

**SEXUAL BEHAVIOUR OF THE MENTALLY
RETARDED IN SELECTED VOCATIONAL
TRAINING INSTITUTIONS**

THESIS

BY

OLIVE SAMUKOLO

FEBRUARY, 2007

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A dissertation submitted to the University of Zambia in partial fulfilment of the requirement for the award of degree of Master of Education (Special Education).

**THE UNIVERSITY OF ZAMBIA
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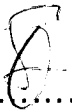
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**Sexual Behaviour of the mentally retarded
in selected Vocational Training Institutions**

DECLARATION

I, Olive Samukolo, do declare that this dissertation is my own work which has not been submitted for a degree at this or any other University.

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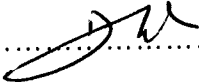
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DEDICATION

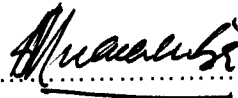
This dissertation is dedicated to my father, mother and family for their patience and encouragement during the course of my study.

APPROVAL

This dissertation by Olive Samukolo is approved as a partial fulfilment of the requirements for the award of the degree of Master of Education (Special Education) of the University of Zambia.

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ACKNOWLEDGEMENTS

In the first place I salute and pay tribute to the Department of Educational, Psychology, Sociology and Special Education.

In particular, I wish to express my sincere gratitude to Dr. D.M. Kalabula my supervisor, for his invaluable guidance and tireless supervision during the production of this dissertation. Thanks also go to Mr. J.M. Mandyata for giving me guidance in Research Techniques. Other thanks go to all my lecturers in Research Methodology and Research Project.

This study would not have been successful without the support of the principals, their members of staff and parents of National Vocational Rehabilitation Centre (NVRC), Lusaka Technical and Business College (LBTC), Holy Family for Children (Ukubalula Training Centre) and Bauleni Vocational Centre (BVC). I am therefore, very grateful to them for allowing me to conduct the main study in their vocational institutions.

Further, I wish to thank the Director, Mr. J.S. Mukuni, Ministry of Science, Technology and Vocational Training for allowing this kind of topic to be conducted in the Vocational Institutions. I also wish to thank all my friends for their encouragement and many others who supported the study in many ways.

I am also grateful to Ms. Sepo Kusiyo for the outstanding typing services provided in preparing and completing this dissertation.

To God, be the Glory, for giving me good health, strength and courage to overcome all the challenges I encountered during my studies and above all for making it possible for me to attain this goal.

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ABSTRACT

The study focused on the sexual behaviour of the mentally retarded students in vocational training Institutions in Ndola and Lusaka districts, Zambia.

There has been no empirical research existing in the study of sexuality and mental retardation in Zambia, although there is scanty literature on the sexual behaviour of the able-bodied adolescents. The few studies that have been done in Europe and elsewhere have mainly focused on mature individuals with mild or moderate intelligence in communities and patients in hospitals. Many people with mental retardation do have a sex drive and express it through sole masturbation, exactly like the majority of adolescents. The mentally retarded have sexually inappropriate behaviour including touching, grabbing, stripping, fondling, masturbation, hypersexuality and sexual abuse (Bouras, 1999).

Both qualitative and quantitative methods were used to study the sexual behaviour of the mentally retarded students. On account of the subjective nature of sexuality, the research study took qualitative stance for the most part. Qualitative data was also used for qualification of the recorded sexual behaviour. The interpretation and detailed discussion of quantitative data was made easier by qualitative data.

60 respondents participated in the study. Respondents consisted of principals, Vice principals, Heads of departments (Administrators) (N = 10), lecturers (20), parents (20) and caretakers or hostel staff (10) from the vocational training Institutions in Ndola and Lusaka districts. Questionnaires and in-depth interviews were used to obtain information from respondents. Frequencies and percentages were used to analyse the quantitative data obtained. The qualitative data collected was transcribed from the field notes and subjected to thematic analysis. It was presented in form of document analysis in which data was examined closely by the main emerging themes.

The study found that the sexual behaviour of the mentally retarded in Vocational training Institutions is a reality to practically everyone who works in this field. The mentally retarded have a high sexual feeling which sound an alarm, particularly as the gravity of the risks of sexual conduct has risen dramatically with the spread of HIV infections. The study also found that the mentally retarded have high sexual desires despite their retardation justifying that their impaired cognitive development functioning does not result in limited sexual development.

The study recommended that:

1. Service providers, caregivers and parents should be trained on how to handle the sexuality of the mentally retarded.
2. All vocational training institutions must provide sex education which calls for an intensive amount of programme development in the area of sexual health to avoid placing persons with retardation at increased risks for unwanted pregnancies, sexually transmitted diseases (STDs), HIV/aids and sexual abuse.
3. The Ministry of Science, Technology and Vocational Training, parents, service providers, local communities, non – governmental organizations and line ministries should work together in ensuring the success of the provision of sex education as well as the appropriate means of sexual expression and the reinforcement of appropriate expression at the right time.
4. The Ministry of Science, Technology and Vocational Training and other line ministries should include a clause within their policies to address the sexual behaviour of the mentally retarded.

CHAPTER ONE

1.0. INTRODUCTION

The issues related to sexuality and Mental Retardation have become a major topic of professional discussions and public debate in most countries. Sundram (1992) on plain talk about sex and mental retardation explained that the sexuality of people with Mental Retardation in vocational training institutions is a reality to practically everyone who works in this field, yet many seem to have found it more convenient to hide or ignore this sexual conduct. They may be scared because it may raise complex legal, social, moral, ethical, religious, health care and even political questions. The service providers and parents have been content it does not happen or if it does, to hope fervently that they aren't faced with pregnancy or a sexual transmitted disease or HIV/aids that force acknowledgement of sexual conduct.

Forces such as the implementation of the normalization principle in Europe, the effect of deinstitutionalization efforts, and the impact of the Government policy have created a need to understand and accept the person with mental retardation as a sexual being. But the development of appropriate service provisions has not kept pace with this growing awareness (Ludlow 1991).

There is no empirical research existing in the study of sexuality and mental retardation in Zambia although there is scanty literature on the sexual behaviour of the able-bodied adolescents. Little empirical research exists elsewhere and few model programs have been developed, even those disposed to facilitate sexual expression by people with retardation are confused about appropriate actions to take. A number of complex issues, therefore, remain to be resolved: for example professional and parental attitudes.

The purpose of this research is to explore this significant and highly charged contemporary topic in the field of mental retardation.

1.1. HISTORICAL BACKGROUND

Zambian Society's long history of discomfort with the topic of sexuality and Mental Retardation is the product of strict moral attitudes upon which social customs and legal restrictions were founded, as well as *the drive of the eugenic movement toward the improvement of human traits through selective reproduction*. Tredgold's (1920) in Ludlow (1991) early conceptions of mental retardation associated the condition with uncontrollable libido and perverted sexual habits. Some of the more recent studies tend to agree with the findings of some earlier studies. For example Bouras (1999) presented evidence of human sexuality which encompasses the totality of the concept of love in its broadest definition. He said sex in mental retardation is a challenging behaviour.

Harris (1995) added that the mentally retarded have a sexual inappropriate behaviour. Such a behaviour in this case present challenges for service providers as they threaten the physical safety of other peers and risk exclusion from the vocational training institutions.

Both Galton (1909) and Goddard (1920) in Ludlow (1991) said that Segregation and institutionalization especially in Europe were proposed to protect the public from sexual excesses and to control promiscuous behaviour by people with retardation. When continent failed to restrict sexual expression, sterilization techniques were developed and tested on residents of institutions (Landman, 1932 in Ludlow). Even castration was practiced in some settings to stop 'uncontrollable' masturbation, inappropriate sexual behaviour and homosexual activity (Robitscher, 1973 in Ludlow).

Although these misconceptions were never supported by sociological studies or empirical data (Sarason, 1969), they not only had a profound impact on subsequent service delivery, but continue to influence public attitudes even today.

The prevailing mood of this period is well portrayed by the story of Benji in "The Sound and the Fury" by Faulkner, (1939) in Ludlow (1991) Terman (1916) in Ludlow (1991) summed it up:

"All the feeble minded are potential (sexual) criminals. Terman feels that every feeble minded woman is a potential prostitute would hardly be disputed by anyone". (Terman, 1916, p.11. in Ludlow).

As additional opportunities were provided for individuals with mild to moderate mental retardation, the concept of sexual perversion shifted to one of immature sexual development.

Individuals were forced to sublimate some forms of sexual expressions such as masturbation through constant activity (Katz, 1970), while maladaptive behaviours like public exposure were corrected through behaviour management procedures (Rosen, 1970). Penrose (1963) said the implementation of intelligence testing and the use of mental age to measure functioning levels suggested that persons with intellectual impairment could be regarded as developmentally younger, with little or no sexual desire, incapable of meaningful heterosexual interactions. This means individuals were forced to sublimate some forms of sexual expression such as masturbation through constant activity. While maladaptive behaviour like public exposure were corrected through behaviour management procedures. Carrera (1981) noted that sex education was not offered to avoid creating needs and urges beyond the ability of the individual to understand or control.

A typical account is provided by Pearl Black's description of her child in ***"The Child who never Grew"*** (Buck, 1950) in Ludlow (1991). The Utah Supreme Court said it clearly:

"--- a person with a low IQ does not have the same capacity to love and show affection as a person with normal intelligence." (In re MacDonald, 1972, p.449) in Ludlow (1991)

More recently, advocacy efforts directed at guaranteeing civil rights and studies of adaptive behaviour in sexual functions have focused on the *similarities in sexuality between persons with mental retardation and their non-handicapped peers*. Psychologists now recognize that impaired cognitive functioning does not result in limited sexual development (Biggs, 1976).

Programmes in Europe have begun to provide sex education even to the most severely involved clients, with an emphasis on development of appropriate sexual behaviour and social interactions (Haavik & Menninger, 1981). McCabe (2001) addresses the programmes of homosexuality and masturbation, as well as appropriate means of sexual expression and the ramifications of inappropriate expression, in sex education curricula for this population. Lack of sex education may place persons with mental retardation at increased risk for unwanted pregnancy, sexually transmitted intercourse (STIs), HIV/aids and abuse, particularly when they are deinstitutioned (inclusive education). These changing times are chronicled in a popular book, "Like Normal People" that describes one couple's marriage (Myers, 1980).

The philosophy has been stated succinctly by Mitchell (1985) in Ludlow (1991):

"--- interest in sexuality should be greeted joyfully as a welcome manifestation of normality in mentally handicapped person" (Mitchell, 1985, p.11 in Ludlow 1991).

The case of Zambia is unique because it does not have any empirical data on the sexual behaviour of the mentally retarded which is a critical issue in the literature of mental retardation. It depends mostly on research done in Europe, United States of America and elsewhere.

1.2. THEORETICAL FRAMEWORK

The study used Wilson (1977) theory. This theory is the phenomenological approach model upon which the research study is based. This is one of the most widely used models in the study of sexual behaviour. It is therefore phenomenological in so far as the understanding of social phenomena is grounded in people's experiences and interpretation of their reality. It is also symbolic in nature because the professionals and parents were able to interpret the sexual behaviour of the mentally retarded in vocational training institutions.

According to Wilson, the phenomenological approach understands the Framework within which the subjects interpret their thoughts, feelings and actions, before understanding human behaviour. In this regard the researcher found the qualitative research develop context-bound generalizations. It also helped to combine both qualitative and quantitative research methods in this study in order to investigate the sexual behaviour of the mentally retarded students.

1.3. STATEMENT OF THE PROBLEM

There is no empirical research existing in the study of sexuality and mental retardation in Zambia, but few studies that have been done in Europe and elsewhere have mainly focused on mature individuals with mild or moderate in communities and patients in hospitals. These studies have further provided suggestions on how best to deal with sexuality and mental retardation as a way of improving their sexual expression.

Regardless of what we do not know, it is clear that many people with mental retardation do have a sex drive and express it through sole masturbation, exactly like the majority of adolescents. The mentally retarded have sexually inappropriate behaviour including touching, grabbing, stripping and self exposure (Bouras, 1999).

Therefore, there is need to discover the views of parents and service providers in order to explore this significant and highly charged contemporary topic in the field of mental retardation.

