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An evaluation of a socio-sexuality education program for individuals with a developmental handicap

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AN EVALUATION OF A SOCIO-SEXUALITY EDUCATION PROGRAM FOR INDIVIDUALS WITH A DEVELOPMENTAL HANDICAP

By

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THESIS

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Abstract

AN EVALUATION OF A SOCIO-SEXUALITY EDUCATION PROGRAM FOR INDIVIDUALS WITH A DEVELOPMENTAL HANDICAP

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This thesis is an evaluation of eight week socio-sexuality education group for seven individuals with a developmental handicap who live in a twenty-four hour supervised group home. Pre and post-test data collection measured the socio-sexual knowledge of the participants. Attitudes of their primary counsellors toward the sexuality of individuals with developmental handicaps were also measured pre and post-test. A qualitative analysis of the facilitators' process notes and a post participation focus group with the counsellors provided an understanding of why changes in knowledge and attitude had, or had not, occurred.

There was a significant increase in the client groups overall socio-sexual knowledge at post-test with minimal group change on the attitude indicators. Qualitative findings demonstrated that this approach was successful in enhancing the learning and retention of socio-sexual didactic material and facilitating a change in attitude of the individual members of both groups.

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Finally, I would like to express my appreciation to the participating agency and the participating group home counsellors. Most of all, I would like to express my appreciation to the women and men with developmental handicaps who participated and shared with me the most

intimate details of their lives. Because of them, I am a better person today.

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Chapter One

Introduction

In the first half of this century people with a developmental handicap in Canada were destined to live their lives in large institutions segregated from the community proper. At the time the prevailing attitude of the community was that individuals with a developmental handicap were feeble minded criminals involved in constant states and acts of sexual promiscuity. The Eugenics movement supported this attitude and campaigned for the further sexual oppression and control of individuals with a developmental handicap by means of mandatory sterilisation and selective breeding processes (Kempton, 1991a).

Approximately 20 years ago attitudes started to shift and deinstitutionalization became a reality. In 1974 the government of Ontario committed to providing homes in the community for people with developmental handicaps (Ministry of Community & Social Services, 1990). This commitment resulted in the movement of thousands of people from institutions into community group homes. As a result of this movement Kempton (1991a) suggests that group home caregivers became aware of the need for client training in the areas of social skills, sexual education and protection from sexual exploitation.

Numerous studies, for example Robinson (1984), have found that the participation of an individual with a mild to moderate developmental handicap in a socio-sexuality education program results in a change of attitudes and an increase in knowledge. The results of a study on the attitudes of group home workers by Coleman and Murphy (1980) found that 75% of the workers surveyed approved of or requested sex education for their charges. However, the approval rate dropped significantly on the issues of the client engaging in heterosexual petting (42%), sexual intercourse (32%) and homosexual behaviour (23%). This indicates that the caregiver's acceptance of sex education may be inconsistent with their attitudes regarding permissible sexual behaviours of their charges.

A myriad of societal myths regarding the sexuality of people with a developmental handicap continue to shape the attitudes of the community. One such myth or attitude holds that individuals with a developmental handicap are incapable of comprehending and experiencing sexuality and the corresponding feelings. Such restrictive attitudes have been found to be pervasive and as a result, individuals with a developmental handicap are not only denied their sexuality by the general public, but often by group home caregivers and other professionals as well (Giami, 1987; Huntley &

Benner; 1993). Due to caregiver negative attitudes and discomfort or lack of knowledge concerning sexuality education, it is often the function of other professionals to educate people with a developmental handicap on issues of sexuality and relationships (McCabe, 1993)

Savage and Rowe (1987) indicate that individuals with a developmental handicap will be exposed to their caretaker's attitudes due to interaction and the socialisation processes. As well, because they are paid caregivers, group home staff will often dictate to the client what is healthy sexuality based on their own attitudes and not the attitudes or needs of the client. Therefore caregiver attitudes may be very important to study when looking at the ability of the individual with a developmental handicap to experience an increase in knowledge and a change in attitudes following a socio-sexuality education program.

Rationale

Denial of the client's sexuality and attitudes leads to the dehumanisation, desexualisation and negative evaluation of the individual with a developmental handicap (Hingsburger, 1994). As a result of the denial of sexuality and the negative valuation of individuals with developmental handicaps, their sexuality needs are often neglected or

controlled by their caregivers (Boyle, 1993). This in turn can lead to a suppression of sexuality feelings and an inability to make decisions as the individual with a developmental handicap becomes dependent upon others.

Carrasquillo, Ing, Kuhn, Metzger, Schubert, and Silveira (1981) believe that the suppression of feelings will lead the individual with a developmental handicap to conclude that sexuality is something to be ashamed of, or bad. Consequently, the individual with a developmental handicap experiences low self-esteem and an inability to make decisions regarding sexuality and social relationships due to a lack of knowledge. According to Anderson (1993), it is this lack of knowledge about sexuality and relationships that increases the vulnerability of individuals with a developmental handicap to assault and abuse.

This study and thesis was designed to test the impact of a socio-sexuality program with concurrent groups for clients and group home workers on both the clients' level of knowledge and attitudes and the workers' attitudes. Furthermore, it was designed to provide an exploratory qualitative identification of systemic factors that may enhance the client's ability to learn socio-sexuality

didactic material and factors that may serve as catalysts for both client and worker attitude change.

Literature Review

The Use of Group In Socio-Sexuality Education Programs

Although several studies support the use of group intervention for adults with mild developmental handicaps, the literature on groups is mainly descriptive (Carrasquillo et al., 1981; Robisnson, 1984). However, there appears to be consensus in the literature on the goals of a sexuality group. On an individual basis the literature suggests goals are to increase self-esteem (Burke & Gilmour, 1994), increase self-confidence and decision making abilities (Hingsburger, 1994) and to increase the individual's ability to self-control one's own sexual expression (Monat-Haller, 1992; Sobsey & Mansell, 1990). Ragg and Rowe (1991) state that this occurs when the curriculum of the group successfully integrates appropriate social sexual knowledge, attitudes and skills.

Ragg and Rowe (1991) suggest that socio-sexual education programs have been successful with respect to transmitting information about anatomy, maturation, birth control and sexually transmitted diseases, but continue to have difficulty enhancing attitudes and skills. Monat-

Haller (1992) and Ludwig (1992) stress the importance of group members gaining knowledge about and an understanding of their feelings about different sex acts. This includes knowledge about masturbation, heterosexuality and homosexuality. According to Monat-Haller (1992) it is also advantageous to learn about inappropriate behaviour, sexual offences and the individual's personal responsibility and choice to engage in sex or not. Savage and Rowe (1987) add that it is imperative for any sexual education program to include a component about relationships and the emotional aspects of sexuality.

Carrasquillo et al (1981) and Lee (1977) suggest that the developmentally handicapped require a highly structured group whereas Empey (1977) found that individuals with a developmental handicap can work well in a group that is not highly structured. The groups in this study functioned within the mainstream model of groupwork supported by Monat-Haller (1992), Ragg and Rowe (1991) and Savage and Rowe (1987) for socio-sexuality education with individuals who have a developmental handicap.

The Mainstream Model of Social Group Work

The mainstream model appears to be optimally suited to socio-sexuality education groups with this population

because it allows for knowledge, attitude and skill integration (Savage & Rowe, 1987) and at the same time provides both the structure and flexibility individuals with a developmental disability require (Monfils & Menolascino, 1984). This social group work model balances didactic teaching with interactive activities. The members of the group are required to take an active role in the development of the curriculum, activities and the group rules and at times are asked to negotiate and make decisions in interactions and partnerships while learning about human relationships. Simply, the group is structured on the philosophy of democratic process, member responsibility, mutual aid and empowerment (Papell & Rothman, 1980). Ultimately the group is structured to lead itself through consensus rather than by the group facilitator. Providing the group members with these options and decision making tasks may be the first time the group members with a developmental handicap have felt in control of their lives and environment (Empey, 1977).

According to Ragg and Rowe (1991) the model provides the structure in which member interaction must occur and consequently allows for the emergence of the individual's attitudes towards human sexuality and or human relationships. The model also allows for flexibility and

spontaneity with respect to the evolving group processes. The group facilitator may choose to abandon the didactic material and choose to utilise group psychotherapy techniques to influence the members' attitudes and social skills. If competently facilitated the members will be able to generalise the knowledge gained from the didactic instruction and at times be pushed by the other group members to change their sexuality attitudes and behaviours outside of the group (Monat-Haller, 1992).

Although the mainstream model of group work provides a clear philosophy, a structure for interactive psychotherapeutic interventions and suggests that the group moves through normative group stages (Papell & Rothman, 1980; Savage & Rowe, 1987), it does not delineate a clear vision or model of group development. However, the model's philosophies of democratisation, mutual aid, shared responsibility and empowerment closely parallel those of the Boston model of group development.

The Boston Model of Group Development

The Boston model of group development posits that the group as an entity will progress through five interdependent stages of development in a way that is orderly and predictable (Berman-Rossi, 1993; Wickham, 1993). The five

stages of group development identified by the model are preaffiliation, power and control, intimacy, differentiation and termination or separation. At each stage the worker and group members must accomplish certain tasks before advancing to the next.

Due to the apparent compatibility of the two models' philosophies and support in the literature suggesting that groups for people with a developmental handicap do go through the stages of development albeit slower (Carrasquillo et al, 1981; Fletcher & Duffy, 1993), the Boston model served, where relevant, as the context for an illustration of group process and the mainstream model's account of the roles and or style of the group facilitator.

Sexual Abuse and Exploitation

In a review of 148 cases of sexual abuse of adults with a developmental handicap reported across a five year period, Furey (1994) found that in 76% of the cases the victim was functioning in the mild to moderate range of developmental handicap. In 77% of the cases the abuse occurred in the individual's residence and in 92% of the cases the perpetrator of the abuse was known to the victim: 21% of the abusers were residential staff and 71% of the perpetrators were family members or family friends. Furey concludes that

this is a good argument for sexual education for the client and the caregiver.

McCabe, Cummins and Reid (1994) compared the sexuality knowledge of 30 adults with a mild developmental handicap residing in group homes to a control group of 50 volunteer university students. They report that individuals with a developmental handicap are less likely to know how to stop unwanted sexual touching. It was also found that 36% believe that someone other than themselves should control their sex lives. They concluded that the individual's neutral feelings about abuse combined with their lack of knowledge about how to stop unwanted sexual activity results in a greater chance of being exploited. This provides an illustration of the importance of sexuality education to increase knowledge.

Socio-Sexuality Education: Increases in Knowledge

Studies have indicated that people with a developmental handicap have a considerable lack of sexuality knowledge. Wish, McCombs, and Edmonson (1980) found that institutionalised individuals with a developmental handicap, as compared to those in the community, were more naive about marriage and children, and possessed less knowledge about community hazards. Although they report that in general

community men and women with a developmental handicap are more knowledgeable on socio-sexuality issues, both groups were least knowledgeable about birth control, sexually transmitted diseases and homosexuality.

Evans and McKinlay (1988) investigated this lack of knowledge in 164 girls and young women with a developmental handicap. They concluded that it is a lack of socio-sexual knowledge on the part of the individual with a developmental handicap and the caregiver and not a lack of self-control, that is responsible for inappropriate sexual behaviours. Ousley and Mesibov (1991) studied the sexual knowledge, experiences and attitudes of 21 high functioning adults with autism and 20 adults with a mild to moderate developmental handicap. They agree with the conclusions of Evans and McKinlay that sex education programs should meet the needs of each individual with a developmental handicap and that the programs will be more effective if they are based on what these group members know and want.

There is some indication that individuals who live in community group homes are learning more about sexuality. Edmonson, McCombs & Wish (1979) found that individuals with a moderate and even severe developmental handicap can acquire facts and attitudes which are components of self-sufficient and responsible behaviour. Studies by Robinson

(1984) and Lindsay, Bellshaw, Culross, Michie and Staines (1992) support the findings of Edmonson et al.

Robinson (1984) conducted a 10 week socio-sexuality education program for adults with a mild or moderate developmental handicap. Eighty-three participants were randomly allocated to either a sexuality education program or a control group. The Socio-Sexual Knowledge and Attitudes Test designed by Wish, McCombs and Edmonson (1980) was utilised to pre and post-test the individual's knowledge and attitudes. Robinson (1984) found that there was a significant increase in knowledge between the pre and post-test of the individuals who participated in the program. The scores of the control group remained unchanged. Robinson does report a significant change in attitudes between the tests but does not provide statistical analysis to support this statement.

Lindsay et al (1992) conducted a similar study where sexuality education was provided and assessments were conducted in 7 areas of sexual knowledge by means of pre and post-testing. They report that on all measures the group that received the educational program showed an increase in knowledge while the control group remained unchanged in their scores. They further conclude that there is little

evidence in the research and literature to suggest that the material taught in such programs is retained.

Socio-Sexuality Education: The Retention of Knowledge

A literature search uncovered only one study investigating this issue. Penny and Chataway (1982) provided a 9 month socio-sexuality education program for 46 adults with a mild or moderate developmental handicap. The groups were comprised of 6 to 8 members and included both men and women. Every participant received a pre, post and 2 month follow-up test. The results of the post-test indicated an increase in knowledge and the results of the 2 month follow-up test indicated that this increase was maintained. The researchers concluded that the knowledge increase will be retained following completion of the program.

However, Penny and Chataway (1982) did not utilise a control group for comparison. This prevents them from making firm conclusions regarding the ability of an individual to retain the knowledge increase following the completion of a sexuality education program. It also prevents them from being certain that those not receiving the educational program also have an increased knowledge level which is retained as a result of incidental learning

opportunities like television programming. As well, it is proposed that a longitudinal approach needs to be considered. A 2 month follow-up test may not be sufficient to establish a significant relationship between participation in a program, an increase in knowledge and retention of that knowledge.

Socio-Sexuality Education: Change in the Client's Attitudes

In 1980 Wish et al. reported that the attitudes of people with a developmental handicap regarding socio-sexuality differed between individuals living in large institutions and those living in community based group homes. Interestingly, they found that individuals living in institutions possessed more positive attitudes about sexuality and relationships than those people living in the community. This encourages one to discover if the generally more negative attitudes of the individuals living in the community are influenced by the attitudes of the individual's primary caregiver.

Lindsay, Bellshaw, Culross, Michie and Staines (1994) conducted a study where socio-sexuality education was provided and assessments were conducted with respect to 3 areas of sexual attitudes by means of pre and post-testing. They report that the group that received the sexuality

education showed improved attitudes with respect to dating, heterosexual relationships and gay and lesbian relationships while the control group maintained relatively conservative attitudes. A 3 month follow-up indicated that the liberal shifts in attitude toward gay and lesbian relationships were not maintained to the same significant degree as the shifts in attitude toward heterosexual relationships.

Socio-Sexuality Attitudes of the Caregiver

Studies with the caregivers of individuals with a developmental handicap have often showed negative attitudes toward the sexuality of this group. A study done by Mitchell, Doctor and Butler (1978) was designed to determine the strengths and direction of institutional caregiver attitudes. One-hundred and seventeen staff were interviewed in three institutions. It was found that a large percentage (69.2) of staff members felt that no sexual behaviour on the part of the residents was acceptable. Most acknowledged, nevertheless, that masturbation, heterosexual behaviour and homosexual behaviour did occur in the facility. They felt that these behaviours were generally considered inappropriate. They concluded that the staff held generally conservative attitudes and this was concerning because the

same staff would be implementing sexuality education programs for individuals with a developmental handicap.

Adams, Tallon and Alcorn (1982) believe that the interpretations made by Mitchell et al (1978) are difficult to accept because they did not investigate the caregiver's attitudes toward the sexuality of individuals with no known developmental handicap. Adams et al (1982) suggest that the participant's attitudes as reported by Mitchell et al, may encompass sexuality in general and not just the sexuality of people with a developmental handicap.

Adams et al. (1982) studied the sexual attitudes of primary caregivers and a control group with respect to the sexual behaviours of both people with and without a developmental handicap. The primary caregivers worked in both institutional and community settings while the control group was comprised of university students. They found that the 3 groups had significantly more tolerance for heterosexual behaviour than homosexual. All posthoc analyses indicated that there was no difference in the respondents' attitudes towards the sexual behaviours of individuals both with and without a developmental handicap. They also concluded that people working in community based group homes were not significantly more liberal in their sexual attitudes than those in institutions. However, in a

study by Brantlinger (1983), group home staff were found to hold more liberal views.

In Brantlinger's (1983) study the attitudes to sex education of staff working in various types of residential settings for people with a developmental handicap were compared. A 40-item Likert-type scale was developed. Subscales dealt with general attitudes toward sex, sex education, sexual rights of people with a developmental handicap, rights of minors and stereotyping the sexuality of people with a developmental handicap. Results showed group home staff to be more liberal in comparison to institutional and nursing home staff.

Although little research has been undertaken in this area since 1983, the studies prior tend to report more negative views of staff attitudes regarding the sexuality of people with a developmental handicap. However, there is conflicting evidence indicating that staff are working on client needs in the area of independence. It is possible that views on general independence for this group are more liberal than attitudes toward sexual independence.

Nevertheless, the literature suggests that participation in educational training programs concerned with sexuality and handicaps can have a positive impact on a staff's attitudes toward the sexuality of people with

developmental handicaps (Brantlinger, 1983; Rose & Holmes, 1991; Boyle, 1993). The first step in any educational training component for residential staff working with individuals with developmental handicaps is the provision of correct socio-sexuality information (Gardner & Chapman, 1985; Kempton, 1991b). If the correct information can be presented and learned then the positive attitude toward the sexuality of people with developmental handicaps can begin to develop.

Caregiver Training: Sexuality and Disability

A second task in the Brantlinger study (1983) was the development of a treatment modality that would result in a change of the residential care staff's attitudes toward the sexuality of individuals with developmental handicaps. Films, lectures, small group activities and role plays were utilised to present didactic material and topics during a one day workshop. All sessions started "...with historical perspectives of handling sexuality of the mentally retarded persons, contrasting how the concepts of normalization conflicts with these traditional approaches" (Brantlinger, 1983, p.19). Traditional approaches were viewed as negative and served to control the sexual behaviour of the individual. Workshop participants were encouraged to take

on new roles in their interactions with clients with a developmental handicap by supporting their relational choices and respecting their rights.

The same 40-item Likert-type scale Brantlinger (1983) employed to test the nature of residential staffs' attitudes toward the sexuality of their clients was utilised to determine if there was a change in the residential staffs' attitudes after participation in the training workshop. Pre and post-test results indicated that participants in the workshop experienced a change of attitude in a more liberal direction. These findings were supported by Rose and Holmes (1991).

Rose and Holmes (1991) utilised the 40-item Likert-type scale developed by Brantlinger (1983) to pre and post-test the attitudes of 71 staff members who participated in either a one or three day in-service training workshop. The one day workshops utilised small group activities, attitude exercises and card games, lectures and discussions to provide a basic introduction to the sexual issues of people with developmental handicaps. The three day workshops included all of the activities of the one day workshops but also included films, role plays and large group activities. Results showed that both groups experienced a change of attitude in a more liberal direction and the results also

indicated that the attitudes of the participants in the three day workshop showed a greater directional change then those of the individuals in the one day workshop.

Boyle (1993) does not provide quantitative analysis of caregiver attitude change following participation in a socio-sexuality education training program, but she does provide an excellent guide for such programs. The first component of the program involves participants in an exploration of the origins of individual sexual attitudes, values and beliefs and the effect they could have on the provision of sexuality information and guidance to people with developmental handicaps.

Boyle (1993) utilised small group activities and experiential exercises that initially require little self-disclosure and are "not intended to force participants to change their attitudes, values or beliefs related to either sexuality or more specifically, sexuality and disability" (p.49). She further suggested that participants most enjoyed the activities that involved the exposure of family, societal and cultural myths, misinformation and influences. A subcomponent of the attitudes, values and beliefs training involved the workers' attitudes toward the sexuality of people with developmental handicaps. She reported that this component of the training program often

left workers with a better understanding of how their attitudes, values and beliefs impact on their work with sexuality issues.

The second component of Boyle's (1993) approach provided workers with factual information that pertained to sexuality in general and to the sexuality of people with developmental handicaps. The provision of sexuality information may help the worker more comfortably discuss sexuality issues, answer sexuality questions and offer factual information that will correct any myths or misconceptions the individual with a developmental handicap may hold. It has been her experience that workers possess little factual information about sexuality and handicaps.

Summary

The literature suggests that socio-sexuality education groups have been successful with respect to transmitting socio-sexual information, changing attitudes towards sexuality and enhancing the interactional and social skills of individuals with a developmental handicap. It has also been suggested that the group format is the preferred modality for the conveyance of socio-sexual information to individuals with a developmental handicap. It appeared, until quite recently, that socio-sexuality educators had not

reached a consensus on the most effective group structure for individuals with a developmental handicap. The literature presently supports the Mainstream model of social group work due to its structural flexibility and its emphasis on the empowerment of the individual with a developmental handicap.

The empowerment of the individual appears to be important because the literature suggests that the sexuality of individuals with a developmental handicap has tended to be controlled by the group home caregiver. Caregivers' attitudes towards the sexuality of individuals with a developmental handicap have tended to be negative. However, it has been reported that the involvement of the counsellor in a socio-sexuality workshop or seminar has resulted in a positive impact on the counsellor's attitudes towards a client's sexuality. Still, several gaps in knowledge appear to exist in the areas of client and counsellor socio-sexuality education.

The literature suggests that the clients' and the counsellors' knowledge gain and attitude change will be retained and generalised outside of the group experience. However, the studies have failed to provide conclusive evidence that suggest an increase in knowledge and a change in attitude will be retained and generalised. As well,

there exists no evidence to suggest that group home counsellors support nor nurture the clients' knowledge increase and change in attitudes during and following their participation in a socio-sexuality education group.

The focus of this study will be on the participation of the counsellor who participates in a group for counsellors that covers the same didactic material as the client and occurs during the same time frame as the client group and the impact that this modality of intervention may have on their client's learning and attitude change after participation in a socio-sexuality education group. To date, the service delivery of socio-sexuality education groups or workshops occurs separately for the counsellor and client respectively. Accordingly, there is no indication that changes in the counsellors' attitudes or in the clients' knowledge or attitudes will be retained and generalised to or supported in the group home.

Chapter Two

Methods

Quantitative Research Questions

Quantitative data were collected to answer two general research questions. The first research question enquired: What is the impact of a socio-sexuality program with concurrent groups for clients and workers on client level of knowledge and attitude? The second question asked: What is the impact of a socio-sexuality program with concurrent groups for clients and workers on worker attitudes? This study tested three hypotheses to answer the research questions.

Hypothesis One

The mean knowledge scores on the Sexual Knowledge Interview Schedule for individuals with a developmental handicap who participate in a socio-sexuality education group will be significantly higher at post-test than at pre-test.

Hypothesis Two

The mean attitude scores on the attitude subscales of the Socio-Sexual Knowledge and Attitude Test for individuals

with a developmental handicap who participate socio-sexuality education group will be significantly higher at post-test than at pre-test.

Hypothesis Three

The mean attitude scores on the Sexuality and the Mentally Retarded Attitude Inventory for group home staff who participate in a socio-sexuality education group will be significantly higher at post-test then at pre-test.

Conceptual Operational Definitions

Independent variable.

The independent variable in this uncontrolled study was the provision of a socio-sexuality education group to adults with mild developmental handicaps and a concurrently running training component for the individual's primary caregiving staff.

Socio-sexuality education, for the purpose of this study, covered all areas involved with human sexuality, including attitudes, feelings, behaviour and the relationship to ourselves and others.

For the purpose of this study a community group home was defined as any 24 hour supervised residence for people with a developmental handicap. The group homes in this study were under the mandate of the participating

habilitation organisation which was located in South Western Ontario.

A group home worker, for the purpose of this study, was defined as the primary caregiver of the participating individual with a developmental handicap. The group home worker was in the full-time employ of the agency involved in the study.

A mild developmental handicap, for the purpose of this study, was defined as an intellectual and adaptive behaviour impairment. It was operationally defined by the following criteria: a) an IQ score of 50-70; b) an inability to adapt to a changing environment; and c) onset of disability before 18 years of age (American Psychiatric Association, 1994).

Dependent variables.

There are three dependent variables in this study. The first was the level of the client's knowledge about sexuality. For the purpose of this study knowledge was defined as having and understanding information about related topics to human sexuality. Change in knowledge was operationalised by comparing the individual's pre and post-test scores on the SKIS-Sexual Knowledge Interview Schedule (Forchuk, Martin, & Griffiths, 1995).

The second and third dependent variables were changes in the attitudes of the client and the group home worker respectively. For the purpose of this study attitude was defined as the individual's opinion with respect to both their personal and other people's beliefs and behaviours as they relate to human socio-sexuality. The attitude of the client regarding human socio-sexuality was operationalised by comparing the individual's pre and post-test scores on the attitudes subscales of the Socio-Sexual Knowledge and Attitudes Test (SSKAT) (Wish et al, 1980). The attitudes of the group home worker were operationalised by comparing the individual's pre and post-test scores on the Sexuality and the Mentally Retarded Attitude Interview (SMRAI) (Brantlinger, 1983).

Contribution of A Concurrent Group for Counsellors: A Qualitative Analysis

The facilitators' content and process notes and the data collected from a worker focus group were utilised to answer a third research question: What is the perception of workers and facilitators of the factors which facilitated change in knowledge or attitudes in the socio-sexuality program.

Design

Two groups were involved in a pre and post-test design. The first intervention group involved the participation of the individual with a developmental handicap only in a socio-sexuality education group. The second group involved the participation of the primary caregiver in a separate but concurrently running group for staff only. The members of these groups either resided in a group home operated by or worked for the participating agency at the time of the research project.

Procedures

The administration of the participating agency was contacted by the principal investigator in December of 1995. The agency was informed of the nature and purpose of the proposed research and was offered a socio-sexuality education intervention with the concurrently running staff training component. The principal investigator met with an administrator of the agency in January of 1996 and presented a fully developed proposed research plan.

The administration of the agency was asked to formally announce the study within their service delivery system for the purpose of identification of volunteers who met the criteria for participation. To qualify for potential group

participation the individual with a developmental handicap required a documented diagnosis of mild to moderate mental retardation, were receiving Family Benefits as a source of income at the time of the study, and had not participated in a sexuality education group or counselling in the past five years. The administrator was asked to contact the principal investigator with the names and phone numbers of potential participants after they had been identified and consented to contact from the primary investigator.

Following this referral procedure one of the two co-facilitators contacted the primary caregivers within the group home system. The contact was by telephone. The worker and the individual with a developmental handicap were invited to an information sharing and prescreening session with one of the two co-facilitators. In cases where there was parental involvement and or a legal guardian, the group home worker was asked to notify the guardian prior to inviting their charge to the meeting. Where the parent or guardian was amenable to the meeting and their adult child's participation, the group home worker was asked to invite the parent and or guardian. The principal investigator served as one of the co-facilitators and a female therapist with experience in the area of group work with individuals with a developmental handicap served as the second leader. It was

proposed that the presence of a male and female co-facilitator provided a balanced and comfortable environment for the participants.

The principal investigator asked the group home worker to extend a pressure-free invitation to their charge with a developmental handicap to attend the information sharing and prescreening session. The invitation was considered pressure- free only if the group home worker fully explained the purpose of the meeting and conveyed to the individual with a developmental handicap and their parent or guardian that their attendance at the meeting was voluntary. The group home worker was encouraged to invite the individual with a developmental handicap in a private manner that they deemed appropriate. The group home worker was also encouraged to provide the individual time to contemplate their decision and to ask questions of their worker if clarification or more information was required. If the client, worker or parent or guardian had further questions with respect to the meeting, they were encouraged to contact one of the co-facilitators or Dr. Anne Westhues if they believed this provided assistance in making the decision. The group home worker was asked by the contacting co-facilitator to respect the client's or their guardian's decision and not to pressure the client to attend the

meeting or to participate in the study if they decided not to. An appointment was made at this time if the staff, the individual with a developmental handicap and or their parent or guardian accepted the invitation to meet and learn more about the socio-sexuality education groups.

