adult-like empathy, moral reasoning, and the capacity to form intimate sexual and nonsexual relationships. This also means that the intellectually disabled individual may not recognize or understand the nature of emotional and cognitive experiences in others; thus, they may lack age-appropriate metacognition.

Determining the level and complexity of the materials to use in treatment is a necessary first step. It is also an ongoing aspect of treatment as clinicians learn more about each client and as each client progresses through treatment over time. The format of treatment materials and the level of treatment content must be specifically designed for adolescents with ID. Written materials should be at approximately the third to fifth grade reading level, depending on the individual's abilities (Blasingame, 2020).

Treatment aims to decrease the presence and influence of risk factors and to identify strengths in each youth and their family and environment. Building upon strengths and developing new prosocial skills, rather than simply treating problems, can contribute to the growth and change process.

Treatment Delivery, Content, and Material

The behavioral and relational issues addressed in treatment for youth with ID are largely the same as those for adolescents without ID; however, treatment for youth with ID may be narrower and more concrete in depth, content, and delivery. It may focus more on and revolve around behavioral management and reinforcement (Blasingame, 2014a). In addition, experience-based forms of treatment may be more helpful than verbally based forms.

Experience-based therapy addresses treatment and stimulates change in ways that rely more on performance skills than verbal and language-based processing and expressive skills. In many individuals with ID, performance skills are often better developed than verbal skills. Experiential methods typically involve multisensory learning, considered to be an important method in the education and treatment of individuals with ID (Baillon et al., 2002; Houghton et al., 1998). This suggests that treatment and intervention methods should induce learning through at least three channels: auditory, visual, and tactile or kinesthetic. In addition to written and verbal work, art, drama, music, recreational, and other largely nonverbal therapies facilitate self-expression and discovery, and present a multisensory approach to treatment. However, as many individuals with ID may have difficulty generalizing learned information to new or novel situations (described below), treatment strategies and interventions must also be developed that allow the application of new learning to a wide range of situations that individuals will face in their lives outside of the treatment environment.

Social skills training for youth with sexual problems or sexually abusive behaviors (SPSAB) is especially important in the treatment of youths with ID (Blasingame, 2005, 2011) and should be included in their treatment programming. Occupational and physical therapies are frequently useful in work with individuals with ID, with a focus on addressing, remediating, and developing a range of functional, social, and physical skills. These are necessary for improving social adaptation and self-management—common areas of concern for individuals who have SPSAB. Other special education services are commonly needed as well, including speech and language interventions.

Treatment materials, including workbooks and homework assignments, must be tailored for work with individuals with ID to accommodate their specific cognitive strengths and weaknesses (Blasingame, 2014a, 2020). One aspect of this is to ensure that the youth can read and comprehend any written materials used. With respect to cognitive abilities in the mild intellectual disability range, materials should be at a reading comprehension level that is between the third and fifth grade levels. Examples of these types of published materials include the workbook *Footprints: Steps to a Healthy Life* (Hansen & Kahn, 2012) and worksheets from the *Developmentally Disabled Persons with Sexual Behavior Problems* (Blasingame, 2005).

The dysfunctional behavioral cycle historically has been a feature of treatment for typically developing youth who have offended sexually. The issues identified in one's behavior cycle are often targeted with additional interventions. Changing one's cycle, if there is one, becomes an element of safe behavior and relapse prevention plans. However, not all adolescents who have offended have an actual cycle. Additionally, although this cycle model might appear simple, it can be too complex and abstract for youth with ID (Blasingame, 2005). Alternatives have been developed that are easier for developmentally disabled individuals to recognize and intuitively understand. For instance, Blasingame (2005) uses a linear model, referred to as the "ladder to trouble," rather than a cycle, in which seven rungs of a ladder illustrate steps toward problematic behavior. Using this model, individuals with ID can learn in a stepwise fashion about issues that contributed to their SPSAB. They also are taught alternative choices and behavior to avoid climbing the ladder. In *Footprints: Steps to a Healthy Life*, Hansen and Kahn (2012) use a board game format. Rich (2011) uses the safe steps model, which is also designed for work with individuals with ID, to replace the behavioral cycle with twin stairways, each with four steps progressively getting closer to either problematic or successful behavior. This also provides a linear and less complex model to help adolescents with ID learn about safe or problematic behavior.