1.4. PURPOSE OF THE STUDY

From the review of the literature, very few studies have been done on sexuality and mental retardation in Europe, United States of America and elsewhere. There is no empirical research that exists in the study of sexuality and mental retardation in Zambia, although there is scanty literature on the sexual behaviour of the able-bodied adolescents. The literature that exists elsewhere is not enough to determine whether the sexual behaviour is unhealthy, hurtful or illegal due to receiving little or no sex education (Nezu et al 1978). On the other hand, sexual activity in vocational training institutions sometimes go unreported since professionals and parents are unsure as to how to handle an individual with this type of disability. In the light of the foregoing, the general purpose is to explore and describe the present status of the sexuality of the mentally retarded and whether professionals and parents are in favour of this challenging behaviour.

1.5. OBJECTIVES OF THE STUDY

The objectives of the study are to:

- Find out the present status of the challenging sexual behaviour of the mentally retarded.
- Investigate the views of parents or family on the sexual behaviour of the mentally retarded.
- Find out the opinions of the professionals on the sexual behaviour of the mentally retarded in vocational training institutions.
- Identify factors influencing the sexual behaviour of the mentally retarded in vocational training institutions.
- Ascertain professionals' and parents' expectations of the sexual behaviour of the mentally retarded in vocational training institutions.

1.6. RESEARCH QUESTIONS

The research was guided by the following questions:

- What is the present status of the sexual behaviour of the mentally retarded in vocational training institutions?
- Are parents or families in favour of the sexual practices for their mentally retarded children?
- Are there differences in perceptions towards the sexual behaviour of the mentally retarded between parents and professionals?
- What factors influence the sexual behaviour of the mentally retarded?
- What innovations do professionals and parents expect to see in vocational training institutions?

1.7. SIGNIFICANCE OF THE STUDY

Service providers are more likely to work together to increase awareness of the need for people with mental retardation to express their sexuality and their ability, with education and training, if they feel they have been consulted and have contributed to the change. It was therefore, hoped that the study findings would provide literature on the significance and highly charged contemporary topic on sexual behaviour in the field of mental retardation. It was further anticipated that it might contribute to knowledge about sexuality that the mentally retarded can comprehend.

Further, it is hoped that the information obtained from this study, will be of use to national leaders, vocational planners, professionals or service providers, parents and the community in Zambia. It may also reveal the sexual activity and mental retardation existing in vocational training institutions, the kind of handling currently existing to this type of disability and what should be done to them for the purpose of sexual behaviour.

It is therefore hoped that the study may bring to light vital knowledge concerning views of sexual behaviour and the aspirations of service providers in vocational training institutions.

DEFINITIONS OF TERMS IN THE STUDY

Deinstitutionalisation: Implies that all students no matter how severe their disabilities or how intensive their needs are, can be accommodated in an ordinary class or school.

Normalisation: Means making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life or society.

Puritan: A person who has extremely strict moral attitudes and who tends to regard pleasure as sin.

Eugenics: Ludmere (1975) defines it as a science that investigates methods to ameliorate the genetic composition of the human race, a program to foster such betterment, a social movement, and in its perverted form, pseudo-scientific retreats for bigots and racists. Or the science of producing healthy intelligent children with the aim of improving the general characteristics of the human race.

Libido: The urge or energy for sex.

Sex: The state of being male or female.

- Sexuality:** Fundamental component of personality, one of its modes of being manifestation of communicating with others, of feeling, of expressing and of living human love.
- Castration:** To remove the testicles of the male.
- Challenging behaviour:** This term refers to severe and usually chronic combination of aggressive, destructive, attention seeking, sexually inappropriate, self injurious, noise, hyperactive and socially inappropriate behavioural disorders.
- Inappropriate Sexual Behaviour:** Include touching, stripping, grabbing, fondling, masturbation, hyper sexuality and sexual abuse.
- Homosexual:** Sexually attracted only to people of the same sex as oneself. It is the same sex relationships.
- Masturbation:** Self-stimulation for sexual pleasure. It may or may not result in orgasm. It is a common practice particularly in adolescence.
- Mental Retardation:** It's a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, contributing to the overall level of intelligence, i.e. cognitive, language, motor and social abilities.

CHAPTER TWO

LITERATURE REVIEW

The tremendous changes taking place in the field of mental retardation are nowhere more evident than in the area of sexuality. Bernard (1970) studied the sex between biologically mature individuals with mild or moderate mentally retarded in hospitals. He says, the "sexual activity" and "mental retardation" are challenging and sometimes rather awkward.

However, Goodman et al (1971) in their surveys of family attitudes reveal that many parents deny or fear the sexuality of children who are labelled retarded. In addition, many parents prolong dependency, restricting opportunities to develop social skills to protect their children against sexual exploitation or unwanted pregnancy. Others refuse to believe that their children have sexual needs and feelings. Some even reject attempts at providing sex education, in the mistaken belief that ignorance will prevent sexual activity.

Research has shown (Sorensen 1972) that by the end of the adolescent period the majority of males and approximately 50% of females report that they have masturbated. By age, 19, 72% males and 57% of females report that they have experienced full sexual intercourse. Furthermore, Mortlock (1973) stated that from the beginning of puberty, the normal adolescent had to learn to deal with increasing strong sexual impulses.

Persk (1975) in his investigation of family members observed that the developing of sexuality of family members who are labelled mentally retarded reflect their own personal experience. He adds that family attitudes towards sexuality and mental retardation determine how the developing sexuality of family members who are labelled mentally retarded is viewed. He said family members are also members of the society, their individual attitudes towards the sexuality of people with retardation reflect those of the community at large, as transformed through their own personal experience.

Saraswathi (1980) reported that mentally retarded persons have as much right to satisfying sexual urges as normal people. Her study focused on the problems parents faced in coping with the mentally retarded given to sexual impulses as they gained adolescence. Narrating her experience in dealing with the mentally retarded children, she said while Governments all over the world had bestowed equal rights and opportunities on the mentally retarded persons the problem of their sexual management had not been adequately addressed to even in advanced countries. However, experts the world over have now recognized this need and were engaged in evolving strategies to meet the needs of such persons in all aspects.

She further cited cases of how certain behaviour problems in mentally retarded adolescents were traced to their sexual urges. Parents in particular were hard to deal with such situation and were afraid to discuss the problem for fear of social stigma. She says, the concept of sexuality is often misunderstood in a society like ours with a strong social stigma and its application is almost tabooed. However, sex is an important aspect of anybody's life. Without this, total human development cannot be imagined. Any attempt, either to suppress or destruct the sex related desires resulted in cramped personality and severe behaviour disorders. Mentally retarded persons may not be able to express their desire for sex in a proper manner but it can be noticed through the changing behaviour, which requires careful observation.

According to Rosen (1982) in Ludlow (1991:7), sexual exploitation of family members with mental retardation is also a growing problem. People with retardation are socialized to be vulnerable, trained to be compliant to the demands of others, and denied opportunities for sexual expression. He declared that, the incidence of sexual exploitation of individuals who are labelled retarded is higher than that of their non handicapped peers, and nearly 99% of all incidents are perpetuated by family members or caretakers. He further explained that, parents who want to protect their children from exploitation are often at a loss as to what or how to teach them, and few

programmes have been developed to train individuals with retardation to recognize exploitation and protect themselves against it.

In the same vein, Heshusius (1982) in his extensive interview with people with *mental retardation in institutional and non-institutional setting* indicate that adolescents living in the community, especially those in co-education environment have a slightly higher level of knowledge in sexuality than those living in institutions. Furthermore, both adolescents with and without disabilities have fairly low levels of knowledge, but those with disabilities are more likely to get their information from peers (often misinformed) than from more reliable sources like books. Thus access to accurate information is low, increasing the need for more comprehensive sex education programmes for this population (Rogers and Watson 1980).

Shulz and Adams (1987) in McCabe (1993) in their study showed that over half of the adolescents expressed that their needs were currently unmet in the area of sexuality. They recommended sex education, appropriate means of sexual expression which should be addressed in sex education curricula for this population. They said lack of sex education may place persons with retardation at increased risks for unwanted pregnancies, sexually transmitted infections (STIs), HIV/aids and sexual abuse.

Shulz and Adams (1987) added that most parents favour sterilization because they fear the dangers of pregnancy and the added burden on the family of unwanted child. Although a few parents accept the need for sex education, they transfer the responsibility for training to professionals.

Coley and Marler (1987) stated that the sexuality of people with mental handicap traces some restrictive attitudes to the way human services are operated. For example, many group homes are run by Christian groups who insist that residents live up to what is seen as "Christian Principles of high morals and values". The authors point clearly that people with mental retardation have the same rights and needs to enjoy their sexuality as anyone else, and should have the same right to marry or cohabit as anyone else.

Ludlow (1991) argued that parents in general are not yet comfortable dealing with their children's sexual needs and behaviour. Parents of children who are labelled retarded, therefore, experience this ambiguity toward sexuality in combination with their ambiguity toward mental retardation. The anger, grief and denial on the part of parents have resulted in many families, repressive treatment of emerging sexuality and lack of education in socio-sexual skills remains a subject of concern.

Monat - Haller (1992) in his study found that for too long individuals with developmental disabilities and mental retardation have been expected to be asexual. Consequently, these people have been expected to repress their inherent sexuality and to obey rules and regulations that deny their right to sexual expression.

McCabe (1993) examined the parents of children or adolescents with developmental disabilities. She confirms that attitudes are influenced by concerns for the child's well being, lack of knowledge about how to provide sex education, and simple denial of the child's sexuality. She added that although sexuality is a normal part of development for all humans, society often views sexuality of individuals with mental retardation as a problem. As a result, these individuals' needs and rights are often ignored or denied. Studies indicate that the level of discontent is so high that even mild displays of affection, tenderness and simple human touch are sometimes discouraged.

Amado (1993) explored that some sexual "subculture" for individuals with disabilities that have been created as a result of the service system are described, as well as system factors that affect normal sexual development. The importance of sexuality of education is delineated from the vantage point of enhancing quality of life and enhancing relationships, and as an important precursor to prevention of abuse.

According to McCarthy et al (1993) many people with mental retardation are disadvantaged with regard to sexual fulfilment and enjoyment; therefore, parents need to be assisted so that they help their children to better

understand their sexuality and to incorporate this dimension of themselves *into their lives as a whole*. This is based on the underlying premise that all people, regardless of intellectual ability, are sexual beings.

Likwa (1996) explained that in Uganda, it's common to find 15 year olds with HIV/aids. In addition, prevalence of unplanned pregnancies in teens are on the increase as well as abortions and sexually transmitted diseases (STDs). In another study (47.8% for girls, 52.2% for boys) almost half of both sexes generally in secondary schools were involved in penetrative unprotective sexual intercourse. Therefore, there exists not only a bad sexual Behaviour in school going adolescents, but this even involves young ones such as nine (9) year olds.

In the same vein it is understandable that parents of children or adolescents with mental retardation are concerned for their children's well being. This concern, however, may be influenced by a lack of knowledge about how to provide sex education and a simple denial of the sexuality of the individual (OMahony, 1997).

Furthermore, the adolescent years are a particularly difficult time for all teenagers, but worse for the teenagers with a mild or moderate intellectual disability. Generally, according to OMahony (1997) in Saraswathi (2002), at this period in their development, their parents realize the true extent of their situation. Some adolescents' problems are more acute than others and they may have longstanding consequences. They often experience peer pressure and because of their vulnerability, naivety and innocence, they are prone to be taken advantage of during this period. Some may find themselves involved in criminal and sexual activities or drug abuse.

In another development Ankraw (1989) in Michelo (1998) noted sexual activity among adolescents without disabilities. He said sexual activity among adolescents is increasingly becoming more apparent than in earlier decades. Furthermore, sexual activity has been reported as early as 10 years of age and seems to be more in females from age 12 – 15 years and above than

males of the same age. The biggest problem that has arisen out of sexuality is the *HIV/aids pandemic*. There is however no published studies of HIV seroprevalence among adolescents in Zambia (US Bureau of the census, 1994) in Michelo (1988).