At this meeting the clients and staff were informed of the curriculum, the nature of the topics and the research component of participation in the groups. Both the client and the staff were informed that some simple tests would be required to be completed at the beginning of the group and at the end of the group participation. Both the client with a developmental handicap and their staff were assured that participation in the testing and the groups was voluntary and that they had the right to change their mind and stop participation at any time. Moreover, the participants and the parents and or guardians were informed that they can ask questions about any aspect of the groups or research at this meeting or at any time during the entire process.

The client with a developmental handicap was asked to sign a consent to participate in the socio-sexuality education group (Appendix A) and a separate consent to participate in the research component of the project (Appendix B) only after the co-facilitator determined they met the criteria to participate as outlined in the

methodology section. Although agreement to participate in the research component was essential for participation in the group, it was decided to have two separate consent forms to distinguish the two concepts as concretely as possible for the individual with a developmental handicap. Parental and or legal guardians were asked to co-sign the consent forms when and where they decided that their participation was deemed necessary.

Although every effort had been made to utilise simple language in the design of the consent forms for the individuals with a developmental handicap, the co-facilitators did at times rely on the primary caregiver and or the parents or legal guardian to clarify the message and intent of the consents to their charge.

The participating group home staff were asked to sign a consent that takes into account their participation in both the research project and a socio-sexuality education group (Appendix C).

A second appointment was made with the staff and the individual with a developmental handicap to complete the pre-tests with one of the two volunteer research assistants. Pre-testing utilised research assistants and was administered employing a double blind format to maintain independence between the roles of principal investigator and

group co-facilitator. In order to increase their comfort, female and male individuals with a developmental handicap completed all testing with a female and male research assistant respectively. At the time of the data collection the female research assistant had her MSc. and the male research assistant was completing his honours B.A.. The research assistants underwent intensive training with the principal investigator in order to become comfortable and competent with the administration of the SKIS (Forchuk et al., 1995) and the SSKAT (Wish et al., 1980).

The research assistants were not utilised for the post-testing of the individuals with a developmental handicap. During the final session with the group home workers a discussion took place as to who should post-test the individuals; research assistants or the group facilitators? The group home workers unanimously decided that the facilitators should post-test the individuals with a developmental handicap. The facilitators concurred because the relationship with the client, in the context of socio-sexuality education content, had been developed in a safe atmosphere and because the facilitators had an understanding of the individuals' communication patterns and styles. It was believed that the reintroduction of research assistants would have potentially placed the individual with a

developmental handicap in a position where they did not feel safe discussing socio-sexual material. In turn, this situation may have created increased anxiety in the individual and may have potentially jeopardised performance on the SKIS and SSKAT.

All participants were informed that their identities and test scores would remain strictly confidential both for the duration of the project and in any written and or oral report. Confidentiality was maintained through employment of pseudonyms. All participants and their counsellors were assigned a pseudonym. The master list identifying the individual's pseudonym was kept in a locked file in the possession of the principal investigator. The participants were informed that the written test results and the identification list would be destroyed when data entry and this research project was completed.

Sample

This study utilised a purposive sampling strategy (Babbie, 1989; Gabor & Grinell, 1994). Twelve individuals with a developmental handicap were identified by the participating agency for the purpose of pre-testing and prescreening. To qualify for potential group participation the individual with a developmental handicap required a

documented diagnosis of mild to moderate mental retardation, a score below 70% on at least 3 subscales of the SKIS (Forchuk et al., 1995), were receiving Family Benefits as a source of income at the time of the study, and had not participated in a sexuality education group or counselling in the past five years. Although the principal investigator initially requested a documented I.Q. score and specified an age range for participants, these variables were abandoned for two reasons. First, the participating agency was able to provide documented labels of moderate to mild mental retardation but were unable to provide documented I.Q. scores. Second, the literature suggested that the organisation of groups for people with developmental handicaps is best served when the developmental levels of the members and the common needs of the participants are given priority over membership and participation based on variables such as I.Q. or age (Brown, 1994; Hurley, 1989).

During prescreening interviews the principal investigator observed the participants for the ability to demonstrate a desire to participate and an ability to sustain a 2 hour session, to share time and resources with others, and to speak in clear, short sentences of at least two words. Two of the potential participants were excluded from consideration for participation because the primary

investigators determined that they would not be capable of sharing time and resources with the other group members. Two other potential participants were excluded from consideration because at the time of the prescreening and pre-testing they experienced high levels of anxiety and distress as a result of the sexuality content and were unable to attend to the pre-testing material.

According to Burke and Gilmour (1994), exclusion must be considered if the individual with a developmental handicap experiences anxiety or distress as a result of the sexuality content. In fact, one of the individuals became aggressive and hostile toward the research assistant and as a result was excluded from consideration as suggested by Carrasquilo et al. (1981) and Empey (1977). A fifth individual was offered group participation and membership but did not attend the first or second session. After the first session the individual told the principal investigator that he would attend the second session. When he failed to appear the group decided that he would not be allowed to participate. The principal investigator notified the individual of this decision.

The seven remaining individuals with a developmental handicap comprised the group membership and study sample. Composition of the group by gender consisted of four women

and three men (Figure 1). The mean age of the client group participants was 35.6 years, with a range of 46 years where the minimum age of the participants was 20 and the maximum was 66 (Figure 2).

It is important to note that the demographic variables of the participating workers could not be controlled for because the composition of the primary caregiver group was based on the participation of the individual with a developmental handicap. It is also important to note that the counsellor of the individual who did not attend the first or second session and was subsequently excluded from participation, did participate in the worker group for the duration of the project. This counsellor had attended the first two counsellor sessions and desired to complete the program. This was permitted as the other counsellors desired and welcomed the participation of this individual. Of the remaining counsellors, it is important to note that two had two clients each who participated in the client socio-sexuality education group whereas the remaining three counsellors had one. In total, six counsellors participated in the research project and concurrently running counsellor group.

Composition of the counsellor group by gender consisted of five women and one man (Figure 3). The mean age of the

counsellor group participants was 36.5 years with a range of 8 years where the minimum age of the counsellors was 32 and the maximum age was 40 (Figure 4). The workers' levels of educational attainment varied: three held a Bachelors degree, two held diplomas from a community college and one had completed high school (Figure 5).

Figure 6 provides a graphic illustration of the length of time measured in years that the counsellors have been employed in habilitation services. The mean number of years that the counsellors had worked with individuals with a developmental handicap was 11.7 with a range of 10 years where the minimum was 7 and the maximum was 17. Certainly 66.7% (n=4) of the counsellors had over 10 years experience working with individuals with a developmental handicap.

The mean number of months the counsellors had worked for the individual with a developmental handicap at the time of the research project was 26.33 with a range of 77 months where the minimum was 7 months and the maximum was 84. The use of the mean as the primary descriptor appears to be somewhat misleading as a visual inspection of Figure 7 indicates that 4 of the counsellors (66.7%) have less than 12 months experience as the primary worker of the individual with a developmental handicap.

Data Collection

Three methods were triangulated to collect data: quantitative, content and process records and a focus group. Triangulation refers to the combination of methodologies in the study of the same phenomena (Patton, 1990). In this research project methodological triangulation allowed the primary investigator to compare quantitative data with the group facilitators' content and process notes, and/or the data collected by way of a focus group conducted with the group home workers.

Quantitative Data Collection

Sexuality and the Mentally Retarded Attitude Inventory (SMRAI)

This instrument is a 45-item Likert-type scale developed by Brantlinger (1983). The SMRAI was utilised to collect pre and post-test data with respect to the attitudes of the participating group home worker towards the sexuality of individuals with developmental handicaps.

The test can be quickly administered indicating good utility. Subscales deal with the general attitudes of group home staff toward sex, sex education, the sexual rights of the individual with a developmental handicap, the rights of minors and the stereotyping of the sexuality of persons with

a developmental handicap. Since a factor analysis indicated that the subscales are not independent, a single attitude score is utilised. A perfect liberal score is 225 and a perfect conservative score is 45.

The instrument has demonstrated excellent internal consistency (Brantlinger, 1983). The alpha coefficients were calculated for a sample size of 232 people with a result of .95 ($p<.001$). Construct validity was supported when different populations responded in predictable ways. The respondents included parents of adult individuals with a developmental handicap, sheltered workshop staff, college students in a teacher training program for individuals with a severe developmental handicap, nursing home staff, participants of a sexuality summer workshop, managers of group homes for individuals with a developmental handicap and employees of a large residential institution for individuals with a developmental handicap. According to Brantlinger (1983) the respondents were "known groups" (p.19) and it was concluded that they responded in predictable ways. For example, individuals with more education tended to score higher than the respondents with less education. A test, re-test analysis indicated no significant gains in score and it was concluded that the changes in attitude were not a function of the re-testing.

This indicates internal reliability. An analysis of covariance with respect to the pre and post-test indicated no significant difference between the two conditions indicating the pre-test did not have a sensitising effect.

The Sexual Knowledge Interview Schedule (SKIS)

The SKIS is a pre/post-test instrument developed by Forchuk et al. (1995) to be used in conjunction with a sexuality education program for people with a developmental handicap. The principal investigator of this research project utilised the schedule to collect pre and post-test data consistent with the original purpose of the SKIS. It is designed to measure knowledge and experience through 46 open-ended questions across five subscales including sexual abuse, feelings, body parts identification, body parts function and general sexual knowledge.

Minimal time is required for administration and this indicates good utility. The participant's answers are arranged into closed-ended categories. Understanding or an appropriate response is scored as 1 whereas an inappropriate or inadequate response receives a score of 2. Not knowing the answer or not answering receives a score of 0. The abuse subscale includes a score of 3 and this reflects aggressive behaviour in certain situations. Perfect

knowledge or experience across all of the subscales results in a summated score of 46. Scores over 46 indicate inappropriate or a lack of some sexual knowledge. Scoring under 46 may indicate participant sensitivity to the content of the test or an extreme lack of knowledge.

Internal validity for this instrument is excellent. Results from a Cronbach's alpha ($p<.001$) indicate the internal consistencies for the five subscales to fall between .96 and .78. Reliability for this schedule is also good. The researchers calculated the inter-rater reliability to be 95.3. Test, re-test reliability was calculated at 70.1. This may have been lower because of a 3-7 day wait between administrations. Questions scoring less than 65% agreement were excluded from the test. These results indicate good internal validity and reliability.

The Socio-Sexual Knowledge and Attitude Test (SSKAT)

The SSKAT is a 240 questions instrument used to measure the extent of knowledge an individual with a developmental handicap possesses in a given socio-sexual area and to assess the participant's attitude with respect to socio-sexual behaviours. The developers of the test, Wish et al. (1980), found that it takes approximately 2 hours to complete the test and therefore should not be administered

in its entirety all at once. Although comprehensive, this suggests poor utility. Meister (1992) utilised the 46 questions relating to the attitudes subscales and found that only 20 minutes was required for administration. For the purpose of this study only the 46 attitude subscale questions that covered the areas of menstruation, dating, marriage, intimacy, intercourse, pregnancy, masturbation, homosexuality, alcohol/drugs, and community risks and hazards were utilised to collect pre and post-test data. Most of the attitude questions can be answered by pointing to a smiling, frowning or neutral face or by a yes or no answer (Edmonson et al., 1979).

Scoring is simple when using the attitudes subscale alone. Attitude answers are scored 2 points for positive, 1 point for neutral and 0 points for negative. The summated raw score is converted into a percentile score by using a conversion table and then plotting the percentile score on to a graph. Findings will indicate if the participant's attitudes towards socio-sexuality behaviours and beliefs are more consistent with liberal or conservative attitudes.

Internal validity for the attitude subscales is excellent. Coefficients for the subscales were calculated for a sample size of 199 with a result of .83 ($p<.001$). Test, re-test reliability procedures with 100 men and women

with a developmental handicap tested at intervals from 1 week to 10 days, produced excellent results. The score ranged from 76 to 91.5 across the 10 attitude subscales. Speaking to the validity and reliability of the schedule, Fisher and Hall (1988) employed the SSKAT to aid in developing construct validity for a sexual attitudes instrument during its development.

Qualitative Data Collection

Content and Process Notes as Sources of Data Collection

The group facilitators would meet for approximately 45 minutes to one hour immediately after sessions with the client or group home worker groups. The facilitators would spend this time debriefing and constructing detailed notes of both the group content and process. Emphasis was placed on the identification of group formation and development as it pertained to the Mainstream and Boston models of group development and process, and observable or behavioural individual member change in attitudes, knowledge and behaviour.

The facilitators also spent part of this time engaged in discussion with respect to the role they had played in group during that particular session and the perceived impact their leadership styles may have had on the group and

the individual group members. These content and process notes were later transcribed into WordPerfect 5.1.

Focus Group as a Source of Data Collection

The primary investigator designed a focus group questionnaire (Appendix D) and co-facilitated a focus group with the group home workers after the cessation of all group participation and post-testing. The focus group was deemed appropriate for several reasons. Focus groups utilise purposive samples to gain information and insight from members of a distinctive group or culture (Wolff, Knodel & Sittitrai, 1993). Focus groups are extremely well suited for the collection of data with respect to attitudes and cognitions (Morgan, 1988). Focus groups also serve as excellent tools for follow-up data collection (Frey & Fontana, 1993) and when this follow-up data is linked to data collected from other sources such as quantitative methods, it can serve to enhance the analysis and/or researcher's understanding of the data collected via other methodologies (Morgan, 1988; Wolff et al., 1993).

In this project the lack of a control group made the use of a focus group imperative. Without the focus group the primary investigator would only have been able to identify if a significant difference existed between the pre

and post-test scores of the individuals involved and if this change did or did not occur by chance. Analysis of this data alone would not have allowed for the identification of the strengths and weaknesses of this program and therefore, would not have allowed the principal investigator to determine the usefulness of the program approach. Morgan and Krueger (1993) suggest that "when the research topic involves understanding the success or failure of a particular program in a specific setting, focus groups may well be the most efficient and effective tool for uncovering the reasons behind this outcome" (p.9).

A detailed description of the content and process of the two groups will be provided in the following chapter.

Data Analysis

The nonparametric Walsh Test was utilised to determine if there was a significant difference between the group's pre and post-test scores on the subscales of the SSKAT and SKIS. This test was chosen because the scores on the SSKAT and SKIS have been defined as interval data and according to Siegel (1956) "the Walsh test requires measurement in at least an interval scale" (p.84). As well, the participants with a developmental handicap, for statistical purposes, served as their own control, and therefore we can use a

statistic that assumes that the data comes from two related samples, and "that the numerical difference scores came from symmetrical populations..." (Siegel, 1956, p.85).

The Wilcoxon Matched-Pairs Signed-Ranks Test was utilised to determine if there was a significant difference between the counsellor group's pre and post-test scores on the SMRAI. This test was chosen because the scores within each pair and the differences scores were both at least ordinal in scoring and scaling respectively (Siegel, 1956). The scores of the workers were compared to determine if a change in attitude occurred across the course of the study.

An analysis of the group facilitators' content and process notes and an analysis of the content collected from a focus group with the workers were utilised to enhance the quantitative analysis through the identification of any observable group changes in knowledge, attitude or behaviour in either the individual with a developmental handicap or their group home worker as a result of participation. The group facilitators' content and process notes and the content from the focus group were further utilised to determine if there were indicators that suggested any change in knowledge or attitude would be retained or generalised upon completion of group participation.

Analysis of the facilitators' content and process notes allowed for the emergence and identification of themes. This included themes relevant to the development and processes of the group, the roles of the group facilitator and changes in the knowledge, attitudes and behaviours of both the participants with a developmental handicap and their group home worker. The recognition and identification of these themes formed the basis for the questions of the focus group guide. When triangulated with the quantitative analysis, the qualitative analysis provided further information to determine if this new program approach was successful.

Chapter Three

The Systems Model of Socio-Sexuality Education

Philosophy and Purpose of the Program Approach

Brown (1994) has suggested that individuals with developmental handicaps tend to have short-term memory difficulties and as a result information that is presented may not be retained in the individuals' long-term memory. This would suggest that more repetition or rehearsal is required for material to be learned and retained. Individuals with developmental handicaps have less of an ability to generalise learned material to similar situations and as a result new behaviours are acquired at a slower rate then in the general population. However, it has been proposed that careful linking of the material from session to session will provide the necessary repetition and rehearsal to enhance memory (Brown, 1994; Ludwig, 1991).

This program approach is quite simple: the participation of the group home counsellor in a concurrently running socio-sexuality education group provided the didactic material link between the group sessions of the participant with a developmental handicap. This enhanced the ability of the individual with a developmental handicap to learn, retain and generalise the didactic material presented in group to their every day living situation

because their group home counsellor had been exposed to the same didactic content and could reinforce application of the material in the group home.

This program format and approach is unique because it provided intervention and service at the interface of the individual resident's and the individual worker's systems. It not only delivered a socio-sexuality education curriculum to the individual with a developmental handicap, but it also provided the counsellor training and attitude development within the here and now context of the relationship with their charge. This model of education delivery differs significantly from the mainstream models that educate the resident of the group home and train the workers in isolation of each other.

This approach appears to have solved an inherent dilemma in the current service delivery system. Research shows that a lack of worker involvement in socio-sexuality training may result in the development and persistence of negative worker attitudes toward the sexuality of individuals with developmental handicaps. Subsequently, the worker may neglect or control the sexuality needs of the individual (Boyle, 1993). If that is the case, it is highly unlikely the counsellor will engage the individual in discussion about what they have learned in a socio-sexuality

education group. It is thus highly unlikely the increase in knowledge, positive attitude change, change in behaviour or increase in self-esteem will be supported, generalised and retained in the group home where the individual is subjected to the attitudes of the caretaker.

Conversely, if the client has never participated in a socio-sexuality education group, what assurance exists that any change in the counsellor's attitude toward the sexuality of their client will be retained or generalised as a result of their participation in a workshop or seminar. Changing one's attitudes as a result of role play with other staff members would appear to be significantly different then learning factual information and utilising it in the here and now relationship one has with a client.

The client group.

The client group met once a week for eight weeks at the university attended by the principal investigator. Sessions were two hours in duration. The didactic sessional topics that were presented to the group included: basic human and socio-sexuality interactional feelings, male and female maturation, male and female anatomy, anatomy functions, masturbation, hygiene, qualities of relationships, heterosexual and same sex relationships, private and public

behaviours, sexual assault, intercourse, pregnancy and contraception, sexually transmitted diseases and sexual abuse and community awareness. A specific sessional topic and in some sessions two topics, were presented weekly for the entire eight week program. This content was consistent with the curriculum developed and employed by other educators (Ludwig, 1991; Martin & Forchuk, 1987; Meister, 1992; Monat-Haller, 1992; Savage & Rowe, 1987).

As suggested by Savage and Rowe (1987) the facilitators attempted to provide several activities for each subject matter where possible so that the group members could democratically choose the activity they felt most comfortable with. As well, the liberal use of concrete aids and activities by the facilitators was an attempt to take into account the historical difficulties with abstract concepts, short-term memory, attention difficulties and self-expression often experienced by individuals with developmental handicaps (Brown, 1994; Fletcher & Duffy, 1993). To this extent the facilitators utilised concrete activities and visual aids because other educators believed that their employment involved the individual in the change process instead of simple conversational interaction. As a result, they have been found to be instrumental in the reinforcement and integration of knowledge, the challenging

and adjusting of attitudes, skills development (Laterza, 1979; Ragg & Rowe, 1991) and information retention (Savage & Rowe, 1987).

Fifteen minutes were scheduled for group break and snack approximately half-way through each session as suggested by Carrasquillo et al. (1981) and Ludwig (1991). Group members were provided with this time to refresh themselves, go to the washroom and to socialise. It was the responsibility of the group members to discuss and decide what the snack would be for the next session. The facilitators believed that this time would foster cohesion and provide an opportunity for the group members to practice social skills learned in group, to provide an opportunity to develop decision making skills, and take a shared responsibility for the decision making and leadership of the group as espoused by the Mainstream model.

At the end of each session, excluding the first, the group members received homework assignments that included questions and visual activities based on that day's session. The group members were asked to complete the homework with their counsellor before the following week's session. The facilitators reviewed the homework with the group members and then collected it at the beginning of the session the following week. The facilitators spent a great deal of time

with the completed homework and provided positive feedback by writing positive comments on the group members' homework and affixing encouragement stickers such as "Excellent Work!" or "Great Job!". The homework assignments were returned to the clients the next session and the group members were encouraged to review the homework and facilitators' comments with their counsellor.

The facilitators believed that the assignment of homework, the completion with the counsellor, review in group and further review with the counsellor would assist in the client's learning and retention of the knowledge. It was also believed that the consistent review of the material would lead to mastery of the material and consequently an increase in self-esteem and an increase in the individual's post-test scores with respect to both socio-sexuality knowledge and attitude change.

The counsellor group.

The counsellor group was at the group home of one of the participating counsellors. Sessions were generally one and a half to two hours long although they were originally scheduled to last one hour. The counsellor group met in the afternoon the day before the clients' group was scheduled. The facilitators met with the counsellors and presented the

didactic material their client would be exposed to the next night in group. Consequently the counsellors knew the exact content of the material and the form in which it had been presented to the client participant.

The counsellor groups generally started with feedback from the counsellors about the homework assignment, interaction with their clients and or any issues that concerned the clients or their own participation in the group. This was typically followed by feedback from the facilitators about client group development and or positive occurrences within the client group. The final task of each counsellor group was the introduction of that week's sessional topic.

Counsellor Session 1

Content.

The first session started with the introductions of the facilitators and participants. The counsellors requested a clarification of their role in the program because little information about the study had been disseminated from the administrators of the agency. The facilitators explained that their roles and responsibilities were to attend the counsellor groups to learn the curriculum of the socio-sexuality education group for their client and to utilise

that knowledge to assist the client in the completion of their homework.

The facilitators then asked the counsellors why they wanted to participate in the group. All of the participating counsellors stated that they wanted to learn more about facilitating socio-sexuality groups and four of the counsellors added that they wanted to learn about the sexuality issues of people with developmental handicaps. One of the counsellors suggested that it would also provide an opportunity to learn more about her own socio-sexuality issues. Three of the counsellors also stated that their participation would assist their client in the generalisation of the didactic learning to the group home. Three of the counsellors stated that they had struggled to deal with their clients' socio-sexuality issues and as a result were frustrated and no longer knew what to do.

Counsellors wanted their clients involved in a socio-sexuality group for several reasons. Three reported that they wanted their client to experience increased participation and socialisation whereas two of the counsellors mentioned that they felt their clients were too dependent on others and thus vulnerable to abuse. One of the counsellors felt that her client had unrealistic perceptions about marriage and another believed that her

client was fearful of sexuality. Poor self-esteem and self-image, inappropriate public behaviour, illegal behaviour, poor hygiene and excessive masturbation were further reasons the counsellors wanted their clients to be involved.

The facilitators also provided the counsellors with an overview of the first session of the client group. The philosophy of the Mainstream model was explained and the counsellors were informed that their clients would be responsible for the development of the group rules, structure and to some extent the curriculum. The counsellors were encouraged to spend time during the week talking to their clients about their group participation and to review the group rules. The first session ended with a facilitator initiated discussion of the myths and misconceptions regarding the sexuality of individuals with developmental disabilities.

Process.

Several of the counsellors were described in the facilitators' process notes as quiet or withdrawn and it was further noted that they made no attempts to interact unless called upon to do so. Two of the counsellors were described as humorous. One was very interactive during discussions and her humour appeared genuine. The second counsellor

engaged in humour that appeared to have been a defense against anxiety. Although this group was not designed to be therapeutic in nature, the facilitators observed that all of these reactions were consistent with the anxiety and uncertainty experienced by individuals at the beginning of therapeutic groups as suggested by Berman-Rossi (1993) and Wickham (1993) and in regard to a sensitive topic like sexaulity.

Wickham (1993) also suggests that group participants will communicate their anxiety concerning participation by engaging in approach-avoidance interactions. In this session Bill felt that he really wanted to participate but had experienced some anxiety because he was the only male counsellor in the group and was afraid that he would be misunderstood. However, by the end of the group he suggested that he felt quite comfortable within the group atmosphere.

Client Session One

Content.

The initial task was the introduction of the facilitators and the group members. The facilitators modelled introductions and shared with the group members where they live, work, go to school and their favourite

food. The members were also required to do the same. Several of the group members easily shared this information whereas others required assistance and encouragement to accomplish this task.

The second task was the engagement of the group members in the development of the group rules, curriculum, structure and naming of the group. Papell and Rothman (1980) suggest that this linking for the specified purposes is a major initial requirement of the Mainstream model. The facilitators spent time making clear to the members that this was their group and that they would have to make decisions, vote and come to conclusions together on certain issues. All of the group members were very active in the development of the group rules and consequences.

A discussion of the curriculum resulted in the members coming to agreement with the facilitators' proposed topics and they liked the fact that we were to meet at the "university." The group ended with the members discussing and then voting on a name for the group. They chose the "CoEd Club."

Process.

The Boston Model's first stage of group development is preaffiliation (Berman-Rossi, 1993; Wickham, 1993). It is

often characterised by anxiety, uncertainty, doubts and fears. This anxiety was evident throughout the session. Initially Jocelyn did not want to enter the room and Jim and Shayne did not take off their coats for the first forty-five minutes. Several of the individuals engaged in their ritualistic beginnings which appeared to be attempts to decrease anxiety and provided insights for the facilitators as to the individuals ability to deal with anxiety in beginning new relationships. For example, Lindsay immediately began to aggressively confront other members about their behaviours; she admonished one individual for rocking in his chair, another for burping and repeatedly told another that she was silly.

Several of the members did not initiate interaction but had to be repeatedly called upon. Perhaps most evident and to be expected due to historic dependency according to Fletcher and Duffy (1993) and Savage and Rowe (1987), was the interactional and conversational flow through the facilitators and not between the members. Wickham (1993) refers to this as "no close ties" dialoguing. For the most part this was typical of the interaction during the break as well although the facilitators did observe some very brief small talk or non-intimate relations (Berman-Rossi, 1993;

Wickham, 1993) between Melissa, a female member, and Joe, a male member, about the evils of fighting in hockey.

Member interaction increased during the development of the group rules. However, this is to be expected as Ludwig (1991) suggests it serves to decrease anxiety, starts the decision making process, introduces socialisation and fosters cohesiveness. Konopka (1978) further suggests that the involvement of the members in the development of the group rules and the curriculum provides a feeling of safety as members experience some control over the environment. Interestingly, Laura who showed the most anxiety during prescreening and initially did not think she wanted to attend group, suggested that one of the rules should be that you must be committed to the group.

Counsellor Session Two

Content.

The session started with feedback from the counsellors with respect to their clients or the homework. Terri stated that she did not feel her client wanted to talk about the group nor did she feel he remembered anything other than the snack. Sue reported that Jocelyn had become more vocal in the home about sexuality. Bill reported that Jim returned home and telephoned his brother to thank him for stopping

neighbourhood children who used to tease him about his developmental handicap when they were younger. Chris and Heidi stated that their clients said they enjoyed the group but would not talk about it.

The facilitators provided feedback about the clients participation in the development of the group rules and all of the counsellors appeared visibly surprised and proud to hear that their clients had participated. The counsellors were informed that the development of each rule resulted in discussion. For example, one of the rules stated that members would not tease each other in the group. The group members were asked why this was such an important rule. Group members stated you should not tease because it can hurt feelings, it is mean and it is wrong. The facilitators believed that this is why Jim found it so important to telephone and thank his brother.

The third task was the introduction of the sessional topic of feelings. The facilitators demonstrated how Ludwig and Hingsburger (1989) have utilised drawings of faces that depict the emotions of sad, angry, surprise and happy to teach individuals with developmental handicaps how to recognise feelings. The facilitators and counsellors also watched the LifeHorizons II (Kempton, 1993) slide show that pertained to feelings and relationships. The facilitators

demonstrated how each slide would be utilised as didactic material and catalysts for discussion, interaction, role play, personal identification of issues and generalisation to the home. The facilitators informed the counsellors that the homework would relate to the feelings curriculum and they were encouraged to complete the homework with the client.

Process.

The facilitators noted that counsellors were involved and interactive with the facilitators and each other whereas the conversation in the first session was minimal and primarily between the counsellors and the facilitators. In fact the counsellors appeared to be engaged in exploration and affiliation (Wickham, 1993) as they often supported what a counsellor had said and provided a common experience with their client. However, the facilitators also observed issues of power and control.

