OKLAHOMA CHILD WELLBEING • DISABILITY, SAFETY & AUTONOMY

Healthy Relationships, Boundaries & Consent

Accessible education for safety, autonomy, respect, privacy, and connection

Evidence-informed • person-centered • rights-respecting • plain-language

CORE IDEA

People with disabilities have the same human need for friendship, affection, privacy, belonging, intimacy, and meaningful relationships as other people. Safety education should build knowledge and skills—not erase relationships or replace a person's choices.

1. What a healthy relationship looks like

Relationships can include family, friendship, dating, romantic or sexual relationships, roommates, co-workers, classmates, neighbors, online contacts, caregivers, direct-support professionals, and other paid helpers. The rules and power dynamics differ, but respect and safety matter in all of them.

- You can say yes, no, stop, not now, or I changed my mind.
- The other person listens to your boundaries.
- You can have other friends and trusted people.
- You are not threatened, punished, humiliated, isolated, or controlled for disagreeing.
- Your private information, body, belongings, money, communication, and personal space are respected.
- Support is not used as leverage for affection, secrecy, money, sex, obedience, or access to basic needs.
- Conflict can happen in healthy relationships; fear, coercion, violence, exploitation, and retaliation are not healthy conflict.

2. Consent: a practical framework

Consent is an agreement to a specific activity. For consent to be meaningful, the person needs enough information to understand what is being proposed and a genuine opportunity to choose without force, threats, manipulation, or improper pressure. Consent is specific and ongoing.

Freely chosen

A yes obtained through force, threats, intimidation, blackmail, exploitation, or coercion is not freely chosen.

Specific

Agreeing to one activity does not automatically mean agreeing to another. Agreeing once does not mean agreeing forever.

Ongoing

A person can change their mind. If someone says or communicates stop, no, or withdrawal, the activity should stop.

Communicated

Consent can be communicated in different accessible ways. A communication disability does not mean a person has no preferences or cannot communicate choice.

Informed

The person needs relevant information in a form they can understand. Understanding may require plain language, visual supports, repetition, AAC, interpretation, or time.

Capacity is decision-specific

A disability diagnosis by itself does not answer whether a person can consent. Legal standards for sexual consent capacity vary by jurisdiction, and capacity questions require individualized, context-sensitive assessment.

> **IMPORTANT DISTINCTION**
> Compliance is not the same as consent. A person may have been taught to obey adults, caregivers, authority figures, or staff. Prevention education should explicitly teach that they can question, refuse, seek another opinion, and tell someone when a request feels wrong or unsafe.

3. Boundaries

A boundary describes what a person is comfortable with and what they are not comfortable with. Boundaries can involve touch, conversation, time, privacy, money, digital access, personal care, transportation, relationships, and many other areas.

- Body: who can touch you, where, when, and for what purpose.
- Privacy: who may enter your room, bathroom, messages, medical visits, or personal conversations.

- Communication: when and how people contact you; whether they may read your phone or messages.
- Time: whether you want company, need space, or want to leave.
- Money and property: who can use, borrow, manage, or access your money and belongings.
- Online life: passwords, photos, location sharing, private messages, and social-media access.
- Care and support: how assistance is provided, who is present, and what explanations or choices you receive.

Boundaries can change. A person does not owe the same access to everyone. Some professional relationships also have ethical or legal boundaries that apply even if the person receiving services appears to agree.

4. Bodily autonomy, privacy, and personal care

Needing help with bathing, dressing, toileting, medication, transportation, communication, or other daily activities does not erase a person's right to dignity and privacy.

- Explain what you are going to do before providing intimate or hands-on care.
- Ask permission and offer choices whenever possible.
- Use draping, closed doors, privacy screens, and the least exposure necessary.
- Do not make jokes, comments, photos, or conversations about a person's body that would be inappropriate with someone who did not need support.
- Give the person a way to report concerns that does not depend solely on the person providing the care.
- Where appropriate, create private time with healthcare, advocacy, or support professionals.

5. Pressure, coercion, grooming, and exploitation

Harm does not always begin with physical force. It may begin with trust, special treatment, secrecy, dependency, gifts, threats, isolation, rule-breaking, or gradual testing of boundaries. These behaviors should be evaluated in context rather than reduced to a single checklist.

Pressure

- Repeatedly asking after a no
- Making someone feel guilty for setting a boundary
- Saying they must prove love, loyalty, gratitude, or maturity

Coercion

- Threatening loss of housing, care, transportation, money, services, relationships, or safety

- Using authority or dependency to obtain compliance
- Threatening self-harm, exposure, punishment, or retaliation to force a choice

Grooming / boundary erosion

- Creating secrecy around the relationship
- Giving unusual gifts or privileges tied to access or loyalty
- Isolating the person from trusted people
- Normalizing increasingly invasive touch, sexual talk, or rule violations
- Convincing the person that others will not believe them

Exploitation

- Taking or controlling money or benefits
- Using a person for sex, labor, housing, transportation, status, or access to others
- Pressuring a person to share passwords, images, medication, property, or financial information

6. Power matters

A relationship may involve unequal power when one person controls essential support, transportation, communication, housing, medication, money, employment, grades, services, or access to the community. Unequal power does not automatically mean abuse, but it can make refusal harder and retaliation more consequential.

