

**An Exploration of a Socio-Sexual Education Program for Individuals with
Developmental Disabilities: Changes in Knowledge and Attitudes**

Nancy Miodrag

A Thesis

in

The Department

of

Education

**Presented in Partial Fulfilment of the Requirements
for the Degree of Master of Arts (Child Study) at
Concordia University
Montréal, Québec, Canada**

March 2004

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ABSTRACT

An Exploration of a Socio-Sexual Education Program for Individuals with Developmental Disabilities: Changes in Knowledge and Attitudes

Nancy Miodrag

People with developmental disabilities (DD) rarely have opportunities to engage in programs that teach about socio-sexuality. The purpose of this study was to examine changes in knowledge and attitudes of people with DD after participating in a 6-week Socio-Sexual Education Program. Participants included 10 adults (5 males and 5 females) with mild to moderate DD who were assessed at the beginning and end of the program using four data tools including: (1) a questionnaire (2) an interview (3) observations and (4) personal documents. Analysis of questionnaire scores using a paired sample *t*-test was significant at the .05 level. That is, participants' scores significantly improved from Time 1 to Time 2. This suggests that participants' knowledge in socio-sexuality improved by participating in the program. Qualitative analysis using themes and case examples revealed that participants had mixed and ambivalent attitudes about issues such as discussing sex, masturbation, STDs and contraception, but showed learning in friendships, intimate relationships, dating, choice, feelings, gender, decision making, personal space, stranger safety, appropriate versus inappropriate behavior as well as identification of male and female body parts, private and public body parts, touch, condom use, hygiene, reproductive health, and abuse prevention. However, major misconceptions for masturbation and STDs were evident. The findings suggest that when SSEP are comprehensive and consider group needs' learning can occur.

Acknowledgements

This research study has been made possible through the extraordinary generosity of several individuals. First and foremost, Debbie Richards deserves particular recognition, as her support made it all possible. Without her efforts, the project could not have been completed, and for that and her friendship, I am extremely grateful. Next, I would like to extend my warmest appreciation to the centre for seeing value in this project and to the 10 participants who volunteered their time and participation. These individuals were courageous in sharing their personal stories, and for that I dedicate this project to them. In addition, I would like to extend my gratitude to Dr. Miranda D'Amico, my supervisor, for her constant guidance and support during the completion of the project. As well, words alone cannot express how lucky I am to have the kind of friends that have supported me in this journey. I am thankful for the “sessions”, suppers, and daily conversations that only my true friends could understand—Thank you to the “girls” (you know who you are) who have been there from start to finish. Thanks also to Courtney who though afar has always been near in heart. In addition, there are some very special families whom I owe everything to. First to my wonderful family—My mom Dragica, my dad Milan, my brother Ranko and his girlfriend Jovanka, Nick, and to “Majka” my grandmother for their unconditional love and caring, and for encouraging me throughout life. I cannot forget the Bozics, the Korovesi's, the Filipovics, as well as the Francis's, who have also been a constant support in my endeavors. Last but not least I am grateful to Dean, who has stood by me from the beginning, and who pushes me to better myself a little everyday. I cannot begin to express my appreciation for his love and understanding and for enriching my life and supporting my dreams.

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An Exploration of a Socio-Sexual Education Program for Individuals with Developmental Disabilities: Changes in Knowledge and Attitudes

“Sexuality is an integral part of the personality of everyone...It is the basic need and an aspect of being human that cannot be separated from other aspects of human life” (World Health Organization, 1975). Like anyone else, individuals who have developmental disabilities (DD) are social and sexual beings, irrespective of the fact that they have challenges learning. They deserve and have the right to sexual rights and social opportunities. Unfortunately, “the violation of human rights is nowhere more evident for individuals who have developmental disabilities in the area of sexuality” (Griffiths, Richards, Federoff, & Watson, 2002, p. 19-20). To date, people with DD have not been provided with adequate education in social skills and sexuality. For the most part, it is only when these individuals have committed a social or sexual mishap that they are referred to for intervention (Griffiths et al. 2002).

Literature Review

Historical Perspective

Given the long and tragic history of abuse and maltreatment of people with DD, a review of *socio-sexuality* education seems particularly timely. Historically, sexuality and sexuality education for people with DD was virtually nonexistent and ignored. Individuals with physical, cognitive, and social deficits were overlooked, demoralized, feared, and vastly underestimated. Unfortunately, these dehumanizing misconceptions were in full force throughout North America. People with DD were “portrayed and viewed as less than full members of our society” (Sobsey & Mansell, 1990, p. 61) and were branded as unproductive and inhuman. Because of this gross misunderstanding, they were segregated

according to their sex, in order to prevent them from reproducing other “mentally retarded” offspring. Quite blatantly, their sexuality and right to sexual expression was completely oppressed (Kempton & Kahn, 1991). Negative attitudes that demean the sexuality of these individuals continued to prevail and dominate conventional thought. For years people with DD were perceived as *asexual*, and because of this, society felt that they did not need sex education (National Information Centre for Children and Youth with Disabilities [NICHCY], 1992; Williams, 1991). They were also identified as eternal children, individuals who would never mature into adulthood (Horgos, 1998). On the contrary, the fact remains that “all children are social and sexual beings, from the day they are born” (Sugar, 1990 as cited in NICHCY, 1992, p. 2). Furthermore, NICHCY (1992) contends that sexual growth occurs through similar stages for both those with DD and those without.

Between 1880 and 1940 the wide spread *eugenics movement* began in order to keep restraint on the sexual reproduction of persons with mental retardation. According to researchers, “the proposed solution to societies problems was to improve the human race through selective breeding or eugenics” (Kempton & Kahn, 1991, p. 95). Selective breeding and mass sterilization was perpetuated by the misconception that people with DD were immune to physical and emotional pain and suffering. As a direct consequence, several hundred procedures of castration, ovariectomies, and hysterectomies were involuntarily performed (Griffiths & Lunskey, 2000; Kempton & Kahn, 1991). The trend for mass sterilization continued; people with DD were continuously being viewed as “damaged merchandise” the argument was “that the potential quality of life for such a person is so poor that the person is better off dead than alive” (Sobsey & Mansell, 1990,

p. 61). Consequently, “between 1907 and 1957 about 60,000 individuals were sterilized without their consent, many without their knowledge” (Paul, 1974 as cited in Kempton & Kahn, 1991, p. 96).

Quality of Life and Normalization

The civil rights movement of the 1960’s and 1970’s led to discussions of “normalization, de-institutionalization, civil rights, sex education, and birth control” (Kempton & Kahn, 1991, p. 100), which helped challenge traditional ideologies. Dramatic improvements in the lives of people with DD can be attributed to two significant trends—the principle of normalization and quality of life. Normalization materialized as a result of deinstitutionalization where people with DD were slowly being shifted to residential settings (Renwick, Brown, & Nagler, 1996). Essentially, normalization refers to the “normal modes and rhythms of life and patterns of culture in any given community” (Nirje, 1980 as cited in Pedlar, Haworth, Hutchison, Taylor, & Dunn, 1999, p. 18). The principle places emphasis on communal affairs so that people with DD can actively participate in an environment with similar activities to that of people without DD (Pedlar et al. 1999). As such, integration and inclusion in the larger community allows for leading fulfilling lives, and thus achieving a greater quality of life.

Quality of life is another broad social construct that “builds on other concepts that have already gained international recognition such as inclusion and normalization” (Matsumoto, 2000 p. 6). According to researchers, quality of life is defined as “the degree to which the person enjoys the important possibilities of his/her life” (Renwick, Brown, & Raphael, 2000, p. 10). More specifically, it is often associated with ones “life satisfaction, happiness, contentment or success” (Stark & Goldsbury as cited in Rowitz,

1992, p. 52). Although quality of life is abstract in nature, various components make up its entirety. These components include, but are not inclusive to “emotional, material, physical well-being; interpersonal relations, personal development, social inclusion, self-determination, rights” (Seltzer & Krauss, 2001, p. 9); “empowerment, autonomy, independence, personal satisfaction” (Pedlar et al. 1999, p. 54); “leisure, independent living skills, residential living conditions, community integration, social status, and financial security” (Edgerton, 2001, p. 9). The significance of quality of life to the socio-sexual lives of people with DD lies in the notion of choice and empowerment. As Brown (1996) suggests

Quality of life appears more related to an ability to gain power over a situation, to be able to express one’s opinion, and then be able to manipulate the environment to the best of one’s ability and according to one’s choice. It also appears to be related to improvement and a desire to have more effect on the environment (p. 260).

Recent trends towards normalization and quality of life are consistent with the philosophies and standards set out in many socio-sexual education programs (SSEP) such as choice, empowerment, decision-making, self-worth, self-esteem and relationship building with family, friends and the community. SSEP aim to integrate people with DD into the community by equipping them with practical tools to live “normalized” lives.

From the 1970’s until today, service providers and the community have begun to realize the importance of adhering to these concepts so that people with DD could achieve personal growth and healthy well being. Some of these efforts include a refocus on developmental services; a shift in living in independent housing facilities and group

homes; an introduction and integration of SSEP (Griffiths & Lunsky, 2000) and the perception of people with DD as capable learners and sexual beings (Kempton & Kahn, 1991). The misconception that people with DD did not have the knowledge to comprehend and put into practice socio-sexual information was slowly being dispelled (Horgos, 1998). Researchers found that even individuals with *severe* cognitive deficits could acquire and put into practice these skills (Page, 1991).

Recently there has been an increase in the promotion of SSEP. Parents, educator's, and professionals have begun to collaborate their expertise of social skills, sexual knowledge, and special needs; establish family planning education, and make way for appropriate and comprehensive programs (Kempton & Kahn, 1991). Other initiatives include establishing large scale conferences to address sexual rights and social skills learning; training educators "not just about biology, but also about relationships, marriage, dating, and parenting" (Griffiths & Lunsky, 2000, p. 18); creating guidelines in both law and practice; attending to the emotional needs of parents and providing them with support to teach socio-sexuality; developing a body of literature including books, guides, and training manuals; and finally, establishing policies and procedures to ensure successful outcomes for reproductive health and fertility rights (Abramson, Parker, & Weisberg, 1988; Griffiths & Lunsky, 2000; Kempton & Kahn, 1991).

Despite these advances, society still needs to address two controversial issues that faced the early 80's, today, and inevitably the future—HIV/AIDS, and the surge of sexual abuse and exploitation (Kempton & Kahn, 1991). According to research, "STDs constitute an important public health problem in terms both of their frequency and seriousness of the complications that can manifest when they are treated improperly or

not at all (Québec Ministère de la Santé, 2000, p. 13). While the movement towards prevention was well underway, “the first cases of AIDS were diagnosed in 1981” (Kempton & Kahn, 1991, p. 107). In general, individuals who had DD were minimally aware about the epidemics of HIV/AIDS and ways in which to reduce risk of contraction (McGillivray, 1999). Society began to realize that people with DD should not be exempt from learning about HIV/AIDS regardless if they were sexually active or not. Thus, many SSEP have included AIDS awareness as a critical component to holistic programming (Kempton & Kahn, 1991).

In addition to developing practical tools, investigators began to conduct empirical research. A number of studies confirmed the need for socio-sexual education. For example, researchers found that people with a DD were far more vulnerable to sexual abuse in the community than people without (Sobsey & Doe, 1991). According to the helplessness myth proposed by Sobsey and Mansell (1990), merely characterizing these people as weak and defenseless plays a part in their victimization. As well, investigators at Toronto’s Roeher Institute revealed that the rates of sexual abuse for people with DD who had participated in sex education were significantly lower than for those who did not participate. Consequently, socio-sexual education is now a major predictor of protecting individuals from sexual abuse and further victimization (Griffiths & Lunskey, 2000).

To date, dramatic improvements in all areas of socio-sexuality are being made. For example, people with DD have learned to form healthy social and sexual relationships with others, and society in general is beginning to view SSEP as both beneficial in the prevention of abuse, and in acquiring knowledge in social skills such as establishing friendships, and displaying appropriate behavior (NICHCY, 1992).

What is Sexuality?

According to current literature, sexuality can be defined as:

Encompassing the sexual knowledge, beliefs, attitudes, values and behaviors of individuals. It deals with anatomy, physiology, and biochemistry of the sexual response system; with roles, identity and personality...it addresses ethical, spiritual, and moral concerns and group and cultural variations

(Haffner, 1990 as cited in NICHCY, 1992, p. 2).

“Sexuality is a social phenomenon, in that all of us are social creatures who seek and enjoy “friendship, warmth, approval, affection, and social outlets” (Way, 1992, Edward & Elkins, 1988 as cited in NICHCY, 1992, p. 2). Other researchers such as Ikeler (1990) suggest that sexuality comprises more than just sex organs and physical sexual contact. Much more than the biological desires, he states, is the emotional and spiritual desire that drives one individual to another. Researchers such as Meister, Norlock, Honeyman, and Pierce (1994) further assert that sexuality cannot be learned overnight; rather, “sexuality is a lifelong process, present from birth or before birth...that consists of a sequential unfolding of behavioral, physiological, and emotional responses” (p. 285). As such, human sexuality is an intermingling of the biological, such as bodily drives and needs, the spiritual, such as the deeper more intimate connection one has with another individual, and the social, such as the feelings individuals possess about themselves, understanding oneself as a sexual creature, and the bonds that are formed as humans devote themselves to others (NICHCY, 1992). Hingsburger, vanNoort, and Tough (2000) state, “The drive and need for intimacy is greater than the drive and need for sex” (p. 11).

Sex Education: Content, Design and Method

Social skills and relationship training

A well-structured program often takes the best from successful sources, philosophies, and disciplines. According to Kempton (1993), the work that educators do “under the heading “sexuality” encompasses the whole and complete person” (preface). Taking into consideration the complete person includes one of the most basic yet critical areas of sexuality training—Social skills and relationship building. Social skills training allows for people to build basic skills that may be lacking. Sadly, people with DD have few opportunities to socialize, and end up having few experiences and friends. According to Hingsburger (1990) most of their social circle revolves around workers such as staff at group homes who are paid to be there, not on their own free will.

Working to enhance social skills teaches people with DD to conduct themselves in socially acceptable ways, which can lead to developing relationships (Kempton, 1993; NICHCY, 1992). This derives from the notion that society is based on a system that upholds socially appropriate rules and norms. Knowing what to say and what not to say in public for example, is a required skill for social integration and acceptance (Whitehouse & McCabe, 1997). However, a lack of social experience can greatly hinder the person with DD. According to researchers, limited contact with others in the community “may lead to difficulty in establishing meaningful relationships and curtail development of essential social and emotional skills in adult life” (Thomas et al. & Blackburn, 1993 as cited in Blackburn, 1995, p. 352). For example, NICHCY (1992) states that individuals may struggle with acquiring basic social actions such as “turn-taking during conversations, maintaining eye contact, being polite, maintaining attention,

repairing misunderstandings, finding a topic that is of mutual interest, and distinguishing social cues, both verbal and non-verbal” (p. 6). Foxx, McMorrow, Storey, and Rogers (1984) explored issues that they felt warranted investigation such as “compliments, social interaction, politeness, criticism, social confrontation, and questions/answers” (p. 10).

People with DD, especially young children and adolescents may experience social isolation because of their disability (Cole & Cole, 1993). Consequently, researchers report: “It is entirely possible that the adolescent with a DD may have to be a spectator on the sidelines rather than a participant in exciting and demanding experiences of socio-sexual development” (Cole & Cole, 1993, p. 196). There are countless reasons why they may experience social segregation during adolescence. For example, they may have a deficit in knowing how to approach others; they may be shy in initiating conversations because they lack self-confidence; the disability itself could physically hinder transporting to and from social events; or they may require continuous care or direct supervision from an adult (NICHCY, 1992). Cole and Cole (1993) add that individuals with *specific* physical disabilities may find it physically challenging to become socially integrated into group atmospheres and end up accepting a more passive versus active disposition. Unfortunately, these individuals learn to experience life by observing rather than by engaging. In spite of this, Edwards and Elkins (1998) as cited in NICHCY (1992) maintain that: “Socialization skills are learned everyday” (p. 6) giving hope to people with DD for lifelong learning.

Likewise, research conducted by Hobson, Ouston, and Lee (1989) as cited in Kempton (1993) state that the need for social skills training is invaluable to ones quality of life. Investigators in this study explored whether people with mental retardation “have

impairments in the recognition of other people's facial and vocal expressions of affect" (p. 114). The results provide evidence to suggest that in comparison to a group of typically developing individuals, people with mental retardation were less capable in measurements of coordinating and thus "recognizing, facial and vocal expressions of emotion" (p. 114). As such, people with DD need constant practice for doing the right thing, at the right place, with the right people (Kempton, 1993).

Some social skills can be particularly challenging to tackle. According to Duncan and Canty-Lemke (1986) as cited in NICHCY (1992), the two most common social blunders that people with DD make are "stranger-friend errors and private-public errors" (p. 7). In the first situation, individuals often have trouble distinguishing between a friend and a stranger, and as a result, end up treating everyone as the former. The second situation occurs when individuals do not have the skills to distinguish between a private and public act (NICHCY, 1992). Fortunately, both social mistakes can be avoided by teaching this in SSEP. One of the most highly acclaimed educational programs for social skills teaching is the Circles Method of Teaching Social Behavior created by Walker-Hirsch and Champagne in 1982. According to Kempton (1993) *Circles* is a non-threatening, highly effective tool addressing "one of the most troublesome behaviors of persons with mental handicaps—approaching or touching others inappropriately" (p. 88). The concept is based on a concentric colour coded system, which teaches that there are different kinds of relationships, and "behaviors commonly associated with differing degrees of intimacy" (p. 88). The six concentric circles include: The purple *private* circle, in which no one should touch you unless you want to be touched; the blue *hug* circle, in which a mutual decision exists to be close to someone; the green *far-away* circle

indicating that there are few people who hug you such as your mother, or a girl/boyfriend; the yellow *handshake* circle reinforcing that there are certain people that you only ever shake hands with; the orange *wave* circle, reinforcing who you wave to, such as children; and finally the red *stranger* circle, which teaches that some people are strangers for life. The message of the red circle is that you do not touch them and they do not touch you (Kempton, 1993; Walker-Hirsch & Champagne, 1991, p. 145; Whitehouse & McCabe, 1997). The overall goal of this program “has always been the development of an internal locus of control and the empowerment of the individual through education, self-esteem building, and assertiveness training” (Walker-Hirsch & Champagne, 1991, p. 146).

Another noteworthy program that teaches social skills development is the CATCH program. This was created to teach 11 specific skills, which are: “Eye contact, social distance, listening, posture, voice modulation, questioning, answering, and talking in a group, how to interrupt a conversation, how to greet people and how to end a conversation” (Whitehouse & McCabe, 1997). The program initially begins with non-verbal communication, and leads to verbal and interactive communication skills. Researchers evaluated the CATCH program and found that it was successful for improving *some* of the 11 target behaviors. Conversely, researchers such as Foxx et al. (1984) found that people with DD do not have to wait to be taught interactive social skills, and that they have the capacity to learn social skills such as initiating social conversations and asking questions. In an evaluation on education curricula, Blanchett and Wolfe (2002) reported that 11 out of 12 programs addressed areas of social skills such as establishing good communication between partners for sexuality protection.

An extensive review of the literature on social skills development has clearly documented that socio-sexual education starts with fundamental people skills. Social skills are the basis from which to build on complex skills, such as abuse prevention. Due to the nature of certain disabilities, many people with DD will not likely acquire all social skills, nor will they have the same opportunities as their non-disabled counterparts to practice them. Despite this, there is great incentive to create, implement, and include social skills and relationship building into curricula. As the proponent of normalization, Wolfensberger (1990) stated: “If one rules out other handicapped people, relatives, and paid service workers, a large portion of our population have few or no friends” (as cited in Kempton, 1993, p. 113).

Instructional design

In order to enhance learning in socio-sexuality, there are a number of strategies, techniques, and instructional methods that can be implemented. Of the most popular is group format (Muccigrosso, 1991). Although programs are effective on a one-on-one basis, the rewards of group format are plentiful. According to Fegan, Rauch, and McCarthy (1993) a group approach allows students to listen effectively to other group members’ ideas, and encourages students to develop social skills with peers. Similarly, Ragg and Rowe (1991) suggest that supplementing the traditional format of SSEP with the use of group treatment, group work, and group psychotherapy can develop “sexual knowledge, attitudes, and skills” (p. 337). Ragg and Rowe (1991) discuss in detail the three approaches to group treatment, which are the *structured approach*, the *mainstream model*, and *group psychotherapy*.

The structured approach is used through exercises that can “reinforce/integrate knowledge, challenge and adjust attitudes, as well as to develop skills” (Ragg & Rowe, 1991, p. 338). For example, some exercises are knowledge-based such as group games, group outings, and nonverbal activities. These provide students with the necessary concepts that can improve learning in an entertaining way. Other exercises are attitudes-based, which are essential since people’s attitudes “directly affect how knowledge is used and skills develop” (Ragg & Rowe, 1991, p. 340). Sample exercises are guided imagery, structured role play, and gender reversal games, which allow both genders to experience what the other is feeling. Finally, skills-based exercises help increase specific social skills. For instance, role playing can facilitate learning how to ask someone on a date (Ragg & Rowe, 1991).

The second approach to group format is the mainstream model. This approach “provides opportunities for attitudes to be expressed in interaction and for skills to be developed in a natural manner” (Ragg & Rowe, 1991, p. 343). When the relationships among group members are true and genuine, then what has been learned is extremely powerful. For example, group members learn about attitudes toward others (whether positive or negative), attitudes about the opposite gender such as existing myths or stereotypes, and attitudes regarding sexuality in general (Griffiths, 1999). Moreover, the three components that make the mainstream model effective are a *democratic process*, which allows group members to make important decisions about the program, *mutual aid* in which there is a deep human accountability for one another, and *member responsibility*, where members are “responsible for themselves as well as the program... These responsibilities provide an initial experience for a population which is

seldom expected to be responsible” (Ragg & Rowe, 1991, p. 345). The third approach to group format is group psychotherapy in which “techniques provide the technology for influencing member attitudes and skills” (p. 346). This is achieved through interactional coaching, making sure that communication is clear and comprehensive, and by facilitating affective disclosure so that emotions become more easily and naturally expressed (Ragg & Rowe, 1991).

In contrast to traditional SSEP, Lumley and Scotti (2001) suggest using an individualized program approach. While traditional programs typically set out to increase knowledge, some shortcomings must be addressed. First, traditional programs often do not include an evaluation of learning (Whitehouse & McCabe, 1997). More significantly, they often ignore attitudinal change. Two significant downfalls are (1) individual needs are often not considered and (2) there is a deficiency in ensuring that learning is assimilated into everyday life (Lumley & Scotti, 2001). According to proponents of the individualized program approach, several areas must be considered. First, “a team approach is recommended to maximize, coordinate, and integrate assessment, program development, and provision of support” (Lumley & Scotti, 2001, p. 117). As well, person-centered planning is required in order to tailor the program to the specific needs of the individual. Next, an assessment process is needed so that information of individuals’ baselines can be assessed alongside any gains from SSEP. Pre-program assessments also contain assessment of knowledge by using standardized tools such as the Sexual Knowledge, Experience and Needs Scale (McCabe, 1999) or the Socio-Sexual Knowledge and Attitude Test (SSKAT) (Wish, McCombs, & Edmonson, 1979). In addition, assessing behavioral skills is a must, particularly in social skills development

and assertion. Other areas that require assessing are sexual orientation, birth control, and prevention skills. Similar to strategies outlined by Ragg and Rowe (1991) on group format, Lumley and Scotti (2001) suggest the use of a group instructional approach, which allows a large number of participants to acquire the same information simultaneously. Moreover, an individualized program approach takes into consideration the developmental level of the individual, thus “being able to progress through a program at an appropriate pace, based on individual progress” (Lumley & Scotti, 2001, p. 115). As well, agency support is critical for success. An area that has been underestimated and under researched is the significance of group effort and the partnership of families, professionals, and the larger community (Blanchett & Wolfe, 2002; Romaneck & Kuehl, 1992). Agency and external support can address greater issues such as changing public policy at the micro and macro level.

Other researchers believe that successful programs are designed to tailor to individual needs. These needs include “age, environment, and communication skills” (Sobsey & Mansell, 1990, p. 52). Within these individually customized programs, some important recommendations for strategy use are made. Educators should become aware of the following: to teach according to chronological age; to evaluate instructional materials and revise materials accordingly before administered; to consider that there will be students in the program that have values and beliefs that may not coincide with the educators’; to listen to students needs’ as opposed to simply regurgitating information in direct instruction; and lastly, to avoid making “judgments and expressions of personal bias, which can hinder both teaching and learning outcomes” (Romaneck & Kuehl, 1992, p. 23). In addition, Romaneck and Kuehl (1992) state that educators need to address four

chief components of SSEP—knowing *what*, *when*, *where*, and *how* to teach. Likewise, Griffiths, Baxter, Haslam, Richards, Stranges, and Vyrotsko (1995) state that one should avoid direct instruction. In contrast, SSEP need to utilize student-to-student and facilitator-to-student interactive strategies because the former can be boring and mundane. Furthermore, successful programs are highly dependent on the qualities that the facilitator possesses. According to Griffiths et al. (1995) the *best* facilitators are not necessarily those who know the most about sexuality, or even those who have been educators for years. Rather, the best instructors identify with the purpose behind SSEP and convey a positive attitude. According to Fegan et al. (1993), socio-sexual educators need to be keenly aware of their personal ideas about sexuality, and that they are using a neutral approach to convey these ideas. In addition to attitudes, Romanek and Kuehl (1992) state that educators need to be flexible in their teaching approach, in knowing how and when to change curricula, and in their personal disposition. Other traits include having a solid and an up-to-date knowledge base on topics, being confident and self-assured, being someone that people can trust, ensuring that students feel safe, welcome, and approachable, accepting differences, and being authentic and caring.

Effective sex educators also teach a variety of subjects such as assertiveness and communication skills. According to Sobsey and Mansell (1990) “assertiveness training, choice-making, and personal rights education are essential educational content for people with disabilities” (p. 53). Sadly, the emphasis of some SSEP has been on generalized compliance. Sobsey and Mansell (1990) suggest however, “education should aim at teaching students to discriminate between appropriate times for compliance and for

asserting personal rights” (p. 53). In addition, building strong communication skills can help protect against sexual abuse (Sobsey & Mansell, 1990).

Educators can also teach self-regulation. According to Whitman (1990) self-control is critical to sexual behavior and is applied to educating people with DD about using socially appropriate behaviors. A self-regulation approach encourages the training of skills which are particularly appropriate to sexuality. Since many people with DD lack self-control in expressing appropriate sexual behavior, this approach is undoubtedly needed. Whitman (1990) states that self-regulated behaviors can be learned in four steps, which include gaining novel behaviors, generalizing these new skills, discerning appropriate contexts where one can engage the strategies, and making an evaluation of these actions. The self-regulated approach is consistent with the principle of normalization, which suggests that people with DD should to the greatest extent, be motivated to live as “normal” as possible. With respect to SSEP, this implies that regardless of ability and when given the chance, people with DD can learn and practice self-control.

According to Fegan et al. (1993), other aspects of SSEP need to be considered. First, is to create a pleasant and stimulating environment that is conducive to learning. Second, is to ensure that information presented is meaningful to the learner. This implies that educators may need to revise material, and an effective educator should grasp this notion early on. Third, all students with DD need to be presented with terminology and language that is at their level. Educators should avoid complicated medical terminology and use students’ everyday lingo instead (Fegan et al. 1993). Likewise it is critical to create aims and objectives well before the program starts. Setting goals allows for

measurement of learning. Although all topics of sexuality need not be covered extensively, a basic overview of major topics such as relationship building and sexual abuse prevention should be presented. Finally, tips include using audio-visual materials such as movies, documentaries and posters that are clear and interesting, and “three dimensional teaching resources such as lifelike dolls with genitals, or a contraception kit can also be extremely useful” (Fegan et al. 1993, p. 103).