The first power and control issue surfaced during counsellor feedback when Terri confrontationally stated that her client did not want to talk to her about the group and that she "will not pressure him to do so" in order that she "may preserve his dignity and maintain least-intrusive interaction." The counsellor was reassured that her

approach was the best to take. The second situation occurred when the female facilitator suggested that we would work with Lindsay on redirection to interaction with other group members because she appeared to only want to form a relationship with the facilitators. Heidi replied "we've been trying that for a long time! Good luck, it'll never happen!"

Presentation of the material and feedback resulted in spontaneous discussion initiated by the counsellors. For example, during the facilitator feedback Bill wanted to know if anxiety was responsible for the clients' problematic or quiet behaviour during the drive on the way to the group because Heidi reported that the clients were animated and interactive on the drive home. The counsellors agreed that the clients were anxious about the start of the group and this resulted in a discussion about anxiety and dependency. One of the counsellors suggested that dependency forces people with developmental handicaps to please others, whereas Sue suggested they are anxious about participation but they participate because positive interaction means more positive reinforcement from the counsellor.

A second group discussion of interest occurred during the presentation of the slides. The counsellors identified that their clients have minimal, poor or non-traditional

contacts with their families as a result of living in a group home. Consequently, they have little opportunity to learn about appropriate intimate relationships with family members and especially with children. The counsellors agreed with each other that this is an area that is often missing and not fully realised because it is neglected by the workers. They suggested there is often a wide range of ages in one group home and as a result counsellors may fail to realise that a younger resident may need to learn basic relational skills. The counsellors concluded that they require more education with respect to childhood stages of development and the needs of differently aged people with developmental handicaps in order to help the individual learn stage of development appropriate skills.

Client Session Two

Content.

This session started with a review of the eight group generated rules from session one. It is important to note that topics and group developments are not dealt with once and then discarded. Repetition and reviews of the topics were common place throughout the life time of the group as suggested by Anderson (1993) to increase the potential for information absorption, generalisation and retention. The

second task involved a discussion that concerned the membership of an individual who had not attended the first session and had not appeared for the second. The group discussed the issue and a vote was held. All group members agreed that the group should be closed to membership and that this individual would not be permitted to join subsequent sessions.

The Ludwig (1991) feelings pictures were utilised to introduce the sessional topic of feelings. Ludwig and Hingsburger (1989) have used these to assist group members as they learn to identify faces depicting different feelings that include sad, angry, surprise and happy in order that they might learn to read the feelings of those with whom they interact. This exercise generally requires little self-disclosure on the part of the group member. However, when the facilitators asked if any one in the group had ever felt sad, Laura responded that she had recently experienced sadness because someone on the public bus had called her a "mental retard." Laura's self-disclosure resulted in a group discussion during which Melissa talked about how she used to be the smartest in her class and how in grade eight she started to fail tests and her classmates teased her and called her stupid. Hollins and Evered (1990) and Szivos and Griffiths (1990) suggest every group for individuals with a

developmental handicap will eventually work with the implications of living with a mentally retarded identity.

The Life Horizons II (Kempton, 1993) slides on feelings were utilised to further assist in the identification and discussion of feelings. The photographs in this series provide the group members with feelings scenarios that are placed in the context of group homes and the life experiences of individuals with a developmental handicap. The group members were asked to describe what was happening in the photograph and from the descriptions the group leaders were able to facilitate a discussion based on the group members' experiences. Three slides produced considerable interaction amongst the group members.

The first was a slide of a person with Down's Syndrome. When the group was asked to describe the person in the picture Lindsay said "she looks handicapped." This furthered the conversation of living with the label "mentally retarded" and how people define handicapism differently. The second slide showed a person with a developmental handicap sitting in a funeral home. Several of the group members cried as they talked about parents, siblings and friends who have passed away. All of these individuals stated that they had never talked about the issues before. The third slide involved a picture of

friends enjoying an alcoholic beverage. All of the group members said that they did not drink alcohol until Laura, one of the quieter members, stated that she liked to drink once in awhile. After this statement the other members said that in fact they did like an occasional drink as well. The group ended with the handing out of the first homework assignment. The facilitators encouraged the group members to complete the feelings homework with their counsellor.

Process.

The process during the group and break continued to demonstrate signs of preaffiliation. Interactions and communication continued to flow through the facilitators and not between members. `No-close-ties' dialoguing and intimate relationships continued as individuals were either quiet, engaged in limited conversations with each other or attempted to engage the facilitators in private discussion. Approach and avoidance (Wickham, 1993) was also observed. For example, approach occurred when individuals engaged in risk taking and self-disclosure with respect to being called names or recounting both sad and happy relational memories, but avoided risk taking and self-disclosure when admittance to alcohol consumption was required.

However group ownership, democracy and structure development continued and was evident when the members voted to be a closed group and decided not to allow subsequent membership. A second structural development occurred when Melissa independently requested that a ninth rule be added to the list. She suggested that members were not allowed to come to group if they were under the influence of alcohol or illicit drugs and requested that a vote be taken on the matter. All group members agreed that this was an excellent rule and voted to make it permanent.

Counsellor Session Three

Content.

During this session, the facilitators explained how in the client session the introduction of the topic of feelings resulted in a discussion about living with a mentally retarded identity and the emotion presented by the client group members with respect to this topic and the death of loved ones. The facilitators provided the counsellors with an example of how the didactic material may have to be abandoned to deal with therapeutic process in the group. The counsellors stated that they were surprised to hear how deep the emotions of their clients were and were further surprised by their clients ability to share and comfort each

other. One of the counsellors stated that they were surprised it happened so quickly.

Four of the counsellors reported that their clients were committed to the homework and demonstrated a great deal of effort. Two reported that the homework had not been done yet. Bill was concerned because his client consistently confused mad with sad. This was noticed in the client group as well and resulted in a counsellor discussion about why this might be. Through discussion the counsellors came to the conclusion that this individual has been prone to violent outbursts followed by extreme remorse and as a result he concretely related the end state of sadness to the anger. One of the counsellors wanted to know if she should have corrected the homework when the client had answered it wrong. The facilitators suggested that the homework is not graded right or wrong and that they should take the opportunity to engage the client in an exploration to find the answer and in this way model the learning process.

Sue suggested that her client had often fabricated stories when she was mad or angry. For example, she will state that her parents do not care for her or they abandoned her. This resulted in a discussion about the age she entered the group home and Sue pointed out that individuals with developmental handicaps are launched out of the

parental home at a much earlier age then other people. This resulted in a group discussion about the emotional upheaval experienced due to movement into a group home even when there is consistent parental involvement. For example, Jocelyn moved into the group home at age 12 and the counsellors discussed that she would have required more nurturing than a young adult who needs to learn boundaries with the counsellor in order to learn how to form appropriate relationships.

The introduction of the LifeHorizon II (Kempton, 1993) slides on female and male socio-sexuality behaviours and maturation and anatomy also resulted in counsellor interaction and spontaneous discussion. All of the counsellors stressed that the facilitators should emphasise both male and female hygiene. Heidi wanted to know if the men would learn about pre-menstrual syndrome (PMS) because Shayne lives in a house with four women and PMS certainly has had an impact. She desired that Shayne develop an understanding of that impact. The topic of anatomy resulted in the most discussion.

Several of the counsellors reported that their clients experience pain when they are masturbating and suggested that they did not even know if the individual was manipulating their penis appropriately. The counsellors

suggested that they wanted to teach their client how to manipulate appropriately but they do not know how. The facilitator suggested purchase of a realistic penis model for demonstration purposes and possibly a lubricant to decrease friction. The facilitators also suggested that the counsellors can borrow a cervix and vaginal model from the Regional Health Unit to illustrate and demonstrate manipulation for the female clients.

The facilitators also facilitated a discussion about the impact medication or a syndrome can have on sexuality. The counsellors were encouraged to discover if any of their clients' medications could affect sexual performance. Heidi disclosed that her client told her that she had allowed her boyfriend to touch her private body parts but it makes her feel uncomfortable when it is prolonged. The counsellor believed the client was afraid of sexual contact. The facilitator pointed out that this was an individual with cerebral palsy and that people with cerebral palsy are often hyper or hyposensitive to touch. It was suggested that the client's uncomfortable feeling might also indicate hyposensitivity and an aversion to prolonged touch in the absence of fear or anxiety towards sexual contact. However, it was possible that both hyposensitivity and fear or anxiety of sexual contact were simultaneously present.

Process.

The counsellors appeared to be more cohesive as a group than in earlier sessions. They engaged in mutual aid and problem solving during the slide presentation when they engaged in discussion about the usefulness of a slide or when they generalised the material they had learned to other clients in the group home. The counsellors were observed talking to each other versus over each other as they had in the first two sessions. However, two of the counsellors were absent and this may have been a factor. One of the members was absent due to a recurring illness and the other was attending to a sick relative who was hospitalised.

The power and control struggles of the second session were noticeably absent in this session. The facilitators noted that the counsellors viewed them as the experts on sexuality and disability and presented the facilitators with many questions.

Client Session Three

Content.

Session three started with the review and collection of the feelings homework from the week before. Several of the members were excited to show their homework except for Shayne and Joe who had not completed theirs. Joe had not

completed his because his counsellor had been sick during the week and Shayne did not complete his although he had been approached by his counsellor on several occasions to do the homework.

The second task consisted of the introduction of the sessional topic. The group was segregated by gender: the male group members accompanied the male facilitator and the female members accompanied the female facilitator to work with the Life Horizons II (Kempton, 1993) Male Socio-sexuality slides and Female Socio-sexuality slides respectively. These slides have been utilised by Martin and Forchuk (1987) to convey didactic information concerning maturation, anatomy, masturbation, menstruation, hygiene, public and private behaviours and appropriate and inappropriate behaviours.

Following the break the group was reunited and the male members were encouraged to educate the women about male maturation and anatomy and the women were encouraged to do the same for the men. The group members were further encouraged to use the LifeFacts diagrams (Stanfield & Cowardin, 1990) and anatomy diagrams supplied by the Regional Health Unit to help in the explanation of topics such as menstruation and ejaculation to their fellow group members.

The session ended when the group members received their homework covering the session's topics (Appendix E). The facilitators asked the group members to keep the homework in a safe place and out of the public view due to the graphic and explicit content of the homework.

Process.

The facilitators observed some movement in process from the stage of preaffiliation into the stage of power and control (Berman-Rossi, 1993; Wickham, 1993). This stage is characterised by some conflict between the members and the members challenging the authority of the facilitators. Some trust is developing and members become anxious as the facilitators begin to pull out of the process in order to foster the further development of mutual aid. The Mainstream model maintains that challenges to facilitator authority are natural and relate to the group's movement towards autonomy (Papell & Rothman, 1985).

The noncompletion of the homework on Shayne's part was viewed as a power and control issue. His counsellor had approached him on several occasions and he refused to do the homework. Shayne attempted to complete the homework while the other Joe became angry during the group discussion about this issue. With assistance from the facilitators the group

engaged in problem solving and decided that if homework was not completed that member had to complete it outside before they could join the group that evening. This resulted in the group adding rule number ten that states "individuals will complete their weekly homework and acknowledge the consequences."

Power and control was also evident when the men refused to participate in the slide presentation as they appeared to be shocked and embarrassed by the content. Although this reaction was the result of anxiety, the mens' reactions were certainly power and control in nature as they either turned and looked out the window or verbalised "I'm not going to look at that!" Their anxiety was also apparent when all three initially disclosed that they do not experience erections nor do they masturbate. According to the female facilitator the women reacted well to the curriculum content with the exception of one of the women whose reactions were similar to that of the men.

The women remained interactive and all participated in the explanation of female development and maturation to the men. Jocelyn confidently told the men that "women can masturbate too!" Melissa used the LifeFacts drawings and the anatomy charts to explain to the men how and why women menstruate while Lindsay described to the men that women can

sometimes be very "moody and cranky" during this time and Laura explained that you do not have to menstruate. She continued on to comfortably explain that she had an operation and had not experienced a period for sometime.

The men on the other hand were quite subdued and quiet. Their answers and explanations were short and generally consisted of two to three word answers and or explanations. As a result the male facilitator assisted the men by using the drawings and pictures. The women remained captivated throughout the discussion and easily engaged the facilitators in discussions about erections and male anatomy.

Interaction during break continued mostly with the facilitators. However, the facilitators did observe some interactions but these tended to be of the non-intimate nature and between members of the same sex only. The facilitators also noticed that interaction between themselves and the group members also tended to be within gender.

Counsellor Session Four

Content.

The counsellor feedback focused on homework during this session. The counsellors reported that the clients are

excited to do their homework and proud of the completed product. Heidi said that when she asked Shayne if he wanted to do his homework he said yes and then went to his dresser to retrieve it from the bottom of the drawer. She said she had to laugh because he had hidden it under his clothing. The other counsellors all stated that their clients had hidden their homework as well. In fact, Sue reported that Jocelyn wanted the homework locked in the medical cupboard.

The facilitators explained that the clients had only followed group rules as they were asked to hide it and not show it in public because of the explicit material it contained. The counsellors continued to think it was funny but did understand that this was a continuation of the private and public component of the curriculum. Bill said he now understood why the other group members with a developmental handicap had "loudly" told Jim to put the homework away when he had looked at it on the drive home last week.

Heidi stated that Shayne appeared to be confused and embarrassed when he attempted to complete the anatomy homework. The counsellor group discussed the issue and deduced that the client used ambiguous or inappropriate answers to distance himself from anxiety provoked by the material or the situation. The group and Heidi both

concluded that he might have felt uncomfortable and anxious about completion of the homework with a female counsellor. Bill stated that he has found it difficult to complete the homework because his client is tired from work. He suggested that he could do the homework with both as it might be more comfortable for Shayne and Jim might be more motivated to do it if the work is completed with Shayne. The group agreed that this was an excellent suggestion.

The facilitator feedback consisted of positive remarks about the progress of the group members with a developmental handicap. The facilitators agreed with Sue that Jocelyn utilised "fantasy stories" to defend against the anxiety produced by the material. However, we suggested that she returned to the "here and now" when confronted with humour and capably answered questions. She had also increased her interaction with other group members.

All of the counsellors were surprised to hear about their client's commitment and involvement in the group, but none so much as Chris who has two clients in the group. The facilitators reported that Laura no longer looked to Melissa to gauge the safety in the group but had started to initiate contact on her own. Melissa was described as a natural group leader who has initiated the inclusion of other group members and has empathised with them. Chris states that she

did this the other day. Chris had called herself stupid and Melissa gave her a hug and said "you are not stupid, don't ever call yourself that." Chris stated that after having heard about how Melissa was teased in school she could understand the hug, empathy and importance of the support. Chris stated that she has decided to talk more positively around Melissa.

The group finished for the session after the counsellors viewed the LifeHorizons II (Kempton, 1993) slides with respect to relationships. The facilitators quickly presented the game Perfect Partner Poker that was to be played in the client group the following night. Both presentations were short because of the amount of discussion during the counsellor group.

Process.

The group members were engaged in problem solving and mutual aid throughout the session. The facilitators noted that it appeared the distinctive group home boundaries had disappeared and that the group was at its most cohesive. This was illustrated by the process the counsellors underwent to ensure that Shayne completed his homework in a dignified and comfortable atmosphere. The counsellors also stated that their time together in group had continued to be

an invaluable experience. They suggested that after the program they would like to continue to meet to learn more about sexuality in general and sexuality and developmental handicaps.

The facilitators further observed that the cohesion and trust had developed to the point where the group members felt safe enough to sensitively challenge another's attitudes. This occurred when the facilitators told Heidi that they were impressed with Lindsay and praised her because she had said that she had talked to her boyfriend about her PMS. The counsellor replied that "it's sad if that is the only positive of the relationship." Bill and Sue replied with "it's a starting point" and "yeah" respectively. The facilitator suggested that we should identify the positives because Lindsay has probably heard only the negatives of her relationship. Heidi agreed and said that she could see the point.

Client Session Four

Content.

The session started with the collection and review of last week's homework assignment. Once again all of the members were eager and appeared proud to hand in the homework. Especially proud was Joe who had not completed

his homework because his counsellor had been ill. He smiled quite broadly as he handed in two weeks of completed homework. The other group member who had not completed his homework participated in the review by holding up the pictures on the homework as the group reviewed.

The second task involved a continuation of the topic of anatomy. Group members continued to discuss topics related to grooming, genital cleanliness, menstruation, erections, and masturbation while opportunities were presented to discuss these issues. The introduction of relationships as the sessional topic followed the brief continuance of anatomy and maturation. The Life Horizons II (Kempton, 1993) slides pertaining to the topic were utilised to present didactic material and encourage discussion.

Group members viewed the slides and discussed the many different types of relationships that one can have during their lifetime. These included friends, family and intimate partners. The presentation and subsequent discussion also included components about dating and differentiating between dating and social activities with counsellors and other caretakers as well as an introductory component about gay, lesbian and heterosexual relationships. Group members were also presented with material and encouraged to discuss what they perceived to be good and bad qualities of

relationships. During this discussion Lindsay disclosed that she does not like when her boyfriend touches her breasts because "he is too rough and hits my chest hard." This comment resulted in a discussion with respect to the importance of the ability to communicate to your partner how you like to be touched and how you do not like to be touched and that this communication is a sign of a good relationship. This discussion also allowed movement into the presentation of the topic of sexual assault and the legal consequences.

Melissa had asked "what if he continues to touch your breast and you say no?" The group was told that this constituted sexual assault and that the consequence for such behaviour was being arrested and going to jail. The sexual assault curriculum and presentation was designed to provide group members with the ability to identify sexual assault and how to protect themselves from becoming a victim and the legal consequences if they sexually assaulted a person.

The group discussed other scenarios of sexual assault and role played "no, stop and go." Group members were taught to scream "no" or "stop" and then to run. It was also suggested to the group members that they can yell "fire" or carry a whistle to blow if someone is attempting to hurt them or touch them in a way that is considered a bad

touch. Bad touch was defined as any touch that feels uncomfortable or that is not welcomed. Time was also spent discussing the concept of "crying wolf" and only yelling "fire" or blowing the whistle if someone is trying to touch or hurt you. The homework for this session included sections on the characteristics of good and bad relationships,
dating, gay, lesbian and heterosexual relationships and sexual assault (Appendix F).

Process.

The group appeared to be fully in the group development stage of power and control as defined by Berman-Rossi (1993) and Wickham (1993). Recall that this stage is characterised by conflict between group members and with the facilitators. Wickham (1993) refers to the formalising of relationships that may occur during this stage. Generally one will observe the development of cliques and alliances that will often attempt to scapegoat certain group members. Jim and Lindsay, a male and female, colluded, criticised and teased Shayne for the way he had operated the slide projector. Shayne, who had been described by the facilitators as quiet and shy, independently admonished the two members for having told him how to run the slide projector.

Earlier Jim had also engaged in testing of the emotional and psychological positions of the group (Wickham, 1993). When he first arrived he was accompanied by his counsellor and as they approached the male facilitator the group member stated "I don't want to be here!" When he was asked if he wanted to continue in the group he mumbled "yeah." As soon as the counsellor left he smiled and interacted during group. Although this behaviour indicated that he was secure within the group (Wickham, 1993), it was also indicative of his affront to the authority of the facilitator and how this would be handled in the presence of his primary caregiver.

Wickham (1993) suggests that withdrawal from the group process is also a sign of testing of the emotional and psychological positions within the group. This occurred throughout the group session when Jocelyn continuously attempted to interrupt and change the subject. The facilitators believed this was an attempt to decrease anxiety caused by the content. However, Laura directly confronted the male group facilitator who has a habit of speaking boisterously. At the beginning of the group she stated "I have new hearing aids and my ears and hearing are really sensitive, so could you please keep your voice down?"

She also later disclosed that she did not like talking about rape.

The facilitators did observe some of the characteristics of the Boston model's third stage of intimacy. The stage of intimacy is characterised by the development of trust, a willingness to take risks, increased self-revelation and a sense of cohesion that results in members becoming more supportive as mutual aid develops (Berman-Rossi, 1993; Wickham, 1993). Three of the female members took a risk and self-disclosed about their boyfriends. Jocelyn said that she is not allowed to call her boyfriend and he is not allowed to call her. A second member shared with the group that she met her boyfriend when they were living in the same group home. She continued on to share that she has allowed him to kiss her and touch her breast, "but that's it!" The third member, Lindsay, had disclosed that she does not like when her boyfriend touches her breasts because "he's too rough."

Mutual aid and problem solving were introduced by Melissa who took a leader role and attempted to facilitate the resolution of some of the power and control issues she had observed in the group. Melissa also attempted to increase interaction between group members during break but

for the most part conversation and interaction continue to flow through the facilitators.

Counsellor Session Five

Content.

Bill and Terri were unable to attend the session. Bill was attending a meeting and Terri was absent due to a recurring illness. Two of the counsellors stated that their clients had not completed the homework but had made appointments to do it that night. Heidi also reported that Shayne was to have met with Jim and his worker to complete the homework but there had been a scheduling problem and they had not met. Sue reported that her client procrastinated for one hour before she would complete the homework with her.

The facilitators wondered if the counsellors had explored the answers with their clients because several homework assignments were handed in to the facilitators with incorrect answers, blanks and "I don't knows" written on them. The counsellors suggested that they had explored the answers and Chris inquired if we wanted both the original and the corrected answer. The facilitators suggested that this would be acceptable but certainly the correct answer should be there because the philosophy of the approach has

remained the reinforcement of the didactic material presented in group. The counsellors also wanted to know if they should correct what they have perceived as negative attitudes. The facilitators felt the counsellors should discuss the attitudes with the client but should not deny them their attitudes. The counsellors agreed.

The facilitators provided feedback about Jocelyn because her counsellor continued to be concerned about her fantasies and how to work with them. The facilitators assured Sue that they concurred with her observation that Jocelyn has maintained a fantasy perspective with respect to relationships. We also understood the frustration because Jocelyn had demonstrated a refined skill of changing the subject when it appeared her fantasy would be challenged by realistic material. However, we felt that this was a defence against the anxiety of lost fantasy. As a result the group discussed the function served by defences and what to do once they had been identified. Techniques suggested included role modelling comfort, directives, normalisation using self-disclosure, legitimisation of anxiety, discussion about the importance of knowledge and working to develop a safe and secure environment by engaging the individual in an accepting and private discussion.

The facilitators introduced the use of the anatomically correct dolls to teach intercourse. The facilitators demonstrated how the dolls would be utilised to demonstrate foreplay, intercourse and different sexual positions. The facilitators also explained that the client group had not played the Perfect Partner Poker game in the last session and thus it would be played as a review of the relationship component of the curriculum in the next session.

Process.

The facilitators noted that the group was quiet and this may have been a result of the absent members. However the group continued to engage in problem solving and mutual aid. Interestingly the group changed the subject at the start of the intercourse demonstration with the anatomically correct dolls. The group laughed when the facilitator pointed out that they had changed the subject and wondered if this behaviour was comparable to the client's utilisation of subject change to move the group process away from anxiety provoking topics. The facilitators noted a great deal of nervous laughter and joking throughout the remainder of the presentation. However, it was humorous and appropriate at times.

Client Session Five

Content.

The session started with the collection and review of the following weeks homework. The members suggested that they enjoyed doing the homework but found the sexual assault component disturbing. The group then proceeded to review and practice when to yell "rape", "fire" or blow the whistle and discussed the importance of not "crying wolf." The group was also reminded that sexually assaultive behaviours can result in being charged and jailed. Shayne was able to verbalise to the group that he did not feel comfortable doing his homework with his female counsellor. He told the group that he had discussed this with her and that he was going to do his homework with Jim and his counsellor. Unfortunately there had been some miscommunication between the group homes and Shayne was unable to complete the homework.

This was the first session where a group member wanted to share something with the group in an open forum. Group members had been invited to share anything they wanted they wanted to share with the group since the first session. Jim told the group that he had been at a convenience store during the week and that a teenage boy had punched him. He then pulled up his sleeve and showed the bruise. He

commented that it is wrong to hit people and so he used the telephone at the store to call his counsellor and then the police.

The third task was to finish the relationships component of the curriculum by playing a card game produced by the Regional Health Unit called Perfect Partner Poker. Each card has a positive, neutral or negative statement on it about an intimate partner. Refer to the first page of Appendix F for examples of the statements. All of the statements for the exercise in the homework were taken from this game. Again, this provides an excellent example of linking material from session to session.

Group members formed three teams. The teams were dealt five cards and the goal of the game was to discard statements that were indicative of a bad relationship. Each team had two opportunities to throw away two cards at a time. The teams were then required to read and explain why a card illustrated a good or a bad relationship. The team with the most positive statement cards left was declared winner.

The fourth task was the introduction of sexual intercourse as the sessional topic. The group facilitators used anatomically correct dolls to demonstrate sexual intercourse as suggested by Huntley and Benner (1993) and

Martin and Forchuk (1987). The dolls were fully clothed when introduced to the group and the facilitator placed a towel over his lap and chest as suggested by Ludwig (1991). The facilitator explained that he would cover the dolls up during discussion in the group and if someone came to the door or into the room. This was done to reinforce the concepts of dignity and private and public behaviours.

The facilitators utilised the dolls to explain the concept of foreplay and the foreplay behaviours of hugging, kissing and touching. The facilitators also identified the physiological changes associated with foreplay and arousal which included: perspiration, breathing changes, erect nipples, erect penis, moisture and warmth in the vagina and pre-ejaculate on the tip of the penis. This component of the curriculum also included a discussion with respect to relationships and sexual intercourse and emphasised relational boundaries to decrease the possibility of exploitation and abuse. The presentation ended with a demonstration of the anatomically correct dolls having intercourse in different body positions. The facilitators also used the dolls to illustrate oral sex and encouraged the group members to discuss this with their partners because they should never be forced to do this if they do not like it. The group received the relationships and

sexual intercourse homework (Appendix G) at the end of the session.

Process.

The facilitators observed that the process at the beginning of the session was affected by the presence of the counsellor who transported several of the group members to and from group. The group members became quiet and less animated whereas they were loud and boisterous when they had entered the room. When the counsellor left there was a systemic change back to loud and boisterous with happy undertones.

The facilitators observed the group movement fully into the stage of intimacy. Cohesion and support were evident when Jim shared his story about being hit and phoning the police. Praise was initially given him by Melissa and then the other group members joined in. As well, the group members also appeared to be more engaged and socialised independently during break. The facilitators noted that there was no longer just one person speaking, but several conversations were taking place.

Cohesion, mutual aid and decision making were also observed during the Perfect Partners Card Game. The group members listened intently to the female facilitator's

description of the game's rules. The group members were interactive during the game as observed when they helped each other, stated their opinions and made decisions about the cards to keep or throw away. There was laughter throughout the process. In fact, Jocelyn who had been resistant to group interaction in prior sessions insisted on reading her team's cards to the group even though she had a terrible cold and laboured speech.

The facilitators also observed some regression and increased anxiety during the use of the anatomically correct dolls and the sexual intercourse presentation. The group members were very quiet and sat with closed body postures and for the most part they had horrified and shocked looks on their faces. Although Jocelyn's participation had improved during the card game, she regressed to her early interactional patterns and attempted to change the subject. As a result the other group members had become annoyed with her and had started to tell her to be quiet. According to Ragg and Rowe (1991) this type of monopolising and scapegoating is quite common. They suggest that this behaviour usually coincides with sensitive sexual topics and may serve to decrease anxiety by moving the group away from sexually explicit material. When she realised that the content of the session was not going to change Jocelyn was

apparently forced to say "could you please put their clothes on and put them away. I don't like this. It makes me feel very uncomfortable." This resulted in a discussion about feeling uncomfortable with the material after which all members appeared to experience a decrease in anxiety, became more interactive, took risks and started to ask questions.

Melissa asked if it hurts the first time and also wanted to know if your husband can force himself on you when you do not want him to. She and the other group members appeared shocked to learn that this would also be considered sexual assault. Apparently Jocelyn's anxiety had decreased because she stated "then you can arrest your husband and send him to jail." After having witnessed the risks taken Laura pointed out to the group that "the man doesn't always have to go on top because the woman can go on top too."

Counsellor Session Six

Content.

Sue reported that Jocelyn was explicit when she came home and excited to show her how the dolls work and what intercourse is. Sue was pleased because her client had procrastinated in the recent past when it was time to do the homework. At one point Jocelyn grabbed the pen out of Sue's hand and said "I can do this." Bill reported that he

believed both Jim and Shayne had benefited from doing the homework together. Chris reported that her women like to complete the homework together as well. She said it is very much a peer relationship and they discuss the answers not only with her but with each other.