Butler (2000) stated that people with mental retardation experience the same diverse range of sexual needs and desires as the rest of the community. However, they often have different life experiences that limit opportunities to understand the complexities of human relationships and the rights and responsibilities that encompass sexual maturity.

She further stated that people with disabilities and their various carers with this particular domain of life skills is seen as a condition of complex and divergent problems that rarely has easy answers. It is one that challenges our cultural, moral and ethical mores both as individuals and as a community. It is only in the recent past that specialized services have realized that regardless of a person's developmental disability, sexual development and expression are inherent to the existence and growth of all human beings.

The Zambia sexual Behaviour survey (2002) indicated that about 50% of Zambian boys and girls generally have their sexual debut by the time they reach 17 years. A lot of attention needs to be implored to the adolescents. This is because they constitute a special group that is vulnerable to HIV infection, unwanted pregnancies and unsafe abortions. Therefore, there is still little that has been done to appraise strategies to protect the lives of young people from HIV/aids.

However, Davis (2004) in his investigation of the sexual behaviour of the mentally retarded observed that individuals do not demonstrate such behaviour from having an unusually strong sexual impulse as some mistakenly believe. In addition he observed that such behaviour often stems from not having enough opportunities for appropriate sexual expression, ignorance of what is considered appropriate, inadequate social education and poorly developed or lack of self-control.

Gordon (1971) argued that staff attitudes about sexuality reflect family values, *formal sexual education and exposure to sexuality training*. These attitudes, then, affect how well they are able to understand and manage sexual behaviour by students. Staff members experience the same sexual hang-ups that plague the population at large and few have received sufficient instruction in sexuality training for clients. Neither professionals nor direct care staff can be expected by clients without intensive direct instruction in specialized techniques.

Morgenstern (1973) argued that staff or caregivers attitudes towards sexuality of clients with mental retardation are not as positive as they might be. Regardless of the amount of direct contact, many staff members, even well trained professionals, tend to reflect the general community perceptions and stereotypes. Research suggested that staff routinely discouraged all forms of sexual expressions, even masturbation in private (Carruth, 1973; Mitchel et al 1978) in Ludlow (1991). Some insist on high standards to preserve their own moral character, others to avoid liability in the event of injury or unwanted pregnancy. Many recognize sexual frustration as a major cause for adjustment problems in clients but are reluctant to recommend sexual expression or contact as an acceptable outlet or solution.

As long ago as 1975, Mulheren noted that a commitment to the principles of normalization encounters severe strains in the area of sexual behaviour. Some 67% of professional staff responding to Mulheren's survey felt that the sexual frustration played a significant part in the difficulties that mentally retarded people experienced. Mitchell's survey (1978) in Ludlow (1991) found that no sexual behaviour was acceptable amongst their adult clients. The Jay report (1979) found that 25% of hospital staff and 20% of hostel staff thought that adult clients should be discouraged from developing sexual relationships. According to Mulheren, it appears that many professional staffs are repressive in their attitudes.

Cornelius et al (1979) in Ludlow(1991) conducted a survey on staff attitudes towards sexuality and mental retardation. They determined that the sexual behaviour by clients who are labeled retarded is treated in programme

settings. Treatment may range on a continuum from indifference, to avoidance, to suppression, to resigned tolerance, to active encouragement. They further said that attitudes reflect both societal and individual attitudes, but also influence them, since they have a responsibility to educate both families and the public about the needs of people with retardation.

DeMyer (1979) in his survey noted that adolescents with mental retardation showed no drive towards sexual intercourse. Dewey and Everard (1974) reported that few sexual problems were observed amongst teenagers with intellectual impairments. DeMyer found that 63% were masturbating and that 6% of these were masturbating frequently all the time. He concluded by saying that many people with intellectual impairments have a sex drive and expresses it through solo masturbation like the majority of adolescents.

Some studies have also shown that staff attitudes may even create many of the problematic sexual behaviour exhibited by clients who are labelled mentally retarded. Those who view clients as sexually immature allow more physical contact at older ages, inadvertently arousing sexual feelings and establishing behaviour patterns that may result in misunderstandings or legal complications. Those who regard them as sexually deviant and incapable of learning appropriate behaviour tolerate unusual forms of sexual expression that lead to personal problems or social disapproval. And those who see them as objects rather than persons take advantage of them sexually, using positions of authority to abuse and exploit. Although lack of treatment and appropriate intervention may develop maladaptive sexual behaviour in people with mental retardation, it may also develop maladaptive sexual behaviour in people with mental retardation that interfere with healthy sexual development and make normal interpersonal relationships difficult if not impossible (Madock, 1974 in Ludlow, 1991:8).

Ames et al (1980) added that other members of staff question the morality of training social sexual skills when society provides few outlets for their use. Staff members also become defensive when asked to deal with sexuality

because they feel uncomfortable with the topic and unqualified to provide appropriate services.

Goffman (1980) in Sundram (1992) reviewed and investigated sexual activities that pose a risk of pregnancy, transmission of disease or infliction of injury to one of the participants. He learned that such cases were frightening to sound an alarm, particularly as the gravity of the risks of sexual conduct has risen dramatically with the spread of HIV infection. While there is some support in the literature for the proposition that people with mental retardation are at a greater risk of sexual abuse and exploitation at the hands of staff, care givers and family members than the general population, there is much less written about their abuse and exploitation by other programme participants.

However, Brantlinger (1983) explored the attitudes of both caregivers and parents. He said the findings on caregivers' attitudes are inconsistent. Those working with institutions often recognize that sexual activity exists, but they do not necessarily condone it. Group home staffs are generally more liberal and accepting institutional or nursing home staff. The variations in caregivers' responses may be partially explained by such factors as the setting in which the caregivers works, the selection and phrasing of questions asked of the caregivers and simple denial of the child's sexuality.

Murphy et al (1983) in their study found that the mentally retarded are more likely to commit sexual offences, while others found they were not. On comprehensive review of sex offenders found that approximately 10% to 15% of all sexual offences are committed by people with mental retardation, which is only slightly higher than the general population (around 9%). Another study found that almost 50% of incarcerated offenders with developmental disabilities and 34% of those living in the community had been convicted of sex offences (Gross, 1985) in Ludlow (1991). Research from Day (1997) in Ludlow (1991) found sex offences to be the second common crime among people with developmental disabilities and that sex offences are crimes for which most offenders with developmental disabilities are incarcerated.

According to Vitello and Soskin (1985) in Ludlow (1991) staff attitudes about mental retardation develop as a result of training and experience with people who are labeled mentally retarded. These attitudes influence their own interactions with individuals with retardation as well as the statements they make about mental retardation to others.

Mejuin(1992) in Mwanza (2000) revealed that generally adolescents without disabilities who are incarcerated, homeless or run away, involved in drug abuse or have had pregnancies during early adolescence are more likely to have a history of either physical or sexual abuse than other youths.

In Zambia for instance, child in crisis – YWCA show that out of 45 cases of defilement reported 7 girls had babies or were pregnant as a result of the abuse. Fourteen (14) were confirmed as having STDs. While the biggest problem that has arisen out of the sexuality is the HIV/aids pandemic and adolescents have not been spared worldwide (Hira et al, 1991 in Mwanza, 2000), *there is a definite correlation between HIV/aids and other STDs in direct proportion.*

Literature has also revealed that most perpetrators of sexual abuse reported at child crisis, 57% of girls were abused by people they knew; included fathers, brothers, uncles, brother-in-law and visitors. These are most insidious forms of sexual abuse and the most difficult to document. However, there is little literature in Zambia to document how much knowledge adolescents have and what their views are regarding sexuality and sexual abuse.

Ryan and McConkey (2000) argued that in general, staff are well disposed to their clients 'having sex education', are supportive of marriage, appreciate the need for privacy of sexual behaviour and are tolerant of masturbation. This seems to support the contention that attitudes among caregivers have become more liberal in recent years. However, it was also noted that this did not extend to homosexual activities and to people having one-night stunts. It is often the case that clients may find themselves having to adjust different staff attitudes even with the same staff team.

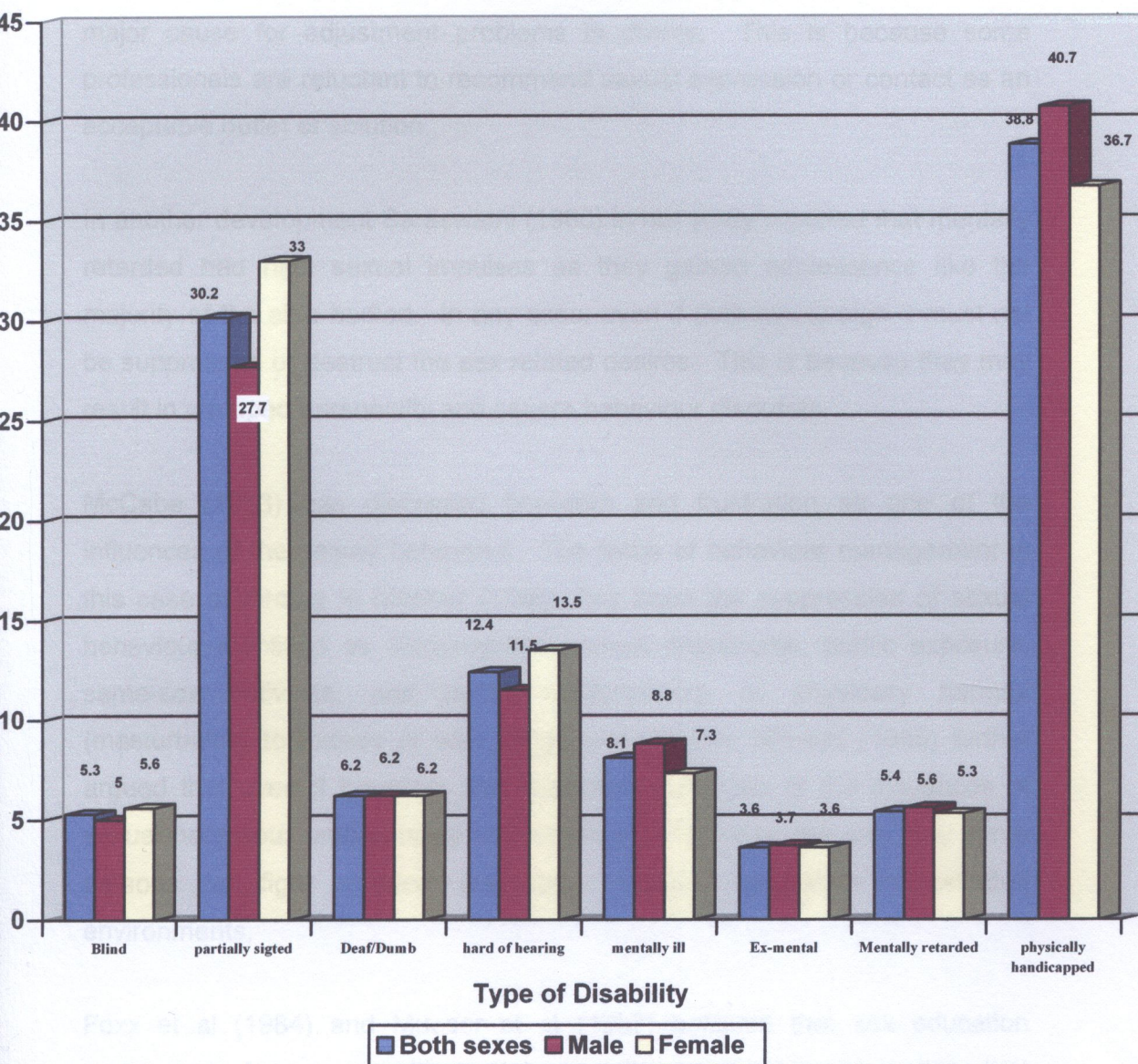
McCabe (2001) argued that many institutionalized individuals experience some sexual activity, though the range of behaviour is likely to be limited. This is mostly likely due in part to caregivers' suppression of the individual sexual expression.