Furthermore, Lunsky and Benson (2000) conducted a study to see “if adults with developmental disabilities could reliably report events using anatomically detailed dolls and drawings, tools commonly used in sexual abuse investigations” (p. 68). It was suggested that events using anatomically correct dolls and pictures could be reported accurately by several participants in the study (Lunsky & Benson, 2000). In comparing the dolls to the drawings, the study revealed that the dolls were more accurate as a teaching tool. Furthermore, there was a 90% accuracy rate when assessing whether people with moderate DD could use the dolls and the drawing tools to see the relationship between the symbols and themselves (Lunsky & Benson, 2000). Although the study was a preliminary investigation, the dolls should not be discarded as a teaching tool.

In a review of sexuality education curricula, Blanchett and Wolfe (2002) examined effective instructional methods consistent with previous research. For example, in an evaluation of 12 programs “Discussion, lecture, and role-play were the primary instructional strategies that were suggested for use with students” (p. 53). Discussions as a tool was used in all programs and researchers reported that the effectiveness of the tool is dependent on the capabilities that the facilitator has in getting students to remember and retain material. Moreover, role play allows students to directly engage and

experience the activity on a firsthand basis. Role play can effectively enhance interpersonal skills such as dating and can illustrate abstract concepts such as socially inappropriate behaviour (Blanchett & Wolfe, 2002). This finding is consistent with Muccigrosso (1991) who argues that “roleplay and dramatization are superior techniques for educating, and for checking learning” (p. 270). In sum, many of the tools outlined have been used to help increase knowledge in socio-sexuality.

Socio-Sexual Knowledge

McCabe and Cummins (1996) assessed the sexual knowledge, experience, feelings, and needs of people with mild DD. A group of 30 adult women and men dwelling in community residential homes were compared to a contrast group of 50 typically developing University students. The SexKen-ID was used to evaluate both groups. Results suggest that there were no significant differences in knowledge on topics of menstruation and identification of body parts. Nonetheless, there was a significant difference showing that adults with mild DD had less knowledge in areas of “dating and intimacy, sexual interaction, contraception, pregnancy, abortion and childbirth, sexually transmitted diseases, masturbation, and sexual abuse” (McCabe & Cummins, 1996, p. 16). Despite their lack of knowledge in intimacy and intercourse, participants had more negative sexual experiences in unwanted pregnancy, masturbation, and STDs. Results also showed that people with DD did not feel negative about sexual abuse, used condoms less frequently, and believed that it was appropriate to have intercourse with strangers (McCabe & Cummins, 1996), giving greater impetus for implementing SSEP.

Similarly, McCabe (1999) conducted a study on knowledge, experience, and needs of people with intellectual disabilities (ID) or physical disabilities in comparison to

people without disabilities. Participants included 60 individuals with mild DD, 60 with physical disabilities, and 100 without disabilities. The SexKen was utilized to measure 12 areas of sexuality such as friendship, dating and intimacy, marriage, body part identification and STDs. The findings suggest that in all areas, people with ID had lower levels of knowledge and experience, had more negative perceptions about sex, as well as more intense sexual needs when comparisons were made to people with physical disabilities. In turn, people with physical disabilities also showed the same outcomes when compared to those without.

Similarly, Lindsay, Bellshaw, Culross, Staines, and Michie (1992) investigated the increases in sexual knowledge following a sex education program for 46 people with varying DD. The rationale for conducting this study was that no evidence supported the fact that knowledge was being retained. The authors assessed two groups before and after the program on levels of knowledge in areas of body parts, masturbation, male and female puberty, intercourse, pregnancy, childbirth, contraception, and STDs. The first group received the Sexuality Education for the Lower Functioning Mentally Handicapped program, while the second group served as a control with no treatment. The results revealed that the treatment group had significantly higher levels of sexual knowledge than the control. In addition, the treatment group retained the acquired knowledge at follow-up. According to researchers, the likely contribution to maintaining knowledge was program length, spanning a 9 month period, and because the study was based on a well-known program “providing a strong educational foundation for participants” (Garwood & McCabe, 2000, p. 270).

Whitehouse and McCabe (1997) state that “the Lindsay et al. study (1992) is one of few studies to have provided adequate pre and posttest measures, used a control group, and provided follow-up data to evaluate whether the information learned by the participants was retained” (p. 234). However, other investigators suggest that it would be interesting and an added feature to evaluate how this increased knowledge plays a factor in developing participants’ positive attitudinal change regarding sexuality (Garwood & McCabe, 2000). Whitehouse and McCabe (1997) also conducted a study that looked at the sexual knowledge of 11 men and women with mild and moderate cognitive deficits. The participants were compared to a matched control group, and assessed using a short-term sex education program. In comparison to controls, an increase in the level of sexual knowledge for the treatment group at posttest was found. However, “there was a low level of sexual knowledge in a number of areas, especially in areas of contraception, dating and intimacy, homosexuality, marriage, masturbation, menstruation, pregnancy, and STD’s” (Garwood & McCabe, 2000, p. 270). Similar to Lindsay et al. (1992) Whitehouse and McCabe (1997) recommend that the program should have been long-term since its brevity may have contributed to insignificant results.

Correspondingly, Garwood and McCabe (2000) conducted a study investigating two sex education programs and their effectiveness in increasing sexual knowledge and positive sexual feelings. Participants included six adolescent and adult men with DD. Three men attended the Co-Care program, while the other three attended the Family Planning Victoria program (FPV). The programs were unique and differed in their philosophical outlook and practical application. Both programs taught similar content including feelings, social skills, body awareness, sexual relationships, public and private

issues, and protective behaviors (Garwood & McCabe, 2000). Both groups were assessed at pre- and posttest using the SexKen-ID. The results suggest that although there was an increase in sexual knowledge at posttest for both groups, they were insignificant and minimal. *Some* improvements in knowledge occurred in areas of “friendship, marriage, sex, contraception, and homosexuality for the Co-Care group, and in areas of sex, pregnancy, childbirth and STDs for the FVP group. The results are consistent with those of the Whitehouse and McCabe (1997) study showing that sexual knowledge is least improved in areas of birth control, homosexuality, and STDs. Of most concern is that participants had virtually no knowledge, or were misinformed about STDs and AIDS, stating that they believed STDs and AIDS were transmitted through coughs and kisses (Garwood & McCabe, 2000). In addition, the results showed more negative feelings toward marriage, pregnancy, and having children. This is consistent with previous findings by McCabe and Cummins (1996) who found that people with DD also had negative outlooks on having children and being married.

Szollos and McCabe (1995) also examined the knowledge, experience, feelings and needs of people with DD, in comparison to responses provided by care providers and in addition to individuals without disabilities. Participants included 25 people with mild ID, 10 volunteer staff, and 39 first-year psychology students as the comparison group. Researchers used the SexKen-ID to measure sexuality knowledge, experience, feelings and needs as well as the SexKen-C for care providers. The findings suggest that in general, women’s knowledge and experience in sexuality was higher than men’s, with the exclusion of masturbation. Significant differences were found for menstruation and marriage. Few differences were revealed for feelings and attitudes for both men and

women with DD, with the exception that women had more positive feelings about marriage. With respect to needs, men rather than women expressed a greater need to “know” and to “need” sexuality. Moreover, the results show that care providers clearly overestimated the responses provided by their clients in all areas. That is, they believed that their clients were more knowledgeable, experienced, had positive attitudes and a greater need to know about sexuality than clients had actually reported. In comparison to the psychology students, they found that people with DD had experienced more sexual abuse, but had the same amount of homosexual experiences. Students also showed greater knowledge and experience sexually than people with DD, apart from body part identification and dating and intimacy (Szollos & McCabe, 1995).

Furthermore, participants with DD showed major misconceptions about sexuality such as “sexual intercourse is intended to harm the female, that women can give birth without being pregnant, that masturbation causes harm, that men have periods, and that in heterosexual intercourse the penis generally goes into the woman’s anus” (Szollos & McCabe, 1995, p. 216). Clearly, SSEP can help foster accurate factual information and demystify these major misconceptions.

Moreover, Cheng and Udry (2003) conducted a study examining the knowledge of people with DD on sex and birth control and whether these issues were addressed by parents in the home. Researchers used data collected in 1994-5 from the National Longitudinal Study of Adolescent Health. The sample consisted of students from the U.S in grades 7 to 12. The data included three specific sections including the In-school, the In-home, and the Parent survey. These surveys assessed sexual attitudes and behaviors. A measure of the mental ability of participants was also included using the Add Health

Picture Vocabulary Test (AHPVT) in order to categorize cognitive ability. In terms of knowledge on sex and birth control, the findings reveal that participants with DD had very limited knowledge in these areas, and that their knowledge was inaccurate. In addition, parents of boys with DD did not talk to their children about sexuality in comparison to boys with average intelligence. For example, for boys who were mildly mentally disabled (AHPVT scores of 55-69) 44% of parents had yet to discuss birth control methods, compared to 16% of parents for boys with average intelligence (AHPVT scores of 91-110). The findings are similar for girls with DD. For example, for girls with mild disabilities, 26% of parents had yet to talk to their children about birth control compared to 16% for girls with average intelligence (Cheng & Udry, 2003). Interestingly, the results increased as the scores of the AHPVT tests decreased. That is, the lower the functioning of the child, the less parents talked about sexuality with them. When comparisons were made between average intelligence students and those with DD, the results reported lower levels of learning about AIDS and pregnancy for the latter. Moreover, when comparisons were made between parents of children with average abilities and parents of children with DD, the authors concluded there was very little sex education in the home, with little reference to STDs, pregnancy and contraception, and more negative attitudes reported about sex education for parents with children with DD.

Attitudes Towards Sexuality

To date, there has been limited research on socio-sexual attitudes of persons with DD. According to researchers “In order to educate and instill healthy attitudes towards sexuality among those with disabilities, an understanding of their existing attitudes is necessary” (Lunsky & Konstantareas, 1998, p. 24). Most studies only focus on attitudes

of professional or family and workers. McCabe and Schreck (1992) did however compile a report on the sexual feelings and attitudes of people with DD. In one study in this report investigators interviewed men with moderate intellectual DD on their attitudes toward specific sexual behaviors. The results demonstrated that 37% of participants viewed masturbation as disapproving, 31% saw heterosexual intercourse as wrong, and 86% indicated that homosexuality was inappropriate (McCabe & Schreck, 1992). This finding is consistent with previous cited research showing increased negative attitudes towards a wide range of issues including intercourse, oral sex, masturbation and homosexuality (McCabe & Cummins, 1996).

Furthermore, Lunsky and Konstantareas (1998) looked at the socio-sexual attitudes of adults with Autism and adults with mental retardation. The attitudes of 15 people with Autism and 16 with mental retardation were assessed via structured interview. Their attitudes were then compared to 25 students from a Canadian University, and 28 students and non-students who did not have DD. Results showed that people with mental retardation displayed most frequently, the greatest differences between the four groups. They exhibited less accepting attitudes towards social and sexual issues than did participants with Autism. In general, both groups with DD were much more conventional in their thinking about sexuality than controls. Moreover, there were fewer acceptances in 12 out of the 20 socio-sexual scenarios provided in the assessment for the DD groups. For example, 65% of people with DD disapproved and were not accepting of a man and woman having sex, in comparison to 92% of the controls who approved of this scenario (Lunsky & Konstantareas, 1998). These findings, which illustrate that people with DD in general have less accepting outlooks on sexuality is supported by previous research

conducted by McCabe and Cummins (1996). In sum, the attitudes of people with DD are an important aspect that can “affect their feelings and behavior towards themselves and others” (Lunsky & Konstantareas, 1998, p. 24).

Moreover, Lesseliers and Van Hove (2002) conducted a qualitative study exploring the feelings and attitudes of people with DD, specifically looking at relationships, and their own sexuality. Forty-six participants with DD from Belgium were interviewed. The researchers presented nine themes that were important to participants. Collective findings suggest that participants felt that they did not have adequate support to develop meaningful and healthy relationships, or were able to deal with the challenges presented in their personal relationships with boy/girlfriends. Moreover, the findings reveal that participants life conditions seemed to be dictated by impediments related to structural and organizational consequences such as communal living, frequent changes in living arrangements, lack of choice in who they could live with and where, lack of privacy in residential facilities, lack of sexuality education, and the suppression of sexual expression by care providers and professionals. In sum, these and many other obstacles appear to influence the beliefs and negative attitudes that people with DD have about their sexuality (Lesseliers & Van Hove, 2002).

Other researchers such as Griffiths and Lunsky (2000) examined critical areas of socio-sexual assessment and SSEP by conducting research with people affiliated in the lives of people with DD. The authors replicated one of the first studies evaluating levels of sexual knowledge conducted by Edmonson et al. (1979). The SSKAT-R was administered to parents, educators, healthcare and community workers of people with DD to assess whether there had been progressive changes over a twenty-year period. The

1999 findings suggested similar results to the 1979 findings however, there were less conventional perspectives towards sexuality in the latter. The five areas that showed significant increases in inclusion were “body parts, masturbation, incest, inappropriate sexual contact, rape and going steady” (Griffiths & Lunsky, 2000, p. 23). As well, results revealed significant decreases away from inclusion when comparing 1979 and 1999 results on marriage and pick-up lines from strangers (Griffiths & Lunsky, 2000). Moreover, one of the most increased areas and positive changes was in relationships such as dating, but not marriage. Other significant findings over the twenty-year comparison were changes in supportive attitudes towards masturbation and disapproval for inappropriate sexual behavior. Thus, the findings support the notion that the attitudes of society is changing to support socio-sexual education.

Plaute, Westling, and Cizek (2002) explored the attitudes of various target groups including professional educators and residential staff, gynecologists, as well as people with DD. Attitudes surveys were conducted in Austria to identify current knowledge and attitudes. Based on the findings, a program called the “Special LoveTalks” initiated by personnel at Lebenshilfe Salzburg was developed for teaching sexuality education to adults with DD. Several assessment tools were used for each of the targeted groups including Sexuality and the Mentally Retarded Attitude Inventory (SMRAI) for professionals, and the Interview on the Sexuality of People with Mental Retardation (ISMB) for people with DD. Both tools contained the same topics, which allowed for comparisons to be made. The results of the study were divided according to each group. For professional educators and residential staff, the results suggest that they held more liberal and relaxed attitudes about sexuality and sexuality education for people with DD.

It was found that professionals with higher levels of education, living in urban areas, who had fewer beliefs in God and who were younger tended to hold the most liberal attitudes.

In addition, the results reveal that gynecologists held less liberal views than the first group of professionals, but when compared to participants in American studies, they hold more liberal views. Finally, 50 people with mild to moderate DD were also surveyed. The results demonstrate that for body, function of sex organs, sexuality as a whole, menstruation, contraception, fertilization and sterilization, participants had virtually no knowledge. These findings are not surprising and are consistent with past research (McCabe 1999; McCabe & Cummins 1996; Szollos & McCabe, 1995). In terms of attitudes, 90% of participants expressed that sexuality was important to them, and only 50% expressed approval for masturbation (Plaute et al. 2002). Wish et al. (1979) reveal similar findings suggesting that 63% of participants from their study reported negative feelings towards masturbation. From the Plaute et al. (2002) findings, the researchers view Special LoveTalks as a practical solution for parents, professionals, and people with DD looking for educational programs. In contrast to most SSEP, such as Life Horizons I and II and Life Planning Education (Blanchett & Wolfe, 2002) Special LoveTalks does not adhere to a predisposed curriculum, rather follows participants' interests, which may also be effective.

Furthermore, many studies have focused on attitudes of people with *mild* DD, and not moderate or severe DD. For example, Ousley and Mesibov (1991) conducted a study on the sexual attitudes and knowledge of high-functioning adolescents and adults with Autism. Forty-one participants were interviewed. Twenty-one were high functioning adults with Autism, and 20 had mild mental retardation without Autism. The materials

used were a sexuality vocabulary checklist and a choice questionnaire that “assessed experiences and attitudes about sexuality and dating” (p. 473). The results revealed that people with Autism had less experience with sexuality and dating than those without. There were no group differences in knowledge or interest of sexuality. In both groups, males exhibited significantly more interest in sexuality than females, and showed a “significant correlation between sexual knowledge and IQ” (Ousley & Mesibov, 1991, p. 476). More research needs to be conducted on people with a range of DD such as moderate, severe and even people with dual diagnosis.

According to Whitehouse and McCabe (1997) the majority of sex education programs “are hampered by methodological problems; they either fail to evaluate the effectiveness of the program or use inadequate measures or controls” (p. 233). Like many studies evaluating socio-sexual learning, there are several reasons why some studies have shown negative results. For example, problems may be attributed to the instructional design of the program, or the tools and techniques used; they may lack the basic foundation of sexuality that is needed to build on complex topics; the nature of the questions may be too ambiguous; the questions may be too open-ended; or the program itself may be too short. Moreover, most of these programs, although do investigate sexual knowledge increases after a treatment is implemented, rarely examine *attitudinal* changes that may result from programming (Zylla & Dementral, 1981). Consequently, ignoring attitudes only reinforces that people with DD can be provided with sufficient information about socio-sexuality but not have consent to apply it.

Abuse Prevention

There is an overwhelming and emerging body of literature on sexual abuse of people with DD because of its high incidence. According to researchers, over 90% of people with DD have experienced some form of abuse in their life. Statistics reveal that women with DD are more likely to become targets of sexual abuse and assault than non-disabled women, or children. These statistics are one and a half times more likely for women with DD (Sobsey, 1994). In addition, according to Nagler (1996) men who have a DD are more likely to be abused than men without. Furthermore, “the incidence of abuse is 20 percent higher among people who are deaf or have developmental disabilities” (Sean, 1988 as cited in Nagler, 1996, p. 193). People with DD are simply more vulnerable (Conway, 1994; Fegan et al. 1993; Whitehouse & McCabe, 1997). More specifically, Fegan et al. (1993) argue that this increased vulnerability exists “because they are less likely to resist, less likely to report, and if they do report less likely to be believed” (p. 75). Unfortunately, the chances of people with DD being believed of abuse is very slim because of issues pertaining to credibility (Nagler, 1996). Similarly, Marchetti and McCartney (1990) state that barriers to reporting sexual abuse are overwhelming. These barriers include taking into consideration the rights of staff and clients, ensuring the rights of due process to staff members, and making sure that evidence is credible and authentic.

Likewise, other investigators contend that vulnerability exists as a direct result of confinement and isolation, and by having virtually no control or power over oneself in social settings. According to Tharinger, Burrows-Horton and Millea (1990) people with DD are for the most part capable of doing things independently. This however, becomes

habituated by the dependency that is created with caregivers, and becomes a difficult habit to break. In a quote regarding sexual assault, Crossmaker (1991) states:

It is the people who are institutionalized, the people on the lowest rung of the institution ladder, the residents, that are reinforced for compliant behavior, economically, physically, psychologically dependent, isolated and lacking incredibility: all factors increasing vulnerability to sexual abuse (as cited in Whitehouse and McCabe, 1997, p. 232).

Similarly, Tharinger et al. (1990) argue that people with DD have fewer chances to become sexually aware, to discover their sexual inquisitiveness, and as a result become victims of exploitation. The authors compiled information on the sexual abuse of children and adults with DD, and argue that four factors help explain vulnerability. These include: (1) long-term over dependence on care providers, (2) lack of control and power in social status, (3) inadequacy in social and emotional security, and (4) deficit in developmentally appropriate socio-sexual knowledge, and awareness of sexual abuse prevention.

Moreover, Sobsey (1994) conducted a study investigating factors related to vulnerability in sexual abuse for persons with DD. Participants included 107 people who had been sexually assaulted. Participants and their care providers were asked what they felt had been a factor to their abuse. Among the most popular responses, 31.7% believed they had a deficit in sexuality education, or had an “impaired judgment” (p. 99). In addition, 24.4% stated that there was a lack of confidence and an excess of compliance toward others. Finally, 13% stated that they did not have the ability or the knowledge to come forward with their abuse. Other responses included being too trustful of others (8.1%), unable to defend oneself physically (7.3%), and too reliant on others (4.9%).

People with DD need to be provided with sexual abuse prevention skills. In one study, Lee and Tang (1998) conducted a preliminary investigation on 72 female adolescents of Chinese origin that were diagnosed as having mild mental retardation. The authors attempted to determine the effectiveness of an abuse prevention program called Behavioral Skills Training Program (BSTP). Participants were assigned one of two groups. The BSTP group learned about “self-protection skills from a behavioral perspective” (p. 108). Participants were taught about appropriate and inappropriate touch and how to protect themselves from harmful situations. The tools that were employed combined “instruction, modeling, behavioral rehearsal, shaping, social reinforcement, and feedback (Lee & Tang, 1998, p. 108). The second group was a control group, which used the Attention control program. Participants were taught about general safety such as car and stranger safety with no reference to abuse prevention. The results revealed that participants in the BSTP increased their knowledge from pre- to posttest on self-protection skills and abuse prevention. As well, participants maintained their knowledge at 2-month follow-up, and had a better knowledge base about sexual abuse. For example, they were aware of who could and could not touch their bodies, and had less fear about “objects, people, and situations” (p. 112). The control group showed lower levels of knowledge in abuse prevention (Lee & Tang, 1998).

Moreover, Muccigrosso (1991) adds that prevention of sexual abuse is as much a community problem as it is an individual one. In order to ensure the success of any program, society needs to change its negative attitudes, misrepresentations and cultural images about the sexuality of people with DD. Communities need to view individuals as people first “with more sameness than differences” (Muccigrosso, 1991, p. 264). Doe

(1990) provides research on an ecological model of abuse in order to understand the factors that make up abuse at various levels. These levels include the microsystem such as the interactions between victims and offenders, the macrosystem such as the setting of abuse, and the exosystem, similar to conclusions made by Muccigrosso (1991) which focuses on cultural and societal beliefs, such as the “dysfunction within the reaction of society to persons with disabilities” (Doe, 1990, p. 18). Once issues in the exosystem are addressed, provisions set out by organizations that work to support people with DD can improve.

Muccigrosso (1991) also provides recommendations for socio-sexual education with respect to abuse prevention, which includes: Conducting preliminary work with parents and caregivers, having close collaboration with the criminal/legal system, and educating professionals within schools and people such as social workers, psychiatrists, and psychologists. In addition, Muccigrosso (1991) discusses long- and short-term SSEP currently available. In long-term programs, it is assumed that students have previously been educated about basic issues such as reproduction, anatomy, relationships and so forth. One example of a long-term program is Life Horizons. This curriculum teaches human sexuality with an emphasis on abuse prevention. The program uses audio-visual colour slides as its main teaching tool. In addition, role play is encouraged to reinforce the information in a concrete and interesting way. If however, the educator has a time constraint to teaching the program, then a time-limited program should be used. An example of this is the Empowerment program. This curriculum uses “scripted role-plays” (p. 267) and focuses on providing people with the necessary tools to develop a sense of ownership and personal empowerment.

Sometimes however, long- and short-term programs work best collectively. Many programs that combine the two are available, however educators should be cautious to choose a program that best fits their students' needs. A few noteworthy programs include: The Family Education Program, which emphasizes "sexuality, self-esteem, and abuse prevention to students with developmental and learning disabilities" (p. 268); Preventing Sexual Abuse, which is geared for children and adolescents; and Sexual Abuse Prevention: Five safety rules for persons who are mentally handicapped. This curriculum displays safety rules through vignettes, which are: Your body belongs to you, keep your clothes on in public, say no, get away, and tell someone" (Muccigrosso, 1991, p. 269). Although these programs use their own approaches to teach sexual abuse prevention, the underlying notion is that they all take into consideration the collective group, and the individual needs of the students' DD *and* abilities. For programs to be effective, educators need to work closely with other professionals, and their goals should be situated around making people feel good because "when someone feels good about themselves, that person is much less likely to become a victim of abuse" (Muccigrosso, 1991, p. 279).

Despite the fact that there is no empirical evidence to show that SSEP reduce the vulnerability of abuse for people with DD (Sobsey, 1994) the consensus is that programs should include abuse prevention because "several different skills may be involved such as learning to recognize and avoid dangerous situations, and becoming aware of personal feelings of discomfort" (Watson, 1984; Ryerson, 1981 as cited in Sobsey and Mansell, 1990 p. 53). Furthermore, SSEP can help foster prevention strategies by teaching about healthy sexuality first. As one research states "if one must teach about sexual abuse, one

must first teach them, in an age-appropriate manner, about sexuality and healthy appropriate forms of sexual expression” (Krivacska, 1990, p. 6).

Statement of Problem

Without proper education in socio-sexuality, people with DD have very little knowledge as to their rights, both socially and sexually. According to Griffiths et al. (2002) information has generally been withheld to prevent interest in sexual activity often as a result of society’s negative attitudes towards the sexuality of this population. The socio-sexual needs of people with DD have yet to be met on a consistent and systematic level (Cheng & Udry, 2003). Studies have steadily documented that when these individuals transition into adulthood, they possess minimal awareness and understanding about reproductive, emotional, and social health (McCabe & Cummins, 1996; Stinson, Christian, & Dotson, 2002). For example, individuals with DD have exhibited low levels of knowledge and awareness in areas of contraception, pregnancy, STDs, HIV and AIDS, sexual intercourse and marriage (McCabe & Cummins, 1996; Stinson et al. 2002).

What’s more, it has been shown that individuals with DD hold negative views about expressing their sexuality and have drastic misconceptions about human sexuality (Szollos & McCabe, 1995). Even more alarming is the high rate of sexual abuse perpetrated against this population (Sobsey & Mansell, 1990). In a survey of 85 women who had a disability, 70% reported that they had been sexually abused (Goldman, 1994). Individuals often fall prey to vulnerability and victimization of abuse and exploitation by those who ill-use their impoverished knowledge (Sobsey & Mansell, 1990). “According to Health and Welfare Canada (1993) the danger of sexual exploitation of people with impairments is apparently at least 150% higher than that of same-sex, same-age

individuals without impairments” (Québec Ministère de la Santé, 2000, p. 14). Even more deplorable is that these injustices are often perpetrated by individuals who know the victim (Muccigrosso, 1991; Sobsey, 1994) such as support providers, family, caregivers, and personal care attendants such as transportation aids (Doe, 1990). Difficulties are evident when the sexual rights of people with DD are denied in terms of policies and procedures. For example, Owen, Griffiths, and Arbus-Nevestuk (as cited in Griffiths et al. 2002) state: “While the development of policies and procedures concerning sexuality is difficult, a failure to address the issue does not prevent the occurrence of problems. It is more likely that organizational avoidance of the issue creates fertile ground for abuse” (p. 59). On a broader note, Blackburn (1995) states that “The manner in which sexuality and abuse are dealt with often reflects the way disabled people are regarded by the society” (p. 351).

Programming

Presently, there are a number of well-formulated and available programs; very few however, combine sexuality with social skills training, an important component to a complete curriculum (Kempton, 1993). There are several factors that define quality in the development of these programs. First, successful programs incorporate not only materials concerning biological and reproductive sex, but place an equal emphasis on teaching social and emotional development—areas that are often underemphasized (Griffiths et al. 2002). Second, successful programs incorporate and teach a wide variety of topics. For instance, many researchers believe that the following topics comprise a comprehensive program: relationship building, social skills training, self-regulation, personal touch, space and boundaries, intimacy, dating, male and female reproductive systems,

menstruation, masturbation, intercourse, pregnancy, contraception, marriage, parenting, abortion, STDs, sexual abuse and abuse prevention, and HIV/AIDS (Kempton, 1993; Page, 1991). Nevertheless, merely presenting these topics without consideration of the target audience is insufficient. Many times, the “specific characteristics of the learner may not be taken into account, such as language ability, physical limitations, or behavioral issues” (Stinson et al. 2002, p. 21). Therefore, the third factor of evaluation is necessary. One of the most significant measures of quality programs is to establish a needs assessment. In needs assessment “educators must develop a sense of what the actual sexual needs and experiences of people with DD are, and then tailor programs to address these needs” (McCabe, 1993; Whitehouse & McCabe, 1997, p. 230). An adequate evaluation leads to developmentally appropriate, suitable programs that may ultimately play a part in increasing learning.