Heidi stated that she utilised the homework with her client to reintroduce the topic of touch. Lindsay disclosed that she liked when her boyfriend touched her but he tended to touch her roughly. She also disclosed that her vagina gets very warm when he has touched her and Heidi reported that she was "stunned" that her client would self-disclose this kind of information to her. Terri reported that Joe yelled at her to wait when she was leaving work last week. Joe had just returned from group and he wanted to show her his homework. She stated that he was very proud.

Two of the clients reportedly continued to experience some anxiety with respect to intercourse. Chris stated that Laura would not discuss masturbation or intercourse and Sue reported that Jocelyn closed the book when they reached the homework question with the picture of a couple engaged in intercourse. However, all of the counsellors stated that they have seen dramatic changes in their clients and Bill stated that the experience has changed the way he has interacted with all of his clients.

The counsellors reported that they were concerned about one of the questions on the last homework assignment. They did not know if two men or two women could have intercourse. As a result Heidi called Chris and because they did not know the answer they called Bill. When Bill could not provide an answer Heidi called a lesbian friend but could not reach her. Thus, Bill asked the facilitators what the answer was because they did not want to have the wrong answer on the homework. The facilitators asked: "How did you handle the question with your client?" Bill stated that they "talked and explored the possibilities together."

The facilitators suggested that "the wrong answer was not the issue. Perhaps more important then the correct answer was that you engaged in discussion and problem solved with your client." Bill suggested that maybe for the first time he truly engaged in reciprocal communication and problem solved with a client. He further stated that since he started the group he has questioned how he has operated in his role as a counsellor over many years. The facilitators added that regardless if the counsellor felt they reached a satisfactory answer, when they contacted each other they role modelled problem solving, reciprocal communication, networking, the concept that it is okay not

to know and how to go about researching to find the answer and rectify the dilemma.

The presentation of the sessional topic of pregnancy and contraception was shortened due to the amount of discussion and interaction with respect to homework issues. During the presentation the facilitators observed that the counsellors knew little about the different types of female contraception and how they are applied or utilised. In fact, there was one instrument in the Regional Health Unit's package that the facilitators could not identify and hence promised to discover what the instrument was.

Process.

The counsellors' sense of cohesion and ownership of the group appeared to be at its strongest yet. Several discussions throughout the group illustrated the use of mutual aid and problem solving. The fact that they called each other for clarification purposes would indicate that mutual aid and problem solving are supported outside of the group as well.

The group members also supported each other as they took new risks and disclosed their own feelings and insights into their work with people with a developmental handicap. The support of group members' emerging uniqueness or

difference is a sign of ultimate cohesion according to Wickham (1993).

Client Session Six

Content.

Melissa wanted to share a story about something she had observed on the bus the day before. She stated that the two people sitting beside her "necked" the entire ride. She wanted to know if this was okay. The group reviewed and discussed private and public behaviour and concluded that kissing for prolonged periods of time is private and they should not have done it. They did agree that a quick kiss hello or goodbye would have been acceptable. This discussion was followed by a review and collection of the relationships and intercourse homework. Shayne told the group he had completed his homework with Jim and his counsellor and had enjoyed the experience. Jim said it was fun and all of the other members were excited to hand in theirs as well.

The topic for the session was pregnancy and contraception. The facilitators used the anatomically correct dolls to reintroduce the topic of intercourse and pregnancy and to illustrate the birth of a child as suggested by Ludwig (1991), Martin and Forchuk (1987) and

Monat-Haller (1992). The LifeFacts pictures (Stanfield & Cowardin, 1990) and flip charts from the Regional Health Unit were utilised to illustrate the processes leading to conception and the moment of conception.

The facilitators noted that the group members were extremely interactive on topics such as female genitalia and ovulation, male genitalia and ejaculation, the process of conception pregnancy and the corresponding body changes and the delivery process. Although Jocelyn initially stated for the second week in a row that she did not like the material and proceeded to wander around the room, she eventually returned to the group on her own volition and participated. Lindsay used the pictures and was excited as she explained to the other group members how the sperm "swims to the egg." Melissa wanted to know what the term stillborn meant. This resulted in a discussion of the problems and corresponding feelings that can accompany a pregnancy.

The goal of the curriculum component that included contraception as suggested by Anderson (1993) and McCabe (1993), was for the group members to gain knowledge about how to use contraceptives, where to obtain them and that contraception is the responsibility of both men and women. A female contraception kit that is similar to the one used by Martin and Forchuk (1987) was borrowed from the Regional

Health Unit. Most of the female members identified the contraceptive pill and Lindsay explained to the men that you have to get a prescription to go on them. However, like the men, they did not know about the other methods of female contraception in the kit.

The group members received a demonstration of how to check a condom for the expiry date, tears and punctures. The members knew that the condom should be thrown away if there was a tear, puncture or if it had expired. The male facilitator then demonstrated how to open the package carefully and placed the condom on a realistic model of a penis. The group members were then provided with their own condom and were asked to practice placing it on the penis. Laura happened to have the one with a puncture placed in it by the facilitator and she quickly reported this to the group at which time several members told her to throw it out. The session ended with the handing out of the human reproduction homework (Appendix H).

Process.

During this session the facilitators observed that the group process continued to operate in the stage of intimacy but moved slightly towards the Boston Model's stage of differentiation (Berman-Rossi, 1993; Wickham, 1993). The

facilitators observed increased cohesion and a sense of security that is consistent with the stage of intimacy. Observations indicated that the group members no longer interrupted each other but had taken the initiative to interact with each other and the facilitators. The most dramatic change was observed during break. The group members initiated topics of conversation and interaction with each other where they had relied on the facilitators for interaction and topics of discussion in prior sessions. The interaction was very relaxed and appropriate.

The facilitators also identified increased risk taking when individuals volunteered to place the condom on the penis. This exercise also presented the group with an example of acceptance and support and hence one of the first signs of movement into differentiation (Wickham, 1993) when members who had initially refused to place the condom on the penis where encouraged by the other members to attempt the task. In the end all but Joe participated in the exercise. In fact, the facilitators had often wondered if Joe was viewed as a valued group member by the others because of his quiet nature. However, this session provided an opportunity for the facilitators to observe how important he was to the cohesion of the group and the group identity.

Joe tended to be fifteen minutes early to every group and was always the first arrival. When he had not arrived by the start of the group the male facilitator suggested we commence with out him. At this point Jim said that we should not start without him and several other group members agreed. Four of the group members volunteered to go look for him and as they moved towards the door he entered and the group cheered. He looked confused and apologised for being late because he "had to pour pills at home."

According to Wickham regression and ambivalence to the change process is also a characteristic of the stage of differentiation. This was observed on two occasions during this session with Jocelyn. The first involved Joe when he and Jocelyn announced that they had talked at work and that they had decided to get married and go on a honeymoon. When Jocelyn was sensitively confronted, another characteristic of the stage of differentiation (Wickham, 1993), about her relationship with her other boyfriend she apologised to Joe and told him that the other party was still her boyfriend. Jim noticed that Joe appeared to be on the verge of tears and pointed that out to Jocelyn. At this point the other group members sensitively challenged her and told her that she cannot tease people like that and play with their emotions.

The second incident occurred when Jocelyn pulled her skirt up and "flashed" the male facilitator. Lindsay observed this and immediately and appropriately challenged the behaviour of Jocelyn. Laura later added that when she sits down she crosses her legs and never lifts her skirt. However, the group members did not scapegoat her as they welcomed her back into the group process and discussion quickly.

Testing of new behaviour is also a characteristic of the stage of differentiation. Jim stated at the start of the group that he wanted to lead the session. When the facilitators suggested he could he said "no, no." The facilitators then offered him the opportunity to start the group and he smiled and told the other members to get their homework out for review.

Counsellor Session Seven

Content.

Terri started the session when she reported that her client came home angry after group last week and said that he wanted to talk in private. Joe stated that Jocelyn had told the whole group they were to be married and that it made him angry. The counsellors praised him for his desire to talk about how he felt and for the expression of his

anger instead of negative behaviour. Terri stated that the staff were quite amazed because the client's clear and appropriate communication and his request to speak in private were a first. The story was clarified for the counsellors and all were impressed with the role their client played.

Sue was impressed by the fact that her client could be confronted and then return to the group as she has always withdrawn from interaction after having been challenged. She also stated that Jocelyn returned from the group and asked if she could take her boyfriend to a movie and if Sue would chaperone. Sue telephoned the client's mother who has been against her daughter dating in the past because she felt that her daughter is naive and will be taken advantage of. However, she gave her permission for her daughter to go on a chaperoned date.

All of the counsellors reported that their clients were excited to do the pregnancy and contraception homework. Bill, Sue and Heidi stated that they were surprised and impressed with the knowledge their clients had retained and knew about the topic. Bill also stated that Shayne had easily answered the homework questions and interacted with Jim. He believed that the successful completion of the

homework for Shayne was the direct result of interaction with a male counsellor.

Several of the counsellors continued to report other changes observed in their clients. For example, Bill reported that Jim has controlled his anger since the start of group and that there has been a complete cessation of aggressive behaviour. The female staff in the home reported that he had sought more interaction with them and this had surprised them because he tended to seek interaction with men only. He reported that he also believed that his client was happier and that his self-esteem had improved. Heidi reported that reports were received at all the group homes that their clients were actively policing each other outside of the group. She believed that the group rules have generalised. The counsellors also suggested that their clients' general hygiene had improved and Terri said that the group was important to her client and that she was happy to hear about the other members who wanted to go look for him when he was late.

The presentation of the sessional topic of Sexually Transmitted Diseases (STDs) resulted in a great deal of discussion. The counsellors enquired whether or not the facilitators were going to distinguish between STDs and rashes because several of their male clients have rashes in

their groins. It was also stated that the men cannot apply the medicated creams independently because they cannot see all of the rash and the counsellors further stated that this is an impediment to teaching privacy and good and bad touch. The facilitators said they would emphasise to the client group that one probably does not have a STD if sexual touching is not occurring. It would be further stated that any time the client experienced discharge, pain, a burning sensation when urinating, a rash, or blistering that they should inform their caregiver or a Doctor immediately.

The facilitators also suggested that the counsellors purchase a mirror with plastic or rubber edging and that it be used to teach the individual to see under the scrotum and the anal area. The counsellors thought this to be a great idea and one that would be useful to utilise with the women as well. The facilitators also suggested the purchase of boxer type shorts where brief style underwear is not required for support. This would decrease the chaffing and contact of the underwear on the skin of the groin in perspiration areas.

Process.

The facilitators observed that the members' earlier group participation in problem solving and mutual aid had

shown dividends. In an earlier session the group had come to the conclusion that Shayne was uncomfortable when he attempted to complete his homework with his female counsellor and so the counsellors decided that Bill would attempt to complete the homework with him and Jim. During this session it was reported that Shayne had easily and knowledgeably completed his homework and that the arrangement had a positive impact on Jim who appeared to be more motivated.

The facilitators also noted that the counsellors had actively sought out answers and were committed to the work of the group. In a prior session the group had sought information about gay and lesbian intercourse and then wanted to know about the use of the contraceptive foam plunger. These situations resulted in a member initiated discussion about how little they know about sexuality issues that have never effected their own lives but might effect their clients. As well, Heidi not only wanted the homework before the client group so she could better meet her clients' educational needs, but she also brought in a rubber model of a vagina for the facilitators to help illustrate STDs and intercourse.

The counsellors continued to engage in self-disclosures and supported the emergence of each members' unique

attributes. Paula enquired how she could teach a client with a chronic groin rash not to sleep with underwear on under his pyjamas. She stated that when she told him he did not have to, he reacted with shock and disbelief. This resulted in another worker sharing a personal story about how she also did not know that until she went to university. She laughed and said that when her mother found out she shrieked "I raised you better than that!"

As a result of this self-disclosure two other group members discussed recent conversations they had with family members. One said she had told her mother about some of the topics and activities she had talked about or participated in during group. She said her mother nearly went into shock and could not believe she was openly talking about this material. The counsellor admitted to her mother that she has realised there is a lot that she does not know about sexuality. The second member stated that she told her husband about some of the topics and activities too. She stated that he was horrified and said "My God, just what are they doing in this group?" She laughed and told him models and anatomically correct dolls are being utilised and that she has learned a great deal.

Client Session Seven

Content.

The session started with the entrance of Lindsay who was extremely agitated. She was screaming and swearing and banging her umbrella on the coffee table. She told the group that her boyfriend wanted to go to his brother's house on the coming weekend. She said that she did not want him to go because they are supposed to go to an all weekend workshop together. She continued threatening to punch him in the head and forcing him to go with her. This situation continued for approximately thirty minutes and ended when the facilitators directly stated to Lindsay that it is her relationship and her right to be angry with her boyfriend and that it appeared that she and her boyfriend needed to discuss the matter further. It was explained that this might result in a fight and that happens in good relationships as well but it was made clear that she cannot hit her boyfriend or threaten him because we do not want to see the boyfriend hurt, Lindsay in legal trouble or the end of the relationship. Lindsay appeared calmer and stated that she will call him but will not hit him.

The second order of business involved Jim who wanted to share with the group an experience he had the day before. He stated that his mother had been hospitalised and was not

in good health. He stated that he had difficulty at work the next day and could not concentrate so he approached his manager and told him about the phone call. The manager asked him if he wanted to go home and Jim said "no, back to the workshop to calm down and see people." He told the group he went to the workshop and relaxed and talked with "friends." He returned to his community job the next day.

The group then handed in their pregnancy and contraception homework and the review of this material served as a springboard into the sessional topic of sexually transmitted diseases (STDs) and prevention measures. Anderson (1993), Monat-Haller (1992) and Savage and Rowe (1987) suggest it is important that individuals with developmental handicaps receive knowledge on this topic and all include this component in their own socio-sexuality education group curriculums. The goal was for the individuals in this group to gain knowledge about the types of STDs, the symptoms and how to recognise them, where to get medical examinations, treatment and the use of condoms to reduce the risk of catching or transmitting a STD.

The concept of disease transmission is abstract at best and therefore the facilitators utilised as many visual aids and teaching techniques as possible to convey STD information. The facilitators utilised condoms and a

realistic model of a penis to help illustrate the point as suggested by Ludwig (1991) and Martin and Forchuk (1987). The facilitators also used a rubber model of a vagina that was donated by Heidi who participated in the counsellor group.

The facilitators demonstrated the spread of germs by placing a mixture of hand care lotion and pepper or paprika on their hand and then shook hands with one of the group members. When the group member looked at his hand he reported that the pepper and paprika were "all over me." This technique was suggested to the author by G. Katz (personal communication, May, 1995) a socio-sexuality educator for people with developmental handicaps at Surrey Place Centre in Toronto, Ontario. The facilitators emphasised that germs cannot be seen but just as the demonstration proved, STD germs are spread by skin to skin contact and almost always by skin to skin sexual contact.

The facilitators proceeded to demonstrate the spread of STDs via sexual intercourse and used the hand lotion, pepper, paprika and vagina and penis model to illustrate. For example, the lotion mixture was placed on to the penis which was inserted into the vagina. The vaginal model was then passed around the room so that group members could identify that the "germs" had been transmitted from the male

carrier to the woman's genitalia. The facilitators also demonstrated with a female carrier and transmission to a man's penis to illustrate that both men and women can be carriers and transmitters of STDs.

The same process was carried out with a condom on the man's penis. The first demonstration involved the condom being placed over the penis with the lotion mixture. The vaginal model was once again passed around the room and the group members reported that the STD had not been transmitted to the woman's genitalia. The second demonstration illustrated how the lotion mixture was on the condom and not the penis after a man had intercourse with a woman who had a STD.

A discussion of how to recognise STD symptoms followed the transmission demonstrations. The LifeFacts pictures (Stanfield & Cowardin, 1990) of STD symptomology were utilised to provide graphic drawings of the visual symptoms. This component of the curriculum was followed by a discussion of who to tell and see if a person thinks they might have a STD and the various treatments available for the different STDs. The facilitators repeatedly emphasised to the group members that it was highly unlikely that they would have a STD if they were not having sexual contact of any kind.

The last segment of group was spent viewing the Life Horizons II (Kempton, 1993) slides to illustrate and provide catalyst for discussion about marriage and marital issues. This provided an excellent opportunity to further discuss disagreements in relationships and allowed the group explore options for reaching an agreement. Lindsay participated and listened closely. The session ended when the STD homework was handed out (Appendix I).

Process.

The facilitators observed that the group process has moved from the Boston Model's stage of intimacy to the stage of differentiation (Berman-Rossi, 1993; Wickham, 1993). During the stage of differentiation the group is actively engaging in mutual aid and is continuing the work from the intimacy stage. Fletcher and Duffy (1993) suggest members are now more accepting of individual differences and support each other's attempts to try new behaviours and skills developing as a result of the increase in knowledge the curriculum and the feedback group interaction provides. They also suggest that the support of the group and the mutual aid can be a powerful experience for people with a developmental handicap because it may be the first time they

are helping other people instead of being dependent upon others for help.

The facilitators observed an increase in group member interaction and mutual aid. The group was very interactive during the review of the homework, the STD demonstration and the marital slides and the facilitators could hear the group members helping each other and at times they could be heard whispering the answers of questions to each other. The facilitators also noted that group communication, conversation and interaction during the group and at break no longer flowed through them. The group members socialised and communicated with each other independent of facilitation by the group leaders.

Mutual aid was also observed at the beginning of the session during Lindsay's aggressive and threatening discussion with respect to her problem with her boyfriend. During this situation the group members seated near Lindsay showed signs of anxiety and fear. They sat back in their chairs and averted eye contact with her. Jocelyn stood and ran to a corner of the room when Lindsay started to swear and hit her umbrella on the coffee table. Jim commented that Jocelyn was "scared and ran away." The facilitators suggested Jim go and assure her it is okay to return to the group. Jim walked over to her in a very upright and

purposeful manner but softened his demeanour as he approached her. He did not touch her but gently said "...it's okay. No be scared. You can come back it's okay. Lindsay won't hurt you."

This situation also provided an example of an observed characteristic of the stage of differentiation. Acceptance and support of testing new behaviour (Wickham, 1993) was evident when Lindsay calmed down and assured Jocelyn she would not hurt her or anyone else in the group. All of the group members have experienced or observed Lindsay's aggression in the past and for Jocelyn to trust Lindsay's word of safety and return to the group was certainly acceptance on the part of the group that Lindsay could control her anger and aggressiveness.

A second example of acceptance and support of testing new behaviour was provided when Jim shared his story about his mother's illness and his desire to return to the workshop to relax because he could not concentrate at work. In the past this individual would have become angry, aggressive and gone home on his own. However, his decision to handle the situation by the employment of problem solving and maturity brought cheers and applause from the other group members. Lindsay also cheered and applauded and this indicated that after her own highly stressful experience she

was able to remain within the group process. According to Berman-Rossi (1993) and Wickham (1993) this is indicative of the high level of cohesion in the group during the stage of differentiation.

Cohesion was also evident by the group members' relaxed approach to the ongoing topic of sexual intercourse. The group members used the appropriate terminology confidently and freely with no hint of shame or anxiety. In fact, they appeared to be pleased and proud that they know the material and can freely speak about it in an atmosphere of support, acceptance and safety.

Wickham (1993) suggests that the group members will begin to view the group facilitators as real people during the stage of differentiation. Prior to this group the members would ask questions that placed the facilitators in the role of content expert and the facilitators would self-disclose personal information only where they believed it would foster the process of the group. However, the group members started to ask the facilitators personal questions during the slide presentation with respect to marital issues. In particular they were interested in knowing what the facilitators and their partners fight about and if we ever have hard times getting by day to day. The group facilitators asked if the group members thought we would

have hard times and they concluded that we did because as Melissa pointed out "sure, you're just like everybody else."

Ambivalence regarding the change process and sensitive challenging of members were two further characteristics of the stage of differentiation (Wickham, 1993) observed by the facilitators during this session. Lindsay had participated in the earlier sessions where the curriculum and interactions had resulted in discussions about the necessity of open communication, compromise and spending time apart from your partner to pursue personal activities in relationships. However, she appeared to be ambivalent about changing her behaviour and perception even though she recognised these as characteristics of good relationships in earlier sessions.

As a result of Lindsay's issue with her boyfriend the group facilitators and members were able to sensitively challenge her perceptions, attitudes and behaviours. The male members of the group defended the boyfriend's desire to spend time with his family and the importance they have placed on time spent with their own families. Shayne and Joe further shared with Lindsay that they do not like being told what to do and they highly doubt that her boyfriend does either. Jocelyn even offered input after her return to the group when she suggested to Lindsay that she can get

into trouble if she hits her boyfriend. At this point Laura and Melissa joined the challenging of behaviour and attitude when they sided with the boyfriend and echoed the sentiment that Lindsay should not him.

As a result Lindsay appeared calmer and said that she would call her boyfriend at the end of the session and promised not to hit him. This situation and Jim's ability to talk to his manager and return to the workshop are examples of the acceptance and practice of the problem solving sequence, a further characteristic of the stage of differentiation (Wickham, 1993), observed by the facilitators.

Counsellor Session Eight

Content.

All of the counsellors reported that they found the STD homework difficult and that completion required a great deal of interaction and explanation on their part. Although difficult concepts to explain, Sue and Heidi stated that it helped to have seen the homework before and so they knew what to expect.

The homework was the catalyst for several discussions during which the counsellors disclosed that they knew very little about STDs and the prescribed treatments. Chris

stated that when she was married people knew about condoms but only worried about one or two types of STDs because "we just didn't know about them. They weren't part of my health education." The counsellors asked the facilitators how do you know if a person has an STD. The facilitators suggested that you can ask or go for a blood test. This resulted in a discussion about the fact that young couples today have had blood tests together because it is not unusual for two people to meet, become engaged and marry within a ten year period. The couple may have been monogamous throughout their relationship but HIV could have been in their systems for up to ten years and they might not have experienced a symptom. As a result an individual could have infected a long time partner without ever having known until it is too late. Another counsellor stated that she did not realise that an instrument can be placed up the penis when the individual is tested for a STD. The group agreed that STDs was a topic they knew little about.

Heidi reported that her client called her boyfriend immediately after the group last week and told him that he could go to his brother's. Her boyfriend said he was not going to go until Saturday so he could go with her to the meeting on Friday night. At the meeting on Friday night Lindsay told several people she was angry and in a bad mood

because her boyfriend was going to his brother's house the next day. It was later reported to Heidi that Lindsay had hit her boyfriend in the head several times.

The facilitators elucidated what had happened with Lindsay in the last group. All of the counsellors were impressed with the roles that their client played. Terri stated that Joe had been talking more about his feelings at home and that she and the other staff members had been quite impressed. Heidi stated that she had also been impressed with the way Lindsay had initially compromised with her boyfriend when she telephoned him but was now somewhat concerned. There has been talk that her boyfriend wanted to end his relationship with her.

The counsellors were eager to watch the LifeHorizons II (Kempton, 1993) slides with respect to sexual abuse and community awareness and protection because they believed that many of their clients have excellent skills in this area. However, Sue was concerned about Jocelyn's vulnerability and felt that this would be an important component of the curriculum for her. During a slide about telephone protocol Bill stated that Jim had been accused of obscene telephone calls because his expressive and receptive speech is poor and when he does not understand he becomes

frustrated and swears at people. Thus, Bill felt that this would also be an important component for his client.

Process.

The counsellors continued to self-disclose personal experiences and yet supported each other's disclosures because it appeared that the experiences and opinions were often shared by other group members. This had been consistently illustrated in the counsellors' disclosures about how little they knew about certain topics such as STDs. The facilitators noted that the group members have continued to seek answers when they do not know the information. It appeared that they continued to be committed to the work of the group and their own education.

The facilitators observed that the group continued to be engaged in mutual aid and problem solving throughout the session. The counsellors participated in the discussion of the slides and suggested to each other how a slide could be utilised to deal with a specific client problem. What was interesting to the facilitators was counsellors suggesting certain slides could be utilised for another group member's client and the issue that was relevant had been discussed several sessions earlier and not since.

Client Session Eight

Content.

The session started with the collection and comprehensive review of the STD homework. The review was comprehensive because the facilitators were unsure if the group members fully understood the curriculum content based on feedback received from the individual's participating counsellor. The facilitators believed that the group members understood the importance of safe sex but had difficulty understanding the process of germ transmission and STD symptom identification.

The sessional topic of sexual abuse and community awareness was introduced to the group. The facilitators utilised the Life Horizons II (Kempton, 1993) slides to present the didactic material which covered topics such as good and bad touch, relational boundaries and people in positions of trust, community protection issues, being at home alone and answering the telephone and interaction with strangers at the door. The curriculum content and the use of the Kempton (1993) slides were consistent with Ludwig's (1991) presentation of the didactic material associated with this curriculum component.

The group members were very interactive during the slide presentation and enjoyed the role-plays associated

with community protection issues, answering the telephone and dealing with a stranger at the door. The group laughed and appeared to enjoy the freedom of yelling "no, stop, and go", "help", "rape", and "fire." Again, time was taken to explain the importance of not "crying wolf" and yelling only when in true danger of being assaulted or hurt.

The slide presentation included pictures of adult sons and daughters in bed with their parents and of adult siblings in bed with each other. This resulted in a discussion of relational boundaries and the fact that people should not have had or be having sexual intercourse or contact with their parents, grandparents or siblings. As the discussion proceeded the facilitators suggested that group members should not touch, be asked to touch or be touched sexually by any person in a position of authority. The facilitators identified doctors, dentists, nurses, police officers, bus drivers, workshop instructors, teachers and group home counsellors in the list of people in positions of authority. It should be noted that this list certainly is not exhaustive.

During this component of the curriculum two of the group members asked if it was okay for them to kiss their counsellor good night because they do all of the time and they do not see anything wrong with this. The facilitators

suggested that perhaps the individuals should say good night instead of kissing the counsellor even though we fully understood that both of these individuals had known their counsellor for a long time and further understood the need for affection for individuals often denied such interaction. This comment met with resistance and both individuals continued to espouse that there was "nothing wrong with it."

Lindsay was not happy and voiced her opinion when she received her homework on the topic of community awareness and sexual abuse prevention (Appendix J) because "this is the last group and we don't get any more homework." She and the rest of the group relaxed when the facilitators suggested they can continue with home work with their counsellor if they so choose but did not have to hand it back if they did not want to. The last half of the group was spent in conversation about all of the positive group and individual changes and gains in the group members' knowledge, behaviour and independence. This was followed by a pizza party and socialisation.

Process.

The group members entered the session room extremely talkative and animated with Jocelyn wondering if we were still going to have the pizza party. All of the group

members reminded the facilitators that this was the last night for group and the facilitators noted that they were surprised the group was so accepting of this fact. However, it should be noted that the facilitators had engaged group members in discussion in prior sessions about the termination of the group and therefore believed the members had been adequately prepared.

The facilitators observed several of the characteristics of the stage of differentiation during the final session. Mutual aid continued to be observed when group members could be heard whispering answers and thoughts to each other. As well, the facilitators observed that the group members had continued to view the leaders as real people. The female facilitator started the session by sharing with the group that her father-in-law had experienced a stroke. Laura and Melissa were very sympathetic and several other group members also wanted to know how bad the situation was and if her father-in-law would be okay. Melissa wanted to know if the female facilitator and her husband were emotionally okay.

Testing of new behaviour and sensitive challenging of behaviour (Wickham, 1993) was also observed. During the slide presentation the female facilitator brought the group's attention to Jocelyn who had not been watching the

screen but was engaged in rubbing Joe's arm. When the group members looked at Jocelyn and Joe they observed that Jocelyn had her back turned to the screen and that they were looking at each other and smiling. Jocelyn shared with the group that her old boyfriend does not want to go out with her any more and that she and Joe had talked and they really do like each other. The group members were supportive and accepted this development but sensitively challenged their touching in group. Laura informed them that they should watch the slides and participate and leave the personal interaction until the group was over. Jocelyn and Joe agreed and proceeded to participate for the remainder of the group.