These methods call for less abstract thinking. Additionally, they can be modeled in sessions using a real set of steps or a real ladder, by role-playing taking steps or climbing a ladder, or by drawing steps on a marker board. All these options create an opportunity for kinesthetic and multisensory learning. Even when content and materials are designed for clients with ID, depending on the intellectual capacities and skill sets of different individuals, treatment must ensure the clients comprehend the language and words used, as well as the ideas behind what may seem to nondisabled individuals to be a simple model.

As mentioned above, it is also important to recognize that some adolescents with ID may attempt to conceal their cognitive limitations and deficits and may avoid situations where these become apparent. Acquiescence has been identified as a potential problem in assessment and treatment (Blasingame, 2005; Blasingame et al., 2011; Finlay & Lyons 2002). Many may seem to acquire information but may not grasp its full meaning, understand how to apply ideas to everyday life or risky situations, or retain the information learned. In working with individuals with cognitive impairments, there is a risk that they may become effective at repeating, or parroting, information in a manner well enough to make it appear that they fully comprehend the material when that is not the case.

As noted above, another aspect of interventions for adolescents with ID is the task of *generalization*—the ability of the individual to apply learning about one situation to a different, novel situation. Because individuals with ID may have difficulty generalizing learned information, in addition to a multisensory approach, treatment and treatment materials must be designed so that concepts and behaviors are: (a) taught in a manner that best supports comprehension, (b) taught repetitively to help ensure retention, and (3) taught and applied across a variety of situations that best support generalization. Ideally, treatment interventions designed with generalization in mind will include a focus on the teaching and supervision of treatment activities and interventions under real-life circumstances rather than only those provided in controlled treatment settings.

Treatment should focus primarily on approach goals, such as healthy thoughts, behaviors, and relationships, rather than only on avoidance goals, or thoughts, behaviors, and situations to avoid. Approach goals are important in producing effective outcomes (Ward et al., 2006). They include goals desired by the individual, such as improving social skills, developing healthy relationships, and accomplishing school or work-related goals, among others. Promoting the acquisition of new skills while reinforcing and maintaining already known skills has significant support in the literature (Blasingame, 2011).

As mentioned previously, treatment should be multifaceted and address needs and goals relevant to the individual, including goals related to family, peer group, school, and the individual's community. Treatment should include a focus on mental health issues as well, ensuring that psychiatric needs are recognized, understood, and addressed. These domains for assessment and treatment are as important in a comprehensive approach to the treatment of clients with ID as with any other adolescent with SPSAB.

In work with clients with ID, it is important to provide opportunities for teaching and reinforcement of ideas and behaviors. For instance, visual cues can be posted that help clients to be honest, think about others, consider personal boundaries, and stop and think before engaging in behavior (Blasingame, 2005; Hansen & Kahn, 2012). These can help remind clients about the ideas of treatment, social expectations, and how to avoid difficulties and problem behaviors. Examples of visual cues are an angel's halo as a reminder to think of others, a broken fence to represent damaged boundaries, a traffic stop sign as reminder to think first, or an exploding bottle as a reminder of bottled up emotions.

Developing Appropriate Sexual Knowledge and Healthy Expression

Adolescents with intellectual and other developmental disabilities face several challenges in their sexual maturation process. The physical development for most of these youths follows the same pace as that of their typically developing peers, yet they lag in terms of the psychological and social aspects of sexuality (Blasingame, 2005, 2011; Mussack, 2006b). There are times when their behavior is more consistent with their mental age rather than their chronological age (Mussack, 2006b). There are also times when their behavior may result from nondeviant motivation, referred to as counterfeit deviance or pseudodeviant behavior, which nonetheless needs to be addressed (Blasingame, 2005; Hingsburger et. al., 1991; Mussack, 2006b). These nuances need to be differentiated during the assessment process (discussed above) to ensure that the behaviors are not overpathologized during assessment or intervention (Mussack, 2006b).