Once an evaluation of group needs is established, the next step requires knowing *how* to teach so that learning is representative and meaningful. Many researchers believe that providing solid programming is the sole responsibility of the educator. However, educators often become the barrier because their values and attitudes dictate what subjects they are comfortable teaching, and not what subjects they should be teaching (Stinson et al. 2002). Romaneck and Kuehl (1992) state that educators need to be: “honest, direct, specific, information-based and nonproselytize in responding to questions and comments” (p. 23). According to Griffiths et al. (2002) teaching socio-sexuality education is challenging because the topics are intimate and personal. As such, another critical component to quality programs is having an educator who acknowledges “his or her own perceptions, attitudes and values (Québec Ministère de la Santé, 2000, p. 16).

Although there are misconceptions that educators must be experts, have all the correct answers, and not show that they are uncomfortable, “certain basic attitudes can facilitate educational practice and make interventions more significant for students and more satisfying for teachers” (Québec Ministère de la Santé, 2000, p. 23). These basic attitudes include trusting students’ capabilities and considering the value in socio-sexual education. Similarly, other researcher’s attribute successful programs to the teaching strategies that educators employ. For example, Ragg and Rowe (1991) conclude that a group setting allows for an “open exchange of ideas...which offers an effective method for transmitting information” (p. 337). Implicit within this, group settings can facilitate role playing, group games, field trips, guided imagery, nonverbal exercises, negotiation games, and gender reversal dramatization (Ragg & Rowe, 1991). When used in the proper context, these methods and others similar to it, increase the chances that “people will adopt positive attitudes and behaviors favorable to their health” (Québec Ministère de la Santé, 2000, p. 24) since formal sex education has been shown to be ineffective (Watson et al. 2002).

What *is* recognized about that phenomenon of SSEP is that when programs are carefully considered, constructed and implemented to include social skills and sexuality, learning can occur. In general, research reveals that people with DD can acquire skills in socio-sexuality, but only when clear methods are employed such as the use of concrete examples, visuals (Muccigrosso, 1991) group format (Ragg & Rowe, 1991) and significant efforts by professionals to implement programs (Lumley & Scotti, 2001). More complexly, successful SSEP are an intermingling of factors both broad and specific in scope. These include: adequate support from parents and educators, a shift in societal

attitudes towards more acceptance and treatment as socio-sexual beings, consideration of learning style, individual disability, educator training, and developmentally appropriate practices in program development (Griffiths et al. 2002). Thus, the framework that quality programming is built upon consists of an array of strategies, techniques, resources and materials that must be considered.

Significance of This Research

The benefits of SSEP are considerable. First, participating in this program provides an opportunity for people with DD to learn about issues that are valued in society, such as making informed choices about sexual behavior (Szollos & McCabe, 1995), social appropriateness, and socio-emotional skills (Griffiths et al. 2002). The program also plays a role in developing empowerment skills by teaching about rights and choices namely, the right to freedom, sexual equality, sexual health, and the right to make free and responsible choices (Griffiths et al. 2002). As well, people with DD are afforded the chance to learn about prevention from abuse and exploitation—a significant issue raised in this and other research. Although knowledge not always transcends into behavioral change, being informed can help reduce sex-related risks, like AIDS and other STDs (Québec Ministère de la Santé, 2000, p. 24). Providing socio-sexual education can lead to empowerment of the individual (Brown, 1996). For example, knowing about socio-sexuality fosters a sense of confidence, safety, and satisfaction in one's life. SSEP are appropriate approaches to increase gaps in knowledge and change the limited, inaccurate, and inconsistent information that people with DD currently hold.

Second, out of this study there are significant advantages for professionals. For example, educators can learn what techniques, tools, and strategies were ineffective and

ineffective in teaching people with DD; this enables them to craft their techniques to successful in future teachings. In addition, educators are provided with a basic framework for how SSEP should be implemented and can use techniques from this study to teach similar populations such as people with dual diagnosis or adolescents with learning difficulties. For professionals such as care providers or support staff, the potential benefits that can be reaped from SSEP include fostering increased empowerment skills, self-esteem, and ultimately, increased quality of life for people with DD by enabling them to provide choices and opportunities for making these choices. This research also renders support workers insight into issues that are most pertinent to people with DD; being aware allows for the provision of adequate support and a safe environment.

Third, this study can help program planners create better decisions in planning, developing, and implementing comprehensive and up-to-date programs so that learning can be attained. Next, this study brings to light controversial issues that are often ignored because they are difficult to deal with, such as sexual abuse. Intervention programs similar to the one in this study can provide a voice for such delicate issues, and empower participants to express their feelings. Programs of this nature can both support the needs of those with negative experiences, and act as a preventative tool for self-protection.

From a broader perspective, this study addresses a fundamental human right that people with DD consistently have to fight for—their sexuality. Acquiring knowledge seems to equate to gaining empowerment. In knowing what is and what is not acceptable in the community, individuals can make well-informed life choices. Finally, this study will help bridge the gap between people with DD and those without by highlighting how negative misconceptions that predominate our culture can “colour our attitudes and direct

our actions” (Québec Ministère de la Santé, 2000, p. 18). SSEP are a good first step to ceasing the dehumanizing stereotypes that compromise the humanity of people with DD.

Ultimately, people with DD deserve to experience fulfillment and joy as social and sexual beings (Griffiths et al. 2002) and service providers, professionals and educators play a role in fostering this. In sum, there is much to be learned from research in socio-sexuality for people with DD because the field has yet to be explored in its fullest. Although there is no shortage of research on available programs (Blanchett & Wolfe, 2002), many studies have not explored in depth the attitudes that people with DD have about their sexuality. Of the studies that have cited comprehensive curriculum, the emphasis has always been on the changes in, or the acquisition of knowledge.

Consequently, changes in attitudes and feelings are often ignored. Equally challenging is the fact that there are no standardized measurement tools that assess the changes in attitudes as a result of taking part in SSEP. The impetus for this research is that few studies currently exist that teach social skills training and sexuality education together, and that examine both knowledge and attitudes. As such, the purpose of the present study is to examine changes in knowledge and attitudes of people with DD after participating in a 6-week socio-sexual education program.

Research Questions

Given the potential benefits of SSEP for people with DD and the lack of research to date, this study was undertaken to assess the impact of an intervention on changes in knowledge and attitudes. Specifically, the study set out to explore the following research questions: (1) Does participation in a 6-week program contribute to socio-sexual knowledge and learning for 10 adults with DD? Moreover (2) what are the socio-sexual

attitudes, perceptions, and beliefs that participants hold before and after participation?

Areas investigated include social skills (friendship, intimate relationships, dating, choice, feelings, gender, decision making, personal space, stranger safety and appropriate versus inappropriate behavior) and sexuality (male and female body parts, private versus public parts, touch, condom use, hygiene, reproductive health, and abuse prevention).

Methodology

Research Design

The present study used a triangulation mixed methodology approach. The purpose of this design was to simultaneously collect quantitative and qualitative data (Creswell, 2002) in order to provide the most complete composite of the changes in socio-sexual knowledge and attitudes from participating in the program. Qualitatively, it is a *basic interpretive study*, which attempts to understand the phenomenon of and explore socio-sexual knowledge and attitudes of people with DD. The study used a combination of videotaped observations and an interview. The reason for using qualitative methods was that “qualitative methods are uniquely suited to studies imbedded deeply within a setting of naturally occurring interactions among people” (Drew, Hardman & Hart, 1996, p. 162). Using observational notes as a form of evaluation as well as interviews allowed for an exploration of major themes and patterns on socio-sexual attitudes and learning, which helped answer the research questions. The quantitative aspect is a *pre- posttest design*. The test was an in-take questionnaire that evaluated the effectiveness of a socio-sexual program on socio-sexual knowledge.

Research Site

Community organizations such as the one used in this study collectively bring together people with DD and their communities in two distinct ways. First, they provide support to the individual in order to successfully live, learn, and work in the larger community. Second, they render opportunities for the greater community to acknowledge, welcome, and provide for people with DD who have otherwise not had the same prospects as the rest of society in terms of full participation in community life. The organization selected for this study will hereon in be referred to as the “centre”. The centre is governed by a 12-member board of directors, and seeks the support of private donors such as charitable foundations and businesses to stand in financial support of the programs and principles, which are championed by the centre. The centre provides direct supports and services to persons with DD and their families in order to live fully participatory and productive lives in the community. It advocates for an integrative and inclusive environment for and on behalf of individuals with DD. Since its inception, the centre has invested in the provision of care for hundreds of people and their families. A number of different programs exist as part of the framework of the centre. These programs include, but are not inclusive to Family Support Services, Children’s Services, Social Skills Resource Centre, Vocational Services, Residential Alternatives and Recreation/Leisure activities.

The program within the centre

The program at the centre was selected because its clientele are individuals with DD. A variety of initiatives and adaptive behaviors are taught on a daily basis, which include: cooking, budgeting, using local transportation, computer skills, consumer

shopping strategies, exercise plans, functional academic work in math and reading, and arts and crafts. The program is for adults and is supervised, which allows for optimal and maximum growth and development within an environment that guarantees opportunities, dignity, and safety. Individuals also take part in community outings, social activities, and classes such as Human Rights and Sexuality training in order to increase recreation, community, social and leisure skills (Schalock, 1994).

Sampling Procedure

Sampling for this study was purposeful. Specifically, it used convenience and homogeneous strategies. Participants were selected due to their DD characteristics, which were relative to the overall study and “based on membership in a subgroup that has defining characteristics” (Creswell, 2002, p. 196). All individuals from the centre were willing to participate and fit the required criteria of adults with DD.

Gaining Permission and Negotiating Entry

Procedures for gaining entry to the site were followed at the institutional level (Concordia University’s ethics board), and organizational level (centre). In the initial attempt to recruit participants, the centre was contacted via telephone. Correspondence was conducted with the Senior Resource Advisor. She accepted the position of gatekeeper and fulfilled this position throughout the study. The gatekeeper facilitated access to the site and was the liaison between participants and the research. A copy of the thesis proposal, consent forms and schedule of the project (See Appendixes A, B, & C) was provided for review and consideration. The feedback from the centre was that the project was an initiative that the centre was interested in pursuing. One stipulation in running the program was to conduct weekly debriefing sessions, which was obliged. The

final decision was filtered through the director, and the project was accepted shortly thereafter.

Participants

A total of 12 people were approached. All were English-speaking adults ranging in age from mid-twenties to early fifties. After initial pre-testing, two individuals dropped out. The final study comprised of ten participants (five males and five females with a mean age of 42). All individuals were residents of the same region with similar socio-economic status. One person lives with parents, two live independently but have support workers, three reside in group homes with daily supports, two live with family, and two live as part of Family Supports. Half ($N = 5$) of the participants had no previous education in socio-sexuality.

Participant characteristics

All adults were previously diagnosed as having DD. However, deficits varied from person to person. The types of DD found within this group include six (6) individuals with mild mental/ID, two (2) with Downs Syndrome, one (1) with high-functioning disability, and one (1) with Hydrocephalous, Dandy Walker's Syndrome, and Tourette's Syndrome. Some participants have also been documented as having behavioral deficits such as anger management issues and social deficits such as anxiety. One person uses a wheelchair. All individuals are verbal and have varying degrees abilities.

Data Collection Tools

The study utilized four measurement tools to collect data. Prior to being administered, a demographics questionnaire was conducted to collect background information (See Appendix D). The tool was non-intrusive and served as an icebreaker.

Interview

The Attitudes Interview was self-constructed and semi-structured. This tool was used to provide participants with a forum for discussing and voicing their opinions unimpeded by the viewpoints of the “researcher”. The questions were designed to explore attitudes and perceptions that individuals held towards their social and sexual self. The interview was administered individually, before and after the intervention at the same time as the Knowledge Questionnaire. The interview comprised four open-ended questions, which were non-intrusive, and adjusted to participants’ developmental levels (See Appendixes E & F). Repetition and rephrasing were used to facilitate ease and comprehension. Interviewer elaboration probes were used to explore questions in more depth (Creswell, 2002). Participants were free to disclose as much information as desired, and were provided with adequate time to do so. Participants were not obliged to answer questions or divulge personal information if they did not feel comfortable. During the interviews, notes were taken.

Knowledge questionnaire

The Knowledge Questionnaire was used as a pre- and posttest evaluation of participants’ learning. The original questionnaire (Casper & Glidden, 2001) was created without social skills questions therefore, in order to measure for this it was adapted by adding questions on social skills (See Appendix G). The purpose of the adapted questionnaire was to survey participants’ social and sexual awareness, knowledge, and self-reported behavior. It comprised of True/False and Multiple Choice questions, which measured factual knowledge taught in the program. It also comprised of Yes/No questions which purpose was to examine participants’ personal opinions of their socio-

sexuality. A sample of a true/false question is: *You can tell if a person has HIV/AIDS because they look sick* (T or F). A sample of a multiple choice question is: *Condoms can be used* (a) once (b) a few times. A sample of an opinion question is: *It is okay to say NO to your support worker when you do not agree with him/her* (Yes or No). The questionnaire was originally created as a pen and paper test but was administered verbally to accommodate reading abilities.

Observations

Data were also collected by observing the group in the intervention. Field notes were compiled immediately after each session was complete, and were gathered in two ways: (1) by recording notes (2) by transcribing videos of the sessions. Observational notes included information such as date, time, setting, observer name, participant names, absentees, and a visual layout of where each individual sat. Descriptive notes of the activities, statements, and actions were also recorded. Furthermore, issues related to the “process of observing” were addressed. For example, a definition of *who* the observed was (group of 10), and *what* behaviors to observe (participants’ actions and comments) was outlined.

All sessions were videotaped. Equipment was set up prior to the beginning of each session. Taping the sessions did not require any major maneuvering, however from time to time a check was conducted to ensure proper functioning. During the first session only, an assistant from the centre helped set up the equipment. Individuals were informed prior to the study that a video camera would be present, and that information collected was strictly confidential. Sensitivity was also ensured for camera-shy individuals (Creswell, 2002) by keeping the camera at a far enough distance from their faces so that

it was not intrusive. The equipment did not interfere with the activities presented, or active participation. Videotapes were transcribed verbatim, copied, and originals stored in a locked office.

Personal documents

Personal documents were worksheets derived from the program “Preventing AIDS and other STDs through Sexuality Education for Students with Intellectual Impairments”. The purpose of the worksheets was to evaluate learning of session material. Worksheets were selected from various sections of the program to ensure that a variety of learning methods were employed and that they corresponded with session topics. The worksheets were concrete and appropriate (i.e. cartoon-based but not childish) and emphasized visual stimulation through the use of visual representations. They included: cut and pasting images in proper sequence, colouring appropriate areas of an image, placing a check mark in the correct box, placing a check mark to indicate feelings towards an issue (i.e. I feel o.k./not o.k. talking about masturbation), placing an X to indicate a correct response, drawing pictures, and placing a check mark on a HAPPY or SAD face to indicate appropriate versus inappropriate situations. Participants were encouraged to complete all worksheets, but had choices as to which worksheets they wanted to complete. Documents were collected for analysis.

Materials

Entertaining multiple sources

Materials chosen for this study originated from several sources that have been developed, used, and evaluated for teaching social skills and sexuality to people with DD. The sources include: The questionnaire from Casper and Glidden (2001); socio-sexual

material created at the centre; a self-esteem curriculum (Borba, 1989); the Making Waves Program (www.mwaves.org); a training manual for educators (Kempton, 1993); Preventing AIDS and other STDs through Sexuality Education for Students with Intellectual Impairments (Québec Ministère de la Santé, 2000); and the Circles Concept (Walker-Hirsch & Champagne, 1991). The impetus for entertaining multiple resources was that existing programs (commercially-based and not) focus solely on either reproductive health (Lumley & Scotti, 2001) or social skills training.

Creating material

Some materials used in the program were created during past work as a socio-sexual curriculum developer. These include: ice breakers, stretching and breathing exercises, interactive activities such as role play situations (See Appendix H), creating discussion topics, brainstorming questions, practice exercises such as the use of the hoola hoop for personal space, greetings, posters for teaching gender, for recognizing emotions, and for relationship building, using a breast self-examination board, demonstrations on personal hygiene, and contraception, using popular women's magazines to discuss gender, sexual identity, body parts, private parts, and judgment cards (See Appendix I) created to teach appropriate versus inappropriate behaviors.

AIDS and STDs curriculum

The bulk of the materials emerged from the learning activities taken from the Preventing AIDS program (See Appendix J for learning activities). The purpose of this program is summarized. It states:

AIDS and other STDs are current problems of concern to everyone, including students with intellectual impairments. Because such students

are few in number, the availability of special educational tools on this subject is rather limited. To remedy this situation, the Centre de coordination sur le sida of the Ministère de la Santé et des Services sociaux du Québec, in collaboration with the Ministère de l'Éducation has agreed, in the framework of a common action plan, to support schools and teachers by producing educational materials on the subject. Accordingly this publication was developed in order to support educational activities aimed at preventing AIDS and other STDs (p. 5).

Learning activities integrate many of the same basic principles of educational practice for young people (students) with intellectual impairment, and can be used to teach about sexuality. Outlined in the publication is a list summarizing the basis for educational practices, which was reviewed and considered as part of this project (See Appendix K). Not all chapters of the program were used however, the general format outlining how an education program runs was followed. The program takes into consideration individuals' developmental levels since materials are visually based and language is simple and concrete. Topics selected from the program include: *Talking about sexuality* (feelings and emotions); *Knowing your body* (anatomy, male and female genitals, private parts: underneath a bathing suit, your body: it belongs to you, you decide); *Masturbation* (definition, health masturbation, personal choice, myths, privacy, feelings, alternatives); *Self-confidence and Assertiveness* (ways of communicating: a passive or an assertive attitude, characteristics of an assertive attitude, reacting); *Confiding in others* (list of people you know: family, friends, professionals, list of people you can trust); *Reacting to sexual exploitation* (types of exploitation, telltale signs of exploitation, and how to react

in cases of sexual exploitation: say no, get away, talk about it); *Having a boyfriend/girlfriend* (time, stages, mutual consent, personal choice; types of sexual behavior; positive and negative consequences of sexual intercourse; criteria: time, stages, mutual consent, psychological security, prevention); *Knowing about STDs* (definition; diseases transmitted during sexual intercourse; main mode of transmission: sexual intercourse; symptoms, what to do: see a doctor; prevention measures: use a condom, abstinence); and *Using a condom* (usefulness: protection against STDs, contraception; appropriate steps; availability of condoms; negotiating condom use).

Triangulation

Different types of data and data collection were triangulated by examining each information source and finding evidence to support the findings (Creswell, 2002). For example, the Knowledge Questionnaire was triangulated with the Attitudes Interview; personal documents were triangulated with observational notes. In this process, observational notes were re-read and summarized followed by coding then categorizing. Personal documents were evaluated and used to exemplify participant learning. Themes that emerged from the study were supported with evidence from each of these data sources. Drawing evidence from multiple sources helped ensure that the findings in this report were accurate and credible.

Researcher role

Taking good care to establish rapport with the centre and with participants was of the utmost importance. One of the first questions asked was “*How long do I need to immerse myself at the site before beginning to collect data?*” Care was taken to ensure that time at the centre was not insincere, merely coming and leaving at leisure. One way

of ensuring this was by including pre-study visits. During these visits, participants, care providers, and support workers were introduced to the study. Once a rapport was established with all informants, pretesting began.

Reliability

A second rater coded the Knowledge Questionnaire. Inter-rater agreement for 25% of the coded questionnaires was 100%

Dependability

Prior training

It should be noted that I have professional development in working with adults with DD. Extensive practical experience ranges from therapeutic, community, and educational settings with children, youth and adults with DD. As such, I felt competent and comfortable undertaking this project, and dealing with potential issues such as emotional upsets or behavioral problems. Due to extensive work in interviewing people with DD, I felt well-equipped to conduct the assessments. Competence included knowing when to take breaks, use prompts, and modify testing questions.

Emancipatory

Critical reflexivity

Qualitative researchers believe that you cannot separate the researcher from the research since the entire process of a study is subjective (Methods of Inquiry, 2001). As such, I felt compelled to acknowledge subjectivity as common practice of this study. One way to address reflexivity was to be aware of and openly discuss my assumptions in a manner that honors and respects the participants and the centre. For example, my role was as both participant and non-participant observer. As a participant, I facilitated the

intervention by teaching socio-sexuality. As a non-participant, I removed myself from the former role as best as possible by collecting observational notes after sessions were complete. Another way to address reflexivity was to bring to the forefront the assumptions, biases, and beliefs that guided my inquiry at the onset of this project. One assumption was that all participants would participate equally during the sessions. Another assumption was that the interview was unstructured enough that it would generate in depth responses about participants' social and sexual attitudes. It was also believed that the program could be facilitated as completely participant-centered.

Reciprocity

From the beginning of this exploration, it was important to ensure reciprocity so that a mutual interchange between the research and the "researched" took place. Aside from this being a thesis, it also set out to benefit the centre. The study provided an important service to the 10 participants as it delivered concrete and up-to-date information on socio-sexuality, which is important for increasing quality of life. The beauty of this project was that mutual learning occurred; as the facilitator, a significant discovery was made about conducting research with real people in real settings. For participants, I can only speculate that new learning and attitudes were highlighted, and that this may have empowered them socially and sexually. What's more, reciprocity can filter its way through to the greater community. For example, individuals who have had the experience of participating in this study can use their newfound knowledge to gain self-competence and self-esteem. This in turn, may positively affect the way in which the larger community perceives and ultimately treats them. People with DD who receive

training, particularly in social skills acquisition and sexuality education not only themselves, but also those in their surroundings.

Transferability

This study provided rich descriptions of the data. First, observational data were collected at two different times in order to ensure that no data were overlooked. Second, notes that emerged from observations were lengthy, used descriptive words, were reflective, and were detailed in order to ensure validity. As well, data pertaining to case examples were investigated thoroughly in order to best represent the individual. Thick descriptions were also used to thoroughly describe the research context, participants, their unique characteristics, instances of learning, and assumptions central to the study.

Procedure

Introduction Phase

After receiving acceptance from the centre a schedule was created for pre- and posttests, as well as the intervention. Many of the care providers providing consent worked at the centre, therefore introductions and consent forms were conducted during that time. Some participants signed consent forms independently. During the first pre-study visit, all participants were met and consent forms collected. A plan was executed and the program began in July 2003.

Pre- and Posttest Phase

Pretests were conducted 1 week before the intervention. Participants were tested early in the day. Participants were asked if they were ready for testing, regardless of when they were scheduled in order to ensure a level of comfort. If participants were not prepared when it came to their turn, those who were willing were tested. Pretests were

conducted in the centre resource room. In order to put participants at ease, snacks were prepared and individuals were informed that testing would be quick and easy. Each participant had the chance to take a break. The Demographics Questionnaire was administered first followed by the Attitudes Interview, and finally by the Knowledge Questionnaire. For the latter, each question and answer choice was clearly stated at a slow pace. In some instances prompts, re-phrasing, and repetition were used to ensure clarity and comprehension. Prior to the study, eight questions were omitted from the original questionnaire for fear that testing would be lengthy, creating frustration and possibly hindering the data. Pretests took 20 and 30 minutes depending on participants. Posttests were conducted 1 week after the intervention; for consistency purposes the same format was used as the pretest.

Intervention Phase

The intervention took place in July and August 2003. It was administered at the centre every Friday for 2 hours from 10 a.m. to noon. Halfway through each session, the group had a 10 minute break. Two sessions were held in the centre boardroom and two outdoors. Weekly topics were organized according to content. For example, topics presented in the first 2 weeks were geared to teach social skills and were also more basic, whereas topics presented in the last 2 weeks proceeded to be more abstract-based, covering issues of sexuality. In session 1 topics included: social skills/esteem, empowerment, social support, relationships, and boundaries. In session 2 topics included: sexual physical health, anatomy and hygiene, gender, feelings, and masturbation. Topics in week 3 included: sexual mental health, STDs, and contraception. Finally, topics in session 4 included contraception II, stranger safety, saying NO and abuse prevention.

Each session opened with an introduction of the day's objectives, goals and topics, as well as an icebreaker. With the exception of the first session, a review of the previous weeks' topics was covered at the end of the two hours. A lecture-style approach was used to transmit the information however the program itself was interactive and participant-centered. As the weeks unfolded, topics gradually built on each other. For example, issues related to adaptive social behaviors such as dating built on issues related to sexuality like pregnancy prevention. Topics were presented according to an outline, which was prepared in advance. However, because the program was participant-centered, the group had the chance to interact and ask questions, which dictated the flow of the program. Flexibility on the part of the facilitator was also used. For example, if participants did not want to discuss a topic then it was re-introduced at a later date.

Each week, participants were presented with learning activity worksheets, which correlated with the session topics. Worksheets were completed either as a group or individually. Support sheets for the facilitator were used as a reference guide. For example, the Table of Feelings (See Appendix M-support sheet 1.2) was used to teach basic emotions and to get a sense of how participants were feeling. Accompanying the learning activities were concrete materials used to help facilitate learning. These included condoms, a hoola hoop for personal space, sanitary napkins, bathing suits for private parts, a breast self-examination board and cards, pamphlets on STDs, and various birth control methods. Other useful materials included: relaxation music, chart paper, an easel and paper and women's magazines. Modifications to the instructions of the activities or the activities themselves were made in order to suit the developmental needs of the group. A logbook noting changes to the program was kept.

Ethical Concerns

An important component of this study was to address ethical issues related to conducting research with people with DD. As such, areas outlined in Concordia's Summary Protocol Form (SPF) were addressed. In order to comply with these standards issues were addressed in the strictest manner. This study was conducted rigorously, systematically, and ethically so that the audience can trust the findings. First, consent forms stated the intent and purpose of the study, and introduced the research process that was undertaken. Care providers were informed that knowledge in socio-sexuality can benefit participants' quality of life. For example, acting appropriately in social situations can lead to friendships. Informed consent was obtained in writing, and assistance was provided for those who did not read. A verbal description of the study was provided to participants to ensure understanding. The consent form for participants were simple and easy to understand. By signing the form, participants provided free and informed consent regarding their participation, which was given and maintained throughout the study. In general, the overall study presented no peril to participants, and was set out as a preliminary exploration of knowledge and attitudes. The forms ensured that the recruitment process was by no means physically or psychologically endangering since its sole function was to gather consent.

Next, no form of deception was employed in this study, as all participants were made fully aware of its entirety. Participants were informed as to the purpose, procedures, and measurement tools used. Participants also had the opportunity to ask questions about the research at any given time, either in group or individually. No information was ever withheld from them or care providers. Third, participants were informed in both written

and verbal format that they could discontinue their involvement in the study without negative consequences. Participants had autonomy to make choices ranging from signing consent forms to participating in activities. Moreover, the issue of assessment of risk to subject's physical well being, psychological welfare, or reputation was addressed. Testing and intervention in this study was brief, at the level of participants' understanding, and aimed to be fun. The intervention was created with careful consideration and weekly topics, issues, and activities reflect this thorough process. Furthermore, none of the data collection procedures were used to psychologically evaluate participants; its purpose was to evaluate and explore the learning and changes in attitude. Finally, confidentiality was honored at all times. Information used in the final report includes pseudonyms. This is also the case in the event of publication. Care providers were informed that all published data are based solely on group findings.