Termination or separation is the final stage of group development in the Boston Model (Berman-Rossi, 1993; Wickham, 1993) and the facilitators did observe characteristics consistent with this stage of group development. This stage is characterised by feelings of loss the members experience as a result of the importance the group has come to play in their lives (Berman-Rossi, 1993). Wickham (1993) suggests that the experience of loss if often characterised by the group's or a member's belief that the work is not over and needs to continue. During this session Laura said that she wished the group could continue because "she was learning so much." Other group

members concurred but Melissa stated "I've had fun but it's time for the group to end."

Wickham (1993) suggests that it is not unusual for the group members to regress to issues characteristic of the stages of intimacy or power and control. He further suggests that there may appear to be a lack of cohesion as group members find it difficult to be close and may withdraw from interaction or group involvement. An example of regression to the stage of power and control was observed with Jim when he entered the room saying "me boss" and "not doing anything tonight!" As the group progressed he became more sociable and interactive.

The facilitators also observed two examples of withdrawal from the process. Joe was described in the facilitators' process notes as "quiet and withdrawn except when interacting with Jocelyn." Joe's anxiety with respect to the end of group was also observed in his arriving for the group thirty-five minutes early when he has been consistently ten to fifteen minutes early. The second example involved Melissa who developed into a very active participant and natural group leader. She was described in the facilitators' process notes as "withdrawn and quiet." The facilitators further stated that this was "the least

amount of interaction since the beginning of the group" for this individual.

Interestingly the facilitators also observed regression in the knowledge of several group members and believed that this was an attempt by some of the less verbally communicative group members to illustrate the need for the group to continue. For example, Lindsay suggested that there was nothing wrong with sex for money even though she identified this was wrong in an earlier session. Shayne suggested to the group that two men have intercourse when one of the men places his penis inside the other man's vagina or penis. Again, this was information he had correctly and accurately shared in prior sessions.

Recapitulation is the process of the group as a system or a member of the group attempting to relive an experience the group had dealt with in an earlier stage of development (Wickham, 1993). This was observed during a group discussion about private and public sexual behaviour when Lindsay commented that one of her housemates continues to have his bedroom door open when he is in various stages of undress. However, this housemate also happened to be a group member and he stated that he no longer did this even though he admitted in an earlier group that he had at the time.

The group members had smiles on their faces as the facilitators provided feedback on the gains they as a group and individuals had made during the course of the eight sessions together. Following the review of the gains that had been achieved the group socialised while they listened to music and enjoyed the pizza that had been ordered. The group members said their goodbyes and several, in particular Joe, made this a very brief task and left quickly.

Counsellor Session 9

Content.

The purpose of the final session was to bring the formal counsellor group interaction to a close and to finalise administrative issues. The facilitators asked the counsellors if they were averse to participation in a focus group that would be utilised to explore their opinions with respect to the group format they and their clients had been exposed to. They readily agreed as they were somewhat saddened that the experience had ended. The second task was the arrangement of post-testing and who would conduct the post-tests. The counsellors felt that it would be better if the facilitators conducted the post-tests versus research assistants given the content of the material and the trust

that had developed between the facilitators and their clients.

The counsellor feedback consisted of questions about the ending process of group and the change they had witnessed in their client since the beginning of the group process. Heidi asked the facilitators if they had talked about endings because she had observed an increase in Lindsay's negative behaviours and wondered how much this had to do with group. The facilitators believed it had to do with the end of group but also with the breakdown of her relationship with her boyfriend. The group had discussed endings and the facilitators informed the counsellors that the group had in fact come full circle back to the topic of feelings. For example, the client group members were asked how they felt about the end of group.

Heidi did state that Lindsay had made significant gains. She stated that Lindsay is more apt to talk about her feelings before potentially aggressive situations escalate. She also shared that Lindsay's interaction had improved at the workshop where Lindsay and another individual have talked and supported each other when in the past they have had an adversarial relationship. In fact the co-worker is Jocelyn. Sue reported that they had observed a decrease in her fantasising and an increase in interaction and

socialising. This observation was consistent with those made by the facilitators. Chris reported that Laura had also increased socialisation and independence separate from the influence of Melissa. Again, this process had been followed and described by the facilitators in earlier sessions.

Chris stated that Melissa was usually depressed and stayed home from work on Mondays except during the eight weeks of group when she did not miss a single day of work. She stated that she did stay home the Monday after the last session but felt better after Chris talked to her about the end of group and her feelings. Chris also reported that other counsellors in the group home have noticed that Melissa appeared more confident and happier during the group. She stated that Melissa had never talked about having a driver's licence until her participation in the group. Bill reported that Jim had increased his teasing of others toward the end of group, but like the change with Melissa he believed that his client had also shown signs of improvement in the areas of confidence, competence and happiness. Counsellors have observed that Jim's aggressive behaviours had decreased and his communication and interaction had increased. In fact, Bill reported that there was less anxiety in the house in general.

Terri suggested that Joe had shown improvement in interaction with people in his immediate environment and his ability to talk about his feelings. Heidi reported that these observations were consistent for Shayne as well. The facilitators' feedback related to the same changes they had observed in group with the clients and highlighted areas of content in which further work would be of benefit. The counsellors agreed with the facilitators observations and both Terri and Chris said they would look into the possibility of a bereavement group for Joe and Laura respectively.

The counsellors also provided feedback during discussion about the format and the role they played in the process. Bill suggested that if he had not participated he would not have been able to deal with issues in the group home that concerned Jim. Sue suggested that her participation allowed her to self-disclose more than she generally would have. Heidi agreed with Sue's comments and said it provided her with the "courage" to self-disclose. Heidi said it helped her to understand her clients at a "deeper level" and that this experience was "overwhelming" when she considered how long she had known them. Both Terri and Paula commented on what they had learned in group and

Paula believed her involvement affected her personal life as well. All of the group members concurred.

Process.

The facilitators noted that the counsellors continued to employ the processes of mutual aid and problem solving as they dealt with the end of the group. The group members were very involved in their discussion about the location of the focus group. They initially suggested that it could be held at the administrative offices of the agency but problem solved and decided to hold it at the home where the group had met. They decided against the administrative offices because they did not want others to look in and they felt they would be more comfortable in the home where they had met as a group. This reasoning illustrated the cohesion and group identity that had developed.

The counsellors were genuinely humorous throughout this last formalised group. There was little evidence of anxiety. The facilitators noted in their process logs that the counsellors talked about their clients' with positive regard and positive terminology while they realistically accepted and understood the barriers to their clients' development. The facilitators noted that they no longer heard comments that included "oh sure" or "how long will

that last?". There appeared to be a belief that the barriers were not impenetrable.

The facilitators also noted that the counsellors, moreso then the clients, wished the group could continue. Comments from earlier sessions that suggested the group work should continue after the facilitators were no longer involved were replaced with comments that suggested the group should continue in its present format and with the present membership.

Chapter Four

Results

Hypothesis One

The first hypothesis states that the mean knowledge scores on the Sexual Knowledge Interview Schedule for individuals with a developmental handicap who participate in a socio-sexuality education group will be significantly higher at post-test then at pre-test. The mean pre-test score for the client group participants was 10.9 and the mean post-test score was 30.1. A perfect knowledge score on this instrument is 55. The score differences were calculated for each group participant and then rank ordered (Table 1). A nonparametric Walsh test ($n=7$, $\mu 1>0$) found that there was a significant difference ($17>0$) between the group's pre-test and post-test means ($p \leq .05$). Therefore we conclude that the participants' increased knowledge scores were likely to have occurred as a result of participation in the socio-sexuality education group and not by chance.

Potential abuse subscale.

The mean pre-test score for the client group participants was 1.0 and the mean post-test score was 0.0. The score differences were calculated for each group

participant and then rank ordered. A nonparametric Walsh test ($n=7$, $\mu 1<0$) found that there was a significant difference ($-.5<0$) between the group's pre-test and post-test means ($p \leq .05$). Therefore we conclude that the participants decreased potential abuse scores were likely to have occurred as a result of participation in the socio-sexuality education group and not by chance.

Table One

Participants' Raw Scores, Score Differences and Ranked Differences for the SKIS Knowledge Total

Group Participant	Pre-Test Raw Score	Post-Test Raw Score	Score Differences	Ranked Differences
Jim	12	29	17	d3
Shayne	2	25	23	d6
Joe	3	25	22	d4
Lindsay	13	35	22	d5
Jocelyn	15	28	13	d1
Laura	7	31	24	d7
Melissa	24	38	14	d2

Hypothesis Two

The second hypothesis states that the mean attitude scores on the attitude subscales of the Socio-Sexual Knowledge and Attitude Test for individuals with a developmental handicap who participate socio-sexuality education group, will be significantly higher at post-test than at pre-test.

Menstruation subscale.

The mean pre-test attitude score for the client group participants was 1.3 and the mean post-test attitude conversion score was 1.4. A nonparametric Walsh test (n=7, $\mu 1>0$) found that there was no significant difference (0=0) between the group's pre-test and post-test means($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards menstruation.

Marriage subscale.

The mean pre-test attitude score for the client group participants on attitudes toward marriage was 0.714 and the mean post-test attitude score was 1.7. A nonparametric Walsh test (n=7, $\mu 1>0$) found that there was no significant difference (0=0) between the group's pre-test and post-test means ($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards marriage.

Pregnancy Subscale.

The mean pre-test attitude score for the client group participants with respect to pregnancy was 1.3 and the mean

post-test attitude score was 1.7. A nonparametric Walsh test (n=7, $\mu 1>0$) found that there was no significant difference (-0.5<0) between the group's pre-test and post-test means ($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards pregnancy.

Alcohol Subscale.

The mean pre-test attitude score for the client group participants on the alcohol subscale was 7.9 and the mean post-test attitude score was 8.3. A nonparametric Walsh test (n=7, $\mu 1>0$) found that there was no significant difference (-3<0) between the group's pre-test and post-test means ($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards alcohol.

Dating Subscale.

The mean pre-test attitude score on dating for the client group participants was 4.3 and the mean post-test attitude score was 10.0. A nonparametric Walsh test (n=7,

$\mu 1>0$) found that there was no significant difference (0=0) between the group's pre-test and post-test means ($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards dating.

Intimacy Subscale.

The mean pre-test attitude score for the client group participants on the intimacy subscale was 2.0 and the mean post-test attitude score was 3.3. A nonparametric Walsh test (n=7, $\mu 1>0$) found that there was no significant difference (-1<0) between the group's pre-test and post-test means ($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards intimacy.

Masturbation Subscale.

The mean pre-test attitude conversion score for the client group participants on the masturbation subscale was 5.6 and the mean post-test attitude score was 12.6. A nonparametric Walsh test (n=7, $\mu 1>0$) found that there was no significant difference (-1<0) between the group's pre-test

and post-test means ($p \leq .05$). Therefore we can conclude that participation in the socio-sexuality education group did not have a significant impact on the participants' attitudes towards masturbation.

Gay and Lesbian Subscale.

The mean pre-test attitude score for the client group participants with respect to gay and lesbian relationships was 5.0 and the mean post-test attitude score was 10.9. The score differences were calculated for each group participant and then rank ordered (Table 2). A nonparametric Walsh test ($n=7, \mu 1>0$) found that there was a significant difference ($3.5>0$) between the group's pre-test and post-test means ($p \leq .05$). Therefore we conclude that the participants movement toward a more positive attitude with respect to gay and lesbian relationships was likely to have occurred as a result of participation in the socio-sexuality education group and not by chance.

Intercourse Subscale.

The mean pre-test attitude score for the client group participants with respect to intercourse was 3.4 and the mean post-test attitude score was 9.4. The score differences were calculated for each group participant and

then rank ordered (Table 3). A nonparametric Walsh test ($n=7$, $\mu 1>0$) found that there was a significant difference ($3.5>0$) between the group's pre-test and post-test means ($p\leq.05$). Therefore we conclude that the participants movement toward a more positive attitude with respect to sexual intercourse was likely to have occurred as a result of participation in the socio-sexuality education group and not by chance.

Table Two

Participants' Raw Scores, Score Differences & Ranked Differences for the SSKAT Gay and Lesbian Subscale

Group Participant	Pre-Test Score	Post-Test Score	Score Differences	Ranked Differences
Jim	4	14	10	d6
Shayne	3	12	9	d5
Joe	3	13	10	d7
Lindsay	6	14	8	d4
Jocelyn	11	10	-1	d1
Laura	3	7	4	d3
Melissa	5	6	1	d2

Hypothesis Three

The third hypothesis states that the mean attitude scores on the Sexuality and the Mentally Retarded Attitude Inventory for group home staff who participate in a socio-sexuality education group will be significantly higher at post-test than at pre-test.

The mean pre-test score for the counsellor group participants was 140.5 (SD=8.31) and the mean post-test score was 144.0 (SD=4.38). The score differences were calculated for each group participant, rank ordered and the sums of the signed ranks were calculated (Table 4).

Table Three

Participants' Attitude Raw Scores, Score Differences and Ranked Differences for the SSKAT Intercourse Subscale.

Group Participant	Pre-Test Score	Post-Test Score	Score Differences	Ranked Differences
Jim	3	14	11	d6
Shayne	8	14	6	d4
Joe	0	12	12	d7
Lindsay	3	10	7	d5
Jocelyn	3	4	1	d1
Laura	3	6	3	d3
Melissa	4	6	2	d2

Table Four

Participants' Attitude Scores, Differences, Ranked Differences and Signed Ranks for the SMRAI

Worker Code	Pre-Test Score	Post-Test Score	Difference	Rank of Difference	Signed Rank
Bill	133	140	7	4	4
Sue	150	149	-1	1	-1
Chris	147	145	-2	2.5	-2.5
Terri	134	139	5	3	3
Heidi	132	142	10	5	5
Paula	147	149	2	2.5	2.5

$T_+ = \sum$ (positive ranks) = 14.5
$T_- = \sum$ (Negative ranks) = 3.5

A Wilcoxon's Matched-Pairs Signed-Ranks test (n=7, Tcrit=2) found no significant difference between the group's pre-test and post-test means (α=.50) with an obtained T of 3.5 > 2. Therefore participation in the concurrently running socio-sexuality education group did not have a significant impact on the counsellors' attitudes toward the sexuality of their clients with a developmental handicap.

Chapter Five

Discussion

The results of hypothesis 1 indicate a significant increase in knowledge following a socio-sexuality education group. This result supports the findings of Lindsay et al. (1992) and Robinson (1984). The group participants in this project showed significantly increased scores on all subscales of the SKIS at post-test (Forchuk et al., 1995). The participants' scores on the feelings subscale (Figure 8) indicate that they were better able to identify and comprehend the feelings of sadness, anger, happiness and anxiety. Overall group members scored higher on the body parts identification subscale at post-test (Figure 9) but the men continued to have difficulty with the identification of internal body parts. Body parts that were difficult to identify at post-test included the male bladder, the male and female urethra, the uterus and the fallopian tubes.

The group members were better able to demonstrate an understanding of body part functions at post-test (Figure 10). Although some of the group members did have difficulty with the identification of the internal body parts, they did not appear to have difficulty explaining relevant body part functions at post-test. For example, the men had difficulty identifying the urethra but they knew, as did all of the

women, that urine and semen exit the body through the penis. As well, none of the group members were able to demonstrate an understanding of sexual intercourse at pre-test but at post-test all of the participants were able to identify that intercourse occurs when a man places his erect penis in a woman's vagina. At post-test two of the male members of the group continued to have difficulty explaining the purpose and function of menstruation. One of the men demonstrated an understanding of what happens when women menstruate but continued to maintain that it was not okay for women to menstruate. The other male member was able to state that boys do not menstruate but was unable to demonstrate an understanding of what menstruation meant or how it occurred.

The results also showed a greater general sexual knowledge at post-test (Figure 11). The possible total score on this subscale is 20. The pre-test range was 9 with a minimum score of 0 and a maximum score of 9 whereas the post-test range was 7 with a minimum score of 7 and a maximum score of 14. As a result of participation in the group all of the members were able to demonstrate an understanding of how pregnancy occurs, how to recognise that someone is pregnant and how to avoid pregnancy. Prior to group the members did not know how babies were conceived and only 42.9% of the group knew how to avoid pregnancy. However, it

appears logical that a person will not know how to conceive a baby if they do not understand what sexual intercourse means at pre-test. Before group only one participant was able to identify a STD whereas following the group experience all group members were able to identify at least one STD symptom and two of the group members named more than one. This is of interest because the facilitators and the counsellors identified STDs as the most difficult topic to teach and did not think the group members fully understood the concept.

McCabe et al. (1994) suggest that a lack of socio-sexuality knowledge about how to stop unwanted sexual activity results in a greater chance of the person with a developmental handicap being exploited and abused. This was illustrated in the client group when Melissa appeared shocked to learn that a husband cannot sexually force himself on his wife and underscored the importance of the gained increase in knowledge to decrease exposure to exploitation and abuse. The results of the potential abuse subscale indicated that there was a significant decrease in the scores (Figure 12) and this suggested a decrease in the possibility the individual would be abused. After the group all of the participants were able to demonstrate an ability to firmly stop unwanted touching and were aware of who and under what circumstances people can and cannot touch or see their

bodies. It should be noted that the investigator decided not to employ the community risks and hazards subscale of the SSKAT (Wish et al., 1980) in favour of the potential abuse subscale of the SKIS (Forchuk et al., 1995). The potential abuse subscale appeared to better represent the community and individual factors that could result in increased risk of sexual exploitation and abuse.

Kempton (1991b) suggests that a person's attitudes with respect to sexuality will be affected by the knowledge they have attained about the different facets of sexuality and relationships. Lindsay et al. (1994) suggest that participation in a socio-sexuality education program will result in an increase in knowledge and a corresponding change in attitude in a more liberal direction. The results of hypothesis 2 are more consistent with Savage and Rowe's (1991) assertion that socio-sexuality education groups for individuals with a developmental handicap continue to have difficulty enhancing attitudes. The participants in this study showed movement in a more positive or liberal direction on only two of the nine subscales at post-test.

The results indicated that there was a significant change in a positive direction with respect to the participants' attitudes about sexual intercourse following participation in a socio-sexuality education group. The pre-

test scores indicate that 85.7% of the participants held a negative attitude toward intercourse and 14.3% were neutral whereas only 14.3% of the participants held a negative attitude at post-test. However, it would be misleading to suggest that all of the group members had a positive attitude toward intercourse at post-test as 42.9% held neutral attitudes at post-test with 28.6% on the negative side of neutral and 14.3% on the positive side of neutral. Only 42.9% held a positive attitude with respect to intercourse at post-test.

Figure 13 illustrates the individual participant's attitude conversion scores toward sexual intercourse. Jim, Shayne and Joe were the male group participants and Lindsay, Jocelyn, Laura and Melissa were the female group members in all individual case figures. It is apparent that the male group members held a more positive attitude toward intercourse at post-test. At pre-test all of the women and two of the men answered "no" when shown a picture of a couple engaged in sexual intercourse and asked if it was okay to do this with a boyfriend or girlfriend. Shayne answered "yes". At post-test all of the women maintained that it was not okay to have sexual intercourse whereas all of the men answered that it was okay. Interestingly, at pre-test all of the women answered that people feel happy when they have

sexual intercourse and three of them maintained this attitude at post-test. The exception was Jocelyn who reported at post-test that people are sad when they have intercourse.

The results also indicate that there was a significant change in a positive direction with respect to the participants' attitudes towards gay and lesbian relationships following participation in a socio-sexuality education group (Figure 14). The results support the findings of Lindsay et al. (1994) who report that before the program 87% of the participants did not feel it was okay for two men to kiss and hug with no clothes on. They further report that after participation in a socio-sexuality education group 50% of the participants did feel it was okay for two men to kiss and hug with no clothes on. The results of this study show that before involvement in the group 85.7% of the participants did not feel it was okay for two men to kiss and hug with no clothes on. However, the results of this study show a more considerable positive change in attitude at post-test with 71.4% of the participants answering that it was okay for two men to do this.

The results of this study also indicated that male group members generally held a more positive attitude toward gay and lesbian relationships. After group participation the men appeared to be more accepting of both gay and lesbian

relationships whereas the women tended to be more accepting of lesbian relationships then gay relationships.

There was no significant change in the participants' attitudes towards menstruation, alcohol and pregnancy after participation in the group. Figure 15 provides an illustration of individual members' pre and post-test attitudes towards menstruation. The graph illustrates no significant change in attitude. The female scores provide an example of an extreme ceiling effect as their scores indicated that they already held a positive attitude toward menstruation pre-test. At post-test the male members maintained their negative pre-test attitudes towards menstruation with the exception of Joe who had a more positive attitude. The fact that Jim and Shayne had difficulty understanding what happens when a woman menstruates may account for this maintenance of negative attitude.

The results indicate that the group participants already had a very positive attitude toward alcohol consumption at pre-test. However, Figure 16 illustrates that Jocelyn experienced an attitude movement in a more conservative or negative direction. The investigator was perplexed by this result because Jocelyn had stated in group that she often enjoyed a glass of wine during meals with her family. The

investigator also recognised that Jocelyn was the only age of majority participant who lived in a group home designated for children. Therefore it appears likely that Jocelyn's answers reflected the context of the group home where she does not and/or cannot drink alcoholic beverages. The group also discussed the possibility of sickness if an individual were to over indulge in the consumption of alcohol. It also appears possible then that Jocelyn's answers reflect an association of alcohol consumption with illness in which case she may rationalise that drinking is not okay because it makes you sick.

Interestingly, all of the group members suggested that they consume alcohol in the parental home but not in the group home.

This participating agency does not have a policy that forbids the consumption of alcohol in adult designated homes. However, the principal investigator was not aware of the medications that the group member may have been taking during the study. It appears that if the individual was taking medication that would have an adverse reaction with alcohol, the group home staff would probably have not allowed alcohol in the home. It has been the principal investigator's experience that parents are quite often more willing to minimally break the medicinal rules. The very real

possibility exists that the staff have their own informal policy that does not allow alcohol in the group home.

Figure 17 illustrates that there was little change between the individuals' pre and post-test attitudes with respect to pregnancy. At pre and post-test 52.9% of the participants had a negative reason for why people have children or they simply did not know why people have children. Kempton (1991b) states "...an attitude is the total result of one's emotional, social and intellectual experience" (p.29). The facilitators believe the maintenance of the negative attitudes toward pregnancy reflected the life history of the individuals whose attitudes and perceptions of family may have been affected by poor familial experiences and/or movement into a group home at an early age. The 52.9% roughly reflects the number of participants who talked in group about poor family relationships or as Jocelyn stated: "being sent to a group home because my parents don't want me any more." Trauma associated with being a scapegoat within a family system and or the trauma experienced as the result of being launched from the family system too early may account for negative attitudes toward pregnancy and childrearing. For example, Jocelyn had answered that people have children for positive reasons on the pre-test but answered with a negative reason on the post-test. It appears that the group

provided her with an opportunity to discuss her anger and resentment about movement into a group home at age 12 even though her parents continued to be very involved in her life.

Figure 17 also illustrates that only one individual had a very positive attitude toward pregnancy at post-test. At pre-test 100% of the participants said that they did not want to be a parent and at post-test 85.7% maintained this position while Jim said that he did want to be a parent. The facilitators believe that this change in attitude may be the result of discussions with his counsellor who, in the counsellor group, proved to be an advocate for the right of people with a developmental handicap to parent. In hindsight the investigator realised that attitude questions with respect to pregnancy and parenthood were absent from the homework assignments. This oversight may have prevented conversation in the group home with the counsellors who themselves were undecided about the right of people with developmental handicaps to parent.

The results show that there was no significant change in the participants' attitudes towards marriage after participation in the group. However, the results did approach significance which suggests that with a larger sample it may have been possible to accept the hypothesis that there was a significant change in attitudes toward

marriage. The pre-test results indicated that 57.1% of the group had very negative attitudes towards marriage whereas only 28.6% of the group wanted to be married someday. After participation in the socio-sexuality education group 85.7% of the participants had a very positive attitude toward marriage (Figure 18). Figure 18 also illustrates that Lindsay maintained her desire to remain single at post-test. The group engaged in a significant amount of discussion in session about marriage and the hard work involved to maintaining a strong and reciprocal marital relationship. The fact that 6 of the 7 participants would like to marry someday provides insight into the group members' willingness to work at a relationship to enjoy the benefits of intimate partnership and companionship.

The results show that there was no significant change in the participants' attitudes towards intimacy, masturbation and dating after participation in the group. However, Figures 19, 20 and 21 illustrate that six of the seven group members had a considerably more positive attitude towards intimacy, masturbation and dating at post-test. The exception was Jocelyn who had more positive attitudes at pre-test then after participation in the group. In fact, there is a significant difference between the participants' pre and

post-test scores and hence attitudes when Jocelyn is excluded from the Walsh test analysis.

The results of the intimacy subscale show that before group participation all of the members did not feel it was okay for a naked couple to touch each other on their first date. The results further indicate that before group participation Jocelyn was the only individual to answer that it is okay for a couple to have sexual intercourse on their first date. At post-test she and the other women answered that naked touching and sexual intercourse were not okay on the first date. The investigator concluded that Jocelyn changed her opinion about intercourse because she answered the pre-test question without full comprehension of what sexual intercourse entailed. Recall that at pre-test none of the participants knew what sexual intercourse was. Thus, as a result of her participation in the group Jocelyn learned what sexual intercourse was and adjusted her answers accordingly. As well, she was the group participant who held the negative attitude toward intercourse on that subscale at post-test.

Jocelyn also held a negative attitude at post-test when she was asked if it was okay for two people to have intercourse after many dates whereas she said it was okay for two people to have intercourse after many dates at pre-test.

The remainder of the participants said at post-test that it was okay for a couple to have intercourse after many dates. At pre-test one of the other women had agreed with Jocelyn that it was okay. During the group Melissa suggested that trust should be nurtured in a relationship before a person has intercourse with someone and this concept was reinforced during subsequent group discussions. The investigator maintains that this interaction is partially responsible for the members' overall belief at post-test that intercourse is not okay on the first date but is okay after many dates.

Jocelyn appears to have had the same effect on the masturbation subscale. At pre-test she answered that it was okay for both a man and a woman to masturbate but said that it was not okay at post-test. In comparison, before participation in the group 28.6% of the participants did not feel it was okay for either a man or a woman to masturbate. At post-test 71.4% of the participants said it was okay for a man to masturbate and 85.7% of the participants said it was okay for a woman to masturbate. At pre-test Jocelyn was one of two participants who said that people feel happy when they masturbate and this was consistent with the perception that it is okay to masturbate. However, at post-test, Jocelyn was the only participant to suggest that a person feels sad when

masturbating. The remainder of the group participants said at post-test that a person will feel happy when masturbating. Jocelyn's pre-test SKIS results indicated that she was not able to explain what masturbation meant. Once again it appears her increase of knowledge through participation in the group results in movement toward a more negative attitude at post-test then at pre-test.

Jocelyn was the only individual to have a positive attitude toward dating prior to participation in the group. However, her attitude toward dating moved in a negative direction after participation in the group whereas the other members' attitudes towards dating moved in a positive direction. Three questions were identified that indicated Jocelyn's participation in the group resulted in an increase in knowledge the provided her with the information she required to accurately identify her attitudes towards the topic.

The first question asked if it was okay for people to have intercourse on their first date. At pre-test Jocelyn said that it was okay whereas the other group members said that intercourse on a first date was not okay. Jocelyn concurred with the other group members after participation in the group. The second question asked if it was okay for a woman to date a woman. At pre-test Jocelyn said it was okay

but after participation in the group she said it was not okay. Before participation in the group the other members said it was not okay whereas at post-test five of them said that it was okay for a woman to date a woman. The third question asked if it was okay to date a person who is married to someone else. At pre-test Jocelyn and one other group member said it was okay to date a married person and the remaining five participants said it was not okay. At post-test Jocelyn and the other members said that it was not okay to date a person who is married to someone else.

Rowe and Savage (1987) suggest that "a lack of knowledge influences attitudes because the developmentally handicapped person, who has not received adequate information, will fabricate the information" (p.94). Kempton (1991b) suggests that children will often employ fantasy to fabricate the information. If the correct information is not provided the fantasy based perceptions will be maintained throughout the adulthood of the person with the developmental handicap. The facilitators believe this is true for Jocelyn who appears to have a prepubescent perception of relationships and the fairytale wedding. Sue suggested prior to the commencement of the groups that Jocelyn has a fantastical perception of relationships and marriage. She also suggested that Jocelyn will talk about sexuality and relationships but it is

apparent she uses the terminology incorrectly and does not understand what the terminology means. As a result of Jocelyn's participation in the group the facilitators concurred with this assessment and concluded that her lack of knowledge combined with her marital and relational fantasy influenced her pre-test responses to the intercourse, pregnancy, masturbation and intimacy subscales. Therefore Jocelyn's movement towards a negative attitude at post-test may have reflected the fact that she gained the correct information about sexuality and relationships but continued to hold a positive attitude towards marriage.