Concerns and issues that are typically important to address in the treatment of adolescents with ID who exhibit SPSAB include deepening their knowledge and understanding of age and socially appropriate sexual interests, relationships, and healthy sexual behavior (O'Callaghan, 2004). In the context of treatment and sex education that focus on healthy sexual development, it is important to be aware of the adolescent's sexual knowledge base to identify an appropriate beginning point for intervention. Several aspects of the individual's sexual knowledge base need to be ascertained and addressed during treatment, including the following:

- The vocabulary used by the adolescent and their caregiver to describe sexual anatomy, behavior, and relationships.
- The caregiver's cultural, religious, and sexual value systems.
- The adolescent's understanding of concepts such as private parts, private places, public places, and consent.
- The adolescent's ability to differentiate private sexual parts from the right to have all of one's body considered private and free from unwanted touch.
- The extent of the adolescent's knowledge of general social rules and conventions related to private sexual behavior and romantic relationship skills that might lead to sexual behavior.
- The extent and sources of the adolescent's sexual knowledge or information.
- The adolescent's ability to distinguish between appropriate and inappropriate sexual behavior or partners.
- The adolescent's own history of sexual, physical, or emotional victimization.
- The adolescent's history of exposure to pornography, sexting, sexual images, and other sexual materials.
- The adolescent's understanding of the potential consequences of engaging in inappropriate or abusive behavior, both for themselves and people they have harmed.

- The type of support that the adolescent’s family members or care providers provide them in developing sexual knowledge and expressing healthy sexual behavior.

- The existence of opportunities for the adolescent to express their sexuality in a healthy manner (Blasingame, 2005; Mussack, 2006a)

Efforts to provide adolescents with ID and other developmental disabilities with sexual education or interventions should begin with gaining explicit, informed consent from the youth, as well as their parents or legal guardians (Blasingame, 2011; Mussack, 2006b). Bringing parents and/or caregivers into a discussion of the content to be discussed; the level of sexual explicitness that may be involved; the types of props, materials, or media to be used; and other issues can serve to engage, educate, and empower parents/caregivers in their own roles (Blasingame, 2011). Although several sex education resources exist, it is important to recognize that a great deal of sex education is about relationship training (Schwier & Hingsburger, 2003).

To summarize, adolescents with ID are a heterogeneous group whose treatment requires special considerations. Even if two individuals have similar IQ scores, each person could have a different set of intellectual difficulties and strengths, a different set of functional skills and treatment needs, and different personality and temperament. Recognizing these differences is a critical first step in providing treatment to clients with ID.

Treatment should be comprehensive and directed toward the acquisition of ideas, behaviors, and social skills that promote prosocial psychosocial functioning and relationships. However, treatment must also be developed and delivered in the manner most appropriate for each individual client, including the developmental and intellectual level of each client, to provide the greatest opportunity for success. Whenever possible, this should include an emphasis on skill development, acquisition, and practice in real-life circumstances and not simply in a controlled treatment environment. Under all circumstances, clinicians must be sensitive to the unique needs of each individual client and ensure that there is a match between intellectual capacity, content, and form of treatment activities.

Residential Treatment Considerations for Adolescents With Intellectual Disabilities

Research suggests that adolescents with intellectual disabilities (ID) who exhibit significant behavior problems may be more likely to come to the attention of child protective services (Butchart, 2008). Those with behavioral issues also constitute a higher-than-expected portion of children placed in out of-home care (Fuchs et al., 2007). As discussed above, the presence of a comorbid mental health condition also increases the risk of out-of-home placement (Esbensen, 2011).

A variety of related factors appear to contribute to these findings. Lower intellectual functioning may be more prominent in socioeconomically disadvantaged families, and these families may be more prone to come to the attention of child protective services (Emerson & Hatton, 2007; Weiss et al., 2011). Children with ID may be significantly more stressful to parents, leaving these children more vulnerable to a range of poor parenting responses (Brown & Fudge Schormans, 2003; Govindshenoy & Spencer, 2007). Youth with ID may also have reduced access to health-promoting activities, such as a high level of parent–child verbal interaction and cognitive stimulation in the home environment (Weiss et al., 2011). As higher intellectual functioning is frequently found to be a prominent factor in enhancing resiliency in the face of adverse childhood experiences (Herrenkohl et al., 2008; Weiss et al., 2011), adolescents with ID may exhibit a greater degree of behavioral and social difficulties while simultaneously having fewer consistent family and community-based resources available to them. These problems may be exacerbated for adolescents who exhibit mild or borderline ID, since their learning problems can be unrecognized or unattended to in the context of serious behavioral issues.