Data Analysis and Rationale

Attitudes Interview responses were compared from pre- to posttest in order to explore participants socio-sexual attitudes. Knowledge Questionnaire responses were analyzed quantitatively using a paired sample *t*-test to compare pre- and posttest responses to examine changes in socio-sexual learning. Several methods were employed to organize findings for the major themes. Observation data from the videos were first transcribed verbatim and coded by session. As a result, approximately 40-50 codes were generated. Codes were then collapsed into categories in order to reduce redundancy. Categories were collapsed further, which resulted in 4 major themes. In addition, case examples were created to examine the attitudes and learning of two particular participants. The first case was chosen because the important issue of abuse was

highlighted. The second case was chosen to highlight the knowledge and positive attitude that the participant had about socio-sexuality.

Results

Pre- Posttest Questionnaire

Total test scores of the 10 participants were compared over the 6-week intervention. A paired sample *t* test comparing group means for the test scores across 2 time periods was conducted (See Table 1). The results of the pre- and posttest questionnaire indicate that participants' knowledge significantly improved from Time 1 to Time 2. At Time 1 the group mean for pretest scores was 11.00 ($SD = 3.33$) and at Time 2 the group mean was 13.30 ($SD = 1.88$). The results demonstrate that the participants' factual knowledge in areas of reproduction, sex, health issues, contraception, relationships, touch, and choice was more accurate at Time 2. The *t*-test results reveal that when compared from Time 1, participants knowledge at Time 2 was significantly different at the .05 level, $t(1,9) = -3.023$, $p = .014$ (two-tailed test). An alpha level of .05 was used for this test. This provides evidence to suggest that the 6-week socio-sexual intervention appears to advance and improve participants' overall knowledge in socio-sexuality.

*Table 1**Mean Performance Scores of Participants on Knowledge Questionnaire*

Questionnaire Scores		
	Time 1	Time 2
Participant 1	10	15
Participant 2	13	13
Participant 3	4	9
Participant 4	14	16
Participant 5	10	13
Participant 6	14	14
Participant 7	8	14
Participant 8	10	12
Participant 9	15	14
Participant 10	12	13
<i>M</i>	11.00	13.30
<i>SD</i>	3.33	1.88

Pre- Posttest Opinion Survey

Participants answered six opinion questions in the Knowledge Questionnaire. The questions explored participants' feelings on issues related to socio-sexuality that were discussed in the intervention. A "Yes" response represented an agreement with the statement, and a "No" response represented a disagreement. Qualitatively, the data revealed changes for Questions 2 and 5 from Time 1 to Time 2. The statement in question 2 was: "I think any kind of sex is okay, as long as both people agree to it". Six (6) participants responded Yes and three (3) participants responded No at Time 1. At Time 2, eight (8) participants responded Yes and one (1) participant responded No. This indicates that there was an increase in positive views and approval for sexual relations. That is, more participants felt it is acceptable for sexual relations to occur when there is a mutual understanding and agreement between two consenting adults.

Furthermore, changes were also noted for question 5. The statement in question 5 was: "It is okay to say NO to your social worker when you do not agree with him/her". At Time 1, seven (7) participants responded Yes and three (3) participants responded No, while at Time 2, nine (9) participants responded Yes and one (1) participant responded No. This suggests that individuals felt it is acceptable to say no to a person in an authoritative position when in disagreement with them. Individuals may have felt more empowered, assertive, and confident vocalizing their beliefs, perhaps viewing smaller gaps in power relations between the worker and client.

Pre- Posttest Interview

Question 1 stated: What do you want to learn from this program? At pretest, the findings suggest that there was a keen interest and common desire to "*make friends*",

have a significant other, learn “*about stranger safety and saying NO*” as well as “*communicate better with family and friends*”. Participants also reported a strong interest to learn, but in a more general sense. “*I want to learn everything about sexuality!*” proclaimed one individual, in an overzealous manner. Some participants expressed their eagerness to learn about areas only related to sexuality namely, male and female body parts. Others articulated a desire to learn about things that mattered most in their lives. “*I want to know about getting married*” and “*meeting other people*”.

At posttest, results revealed that the scope and amount of participants’ responses increased, suggesting a desire to learn more and about different areas of socio-sexuality. As well, the responses reported at pretest were still evident at posttest, such as the desire to know about sexuality, establishing new relationships, stranger safety, and marriage, suggesting that these issues were consistently important. In addition to this, participants gave answers concerning “sexuality” suggesting a desire to learn about the sexuality component of socio-sexuality. The details to support this desire for new learning were evident in the topics reported, such as: sexual organs, masturbation as a private not public act, how to protect oneself from abuse, personal touch and other peoples’ bodies, private body parts, correct and slang terminology for male and female body parts, birth control pills, male and female condoms, sexual intercourse, and sex as a private not public act. Furthermore, participants revealed increases in knowledge by naming topics from the program. These areas included learning about other people and their feelings, how to express feelings in an appropriate fashion, and accurately assessing faces and basic emotions such as being happy, sad, angry, and nervous.

Question 2 stated: Do you have any questions that you would like answered and is there something you want to learn about yourself? Before the intervention, participants expressed that they wanted a basic yet critical skill necessary for everyday living. *"I want to learn to communicate with people and get along with others"*. As well, the theme of friendship emerged, as participants reported that they wanted to acquire skills on how to *"make more friends and new friends"* and to build relationships and alliances with others. Although unrelated to socio-sexuality, one individual was concerned with learning about the specific disability he had from a medical standpoint. He stated that he was interested in *"how he came about being different"*. Another participant reported a desire to learn *"how to get a girlfriend"*. This quest for sharing life with a significant other became a recurring theme for this participant throughout the course of the study. At Time 2, the data reveal that the scope of their responses increased, suggesting that participants still had unanswered questions that they were eager to learn. For example, participants wanted to know more about *"family and relationships"*. Some participants reiterated a second time what they had learned from the program. The findings reveal that most of this knowledge was practical. For instance, participants reported that after the program, they knew how to protect themselves from abuse and exploitation—a subject which was never mentioned when the same question was asked before the program. Participants stated that they knew about *"stranger safety"* and about keeping out of trouble. *"I learned to keep hands off of other peoples,"* one participant stated assertively. *"I learned that masturbating is done at home, but NOT in the bathroom"*. Other participants were more reflective in their responses and placed greater emphasis on topics that mattered in their lives *"I learned that my friends respect me"* and about *"my relationship with my*

boyfriend". The most powerful response that emerged from question 2 signified a reflective and understanding of life's importance. "*I want to keep happy*" was the statement. This statement illustrated that above all, happiness was as basic a need as any.

Question 3 stated: How do you feel about things like sex, intimacy, and having a boy/girlfriend? At pretest, the results reveal that participants were apprehensive about these and topics similar to them. Participants used words and phrases such as "*Uncomfortable*", "*I don't like it*" or "*I would rather listen to you than to talk about it*" to describe their feelings. Nevertheless, some participants did report positive feelings such as being "*okay*" with sexuality and intimacy, and in one case, being completely at ease with it. "*Having a boy/girlfriend is really good!*" stated one participant with great confidence in an expressive voice. Some participants appeared the most comfortable about sexuality and reported having no problems speaking candidly about sex. In general, more negative than positive views were expressed at pretest. Nonetheless, at posttest, a more positive outlook on sexuality was expressed. For example, participants' described feelings of embarrassment and anxiety before the intervention yet not after. Participants seemed more at ease answering the questions, generating answers, and described their feelings with more affirmative and expressive statements. "*I feel okay and comfortable*". "*I feel alright about it...Right on!*" Other evidence of positive attitudes toward sexuality was described in a retrospective and open manner by one participant. "*At first I was embarrassed talking about it, but after (the program) I dealt with it*". The data reveal that participants were uncomfortable and afraid at first to talk about issues related to sex at pretest, however at posttest, feelings such as "*embarrassment*" subsided.

Lastly, question 4 stated: How do you feel about things like making friends being with people, and interacting together? At both pre- and posttest no changes were found. Almost all participants expressed a great fondness for having meaningful connections with others. Participants at pretest stated that they took pleasure in going out with large groups of people, but some were selective about their surroundings. *"I like going to social places as long as it's not too loud"*. *"I like hanging out with friends,"* *"I like socializing and going out in the community"*. Other participants however, indicated that they only enjoyed going out with their boy/girlfriends and no one else at pre- and posttest.

Furthermore, participants who rarely expressed themselves in the program, and who did not provide any elaborate answers in the pretest interview began to share and express their feelings more openly at posttest. One participant had this to say. *"I feel good, comfortable. Did it (socializing) last night with friends and had fun with them. Friends are fun to hang out with –if I didn't have friends I'd be very lonely. Used to live on my own, but it was quite lonely"*. She summed up her feelings about the harsh reality of being alone, and more grimly, being lonely. *"The walls don't answer back..."*. As well, the same participant who only liked hanging out with her boyfriend at pretest gave the same response at posttest. *"I only like going out with Jason, Jason and no one else"* she stated, *"I like going out with Jason to the movies and to the dance"*. The results also showed that some participants felt both confident in making friends and uneasy being with people who were not. For example, they expressed at posttest that *"Making friends is easy"* *"but being with others...you never know what could happen"*. Overall, almost

all participants enjoyed being in social situations with friends both before and after the program as no increases or changes were found.

Themes

This study reports some findings under several thematic topics. These themes are as follows: (1) Attitudes and Feelings (2) Learning about Sexuality and Relationships, (3) Misconceptions and Stereotypes and (4) Choice and Empowerment. Theme 1 is delineated by positive, negative, liberal, and conservative attitudes and feelings that participants had throughout the program. Theme 2 is defined by the instances of knowledge acquired throughout the sessions. Theme 3 is defined by participants' statements in discussions of misconceptions and stereotypes. Lastly, theme 4 is created from the instances of empowerment and choice-making revealed in the program. In order to create these themes quotes, examples, statements, and observed behaviors were used as illustration. In addition, in order to help the reader, the data were quantified accordingly: **Most** was used to indicate 8 or more participants; **Some** was used to indicate 4-6 participants; and **Few** was used to indicate 3 or less participants.

Attitudes and Feelings

Negative attitudes and feelings

According to the data, negative attitudes were revealed about socio-sexuality. In a role play activity in session 1, the group was presented with the scenario: You just broke up with your boy/girlfriend, and were asked to explore how that would make them feel. One participant spontaneously recounted a story when she felt jealous about another woman wanting to call and steal her boyfriend away. She claimed that the incident made her very "*angry*" stating "*Not gonna let another girl take him from me!*" Other feelings

such as embarrassment also emerged. When the group role played greetings, participants displayed how uncomfortable they were. For example, one participant placed his baseball cap over his face and held his head down low to ignore the topic altogether. When the topic of “sex” emerged, participants also showed varying levels of negativity. For example, the same participant that hid his face in his hands did the same thing, and slid down in his chair, shaking his head disapprovingly. Another participant reported, “*It’s starting to bother me because of family...*” as her sentence dwindled off and she appeared somewhat saddened.

Negative feelings also corroborated with responses reported from participants’ personal documents. For example, in the activity: How do you feel about the word sexuality? some participants chose the feeling FEAR to describe their emotions (See Appendix M-support sheet 1.2). As well, in an activity on body parts, participants were asked to identify male and female body parts by colouring in the appropriate private parts (See Appendix M-support sheet 2.4). Despite the fact that the pictures were cartoon-like, one participant was clearly opposed to completing this activity. He squirmed around in his chair and constantly looked at his watch; he was clearly feeling uncomfortable. In another activity exploring gender (What is male and what is female?) participants were asked to find pictures of men and women from popular magazines such as Vogue and Cosmopolitan. While the group members looked for pictures, one participant chose to avoid all pictures related to sexuality, and only choose pictures of young children; this behavior suggests his disapproval and discomfort. He also refused to look at the pictures that the others had found (mainly lingerie ads) and turned the pages of his magazine quickly.

Furthermore, at the beginning of each session, participants engaged in icebreakers to help ease apprehension and fear in talking about socio-sexuality however, negative attitudes prevailed. In session 3, the icebreaker called Warm Fuzzies was presented (See Appendix L). Each group member was required to express a nice or warm statement about the person sitting to the right of them until all participant had given and received a “fuzzy”. One participant was completely embarrassed when another participant stated that she was a “*nice girl*” and that he would like to get to know her “*better as a friend*”. The recipient of that warm fuzzy immediately flushed and looked embarrassed; she could not seem to look at anyone, particularly at the participant who gave her the compliment. She smiled and giggled and turned her shoulder to hide the side of her face. Other participants also seemed embarrassed. They had their heads down either on the table or in their hands and appeared uncomfortable receiving their compliments. One participant looked anxious when it was her turn, and seemed unsure of what to say. She sat silent for a long while and played with the warm fuzzy ball. She quickly mumbled “*I don’t know*” and hastily passed the ball.

In a discussion on body care also in session 3, participants’ attitudes suggested feelings of embarrassment, discomfort, and uneasiness. One participant burst into uncontrollably laughter when it was her turn to find the lump on the breast board (made of plastic and resembling a real breast) in the activity on breast exams. When she finally calmed down and decided to partake in the activity, she touched the breast board and shrieked loudly “*Yeah....eeeeeeewwwwwwwww!!!*” in an exaggerated manner. She pushed the board away from her as if it was poison. The rest of the group seemed to feed off of this behavior and started giggling alongside her. One participant held his head

down, even lower than ever; his hands completely covering his eyes. Other participants did not even get so far as to try the activity as feelings of disapproval and anxiety were noted. *"I don't want to try it!"* shaking their heads and making faces as if they had just witnessed a horrendous sight.

Other activities also exhibited disapproval towards socio-sexuality. For example, the group was asked to complete an activity on attitudes about masturbation (See Appendix M-support sheet 4.1). The activity involved placing a check mark on either NOT GOOD or GOOD to indicate how one feels about talking about masturbation, and NOT OK or OK for doing it in a bedroom. The responses suggest that some participants felt disapprovingly about masturbation. Many of the female participants placed a check mark next to NOT OK and NOT GOOD. One participant refused to participate altogether and carried on with a different activity.

Furthermore, in session 4 participants also displayed feelings of embarrassment when discussing contraception. In order to break the ice in talking about condoms, three items were laid out in front of the group—a feminine pad, a pack of birth control pills, and a packaged latex condom. The group immediately began to laugh out of embarrassment when they saw the items. Only one participant raised his hand to answer my question: Which one of the objects is used for protection against STDs? The others sat quietly and looked around the room with nervous expressions on their faces. The group was also asked: How would you feel about asking for a condom? The entire group disclosed that they would definitely feel *"embarrassed"* if they had to ask for a condom. They also stated that they would feel *"kind of shy"*. The same participant who refused to participate in the masturbation activity refused to complete this activity as well, which

entailed pasting on paper the correct sequence of events (cut outs) for using a condom (See Appendix M-support sheet 10.2 & 10.3). He abruptly pushed the activity sheet away immediately after he saw the images of condoms and body parts, and shook his head vigorously stating his disapproval.

Similarly, in a discussion about condoms as a preventative tool (session 4), participants also suggested uncertainty and insecurity. After describing its usage, a condom was held up for the group to see. The group was asked if anyone was willing to open the package to explore its contents. A few participants were completely opposed to this notion and were the most resistant “*NOOOOOOOO!*” they shouted loudly and backed away in their chairs as if the condom were to attack them. Their body language showed fear, anxiety, and embarrassment. Moreover, in a discussion about how participants felt if they had contracted an STD, the group stated that they would feel “*Angry...because you don’t realize that you have it*” or “*scared...and even sad*”. Likewise, most participants admitted that another embarrassing event would be seeing a display of public affection. “*Especially in public! It’s embarrassing and private*”.

Furthermore, participants displayed frustration and hostility about topics related to sexual abuse and exploitation, and good versus bad touch. In a discussion about abuse, the example of a person abusing their pet was provided to exemplify how abuse could make someone feel, what abuse was, and so forth. Sadness and hurt were reported on a number of occasions, as the group stated that they would feel “*sad or painful*” if they had witnessed someone abusing a pet. One participant appeared angry. I asked the group what the cat might say if he/she could talk. “*I know what the cat would say--it would say get the f#@k away!*” he stated aggressively. When the question how does a bad touch make

you feel was posed, one participant emotionally responded "*It makes me feel like a broken down...like a broken down car*". "*Angry*" was the sentiment from the entire group.

Positive attitudes and feelings

Just as negative emotions, feelings, and attitudes emerged, so too did positive ones. In a discussion about touch and personal space, the group sat around the table listening to different scenarios that required them to decide whether the situation was appropriate or inappropriate. In asking the question: Would you touch a staff member? one participant stated convincingly "*Sure...it's okay to care for someone*". Other incidents occurred in the program that were not part of the program, but were used as "teachable moments". For example, one participant seemed to thoroughly enjoy teasing and flirting with another participant whom she described as her "*friend*". She appeared comfortable in her actions, as she was observed consistently touching and poking him, and giggling while he was not looking. In one instance, this participant walked over to her friend and *without* his permission, touched him on the neck lightly. He abruptly turned around to see who it was; when he saw that it was his friend, he smiled gleefully. This opportunity was used as a teachable moment to discuss appropriate and inappropriate touch, and the notion of asking permission to touch someone. At this time, the participant confirmed that he did not mind his friend touching him, but agreed that had it been a stranger, the situation would be different in that it would have been considered inappropriate behaviour. In the Warm Fuzzies icebreaker, participants also showed positive attitudes in giving and receiving compliments. Participants had huge smiles on their faces and were happy to say "*thank-you*" when they received a

compliment; this seemed to make them feel good inside. Participants' responses when they gave compliments were also very positive and genuine. *"I like you as a friend a lot"*, *"She's my friend...she's a nice lady"*, *"She's very nice"*, and *"She's very pretty"* were among the responses. One participant claimed that he was *"okay with it..."* (referring to giving a nice compliment) *"As long as no one gets any funny ideas...only as a friend, because I already have a girlfriend"* he adamantly repeated so the entire group could hear him.

Moreover, positive attitudes were also apparent when the group discussed friendships (session 2). *"Jane is my friend...you feel like you belong because she seems to understand you...she's there for you"*. One individual stated that he considered his mother as his very best friend. *"I feel good around my mom!"* he exclaimed blissfully. When discussing what a friend is, one participant stated that he had no one as a friend, but quickly changed his mind and shyly pointed his thumb towards one of the members in the group. Although he did not appear to want to say her name, he was repeatedly encouraged by this friend to do so. Finally, he mustered up enough confidence to say her name, smiling at her at that moment. The group also explored and discoursed about love and trust. In one activity, the group was asked to locate pictures from popular magazines that expressed emotions of love, and that might represent family members, friends, and trusted others. One participant flipped through a Cosmopolitan magazine and exclaimed assertively *"Now this is love!"* She proudly held up the image of a man and a woman embracing one another in a passionate kiss. What's more, some participants showed positive feelings towards love through public affection. Two participants in particular happened to be in a long-term relationship. In all four sessions, they were observed

publicly displaying their affection for one another. They sat very close to one another, cuddled up against one another, held hands, gazed in each others eyes, squeezed and hugged each other, and constantly stole kisses. During one session, when the word sex was brought up, the one participant looked at his girlfriend and smiled shyly at her. They seemed to show a great deal of love towards one another; clearly they were a couple “in love”. Likewise, participants also reported positive feelings when discussing how a good touch makes them feel. “*Good*” “*Happy*” and “*Warm*” were among the most popular responses.

In addition, affirmative attitudes also manifested during discussions about male and female body parts, sexuality terminology, and masturbation. For example, the activity comparing “the body like a house that you lived in” was presented, stating that it was important to get to know the house, all of its parts, the names, and so forth. One participant stated “*I feel safe in my house*” implying that he was comfortable with his own body. He expressed this proudly and seemed eager to discover more about the human body. Similarly, another participant demonstrated a positive attitude by generating slang terminology for male and female private parts. This was best illustrated through his participation. The participant spontaneously yelled out a number of different answers, and this without hesitation. He did this in a clear and loud voice; it appeared that he wanted the entire group to hear him. Likewise, other participants seemed to be having fun with the slang terminology activity as they generated a number of terms, particularly for women’s breasts. Participants shouted out answers in an assertive and playful manner. “*Doorknobs!*” “*Knockers!*” “*Jugs!*”. They repeated these words several times and laughed amongst themselves in a joking manner. In a group discussion on breast exams,

one participant displayed a positive attitude by showing his eagerness and willingness to engage in the activity; he was the first participant in the group to volunteer to locate the lump on the breast board when no one else offered. The participant did this without hesitation; he smiled and appeared to thoroughly enjoy this.

In an activity discussing female body parts (session 3), one participant seemed to feel content expressing himself in a group setting. He assertively provided answers for the group when no one had anything to say. "*Vagina*" he stated candidly. In another instance discussing gender and masculine and feminine traits, participants showed a keen interest by generating new ideas for the group to think about. "*What about when people have sex changes...then what are they?*" participants asked quizzically and with genuine interest. In general, it appeared that the comfort level of the group was very high when discussions involved terminology, gender, and body parts. Furthermore, the group appeared to feel comfortable and at ease when talking about the female body. Some were even excited when they had the chance to look at pictures of women in lingerie advertisements. "*Whoa....Whoa!*" exclaimed one participant when he saw these pictures. "*Whoa*" and "*Yeah!*" was the extent of his vocabulary during this activity, as he stared and asked to look at them up close. Although other participants seemed to be a bit more reserved with their comments, they laughed and seemed relaxed while the one participant examined the pictures in detail. This activity seemed to spark even more discussions about the female body, as participants revealed personal information. "*I bought a night gown one time for my girlfriend!*" one individual proclaimed, smiling and pointing at the lingerie in the pictures. Answers from a discussion activity on what is and is not appropriate also revealed that participants felt comfortable talking about the human body.

In one scenario role play the statement was: You buy your boy/girlfriend sexy lingerie. Answers were all affirmative ranging from *"It's okay"* to *"Yup!"*

Other positive attitudes were observed from participants' assertiveness in activities. For example, in a role play scenario about Tim and Linda, a fictitious couple used to deal with issues related to sexuality, participants showed how they felt when Tim refused to wear a condom. *"It's not fair"* stated one participant in a frustrated tone. *"It's just not right...if you don't talk about it, you don't say then that you've made a commitment"*, another participant expressed adamantly. Similarly, the activity "Make your own judgment" was presented with the task of deciding whether a scenario was appropriate or not. For example, statements included: You tell your bus driver that he/she is sexy, and you ask your support worker if he/she is gay. Here it appeared that participants warmed up to the activity, and were relaxed and open in providing answers by the end of the session. One participant, who was always reluctant to participate in sessions, spoke for the first time and stated *"That's bad manners!"* referring to the second scenario presented. In another scenario: You walk out of the shower without covering yourself, it was evident that participants could openly discuss these intimate situations. One participant stated *"I have to keep the door open just in case I slip and fall and need help"*. The group also seemed to be quite assertive in answering other similar role play scenarios. For example, the groups' attitude towards overt public affection (e.g. constantly making out in a park), indicated that it was not always appropriate in their eyes; they yelled assertively *"NOOOOOO!"* when asked how they feel about it. One participant revealed a more open and relaxed outlook on public affection and was confident enough to go against the group with her ideas. *"Well....if no one is around then*

it's okay". Furthermore, some participants held positive attitudes and feelings about masturbation. In one activity (session 2) some participants checked off that they felt GOOD and OK for a young person to masturbate in his/her bedroom (See Appendix M-support sheet 4.1).

Finally, some participants showed their eagerness and curiosity about socio-sexuality, and were also able to demonstrate what acceptable sexual behavior was. For example, they seemed curious about condoms when the topic of contraception was introduced. *"I've got one here...do you want me to open it up?"* one individual asked enthusiastically as she waved the unopened condom in the air. Others did not seem to want the sessions to end. *"It's over...already?"* asked one participant when we went for break in session 2. *"I'm going to stay and catch up because I missed the last session"* another participant stated when we took a break. In general, feelings such as curiosity, interest, excitement, happiness, and active participation were evident to support the sub-theme of positive attitudes.

Learning about Sexuality and Social Skills

The intervention suggested a second major theme: learning about sexuality and social issues such as relationships. For instance, when asked what the word "sexuality" meant participants seemed to have varying viewpoints in session 2. *"It's knowing how to protect females,"* informed one participant in a confident voice. *"It's about body parts"* yelled out another. One participant in session 3 stated that she knew another name for menstruation *"It's your period"* she stated confidently. Participants were also able to correctly identify different male and female private parts in a colouring activity. As observed from their personal documents, participants indicated that the vagina, breasts,

buttocks, and penis were all considered “private parts”. In a review in session 3, participants appeared to retain what body parts were “private”. Participants shouted out correct words like “*vagina*” and “*buttocks*” when asked to identify these parts. One participant proudly displayed her personal document to the group so that they could see that she has completed the activity correctly.

In addition, participants were able to correctly define private and public. For instance, private was described, as “*You don’t show anybody*” and public was “*Lots of people see...and it’s okay to show people*”. In a similar activity, all participants showed an ability to categorize body parts into public or private categories. Group findings indicate that participants correctly labeled the following parts as public: feet, head, mouth, neck, stomach, legs, and arms. As well, participants correctly identified the following parts as private: nipples, penis, testicles, buttocks, and vagina. One participant wanted the group to know that nipples were private “*because a woman don’t go around on the street and show her nipples*”.

In a gender categorization activity, participants also correctly labeled pictures of men and women into the proper categories without difficulty. New vocabulary also emerged as a result of this activity. For example, in examining a picture of an androgynous-looking model, one participant spontaneously stated “*It looks like a transvestite*”. In addition, a discussion about heterosexuality and homosexuality emerged from this activity. For instance, participants stated that they had heard the word “*gay*” before. Another participant stated “*What about the word fag?*” as we explored that some slang terminology was also derogatory. In the activity about breast self-exams, one participant who located the lump expressed “*it feels different*” suggesting that he

understood the difference between a healthy breast and a breast that had a lump in it. Another participant explained "*it feels like something is there*" and described it as "*hard*". He added "*the other side is soft,*" acknowledging that differences existed.

Furthermore, participants were observed learning about masturbation in sessions 2 and 3. Although few participants could articulate exactly what it meant, one participant spoke frankly about masturbation when asked what he thought it meant. "*When a guy jerks off*" he informed the group in a nonchalant manner. When asked where it was and was not appropriate to masturbate, some participants stated that masturbation was wrong in public and that people needed to go "*in a private spot*" if they wanted to engage in this behavior. In an activity on touching oneself in public, participants responded that they knew how to deal with the situation if they saw someone touching themselves at the dinner table. One participant stated that he would say "*Excuse me Peter... it's not the right place to do it... You have to go to your bedroom with the door closed and the blinds closed too*". Clearly, the findings reveal that some participants were able to understand acceptable places to masturbate, listing alternative places to do so.

Moreover, of the participants that participated in session 2 on masturbation, it was observed that this information was retained in session 3. For example, participants not only used everyday terminology such as "*touching yourself*" to explain what masturbation meant, but also used the correct terminology such as the word "*masturbation*" which they did not know before the program. One participant explained to another (absent in session 2) what he had learned. "*It's not a good idea to masturbate in the bathroom because other people can come in*" (if you live in a group home). He continued to inform her "*You should go in your bedroom with the doors and blinds*

closed". Another participant added what she had learned. *"Go to your bedroom, close the doors and blinds"*. The group also completed the activity: Mark an X in the places where it is not appropriate to masturbate (See Appendix M-support sheet 4.2). The personal documents confirmed that participants were able to state that the bedroom was an appropriate place to masturbate. This was also exhibited as participants shouted out the correct answer in a review session.