During the group experience Jocelyn was often resistant to information that might break through her perception of marriage. However, towards the end of the group it was noted that her comments were more realistic with respect to relationships and sexuality. Sue also indicated that she had observed an increase in Jocelyn's interaction and a decrease in her fantasising since her participation in the group began. Although the quantitative results of this study showed a significant difference in scores for only two of the nine subscales, the qualitative analysis indicated that there was evidence of attitude change. The change in attitude was evident when the individual client group member's behaviours

were observed in the context of interaction with the other group participants.

Lindsay et al. (1994) state that "attitude change is discussed in terms of the effects that they have on the client's life and their relationships with significant others" (p.70). Therefore improved socialisation and a change in interactional behaviours may serve as good indicators of relational attitude change that the SSKAT did not measure.

The facilitators noted that there was a change in participant interaction during the socio-sexuality education group. Initially group participants interacted mostly with the group facilitators but as the group developed the members interacted with each other during the presentation of the curriculum and at break. There was also changes in interaction and socialisation on an individual level. Shayne who was initially quiet and shy was more vocal, initiated interactions and volunteered answers by the end of the group. Conversely, Lindsay was described by her counsellor as aggressive in her interactions with others and the facilitators of the group initially described her as an aggressive person who is quite critical of others. By the end of the group she was socialising without teasing and was

having mutually supportive relationships with individuals she had historically been in conflict with.

All of the counsellors reported that their clients increased socialisation had generalised to the group home. During the last counsellor session Terri suggested that the group had been a success for Joe as evidenced by his desire to interact with others in his environment and to converse about his feelings. During the focus group Bill stated:

> "And he's [Jim] starting to branch out into developing relationships with other people that are good and meeting his needs and not just filling his time...."

Brown (1994) suggests that individuals with a developmental handicap are often "...fixated at an egocentric state of development" (p.209). As a result the individual finds it difficult to empathise with another. Prior to group participation several of the counsellors suggested that an inability to empathise was an issue that kept several of their clients isolated from healthy relationships. During the initial client sessions the facilitators noticed that several of the clients were egocentric and therefore the facilitators worked to engage them in empathic interactions. During the group when Lindsay was upset that her boyfriend was going away for the weekend Jim noticed that Jocelyn had bolted to the corner of the room and Jim assessed out loud that she was scared. The facilitators praised Jim for his

correct empathic assessment and encouraged him to go to Jocelyn to see if she was okay. The group participants must have developed some empathic skills because Heidi stated:

> "... she's [Lindsay] getting there and I think that's one thing that group has done is opened her eyes to more empathy for other individuals."

During this discussion several other counsellors agreed that their clients were more frequently observed in empathic interactions.

Although very upset, Lindsay was able to maintain her composure and manage her anger during the session she dealt with the issue of her boyfriend going away for the weekend. During one of the counsellor groups Heidi suggested that Lindsay's ability to manage her anger had generalised to home and she also suggested that she believed the group was the reason. Bill also reported during a counsellor group that Jim's anger management had improved considerably since he had started the group. As a result both of the counsellors agreed that their clients had enjoyed improved relationships with other significant people both within and outside of their respective group homes. It appears that these reported changes may have had an impact on the individual's self-esteem.

According to Burke and Gilmour (1994) an increase in self-esteem should be a goal for any socio-sexuality

education group for people with a developmental handicap. In essence a socio-sexuality group should attempt to change the attitudes a person has toward the self. Carrasquillo et al. (1981) suggest that people with a developmental handicap are often expected to suppress their feelings and as a result sexuality is perceived as something to be ashamed of or bad. This can result in low self-esteem and an inability to form relationships.

During the initial group sessions the facilitators identified Melissa as a natural leader with an ability to empathise with others. We also observed that she was very intelligent and knew a great deal about sexuality and relationships but was always unsure of her answers even when it appeared she knew they were right. It appeared to the facilitators that the experience she had shared in group about being terribly ridiculed and called stupid in school had negatively affected her self-esteem. As well, her counsellor had identified low self-esteem as one of the reasons she wanted Melissa involved in the group. Towards the end of the sessions Heidi stated in group that several other counsellors who worked in the group home had noticed that Melissa appeared more confident and happier in the group home. They told Heidi that she had talked about her driver's licence. Heidi told the other counsellors that she would

never talk about having a licence before. During the counsellor focus group Heidi further stated:

> "In [Melissa's] case I was pleased to see her self-esteem and her comfort level in the group was really good and that has come back to home too and she is much more comfortable and pushy. She's a little more assertive now at home..."

Several of the other counsellors also stated that their clients appeared more self-confident at home.

Hingsburger (1994) suggests that on an individual basis goals of a socio-sexuality education group should include an increase in self-confidence and decision making abilities. Rowe and Savage (1987) suggest that acquisition of knowledge is not enough. They suggest that an individual must feel self-confident in the utilisation of that knowledge. The nurturing and development of self-confidence and decision making is important for people with developmental handicaps to ensure that suppression of their sexuality needs and feelings does not occur.

The individual will have lost the knowledge they gained as a result of their participation in the group and may become dependent upon others if self-confidence and decision making are not nurtured and supported. Sue talked in the focus group about a situation where she supported her client's new found assertiveness and self-confidence.

> "In fact at one point in the homework she grabbed the pen out of my hand. Like I just naturally picked it up and just started writing and she grabbed it and said `I

> can do that!'... and she's not an assertive person for the most part. She may get stubborn you know and she may hide in the corner sort of thing, but she doesn't verbalise that assertiveness."

During this discussion Bill said that his client has been making his own decisions as a result of his participation in the group.

> "But it's also something he's working at and it's less you know, like Sue said, it's less my fault. It's more of him making choices and dealing with things and realising that it's okay to make a mistake or it's okay for him to deal with some particular crisis in his life and not have to blame somebody else in order to get through it."

In the past when there was a barrier to Jim's recreational plans he would hold the staff responsible and he would become angry with and aggressive towards the staff. This appeared to be indicative of his dependency upon the staff to make alternative recreational plans for him. This scenario also provided another example of how participation in the group resulted in a Client's increased ability to control and manage their anger.

The results indicated that an increase in knowledge occurred after participation in the socio-sexuality education group. The results also showed that the group members were less likely to be victims of exploitation and abuse as a result of the increase in knowledge. The results with respect to attitudes were somewhat more mixed which indicated that participation in a socio-sexuality education group and

the subsequent increase in knowledge may have an impact on some attitudes but not on others. Observable behavioural and affective changes were noted by the facilitators of the group and the member's counsellor. For example, change in socialisation behaviours, anger management skills and self-esteem indicated that an individual's attitudes towards interaction with others and their attitude about themselves had improved as a result of participation in the group.

The results with respect to attitudes also indicate that participation in a socio-sexuality education group may result in an individual's movement from fairly positive attitudes towards sexuality and relationships at pre-test to fairly negative attitudes at post-test. This occurred when an individual's inaccurate perceptions of sexuality and relationships that were based on fabricated or inaccurate material were replaced by an increased knowledge about sexuality and relationships based on correct and accurate information. In the vernacular of therapeutic interventions, a corrective experience was provided even though it resulted in movement of attitudes in a negative direction.

Factors that Influenced an Increase in Knowledge and a Change in Attitude.

Adherence to the Mainstream model and group process.

The facilitators found adherence to the Mainstream model's concept of democratisation an important factor in the clients' increased knowledge after participation in the socio-sexuality education group. By involving the members in the development of the group rules the facilitators were able to identify areas of the curriculum that required emphasis to enhance a client's learning of specific material or skills. For example, Jim had been described as aggressive and prone to physical outbursts by his counsellor during the pre-screening process. However, during the development of the group rules it was Jim who proposed that members should not hit each other. This contribution informed the facilitators of his awareness of what behaviours are and are not acceptable in relationships. As a result, the facilitators emphasised throughout the presentation of all components of the curriculum that hitting people was not an acceptable behaviour in any healthy relationship. At the end of the group Bill reported a near complete cessation of Jim's aggressive behaviours and it appeared they had been replaced by increased socialisation and anger management skills.

The facilitators' ability to attend to the group process and member reaction to the socio-sexuality material also facilitated the individuals' increased knowledge after participation in the group. The goal of the group was to impart socio-sexual knowledge to the members and as an educator one of the functions was to decrease resistance to the material presented. The male members' adverse reactions to the first series of educational slides that included nudity provided an example of an anxious and resistant reaction that threatened to act as a barrier to the presentation of the material. However, by attending to the group processes and member reactions the facilitator was able to legitimise the reactions of the group members and engage them in a discussion about the range of uncomfortable feelings the material can evoke. As a result there was a decrease in anxiety and resistance allowing a return to the didactic material. In essence then, the group facilitator working within the mainstream model is both educator and therapist. The resultant flexibility this offers assists the facilitation of material and impacts the members' ability to increase knowledge and experience a change in attitude.

According to Fletcher and Duffy (1993) the facilitator should abandon the educational agenda to help an individual and the group explore feelings and issues the material

evokes. The facilitators found that the flexibility of the model also had an impact on and facilitated a change of the clients' attitudes. The presentation of slides and the identification of feelings curriculum evoked reactions to the material and resulted in discussions about what it means to be handicapped and the pain of being publicly labelled a "mental retard." Several of the group members stated that it meant they were dumb and stupid. Several of the members appeared relieved when they realised others had experienced the same rejection and hurt. However, the group members smiled and appeared to reclaim some of their self-esteem when the facilitators encouraged an exploration and discussion of their strengths and competencies.

Member involvement in rule development also appeared to have a positive effect on the individuals' self-esteem. Individuals, such as Jim, were perhaps for the first time cast in the role of rule maker instead of rule breaker as their role had been defined in the group home. The group members were described as quiet and interacted with the facilitators only at the beginning of the first session but became involved during rule development. This can have an impact on self-esteem because it may be the first time the individual feels in control of their environment (Empey, 1977). Thus, it can be said that the mainstream model also

allowed for the facilitation of empowerment. As well, the group members became the enforcers of the rules both within and outside of the group as observed by the facilitators and the counsellors respectively. Bill said of the sensitive challenging within the group:

> "And I just love the fact that the group was able to call, you know, [Jocelyn] on a few things and [Lindsay] on a few things..."

The fact that members enforced the rules outside of the group and pushed each other to change their sexuality attitudes and behaviours indicated that the knowledge gained from the didactic instruction had been generalised.

The Mainstream model's emphasis on group interaction, member responsibility and decision making provided opportunity for the development of member self-confidence both within relationships and individually. During the development of the group rules the members learned negotiation skills and made decisions together. Every individual's suggestion was supported and as the process continued the members became more interactive and self-confident with the ideas and opinions they offered. Self-confidence was facilitated a second time when the group decided to be closed and allowed no further membership. The utilisation of the mainstream model also allowed for the development of problem solving skills that served to inflate

the individuals self-esteem and self-confidence. An example of engagement in group problem solving was facilitated when the group members developed policy and procedures with respect to the completion of homework.

The natural development of the open forum was a factor that appeared to inflate the individual's self-esteem and self-confidence. Members appeared pleased with themselves when they received support and praise from the other group members for a change in behaviour. For example, Jim's story of being upset but returning to the workshop to talk instead of becoming angry and storming off to his home. The end result was the group cheering and applauding him. The group also provided the members with a place to share knowledge they possessed prior to the group experience. Laura sat straight up in her chair and smiled after she had told the group that the man did not always have to be on top during sexual intercourse.

Games, concrete activities and visual aids.

According to Brown (1994) and Fletcher and Duffy (1993) the onus to use concrete aids and activities is on the facilitator to be sensitive to this populations' historical difficulty with abstract concepts, short-term memory, attention difficulties and self-expression. Concrete

activities and visual aids involve the individual in the change process instead of just talking and as a result they can be instrumental in the reinforcement of and integration of knowledge, challenging and adjusting attitudes, skills development (Laterza, 1979; Ragg & Rowe, 1991) and information retention (Savage & Rowe, 1987). Concrete activities, visual tools and games had an important role in this group and their utilisation cannot be overemphasised.

The use of activities, visual tools and games fostered increased knowledge, a change in attitude, interaction, cohesion, mutual aid and problem solving within this group. For example, the Perfect Partner Poker game resulted in several learning opportunities and attitudinal discussions. During the game the group discussed the fact that forced or manipulated sex acts were illegal and were called sexual assault or rape. This provided the group with an opportunity to role play yelling fire, help or rape. During the game the group discussed a card that suggested it was important that your partner's family had money. Jocelyn and Melissa agreed that this in fact could be good. The facilitators suggested that money did not mean the individual was a good person. The group was asked if their opinion of their partner would change if the person was abusive. Jocelyn responded "then

they're out" and Melissa suggested that she would have her partner arrested and charged with abuse.

The facilitators observed that several of the group members participated and interacted more when visual tools were utilised. The facilitators suggest that the use of the anatomically correct dolls, the slides and other visual materials were responsible for the individuals' increase in knowledge as their scores at post-test indicate. The facilitators also concluded that the use of the realistic penis and vaginal models must have had some impact on the members as their scores indicated that they understood the concepts of STDs better at post-test then at pre-test. It is a possibility that members continue to have difficulty with the abstract concept of germ passing at post-test, but the results do indicate that they know how to protect themselves, how to identify symptoms and the importance of seeking medical treatment in the event of symptom development. It is suggested that this knowledge is far more important then an abstract microbiological understanding of disease after participation in one's first socio-sexuality education group.

The utilisation of homework assignments.

Brown (1994) has suggested that individuals with developmental handicaps tend to have short-term memory

difficulties and as a result information that has been presented may not be retained in the individual's long-term memory. Brown (1994) and Ludwig (1991) propose that careful linking of the material from session to session will provide the necessary repetition and rehearsal required by most people with developmental handicaps to enhance memory. They suggest that a facilitator accomplishes this by utilising a curriculum that allows for an orderly and commonsensical movement through topics. By commensical, they meant that it is reasonable to expect that the topics will progress in an orderly fashion from general concepts to more explicit and involved concepts. This allows for the reintroduction of issues from earlier sessions to clarify or build upon the individual's knowledge in subsequent sessions. The groups in this study followed a curriculum comparable to Ludwig's (1991) but also utilised homework assignments that provided further repetition of the didactic material and a link from session to session.

The homework was utilised as a review tool at the start of every session and the facilitators believed that it was invaluable as it appeared to play an significant role in the members' learning and retention of that didactic material. On several occasions during a group session a member, specifically Shayne, would hold up pictures from past

homework assignments to illustrate for the other group members the material being taught at the time. This often prompted the other members to independently refer to their homework during the session.

The completed homework also provided the facilitators with information that could be utilised to better instruct the members. For example, the facilitators were able to identify topical areas where it appeared an individual or the group as a collective had experienced learning or comprehension difficulties. The facilitators would reintroduce a topic in the following session if an area of difficulty was identified. The time between sessions allowed the facilitators to formulate a lesson plan that included options to better teach the material in the hope that the new approach would increase the likelihood the material would be comprehended and retained by the members.

The facilitators always provided feedback to the group members with respect to their completed homework. The facilitators believed the study of the homework and the provision of written feedback was important because the member had dedicated their time and a great deal of effort to the completion of the assignment. The counsellors were informed that the homework was never marked correct or incorrect. The facilitators supplied the answer or

elaborated on the answer and added additional positive comments that encouraged the group member to further discuss the topic with their counsellor. This assisted in the acquisition of knowledge because the members never felt they had failed and it allowed for further repetition of the material with the counsellor.

Furthermore, the homework provided the facilitators with the opportunity to learn about each individual group member and some of the issues that may have affected their attitudes towards relationships and sexuality. For example, Laura wrote on the bottom of the feelings homework that she liked the first session but found it very difficult to talk about her father's death and the sadness this had evoked. She stated that she had never talked about it before. The facilitators wrote a comment on the homework that legitimised her sadness and the difficulty of discussing death and praised her for the risk she took when she self-disclosed this information in group. As a result of this disclosure several other group members discussed the sadness they experienced when a loved one passed away and in Joe's situation, the abandonment he felt.

The emergence of bereavement as a topic of discussion resulted in the abandonment of the official curriculum as the members engaged in active listening and empathising, skills

important in the development and maintenance of healthy relationships. The results were increased cohesiveness and exposure to the topic of relationships in general and not just sexual relationships. The facilitators kept this occurrence in mind when the relationships homework was developed. Several pictures that represented different types of relationships were presented and members were asked to circle one of the pictures and to be prepared to discuss why they circled the picture in the next session. Laura circled the picture of a baby and a father and although she spoke of the sadness she felt because of her father's death, she also recounted the happy times she had with him. At the end of the session she said she was sad but not as sad as she had been before the session.

The homework also included questions that asked the group member to question and discuss with their counsellor, if they wanted to, their attitudes with respect to dating, sexual intercourse and gay and lesbian relationships. For example, one of the homework questions with respect to dating asked if it was okay for a woman to date a woman. These answers were not marked right or wrong but were included, as they were in the group curriculum, to ensure that any of the members who were bisexual, gay or a lesbian understood that

their lifestyle and attraction to members of the same sex was normal and healthy.

The homework had an impact on the self-esteem of the group members. The facilitators observed that the group members were very proud when they reviewed or handed in their homework. The group members would also state that they looked forward to the return of the homework. In the counsellor group Terri had shared a story of when Joe ran down the road and stopped her from leaving work for the night because he wanted to show her his homework. She reported that he was very proud because of the facilitator's comments. Other counsellors also referred to the homework and the effect that the facilitator's comments and the congratulatory stickers had on the self-esteem of their client.

> "But I know for [Jocelyn] that feedback was really important because she could read it and it was in red pen and the stickers were on it. She was very, very proud of that." (Sue)

> "Yeah, yeah. Very proud and that's great for, I think that helps a lot towards the self-esteem and the comfort level in the group too. I would do really well too if no answers were ever wrong you know and I think that's great." (Chris)

The facilitators initially worried about the use of the stickers because they felt that the members might view them as juvenile or patronising. However, the counsellors stated that they were quite effective and facilitated an increase in self-esteem. Heidi stated that Lindsay was very loyal to the

homework and looked forward to doing it with her. Bill stated that the homework had an impact on his client's self-esteem and he suggested that it was manifested in his body language and self confidence.

> "Ah, yeah. But it wasn't primarily verbal with [Jim]. One of the things was, what he started to do was he got a separate duotang and he started to put his homework that he got back from you in a separate duotang. Another thing that he did is he would sit, his whole body language would change when we were doing homework and he had this air, this look of knowledge you know. He would nod to questions...But his whole body language was very good in the sense that he was very secure with the knowledge."

Sue said that she had also noticed an increase in her client's self confidence when they did the homework together.

During one of the counsellor session Heidi had commented that Laura and Melissa had taught her something while they completed their homework. One of the questions had asked the members to list biological reactions or signs that indicated a man was sexually aroused. Laura and Melissa decided that one of the answers was that a man's nipple becomes hard. Heidi said that she told her clients that she had not known that. She said that her clients appeared very proud as they explained to her that a man's nipples can be very sensitive and can get hard when he is sexually aroused. Heidi believed that their ability to teach her something resulted in a role reversal and had a positive effect on her client's self-esteem and self confidence.

The involvement of the group home counsellor.

The involvement of the group home counsellors in a concurrently running group appears to have had a significant impact on the client's increased knowledge scores following their participation in the socio-sexuality education group. The homework certainly was the didactic material link between sessions, but the participation of the counsellor provided the opportunity for the client group member to repeat and rehearse the material with assistance in the context of their living environment.

The counsellors felt that their participation assisted their client's learning because the information they received in the counsellor group resulted in consistency. Consistency in the sense that the information they provided to the client while they assisted with the homework assignment was consistent with the didactic material the client had been exposed to during their group. During the focus group Heidi stated:

> "I really, the whole thing about us meeting too, I think, was so beneficial. Knowing the knowledge or getting the knowledge so that you could be consistent with that. So, when we are talking about terminology for instance, we can be consistent: "No! This is not what you talked about in group. This is not the name of that. That's your name for this. This is the name for that. So at least we could get some specific knowledge that was consistent."

Perhaps more important, is the fact that the counsellor's participation allowed for the consistent provision of correct information during the homework assignments.

Boyle (1993) suggests that the workers may feel more comfortable discussing sexuality with their clients if they can provide the correct information to the person they work with. The counsellors felt that if they had not had the correct information they may not have been able to help the client with the homework or may have provided incorrect or incomplete information. They felt the client may have been confused and their knowledge may not have increased to the degree it did. In fact during one of the counsellor groups several of the participants were confused about a question that asked if two women can have intercourse. This questioned surprised them and they suggested that it would have assisted them and hence their client's learning if they could have seen the homework before the client brought it home. This request was facilitated and during the focus group Sue reported:

> "It also helped, what about half way through, you were starting to show us the homework prior. Just getting that and being prepared for that was excellent."

As a result of their participation counsellors provided information and feedback that enhanced the clients' learning and therefore, was a factor in the clients' increased

knowledge at post-test. Counsellor involvement in a concurrently running group also resulted in the development of mutual aid that served to enhance the client's learning of the didactic material. A discussion during one of the counsellor sessions resulted in the identification of a client who was too embarrassed to complete his homework with his female counsellor. The counsellors problem solved until they felt they had identified a workable solution. They decided that Shayne would be asked if he wanted to complete his homework assignments with Bill and Jim. According to Heidi the embarrassment was replaced with enthusiasm as Shayne started to look forward to night for homework.

> "When I was doing homework with [Shayne] he didn't want to do it. When [Bill] and [Jim] started doing homework with [Shayne], ...he would sit and wait until after supper, like he'd sit on the stairs from 5:30 until 7 waiting."

Without the participation of the counsellors there remained a good possibility that Shayne would not have completed his homework assignments and the homework would not have provided the link for the material from session to session. However, Shayne completed his homework which allowed for the repetition of the material he had been exposed to because of the counsellor's participation and the mutual aid that developed in their group. The principal investigator also concluded that the participation of the

counsellors facilitated a change of the client's attitudes towards relationships and sexuality.

According to Boyle (1993) the provision of the correct information not only allows the counsellor to more comfortably discuss sexuality with their client, but it also allows the counsellor to begin the process of correcting any of the myths or misconceptions their client may have about sexuality. There was evidence that the counsellors' participation in the completion of the homework resulted in the identification of their client's attitudes towards relationships and sexuality. For example, Sue had talked in group about how she was able to engage Jocelyn in an exploration of her feelings towards intercourse as a result of a reaction Jocelyn had to the homework content. The result was a decrease in Jocelyn's anxiety to the material and they were able to have a productive session and complete the homework. It is interesting to note that the intercourse attitude subscale was one of the only subscales where Jocelyn had a more positive attitude at post-test then at pre-test.

According to the counsellors their participation with respect to the completion of the homework required them to become committed to the group and to their client's learning. During the focus group Chris stated:

> "...yeah, and like we had to become dedicated to this group and everything that's involved and we have to work

> hard on the homework and the understanding part and stuff."

Due to this dedication and commitment to the group it appeared that the counsellors looked for change in their client's and became aware of changes in their client's attitudes towards relationships and significant others. Conversely, it appeared that the change may not have been recognised and supported if they had not participated in their client's socio-sexuality education.

> "Like simple little things. Like I didn't think it was such a big deal when [Jim] came home that first night and started calling up his brother and thanked him for something he had done some years ago. But I wouldn't have learned the richness of what was happening if I hadn't of had this group to come to and phase into what was happening and then everybody else was going 'wow' you know...and when you take each little piece and put it together you can see how it really gets exciting; how the individual that you are working with is growing. If, and if I'd just been isolated and didn't have this group to come to, then I would have just written that off." (Bill)

The group provided Bill with a place where he could share his observations with respect to a change he had seen in his client's behaviour and attitude. As a result of his sharing the observation the facilitators were able to provide the context of the telephone call. Teasing had been discussed in the last client group and apparently Jim's brother had stopped some neighbourhood children from teasing Jim many years earlier. Subsequently, Bill was able to return to the group home and engage Jim in a conversation

about his family and his attitudes with respect to his family. For Jim simply talking about his family reflected a change in attitude.

Format Factors That Influenced an Increase in Knowledge and a Change in Attitude

During the focus group the counsellors identified several format factors that they believed facilitated or enhanced the ability of their client to learn and thus resulted in an increase in knowledge and a change of attitudes and behaviour.

Flexibility.

The counsellors felt that the format of the socio-sexuality education program provided a flexibility that took into account the fluid and dynamic atmosphere of the twenty-four hour supervised group home but also provided enough structure to meet the educational needs of their charge who was involved in the group.

> "I think the format was good for the group home atmosphere. Like it was flexible enough to fit in to our changing schedule...come what may because there's times when something happens and you can't get to homework on a particular night. So it was flexible enough to allow that. But it was structured enough so that the individual could say "Thursday night, that's the night for group." And we've, you got the whole week to prepare for Thursday night." (Bill)

The role of the counsellor was to assist the client with the homework and this in turn would provide the client with repetition to enhance the short-term memory of the didactic material. It appears that the week between the sessions allows the counsellor to attend to the other demands of the group home reality as well as to meeting the requirement of completing the homework with the participating client.

A group of peers.

The counsellors believed that their client's participation in a socio-sexuality education group of their peers resulted in changes in behaviour that they believed they could not have facilitated. They felt that the client's sensitive challenging of each other's behaviour in group was far more effective in changing the individual's behaviour then if the challenge had come from the counsellor. The counsellors discussed in their group sessions that they felt their clients were to a certain degree desensitised to repeated worker attempts to have them change their interactional behaviours.

Within the same realm of reasoning, the counsellors believed that the peer group format provided the group members with a place where they learned from others who shared a common life experience. As a result the counsellors

felt that the clients could identify issues that were important to them and not to the counsellor. The counsellors reported in their group sessions that they believed there was a decrease in the clients' dependency on them as their sole emotional support because they could discuss issues with their peers and learned that their peers can provide understanding and support. Several of the workers' believe that it is through peer support and the sharing of common issues that individual's with developmental handicaps will begin to overcome interactional and relational insecurities.

The counsellors also felt it was important that the group members were exposed to the perspective of opposite sex peers. Heidi said that she believed it was important for Lindsay to hear from the men in the group that they thought she was unfair when she told her boyfriend that he could not go to see his brother. She believed that Lindsay's attitudes towards her boyfriend's needs changed as a result of that interaction. For the most part however, the counsellors believed that the co-ed peer group resulted in increased socialisation skills and an attitude that reflected a desire to interact with people.

> "...and again the social aspect of it I think was extremely good for her...But she seems generally more happy, like more motivated to get up and go to work...Being part of a group I think made the difference for her and I think always will." (Sue).

Facilitation and location.

McCabe (1993) suggests that it is usually the function of other professionals to educate people with developmental handicaps on issues of sexuality and relationships because of the caregiver's negative attitudes and their discomfort with or lack of knowledge concerning sexuality education. Feedback from the counsellors indicated that this was probably not the case in this study. Although the counsellors indicated that they felt they needed to learn more about the sexuality of individuals with a developmental handicaps, they simply felt that it would be more beneficial for their client to learn from somebody else. During the focus group Chris stated:

> "because I could say the same thing over and over again but somebody else saying it and helping them with it is probably very beneficial."

However, the counsellors believed that it was very important that their clients knew one of the facilitators and that the facilitator had worked as an employee of the agency. They felt that this resulted in client trust and that the development of trust was reflected by increased knowledge. However, when it was brought to the attention of the counsellors that one of the facilitators did not have connections to the agency prior to the group, Heidi replied:

> "I think the two of you are linked together because they trusted you and knew you. It came to [female facilitator] because she was with you, because you

> brought her and they knew you trusted her so therefore they could. But I think if two unknowns had come in, you wouldn't have gotten half of what you did out of them."