Variables in Residential Placement for Adolescents With Intellectual Disabilities

Beyond the problems typically experienced in treating adolescents with serious behavior problems, adolescents with ID come to residential treatment settings presenting with a variety of other possible complications.

Broad Discrepancies Between Chronological Age, Cognitive Functioning, and Social/Emotional Development

All treatment programs and individual treatment providers should consider the adolescents they are treating within a developmental context. It is important to appreciate that adolescence is a period of significant growth and change and that there is a great deal of variability in the pace at which different adolescents will progress through these developmental changes. As noted above, it has become increasingly recognized that adverse childhood experiences and specific experiences of child maltreatment have significant neurodevelopmental impacts. These create serious obstacles to a more normative developmental trajectory for these adolescents. Balancing the capacities of the individual with the demands that are placed on them requires thoughtful consideration.

These variabilities can be accentuated in adolescents presenting with ID. When an adolescent is chronologically age 16 but has the adaptive social functioning of a 5- to 6-year-old and the cognitive skills of a child in the third grade, the treatment program must continually make decisions about the level of functional and behavioral demands the adolescent is capable of meeting and the level of social and emotional challenges with which they should be presented. In addition, provincial, state, or local educational systems often have different regulations regarding the limits on chronological age groupings allowed in classrooms or living environments. This can result in adolescents being placed in a setting with peers who have much more divergent levels of social interests and higher levels of adaptive functioning. Under these circumstances, individualizing day-to-day residential services becomes more challenging.

This may prove especially difficult when addressing psychoeducational and behavioral issues associated with normative adolescent sexual development in work with youth whose social, cognitive, and adaptive functioning skills are not congruent with their chronological age.

A Wide Range of Learning Disabilities

The heterogeneity of youth with abusive sexual behavior is "one of the most resilient findings in the research" (Caldwell, 2002, p. 296). The same is true for adolescents with ID. They do not all present with the same learning challenges. These adolescents can present with pervasive and wide-ranging developmental disabilities or with very specific deficits, some of which may have previously gone unidentified (Kira et al., 2012). These adolescents may have an autism spectrum disorder or attention-deficit/hyperactivity disorder, clear language-based processing problems, or another specific form of learning disability. On the other hand, although they may have deficits that make academic performance and adaptive learning especially difficult, other specific skills may be intact. This can lead residential staff and other involved adults to consider them more functional than they really are. The range of learning obstacles presented by adolescents with ID demands a higher degree of flexibility, more resources, and greater staff training than most residential treatment services consider when their programs are developed.

The Challenges of Residential Staff Training and Support

Adolescents with ID who engage in SPSAB and are placed in residential care are likely to exhibit a range of other behavioral and mental health difficulties. We have already noted the additional stress that these adolescents can place upon families and these stressors can not only continue but may be exacerbated when these adolescents are placed in group care. High levels of impulsivity, aggression (verbal and physical), and self-harm (intentional and unintentional) frequently accompany these adolescents into residential settings. Additionally, these adolescents' learning difficulties combined with the associative learning and cognitive flexibility problems that often accompany early child maltreatment (McLaughlin & Sheridan, 2016; Harms, et al., 2017) can make more typical behavior management strategies frustratingly ineffective. When we combine these challenges with an increased risk for engaging in sexually problematic or harmful behavior the demands on residential line staff and clinicians in a residential setting can be quite intense.

The majority of clinicians who work in residential treatment settings with ID adolescents do not come to the position with a great deal of experience or training working with adolescents with intellectual disabilities or working in residential treatment. Most graduate training does not include treatment approaches for working with ID clients. These clinicians tend to be newer to the field and rely on good supervision and a well-developed treatment program to support their professional growth and effective clinical interventions. Clinicians must be adaptive, patient, resourceful and open to utilizing a wide range of treatment modalities in order to meet the needs that these adolescents will present.