In another development Saunder (2001) investigated staff member's attitudes toward the sexuality behaviour of the mentally retarded residents. Seventy five (75) staff members from four private residential facilities and four (4) mentally retarded adults were surveyed to elicit their attitudes towards the sexual behaviour and sexual knowledge of residents in their care. Facility policies and programmes applicable to resident's sexuality were also the subject of enquiry. He found that the sexuality of people with mental retardation in residential facility is a reality to practically everyone who works in this field, yet many seem to have found it more convenient to turn a blind eye to their sexual conduct because of society's discomfort towards the topic of sexuality.

In another development Betsey et al (2005) reported that an assessment on sexual consent of individuals with mental retardation examined the consensus of psychologists on specific criteria for sexuality. Randomly selected doctoral level members (N = 305) of the American psychological association completed a questionnaire regarding their opinions about various components of sexuality. Generally, it was reported that sexuality of mental retardation is a complex issue. The assessment identified basic sexual knowledge of the consequences of sexual behaviour and abilities related to sexual protection as integral to sexual capacity.

Muyenga (2005) reported that out of 256, 690 people with disabilities in Zambia, 121,077 (47.2%) were women facing challenges due to impairment, functional loss or disability. She said women with mental retardation 6, 267 have no resistance to sexual abuse. She said such women were offered nothing except sexually transmitted infections or HIV and aids.

Figure 1: Percentage Distribution of the disabled persons by types of Disability, Zambia 2000. (Central Statistics Office)



The distribution of disabled persons by type of disability is shown above in figure 1. The figures show that out of a total of 256,690 disabled persons in Zambia, 52.8% (135,613) percent are male and 47.2 (121,077) percent are female.

On the influences of the sexual behaviour of the mentally retarded, Goffman (1980) in Sundram (1992) and Murphy et al (1983) identified high sexual feelings as one of the factors influencing sexual behaviour. However, Goffman and Murphy did not consider other variables such as sexual frustration as a major cause for adjustment problems in clients. This is because some professionals are reluctant to recommend sexual expression or contact as an acceptable outlet or solution.

In another development Saraswathi (1980) in her study reported that mentally retarded had high sexual impulses as they gained adolescence like the majority of the able bodied. In any case, even if their sex is high it must not be suppressed or destruct the sex related desires. This is because they may result in cramped personality and severe behaviour disorders.

McCabe (1983) has discussed boredom and frustration as one of the influences of the sexual behaviour. The focus of behaviour management in this case according to Mitchell (1985), has been the suppression of sexual behaviour identified as inappropriate (sexual intercourse, public exposure, same-sex activities, and public masturbation) or physically harmful (masturbating to excess or with dangerous objects). Mitchell (1985) further argued that even if boredom and frustration were one of the influences of sexual behaviour unfortunately masturbation is too often the only way some persons can fight boredom and obtain sensory stimulation in restricted environments.

Foxx et al (1984) and Mueser et al (1987) believed that sex education programmes for persons with mental retardation is one of the innovations that professionals and parents expect to see in vocational training institutions.

Smith et al (1985) in McCabe (2001) said new innovations calls for sex education curricular for the mentally retarded. McCabe (2001) argued that many sex education programmes have focused on development of sexual skills, improvement of sexual knowledge, or in-depth education on one issue.

Many of these programmes lack the evaluation of assessment data necessary to determine their adequacy or efficacy for the mentally retarded

In addition the Technical Education, Vocational and Entrepreneurship Training (TEVET) Act No. 16 (1988) targets training to the element of gender imbalance. It provides access training opportunities to all the people in the community including the mentally retarded. The TEVET Policy does not have a policy statement on sexuality for the mentally retarded. People with mental retardation and related developmental disabilities, like all people, have inherent and basic human needs. These rights and needs must be affirmed, defended and respected. However, some evidence suggests that sex education lead to positive changes in behaviour modification and social skills development.

Rosen (2000) added that sex education programmes have traditionally focused on suppressing inappropriate behaviour instead of reinforcing appropriate expressions of sexuality. The vocational sex education curricular must enable all concerned to better support the development of the individual's whole sexual being.

Conclusively, the review of literature on sexuality and mental retardation as a major topic of professional discussion and public debate is a challenge. It is increasingly becoming the most evident area and growing problem. By the very nature of their handicap, they are always overlooked; their lives are controlled and directed. This is to say that not only do mentally impaired people need sex education and counseling but so too do the parents and the professionals, and the "over lookers". Their attitude must be examined and if necessary, undergo change if mentally retarded are ever going to have their sexual needs recognized and met.

CHAPTER THREE

3.0. RESEARCH METHODOLOGY

3.1. Introduction

The research focused on the study of the sexual behaviour of the mentally retarded students in vocational training institutions. Both qualitative and quantitative methods were used to study the sexual behaviour of the mentally retarded or intellectually impaired students.

On account of the subjective nature of sexuality, the research took qualitative stance for the most part. However, for reasons of validity, reliability and the production of a holistic view of the professionals, caretakers' and parents' experiences, the researcher found it more convenient to use interview schedules and more convenient questionnaires which were structured and unstructured. Qualitative data was used for qualification of the recorded sexual behaviour. The area of validation was helped by qualitative data.

The interpretation and detailed discussion of quantitative data was made easier by qualitative data. Qualitative interviews gave the opportunity to answer in its own way, where quantitative interviewing was not able to fully address the research.

In addition, the subject nature of sexual behaviour necessitated that the more value - laden qualitative narration be used to explain issues in greater depth.

3.2. Research Design

On account of the ability to collect data on subjects, a survey was chosen. In the study, a survey deals with the extent to

which sexual behaviour happens in vocational training institutions. It also provided a detailed description of the professionals, caretakers and parents' opinions of the prevailing conditions of the sexual behaviour in vocational institutions.

3.3. Population

The population comprised of professionals such as principals, vice-principals, Heads of departments, lecturers, caretakers such as hostel staff or matrons and parents of the mentally retarded students.

The rationale to select principals, vice principals, heads of department, lecturers, hostel staff and parents was that they are the first people to feel the impact of administering, teaching and being associated to students with mental retardation in vocational institutions. Furthermore, their experiences, views, beliefs and attitude on sexual behaviour for the mentally retarded would contribute to exploring and adding new knowledge to the existing body of knowledge on the sexual behaviour of the mentally retarded or intellectually impaired students in vocational institutions.

3.4. Sample Size and Sampling Procedure

In this research the researcher was concerned only with parents, professionals and caretakers such as hostel or matron staff. This was the total sample for the parents of the moderate or mildly mentally retarded, caretakers and professionals. The researcher used the term "moderate and mild mentally impaired" in this research as the one in common usage throughout the departments in vocational training institutions for the mentally retarded. The parents, professionals and all caretakers were spread across two (2) institutionalized and two (2) deinstitutionalized vocational training institutions in Ndola and Lusaka.

A convenience sampling was used to select the vocational institutions from which respondents were drawn to participate in the study. Convenience sampling was suitable because the audience was a captive one and participated for credit (Bless and Achola 1990). The researcher took all cases on hand until the sample reached the desired size. This is because there are only few special vocational institutions, professionals, caretakers and parents of the mentally retarded students. The respondents came from the following institutions: National Vocational Rehabilitation Centre (NVRC) in Ndola, Holy Family School for Children (Ukubalula training centre, Misundu, Ndola), Lusaka Business and Technical College (LBTC) and Bauleni Street Kids Centre. The classification of the participating institutions was based on whether the institution was institutionalized (segregated) and deinstitutionalized (inclusive) in the two towns.

The professionals such as the principals, vice principals or training managers and Heads of departments were ten (10), Ten (10) hostel staff or caretakers, twenty (20) parents and twenty (20) lecturers. They were all drawn from the four institutions respectively. The total number was sixty (60).

In each institution, all the participating respondents were associated with the mentally retarded students.

3.5. Research Instruments

Lecturers Questionnaires

The structured and unstructured questionnaire was used for lecturers. The questionnaire consisted of two parts all with 13 questions. The first part had the checklist responses. The mode of checklist responses consisted of questions which sought information sex, type of institution, specialization, age, length of service, highest professional qualification and size of class one handles.

The second part of the questionnaire, fill-ins was used to determine teachers or lecturers views on sexual behaviour. This required the lecturers to discuss their own opinions on the sexual behaviours of the mentally retarded students. The structured questions captured quantitative data. It was economical in terms of time and financial resources reliable because of its reliability and encouraged confidentiality in terms of freedom and opportunity to express their views. Its disadvantages included being a problem to some respondents on fill-ins, filled in more quickly than usual.

3.6 Professionals, Caretakers and Parents Interview Schedules

Semi-structured interview schedules obtained information on sex of respondents, specialization, age, educational qualifications, work experiences, personal opinions on the sexual behaviour of the mentally retarded adolescents. The interview schedules were individually set, meaning that the professionals such as the principals, vice-principals or training managers and Heads of department had one interview schedule. The hostel or matron staff had their own interview schedule which elicited for more information on the sexual behaviour of the mentally retarded in the hostels.

Parent's interview schedule was more on relationship, tolerance, promotion of sexual development, experience of confusion towards sexuality and mental retardation.

On average three to four people were interviewed each day. Interviews had the advantage of allowing the respondents to express their opinions more clearly. A lot of flexibility was exercised with regard to the participant's choice of time, venues and content of the interviews. The researcher equally had the opportunity of probing and seeking clarification on issues raised

during interviews. One weakness of interviews however, was that a lot of time was wasted on unplanned issues when additions were allowed. The use of probing questions provided convergent validity, which made the data collected reliable.

3.7 Pre-Testing of Research Instruments

The instruments were not pre-tested. However, verbal questions and discussions were done before collecting data in two institutions (Institutionalized and deinstitutionalized) at National Vocational Rehabilitation Centre and Lusaka Business Technical and College. These vocational institutions were chosen because of their involvement with mentally retarded students. The verbal testing and discussions were aimed at establishing the internal consistency of the questions. Furthermore, because of limited institutions, it was directed at finding out whether items in all the instruments were measuring what was intended to be captured in the study. The verbal questions and discussions ensured clarity and provided an opportunity to design probing questions or statements.

3.8 Sample

The sample comprised of twenty (20) lecturers, twenty (20) parents, ten (10) hostel staff or caretakers and ten (10) administrators. The total number was sixty (60). They represented a captive of the total population of lecturers, parents and administrators in study training institutions. A Convenience sampling was used to select the vocational training institutions from which respondents were drawn to participate in the study. Convenience sampling was suitable because the audience was a captive one and participated for credit. (Bless and Achola 1990). The researcher took all cases on hand the sample reached the desired size. This is because there are only few vocational training institutions, professionals, caretakers and parents of the mentally retarded students.

3.9 Data Collection Procedure

Data was collected during the first term of the institutional calendar, which is from January to May. However, actual collection of data could not be done until the month of February, 2006, because professionals and service providers were now free to participate in the study after the busy schedule of recruitment of first year students in January.

The questionnaires and interview schedules were administered after class time. This arrangement was free for lecturers and not with hostel or matron staff. The hostel staff was not free as anticipated due to constant interruptions. Lecturers were allowed to complete the questionnaire during their free time. Before the questionnaires were completed, lecturers were given instructions on how to complete them. These included a checklist and fill-ins which provided responses on spaces provided on the questionnaire.

To ensure Anonymity and confidentiality lecturers were advised not to write their names on the questionnaires. The same was done with interview schedules for parents, professionals and hostel staff. This helped to minimize fears of victimization and promoted honest responses from respondents.

Interviews took a long period: 40 to 60 minutes at times with interruptions from workmates. With parents at home, interruptions came from their children and relatives. Some parents did not dare to express the more gloomy side of the sexual behaviour of their children. At the time of interview it was discovered that there were few hostel and lecturers in the special vocation department. Therefore, it was apparent that views from the former hostel staff and lecturers from the institutions on study were necessary.

3.11 Data Processing and Analysis

All the quantitative data collected using the lecturers questionnaire was cleaned and coded. The interruption of quantitative data involved the use of frequencies and percentages.

Further, data was cleaned by running frequency tables for the various facts to rule out errors and inconsistencies. Finally, the data from professionals, caretakers and parents was analyzed and presented as cross tabulations between the factors being investigated and the opinions, beliefs and attitude expressed by the respondents. This means the qualitative data collected was transcribed from the field notes and subjected to thematic analysis. It is presented in form of document analysis in which data was examined closely by the main emerging themes.