The counsellors also believed that the location of the client group was somewhat responsible for the client's increase in knowledge and a change in attitude. The counsellor's liked the idea that the client group occurred outside of the agency because it gave the group member's ownership and it was not perceived as just another program that the agency had forced on the client. In fact, Jim could not attend one of the early sessions due to a previously planned trip. The primary investigator and Bill arranged to present that week's curriculum, slides and supporting material to Jim at his group home. It did not go well. Although we had removed ourselves to the basement office, Jim was still distracted and it appeared that he found it difficult to concentrate. A review of the material that immediately followed the session indicated that the client had retained very little.

Problems Identified and Format Changes Suggested or Required

Visual aids and concrete activities.

The facilitators found that the client group members' short-term memory, self-expression and historic attention difficulties were enhanced by the utilisation of visual aids

and concrete activities. However, this group experienced only marginal increased knowledge and comprehension when the visual aids and concrete activities were applied to the presentation of abstract concepts. For example, the members were able to identify all of the external body parts on the SKIS (Forchuk et al., 1995) at post-test, but continued to have difficulty at post-test with the identification of internal body parts including the urethra, bladder and uterus.

There are several possible reasons for the clients' post group lack of knowledge with respect to internal body parts. The first was that the facilitators found the tools utilised were technical and noticed that the group member's lost interest when the information was presented. In hindsight the facilitators realised that they had spent little time on internal body parts identification and function and instead focused on the external. The facilitators reasoned that the client's had little knowledge at the start of the group and because of short duration of the program presented only the most basic information. As well, the homework did not contain a component with respect to internal body parts and as a result the counsellors did not reinforce the material at home. Several options have been identified for future groups. The first involves the use of realistic models that

allow access to the internal organs of the human body versus the use of pictures and charts. A second option involves better preparation of the homework assignment to include a review of the internal organs and better preparation of the counsellor to reinforce the facts about the human body's internal sexual organs. A final option involves de-emphasising but not excluding, the identification of internal body parts and organs where the pre-test scores of the participants' are very low and thus indicate that the individuals require only the most basic and comprehensible of information.

The facilitators and the counsellors identified STDs as an abstract topic that was difficult to teach. However, the participant's post-test scores indicated that they had learned or retained more then the facilitators and counsellors had given them credit for. It appears the use of the model penis and vagina and the use of the hand cream and various kitchen seasonings did succeed in transmitting the information with respect to protection and symptoms. The facilitators did recognise that it was difficult to see the STD sores and discharge in the pictures in the homework. The counsellors also stated that the presentation of the material in their group was helpful but they had difficulty with the homework because of the poor quality of the pictures.

In the future it will probably be useful to find and utilise a film or video that provides a more graphic illustration of the symptoms and side effects of STDs. The investigator also suggests that the counsellors participating in future groups may need more preparation to help their clients with STD homework. This was suggested because the facilitators had little time to present the STD material to the counsellors during their sessional group. The counsellors had engaged in a great deal of conversation early in the session and this resulted in a brief and shortened presentation of the STD material. The counsellors in this group admitted that they knew very little about STDs and the investigator suggests that the lack of knowledge compounded by the shortened presentation of the material may have been a barrier to their ability to comfortably work and talk with their client about this topic.

It appears that one of the male client group members had difficulty comprehending the topic of menstruation and a second male group participant had difficulty with the acceptance of menstruation as a bodily function that was normal, healthy and acceptable. In the first case it appeared that this individual may have had difficulty with the abstract concept of menstruation. It was a body function outside of his personal experience and the visual tools

utilised were of a poor quality. This individual's inability to identify the internal body organs may have been a factor as well. The facilitators believed Jim had a negative attitude because he described menstruation as "bleeding" from the vagina. It appeared that he perceived menstruation as an injury. Jim maintained the attitudinal position that it was not okay to bleed from the vagina even after the facilitators had attempted to enhance his understanding of menstruation and what it meant.

In hindsight the facilitators recognised that menstruation questions, both factual and attitudinal, were absent from the homework assignments. Menstruation was discussed at length in the counsellor sessions but it appeared that it was not discussed when the counsellors completed the homework with their client. The primary investigator suggests that the facilitators of future groups should be including the topic of menstruation in the homework assignments because it does impact on the lives of men with developmental handicaps who live in co-ed group homes. Not to mention women who may not understand what menstruation is or who may hold negative attitudes about menstruation based on misinformation, myths and misconceptions.

During one of the counsellor sessions Heidi was insistent that her client understand menstruation because he

lived and interacted in a house with three female housemates and a female counsellor. She stated that the emotional atmosphere of the house changed dramatically several times a month because of the women's menstrual cycles and that Shayne needed to understand why so that it did not adversely affect him emotionally.

Timelines and timeframes.

The very nature of the mainstream model allows the facilitators of the socio-sexuality education group to abandon the didactic material to attend to member reactions the material elicits and to attend to the process of the group. Unfortunately, the abandonment of the didactic material in this group resulted in a shortened presentation of the information to be learned. In fact, in one of the earliest counsellor sessions Heidi asked how we planned to cover all of the material in eight weeks. The initial intent of the facilitators was to have the counsellors prepared enough in their session to be able to cover the content in the homework with their clients in the event the material had been abandoned in the group. However, the counsellors often engaged in discussions that pertained to their own attitudes and as a result the material was often hastily covered in their group.

Therefore, the primary investigator suggests that future groups operating from this format will need to run longer then eight weeks to accommodate all of the didactic material. As well, individual counsellor group sessions must be longer in duration if the material evokes the amount of discussion in future groups that it did in this group of counsellors. As well, the principal investigator suggests that the counsellors should receive the homework assignments before the clients do and that this should occur from the outset of the groups. In this way the counsellors can prepare for the homework session with their client and will also be in a position to provide the facilitators with feedback regarding material that is absent from the homework that they believe should be present to meet the client's educational needs.

Homework.

Although several of the problems with the homework have already been elucidated, the counsellors identified other problems in this area. Heidi offered:

> "It's just that I find that I seemed to lose them when I was reading long, when the questions were too long and too elaborate I would seem to lose them."

The length of the questions had not concerned the primary investigator because of the counsellors' involvement. Although elaborate the investigator had attempted to make the

wording in the questions as simple as possible. Heidi asked Bill if he had edited the questions during the homework session. Bill replied:

> "Well, what I ended up doing was trying to paraphrase more kind of stuff and when I did that kind of thing and when I felt comfortable doing that kind of thing, it seemed to work better."

This comment suggests that it may be worthwhile to involve the counsellor in the development of the homework and the wording of the questions.

A second issue that the counsellors identified with respect to the completion of the homework involved the hours they worked and their time off. The counsellors felt that the format met the flexible needs of the group home system, but it did not always meet the client's need to complete the homework. For example, Sue was on holidays during the first week homework had been assigned. As a result, Jocelyn completed the homework with another staff member. Sue stated that this set an unfortunate precedent as Jocelyn wanted to complete the homework with any staff member but her. Sue said this made completion of the homework difficult at times but that she was able to eventually resolve the matter.

> "You know, giving her time to review it on her own first without a game plan as such. We did have a few excellent sessions. When it actually got right down to it she realised that I'm the person you're doing homework with and we had some really good sessions." (Sue)

The training of other staff.

This was not the only time the counsellors had mentioned the presence of other staff members in the life of the client. During one of their group sessions the counsellors' discussed the number of workers individuals with developmental handicaps have contact with and how this has historically made the consistent enforcement of consequences for inappropriate behaviours difficult. Another counsellor in a different session had told the group members how a staff had gone into her client's room and looked through that client's homework duotang without his permission. They concluded that consistency and respect for privacy were the key and that all staff should be required to participate in groups for counsellors much like the one they had participated in.

The counsellors suggested that after having had the experience of this format they no longer believed that a conference or a workshop would have the same impact. Bill suggested that this format had obtained a balance between organisation and flexibility that he had not experienced at a workshop or conference. Chris suggested that this format allowed for spontaneity and this was the characteristic that would be lost if the balance between the organisation and the flexibility were altered or lost. They suggested that the

balance between organisation and flexibility, the group member interaction, support and discussion spontaneity were all reasons other counsellors would benefit from this format.

Parental involvement.

During the first counsellor session Sue had asked the counsellor group members if it was acceptable to have the mother of Jocelyn participate in the group because she had shown a keen interest in her daughter's participation. At the time the counsellor's had said no because they believed there would be confidentiality issues and because they felt that their own safety and security would be jeopardised as a result of personal material they may have chosen to disclose. Discussions in subsequent sessions indicated that the parents have a tremendous impact on the attitudes of their child with a developmental handicap. Based on the counsellors' recognition of this impact, the investigator asked the counsellors during the focus group if the parents should have participated in the counsellor sessions.

Following participation in the group all of the counsellors believed that the parents who showed interest should have been involved in their sessions. The group members continued to debate the issue of confidentiality but they felt it could be worked around and that the parents

would have accepted that they were not allowed to talk about content outside of the group. Chris suggested that the permission of the client would have to be sought just as it was for the counsellor group, but she thought it would have been feasible. Bill continued to be concerned about his own personal safety and security issues. He added:

> "I think that probably the only, I mean personally I wouldn't be comfortable with it happening for every single group that we meet in. But I may feel comfortable with it once or twice, having them come in and having the opportunity to share some of the things that we're sharing. But I personally wouldn't feel comfortable disclosing all that I've disclosed if there were certain parents here all of the time."

The group members felt that Bill had made an excellent point and that if the parents were involved it would only be for one or two sessions. Bill thought the parents may have felt just as uncomfortable with respect to self-disclosure. He concluded:

> "...I think what would be an absolute miracle is this: as a result of those parents coming in and sharing with us once or twice, they develop their own group for this which is indirectly connected with and going on at the same time. So if there's some that can do that back and forth."

The counsellors suggested that this proposed format would result in the counsellors' increased learning about their client and why the client holds certain attitudes and the parents wouldlearn about their child and would have a better understanding of the role of the counsellor. The

primary investigator believesthat this would have been a massive strategic undertaking but onethat would have incredible potential to increase consistency and to reinforce the client group members' learning in two of their most significant systems. As well, acceptance of the individual client group member's needs and rights for intimate and adult human relationships in two significant systems may have resulted in a greater positive change in the client's attitudes at post-test.

Joint counsellor and client group member sessions.

The investigator found it of interest that the counsellors believed the participation of the parent would have had a positive effect on the client's learning but they believed that joint counsellor and client sessions would not have been productive. Chris stated:

> "No! No! Because I think the individuals would clam right up, you know, it was much better this way...I think that had we been in the group the comfort level would have gone down because they, I still think that the individuals think we judge them. I think they would have behaved a certain way because `that's the way my counsellor wants me to.'"

All counsellor group members agreed that the groups had to run concurrently but separately. It is of interest to note that after participation in the group the counsellors identified their influence and the dependency of the client

on the worker and how this can have a tremendous impact on the client's behaviours, learning and attitudes.

Discussion: Hypothesis Three

The results of hypothesis 3 indicated that there was not a significant difference between the counsellors' pre and post-test scores on the SMRAI (Brantlinger, 1983). These findings do not support the findings of Brantlinger (1983) and Rose and Holmes (1991). They found that there was a significant change of attitudes in a more liberal direction after participation in a socio-sexuality training workshop for staff who work with people with a developmental handicap. However, both of the studies utilised large samples. The results of this study indicate that the score differences did approach significance following participation in the group. It can only be suggested that a larger sample size may have resulted in significance.

The overall SMRAI (Brantlinger, 1983) score totals provide evidence that there was some change in attitude between the pre and post-test scores and that the change of attitude was in a more liberal direction. The initial range of 17 with a minimum of 132 and a maximum of 149 and the post range of 10 with a minimum of 139 and a maximum of 149 indicated that some of the participants had a change of

attitudes in a more liberal direction whereas others had reached their ceiling score. This indicates that there was not a change in attitude for those participants. Still, Figure 22 illustrates that two of the participants had a slight change of attitude in a more conservative direction after participation in the group.

However, the principal investigator suggests that the movement toward a conservative attitude with respect to the sexuality of individuals with a developmental handicap are negligible. This groups' pre-test mean of 140.5 and post-test mean of 144.0 indicated that the members attitudes towards the sexuality of people with a developmental handicap were already relatively liberal at pre-test when one considers that a score of 45 on the SMRAI (Brantlinger, 1983) would have indicated a perfect conservative score and a score of 225 would have indicated a perfect liberal score. This movement towards a more conservative attitude reflected that the individual participant had reached a decision with respect to a question they had initially answered as undecided.

Interestingly, the counsellor's initial feedback from the focus group reflected the findings of the quantitative analysis. As a group, the participants felt that their

attitudes had not changed as a result of their participation. Chris stated:

> "Their attitudes have changed but my haven't. I have a pretty open attitude about things and I just kind of went with what ever they were bringing back from the group. So I tried not to be judgmental about anything that was going on or anything you know, I just kind of let them, ummm, and that's how I feel now."

The counsellors concluded that a change in their attitude was not important. However, they suggested that it was important that their client's attitudes about sexuality and relationships had changed. They also suggested that as counsellors it was important that they made an effort to support the client's attitude change and that they made an effort not to be judgmental of the change. Chris further stated:

> "Yeah, and that's how I feel too. You know it doesn't matter what I believe. It's what the individual believes and if they are happy with it and if they feel strongly about it then I'll support them. Or feel or whatever, and what I personally feel about it has, should have nothing to do with it."

Gardner and Chapman (1985) suggest that counsellors should be diligent with respect to keeping their feelings and attitudes separate from those of the person with a developmental handicap. Accordingly, "they should work to develop a healthy and supportive attitude toward informed sexual choices of the person with mental retardation" (Gardner & Chapman, 1985, p. 225). Bill felt that his

attitudes had not changed because he felt that he was conservative in his belief that all people should have the right to have opinions that differed from his. He stated:

> "But see that's quite interesting because I consider myself quite conservative...It's that, I believe very strongly in the right of other individuals to hold views and opinions about A to Z that are totally opposed to me."

Therefore the counsellors believed that their positive attitudes and non-judgmental position had always existed. They suggested that what had been required was the conveyance of correct and accurate socio-sexual information to the client and that was something they felt they were unable to provide.

The principal investigator does not doubt that in general the counsellors who were involved in the study believed or perceived that they were supportive and non-judgmental prior to their participation. However, as Rowe and Savage (1987) suggest, "...in the area of sexuality, attitudes are often hazy and hidden" (p.15). In essence, the counsellor may have felt that they had been supportive of their client's individuality and they may have felt that their attitudes had not effected the client's attitudes or behaviours when in fact they may have.

The principal investigator believes that counsellor attitude changes did occur that had an impact on the client's

ability to learn or to experience an attitude change with respect to relationships and sexuality. The principal investigator also suggests that prior to their participation in the group the counsellors held perceptions and attitudes about their clients that did not fully support the client's socialisation. In fact, the counsellors pre-group perception of the client may have resulted in behaviours on the counsellors part that were counter productive to the client's ability to gain knowledge about sexuality and to have a positive attitude towards relationships and sexuality.

For example, when asked at pre-test Bill strongly agreed with the SMRAI (Brantlinger, 1983) statement "most retarded people I know would be unable to make responsible decisions about sex." At post-test he strongly disagreed with the statement. In fact, Figure 23 illustrates that two other participants also strongly agreed with the statement at pre-test but disagreed with the statement at post-test. Although they believed that their client could not make responsible decisions about sexuality at pre-test, it would appear to make sense then that their client's decisions and attitudes with respect to relationships and sexuality prior to the group experience may not have been fully supported by the counsellor.

Figure 24 illustrates that Bill was undecided at pre-test about the right of individuals with a developmental handicap to have their own sexual life whereas at post-test he agreed that they do have a right. A closer examination of Figure 24 revealed that Terri believed in the individual's right to their own sexual life at pre-test, but Figure 23 indicated that she agreed at pre-test with the statement that most people with a developmental handicap cannot make responsible decisions with respect to sexuality. It appears to the principal investigator that there may have been conflicting attitudes at play within the counsellor. As well, if the individual cannot make responsible decisions, then at what point does a counsellor make the decision and thus negate the individual's right to their own sexual life? It appears that the counsellor could experience an attitude dilemma in certain situations that may not serve the best interests of the individual with a developmental handicap. Several other pre and post-test scores for individual questions on the SMRAI (Brantlinger, 1983) indicated that there was some change in the attitudes of the individual counsellor in the areas of attitudes towards sexuality education and attitudes towards the myths and misconceptions associated with individuals with a developmental handicap.

The participation of the counsellor in a concurrently running group appeared to have had an impact on some of the counsellors' attitudes towards socio-sexuality education in general. Prior to the group experience 66.7% of the participants disagreed with the suggestion that genders should be segregated for the purpose of socio-sexuality education. At post-test 50% strongly disagreed and 33.3% disagreed with the suggestion. This may not have appeared significant but Figure 25 illustrates that there were significant changes for individual counsellors. During the focus group some of the counsellors had indicated that they were at first concerned about the integrated group, but felt that it had been a valuable asset as reflected in their client's increased knowledge and attitude change after the group participation.

At pre-test the counsellors also held conflicting attitudes about whether or not socio-sexuality education groups should include drugs and alcohol in the curriculum. At pre-test 16.7% of the participants strongly agreed and 50% of the participants agreed that drugs and alcohol should be taught at the same time as sexuality. However, one of the participants was undecided and a second strongly disagreed. Figure 26 illustrates that there was movement on an individual basis so that at post-test 50% of the participants

agreed and 50% of the participants strongly agreed that a socio-sexuality education program should also teach facts about alcohol and drugs. This change appeared to reflect the counsellors' increased understanding about how drug and alcohol use could result in a decreased ability to protect from, and therefore an increased vulnerability to, sexual exploitation and abuse.

Figure 27 illustrates that at pre-test two of the participating counsellors were undecided about whether or not people with a developmental handicap have a stronger sex drive. However, after participation in the group the two counsellors believed that individuals with a developmental handicap do not have a stronger sex drive then other members of the general population. Interestingly, Figure 28 illustrates that at pre-test 50% of the group members were undecided about whether or not men had a stronger sex drive then women in general. This included Bill, the only male participant. At post-test 50% of the group members strongly disagreed and 33.3% of the group members disagreed with the suggestion that men have stronger sex drives then women. Only one of the group members remained undecided.

The facilitators also observed that all of the counsellors experienced attitude changes during their group sessions. However, the changes were not specifically related

to the sexuality of the individual but more so with respect to the perception and the attitudes the counsellor had of their clients' abilities to socialise and to learn. For example, some of the counsellors initially described their client as egocentric and in later sessions the counsellors commented that they were "surprised" by the level of participation and socialisation of their client.

Heidi was one of the counsellors who had described her client as egocentric. In one of the initial sessions the facilitators suggested that they would attempt to redirect Lindsay to interact with the other group members because the facilitators felt that she only formed relationships with counsellors and people of authority. At the time Heidi had wished us luck and suggested that it had been attempted before without success. She made it very clear that "...it'll never happen!" Several sessions later Heidi appeared shocked when the facilitators informed her that Lindsay had informed Jocelyn that she had hurt Joe's feelings during the previous client group. Heidi said:

> "That is fantastic! [Lindsay] was empathic. That is a great breakthrough for a person who is egocentric."

This provides an example of how Heidi's attitudes and perception of her client began to change as a result of her participation in the concurrently running counsellor group.

The counsellors would also tell the facilitators that they had all found themselves "surprised" and "amazed" by the amount of knowledge the client had retained from group as evidenced when they completed the homework assignments with their client. With respect to socialisation and interaction, Heidi said that the counsellors could not believe Shayne's increased socialisation in the group home and in the community since the group had started. Bill stated during one of the counsellor sessions that he was "amazed" by Jim's increased socialisation and change in behaviours. Bill further stated that his participation in the group had changed the way he interacted with all of his clients.

The facilitators believed that the counsellors had negative attitudes and perceptions of their client's abilities to form relationships, empathise, learn and to engage in appropriate interactional behaviour prior to their involvement in the counsellor group. However, as the group progressed the facilitators observed that the counsellors had started the process of attitude and perception change with respect to their client's abilities and interpersonal skills as a result of their participation in a socio-sexuality education group. Interestingly, as the counsellors continued their interaction and participation in the focus group they too started to identify personal attitude and behaviour

changes that they accredited to their participation in the group.

Changes in counsellor attitude with respect to knowledge.

As a result of her participation in the group Terri had noticed that Joe had started to interact more and had expressed his feelings about an issue on two occasions. The expression of personal and intimate feelings was something he had never done before. Terri said:

> "I think that [Joe], I found out that he knows a lot more which I wasn't aware of. He still doesn't express a lot but there's still a lot of knowledge in there. So that has changed for me in that I have to start pulling that information from him and that will take a lot of work."

The statement suggests that prior to group participation the Worker perceived that Joe did not have a lot of knowledge. Terri had described this client as egocentric in earlier sessions. This leads one to wonder if Joe really was egocentric or if the counsellor's perception that he did not have a great deal of knowledge meant that there was little requirement for interaction. In fact the facilitators found Joe to be extremely sociable and very in touch with his feelings. However, now that the counsellor has had the group experience and is aware that Joe does know a great deal, her perceptions and attitudes have changed and she had engaged

him in more onversation and interaction by the termination of the group experience. The principal investigator believes that it is through this interaction and socialisation that Joe will be provided with an opportunity to practice and further develop the communication and socialisation skills he learned in group.

Attitude change towards working with the opposite sex.

During the focus group several of the counsellors said that prior to the group experience they did not think it would have been a problem to talk about sexuality or to complete the sexuality homework with a client who was a member of the opposite sex. However as the socio-sexuality education groups progressed several of the counsellors noticed changes in the quality of the interactions they were having with the client group members. Bill found that when he drove the group members to the university the female members of the client group were no longer as open to him as they had been in the past. He said:

> "You know the women aren't going to come to me on certain issues and that's what I found too like, even during the group when I was doing the van drive I,I, I know most of these people through group homes and their reaction to me changed. It wasn't as open. Those women in the group weren't as open to me as they would have normally been when it came to me and feeling like they distanced themselves from me."

The counsellors agreed that their attitude was that they had known the client for a long time and so they believed that the client would not have a problem talking about sexual issues or any other general issue. It appeared that the counsellors did not take the client's anxiety nor comfort needs into consideration and in Shayne's situation, it resulted in his inability to complete the homework. During one of the session groups the facilitators suggested that Shayne may not have completed his homework because he was not comfortable completing it with Heidi, his female counsellor. At the time Heidi believed that this was not the issue. However, during the focus group Heidi stated:

> "I don't think I had an attitude about it and I was in that situation and I thought I could do it. I thought I could deal with it. I didn't think it was going to be a big deal but it was. I was more uncomfortable then I thought I would be and [Shayne] was definitely uncomfortable with it. I wouldn't have thought that I would have to deal with something like that."

Heidi identified that not only was Shayne uncomfortable, but she was too. The principal investigator concluded that if the counsellors had not participated in a concurrently running group, then there was a good chance that Shayne would not have completed his homework and as a result the rehearsal and repetition of the material would not have been realised. Subsequently, his post-test knowledge score may have been

lower and perhaps he would have developed or maintained the attitude that his comfort in relationships is not important.

Attitude change towards socio-sexuality education.

Sobsey and Mansell (1990) suggest that people hold to the myth that participation in a socio-sexuality education group or the simple provision of sexual information will result in increased sexual behaviour on the part of an individual with a developmental handicap. During the focus group Bill suggested that prior to participation in the group he believed that Jim's exposure to the material may have resulted in increased sexual behaviour. Heidi stated:

> "Yeah and it was more how immediate the changes were and the fact that the changes weren't primarily focused around sex. They weren't, he wasn't focusing on relationships. Like relationships in the sense of going out and finding a girlfriend like some of the individuals who we work with are just totally fixated on `girlfriend, girlfriend! I need a girlfriend in my life to feel like a human being.' He doesn't think in those terms and that, maybe that's what I thought was going to happen; he was going to start fixating on `well I need a girlfriend in order to feel, in order to be like these other people.'"

Sue pointed out to Bill that this was an attitude change and Bill recognised that he had held this attitude at the start of the group but due to his participation he claimed he no longer held it.

This discussion resulted in Sue's acknowledgement that she too had felt that Jim could have been dangerous because

she said that she believed he was a powerful man and there was fear on her part that he would become sexually active. The fear was the result of past aggressions she had observed. However, they were surprised how this particular individual appropriately interacted and increased his interaction and socialisation during and after the group experience. It appeared that the counsellors had an attitude about who could and could not handle the knowledge that they would learn. Sue and Heidi initially had the perception that Jim could not. Sue further said:

> "I think if anything has changed for me it's not so much that they have a right to that knowledge, it is that even individuals who perhaps I thought wouldn't be able to handle the knowledge can."

It appears that as a result of the counsellors' participation there exists the possibility that they will be more apt to discuss sexuality issues with the client because the counsellors now believe that the client can behaviourally handle the socio-sexual knowledge. If this is the case, it appears that the counsellor will be more apt to work on the homework assignment with the client which may result in an increase in the client's knowledge. It also appears that the counsellor will probably be more apt to positively influence the client's attitudes towards relationships and sexuality.

Attitude change towards dependency.

The principal investigator concluded that the counsellors change of perception with respect to the client's ability to experience a socio-sexuality education group and to responsibly deal with the information gained as a result, allowed the counsellor to identify their own behaviours that may result in the client's dependency on the counsellor. Sue reported during the focus group that she had picked up the pen and started to write down Jocelyn's answers to the homework questions. The resultant response was that Jocelyn grabbed the pen back and said "I can do that." During the focus group Sue said:

> "...and I think sometimes we think well let me do it for you it's easier...and I know I have to watch myself doing that a lot. It's that whole dependency thing you know. As you [Bill] said, you know, it can be very self-fulfilling."

Bill added:

> "I mean what we're talking about is attitudes in ourselves that have been checked. Now, I've just realised right now that that's an attitude in me that's been checked and I didn't realise it you know."

Owen and Symons (1993) suggest that the counsellor's behaviours that result in the client's dependency can be very subtle but the end result is that the counsellor begins to make decisions for the client. During the focus group the counsellors all agreed that they have participated in behaviours and made decisions that resulted in the client's

dependency upon them. The pre-test results showed that 50% of the counsellor participants believed that most people with a developmental handicap cannot make responsible decisions with respect to sexuality and relationships. The reason may have been the client's lack of socio-sexual information in combination with the client's dependency on the counsellor to make decisions. A dependency nurtured by the subtle behaviours of the counsellor.

Marriage and parenthood.

The SMRAI (Brantlinger, 1983) results suggest that the counsellors had varying opinions with respect to whether or not individuals with a developmental handicap should marry if they cannot support themselves. At pre-test 50% of the counsellor participants believed that individuals with a developmental handicap should not marry if they cannot support themselves whereas 16.7% agreed with the statement and 33.3% were undecided. Figure 29 illustrates that there was a change in attitude and at post-test 66.7% disagreed with the statement while 33.3% agreed that the individuals should not marry if they cannot support themselves. However, at post-test all of the counsellors did feel that individuals had the right to get married if there were supports in place. Sue stated:

> "I think the only attitude that's changed for me is the issue around marrying and providing support for married people. I think before this I was really undecided about that because I've got this vision in my head that ahhh, they have enough on the ball to get married, what do they need us for sort of thing. However, I got thinking about a number of other individuals who aren't in that category who haven't been labelled that could use it too; support in terms of relationships. So I think that's changed..."

Figure 30 illustrates that at post-test all of the counsellors believed there should be facilities for married couples who have a developmental handicap. This suggested that the two counsellors who at post-test believed individuals should not get married if they cannot support themselves also believed at post-test that individuals with a developmental handicap can marry if there are supports. It appears that the counsellors did not have a conservative attitude towards marriage but toward the ability of an individual to support themselves in a marriage. However, the group members remained somewhat undecided about the right of any individual, with a developmental handicap or otherwise, to have a child.

The results for this statement suggest that only one of the group members strongly agreed at pre- and post-test that every person has the right to have a child. At pre-test two of the group members disagreed and the final three were undecided. Following participation in the group there was some movement in attitude as the two members who had

disagreed were now also undecided. Figure 31 illustrates that at post-test one of the group members agreed that all people including those with a developmental handicap have the right to have children whereas the remainder of the members were all undecided. However, the counsellors provided more information on this topic during the focus group.