Residential care staff will be equally challenged. The need for patience, empathy, consistency, and persistence can at times feel draining. Change is unlikely occur rapidly and the need for repeating certain instruction and intervention several times can promote frustration. In addition to managing significant behavioral and mental health challenges residential care staff often need to teach basic adaptive skills such as personal hygiene, toileting, and other elements of self-care. Many of these adolescents will initially be resistant to the support and care of staff due to earlier histories of maltreatment or neglect by the adults in their lives. While the work can be tremendously rewarding, the level of energy and commitment required on a daily basis by these staff cannot be under-estimated. The need for training, support, guidance, and recognition for residential care staff needs to be a core element in program development and resources. Additionally, attention to self-care for all staff working in residential care should be a priority for program administrators and supervisors. Without specific and ongoing trauma-informed training, support, and guidance for working with ID adolescents with SPSAB, residential programs will be unable to provide the level of structure, consistency, and positive adult engagement that is required for these adolescents to make sustainable developmental and behavioral progress.

The Role of the Treatment Program in Relation to the Juvenile Justice System

It is not only the adolescents with ID who exhibit significant behavior problems or who have a comorbid mental condition that are more likely to be placed in out-of-home care. Depending on the jurisdiction and the severity of the offenses, many adolescents who are charged with committing a sexual offense may be diverted to a residential treatment program in lieu of immediate prosecution, or they may be committed by the courts to a residential treatment program rather than a more traditional juvenile detention center. Adolescents with ID are sometimes found to be not competent to stand trial for the identified offenses and are placed at a residential treatment program with open charges. The prosecuting attorney’s goal may be for the adolescent to make enough progress in treatment to be found competent to face trial, whereas the adolescent’s defense attorney may advise their client to limit their participation lest they face broader criminal sanctions. In all situations, regular clarification and clear communication with the adolescent and their guardian regarding the adolescent’s standing with the court and the parameters of the program in communicating with the court and other involved parties are recommended. However, clear communication and understanding can be more difficult when the client has notable impairments in language processing, memory, and abstract thinking.

Summary

Adolescents who have intellectual disabilities (ID) and have exhibited sexual problems or sexually abusive behaviors (SPSAB) are being referred to treatment specialists with greater frequency. It is well accepted that there is an overrepresentation of youth with ID within the juvenile justice system. Additionally, adolescents with ID and SPSAB sometimes are not formally adjudicated but are referred for services, nonetheless. Although youth with ID share several characteristics with adolescents who do not have ID, many of their characteristics are quite different. This paper has described several evidence-based and highly promising practices that enable practitioners to provide the most effective services for adolescents with ID and their families.

Several critical elements should be considered: Professionals who provide assessment, treatment, and case management services for these adolescents must be well informed of the available tools, their limitations in use with adolescents with ID and SPSAB, and the required adaptations or modifications to conventional treatment and case management models to deliver services most effectively. Moreover, professionals working with adolescents with ID and SPSAB should be well informed regarding the effects of cognitive impairments on the social and sexual development of adolescents and how these may impact the treatment process for everyone. Further, service providers must be cognizant of the effects on parents of having a child with ID, the effects of the family on the child with ID, the systems of care the family is likely involved with, and the necessity of promoting a collaborative case management process to treat and manage each individual within their broader life context most effectively.

This paper also has noted the need to consider the special needs of adolescents with SPSAB from the outset when designing and implementing treatment models, designs, and content, rather than simply adapting or modifying existing treatment materials that were designed for adolescents without ID. Similarly, attention must be paid to the special needs of adolescents with ID without depriving them of opportunities to engage in normalizing activities. This must be done in a manner that best suits individual learning weaknesses, strengths, and styles and that includes significant opportunities for learning and practicing new skills.

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Appendix 1: Recommendations for Residential Treatment for Adolescents With Intellectual Disabilities

1. Given their need for adapted treatment curricula, broader educational resources, specialized staff training, and greater flexibility in developmental expectations and demands, it is recommended that adolescents with intellectual disabilities (ID) who exhibit sexual problems or sexually abusive behaviors (SPSAB) only be placed in settings or programs that have been designed specifically with staff trained to provide services for individuals with ID. Being placed in more generalized residential treatment settings, even those developed to treat adolescents without ID and with sexual behavior problems, increases their chances for treatment failure and can exacerbate their difficulties with learning, thereby increasing the likelihood for behavioral dysregulation. Being in a placement with more delinquent adolescents can also make adolescents with ID more vulnerable to manipulation, social humiliation, victimization, and antisocial peer influence.