3.11 Constraints encountered during field work

The lack of books and dissertations in Zambia on the subject of sexual behaviour of the mentally retarded students made it extremely difficult to compare what others have done on this significant topic in the field of mental retardation.

The lack of records of house numbers of the parents of the mentally retarded students was rather awkward. The tracing of these subjects was tedious and slow. Further to this, poor town planning and lack of civil authority maps of unplanned townships made it extremely difficult for the individual households to be located. The absence of street names and house numbers concerned were a case in particular.

Some parents and hostel staff were shy to express their opinions because of traditional values and beliefs even if the interviews were not tape-recorded. At first the researcher

wanted to tape-record the interviews but the topic of sexual behaviour was rather sensitive.

During interviews with principals, vice-principals and heads of department, their responses given to certain questions were exaggerated perhaps done to impress the researcher.

There are few vocational training institutions for the mentally retarded, professionals or service providers who are experts in special vocation in Zambia and thus the researcher involved the few four (4) lecturers and three (3) hostel staff who are former employees in the special vocational department. In this regard the convenience sampling consumed a lot of time because the researcher had to wait even for other participants who were on leave.

Limited financial resources made the work extremely difficult for planning and efficient data collection. For example, the researcher was self-sponsored and as such incurred heavy transport costs to and from vocational training institutions. The other heavy costs were on the payment of transport allowances to 10 out of 20 parents who came to National Vocational Rehabilitation and Holy family centre.

CHAPTER FOUR

FINDINGS OF THE STUDY

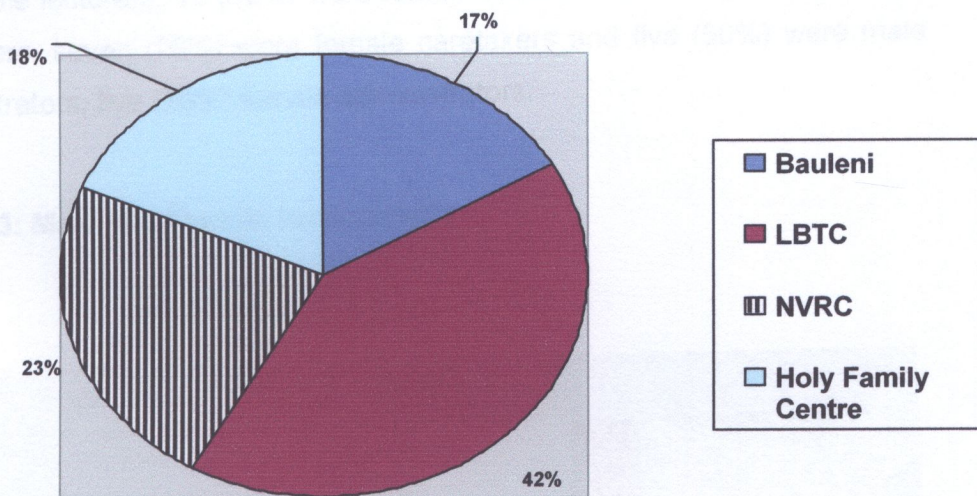
The findings of the interviews and questionnaires conducted to explore the significant and highly charged contemporary sexual behaviour of the mentally retarded in Lusaka and Ndola district of vocational training institutions are presented.

4.2.0. Socio-economic background

4.2.1 Location of respondents

Figure 2: Respondents and their Institutions

n = 60



Bauleni Street Kids Centre had 10 (17%) respondents, Holy Family for Children (Ukubalula Training Centre) had 11(18%), National Vocational Rehabilitation Centre 14(23%), Lusaka Business and Technical College had the Highest 25(42%).

4.2.2 Sex of Respondents

Table 1: Status of Respondents

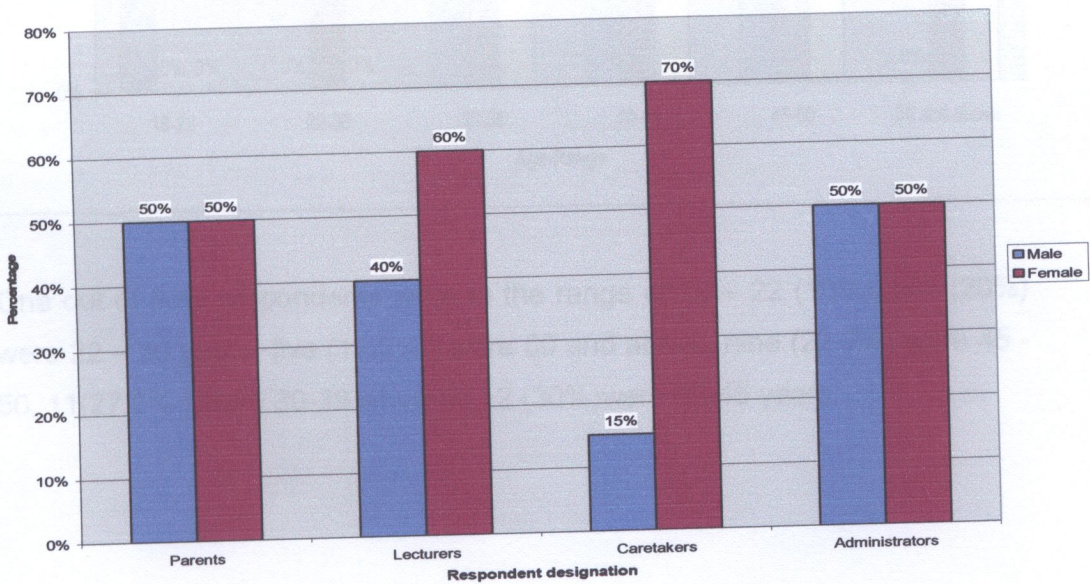
n = 60

Respondents	Responses		
	Male	Female	Total
Parents	10(50%)	10(50%)	20(100%)
Lecturers	8(40%)	12(60%)	20(100%)
Caretakers	3(15%)	7(70%)	10 (100%)
Administrators	5(50%)	5(50%)	10(100%)
Total	26(43.3%)	34(56.7%)	60(100%)

10 (50%) were male parents, 10 (50%) were female parents, Eight (40%) were male lecturers, 12 (60%) were female lecturers, three (15%) were male caretakers, seven (70%) were female caretakers and five (50%) were male administrators, five (50%) female administrators.

Figure 3: Male and Female respondents

n = 60

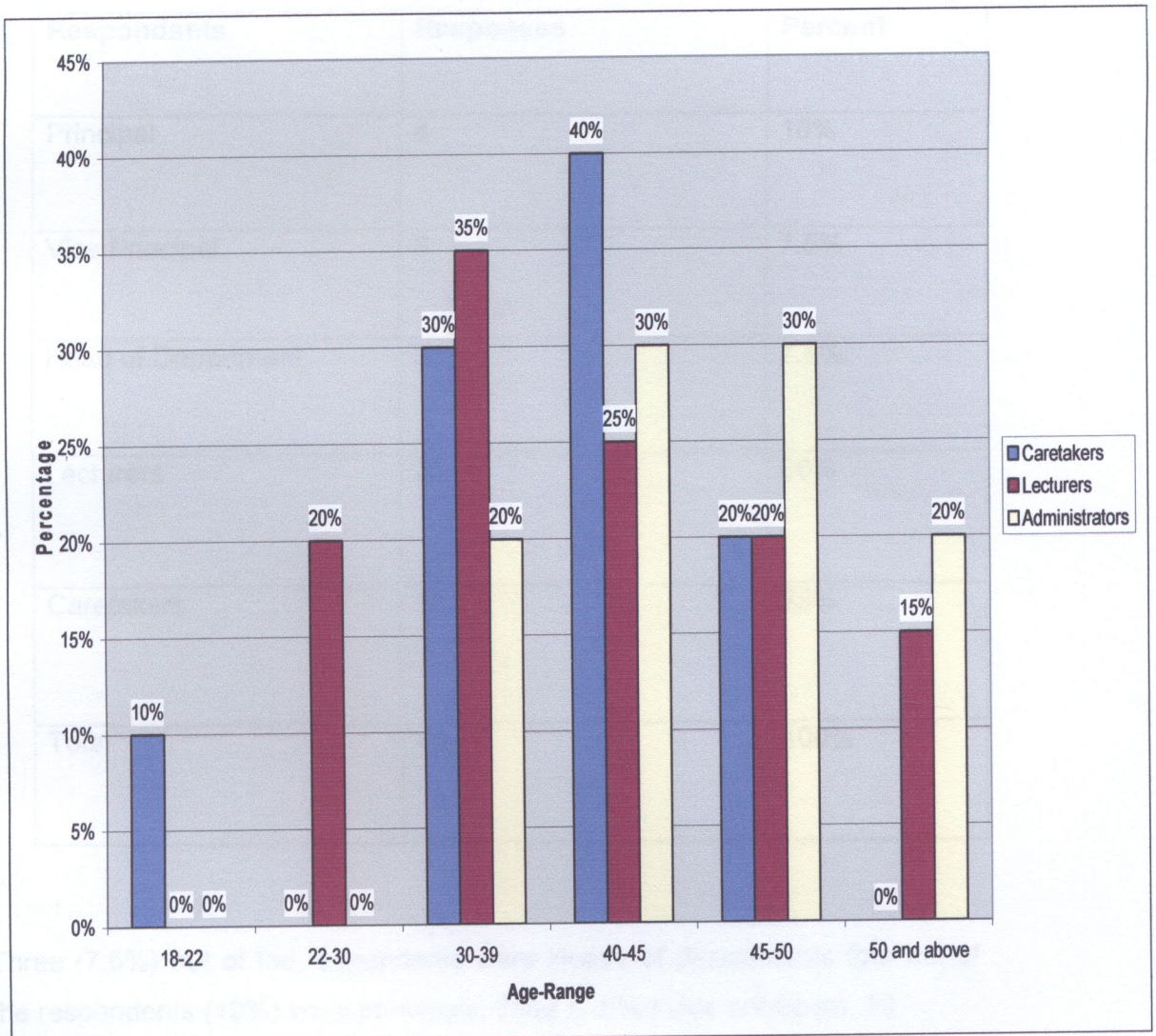


There were 26 (43.3 %) male and 34 (56.7 %) female.

4.2.2 Age of Respondents

Figure 4: Showing ages of respondents

n=40



One out of forty respondents were in the range of 18 – 22 (10%), two (20%) were 22 – 30 years, five (12.5%) were 50 and above, nine (22.5%) were 45 - 50, 11(27.5%) were 30-39 whereas 12 (30%) were 40-45 years.

4.2.4 Position in the institution

Table 2: Showing respondents' position in the institution

n =40

Respondents	Responses	Percent
Principal	4	10%
Vice Principal	3	7.5%
Head of Department	3	7.5%
Lecturers	20	50%
Caretakers	10	25%
Total	40	100%

Three (7.5%) out of the respondents were Heads of departments four out of the respondents (10%) were principals, three (7.5%) vice principals, 10 (25%) were hostel staff whereas 20 (50%) were lecturers.