In terms of STDs, when asked what prevention meant, one participant answered correctly stating *"Trying to stop it"*. Some participants could also explain what treatment meant. *"You would go to the doctor and get stuff for it"*. The same participant also had knowledge as to why an STD cannot be washed away, like germs. *"Because it still stays with you (pointing to her body) when you don't treat it"*. In using the fictitious characters Linda and Tim, some participant's suggested that they understood the concept of how to treat an STD. In the scenario: Tim doesn't have an STD anymore because he went to the doctors and was treated, participants reported that Linda could not get an STD from Tim any longer. *"No...they're okay now"* was one response, however no participant could completely explain why (e.g. you have to have sexual intercourse with an infected person in order to get an STD). In an activity on misconceptions as to how to get an STD (See Appendix M-support sheet 9.1) participants were asked to take turns choosing an illustration corresponding to a specific situation (e.g. an everyday activity). Some participant evaluations suggest that they understood that transmission of STDs was not possible in any of the everyday situations presented; this was evident from their comments. Here are some of the scenarios and responses that were noted: Playing ball with someone: *"No you can't cause you're only playing ball...No, cause you're not*

having sex". Shaking hands: "*No cause they're not having sex*". Sneezing on someone: "*That's just germs*".

During a review in session 3, it was observed that more participants understood that you could only contract an STD through making love with someone who has an STD. Participants also seemed to know more about what to do if infected, prevention strategies, as well as what situations you *cannot* get an STD from. "*You should go to the doctors...right away*". They also seemed to know that STDs could potentially be severe. When asked why it was important to go to the doctors, participants stated: "*To stay healthy*". When asked: If I stay home, can I get better, one participant replied "*You can't...it only gets worst. You don't realize you have it...*" When asked what could be used to prevent the transmission of STDs (See Appendix M-support sheet 9.6), participants replied confidently "*Condoms can be used*" and stated that condoms "*prevent diseases*". For signs of STDs, the group seemed to have retained some information. Participants spontaneously stated "*itchy was one of them*" In evaluating participants' personal documents, 6 out of 7 participants were able to identify a sign of an STD (See Appendix M-support sheet 9.4).

Moreover, participants exhibited new learning about sexual abuse and exploitation, specifically about self-protection skills. As observed from completed support sheet 7.1 (See Appendix M) all participants provided the correct responses for understanding and recognizing exploitative situations. While taking this activity up, group members gave their insight and opinions about each scenario such as "*Yeah that's a good one*" or "*No...that's ignorant!*" were among their responses. In terms of how to react in cases of sexual exploitation or abuse, the group responses suggested that they

knew what to do in this situation. *"I can go for help... Go to the Police..."* they replied. One participant added *"You can scream!"* in an assertive manner. Spontaneously, the group listed people that they would be able to approach in this situation. These included: people in uniform, family, friends, bus drivers, and boyfriends.

With respect to relationships and social skills acquisition, most participants were able to illustrate how to be assertive in session 1. One participant volunteered her answer to the scenario: Someone is touching you and you don't like it. She stated assertively: *"Leave me alone!"* In learning about personal space, participants were able to acknowledge the boundaries of certain relationships. *"Marge likes me touching her....Suzie don't...Suzie told me NOT to give her a hug...she likes her space"*. As well, all participants were able to explain what it meant to be a friend. Participants' responses varied. For example: *"Go over there and help them...I got one...she's my friend (pointing to another group member)...When you go out together...I've got another one for you! I took Jason out for his birthday...Jane makes me cookies"*. The responses suggest that participants knew what friends did for one another and how a good friend treats someone. Moreover, when asked who a good friend was to them (session 4), participants listed off other participants in the program, suggesting that the group seemed to enjoy each other's company and were comfortable by the end of their time together.

In addition to friendships, the group was able to correctly identify different types of relationships in an activity when they were presented with advertisements from magazines that illustrated different relationships. The group also provided alternative answers as to what the relationships in the illustrations *could be*. For example, many participants stated that the picture of a girl and boy could be either a brother and sister or

a boyfriend and girlfriend, their rationale being that the people in the illustrations were “*playing around*”, which was not enough evidence to judge whether in love, or merely part of a loving family. They also displayed a clear understanding of basic feelings as a result of an activity that examined popular magazine advertisements. After having reviewed the Table of Feelings, participants were able to identify the correct basic emotions of SAD, ANGRY, JOY, and FEAR. Evidence of this was shown in an activity in which the group was asked to cut out pictures of people whom they trusted. One participant found a particular image that appealed to her and ripped it out from the magazine. “*She looks kind of sad...*” In a discussion on feelings shortly thereafter, another participant discovered a second image and stated correctly: “*She really looks sad*”. Likewise, participants had the opportunity to role play various basic emotions, as well as other key emotions that they themselves suggested. In session 1, one participant role played the feeling SHY, an emotion he had wanted to keenly enact out. Participants informally shouted out the correct answers. Other emotions that were correctly answered included: EXCITED, SAD, and SCARED. Participants seemed to have retained these basic emotions when they were reviewed in session 2. As well, participants were able to identify appropriate emotions to describe an unhealthy relationship. “*Angry...Sad...feeling unsafe...depressed*” were the responses provided. Moreover, in session 3 participants reviewed the Table of Feelings support sheet and were able to accurately identify what each emotion was. In session 4, participants also reported accurate responses associated with basic feelings, this time in an activity worksheet that involved choosing whether a situation was appropriate or not by representing the HAPPY face for appropriate and the SAD face for inappropriate (e.g. Donna’s mother caresses Donna’s

hair and says it looks like she's done a fine job with her homework). Eight out of the 9 participants that completed the activity, completed it successfully.

Moreover, the group also displayed knowledge in terms of the emotional aspects of a sexual relationship. Participants acknowledged in a group discussion that negative consequences can emerge when dealing with love. For example, participants stated "*your feelings can get hurt*" and "*your feel hurt when someone's done something wrong to you*". Some of their emotions included being "*moody*" "*miserable, and bad*". When suggested that one can have a baby as a result of a sexual relationships, many individuals identified that "*Sometimes you're not ready to have a baby*" acknowledging that babies are a huge responsibility. One participant seemed to know that "*You can get an operation*" (referring to a tubal ligation). When asked if the group can call someone their boy/girlfriend after a short period of time, participants learned from "Linda and Tim" that "dating" was a healthy prerequisite to a relationship. "*No...because you have to know more about them and know more about their background*" stated one participant. Another participant eloquently had this to say: "*No, because they're still strangers. You don't know them, and you can't trust them...It would feel uncomfortable*". Others reported that "*they need to go out on a couple of dates*". When asked whether Linda and Tim were considered a couple after one date, the group acknowledged that: "*They don't look [in love]. I don't think so because they don't look very happy to be honest!*" One participant acknowledged that people who are not in love, like Linda and Tim "*are just friends*".

In addition, the Make your own judgment and situational role play activities in session 3 facilitated learning in terms of what behavior was considered right and wrong

and appropriate versus inappropriate. As observed in the role play, the group showed knowledge for all situations presented and were able to present justification for their answers. For example, some participants reported *“That’s wrong because you got people to look at you and you’d be so embarrassed if it was you!”* or, *“It’s not right because the person may feel embarrassed and upset...it’s wrong because people don’t want to see your body”*. A few participants felt strongly about the following situation: You are at a restaurant and you tell the waiter that you want him/her to be your boy/girlfriend. The entire group was observed shaking their heads vigorously and echoing a loud NO. One participant in particular was the loudest shouting at the top of her lungs:

“NOOOO...NOOO...NO! CAUSE HE’S A STRANGER!” In the situation: You tell everyone at work about how many people you have slept with, most participants seemed to feel a great deal of disapproval. They yelled *“NOOOOOOOOO”* again, and one participant stated *“It’s your business!”* In sum, areas of learning in socio-sexuality in the four sessions included: Knowing that sexuality can be an uncomfortable topic for some individuals to talk about; knowing that masturbation was appropriate in the bedroom as a private act; that one can trust their significant other; not to touch strangers if they are unknown to you; that breast self-exams are conducted once a month; and finally, that STDs *“are diseases and you can only get them from a person who has it”*.

Misconceptions and Stereotypes

Observations and personal documents suggested a third theme that has risen from this study—misconceptions and stereotypes about socio-sexuality. First, participants had skewed ideas about sexuality in general. When the question of what sexuality has to do with was posed, the group associated sexuality with personal attributes of people. *“Don’t*

make fun of people when they talk” and *“Don’t call them fat”* were two of the responses. Next, misconceptions about gender stereotypes, particularly about what characterizes a man and what characterizes a woman were also noted. For instance, the group was asked to identify whether a picture was of a male or a female. The pictures were purposely chosen to represent androgynous-looking people that could be mistaken for either. In the first picture, one participant confidently concluded *“it’s a picture of a guy”*; his rationale as to why he was sure it was a male was *“because he’s got no vagina”*. In a second picture, another participant associated his personal experience with the picture. *“It looks like my mom....that’s why it’s a woman,”* he stated matter-of-factly. Other superficial characteristics were used to identify the pictures. For instance, *“She’s a woman...just look at her boots”*.

Other misconceptions related to menstruation, terminology on sexuality and personal touch, were also evident in session 2. For example, participants reported *“I heard that a woman can have her period....anywhere, anytime”*. Likewise, in generating everyday terminology for different male and female private parts, participants thought that another word for vagina was *“pubic hair”*. Others had the misconception that it was acceptable to touch a social worker. For example, in one activity, participants were asked to state whether a scenario was appropriate or inappropriate; the scenario being: *“You go to give your employer a massage”*. One participant reported: *“If they want to....and if they have a backache”*. Likewise, in the scenario role play: You cuddle up with your roommate on the couch without asking to do so..., participants suggested that *“cuddling up”* without permission was acceptable social behavior. *“You don’t have to ask the person you live with if you can touch them”*, one participant stated with certainty. *“It’s*

okay because you're alone and it doesn't bother them" another participant added. Only one group member stated that you had to gain permission because *"you might not feel comfortable doing it"*.

Furthermore, two major misconceptions that were noted in session 2 and 3 were about masturbation and STDs. First, few participants were aware of what the word masturbation meant, while others took wild guesses. One participant's answers reflected this misconception, and was convinced that he had the correct information. *"I know...it's when a guy wants to put his thing in a woman's vagina"*. In addition, while discussing where it is and where it is not appropriate to masturbate, some participants reported that they believed masturbation was appropriate to engage in *"in a bathroom"*. Second, observations noted that participants had very little knowledge about STDs but that the knowledge they did have was incorrect. This was observed in particular during session 3. For instance, in introducing STDs as "sexually transmitted diseases", one participant immediately jumped to a false conclusion. *"I don't do drugs"* he stated seriously. In the discussion on whether they knew what STDs were and what they were all about, another participant responded *"I heard that you can catch them from toilet seats"*. Debunking this myth led to discussions about how to treat STDs and how to prevent them from manifesting, which seemed to lead to other misconceptions. For example, in brainstorming how to treat an STD, one participant raised his hand with certainty and offered this advice to the group: *"Maybe if you wash your hands a lot"* referring to how it could be treated. Even when the correct information was presented, participants still held certain misconceptions. When asked at the end of session 3 whether a person can get an STD from a toilet seat, the group nodded yes. Participants completed the activity: Can

you get an STD from... with various options to choose from. One participant stated that yes, you could get an STD from a toilet seat, adding in his own words "*If you don't wipe...*" Some group members concluded that STDs could be spread through "*handshaking*" and that it was associated with "*kissing on the lips*".

In addition, participants believed that STDs were contracted by getting "*cuts*". For example, one participant stated that in the past he had cut himself, and as a result, was afraid he had contracted an STD. Similarly, group responses revealed that caressing someone or being caressed was another method of contracting STDs. This was apparent from participants' responses on the activity sheet: How can an STD spread? (See Appendix M-support sheet 9.3). Other participants' thought that "*if someone touches your breast*" a person could get an STD; this was still evident even after learning the correct information. Likewise, participants also believed that a person could get an STD from "*getting pregnant*". Moreover, other misconceptions were further evident when talking about symptoms of STDs. One participant eagerly raised her hand to reveal that symptoms were found "*under the arms,*" while another participant stated that they manifested in the "*buttocks*". Even after a full session of teaching STDs, misconceptions were still prominent. One participant approached me during the mid-session break and pulled me aside to discuss his concern. The participant pointed to his arm and stated that he had a sun "*rash*" and that maybe it was "*what we talked about*". He was clearly convinced that his sun rash was an STD.

Choice and Empowerment

According to the dictionary, empowerment is defined as "Necessary for independence, self assertion" (Bisset, 2000). In this study, participants showed moments

of choice and empowerment through their ability to demonstrate attitudes that foster personal development and self-confidence. Interestingly, few instances of choice and empowerment were observed in sessions 1 and 2, whereas sessions 3 and 4 had frequent instances. In session 1, the group indicated that they had choices as to whom they could trust in life. For example, in an activity listing people that they trusted (See Appendix M-support sheet 6.2) participants drew, wrote, or cut out pictures of at least 3 or 4 people each. Trustees included: Parents, brothers, sisters, social workers, police, oneself, staff at the centre, extended family, and boy/girlfriends to name a few. Group members had no trouble generating names, and quickly labeled and explained to the group who they drew and why. The lists included various trustees, which suggest that people with DD can rely on more than just family for support. These group responses suggest that participants had a network of individuals who were significant in their lives and who they could rely on when they needed to talk to someone about their problems. During session 2, a participant brought in a photo album containing pictures of people in his family, friends, and so forth, and proudly passed it around for the group to see, suggesting that he had a strong social network in his life.

Participants also expressed their experiences with having choices in an icebreaker activity (See Appendix L). The activity was called “If I had a million dollars” where participants listened to the song and then expressed what they would do in this situation. The icebreaker generated statements that suggested a longing and desire to experience some type of “normalcy” in their lives. One individual seemed eager to start and answered without hesitation. *“I’d buy something for my mom and I’d take my family on a trip and on a boat!” “I’d go to France...see all my aunts and uncles. I’d go on a*

plane...pay some bills,” explained another participant as he proceeded to daydream. Spontaneously, one participant asked “*Can I change my mind?*” as he clearly generated better answers. “*I’d buy a restaurant... he shouted enthusiastically, and I’d name it Jamie and Jim’s. I’d serve all kinds of food!*” Other choices were geared more towards what participants would do in social situations suggesting a desire to have increased opportunities for social interaction. “*I’d buy a limousine and I’d pick up a girl!*” one participant stated. “*There’d be drinking in the limo!*” added another individual.

Similarly, in the Warm Fuzzies icebreaker, participants expressed themselves without reservation and implicit within this, seemed to empower each other with their compliments. “*James is a really nice guy...*” “*She’s very pretty*” “*She’s very nice*” “*She’s a nice lady...we get along well...She’s my friend*” were among some of the compliments. Some participants had huge smiles on their faces and seemed to enjoy moments of attention that they received from their peers. In addition, the group seemed to feel empowered by communicating their ideas more freely, particularly in the latter 2 sessions. For example, one participant was the first to raise her hand throughout the entire third session. She appeared to want to be the first to be heard, and was not shy expressing her personal feelings to the group. “*I miss my boyfriend very much...I love him and he loves me*”. In an activity shortly thereafter discussing breast self-examinations, her hand shot up again, the first to speak up, as she informed the group “*my stepfather had cancer*”. Another participant appeared to feed off this openness and boldly stated to the group that his mother also had cancer, and expressed his emotions appropriately.

Likewise, other examples of choice that reflected a more social rather than sexual stance emerged in the first two sessions. In a categorization activity of males and females,

one participant spontaneously stated *"I have a choice!"* referring to all the beautiful women that he was able to look at and cut out from magazines. Furthermore, in "Make your own judgment", one participant confirmed that he knew what making a judgment was. *"I know...it's like where you want to live, and who you want to work with,"* listing choices evident in everyday life. Moreover, in the scenario role play activity, participants also seemed empowered to vocalize their thoughts. The group was presented with a scenario that introduced the topic of mutual consent as a criterion to a healthy sexual relationship. In this scenario, I projected a harsh tone of voice and pretended to be extremely demanding towards my significant other. The group was asked whether they thought the demand was fair as well as their thoughts on how the significant other was treated. One participant had this to say. *"NO! You don't sound right...and you don't sound polite! You didn't make a decision together...you just ordered him around!"* The participant seemed to be quite enraged about the treatment that was projected, and expressed this in her body language and tone of voice.

The discussion about choices continued with an activity about Linda and Tim. A discussion about relationship building stirred up various ideas regarding choice. For example, the question of whether Linda and Tim *had* to make love was posed. One participant asserted herself and stated in a very confident manner *"You don't have to...it's your choice!"* Another participant added his thoughts about Linda and Tim's love relationship. *"You have a choice...you can hang out with your guy friends, and you can hang out with your girlfriend a couple of times a week, maybe call or hold her hand"*. In a discussion about contraception for Linda and Tim, the group agreed that if Tim did not

want to wear a condom during lovemaking then Linda did not have to stand for this behavior. "*He left her no choice!*" one participant added in a frustrated tone.

In general, the group appeared to feel very strongly about treating other people whom one loved and respected with exactly that—love and respect. They seemed to feel empowered to voice their concerns and stand up for the rights of the individuals presented in the real-life scenarios. This was observed most frequently in session 3 (as stated above) as well as in session 4 while discussing: (1) situations about topics such as abuse and exploitation (See Appendix I) and (2) situational role plays in which each scenario presented a challenge with the question: What would you do or say? In the activity, participants provided answers that were not only correct, but also expressed in a self-assured manner. For example, one scenario was: A neighbor wants to exchange his pencil for your walkman. One participant shook her head no and firmly asserted "*NO, It's just not fair!*" understanding and agreeing that the trade-off was in no way justifiable. Another participant very confidently and seriously replied "*That's a NO-NO!*" when the situation was: A student says give me your snack or I'll hide you bag. Participants seemed to recognize and understand the gravity of abusive situations, and that they did not have to comply with or submit to this type of exploitative behavior.

In observing the responses, it appears that participants could communicate the right choices and did so with an assertive attitude; they censured situations such as: Diana's friend touches her breast without her permission. Participants as a group yelled out "*NO NO NO!*". In other situational activities on stranger abuse and touch, participants seemed to have a strong disapproval and censure for each scenario. They often echoed "*NOOOOOOOO*" and according to their body language and faces, felt

assertive and empowered to stand up for their rights. The activity seemed to help participants adopt an assertive manner by way of group brainstorming and discussing why a situation was exploitative or abusive.

Likewise, the group was presented with an illustration (See Appendix M-support sheet 5.3) of a young woman who was clearly uncomfortable with a man touching her. The group agreed that the illustration showed abuse and harassment because the woman was projecting feelings of being invaded. They pinpointed that her body language was “*not right*” the explanation being “*because she’s turning her head away*”. One participant physically showed the group what she meant by turning her head and shoulder to one side. Another participant stated “*He’s touching’ her!*” in an appalled tone. Participants agreed that they would know what to do in this type of situation. “*Tell them to get their hands off a ya!*” or “*I’d tell the bus driver or the Policeman*” “*Say No!*” were among the responses. When asked what one could do in any abusive situation whether physical, emotional, or verbal, the group generated these ideas: “*You can go for help*” “*You can go to the Police*” and “*I know another one... You can scream!*”

In the activity: What would you do or say participants gave numerous suggestions that illustrated assertive reactions to exploitative situations. For example, these responses included “*Stop it...It’s your own money...it’s your own business!.. Screw you... No, that’s just not fair...Don’t lend them out again...Get out of my stuff...it’s NOT yours!...That’s rude...how would you like it if I did it to you? Act your age!...Leave...Get your hands off of my money!... and finally Hands off of it, you have to ask first!*”. The activity seemed to spark spontaneous conversations of personal experiences with abuse and exploitation. One participant reflected on how she learned to take ownership in her life and felt

confident telling her story to the group. "*Nancy...some kids on the street ask me for my money...and I say NO...I learned to say NO!*" Another participant also added that "*Some guys on the bus, they ask me for my money and I told them NO WAY*"; she recited the story in a very self-assured manner.

The issue of personal space also emerged in the choice and empowerment theme noted in session 4. Participants were presented with a hoola hoop that represented the exact amount of personal space that one should give themselves and others around them in social situations. Participants engaged in one of two tasks: Either as the approached person standing in the hoola hoop who controls the distance between him/herself and others, or as the approacher who walks towards the hoola hoop to test the other person's level of comfort. Observations suggested that participants were not only aware of how they felt when they were too close to somebody, but had the confidence to control who crossed the line when invading their space. In one instance where I modeled as the approacher, one participant shouted "*TOO close*" as I slowly approached the hoop. He assertively informed me that I had come too close to him when I asked him how he felt, and showed me the stop sign with his hand. In a self-assured manner, he stated "*no*" when I asked him if I could enter the hoop. All other participants had the same reactions when they participated in the activity. This exemplifies that participants seemed to feel confident enough to tell another person to back off when they felt most vulnerable. In general, responses from the situational activities in session 4 suggest that participants were able to recognize exploitative, abuse situations, and felt comfortable expressing how they would defend themselves. They appeared to be in tune with their feelings and

expressed these feelings in a very assertive and self-confident fashion more so in the latter 2 sessions, and their attitudes could be described as “empowering”.

Case Examples

Paul

Paul is a 36-year old man affiliated with the centre for the last 17 years. His history file reveals a range of developmental disabilities. First, he was born hydrocephalic (an abnormal accumulation of cerebrospinal fluid) with Dandy Walker’s Syndrome, which is a congenital brain malformation that occurs when there is an imbalance between the amount of CSF that is produced and the rate at which it is absorbed. He has mild ID and early on in life was labeled as “trainable” at a functional level. In addition, he has para-paralysis of lower extremities, gait, and his left leg is 2 inches shorter than his right. Paul also has a shunt, which function is to drain fluid from his brain into his digestive tract. The shunt is located in the back of his head on the right side; he is aware of where it is and the purpose it serves. Other areas of deficits include anger management issues. He was also diagnoses as having Tourette’s Syndrome however, no medication was prescribed for this. He uses a wheelchair for mobility purposes, and is also instructed to wear a soft helmet to protect his head from injury.

Paul is a very smart, logical, and verbal individual, who shows inquisitiveness and curiosity about the world around him. He seems to enjoy using his wise-guy nature to humor him and others. He loves to joke around with other people, and is not afraid to express himself, regardless of who it affects. At times, he is heard speaking vulgarities under his breath, and appears to thrive from arousing reactions from others when his behavior is inappropriate. Paul is often seen pounding his fist, or hitting himself in the

chest or head, which may be characteristic of Tourette's. At times, Paul can be antagonistic and verbally aggressive, and out of frustration, has been observed spitting or smashing his wheelchair. However, Paul is a good-natured, amicable, fun-loving and a caring individual who expresses himself well. He appears to enjoy interacting with people, is approachable, and has a genuine interest in learning.

The Attitudes Interview revealed that at pretest, Paul did not have an interest in learning much whereas at posttest he had two specific concerns that he wanted to learn about. "*How not to get abused...and how to get away from strangers*". Paul also indicated that he had no specific questions at pretest however, at posttest expressed an the inquiry "*Where does the person who has AIDS get AIDS?*" In terms of Paul's feelings towards sex, intimacy, and having a girlfriend, his responses before and after the program indicated no notable changes. Both times, he suggested feeling "*Alright about it*". Similarly, no changes were noted for feelings related to socialization. That is, at both times, Paul indicated that he liked to interact and socialize in social settings.

Increases in knowledge were noted in the Knowledge Questionnaire. Significant differences were found for True/False question 1 and Multiple-Choice question 1. For True/False at pretest, Paul responded incorrectly to the statement: The only place you can get any kind of birth control is at the doctor's office. However, at posttest Paul responded correctly (False), suggesting that he learned alternative place that contraception could be obtained. Likewise, Paul's response in the Multiple Choice question: The only way to be sure not to get pregnant is to (*Be on the pill*) or (*Not to have sex*) was incorrect at pretest (*Be on the pill*) and correct at posttest (*Not to have sex*). This suggests that Paul learned about pregnancy prevention from the program.

In general, Paul's attitude towards socio-sexuality was noted as positive. He often used the word JOY to describe how he felt about sexuality and expressed his feelings with ease, suggesting a laid-back attitude and high comfort level. Paul often showed assertiveness and confidence when providing answers in group, and had no noted difficulties discussing issues that other group members considered sensitive or embarrassing, such as masturbation or terminology for body parts. In comparison to other group members, Paul seemed most knowledgeable about socio-sexuality and was curious about sophisticated issues that were curious to him. For example, "*what kind of lubrication is on the condom?*" or "*How do you put a tampon inside the woman's body?*"

However, one issue did emerge that seemed to change Paul's easygoing attitude about socio-sexuality. For this reason, Paul was chosen as a case example to highlight his attitudes and feelings about sexual abuse and exploitation. The issue of sexual abuse and exploitation was very real for Paul during the final session. The purpose of addressing this matter comes from the notion that conducting research with real people conjures real issues that cannot be ignored. This is how the story unfolded.

In a perfect world, data collection would run smoothly with few bumps and minor stops in the road; in reality, I was struck with the all too realness of life for many people with DD. I was aware that conducting an intervention with people with DD was not exempt from hurdles and difficulties, let alone teaching *sexuality*! Having read the literature thoroughly, I was up for the challenge, regardless of its emotional weight. Before this research project was underway, I realized that sensitive issues and personal stories might emerge. As such, extra precautions were taken to conduct the most ethically sound study. These precautions included having the proper personnel such as a counselor

for potential times of need; ensuring that open lines of communication existed between all parties involved such as the gatekeeper, and care providers; recognizing and being vigilant about my attitudes and actions as an educator towards socio-sexuality; gaining and maintaining rapport and trust with participants; and presenting a program that was geared to teach in an educational and preventative way.

In session 4, Paul disclosed personal information regarding abuse, which at the time was not known. I received an e-mail message from the gatekeeper, shortly after session 2. This is what she wrote:

Paul also wanted me to tell you something very personal for him. When he was 12 years old living in a children's group home in another city, a volunteer person sexually abused him. He thought you should be aware of this given you are teaching him about sexuality. He's not sure what impact he thinks this should have.

E-mail log dated July 29th, 2003

I wrote back a brief message letting the gatekeeper know that I had acknowledged

Paul's message

Thank you for the update regarding Paul...I try my best to take these things into consideration while I am doing my workshops since I know that many of these individuals have had negative experiences in the past—Hopefully, the workshops I provide will be a positive experience for him, and I will do my best to be sensitive and provide support where needed.

E-mail log dated July 29th, 2003

I was grateful that this information was disclosed because it allowed me to prepare myself as an educator and re-evaluate the remaining program. In reading this message, I was saddened but not surprised, given the alarming statistics on sexual abuse perpetrated against this population. Literature on the sexual abuse concludes that although it is difficult to pinpoint exact numbers of cases, sexual abuse cases that go unreported is as high as 75% (Sobsey & Varnhagen, 1989). This finding only solidified

my ideas that this intervention was invaluable, as it would afford participants like Paul to express himself in a supportive environment.

During session 4, the issue of stranger safety and sexual abuse prevention was presented. As a group, a discussion evolved around whom the abuser could be, and ways to protect from harmful situations. It was at this point in the session that Paul began to express negative feelings. For example, he stated that he would "*kick him right in the bag*" if someone were to ask for his snack or lunch money. As well, in the scenario: Diane's uncle touches her breast without her permission, Paul stated "*I'd break his arm*" as a means of protection. In the scenario: A stranger wants to touch you, Paul also replies in a hostile manner "*You know what I would do? Take a cigarette and burn him!*" Paul quickly acknowledged on his own that he needed support at that moment and asked to see the gatekeeper. She was only a few feet away in another office. Paul insisted that he wanted to remain in the group while I spoke about abuse prevention, but that the gatekeeper was present throughout the session; he wanted to listen to the information since it was an issue in his life. The gatekeeper stated that her presence would be good for him since the two of them had known each other for almost 20 years, so she joined the group to be with Paul. Paul appeared to feel safe and more at ease having this support. This incident did not appear to hinder his involvement in the intervention; instead, it seemed to provide a safeguard that allowed him to openly express his feelings.