- Professionals and organizations should have clear boundaries, reporting routes, supervision, and conflict-of-interest rules.
- A person should know how to complain or request a different worker without losing essential support.
- Whenever feasible, avoid systems in which one individual controls every route to communication, money, transportation, care, and outside relationships.
- Teach the difference between a rule that protects safety or rights and a rule used primarily for another person’s convenience or control.

7. Accessible relationship and sexuality education

Systematic reviews of relationship and sexuality education for people with intellectual disabilities support person-centered, accessible education, but also show important evidence gaps. Many studies measure knowledge more often than real-world skills, and generalization and long-term maintenance of skills remain challenges. That means one-time instruction is not enough.

- Teach concrete skills, not only vocabulary.

- Use accessible formats: pictures, role-play, social narratives, demonstrations, AAC, videos, plain language, and repetition as appropriate.
- Practice across realistic situations while protecting privacy and dignity.
- Teach both rights and responsibilities: how to set a boundary and how to respect another person's boundary.
- Include friendship, dating, intimacy, online relationships, sexual health, privacy, abuse prevention, and help-seeking—not only "stranger danger."
- Revisit learning over time and across developmental stages.
- Involve people with intellectual/developmental disabilities in designing and evaluating education.

8. A simple relationship check

These questions can be adapted to the person's communication style. They are not a diagnostic tool.

- ☐ Can I say no without being afraid of what will happen?
- ☐ Can I change my mind?
- ☐ Can I spend time with other people?
- ☐ Can I have private conversations with trusted people?
- ☐ Does this person respect my body, belongings, money, phone, and personal information?
- ☐ Do I understand what this person is asking me to do?
- ☐ Can I ask questions without being mocked or punished?
- ☐ Does this person ask me to keep secrets that make me uncomfortable or cut me off from others?
- ☐ Does this person control something I need and use it to get what they want?
- ☐ Do I know at least two people or services I can contact if I feel unsafe?

9. If something feels wrong

1. Get to a safer place if you can. Immediate safety comes first.
2. Tell a trusted person. If the first person does not help, tell another.
3. Use the communication method that works for you—speech, text, AAC, sign, writing, pictures, or another method.
4. If there may have been sexual assault or physical injury, consider prompt medical care. Medical professionals can address injuries, pregnancy/STI concerns, and evidence options where applicable.
5. Preserve messages, photos, financial records, or other information if doing so is safe. Do not put yourself at greater risk to collect evidence.

6. Use appropriate reporting, advocacy, protection-and-advocacy, adult/child protective services, law-enforcement, or victim-service channels based on the situation and local law.

> **FOR SUPPORTERS**
> Listen. Do not interrogate. Do not blame. Preserve the person's words and communication as accurately as possible. Address immediate safety and medical needs, follow applicable reporting requirements, and connect the person with accessible, trauma-informed support.

10. Teaching safety without teaching fear

Overprotection can unintentionally reduce the very skills and relationships that help a person recognize and report harm. A stronger prevention model combines autonomy with safeguards.

- Teach what healthy behavior looks like—not only what danger looks like.
- Build a network of trusted people instead of one gatekeeper.
- Create multiple accessible ways to ask for help.
- Support ordinary friendships and community participation.
- Teach privacy without demanding secrecy.
- Teach reasonable risk, problem-solving, and recovery—not impossible promises of zero risk.
- Review organizational practices that create dependency, isolation, or unchecked power.

11. Guidance for families and professionals

- Do not assume a person is asexual because of disability.
- Do not assume every expression of sexuality is dangerous or inappropriate.
- Do not use disability as a blanket reason to deny age-appropriate information.
- Do not confuse a lack of prior education with inability to learn.
- Do not ask a person to disclose private sexual information in front of unnecessary observers.
- When capacity is genuinely in question, use individualized, functional, context-sensitive assessment and applicable legal standards—not diagnosis alone.
- Teach staff to recognize abuse by caregivers, peers, partners, family members, professionals, and other known people—not only strangers.
- Ensure reporting systems are accessible to people who use AAC, sign language, simplified language, or other communication supports.

12. What the evidence does—and does not—show

The evidence base supports the need for accessible, person-centered relationship and sexuality education and shows elevated violence exposure among people with disabilities. At the same time, systematic reviews identify limitations: programs vary, outcomes are often knowledge-focused, validated outcome measures are limited, and real-world generalization is not guaranteed. Good practice therefore combines the best available research with rights-based standards, accessible teaching, repeated skills practice, individualized support, and evaluation of actual outcomes.

References & trusted sources

Research hierarchy used: government/public-health guidance and disability-rights standards; systematic reviews/meta-analyses; professional consensus/position statements; then supporting peer-reviewed studies. Evidence strength and limitations are stated where important.

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