4.2.5 Experience of respondents in handling the mentally retarded

Figure 5: Respondents' length of service in handling mentally Retarded

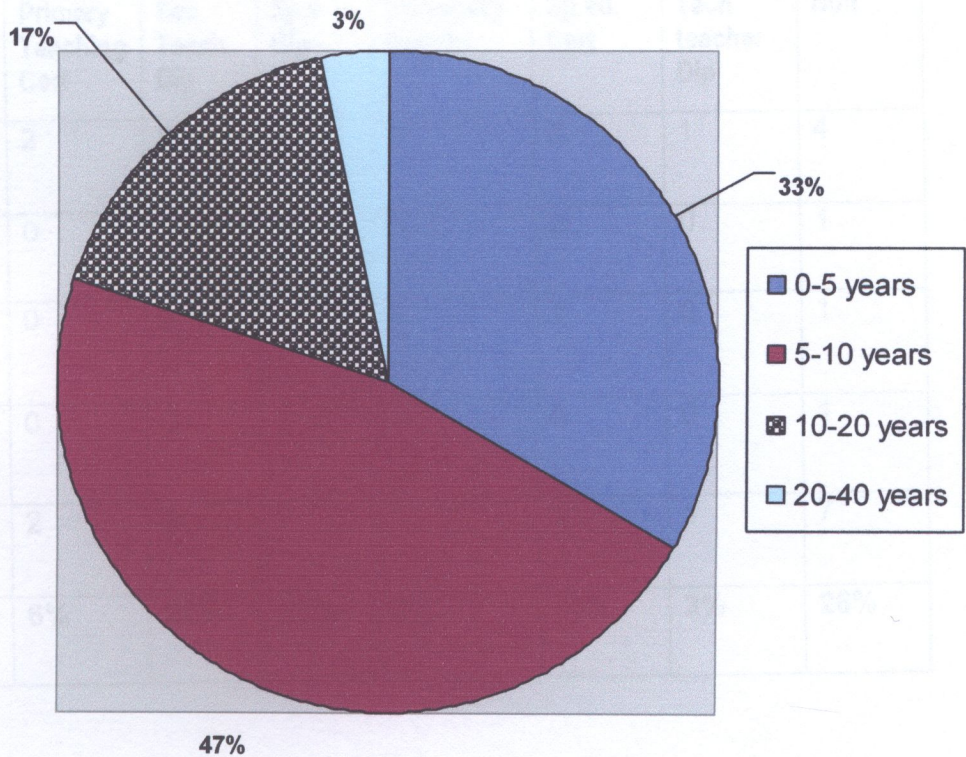


Figure shows the experience of respondents in handling mentally retarded in special vocation. 10 (33%) out of 30 had 0-5 years handling experience for the mentally retarded, 14 (47%) 5-10 years, five (17%) 10-20 years and one (3%) 20 - 40 years.

The majority of Administrators and lecturers had handled mentally retarded served for a period of 5 – 10 years.

4.2.6 Latest professional qualifications

Table 3: Respondents' professional qualifications

n =30

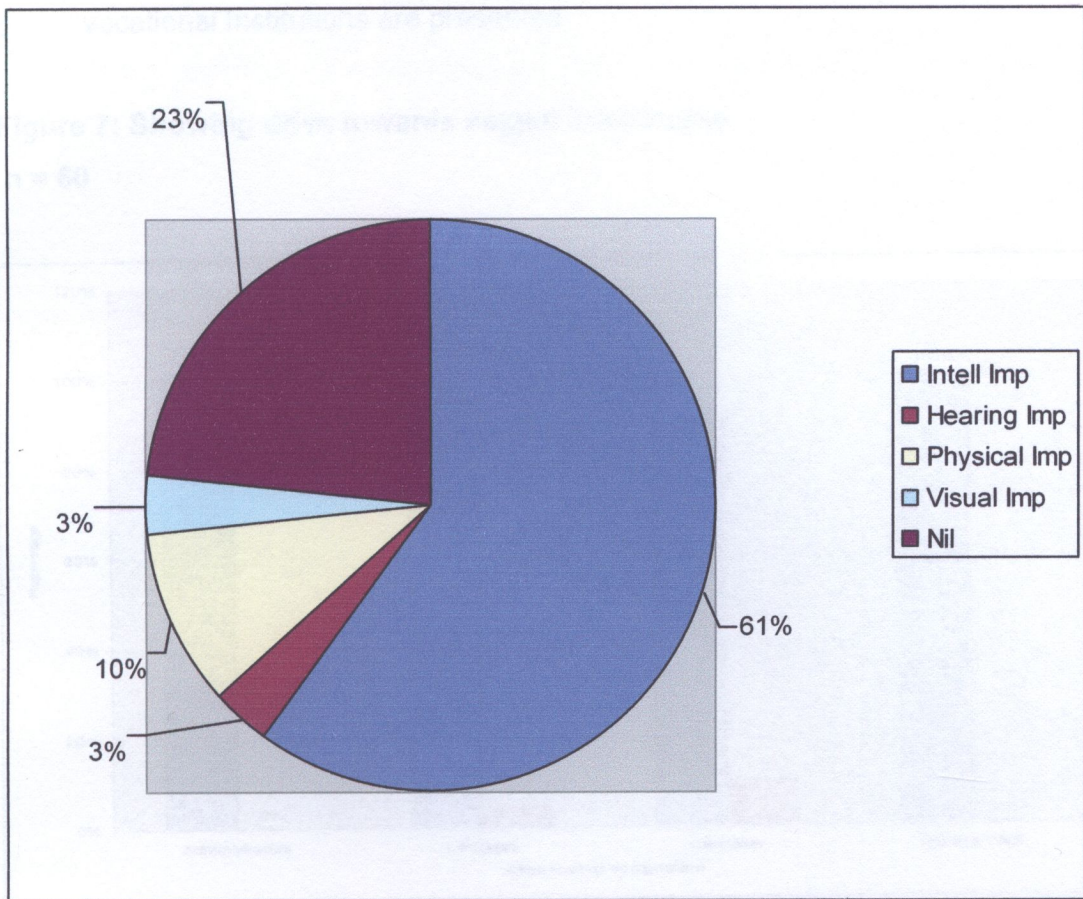
Respondents	Primary Teaching Cert	Sec Teach. Dip	Sp.v Dip	University Degree	Sp.ed. Cert	Tech teacher Dip	Non
Lecturers	2	8	3	0	2	1	4
HOD	0	1	1	0	0	0	1
Principal	0	0	1	1	1	0	1
Vice principal	0	0	2	0	0	0	1
Total	2	9	7	1	3	1	7
Total Percent	6%	29%	23%	3%	10%	3%	26%

Of the 30 respondents, one (3%) had technical teacher diploma, one (3%) sp.ed., certificate, one (3%) university degree, two (6%) were in possession of primary teacher certificate, three (10%) seven (23%) have been trained in sp.vocation, seven (26%) had non whereas nine (29%) had Sec Teacher Diploma.

4.2.7 Field of Specialization

Figure 6: Respondents' and field of specialization

n = 30



Out of 30 respondents, one (3%) were specialised in visual impairment, one (3%) Hearing impairment, three (10%) in physical impairment, seven (23%) had no speciality whereas 18 (61%) were specialised in intellectual impairment.

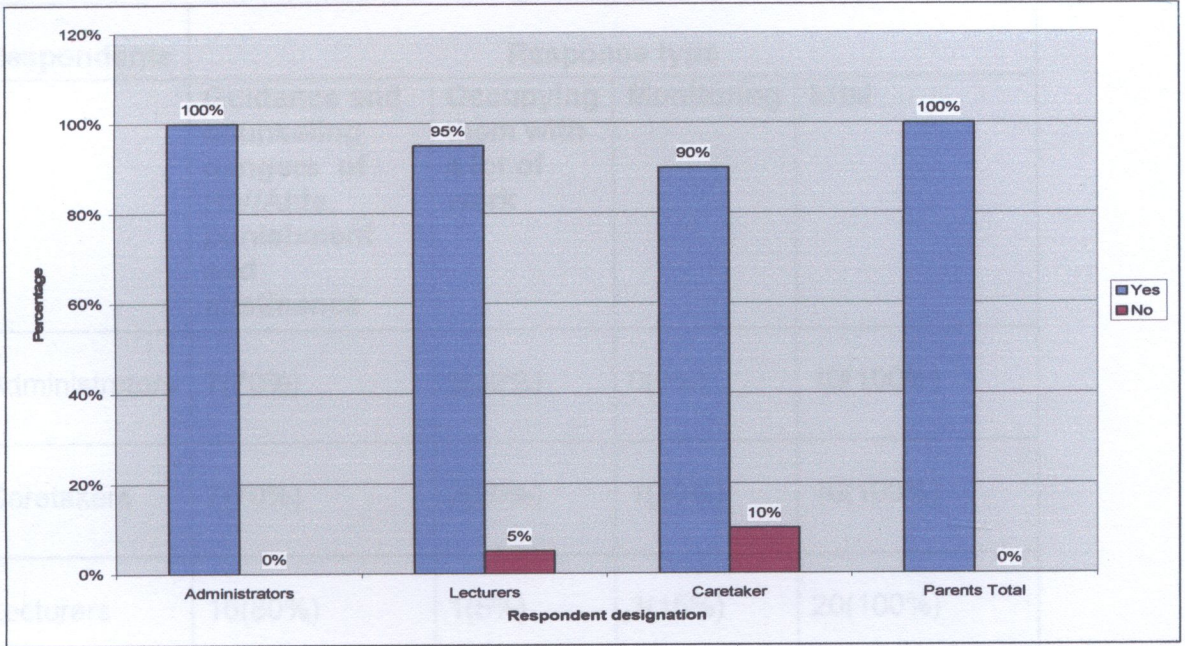
4.2.8 Views on sexual Behaviour

In this section views of respondents on sexual behaviour in the vocational Institutions are presented

Table 4: Dealing with the sexual impulses for the mentally

Figure 7: Showing drive towards sexual intercourse

n = 60



When asked whether mentally retarded students show drive towards sex, the respondents gave various responses.

Figure above shows, 20(100%) of parents, 10 (100%) of administrators, 19 (95%), of lecturers and nine (90%) percent of caretakers felt that mentally retarded students showed drive towards sexual intercourse. One (5%) of the lecturers, and two (10%) caretakers nevertheless, said that mentally retarded didn't show drive towards sexual intercourse.

4.2.9 The mentally retarded learning to deal with increasing sexual Impulses

Table 4: Dealing with the sexual impulses for the mentally Retarded
n=40

Respondents	Response type			
	Guidance and counseling dangers of HIV/Aids, punishment and abstinence	Occupying them with a lot of work	Monitoring	total
Administrators	7(70%)	3(30%)	0(0%)	10(100%)
Caretakers	7(70%)	2(20%)	1(10%)	10(100%)
Lecturers	16(80%)	1(5%)	3(15%)	20(100%)

16(80%) said that guidance and counselling on dangers of HIV/AIDS, two (20%) of caretakers felt that occupying them with a lot of work was the best option. Seven (70%) of caretakers were in support of guidance and counseling while three (15%) supported occupying students with a lot of work and one (10%) of the minority indicated the monitoring of the mentally retarded.

4.3.0 Trained on how to handle sexual behaviour for the mentally retarded

Table 5: Handling sexual behaviour

n =60

Respondents	Responses		
	Respondents who said yes	Respondents who said No	Totals
Caretakers	0 (0%)	10(100%)	10(100%)
Parents	0(0%)	20(100%)	20(100%)
Administrators	0(0%)	10(100%)	10(100%)
Lecturers	6 (35%)	14(70%)	20(100%)

The table above shows that six (35%) of lecturers had few workshops on sexual behaviour, 10 (100%) of parents, 10 (100%) of Administrators, 14 (70%) of lecturers and 20 (100%) of parents indicated that they were not trained on how to handle sexual behaviour for the mentally retarded.

4.3.1 Comfortable to discuss sex

Table 6: Discuss sexual behaviour for the mentally retarded

n = 20

Response type	No of respondents	Percent
Traditional and customary value	9	45%
Belief of epilepsy	1	5%
Growing need of sex and facts of life- HIV/aids, STIs, abuse and pregnancy's	10	50%

One out of 20 parents (5%) said they were hampered with the belief of epilepsy not do discuss sex, nine (45%) believed in traditional and customary values and 10 (50%) were comfortable to discuss sex.

4.3.2 Sexual behaviour is unhealthy, hurtful or illegal

Table 7: The sexual behaviour of the mentally retarded

n=30

Respondents	Response Type			Totals
	Hurtful	unhealthy	Illegal	
Lecturers	4 (20%)	11 (55%)	5 (25%)	20 (100%)
Administrators	2 (20%)	5 (50%)	3 (30%)	10(100%)

Four (20%) lecturers reported that the sexual behaviour of the mentally retarded was hurtful and most of the administrators three (30%) felt that it was illegal, two (20%) of the administrators felt hurtful, while five (25%) said the sexual behaviour was illegal. The majority of Administrators five (50%) and 11 (55%) felt that it was unhealthy.