After the session, Paul spoke to me quaintly about life; about how some people in the world were bad; about how educating yourself was a good first step to protection against abusive situations. Paul's disclosure made me realize on a deeper level, about the importance of rigorousness in qualitative research, the power of external support, and the

necessity of providing a space where socio-sexual expression is encouraged. The intervention seemed to allow Paul to feel safe to talk about his personal issues in this environment and share this experience with people whom he had come to trust. Paul's story shed light on significant issues and raised important questions. *What continuous supports and services are available for people who have been sexually abused? How can people with DD continue to empower themselves after having participated in a SSEP such as this one in order to protect themselves from abuse and exploitation? Is a traditional sex education approach the most effective for teaching people with DD about socio-sexuality? Do any other approaches exist that may be more effective in fostering the acquisition of skills? What works and what does not and what is the key ingredient to a successful program?* Beyond what I had taught the group, this incident taught me that SSEP are appropriate and necessary forums for voicing sensitive issues.

Jack

Jack is a 48-year old man who has been attending the centre for the past 19 years. He lives in a group home with other individuals with DD. He was diagnosed with mild ID and functions socially at a high level. Jack is well spoken and has a good grasp of the world around him. He can talk about many different topics, and is happy to share his thoughts with others. He also has severe epilepsy, which hinders his abilities to walk fast, or to function at all because of the seizures. Jack is a fun loving, extremely sociable and pleasant individual, who has a general interest and eagerness for active learning. He is good-natured and well liked at the centre. In addition, he has many friends at the centre, and seems to enjoy interacting with staff and other clientele. As evident from the

Demographics Questionnaire, Jack stated that he did not have a girlfriend, but that it was one of his biggest interests, and that he had in the past participated in sexuality education.

The pretest Attitudes Interview suggested that Jack was interested in learning “*everything about sexuality*” and specifically about “*male parts*”. At posttest, Jack responded that he learned “*a lot*” from the program and that he was still interested, this time in learning about *different* body parts, proper names, and slang terminology about body parts, birth control pills, and condoms for males and females. When comparisons were made for whether he had any questions that he wanted answered, Jack indicated at pretest that he wanted to know “*how to get a girlfriend*” and at posttest that every topic was interesting to him. However, he reported “*I still don’t have a girlfriend*” and thus wanted to know more. Jack also indicated after the program that he learned about dating strategies, which could potentially get him a girlfriend. Responses before and after the program were noted as the same, when asked how Jack felt about issues related to sexuality and socialization. He stated “*fine and excellent*” to both. Moreover, of the 10 participants interviewed, Jack demonstrated the greatest improvements in socio-sexual knowledge as evident from the Knowledge Questionnaire. Changes were noted for 5 of the 16 questions. The first three improvements were changes in True/False questions 1, 4, and 5. That is, at pretest Jack responded True for question 1 and False for question 1 at posttest, indicating that he grasped the concept that there were alternative places other than the doctor’s office where birth control could be obtained. In addition, Jack responded False for question 4 at Time 1, and True at Time 2. This suggests that Jack recognized and understood the signs of STDs, and that people can have an STD and not know it. Before the program, Jack responded True for question 5 and False after the

program suggesting an increase in knowledge in the area of monthly breast exams. Moreover, increases in knowledge were also evident in Multiple Choice questions 1 and 2. Before the program, Jack responded that *Being on the pill* was the only way to ensure not to get pregnant, and after the program stated that *Not having sex* was the only way to ensure not getting pregnant, suggesting learning about pregnancy prevention. Finally, increases in knowledge about condom use were also evident. Jack responded that condoms could be used a *Few times* before the program, and that they can only be used *Once* after the program.

Observational data and personal documents created by Jack revealed that he had a very positive outlook on all issues related to socio-sexuality. He became especially excited when he spoke about attempting to foster a love relationship; this was a consistent desire and longing throughout the program. He often spoke about wanting someone to share his life with. Jack seemed to enjoy the activities that involved looking at pictures of women; he seemed to project a healthy sex drive and desire for love. He also displayed positive feelings evident from his descriptions of how he was feeling, often stating that he liked being around people in a group setting such as the SSEP. He often stated that he was HAPPY and indicated positive feelings on activity sheets such as feeling JOY about sex (See Appendix M-support sheet 1.2). Jack also showed his positive attitude by actively participating in the program. He was often observed volunteering (this before the others) on almost all activities in all four sessions. He was often heard saying things such as *"I want to learn about everything!"* and had a positive comment about the way he felt about sexuality. *"We can learn more about our body parts"* was one of his primary interests. He was the first participant to try novel activities such as finding the lump in the

breast self-examination activity, while the others were either too embarrassed to try. Jack was often interested in topics that were meaningful to his personal life and took these topics seriously. For example, he asked to have more than one breast self-examination card so that he could share the information with his female family members. Often, towards the end of the sessions, when I started to wrap the sessions up, Jack would be the only one to stay behind and ask “*So soon?*” referring to termination. Jack’s eagerness to learn about socio-sexuality was exhibited by his curiosity. He often sought after detailed information about a topic, and had several questions related to that topic. He seemed to love to listen to anything related to sexuality, even issues like menstruation that did not directly concern him. He openly discussed things like having seen pads and tampons before, and had an interest in learning about how the female body functioned. Jack often responded feeling OKAY and GOOD about masturbation (See Appendix M-support sheet 4.1) and in the Make your own judgment activity, he seemed to have a much more liberal point of view and outlook on situations that other participants were often too embarrassed to discuss. For example, he openly discussed issues about masturbation, condom use, and male and female body parts and was observed actively contributing to discussions about terminology for male and female body parts. Jack never seemed to hesitate or resist a conversation, and communicated assertively and confidently in discussions and brainstorming sessions. He candidly joked about his own socio-sexuality and added humour at the appropriate times. He constantly had a huge smile on his face, and spontaneously contributed by giving answers and questions when asked. Jack was never observed to leave the room, blush during sensitive topics, or avoid participation.

With respect to acquiring knowledge over the course of the program, Jack seemed to learn new things as well as dispel certain myths that he brought with him. In general, Jack appeared to have a solid grasp of various issues related to social skills acquisition. For instance, he was capable of learning about the characteristics that make up a friend, about the boundaries of personal space (e.g. if a person is getting too close in proximity to another individual's personal space), about mutual consent and what it means, and finally, about decision-making and providing a rationale for why that decision was made. He also was capable of understanding the difference between public and private body parts, and was skillful at knowing how to be assertive in situations that required one to stand up for ones' rights (e.g. knowing what to do if someone was touching him inappropriately). Likewise, Jack displayed an awareness and knowledge in the area of personal relationships, particularly related to stages that people go through in establishing a love relationship like Linda and Tim. He was also observed to show acquired skills in discussions about fairness, specifically about condom use (e.g. if a man did not want to wear a condom, Jack knew why he should, and how it would affect the love relationship if the man chose not to).

In general, Jack was able to show learning across all four sessions in a number of different areas. These areas included male and female body parts, distinguishing between public and private body parts (See Appendix M-support sheet 2.4); information about masturbation, such as where it is and is not acceptable to do it (See Appendix M-support sheet 4.2); slang and proper terminology for male and female body parts; how to treat STDs, what to do in a potential STD situation (See Appendix M-support sheet 9.5), as well as steps in using a condom. Nevertheless, it appears from the observation data that

Jack did not acquire accurate information on some topics namely, about misconceptions related to gender. For instance, he believed that a person in a picture could only be a certain gender because he/she dressed in a masculine or feminine way. It was clear that pictures that were more androgynous-looking posed greater difficulty for Jack in terms of deciphering the correct gender. A second area that revealed difficulty was in understanding the difference between a friend and a staff member. Jack revealed a lack of distinction between these two roles, perhaps because of his personal circumstances at the group home. Jack also displayed some misconceptions related to sexuality. For example, he lacked an understanding about what the term masturbation meant, what female private parts included, and perhaps the most complex concepts presented in the program, about general information on STDs such as what it was, transmission (See Appendix M-support sheet 9.3), symptoms and protection of health (See Appendix M-support sheet 9.6). In general, Jack seemed to prosper most from the intervention because he had a willingness to learn and actively participated in the program. His curiosity and open attitude towards socio-sexuality was noted as favorable as he proclaimed that perhaps now after having participated in the program he was ready to "*find a girlfriend*".

Discussion

The present study was intended to explore the changes in knowledge and attitudes that participants had as a result of a 6-week socio-sexual education program. The study shows that people with DD can benefit and acquire knowledge from a short workshop style program in some, but not all areas of socio-sexuality. Participants showed increased knowledge in areas of social skills such as friendships, intimate relationships, dating, choice, feelings, gender, decision-making, personal space, stranger safety and appropriate

versus inappropriate behavior as well as in sexuality such as identification of male and female body parts, private and public body parts, touch, condom use, hygiene, reproductive health, and abuse prevention. These findings are consistent with findings from a study by Lindsay et al. (1992) who found that participants had increased sexual knowledge after a sex education program in areas of body parts, masturbation, male puberty, female puberty, intercourse, pregnancy, child birth, birth control, and STDs. Considering the current proactive movement towards integration and inclusion of people into community, recreation, education, and employment (Watson et al. 2002), home, school, and health and wellness (Schalock, 1994), these findings are particularly timely. However, this study also indicated that some issues remain more difficult for people with DD to fully comprehend such as masturbation and STDs. Difficulties seemed to be in understanding issues of STDs such as transmission, treatments, symptoms, and signs. Likewise, participants had vague ideas about masturbation such as what it is, and where it is appropriate to engage in. As well, some minor misconceptions were found in gender stereotypes, menstruation, socio-sexual terminology and personal touch; however major misconceptions were in masturbation and STDs. This is consistent with research conducted by Garwood and McCabe (2000) who implemented a sex education program assessing the sexuality knowledge, experience, feelings and needs of 6 men at pre- and posttest. The findings revealed that increases in knowledge at posttest were only evident in the areas of contraception, pregnancy, sexual intercourse, and social skills acquisition.

Furthermore, the results showed that participants held mixed and ambivalent attitudes about socio-sexuality. First, positive attitudes were found to increase after the program in two specific areas, which included (1) the belief that sexual relations are

appropriate if a mutual understanding exists and (2) the belief that it is acceptable to verbalize an opinion to a person in a more authoritative position when one does not agree. These findings suggest that participants felt more accepting and approval towards sexual relationships, and were more confident and empowered to voice their opinions. Positive attitudes were also reflected in increases in amount of responses and depth of responses at posttest. That is, participants reported that they had a desire to learn about a number of different topics after the program. They expressed these desires more elaborately, with more positivism, and with an all-encompassing outlook on gaining new information. Positive attitudes were also revealed as participants mentioned topics after the program that had been discussed in the program, suggesting that their interest in these topics increased. In general, positive attitudes found in the themes included feelings of happiness, joy, comfort, confidence, assertiveness, excitement, eagerness, and curiosity. As such, the program might have afforded participants an opportunity to see socio-sexuality as a natural part of life that is to be enjoyed and celebrated. Implicit within this, the program might have facilitated the expression of socio-sexuality because sessions were provided in an open, honest, and comprehensive manner with an “all-embracing, positive view of sexuality” (Québec Ministère de la Santé, 2000, p. 24). Some participants appeared capable of expressing their feelings more openly after the program suggesting that they felt safe in the program; a place where they could share their feelings in an unguarded manner. Participants who reported more receptive and liberal attitudes were individuals who spoke candidly about socio-sexuality, and of their personal love relationships, or who had communicated forthrightly an aspiration to be in a sexual and/or love relationship.

Generally, SSEP are supportive environments that freely discuss socio-sexuality. Despite the fact that programs are plentiful, they are rarely provided for people with DD. This is often limited by professionals and families who fear that SSEP will bring about uncontrollable sexual behaviors (Griffiths, 1999; Page, 1991), or who believe that people with DD are like innocent children (Kempton & Kahn, 1991; McCabe & Cummins, 1996). Researchers state: “We tend to think of their sexuality as a volcano that shows disturbing signs of activity, and is about to erupt at any moment” (Québec Ministère de la Santé, 2000 p. 17). Heyman and Huckle (1995) found that care providers in one study did not approve of sex education because they felt that it would produce a longing for sexual relationships that would have otherwise not been fueled. In fact, it should be acknowledged that “The goal of sexuality education...is not to encourage them to have an active sexual life but to help them make better choices and enjoy better lives” (Québec Ministère de la Santé, 2000, p. 20).

Moreover, participants in this study also expressed negative attitudes about socio-sexuality including feelings of fear, embarrassment, frustration, shyness, uncertainty, insecurity, and resistance to talk about masturbation, sex, personal touch, condom use, and abuse and exploitation. This is consistent with research conducted by McCabe and Cummins (1996) who found that people with DD in general held more negative perceptions about sexuality when comparisons were made to a contrast group of University students. Similarly, Garwood and McCabe (2000) found that participants in their study had challenges openly discussing their sexuality feelings, and that negative attitudes still remained prominent even after a program was implemented. Perhaps this can be attributed to the unfamiliar and overwhelming material that may have been

presented. More specifically, in our study some participants showed negative attitudes before the program in some areas of how they felt about sexuality, such as embarrassed and uncomfortable. Some also stated the desire to spend all their leisure time with a boy/girlfriend, or preferred to be alone rather than socialize with friends, suggesting a negative outlook on socializing. According to several researchers, these negative attitudes may be a reflection of the experiences that individuals with DD deal with everyday, such as having limited opportunities for social stimulation and boundaries and restrictions placed upon them by care providers or families, particularly in the participation of sexual and/or love relationships. These restrictions are usually due to fears of unwanted pregnancy, STDs and abuse (Lesseliers & Van Hove, 2002; Lumley & Scotti, 2001; Szollos & McCabe, 1995; Watson et al. 2002). As such, these experiences can lead to feelings of isolation and loneliness, or “run the risk of provoking or making worse the problems that one hoped to avoid to begin with” (Québec Ministère de la Santé, 2000, p. 20).

Participants who held negative attitudes or displayed negative feelings towards socio-sexuality in this study were those who shared life stories about the negative experiences they had encountered, such as abuse or divorce. These participants may have entered the program with preconceived notions about socio-sexuality, and consequently maintained these attitudes throughout. It seems plausible that a connection exists between attitudes observed and prior socio-sexual experience. As well, participants had conservative attitudes when discussing condom use, masturbation, male and female body parts, male and female terminology, and breast self-examinations. Traditional attitudes may be a reflection of the attitudes that parents and professionals convey. These attitudes

often deny or repress their client/child's sexuality (Lesseliers & Van Hove, 2002), and is a reflection of the lack in knowledge on the parent/professionals' part, which may then lead to ignorance and fear. As well, the findings showed that attitudes remained essentially the same (positive) before and after the program in the area of (1) how they felt about making friends and socializing and (2) enjoyment in socializing in the community. Generally, most participants seemed to enjoy making and sustaining friends and viewed their personal relationships as a significant part of life.

In sum, this study shows that people with DD have varying attitudes about socio-sexuality, can increase their knowledge in key areas of socio-sexuality, have misconceptions and stereotypes, and view having choices and ownership as important in life. Qualitative findings from this study mirror findings from previous research in that people with DD are concerned with their social and sexual lives. For example, Lesseliers and Van Hove (2002) interviewed 46 adults with DD to explore relationships and sexuality. Themes that emerged from their study were that people with DD: Have sexual relations and express sexuality with a significant other; experience conflict in social relationships; have difficulty expressing themselves about sensitive issues like masturbation; lack knowledge about masturbation; experience sexual exploitation; and finally, lack knowledge in many areas of sexuality. Similar to our study, the conclusions were that most people with DD "struggled with inadequate sexual knowledge" (Lesseliers & Van Hove, 2002, p. 78). Our study indicated that participants had mixed feelings on all topics. Some participants were curious while others were indifferent; some were embarrassed while others were comfortable; some were excited while others were uninterested; some had approving attitudes while others had disapproving attitudes.

According to research, a number of methods need to be employed so that SSEP can effectively enhance knowledge and explore attitudes on a firsthand basis. Several techniques used in this study are consistent with those from previous research, showing that successful programs are the result of a multitude of considerations and resources (Kempton, 1993; Muccigrosso, 1991). Consistent with Lumley and Scotti (2001) our program proceeded “from rudimentary sex education...to more advanced concepts...and complex behavioral skills” (p. 115). That is, program content was presented in a logical order so that basic concepts such as friendship and feelings were introduced in the first two sessions, while more complex issues such as abuse prevention were presented in the final session. This structure allowed for a progression of program components to evolve.

Furthermore, recent research contends that real materials facilitate real learning. Thus, in following this trend several practical tools and strategies were used. Namely, these included: a group instructional approach (Lumley & Scotti, 2001); group format, games, and attitudes-based activities (Ragg & Rowe, 1991 p. 340; Whitehouse & McCabe, 1997); hands-on interactive activities such as role playing (Lindsay et al. 1992; Mcadoo, 2002; Ragg & Rowe, 1991); being flexible, “askable” and ensuring confidentiality and trust as the facilitator (Hingsburger et al. 2000; Watson et al. 2002); being open to modifying content (Romaneck & Kuehl, 1992); seizing “teachable moments” (Griffiths, 1999); and creating a relaxed environment (Watson et al. 2002); the use of concrete objects such as condoms, sanitary napkins, bathing suits and birth control pills, as well as using cut and paste activities, and reviewing information at the end of sessions (Québec Ministère de la Santé, 2000, p. 18); brainstorming and fostering discussions (Mcaddo et al. 2002); the use of plain-language (Muccigrosso, 1991);

pointing to body parts and using “pictures of faces to identify feelings” (Stinson et al. 2002, p. 25); and finally, using visual aids such as illustrations, pamphlets and posters (Watson et al. 2002). These tools and strategies appeared effective because they were used dependently to create a comprehensive approach to learning, and were concrete enough for people who have limited cognitive skills. Other tools that proved effective in this study included the use of humour, music, popular women’s magazines, and icebreaker activities. A technique that should be reconsidered in future studies is the use of direct instruction since some participants appeared uninterested in the lecture until it was supplemented with concrete activities. This is inconsistent with some research, which contends that factual information and teaching concepts presented through direct instruction are successful for learning (Kameenui & Simmons, 1990).

The limitations of this study also require addressing. First, this study did not include the perspectives of care providers or family members. Their feelings and attitudes warrant investigation since primary caregivers have the capacity to provide a wealth of information into their child/clients’ socio-sexuality, and because their attitudes have an impact on support and services. Second, this study did not include a control group. A control group would have allowed for comparisons to be made about the acquired knowledge in order to confirm that in fact, gains were a result of the intervention. Third, since the Knowledge Questionnaire is not a standardized measure, reliability and validity coefficients are not yet available for this instrument. Therefore, the results should be interpreted with reservation until further statistical analyses have been conducted. Finally, the 6-week intervention was time-limited, which previous research suggests is restraining

particularly, for people with DD who have difficulty learning at a fast pace and who need ample time to process information (Québec Ministère de la Santé, 2000).

Alternative explanations as to why the particular findings of this study emerged also need to be addressed. One explanation for the increased changes in knowledge may be due to acquiescence. Research has shown the people with DD have a propensity to provide answers they perceive the interviewer wants to hear (Matikka & Vesala, 1997). Participants may have answered affirmatively to testing questions in order to please the tester. This study acknowledges that this may have been the case, however this phenomenon is still unknown (Matikka & Vesala, 1997). Furthermore, an explanation as to why participants held negative and conservative views about their socio-sexuality suggest that the socio-sexual needs of people with DD are still not being met on a consistent level. These unmet needs are often motivated by negative attitudes and misconceptions held by care providers and families. Service providers need to acknowledge that these individuals require access to the same types of activities that people without disabilities have. This is consistent with two theories that this study draws upon, which are quality of life and normalization. When people with DD are afforded similar opportunities to the rest of society, it ensures that they are supported; “it also sensitizes advocates and service providers to the need to ensure that labeled people are afforded the full rights of citizenship” (Pedlar et al. 1999, p. 19).

Essentially, people with DD have the same needs and desires socially and sexually as people without DD however, the former appear to encounter added barriers that prevent them from gaining this information, such as participation in on-going programming. Once these barriers are overcome, people with DD can begin to attain a

greater sense of self and as such, enjoy a greater quality of life. Along with being a fundamental right to all people, socio-sexuality is a critical component to complete health and well being, which should never be denied. In order for them to prosper from SSEP, complete support from service providers is essential. Complete support ranges from providing opportunities for social interaction, to educating individuals using everyday experiences, to changing professionals' perception about their client's socio-sexuality.

Furthermore, it is important to address researcher issues from a research standpoint. First, some assumptions and unanticipated areas must be addressed. An initial assumption before the study began was that all participants would benefit from *all* aspects of the program. Researchers suggest that SSEP that are tailored to address the needs of individuals help ensure "that the target concepts or skills are not only acquired and maintained, but more importantly, incorporated into a person's life" (Lumley & Scotti, 2001 p. 111). Although this was taken into consideration, not all participants appeared completely open to socio-sexuality, and as such, to benefit from the program. In addition, it was not anticipated that socio-sexual concepts might have been too abstract for some participants; this may have resulted in a lack of learning in the areas of masturbation and STDs. As well, it was not expected that certain activities would not stimulate group interest. In reality, some activities did not appeal to the group, which may have been due to the difficulty of the material, and may have led to a lack in learning. Additionally, it was challenging to address both group and individual needs concurrently while facilitating a program that aimed to be interesting and educational. Finally, it was not apparent at the time that the qualitative interview would generate only brief and "on

the surface” responses. The assumption was that participants would divulge more personal information however this was not the case even after questions were rephrased.

Conclusion

The findings from this study provide evidence to suggest that people with DD can acquire learning in key areas of socio-sexuality. As well, people with DD hold positive and liberal as well as negative and conservative attitudes regarding their socio-sexuality. The study also made clear that people with DD learn best when SSEP take into consideration the developmental needs and levels of the group members. In this particular case, interactive, hands on activities such as role play and situational scenarios worked best because individuals could relate to them as occurrences in everyday life.

Implications for Research and Practice

The findings illuminate the phenomenon of SSEP for people with DD on a broad level and have implications for both research and practice. Undoubtedly, people with DD need to be provided with socio-sexual education. Programs such as Preventing AIDS and STDs through Sexuality Education for Students with Intellectual Impairments (Québec Ministère de la Santé, 2000) can be used as (1) a preventative tool for reducing the possibility of high risk behaviors so as to counteract STDs and AIDS and (2) to reduce the risk of vulnerability by educating individuals to protect themselves against abuse and exploitation. When education programs are comprehensive, developmentally appropriate, and practical, people with DD have a greater propensity to make healthy life choices; this can only be favorable to their overall life satisfaction. These issues however, need to be met on a consistent basis by service providers, professionals, and families since “learning about sexuality is a life-long process” (Watson et al. 2002, p. 201).

Ironically, the findings in this study suggest that people with DD have several misconceptions about socio-sexuality when in fact, the literature reveals that society itself perpetuates the greatest misconceptions, having far greater corollary for this population. Society as a whole needs to challenge “in both law and practice” (Griffiths & Lunsky, 2000, p.18) the way in which it thinks about and ultimately treats people with DD. The field of socio-sexual education and developmental disabilities can only prosper from research of this nature because it provides insight into their needs, treating the issue of socio-sexuality as valuable. Advancing empirical research underscores the need for socio-sexuality to expand public policy on two levels. The first is on a smaller scale, such as influencing policies set out by agencies that support the socio-sexuality of people with DD. The second is on a larger scale, such as helping to inform organizations like the Americans with Disabilities Act (ADA) who work towards the dissolution of “segregation and isolation of persons with disabilities in all areas of their lives” (Owen, Griffiths, & Arbus-Nevestuk as cited in Griffiths et al. 2002). As such, this shift in thinking is a critical first step in allowing people with DD to experience the basic and fundamental human right of socio-sexual health.

Recommendations for Future Research

Future research might consider several issues that emerged from this study. First, researchers might consider conducting a long-term intervention. Data collection might be collected longitudinally, for months rather than weeks. Next, a 3- to 6-month follow up study might be considered in order to examine whether results are generalizable and stable over time. Lumley and Scotti (2001) state that what matters most is that information and skills acquired have been used in everyday living. If improvements in

knowledge and attitudes measured by the pre- and posttest are only observed while the participants take part in the SSEP then changes to the intervention might be considered for future research. Future facilitators might consider using strategies that were found to be effective from this study such as the use of small groups, role playing activities that resemble everyday scenarios, discussions, and using concrete objects and visuals such as popular magazines. As well, facilitators might consider an individualized program approach (Lumley & Scotti, 2001) rather than the traditional approach; this might ensure that all participants benefit from the program.

Unfortunately, it appears from the findings that people with DD still hold negative attitudes about certain areas in socio-sexuality and have difficulty understanding complex concepts such as STDs. Future research is necessary in order to ascertain why this is the case and how programs can be facilitated to effectively teach abstract topics of this nature. Clearly, SSEP are necessary; not only do they have the ability to facilitate socio-sexual learning, but more importantly, they pinpoint key areas that matter in the lives of people with DD so that learning is meaningful and practical. At best, research on socio-sexuality such as this one allows for the voices of people with DD to be heard (Lesseliers & Van Hove, 2002). When voices are heard, professional who provide support and services can work towards the provision of healthy socio-sexual attitudes, feelings, and knowledge of people with DD.

References

- Abramson, P. R., Parker, T., & Weisberg, S. R. (1988). Sexual expression of mentally retarded people: Educational and legal implications. *American Journal on Mental Retardation*, 93(3), 328-334.
- Bisset, A. (2000). *The Canadian oxford paperback dictionary*. Don Mills, ON: Oxford University Press.
- Blackburn, M. (1995). Sexuality, disability, and abuse: Advice for life...not just for kids! *Childcare: Health and Development*, 21(5), 351-361.
- Blanchett, W. J., & Wolfe, P. S. (2002). A review of sexuality education curricula: Meeting the sexuality education needs of individuals with moderate and severe intellectual disabilities. *Research & Practice for Persons with Severe Disabilities*, 27(1), 43-57.
- Borba, M. (1989). *Esteem builders: A K-8 self esteem curriculum for improving student achievement, behavior and school climate*. Torrance, CA: Jalmar Press.
- Brown, I. (1996). People with developmental disabilities: Applying quality of life to assessment and intervention. In R. Renwick., I. Brown., & M. Nagler (Eds.), *Quality of life in health promotions and rehabilitation: Conceptual approaches, issues, and applications* (pp. 253-267). London: Sage Publications.
- Brown, I., Renwick, R., & Nagler, M. (1996). The centrality of quality of life in health promotion and rehabilitation. In R. Renwick., I. Brown., & M. Nagler (Eds.), *Quality of life in health promotions and rehabilitation: Conceptual approaches, issues, and applications* (pp. 3-14). London: Sage Publications.