2. Given the learning and social difficulties they are likely to exhibit, an essential element of residential treatment for adolescents with ID is having a consistent and supportive daily structure and schedule. This should include clear and consistent guidelines regarding behavioral expectations and clearly defined consequences (both positive and negative) for engaging in different behaviors. Although these elements are considered to be a primary component of any residential treatment program, adolescents with ID—especially those with a history of traumatic experiences—will likely exhibit greater difficulty in effectively responding to behavioral expectations and limits when they are less clearly defined. They may also have difficulty adjusting to daily schedules that do not help them anticipate and plan for everyday environmental demands. Although expanding the ability of adolescents to respond to a range of environmental and social situations flexibly and adaptively should ultimately be a goal in all residential placements, this is particularly challenging for adolescents who present with limited capacities to self-regulate, accurately read social cues, employ cognitive flexibility and verbal mediation, resolve conflict, and generalize learning from past experiences.

3. Given the presence of a wide range of learning issues and the likelihood that most clients will exhibit deficits in language-based learning, multimodal and multisensory instruction and intervention will be an important element for all aspects of the residential program. Academic instruction, therapeutic interventions, and the teaching of daily living skills need to be accomplished through an integration of visual, experiential, kinesthetic, and verbal instruction. Frequent repetition of instruction with the opportunity to

actively practice newly acquired skills will be required for clients to integrate new information. All staff would benefit from supervision, support, coaching, and resources that assist them in utilizing a multimodal sensory approach in their work, rather than relying on traditional types of instruction for adolescents who may be more verbally oriented.

4. Treating adolescents with ID who have SPSAB should also challenge providers to realistically examine what they consider acceptable or "normal" sexual behavior for individuals with ID. This includes assessing the opportunities that individual programs (and society in general) offer these adolescents to develop more normative peer social and sexual relationships. It also means that residential treatment settings need to establish clear instructions and guidelines for what types of sexual behavior and sexual expression will be allowed in their programs.

   Too frequently, residential treatment programs for adolescents with SPSAB provide a view of sexual behavior and sexual relationships that is too broadly or vaguely defined (e.g., healthy versus unhealthy) or, when defining for clients what is acceptable and unacceptable sexual behavior, the programs do not realistically portray the prevailing, accepted sexual practices for adolescents and young adults in society. This lack of clear, realistic discussion and guidance is especially problematic for adolescents with ID who are likely to have more limited social exposure and sexual knowledge than their peers. These adolescents' view of "normal" sexual behavior is therefore more likely to be shaped by their own experiences of sexual or other traumagenic experiences or by a reliance on pornography as a means for sexual education. Residential treatment programs for adolescents with ID will need to grapple with the issues of providing sex education and guidelines around acceptable sexual behavior in a manner consistent with the learning and developmental capacities of the individuals they treat. This often means addressing social skills, sexual behavior, and sexual relationships in a more direct, concrete, and specific manner than many residential treatment settings may be accustomed to providing.

5. Given that adolescents with ID need experiential learning and regular practice of learned skills, and that they have difficulties in generalizing specific learning to broader situations, it is recommended that residential treatment settings incorporate a broad range of supervised community activities within their treatment programming. These should include opportunities to practice daily living skills (e.g., personal shopping, negotiating public transportation, etc.), engage in vocational training or work activities, attend athletic events and other community gatherings, and participate in individual and group community service activities. The type of community activity and the level of participation will depend on the capacities and developmental level of the individual. To ensure the safety of

the community and the individual adolescent, programs will need staffing to provide a level of supervision, coaching, and structure that is sufficient to optimize successful participation and learning. Perhaps even more than others, adolescents with ID need an opportunity to experience “positive failures.” These include the difficulties faced by many young people, and certainly those in treatment, when they are unsuccessful in meeting their goals, but where such “failures” are instead translated as social growth experiences when supported by the “safety net” of encouragement and guidance provided by effective interventions. Not all community activities will go smoothly but, except for genuine concerns regarding public and personal safety, these adolescents need chances to learn from experiences that do not go well. If supervision and coaching are available, allowing adolescents to sometimes safely struggle in managing the social and environmental demands of a given community situation is part of a useful and typical developmental process. This provides them and the treatment providers a realistic assessment of their adaptive capacities, decision making, and ongoing treatment needs. Participation in supervised community activities can also more accurately inform assessment of treatment progress and current risk.

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