4.3.3 Influences of Sexual behaviour of the mentally retarded.

Table 8: Opinions on the influences of the sexual behaviour
n =30

Respondents	Response Type			Totals
	Sexual feeling	Peers	Boredom	
Lecturers	9 (90%)	0	1 (10%)	10 (100%)
Administrators	11 (55%)	5 (25%)	4 (20%)	20(100%)

In this part of the study, most lecturers nine (90%) said the influences of the sexual behaviour of the mentally retarded was due to sexual feelings while four (20%) of administrators and one (10%) lecturers favoured boredom/frustration. 11 (55%) of administrators were in agreement with lecturers on sexual feelings. However, five (25%) of administrators felt peers influenced the sexual behaviour of the mentally retarded.

4.3.4 Suppressing inappropriate behaviour instead of reinforcing appropriate expressions of sexuality for the mentally retarded.

Table 9: The suppression of inappropriate behaviour
n =20

Respondents	Response Type			Total
	Telling them to wait till they finish their course	Tell them no sex before marriage	Keeping them busy and discourage all forms of sexual expression	
Administrators	3(30%)	5(50%)	2(20%)	10(100%)
Caretakers	5(50%)	5(50%)	0	10(100%)
Total	8	10	2	20(100%)

Table 9 above shows that out of 20 (100%) respondents, two (20%) said they kept the mentally retarded students busy and discouraged all forms of sexual expression, eight (45%) told the students to wait until they finished their course whereas 10 (50%) said no to sex before marriage.

4.3.5 Vocational Setting

Table 10: The respondents identified the best vocational setting

n = 30

Respondents	Response type		
	Segregated	Unsegregated	Total
Lecturers	2(10%)	18(95%)	20(100%)
Administrators	0	10(100%)	10(100%)
Total	2(10%)	28(90%)	30(100%)

Two of the respondents said segregation was the best way of controlling sexual behaviour whereas 28(90%) supported unsegregated setting.

4.3.6 New innovations for the future of the mentally retarded in vocational institutions.

Table 11: Showing new innovations for the future

n=40

Respondents	Response type			Total
	Sex education	Post training for vocational employment	Social sexual and adaptive skills	
Lecturers	16(80%)	2(10%)	2(10%)	20(100%)
Caretakers	6(60%)	1 (10%)	3 (30%)	10(100%)
Administrators	4(40%)	2 (20%)	4 (40%)	10 (100%)
Total	26(65%)	5(12.5%)	9(22.5%)	40(100%)

Out of the 40 (100%) respondents, 26 (65%) indicated sex education as new innovations for the future, five (12.5%) favoured post-training for vocational employment and nine (22.5%) pointed out social sexual and adaptive skills.

CHAPTER FIVE

5.0 DISCUSSIONS

Principals, vice principals, Heads of Departments (Administrators), Lecturers, Caretakers and Parents Views on Sexual Behaviour for the mentally Retarded in Vocational Institutions are discussed.

5.1. Discussion of the Findings

It is evident from the results that the sexual behaviour of the mentally retarded in Vocational training Institutions is a reality to practically everyone who works in this field. The professionals who work in this field said it plainly that the mentally retarded students have inappropriate sexual behaviour. Inappropriate sexual behaviour may include touching, grabbing, stripping, fondling or actual attempts of intercourse.

These findings were consistent with those of Gatton (1909) and Goddard (1920) in Ludlow (1991), McCabe (1993) and Bouras (1999) which observed that mentally retarded have a sexual inappropriate behaviour. In addition, the findings were also in agreement with Harris' (1995) study which found that the sexual behaviour for the mentally retarded was a challenge to all service providers.

On the other hand, Davis (2004) observed that individuals with mental retardation do not demonstrate such behaviour from having an usually strong sexual impulse as some mistakenly believe. In addition he observed that such behaviour often stems from not having enough opportunities for appropriate sexual expression, ignorance of what is considered appropriate, inadequate social education and poorly developed or absent self-control.

The mentally retarded in the study lacked the support of parents and service providers to accept the reality of the expression of sexual needs. In addition to understanding their right to express their sexuality through solo masturbation, touching, grabbing, stripping, fondling and hyper sexuality, in the dignity of privacy, the parents and service providers have to accept that it is their task to teach them to use those rights responsibly, teaching the relevance of time and place.

Parents and service providers in the study area therefore preferred training in the appropriate expression of sexuality. People with mental retardation need training to help them behave appropriately in our society that is tightly constrained by unspoken rules that govern the behaviour of people whose bodies are sexually mature.

On the question whether mentally retarded adolescents show drive towards sexual intercourse: The parents and family presentations and discussions reflected their own personal experiences. It is important to point clearly that although it was sensitive to interrogate them on the sexual behaviour, probing questions and discussions helped to derive their experiences. They reported that their children show drive towards sexual intercourse. They were also concerned for their children's well being although it was difficult sometimes to realize the true extent of their situation. On the other hand they felt that they were too traditional to discuss sex with their children. As a result of Zambia's society's discomfort with the topic of sexuality of people with mental retardation, there has been relatively no one to interview them on the topic.

However, when asked whether they discuss sexual behaviour for the mentally retarded, they said, they were engrossed with traditional and customary value, although some indicated the

growing need of sex and facts of life – HIV/aids, sexually transmitted Infections (STI's), abuse and pregnancies.

Two parents had this to say:

Parent 1 ***“Even if it is difficult to be open to my son to discuss sex, I try to say something. My son is impotent and fears his growing need of sex even if he cannot erect, he can be abused.”***

Parent II ***“I discuss sex with my epileptic daughter and tells her the belief of epilepsy. If she sleeps with a man, she cannot heal from epilepsy according to our Bemba tradition. She just needs to control her sexual impulse.”***

The above revelations are in line with McCabe (1993) who confirms that attitudes of parents and families are influenced by concerns for the child's well being, lack of knowledge about how to provide sex education, and simple denial of the child's sexuality. In addition O'Mahony (1997) in Saraswathi (2002) says adolescent years are a particularly difficult time for all teenagers, but worse for the teenager with a mild or moderate intellectual disability. Generally, some adolescents' problems are more acute than others and they may have longstanding consequences.

Kapungulya (2000:40) argued that, Parents traditional belief does have a bearing on the emotional adjustment. In addition Bronfenbrenner (1979) and Max (1985) in Kapungulya (2000) whose works emphasise that factors such as the ethnic background and belief system of a particular group exerts an influence on the way the family reacts to the child's disability. Ludlow (1991) argued that even though tradition has a direct bearing on sexuality, attitudes of individuals towards the sexual behaviour of the mentally retarded determine how sexual

behaviour by clients who are labelled retarded is treated in programme settings.

With regard to the opinions of the professionals on the sexual behaviour of the mentally retarded in vocational training institutions; the professionals' revealed that while it was evident that the mentally retarded students had high sexual desires despite their retardation, it will be imperative to deal with the sexual impulses for the mentally retarded.

Two caretakers explained the sexual intercourse this way:

Caretaker I *"Each time I found two students (Male and Female) in the thorn bushes near the hostel; I did not know how to report to administration."*

Caretaker II *"High sexual feelings, imaginations and what they see from able-bodied friends, even films they watch influences their sexual behaviour."*

Two special vocation lecturers said the following:

Lecturer I *"Their sexual behaviour is unhealthy because they are unable to use condoms when having sex"*

Lecturer II *"It is unhealthy because they can contract sexually transmitted infections and HIV/Aids."*

The sexual impulses pose a risk for unwanted pregnancy, sexually transmitted infections (STI's), HIV/aids and sexual abuse. The professionals in the study believed that guidance and counseling played a pivotal role in the above risks. Sorensen (1972) agreed that Guidance and Counselling on the dangers of all sexual risks must be done earlier because by age 19 years both male and female report that they have experienced full sexual intercourse. Therefore, the

administrators in the study also recommended sex education curricular for the mentally retarded. This will help them normalize severe strains in the area of sexual behaviour.

Gordon (1971) is in agreement with these findings, he states that staff attitudes about sexuality reflect family values, formal sexual education and exposure to sexuality training. This means that the attitudes affect how well they are able to understand and manage sexual behaviour by students.

On the other hand, the findings were inconsistent with those of Maddock (1974) who disagreed that staff attitudes towards the sexuality of clients with mental retardation are not as positive as they might be. Even well trained professionals tend to have a negative attitude towards the sexual behaviour of the mentally retarded students.

The difference in the way staff attitudes towards the sexuality of students with mental retardation reflected was due to inadequate direct instruction in specialised techniques. In other words, when staff attitudes toward sexuality and mental retardation are combined, conflicts may result. Those who recognise the sexual needs and abilities of clients with retardation may doubt their cognitive understanding and behavioural control. Others who develop the adaptive skills of mentally retarded in areas of independent living and vocational skills may hesitate to develop their sociosexual skills if training is not consistent with their own sexual beliefs. Such conflicts lead to inconsistent or inappropriate treatment practice that serves the needs of staff better than the needs of clients.

On the Identification of factors influencing the sexual behaviour of the mentally retarded in vocational training institutions; it is apparent from the evidence presented that high sexual feelings

influenced the sexual behaviour of the mentally retarded. This study seems to support the contention of Goffman (1980) in Sundram (1992) and Murphy et al (1983) that high sexual behaviour was frightening to sound an alarm, particularly as the gravity of the risks of sexual conduct has risen dramatically with the spread of HIV infection.

In another development Coley and Marler (1987) pointed clearly that people with mental retardation have the same rights and needs to enjoy their sexuality as anyone else, and should have the same right to marry or cohabit as anyone else.

Butler (2000) added that the sexual activity of the mentally retarded challenges our cultural, moral and ethical morals both as individuals and as a community. She further stated that, it is only in the recent past that specialized services, and to a lesser extent mainstream services have realized that regardless of a person's developmental disability, sexual development and expression are inherent to the existence and growth of human beings.

However, Shulz and Adams (1987) in McCabe (1993) showed that most adolescents' needs were currently unmet in the area of sexuality. They recommended sex education, appropriate means of sexual expression which should be addressed in sex education curricula for this population.

On the issues of Professionals' and parents' expectations of the sexual behaviour of the mentally retarded in vocational institutions; the professionals and parents revealed that they expected sex education, Post training for vocational employment, and social sexual and adaptive skills in vocational training institutions. They said sex education will teach appropriate means of sexual expression, and the ramifications

of inappropriate expression must be addressed in the vocational curricula.

One head of department who happens to be untrained said the following:

“To increase capacity of life skills, seminars, workshops and training on how to handle the sexuality of the mentally retarded.”

The study is consistent to Foxx et al (1984) and Mueser et al (1987) who believed that sex education programmes for persons with mental retardation lead to positive changes in behaviour modification and social skills development.

Hinsberger (1988) added that successful sex education programmes would focus on respect for the client's history, improved knowledge and attitude change assessment of the individual's home environment and increased autonomy for the individual. Parents, professionals and caregivers should be included in the programme. This implies that thorough needs and knowledge assessment should also be completed. Programmes should be personalized in order to meet individual needs. Until adequate programmes are developed, the sexual rights of individuals with developmental disabilities cannot be fully met.

However, Rosen (2000) noted that programmes have traditionally focused on suppressing inappropriate behaviour instead of reinforcing appropriate expressions of sexuality. Therefore, the vocational sex education curricular must enable all concerned to better support the development of the individual's whole sexual being.

CHAPTER SIX

6.0 CONCLUSION

The study showed that the sexual behaviour of the mentally retarded in vocational training institutions is a reality to practically everyone who works in this field. It appears that they show drive towards sexual intercourse and yet professionals and parents do not know how to handle their sexuality. Parents in particular were uncomfortable to discuss sex because of traditional and customary values. In this case they suppressed the inappropriate sexual behaviour of the mentally retarded and transferred the responsibility for training to professionals.

The study also revealed that parents and professionals or service providers were not trained on how to handle the high sexual feelings of the mentally retarded which influenced the sexual behaviour despite their retardation. and the sexual impulses posed a risk for unwanted pregnancy, sexually transmitted infections (STIs), HIV/aids and sexual abuse. However, parents and service providers' expectations of the mentally retarded in vocational institutions were sex education, post training for vocational employment, and socio-sexual and adaptive skills in vocational training institutions.