- Casper, L. A., & Glidden, L. M. (2001). Sexuality education for adults with developmental disabilities. *Education and Training in Mental Retardation and Developmental Disabilities, 36*(2), 172-177.
- Cheng, M. M., & Udry, J. R. (2003). How much do mentally disabled adolescents know about sex and birth control? *Adolescent & Family Health, 3*(1), 28-38.
- Cole, S. S., & Cole, T. M. (1993). Sexuality, disability, and reproductive issues through the lifespan. *Sexuality and Disability, 11*(3), 189-205.
- Conway, N. F. (1994). Abuse and intellectual disability: A potential link or inescapable reality. *Australia and New Zealand Journal of Developmental Disabilities, 19* (3), 165-171.
- Creswell, J. W. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research*. Columbus, OH: Merrill Prentice Hall.
- Doe, T. (1990). Towards an understanding: An ecological model of abuse. *Developmental Disabilities Bulletin, 18*(2), 13-20.
- Drew, C. J., Hardman, M. L., & Hart, A. W. (1996). *Designing and conducting research: Inquiry in education and social science* (2nd ed.). Needham Heights, MA: Allyn and Bacon.
- Edgerton, R. B. (2001). The hidden majority of individuals with mental retardation and developmental disabilities. In A. J. Tymchuk., K. C. Lakin., & R. Luckasson (Eds.), *The forgotten generation: The status and challenges of adults with mild cognitive limitations* (pp. 3-19). Baltimore: Paul H. Brookes.
- Fegan, L., Rauch, A., & McCarthy, W. (1993). *Sexuality and people with intellectual disability* (2nd ed.). Baltimore: Paul. H. Brookes Publishing Co.

- Foxx, R. M., McMorrow, M. J., Storey, K., & Rogers, B. M. (1984). Teaching social/sexual skills to mentally retarded adults. *American Journal of Mental Deficiency, 89*, 9-15.
- Garwood, M., & McCabe, M. P. (2000). Impact of sex education programs on sexual knowledge and feelings of men with a mild intellectual disability. *Education and Training in Mental Retardation and Developmental Disability, 35*(3), 269-283.
- Goldman, R. L. (1994). Children and youth with intellectual disabilities: Targets for sexual abuse. *International Journal of Disability, Development, and Education, 41*(2), 89-102.
- Griffiths, D. (1999). Sexuality and people with developmental disabilities: Mythconceptions and facts. In I. Brown., & M. Percy (Eds.), *Developmental disabilities in Ontario* (1st ed., pp. 443-451). Toronto, ON: Front Porch Publishing.
- Griffiths, D., Baxter, J., Haslam, T., Richards, D., Stranges, S., & Vyrotsko, B. (1995). *Building healthy boundaries project*. Unpublished manuscript.
- Griffiths, D. M., & Lunskey, Y. (2000). Changing attitudes towards the nature of socio-sexual assessment and education for persons with developmental disabilities: A twenty year comparison. *Journal on Developmental Disabilities, 7*(1), 16-33.
- Griffiths, D., Richards, D., Federoff, P., & Watson, S. L. (2002). *Ethical dilemmas: Sexuality and developmental disability*. New York: Nadd Press.
- Heyman, B., & Huckle, S. (1995). Sexuality as a perceived hazard in the lives of adults with learning difficulties. *Disability and Society, 10*, 139-155.

- Hingsburger, D. (1990). *"I" contact: Sexuality and people with developmental disabilities*. Mountville, PA: Vida Publishing.
- Hingsburger, D., vanNoort, D. S., & Tough, S. (2000, May). But I thought...sexuality and teens with developmental disabilities. *Tash Newsletter*, 8-11.
- Horgos, J. (1998). *Sexuality education for young people with disabilities: An introduction for service providers*. Sunny Hill Centre for Children Sexual Resource Network. Vancouver, B.C.: Children's & Women's Health Centre of British Columbia.
- Ikeler, B. (1990). Teaching about sexuality: Guidelines for parents of children with disabilities. *Exceptional Parent*, 24-36.
- Kameenui, E. J., & Simmons, D. C. (1990). *Designing instructional strategies: The prevention of academic learning problems*. Englewood Cliffs, NJ: Macmillan.
- Kempton, W. (1993). *Socialization and sexuality: A comprehensive training guide for professionals helping people with disabilities that hinder learning*. Haverford, PA: Winifred Kempton.
- Kempton, W., & Kahn, E. (1991). Sexuality and people with intellectual disabilities: A historical perspective. *Sexuality and Disability*, 9(2), 93-111.
- Krivacska, J. J. (1990). Child sexual abuse and its prevention. In M. E. Perry (Eds.), *Handbook of sexology: Vol.7*. (pp. 395-424). Amsterdam: Elsevier.
- Lee, Y. K., & Tang, S. C. (1998). Evaluation of a sexual abuse prevention program for female Chinese adolescents with mild mental retardation. *American Association on Mental Retardation*, 103(2), 105-116.

- Lesseliers, J., & Van Hove, G. (2002). Barriers to the development of intimate relationships and the expression of sexuality among people with developmental disabilities: Their perceptions. *Research & Practice for Persons with Severe Disabilities, 27*(1), 69-81.
- Lumley, V.A., & Scotti, J. R. (2001). Supporting the sexuality of adults with mental retardation: Current status and future directions. *Journal of Positive Behavior Interventions, 3*, 109-119.
- Lindsay, W. R., Bellshaw, E., Culross, G., Staines, C., & Michie, A. (1992). Increases in knowledge following a course of sex education for people with intellectual disabilities. *Journal of Intellectual Disability Research, 36*(6), 531-539.
- Lunsky, Y., & Benson, B. A. (2000). Are anatomically detailed dolls and drawings appropriate tools for use with adults with developmental disabilities? A preliminary investigation. *Journal on Developmental Disabilities, 7*(1), 66-76.
- Lunsky, Y., & Konstantareas, M. M. (1998). The attitudes of individuals with autism and mental retardation towards sexuality. *Education and Training in Mental Retardation and Developmental Disabilities, 33*(1), 24-33.
- Marcheti, A. G., & McCartney, J. R. (1990). Abuse of persons with mental retardation: Characteristics of the abused, the abuser, and the informers. *Mental Retardation, 28*(6), 367-371.
- Matikka, L. M., & Vesala, H. T. (1997). Acquiescence in quality-of-life interviews with adults who have mental retardation. *Mental Retardation, 35*, 75-82.

- Matsumoto, D. (2000). Person-centered quality of life: Contributions from Canada to an international understanding. In K. D. Keith., & R. L. Schalock. (Eds.), *Cross cultural perspectives on quality of life*. Washington, DC: American Association on Mental Retardation.
- Mcadoo, J., Poplin, T., & Robinson, P. (2002, November/December). Let's talk about SEX...in the special education classroom. *Council for Exceptional Children*, 9(4), 13.
- McCabe, M. P. (1993). Sex education programs for people with mental retardation. *Mental Retardation*, 31, 377-387.
- McCabe, M. P. (1999). Sexual knowledge, experience, and feelings among people with disabilities. *Sexuality and Disability*, 17(2), 157-170.
- McCabe, M. P., & Cummins, R. A. (1996). The sexual knowledge, experience feelings, and needs of people with mild intellectual disability. *Education and Training in Mental Retardation and Developmental Disabilities*, 31(1), 13-21.
- McCabe, M. P., & Schreck, A. (1992). Before sex education: An evaluation of the sexual knowledge, experience, feelings, and needs of people with mild intellectual disabilities. *Australia and New Zealand Journal of Developmental Disabilities*, 18(2), 75-82.
- McGillivray, J. A. (1999). Level of knowledge and risk of contracting HIV/AIDS amongst young adults with mild/moderate intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 12, 113-126.

- Meister, C., Norlock, D., Honeyman, S., & Pierce, K. (1994). Sexuality and autism: A parenting skills enhancement group. *SIECCAN Newsletter-Canadian Journal of Human Sexuality*, 3(3), 283-289.
- Muccigrosso, L. (1991). Sexual abuse prevention strategies and programs for persons with developmental disabilities. *Sexuality and Disability*, 9(3), 261-271.
- Nagler, M. (1996). Quality of life of people with disabilities who have experienced sexual abuse. In R. Renwick., I. Brown., & M. Nagler (Eds.), *Quality of life in health promotion and rehabilitation* (pp. 190-203). London: Sage Publications.
- National Information Centre for Children and Youth with Disabilities. (1992). Sexuality education for children and youth with disabilities. NICHCY News Digest. Retrieved from <http://www.nichcy.org/pubs/newsdig/nd17txt.htm>
- Ousley, O. Y., & Mesibov, G. B. (1991). Sexual attitudes and knowledge of high-functioning adolescents and adults with autism. *Journal of Autism and Developmental Disorders*, 21(4), 471-481.
- Page, A. C. (1991). Teaching developmentally disabled people self-regulation in sexual behaviour. *Australia and New Zealand Journal of Developmental Disabilities*, 17(1), 81-88.
- Pedlar, A., Haworth, L., Hutchison, P., Taylor, A., & Dunn, P. (1999). *A textured life: Empowerment and adults with developmental disabilities*. Waterloo, ON: Wilfred Laurier University Press.
- Plaute, W., Westling, D. L., & Cizek, B. (2002). Sexuality education for adults with cognitive disabilities in Austria: Surveys of attitudes and the development of a model program. *Research & Practice for Persons with Severe Disabilities*, 27(1),

58-68.

Québec Ministère de la Santé et des Centre de coordination Services sociaux sur la sida

(2000). *Preventing AIDS and other STDS through sexuality education for students with intellectual impairments*. Québec: The Direction des communication of the Ministère del la Santé et des Services sociaux.

Ragg, M. D., & Rowe, W. (1991). The effective use of group in sex education with people as mildly developmentally disabled. *Sexuality and Disability*, 9(4), 337-351.

Renwick, R., Brown, I., & Raphael, D. (2000). Person-centered quality of life: Contributions from Canada to an international understanding. In K. D. Keith., & R. L. Schalock. (Eds.), *Cross cultural perspectives on quality of life*. Washington, DC: American Association on Mental Retardation.

Romanek, G. M., & Kuehl, R. (1992). Sex education for students with high-incidence special needs. *Teaching Exceptional Children*, 22-24.

Rowitz, L. (1992). *Mental retardation in the year 2000*. New York: Springer-Verlag.

Schalock, R. L. (1994). Promoting quality through quality enhancement techniques and outcome based evaluation. *Journal on Developmental Disabilities*, 3(2), 1-16.

Seltzer, M. M., & Krauss, M. W. (2001). Quality of life of adults with mental retardation/developmental disabilities who live with family. *Mental Retardation and Developmental Disabilities*, 7, 105-114.

Sobsey, D. (1994). Sexual abuse of individuals with intellectual disability. In A. Craft (Eds.), *Practice issues in sexuality and learning disabilities* (pp. 93-115). London: Routledge.

- Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability, 9*, 243-259.
- Sobsey, D., & Mansell, S. (1990). The prevention of sexual abuse of people with developmental disabilities. *Developmental Disabilities Bulletin, 18*(2), 51-66.
- Sobsey, D., & Varhagen, C. (1989). Sexual abuse of people with disabilities. In M. Caspero & L. Gougen (Eds.). *Special education across Canada: Challenges for the 90s* (pp. 199-218). Vancouver: Centre for Human Development and Research.
- Stinson, J., Christian, L., & Dotson, L. A. (2002). Overcoming barriers to the sexual expression of women with developmental disabilities. *Research & Practice for Persons with Severe Disabilities, 27*(1), 18-26.
- Szollos, A. A., & McCabe, M. P. (1995). The sexuality of people with mild intellectual disability: Perceptions of clients and caregivers. *Australia and New Zealand Journal of Developmental Disabilities, 20*, 205-222.
- Tharinger, D., Burrows-Horton, C., & Millea, S. (1990). Sexual abuse and exploitation of children and adults with mental retardation and other handicaps. *Child Abuse & Neglect, 14*, 301-312.
- Walker-Hirsch, L., & Champagne, M. P. (1991). Circles revisited: Ten years later. *Sexuality and Disability, 9*(2), 143-148.
- Watson, S. L., Griffiths, D. M., Richards, D., & Dykstra, L. (2002). Sex education. In D. M. Griffiths., D. Richards., P. Federoff., & S. L. Watson (Eds.), *Ethical dilemmas: Sexuality and developmental disability* (pp. 175-221). New York: NADD Press.

- Whitehouse, M. A., & McCabe, M. P. (1997). Sex education for people with intellectual disability: How effective are they? *Education and Training in Mental Retardation and Developmental Disabilities*, 229-240.
- Whitman, T. L. (1990). Self-regulation and mental retardation. *American Journal on Mental Retardation*, 94, 347-362.
- Williams, S. (1991). Sex education. *Australia and New Zealand Journal of Developmental Disabilities*, 17(2), 217-219.
- Wish, J. R., McCombs, K. F., & Edmonson, B. (1979). *The socio-sexual knowledge and attitude test*. Wood Dale, IL: Stoeling.
- World Health Organization. (1975). *Education and treatment in human sexuality: The training of health professionals*. Technical Report Series Nr. 572. Geneva, Switzerland: Author.
- Zylla, T., & Dementral, G. D. (1981). A behavioral approach to sex education. *Sexuality and Disability*, 4, 40-48.
- What happens in a healthy relationship?* (n.d.). Retrieved March 30, 2003, from <http://www.mwaves.org/healthy.htm>.
- What is hydrocephalus?* (n.d.). Retrieved February 14, 2004, from <http://www.hydroassoc.org/information/information.htm>

Appendix A

June 3rd, 2003

Dear care provider(s),

I am a second year Master's Child Study student in the Department of Education studying at Concordia University. I am conducting a research study investigating the impact of a socio-sexual education program and the development of socio-sexual knowledge and attitudes of adults with developmental disabilities; for this purpose, I would like consent for your child/client to participate.

Your child/client will have the opportunity to participate in a 6-week intervention that teaches about socio-sexual education. The intervention is a workshop style program that is meant to be educational and fun. Each week, a new topic on socio-sexuality will be introduced through activities. It will be conducted on a weekly basis for 6 consecutive sessions and in a group format with other adults with developmental disabilities. The intervention also includes a questionnaire before and after the program, a short interview, and observations. Your child/client will participate in the program from July, 2003 to August, 2003. An introduction session presenting the overall aim of the study will be provided during the first session in early July, 2003.

Full confidentiality is guaranteed throughout this study, and participants and care providers are free to withdraw their consent and discontinue participation at any time without negative consequence.

I hope that you will agree to your child/client's participation in this project as I feel that we can learn helpful information about the socio-sexual knowledge and attitudes of individuals with developmental disabilities. Being well-informed in this area is an important issue that can provide individuals with practical knowledge for everyday living, and can empower them and positively increase overall quality of life.

I would like to thank you in advance for your collaboration. If you are interested in having your child/client participate in this project, please sign the bottom portion of this form and return it to the association's administration. Furthermore, please provide your telephone number so that I may personally contact you. If you have any inquiries, you may contact me at (514) 270-6206 or Dr. Miranda D'Amico at (514) 848-2040.

Nancy Miodrag

 I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE FOR MY CHILD/CLIENT TO PARTICIPATE IN THIS STUDY.

Name (please print) _____

Name of child/client (please print) _____

SIGNATURE _____

WITNESS SIGNATURE _____

DATE _____

Appendix B
Consent Form – Participants

June 3rd, 2003

I _____, agree to participate in a 6-week Socio-Sexual Education Program. This program will teach me about different issues about social skills like making friends, and also about sexuality issues, like dating. I will participate in talks about sexual or private body parts, hygiene, diseases, birth control, how to protect myself against others who might try to take advantage of me, and how I must treat myself and others with respect. I will also participate in a questionnaire and interview, and know that the group will be videotaped by the researcher from Concordia University. I know that my confidentiality is fully guaranteed.

By signing below, I am saying that I have read, understood, and agree to participation in this 6-week Socio-Sexual Education Program.

Participant

Date

Appendix C
Program Schedule

July 11th to August 15th, 2003
Facilitated by: Nancy Miodrag
Concordia University

**Please note that sessions will start at 10:00 a.m. sharp, but it is a good idea to bring clients half an hour early in order to get them ready for sessions. Snacks and beverages will be provided at this time.*

WEEKS	TIMES	SESSIONS
Week 1-July 11 th	9:00-5:00	Assessments (individual; 1/2 hr)
Week 2-July 18 th	9:30-12:00	Social skills/esteem Empowerment Social support Relationships Boundaries
Week 3-July 25 th	9:30-12:00	Sexual physical health Anatomy, hygiene Gender, feelings
Week 4-Aug 1 st	9:30-12:00	Sexual mental health STDs Contraception
Week 5-Aug 8 th	9:30-12:00	Pers. Responsibility Abuse prevention
Week 6- Aug 15 th	9:00-5:00	Assessments (individual; 1/2 hr)

Thank you for your participation!

Appendix D
Demographics Questionnaire

1. Name

2. How old are you?

3. How long have you been at the program at centre?

4. Do you live alone/group home/parents?

5. Do you have a boy/girlfriend and if so, for how long?

6. Have you ever had sex education before (talking about your body, health, wellbeing etc.)? Where?

Appendix F
Attitudes Interview – Posttest

Name: _____
Date: _____
Time: _____

1. What did you learn from this program? If you had any questions before the program, were they answered?

2. Do you have any questions/issues that you would like to talk/learn about next time? Was there something you learned about yourself, or others?

3. How do you feel about things like sex, intimacy, having a boy/girlfriend after participating in this program?

4. How do you feel about things like making friends, being with people, and interacting together?

Appendix G
Knowledge Questionnaire

Questionnaire Date: _____

Name: _____

True or False: Please circle T if you think an item is true, F if you think it is false. If you are not sure, circle the one you think is probably correct.

-
- T F 1. If you want to have sex but do not want to get pregnant, the only place you can get any kind of birth control is at the doctor's office.
- T F 2. You can tell if a person has HIV/AIDS because they look sick.
- T F 3. Women and men should think ahead and plan for safe sex.
- T F 4. People can have a sexually transmitted disease (STD) and not know it.
- T F 5. Women only need to check their breasts for lumps/soreness once a year.
- T F 6. If you want to hug someone, you have to ask permission to enter his or her personal space
- T F 7. Adults like me should have the right to control or make their own decisions in life, like who their friends are.
- T F 8. A staff member is the same relationship as a boy/girlfriend.
- T F 9. If you have slept with someone before, you still have the right to say NO if you do not want to have sex with them.
- T F 10. If someone doesn't want to have sex with you, you should keep trying to talk him or her into it.

Multiple Choice: Please circle the correct answer. If you are not sure which one is correct, circle the one you think is probably correct.

-
1. The only way to be sure not to get pregnant is to (**Be on the Pill, Not to have sex**).
2. Condoms can be used (**Once, A few times**).
3. Sex is (**Public, Private**).
4. When someone touches your genitals without consent, this is a (**Good, Bad**) touch.
5. Masturbating in public is (**Inappropriate, Appropriate**).
6. Anything people do so that they DO NOT get pregnant is called (**menstrual cycle, Birth Control**).

Opinion Survey: Please circle the answer that best describes how you feel.

-
- | | | |
|--|-----|----|
| 1. Being gay or bisexual is okay. | Yes | No |
| 2. I think any kind of sex is okay, as long as both people agree to it. | Yes | No |
| 3. I can make decisions about my sexuality. | Yes | No |
| 4. It is okay to greet your social worker with a hug and a kiss. | Yes | No |
| 5. It is okay to say NO to your worker when you do not agree with him/her. | Yes | No |
| 6. I can make my own daily life decisions like what I do for fun, or what time I go to bed | Yes | No |

Appendix H
Role Play Situations

1. You just landed a really great job and are very excited to start your first day! Role play how you would go about telling your friends and family about your new job. Show us what emotions you would use.
2. You just found out that your best friend at the group home you are living at is moving out. Express your emotions to this friend. What touches are appropriate in this kind of situation
3. Your support worker tells you that you cannot spend anymore of your own money. This is YOUR own hard earned money. Role play what you would say to your support worker. What would you explain.
4. Your boy/girlfriend is constantly asking you to borrow money and then never pays you back. Role play how you would tell him/her that you cannot keep supporting them but that you still care for them
5. Your parent/care giver is always rummaging through your bedroom when you are not around. Role play how you would approach this situation, letting him/her know that these are your personal belongings
6. You just broke up with your boyfriend because you both knew that it was not working. Explain how you would do this and what feelings you might have in this situation.

Appendix I
Make Your Own Judgment

1. You are touching the penis of another person at the group home
2. You are giving your support worker a massage at the group home
3. You ask your support worker out on a date
4. You are masturbating in a public park
5. You are hot and take your shirt off at a restaurant
6. You dress sexy at a family birthday party
7. You cuddle up on the couch next to your housemate without asking them
8. You greet your bus driver with a friendly hello wave
9. You keep the washroom door closed while you are showering
10. You have sex in your bedroom with the doors closed
11. You visit the doctor's office to get birth control
12. You ask a friend if you can give them a hug
13. You buy your boy/girlfriend sexy lingerie
14. You tell the waiter at the restaurant that you want him/her to be your boy/girlfriend
15. You tell everyone at work how many people you have kissed and/or slept with

Appendix J

Synoptic table of learning activities

ACTIVITY NO.	ACTIVITY NAME	LEARNING TOPIC
1	Talking about sexuality	<ul style="list-style-type: none"> - Feelings and emotions - Sexuality: multi-dimensional aspect; pleasures and problems - Purpose of subsequent activities
2	Knowing your body	<ul style="list-style-type: none"> - Anatomy - Private parts - Your body: It belongs to you, you decide
3	Changes at puberty	<ul style="list-style-type: none"> - Signs of puberty - Feelings - New responsibilities
4	Demystifying masturbation	<ul style="list-style-type: none"> - Feelings - Natural, healthy masturbation - Personal choice - Privacy
5	Self-confidence and assertiveness	<ul style="list-style-type: none"> - The body's messages - Understanding and relying on those messages - Being assertive
6	Confiding in others	<ul style="list-style-type: none"> - Social network - People you can trust - Confiding in someone
7	Reacting to sexual exploitation	<ul style="list-style-type: none"> - Types of exploitation - Signs of exploitation - How to react
8	Having a boyfriend Having a girlfriend	<ul style="list-style-type: none"> - Criteria - Sexual behaviours: types, personal choice - Sexual intercourse: positive and negative consequences - Criteria for an enriching sexual relationship
9	Knowing about STDs	<ul style="list-style-type: none"> - Definition of STDs - Main mode of transmission - Symptoms - What to do - Preventive measures
10	Using a condom	<ul style="list-style-type: none"> - How a condom works and why it's useful - Safe use - Availability - Negotiating condom use

Appendix K

Basis for educational practices: a summary¹²

To consider learning as an active process:

- Facilitate student experimentation and discovery.
- Encourage students to take charge.
- Encourage active group participation.

To recognize the importance of prior knowledge in learning:

- Take prior knowledge into account when planning something new.
- Offer information that will help students access prior knowledge.
- Make sure information remains semantically (meaning) and morphologically (form) stable (e.g. always use the same word for a particular instruction).

To present the students with reasonable challenges:

- Have the students experience success to counter a sense of failure.
- Give the students an opportunity to make choices with regards to activities or materials.
- Reinforce small triumphs.
- Reduce dependency.

To attract and retain attention:

- Use meaningful and attractive materials.
- Eliminate or control non-relevant stimuli.
- Make use of certain elements of verbal expression.

To sustain motivation:

- Make activities meaningful.
- Emphasize progress and success.
- Praise the students' efforts.
- Offer constant encouragement (e.g. feedback, reinforcement, rewards).
- Give the students opportunities to do things the way other students their age do.

To plan activities which facilitate the transfer of skills:

- Choose contexts which are as close as possible to ones in which the students will use the skills or knowledge learned.
- Make the conditions of transfer explicit.
- Decontextualize knowledge.
- Work in close collaboration with parents to ensure that learning is used in daily life.

To make learning activities meaningful:

- Aim for essential objectives.
- Suggest meaningful tasks which have useful, practical and immediate consequences.
- Use new skills in real contexts.

To reduce the complexity of tasks:

- Adapt work and materials.
- Simplify tasks.
- Turn to peers as competent, available resources.

To emphasize visual stimulation:

- Accentuate the characteristics of an object.
- Modify the environment so as to facilitate the visualization of stimuli.
- Offer daily opportunities for social adjustment.

To offer guidance:

- Offer models for imitation.
- Support the students' actions and thinking, using mediation.
- Adapt guiding and mediating interventions.

To facilitate learning retention:

- Reduce support and guidance and encourage independence.
- Intensify situations involving the autonomous practice of an activity (high frequency within a variety of contexts).
- Consolidate the mastery of a cognitive or social skill.

12. Ministère de l'Éducation du Québec (1998), *Challenges: An educational approach that facilitates social integration*, Adapted curriculum, secondary level, preliminary version, Québec, MEO, Direction de l'adaptation scolaire et des services complémentaires, pp. 32-33.

Appendix L Icebreakers

Session 1: Feelings

Feelings are OK. Everyone has feelings. Sometimes we are SAD, HAPPY, ANGRY, or SCARED. Sometimes we are SHY, EMBARRASSED, or a little NERVOUS. Today, I am mostly HAPPY and a little NERVOUS. Sometimes people feel the same about something, and sometimes they feel different. You have the RIGHT to these feelings, BUT you must express them appropriately, without hurting others or yourself. We will go around the room and say how we are feeling today.

Session 2: If I had a Million Dollars...

Listen to the song "If I had a Million dollars..." by the Bare Naked Ladies. Everyone will get a chance to explain in their own words what THEY would do if they had a million dollars. It could be anything, it is YOUR choice.

Session 3: Warm Fuzzies

This object is called the Warm Fuzzy (ball). When you have the warm fuzzy in your hands, it is your turn. You must hold the ball and give a "fuzzy" to the person sitting on your right. A fuzzy can be a compliment or a nice comment about the other person. It is intended to make the other person feel good and could be anything. It is YOUR choice. You must pass the ball to the next person when you are finished. The circle continues until everyone has given and received a warm fuzzy.

Session 4: Your Favorite Pet

Let's talk about our favorite animals and how we feel about our pets. How does your favorite animal react when it feels good, when it is happy? Have you seen situations in which an animal was mistreated? What do you think about those situations? How did the animal feel? How did it react? If it could have talked, what would it have said? Do you think inside the animal said yes or no? If this material upsets you, you do not have to participate or stay. There are people here whom you can talk to.