6.1. RECOMMENDATIONS

In view of the findings and conclusions, the following recommendations are proposed:

1. Service providers, caregivers, and parents should be trained on how to handle the sexuality of the mentally retarded.
2. All vocational training institutions should provide sex education which calls for an extensive amount of programme development in the area of sexual health to avoid placing persons with

retardation at increased risks for unwanted pregnancy, sexually transmitted diseases (STDs), HIV/Aids and sexual abuse.

3. The Ministry of Science, Technology and Vocational Training, Parents, service providers, local communities, non-governmental organisations and line ministries should work together in ensuring the success of the provision of sex education as well as the appropriate means of sexual expression and the reinforcement of inappropriate expression at the right time.
4. The Ministry of Science Technology and Vocational Training and other line ministries should include a clause within their policies to address the sexual behaviour of the mentally retarded.

6.2. FUTURE RESEARCH

A research on the views of the community, medical personnel, mentally retarded students and non handicapped students in the districts would be a worthwhile contribution to the existing knowledge on the sexual behaviour of the mentally retarded in the vocational training institutions.

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APPENDICES

Appendix A:

LECTURERS VIEWS ON SEXUAL BEHAVIOUR OF THE MENTALLY RETARDED IN VOCATIONAL TRAINING INSTITUTIONS

QUESTIONNAIRE

This questionnaire is to be completed by lecturers involved in Special Vocational Institutions and Departments.

SECTION ONE: Socio-Economic Background

Tick in the box of your choice

1. Is your institution
(a) Segregated
(b) Unsegregated

2. What is your specialization?
(a) Fashion design and tailoring
(b) Food and beverage
(c) Weaving and Textile
(d) Mixed Farming
(e) Basketry

3. What is your sex?
(a) Male
(b) Female

4. How old are you?
(a) 22-30
(b) 30-39
(c) 40-45
(d) 45-50
(e) 50 and above

5. How long have you been teaching in special vocation?

- (a) 0 - 5
- (b) 5 - 10
- (c) 10 - 15
- (d) 15 - 20
- (e) 20 and above

6. What is your highest professional qualification?

- (a) Primary Teacher Certificate
- (b) Secondary Teacher Diploma
- (c) University Degree
- (d) Higher University Degree

7. Are you trained in Special Vocation or Education?

- (a) Yes
- (b) No
- (c) Undecided

8. If your response in 7 is yes, what is your field of specialization?

- (a) Intellectual Impairment
- (b) Hearing Impairment
- (c) Physically Impairment
- (d) Visual Impairment

9. What is the size of your class?

- (a) 1 - 10
- (b) 10 - 20
- (c) 20 - 30
- (d) 30 - 40

SECTION TWO: Views on Sexual Behaviour. Write in the spaces provided.

1. In your opinion, do the mentally retarded adolescents display affection, tenderness and simple human touch exactly like the majority of adolescents?

Yes No

If the answer is yes, explain:

.....
.....
.....
.....

2. If the answer is yes in 2, what kind of action do you take to facilitate sexual expression by students with mental retardation? Is it counseling or exclusion from school? Explain.

.....
.....
.....
.....

3. Is the behaviour of touching, grabbing, stripping and self exposure common in the mentally retarded?

Yes
No

4. If the answer in 3 is yes, do you report to the incharge?

Yes
No

5. If the answer in 4 is yes, are the professionals in favour of such activities?

Yes
No

6. How can you protect the mentally retarded from such kind of activities?

.....
.....
.....
.....
.....

7. Which principle do you prefer?

(a) Unsegregated (b) Segregated

Give reasons"

.....
.....
.....
.....

8. Is sex education offered to the mentally retarded?

Yes No

9. What kind of sex programmes are provided in the vocational institutions?

- (a) Developmental tasks of sexual skills and decision making
- (b) Little Nutrition
- (c) Increase of pregnancies
- (d) Study on inappropriate sexual expression

10. Have you been trained on how to handle sexual behavior for the mentally retarded? If yes, explain the appropriate services you have been providing.

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.....
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Appendix B

11. In your opinion, what influences the sexual behavior of the mentally retarded?

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.....

12. Is the sexual behaviour for the mentally retarded unhealthy, hurtful or illegal. Give reasons.

.....
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.....
.....

13. What innovations do you expect to see in vocational institutions?

.....
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.....
.....

14. Do you have any suggestions for the better expressions of sexuality?

15. Do you know how to handle this sexual activity with this type of disability?

16. Is the sexual behaviour unhealthy, hurtful or illegal?

17. Are you comfortable to discuss issues of sex with the mentally retarded students?

18. Do the mentally retarded students need training to help them understand and control the sexual behaviour?

19. What kind of designed programmes would you suggest to help adolescents with mental retardation comprehend the functions of their adult bodies to assist them in moving towards some appropriate and socially acceptable forms of sexual behaviour?

20. Is segregation or unsegregated the best way of controlling sexual behavior?

Appendix B

PRINCIPALS, DEPUTY PRINCIPALS AND HEAD OF DEPARTMENTS IN VOCATIONAL INSTITUTIONS

INTERVIEW GUIDE

1. Sex: Age:
2. What is your position in the Institution?
3. How long have you been teaching?
4. How long have you served as an Institutional Administrator?
5. What is your latest professional qualification?
6. Are you trained in Special Vocation or Special Education?
7. If yes, what is your field of specialization?
8. How many students (Both able-bodied or disabled) do you have in the Institution?
9. How many mentally retarded students do you have in the Institution?
10. Do the mentally retarded students show drive towards sexual intercourse?
11. If the answer is yes in 10, can the mentally retarded learn to deal with increasing sexual impulses?
12. Do you suppress inappropriate behaviours instead of reinforcing appropriate expressions of sexuality?
13. Do you know how to handle this sexual activity with this type of disability?
14. Is this sexual behaviour unhealthy, hurtful or illegal?
15. Are you comfortable to discuss issues of sex with the mentally retarded students?
16. Do the mentally retarded students need training to help them understand and control the sexual behaviour?
17. What kind of designed programmes would you suggest to help adolescents with mental retardation comprehend the function of their adult bodies to assist them in moving towards some appropriate and socially acceptable forms of sexual behaviour?
18. Is segregation or unsegregated the best way of controlling sexual behavior.

Appendix C

PRINCIPALS, DEPUTY PRINCIPALS AND HEADS OF DEPARTMENTS IN VOCATIONAL TRAINING INSTITUTIONS

Probing Questions

1. Do the mentally retarded students have a sex drive and express it through sole masturbation, exactly like the majority of adolescents?
2. Can they learn to deal with increasing sexual impulses?
3. Do you discourage all forms of sexual expression? Even masturbation in private? Do you have management strategies for encouraging appropriate behaviours and counseling skills to help individuals and their families understand and discuss sexual topics.
4. Are your attitudes positive or negative towards the sexuality of the mentally retarded students? Are you enlightened about sexuality and mental retardation than the general public? Your impact on the lives of people with mental retardation is immediate and direct.
5. Is this sexual behaviour unhealthy, hurtful or illegal?
6. Do you become defensive when asked to deal with sexuality for your mentally retarded students because you feel uncomfortable with the topic and unqualified to provide appropriate services?
7. Do the mentally retarded need training to help them understand and control the sexual behaviour?
8. Suggest programmes that are important. Sociosexual skills, adaptive skills for the mentally retarded in areas of independent living. Staff members to be enlightened about sexuality and mental retardation. Personal preparation programs (for preservice staff). Training should include areas such as exploring awareness of one's own and other's sexuality; accurate terminology and concepts of sexual development, instructional techniques for sexual knowledge, self-concept development etc.
9. Is segregation or unsegregated the best way of controlling sexual behaviour?

Appendix D

HOSTEL STAFF VIEWS ON SEXUAL BEHAVIOR FOR THE MENTALLY RETARDED IN VOCATIONAL INSTITUTIONS

INTERVIEW GUIDE

1. Sex Age
2. How long have you been working with the Special Vocation Department?
3. What is your highest professional qualification?
4. Are you trained in special vocation or special education?
5. Do you attend seminars and workshops in Special Education?
6. How do you treat the sexual behaviours of the mentally retarded?
 - Are there any differences in their behaviour from time to time?
 - Do you actively encourage or discourage all forms of sexual expression?
 - Do you suppress them?
 - Do you tolerate them?
 - Do you encourage masturbation?
 - Is homosexual behaviour experienced?
 - Do you expel them from school or give other punishments?
7. Do you feel uncomfortable or defensive with the topic of sexuality?
8. Do you think the mentally retarded are sexually immature or mature?
9. How do you control the sexual impulses of the mentally retarded?
10. Do you experience able-bodied students taking an advantage or abusing the mentally retarded students because of their sexual feelings? If the answer is yes, what is your concrete action?
11. Do the mentally retarded have the same right as the able bodied in society?
12. Have you been trained on how to handle sexual behaviour of the mentally retarded?
13. In your opinion, what influences the sexual behaviour of the mentally retarded?
14. Is their sexual behaviour unhealthy, hurtful or illegal?

15. What are your expectations of the sexual behaviour of the mentally retarded?
16. What kind of new innovations would you like to see in the future?

Appendix E

PARENTS VIEWS ON THE SEXUAL BEHAVIOUR

INTERVIEW GUIDE

1. How do you relate with your mentally retarded child? Do you tolerate their behaviour?
2. Do you encourage or promote sexual development?
3. Are you comfortable to discuss sex?
4. Do you accept the growing adolescents sexuality?
5. What is the complex reaction to the sexuality of the mentally retarded by your family members?
6. Do you take harsh treatment of the sexual behaviour even in the presence of health sexuality?
7. Do you deny or fear the sexuality of your mentally retarded adolescent?
8. Do you prolong dependency or restrict opportunities to develop social skills to protect your child against sexual exploitation or unwanted pregnancy or STDs or HIV/AIDS?
9. Have you been trained on how to handle sexual behavior for your adolescent child?
10. Is there need for sex education?
11. Do the family members exploit the mentally retarded adolescent?
12. Do you ignore or hide the sexual conduct of the mentally retarded?
13. Do you experience confusion towards sexuality in combination with your difficult towards mental retardation?

Appendix F

PARENTS VIEWS ON SEXUAL BEHAVIOUR

Probing Questions

1. Is your attitude positive? Contact with your child will strengthen misconceptions, stereotypes and fears.
2. How do you view sexual development? Sexual development is a lifelong process that must be integrated into all aspects of functioning.
3. Are you comfortable dealing with your child's sexual needs and behaviour? Anger, grief and denial have resulted in many families, in repressive treatment of emerging sexuality and lack of education in sociosexual skills.
4. Don't you think openness and acceptance of the growing child's sexuality is crucial to the development of healthy sexual attitudes in adults. If you have established a secure gender identity, then, haven't you learned to engage in personally and socially acceptable sexual beings? In this case cant you facilitate the development of sexually in family members who are labeled retarded?
5. Is it positive or negative attitudes?
6. Generally, positive attitudes toward mental retardation coloured by restricted sexuality may lead to uncharacteristically harsh treatment of sexual behaviour by persons with retardation; or negative attitudes toward mental retardation, even in the presence of healthy sexuality, may result in restrictions on the sexual development of individuals who are labeled retarded.
7. Is there need to deny or fear sexuality of your child?
8. Do you prolong dependency, restricting opportunities to develop social skills to protect your child against sexual exploitation or unwanted pregnancy? Do you believe that your child has sexual needs and feelings?
9. Do you have information about the stages of sexual development, counseling to develop awareness of and tolerance for sexual expression in yourself and your child? Do you have any suggestions for training appropriate sexual behaviour and managing inappropriate behaviours that are consistent with societal standards and family values?
10. Are you one of the parents who may reject attempts at providing sex education, in the mistaken belief that ignorance will prevent sexual activity?

11. Do you experience incidencies of sexual exploitation of your child? Is it higher than that of their nonhandicapped peers? Do you train your child to recognize exploitation and protect him or her against it?
12. How do you ignore the sexual conduct of your child? Do you favour sterilization?
13. Are you comfortable in dealing with your child's sexual needs and behaviours? Do you understand mental retardation and sexuality?