Appendix M
Support Sheets

Support sheet 1.2 – Table of feelings

Support sheet 2.4 – Girls and boys private parts

Support sheet 4.1 – How you feel or what you think

Support sheet 4.2 – Places where it's not appropriate to masturbate

Support sheet 5.3 – Illustration

Support sheet 6.2 – People I can trust to help me

Support sheet 7.1 – Recognizing exploitation

Support sheet 9.1 – Misconceptions as to how to get an STD

Support sheet 9.3 – STD transmission

Support sheet 9.4 – Recognizing an STD

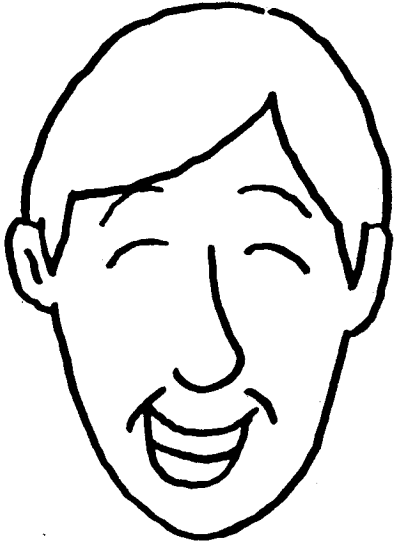
Support sheet 9.5 – STD treatment

Support sheet 9.6-Protecting your health

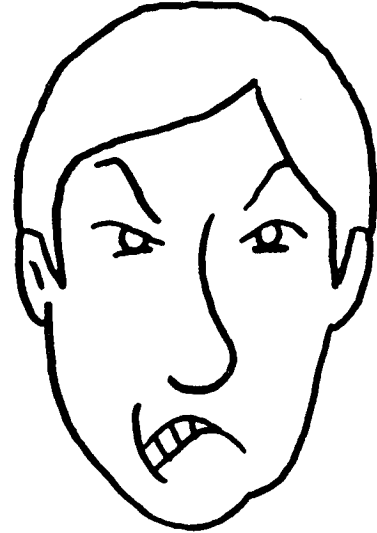
Support sheet 10.2 and 10.3 – Steps in condom use

Table of feelings

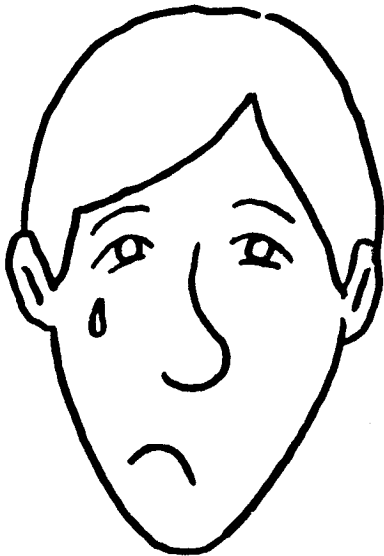
Joy



Anger



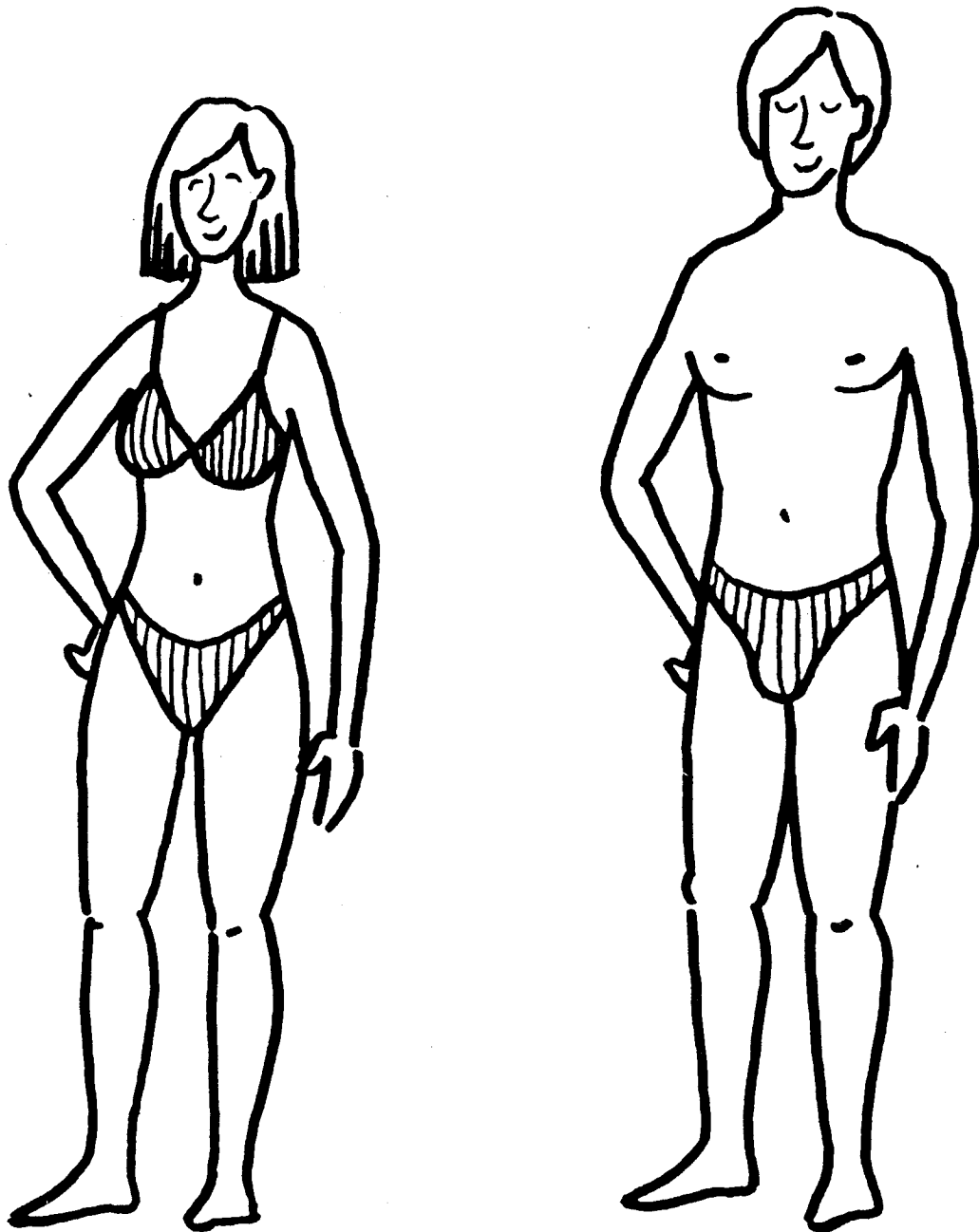
Sadness



Fear

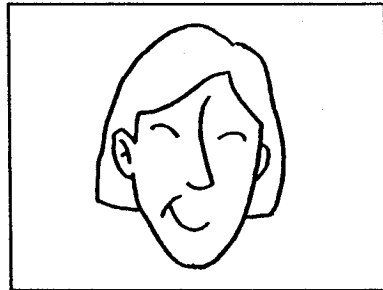


Colour where the girl's and the boy's private parts are in blue.



Place a check mark (✓) in the box next to the drawing showing how you feel or what you think.

When people are talking about masturbation I feel:



Good

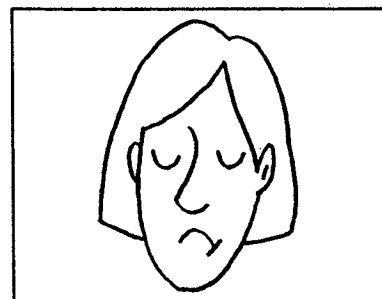


Not good

**A young person says he or she masturbates in his or her room.
I think that's**

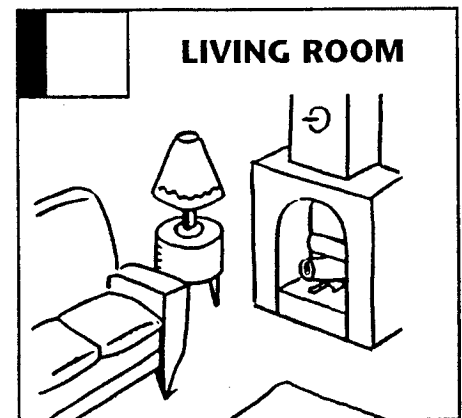
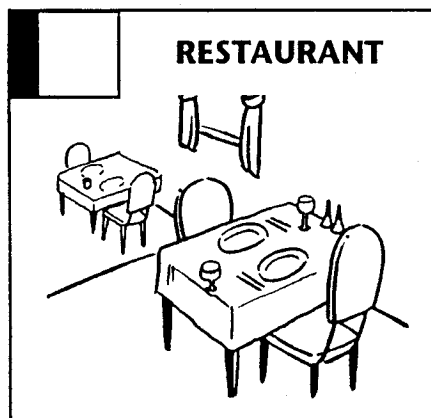
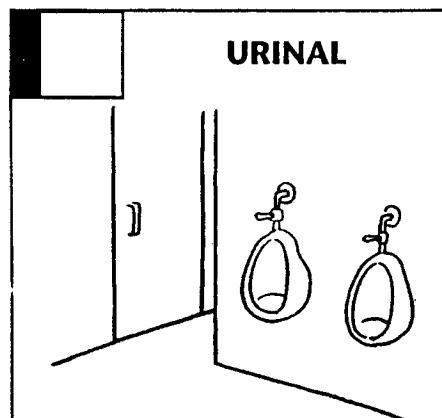
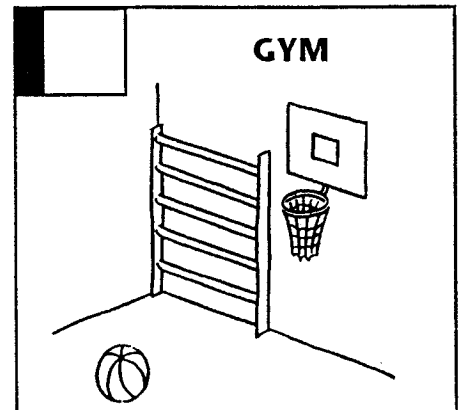
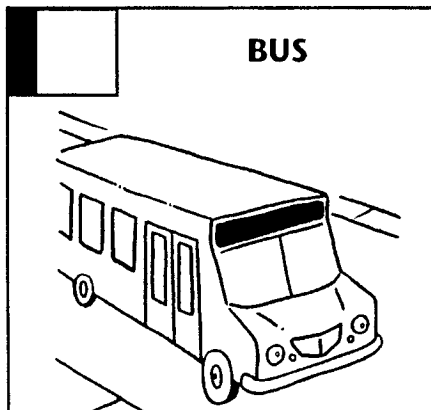
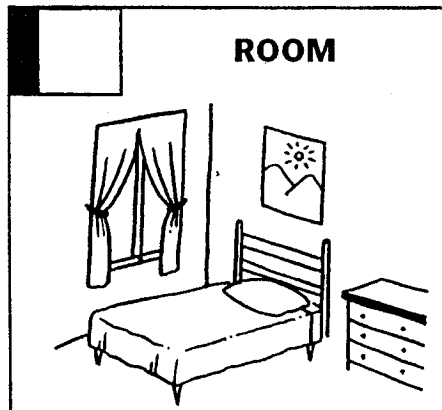
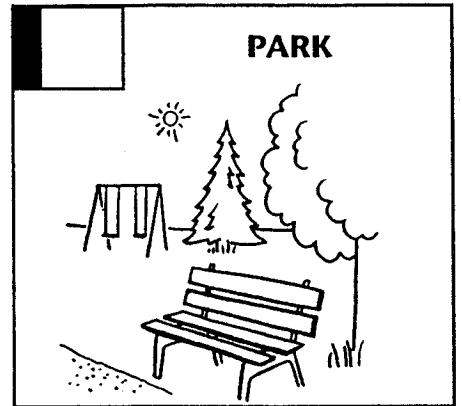
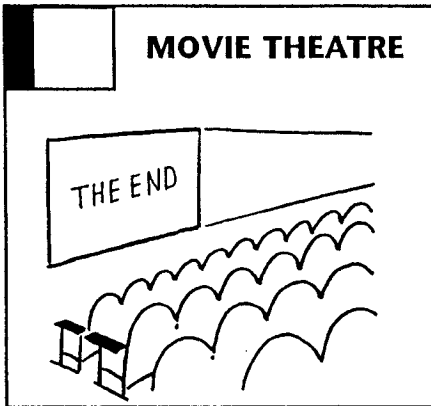
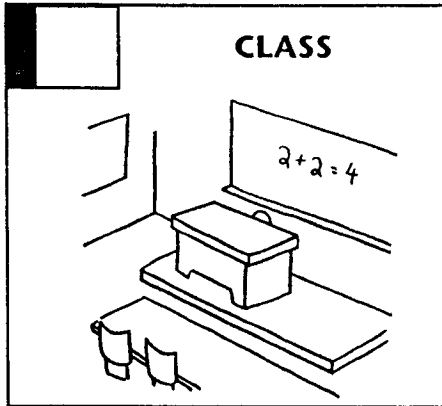


OK



Not OK

Make an X in the places where it's not appropriate to masturbate.





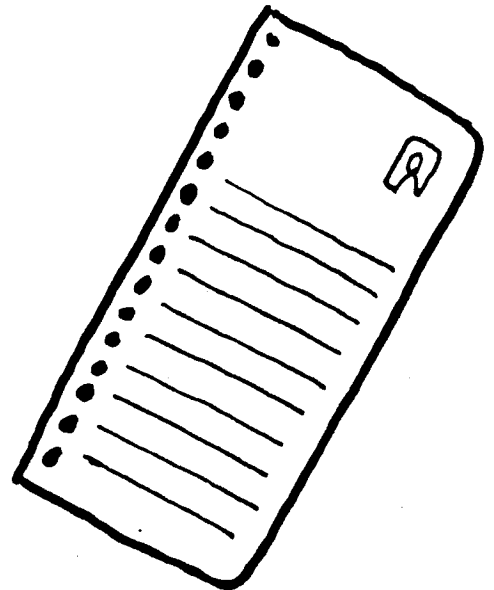
PEOPLE I CAN TRUST TO HELP ME

● _____



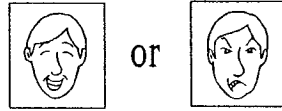
● _____

● _____



Recognizing exploitation




Colour the happy face or the sad face,



or

depending on whether the situation makes something inside you say yes or say no

1 A stranger hurts your cat

		YES	
		NO	



2 Your cousin loans you a CD

		YES	
		NO	

3 A neighbour wants to exchange his pencil for your walkman

		YES	
		NO	

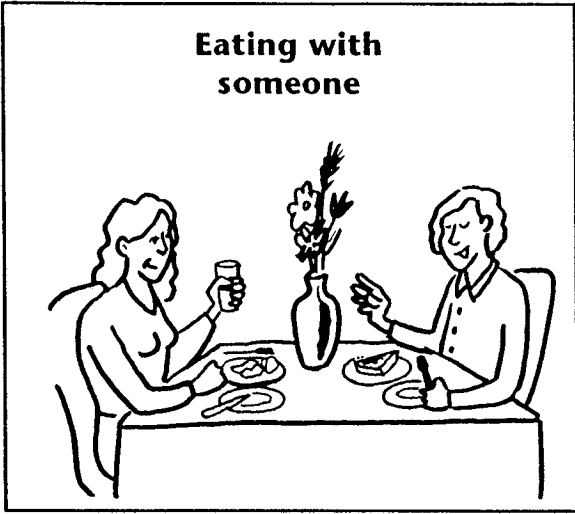
4 Your mother gives you a birthday present

		YES	
		NO	

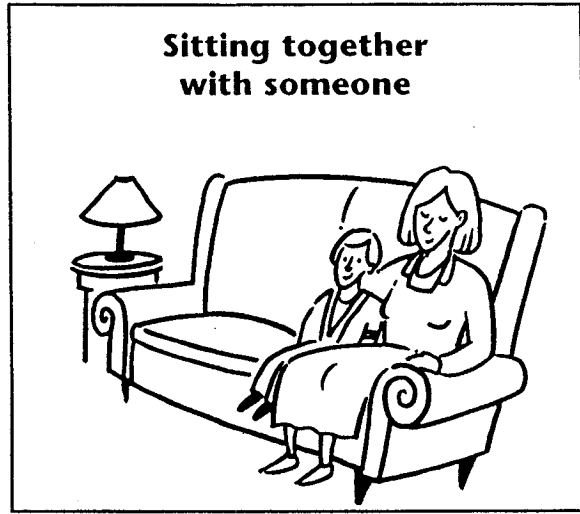
5 A student says to you: "Give me your snack or I'll hide your bag."

		YES	
		NO	

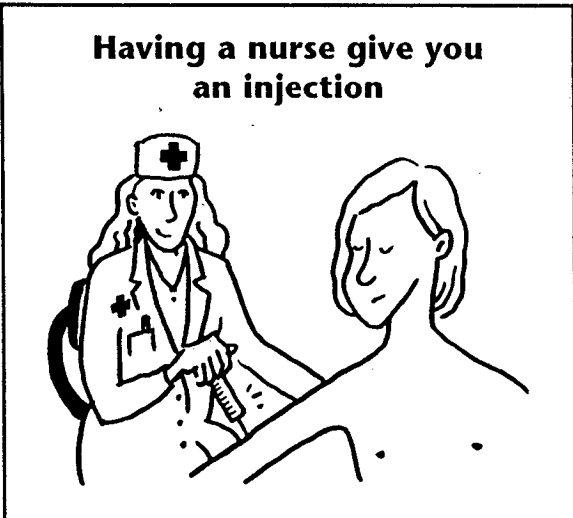
Eating with someone



Sitting together with someone



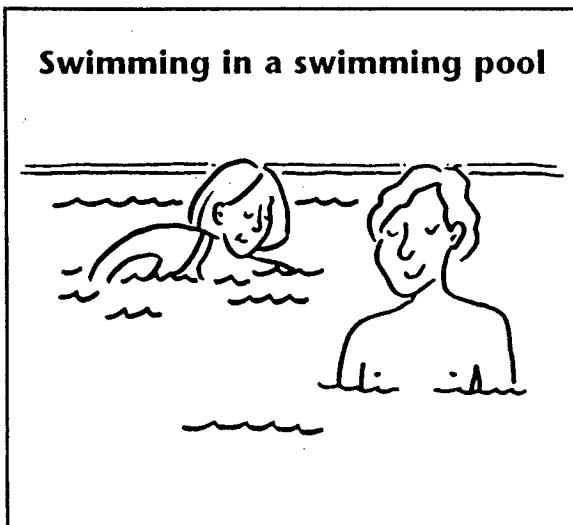
Having a nurse give you an injection



Dancing with someone



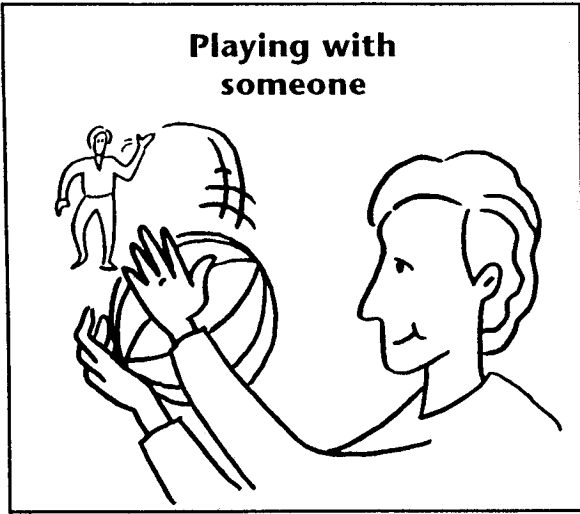
Swimming in a swimming pool



Sitting beside someone



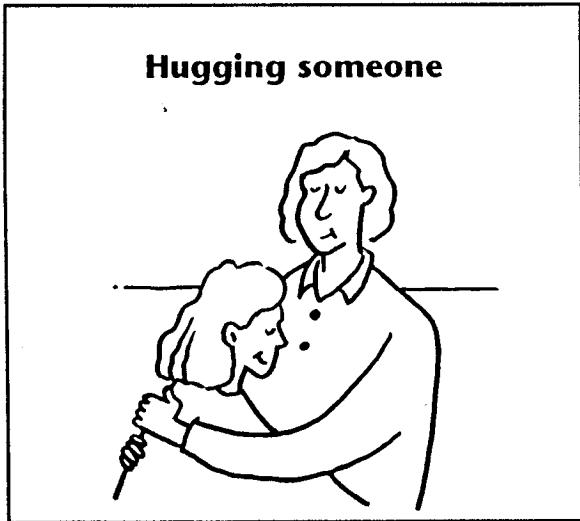
**Playing with
someone**



**Being kissed
on the cheek**



Hugging someone



Using a public toilet



**Talking to someone
who's sneezing**



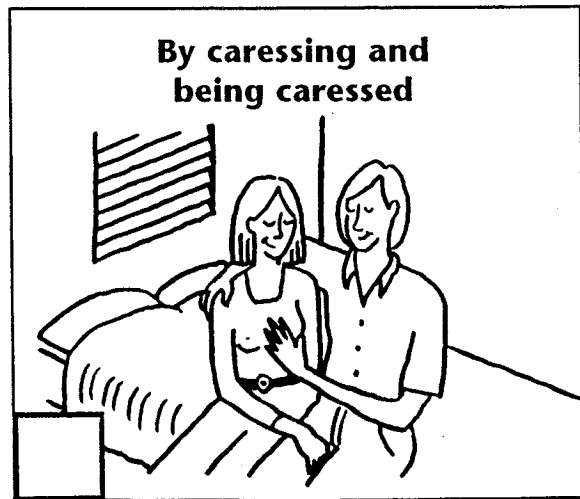
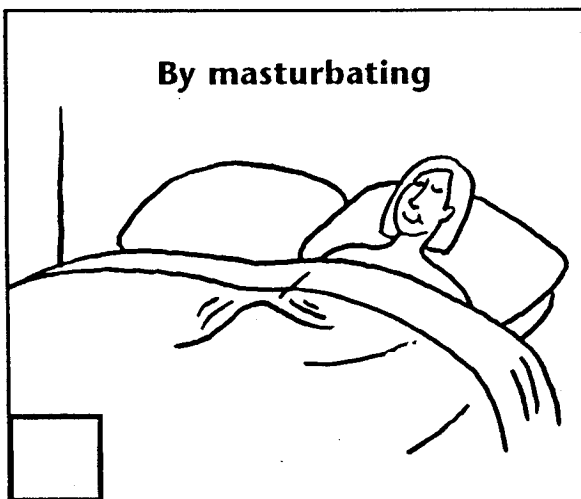
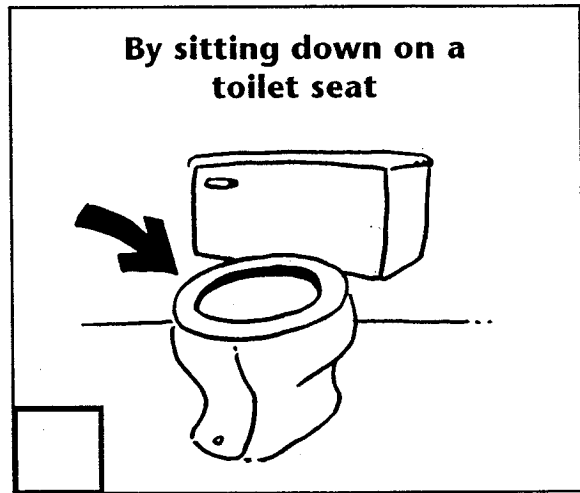
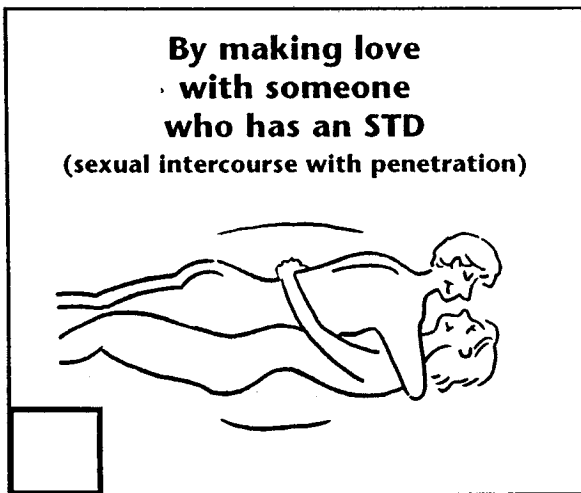
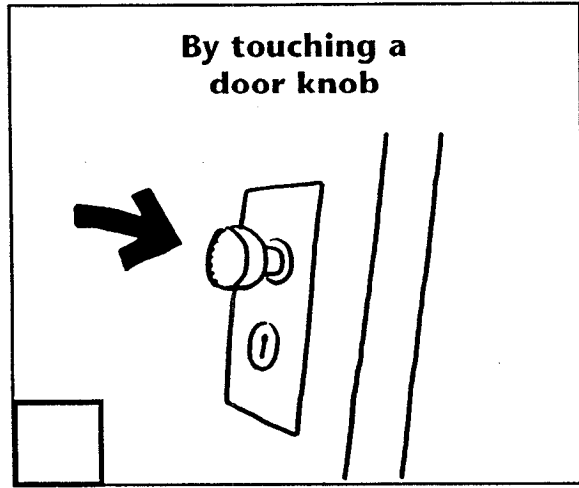
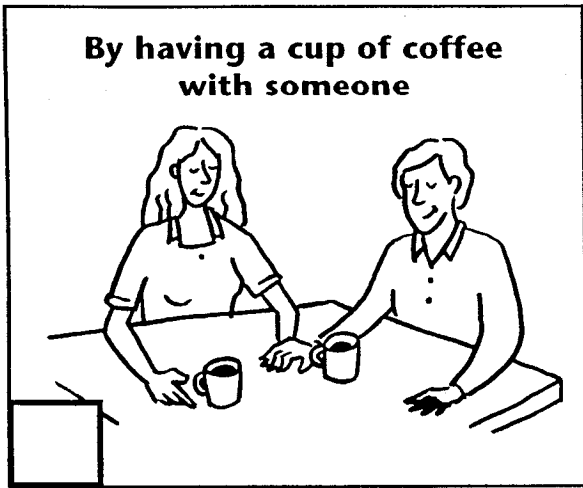
Shaking someone's hand



STD transmission

How can an STD be spread?




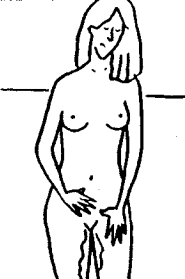
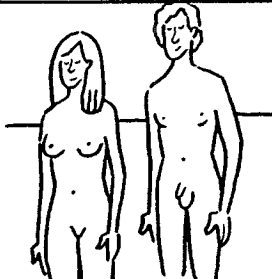
Place a checkmark (✓) next to the correct answer.



Recognizing an STD

What are the possible signs of an STD?

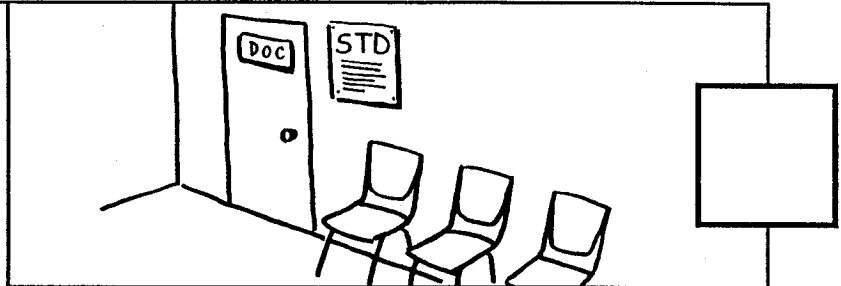
Place a checkmark (✓) next to the correct answers.

<p>"I'm itchy"</p>		<input type="checkbox"/>
<p>"It makes me laugh"</p>		<input type="checkbox"/>
<p>"I have sores on my genitals"</p>		<input type="checkbox"/>
<p>"I have a discharge"</p>		<input type="checkbox"/>
<p>Often, it doesn't show</p>		<input type="checkbox"/>

STD treatment

What must you do if you have an STD?
Place a checkmark (✓) next to the correct answer.

Go see a doctor



Think about something else



Drink a glass of water



Protecting your health

How can I protect myself from STDs?

Place a checkmark (✓) next to the correct answers.

Think before having sexual intercourse



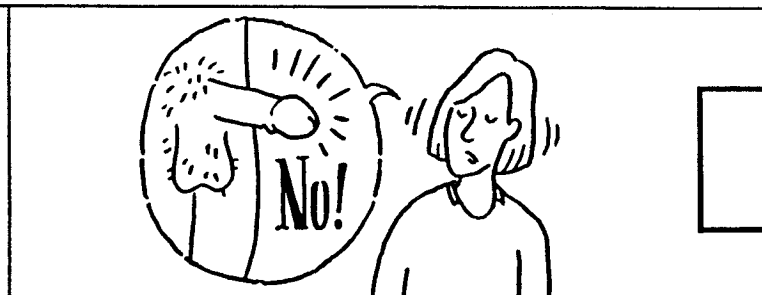
Talk to my partner about it



Use a condom if we decide to have sex



Say no unless a condom is used



Steps in condom use

Cut out the steps in condom use (support sheet 10.3) and glue them onto this page in the proper order.

1	2
3	4
5	6

Steps in condom use