Several of the counsellors suggested that their opinion on the right to have a child had nothing to do with a person who has a developmental handicap. Heidi reinforced that she knew couples with developmental handicaps who have children and are exceptional parents. Paula added:

> "You know, it's not against the handicapped. If you're not able to raise a child; I've got a neighbours who are unable to take care of themselves let alone a child."

Sue agreed and added that there were very few people she knew living in the group home she worked at who could raise a child and her sentiment included those who had participated in the socio-sexuality education group. She felt there were gains as a result of their participation but not enough increased knowledge or attitude change to be responsible to raise a child. Bill replied:

> "Once you have opened the door to basically deciding, or at least saying it is okay to decide, who is capable of raising a child and who isn't, then you've opened it up to, you know eventually being able to say well because you are handicapped you cannot raise a child. And I think there is a more important issue of lets bring a child into the world and then provide alternate services to raise that child appropriately."

Several of the counsellors suggested that it would be possible if the individual had supports but without them they did not think that the majority of people with a developmental handicap would be able to provide for a child. Sue stated:

> "...but in fact environment is certainly a part and I think that every child has a right to a stimulating, safe and secure environment. Without those societal or family or community supports, I'm not convinced that the majority would be able to provide that for a child. And it's not just the developmentally handicapped either. Until we as human beings evolve a little better I don't think it's going to change."

Bill agreed with Sue but maintained that he did not think the answer was that people with developmental handicaps are not allowed to have children.

The quantitative analysis and the initial comments of the counsellors in the focus group suggested that there was no significant change in the counsellor's attitudes towards the sexuality of individuals with a developmental handicap after participation in a concurrently running group. However, by the counsellors own admission and as a result of an analysis of some of the individual statements on the SMRAI (Brantlinger, 1983), it appeared that the counsellor's attitudes had changed to some degree after participation in the group. However, the counsellors did not initially recognise the change. This appears to be because the attitudes of staff towards the sexuality and the

relationships of their clients are "...hazy and hidden" (Rowe & Savage, 1987, p.15).

The counsellors suggestion that their attitudes had not changed may have been misleading even to them. As a result of their interaction in their own group they were able to identify that their behaviours were influenced by their attitudes and these attitudes had an impact on the client's ability to operate in relationships and to make decisions for themselves. The simple recognition on the counsellors part that they were involved in behaviours that fostered dependency may have been the difference between having had seen and not seen the reported observations of change in their clients decision making abilities and increase in self-esteem.

The counsellors also reported that they never recognised the knowledge their clients possessed until they had participated in the group. Their perception that the client had little knowledge or could not have responsibly used the knowledge may have been maintained if the counsellor had not played a part in the program. If that were the case then it would have been highly unlikely that the counsellor would have engaged the client in discussions about what they had learned and highly unlikely the client would have retained the knowledge. As a result of their participation in the

group the counsellors were more cognisant of their client's behaviours and more sensitive to change in the behaviours or in the knowledge. Perhaps simple exposure to and recognition of the client's increase in knowledge and change in attitude is enough to change the attitude of the counsellor.

Hazy and hidden, the idea that the counsellors may have been completely unaware of just how much their attitudes influenced their perspectives of their client and their interactions with the client. As Bill and Sue stated:

> Bill: "...and I wonder if, how much of their growth is through osmosis or whatever is coming through our own personal work and changing..."
>
> Sue: "Oh definitely. Our attitudes, our approaches."
>
> Bill: "...You know, all those things that we are not consciously doing. You know our personality."

Speaking from personal experience, the principal investigator suggests that counsellors who work with individuals with a developmental handicap strive to believe that they are supportive of their client's sexuality and individuality and that their own attitudes are liberal and non-judgmental. However, as Rowe and Savage (1987) suggest, a counsellor's attitudes can be unclear and unconsciously or subconsciously affect their interaction with the client.

Factors That Influenced a Change in the Counsellor's Attitude

The provision of factual information.

The sole purpose of this format was for the counsellor to learn the curriculum that the client was to learn so that the counsellor could assist the client with the rehearsal and repetition of the homework at home. However, the counsellor's attitudes about the sexuality of individuals with a developmental handicapped had to be taken into consideration because research had indicated that the counsellor's attitudes with respect to the sexuality of their charges tended to be quite conservative. As a result it was hypothesised that the client's increased knowledge, change in attitudes and change in behaviours would not be supported in, and therefore not generalised to the group home if the counsellor maintained a negative attitude toward the sexuality of the client.

As suggested, the counsellors and the counsellor group participants had identified some attitude changes as a result of participation in the program. According to Boyle (1993) one of the tasks of a staff training program is the provision of factual information with respect to sexuality in general and the sexuality of people with developmental handicaps. Gardner and Chapman (1985) and Kempton (1991b) suggest that if the counsellors are presented with factual information

then they will begin to develop positive attitudes about the sexuality of people with developmental handicaps. The initial purpose of the counsellor group was the simple provision of the correct information.

As the group sessions proceeded the facilitators noted more frequently that the counsellors were engaged in discussion that concerned how little they knew about sexuality issues that had never affected their lives, but may have affected their client's lives. As the group developed the facilitators noticed that the counsellors were actively seeking information instead of being passively lectured to. They admitted that they knew little about STDs or how to teach their client to masturbate. In one of the earlier sessions Bill stated that he thought his client may have been obsessed with masturbation. However, in a later session he reported that after he and his client had completed the homework that included a component on masturbation his client had said it was painful when he masturbated.

As a result of Bill's initiation of the conversation on masturbation several of the counsellors stated that they were not even sure if their client knew how to manipulate appropriately. This resulted in a conversation during which the facilitator suggested that perhaps Jim was having difficulty because of the pain associated with friction and

if that was the case then perhaps he had experienced difficulty ejaculating. The facilitator suggested that perhaps his obsession reflected a desire to ejaculate just one time. The suggestion was made to purchase a model for demonstration or to purchase a lubricant and to teach Jim how to use it. Following this session Bill reported a decrease in his client's masturbatory behaviour and reported that he no longer believed that the client's behaviour had ever been obsessive.

It appeared that the discussions that the presentation of the sessional topics elicited were more spontaneous as the counsellors became more comfortable in the group. The more freedom the counsellor's were provided to discuss issues then the more their attitudes began to emerge. For example, the counsellors began to discuss the institutionalisation of people with developmental handicaps during the presentation of material about gay and lesbian relationships. The counsellors suggested that there was a policy of segregating the individuals by gender in the institutions, and because of that many of the institutionalised individuals engaged in gay and lesbian acts and relationships. They shared experiences of how they had seen counsellors who attempted to stop individuals with a developmental handicap from engaging in gay and lesbian relationships after they had moved into

community group homes. They felt that this was cruel and based solely on the attitudes of the counsellor and not the needs or desires of the client.

This discussion may explain the changes in attitude with respect to gay and lesbian relationships as illustrated by Figure 32. The figure indicates that two of the counsellors were undecided about whether or not gay and lesbian relationships between individuals with a developmental handicap should be permitted. However, at post-test and following participation in the group, they agreed that gay and lesbian relationships should be permitted. Consequently, one wonders if this change in attitude had any impact on the clients whose results indicated a significant difference between their pre and post-test scores with respect to their attitudes towards gay and lesbian relationships. Another example was the group discussion with respect to the effect that certain medications and syndromes can have on the sexuality of people with developmental handicaps. For example, Heidi engaged her client in a conversation about why she did not like her boyfriend to touch her "too much" when Heidi learned that people with cerebral palsy are often hypo or hypersensitive to touch. Following the conversation Heidi no longer held the attitude that her client was afraid of sex. This was replaced by an understanding attitude that

developed as a result of having had gained correct and factual information.

As a result of participation in the group the counsellors received information that changed their attitudes towards sexuality and their clients and allowed them to begin to develop new perceptions of their clients' behaviours and how their own lack of knowledge allowed the behaviours to become reinforcers of myths and misconceptions. In fact, at pre-test only 50% of the group participants felt that they were well informed about sexual facts and behaviours. Whereas at post-test all of the counsellors agreed that they were well informed about sexual facts and behaviours.

Identification of the origin of attitudes.

As the group members learned, spontaneously interacted and discussed topics they began to identify the origin of their attitudes and how their attitudes may have impacted on their client. The facilitators noted that the counsellors started to discuss their own issues and experiences as the group progressed through its stages of development. For example, during one of the sessions the facilitators had identified the topic of STDs and one of the counsellors mentioned that her client had a severe rash in the groin. Several others voiced the same problem and this resulted in a

discussion about hygiene and the type of under garments the client wears. One of the counsellors said that one of her clients was very resistant when she tried to convince him that he does not have to wear under garments beneath his pyjama bottoms.

One of the counsellors shared with the group that she did not realise until university that she could sleep without underwear under her pyjamas. She stated that the first time her mother found out she was stunned and commented "I raised you better then that!" The group laughed but then engaged in a discussion about where people's attitudes are formed. They concluded that the family and significant others have a tremendous impact on our attitudes and hence our behaviours. The members decided that the client's reaction to the suggestion that he did not have to wear anything under his pyjamas was a justifiable reaction. In his experience he had never known any different and the counsellor provided him with a suggestion that was new and as like all new suggestions can, it provoked anxiety.

As the counsellors continued to spontaneously discuss issues instigated by the curriculum or feedback from the facilitators, they started to apply knowledge and experiences from their own lives to clarify the inequities of relationships experienced by individuals with a developmental

handicap. Bill discussed in one of the sessions that he had always believed in reciprocity within relationships and that it was a requirement and an attitude that he felt was important for a healthy relationship. However, as a result of his participation in the group he began to realise how one-sided his relationship with Jim had been. Heidi suggested that her relationships with her clients had been "lopsided." She suggested that when she had disclosed personal information her clients remembered everything and continuously enquired about her baby, her husband, her dog and her health. The group members concluded that their clients knew everything about their lives and that they actually knew very little about their client other then the client's behaviours, syndrome, etiology and medications. They felt that they actually knew very little where intimate knowledge of the client was concerned.

Homework and attitude change.

The homework provided the counsellors with an opportunity to observe the knowledge that their clients possessed. All of the counsellors were surprised and shocked with the level of their client's knowledge and several described how important the homework had become to the clients. It appears that the counsellors' attitudes and

perceptions of their clients changed as a result of having helped with the completion of the homework. As mentioned before, the counsellors also partially credited the homework with a change in the clients' attitudes. The investigator also suggests that perhaps partial credit for the clients' attitude change can be attributed to the change of the counsellors' attitudes as a result of having completed the homework with the client.

Bill stated that because of the homework he began to view his client differently. He suggested that he started to know his client at a more intimate level. Bill believed that through the homework assignments he became aware of his client's abilities and strengths as a feeling and interactional human being. However, Bill also stated that this realisation and change in attitude had not occurred immediately.

> "Well I think, I mean that's what I was trying to say earlier is that I realise how important that homework is now. Because I mean at one point I was just trying to get through the answers...and no, no, no, no; that's not the point. The point is that we have an opportunity to share and maybe, you know probably one of the ways you know, I realise now how key the homework was. It was more then just giving answers, it was a chance to connect." (Bill)

All of the counsellors agreed that completion of the homework with the client resulted in a stronger and more intimately knowledgeable bond between the counsellor and the client.

The workers' stated that they learned more about their clients but that the client' also learned more about them. In Bill's opinion "it became more of a reciprocal relationship."

Safety within the group.

Development of safety in the counsellor group was also an important factor that influenced a change in the counsellors' attitudes towards and perceptions of their client as well as towards sexuality in general. During the focus group all of the counsellors suggested that they felt safe in the group and that this allowed for increased self-disclosure. Several of the counsellor's suggested that the safety developed partially because the members had known each other prior to participation in the group. Paula added that she believed that the counsellors involved were all open minded and she felt that helped to build the safety as well.

Interestingly, the counsellors also believed that it was important that the counsellors knew at least one of the facilitators. Sue said:

> "Yeah, we've known each other. And I think the fact that we've known you [primary investigator] and hey, you're [female facilitator] an add on so like and that's cool. But yeah, I think that makes a difference because if it was like a professional therapist coming in...I don't think, yeah we'd get as much disclosure or talk about perhaps our feelings so much."

The principal investigator found this interesting because the counsellors had said the same thing with respect to the client group. They believed that the clients would not have experienced as much success as they did if they had not known one of the facilitators. The principal investigator suggests that the clients would have experienced success with an outside educator/therapist and perhaps the counsellor's suggestion was based on their own attitudes about outside professionals, and the counsellors perception of outside professionals as intruders in a closed system.

Feedback from the facilitators.

The facilitators decided prior to the development of the groups that they would provide the counsellors with only positive feedback about their clients' progress in group. The goal was to begin to help the counsellors build a positive image of their client and of their client's abilities, competencies and relational skills. It was believed that if the counsellor had a positive image about the client's behaviours, interactions and knowledge level then the counsellor would begin to internalise that view and develop a positive attitude about the client. If this happened then it may have had a positive effect on the ways the counsellor interacted with the individual and

subsequently a positive effect on the client's learning and attitudes.

It appeared that the provision of only positive feedback had a positive impact on the counsellor's attitudes and perceptions of their clients. Heidi stated:

> "I looked forward to our following week to find out what happened. Yeah but, I think I was surprised with how, the type of leadership role that [Client 9] took on. Like she's never done anything like that and that [Shayne] carved his own little niche as the group's Vana. She (Lindsay) very much follows and though I've been told there's all these wild and wonderful things when I'm not around, obviously I never get to see them."

Sue suggested that hearing all of the positive feedback about their clients gave the counsellors a feeling of pride. All of the counsellors agreed with her. She also noted that because of her participation she was able to provide positive feedback to her client's parents.

> "It gives us an edge of pride, I don't know...that might be self-centred on my part but it's like way to go [Shayne] you want the rich one. Yeah!! (group laughter). But it also gave me information to pass on to mom, ummm, that I think made her a whole lot more comfortable with the whole process too. Like she just, she loved the stories that you told about [Lindsay] in group and I would pass on to her and she just thought that was really neat. So it even went further than just the two of us." (Sue)

The fact that the counsellors felt pride indicated that an attitude change had taken place. After all, Sue had believed that her client was engaged in fantasy and no longer knew what to do for her prior to participation in the group.

However, Jocelyn's participation in the group allowed Sue to have the opportunity to not only hear about how her client had changed, but also provided her with the opportunity to experience her client's change within their mutual relationship. At post-group Sue believed that it was possible to work with her client's fantasy and that Jocelyn could realistically participate in her own maturity and growth.

Sue's statement further indicated that the change in her attitude that resulted from the positive feedback also affected other systems outside of the group home. In earlier sessions Sue had mentioned that Jocelyn's mother was apprehensive about her daughter's participation. As a result of the positive feedback, Jocelyn's mother was more comfortable with her daughter's participation and socio-sexuality growth.

Counsellor involvement, mutual aid and sensitive challenging.

The facilitators noted that the interaction of the counsellors in their group resulted in spontaneous discussions that involved the counsellors in mutual aid and the sensitive challenging of each other's attitudes. An excellent example of sensitive challenging and mutual aid was

observed during the session when the counsellors discussed why Shayne had not completed his homework for two days. Heidi became defensive when it was suggested that perhaps Shayne was uncomfortable having to complete his homework with a woman. Heidi said that she did not think that was the case at all. The other group members suggested that it may be and Bill offered to try to complete the homework with his own client and Shayne. Heidi agreed.

The end result was that Shayne completed his homework with Bill and Jim. As well, Heidi would later disclose that she too felt uncomfortable completing the homework with a male client. Thus, the client's needs were met, his dignity maintained and the counsellor experienced a change in attitude. All a result of the safety that developed in the counsellor group which allowed for the sensitive challenging of the attitudes of other members.

Bill stated in the focus group that because of his participation he had sensitively challenged or checked his own behaviours and attitudes which resulted in the development of better personal and interactional skills.

> "I personally developed a stronger sense of what's appropriate to talk about and what isn't because of the checking that I've gotten from just hearing other people talk about it and how to talk about it personal relationship issues which has helped me. Sometimes I have a tendency to disclose too much and sometimes not enough. So it's good to hear other counsellors, I mean

> how they talk, and I can learn from them you know." (Bill)

The principal investigator suggests that Bill's learning and what is appropriate to talk about from the other group member's, will result in a better ability on his part to teach his clients this very valuable skill. The ability to determine what is appropriate to talk about and what is inappropriate to talk about is a very important social skill for all people to learn but perhaps more so for individuals who have just finished being taught about the language of sexuality and relationships.

All of the counsellors believe that the program would not have worked if they had not been involved in the concurrently running group. The counsellors believed that they have all experienced having their attitudes challenged and checked because of their participation in the group and the knowledge they and their clients gained. Sue speaks to the importance of the counsellor group:

> "...that's where your attitudes are going to be checked...that's where you can be as consistent as possible in terms of providing the information with your individual. If you were on your own it would be so much easier to influence her (Jocelyn), to control."

However, all of the counsellors reported that their changes in attitude and perceptions were generalised to the group home as a result of having had their attitudes challenged in, and checked in group. Paula said:

> "Even with [name of client], this not regarding sexuality, but even going into someone's room to close his bedroom window. You know, there was a comment like how much privacy do they have? And it made me think. So I ask you know, when [client] has the windows open... , is that okay or do you want me to go in to your room?" Before I would see the window's open, go in, shut the window and then be done with it. And now all of a sudden whoa! Whose room is this?..."

All of the counsellors state that they are much more aware of just walking into a client's room. However, it is interesting to note that the SMRAI (Brantlinger, 1983) results indicated that all of the counsellors responded at pre and post-test that people with a developmental handicap had the right to privacy. Again it appears that our attitudes are often significantly different then what our behaviours indicate. The counsellors agreed at pre-test that privacy is a right and yet they all indicated that they have acted in such a way that would deny their client of the right to privacy.

Paula said that going into her client's room had nothing to do with sexuality, but it did. An important and recurrent piece of the didactic material involved the client in learning to distinguish between what was private and public behaviour and what was a private and a public places. If the client's door does not have a lock on it then a counsellor can enter at any time. The client in fact learns that their bedroom is not private and may further develop an attitude

that there are no private places for them. In extreme cases a client may believe that any sexual behaviour is okay at any time and in any place. Gardner and Chapman (1985) remind workers that their "...direct and indirect actions teach people, and that people with mental retardation will model your behaviour..." (p.225).

Limitations of the Quantitative Methodology

The initial research design of this study included a comparison group for control of extraneous variables. The client and counsellor comparison groups were to have been recruited from an agency of similar size to that of the participating agency and were to have been located within the same regional area. The comparison group of individuals with a developmental handicap were to have received the socio-sexuality education group experience without the involvement of their counsellor in a concurrently running group. Problems were encountered when two agencies that had initially agreed to participate decided not to subsequent discussions among the administrators of the agencies. This resulted in the use of an one group pre and post-test design which by its very nature does not control for extraneous variables.

History is one extraneous variable that appears to have been a threat to internal validity in the absence of a control group. The client and counsellor members' results may have been effected by television programming, the deterioration of a relationship or the illness of a parent. Thus the principal investigator cannot be certain that incidental learning opportunities or other occurrences did not have an impact. In addition, it appears that testing was also an extraneous variable that was not controlled in the absence of a comparison group. Group interventions require prescreening and this requirement in combination with the socio-sexual material may have evoked anxiety in the client group member which may have resulted in sensitisation and inaccurate lower pre-test scores. It also appears possible that after participation in the group the clients had an increased awareness about what attitude questions were socially approved by the facilitators and as a result their answers may have reflected the attitudes and beliefs held by the facilitators and not their own attitudes or beliefs.

With respect to delimitations, the findings of this study are not generalisable to other individuals with a developmental handicap and their primary caregivers due to the small sample size, the employment of purposive sampling and the fact that all participants were drawn from one agency

in one geographical area. As well, the likelihood of researcher bias increased with the abandonment of the double-blind scoring design and the decision to abandon the use of research assistants.

Summary

The nonparametric analysis of the SKIS (Forchuk et al., 1995) scores indicated that there was a significant increase between the pre and post-test knowledge scores of the individual with a developmental handicap. The analysis of the attitude subscales of the SSKAT (Wish et al., 1980) indicated that there was a significant difference between the pre and post-test attitude scores of the individual with a developmental handicap on two of the nine subscales while the findings approached significance on five of the remaining seven subscales. However, a qualitative analysis indicated that attitude changes were more apparent when the clients' behaviours, self-esteem and self-confidence were taken into consideration.

A qualitative analysis of the facilitators' process notes and information gathered from the counsellors in a focus group identified several factors that appeared to have contributed to the client's increase in socio-sexual knowledge and change of attitude towards sexuality. It also

appears that several format factors influenced an increase in knowledge and a change in attitudes. However, several factors that may have impeded the clients' increase in knowledge or change in attitude were also identified as being present.

The nonparametric analysis of the SMRAI (Brantlinger, 1983) scores indicated that there was no significant difference between the pre and post-test attitude scores of the counsellors. The qualitative analysis indicated that the counsellors' attitudes did change on both an individual and group level. The qualitative analysis also identified several factors that may have influenced the counsellors' change of attitude towards the sexuality of their client with a developmental handicap.

Chapter Six

Lessons Learned about Facilitating a Socio-Sexuality Education Group for People with a Developmental Handicap

The Role and Characteristics of the Facilitator

The facilitators' attitude and the Mainstream model.

The principal investigator concludes that the facilitators' positive attitudes and positive regard for the client group member with a developmental handicap in combination with the use of the Mainstream model will have a significant impact on the counsellors' attitudes and the clients' knowledge and attitudes. The facilitator must believe that the client group members can learn didactic material, make responsible decisions, engage in mutual support and engage in healthy and reciprocal relationships. The facilitators' persistent and yet subtle vocalisations and belief in these attitudes will serve to offset the counsellors' negative perceptions of their clients' abilities and the counsellors' behaviours that tend to facilitate client dependency.

As the counsellors begin to internalise positive attitudes and perceptions of their clients, their commitment to the work of the program increases and they begin to support their clients' newly emerging attempts at interaction, socialisation and independent decision making.

The counsellors' commitment and support suggests that the clients' knowledge gain and attitude changes facilitated in the group will be rehearsed within the clients' home environment.

The Mainstream model provides the facilitator with a model of intervention that is compatible with the facilitators' positive attitudes and regard for the client. It provides the client with the structure to learn the didactic material as well as structure in which the client can practice the independent and interdependency skills that will be generalised and supported by the counsellor. However, there are times when the didactic material must play a secondary role to the exploration of the clients' relational feelings and attitudes. When this occurs other pertinent issues such as bereavement or living with an identity associated with the developmental handicap will certainly arise.

Attitude and the strengths perspective.

Although the facilitators' positive attitudes and the utilisation of the Mainstream model have an impact on the participating counsellors and clients, facilitating a change in the counsellors' and clients' attitudes will not be an easy undertaking. The counsellors may come to the group

with the perception that they can no longer help the client with their sexuality and self-esteem issues and the client tends to come to the group with low self-esteem and confidence. Weick, Kisthardt, Rapp, and Sullivan (1989) suggest that "assessment and intervention based on the strengths of individuals is the cornerstone of empowerment" (p.354).

The facilitators will enhance the clients' knowledge and the clients' and counsellors' attitudes by utilising the strengths perspective, focusing on the clients' strengths and competencies and providing the counsellor with only positive feedback about their clients' knowledge and competencies. The impact of the strengths perspective on attitudes and knowledge will be further enhanced when the counsellors and clients perceive that the facilitators have a positive attitude toward them. The counsellor begins to believe that their client can learn and that they as the counsellor can have a positive impact on the clients' learning and relational growth. On the other hand the client will feel confident that they can learn didactic material and that they can experience and are worthy of intimate and reciprocal human relationships.

Interactive, Fun, Enthusiastic and Humorous

The use of interactive games and visual activities will result in increased interaction and learning for both the client and counsellor group members. The counsellors and the clients will also increase their interactions within their own groups and with each other when the facilitators are enthusiastic about the didactic material and present it in a way that is both interactive and fun. In addition, the principal investigator found that the facilitator's use of humour will also have a positive impact on the clients' and counsellors' learning and attitudes.

Meister (1992) believes that humour is a significant part of the group process. He suggests that "...examining some serious aspects of sex does not necessarily require a sombre mood...Therefore, the facilitators act as role models for dealing with sex without guilt, fear or embarrassment" (p.16). The principal investigator suggests that facilitator humour is an excellent tool for engaging the clients in the group process, curriculum and serves to decrease anxiety within the group and with resistant members. Humour also serves to decrease anxiety in the counsellor group and as a result group cohesion becomes stronger. Therefore, facilitators must try to make the experience as fun and interactive as possible to facilitate

an increase the client's learning and to maintain the counsellor's enjoyment and commitment to the format and their client's education and growth.

The Gender of the Facilitators

Co-ed socio-sexuality education groups for individuals with a developmental handicap must employ a male and a female facilitator. The principal investigator suggests that the presence of a male and female facilitator will decrease the clients' anxiety and thus increase their comfort level with the didactic material. In this way the client group member will be better able to attend to the often anxiety provoking material.

The presence of a facilitator of the same gender will not only decrease anxiety but also facilitates the clients' learning through the provision of information that can have a positive impact on the participants' attitudes. For example, the female facilitator can provide information relevant to the female perspective that a male facilitator may not have been able to provide. Interestingly, the counsellors believed that their clients felt safe in the group because of the presence of a male and female facilitator.

Facilitation of the Group Process

The feeling of safety.

Monfils and Menolascino (1984) suggest that the first role of the facilitator is the development of a safe atmosphere in which mutual aid can evolve. The facilitator asserts that an atmosphere of safety must develop to ensure the counsellors' participation. When the counsellors feel safe it appears that they are more apt to engage in self-disclosure of their opinions and their attitudes. The safety that develops in the group allows the counsellors to sensitively challenge each other's emerging attitudes towards sexuality and their perceptions of the clients.

The principal investigator also learned that facilitators who utilise this educational format must also make an effort to spend several pre-screening sessions with the counsellor and the client. It appears that counsellors will have somewhat negative attitudes towards outside professionals and spending time with the counsellor and respecting their knowledge prior to the group experience may result in increased safety, trust, group cohesion and counsellor commitment to the group. It appears that the counsellor will be more apt to reinforce the material the client learns if the counsellor feels that they are

respected, trusted and involved in their client's growth and learning.

The Client Group

Konopka (1978) suggests that involving the client group members in the development of the group rules and curriculum provides a feeling of safety in that members experience some control over the environment. However, this requires the clients to engage in interaction and the principal investigator learned that the facilitators will be very active during all sessions and at times directive in their attempts to engage the clients in interaction. The efforts of the facilitator will result in participant mutual aid and an increase in group cohesion.

The principal investigator also learned that power and control issues will arise throughout the lifetime of the group and especially when the socio-sexual material becomes more explicit. The facilitators can confront the power and control issues by legitimising the group members' reactions to the material and by modelling the appropriate expression of feelings. This will be successful in decreasing the clients' resistance to the material. Furthermore, the principal investigator found that the facilitators will further decrease resistance and power and control issues by

allowing the clients to operate the slide projectors and required technical equipment.

The ability of the facilitator to confront power and control issues and obstacles to the work of the group will not only bring the members' attention back to the didactic material, but will also model a nonjudgemental and sensitive challenging of another person's attitudes and behaviour. As a result the facilitator provides a corrective experience for the resistant individual and provides an opportunity for the other group members to engage in mutual aid and empathy while further developing appropriate social and challenging skills.

However, as the clients develop positive attitudes and behaviours the facilitators must make every effort to recognise the changes and allow the group members to share the changes with the group. The facilitator will do well to remember that many of the group members' behaviours have been scrutinised in the group home and the opportunity to receive the support of the group for new behaviours will be very empowering.

The facilitators must also be attentive to the group process and be able to differentiate between power and control issues and the natural comfort level of the client. Given the nature of the educational format, incomplete

homework may not reflect a power and control issue, but may reflect the client's anxiety with respect to the prospect of completing the homework with a counsellor of the opposite gender.

Fletcher and Duffy (1993) suggest that the stage of termination is often extremely difficult for people with a developmental handicap because they have historically had little control over how people enter and exit their lives. The principal investigator found that the client group members may not experience a great deal of difficulty terminating involvement because of the participation of the counsellors. The involvement of the counsellor helps prepare the client for termination and where the participating clients are from the same agency or geographical area, it appears clients may be willing to continue the relationships that developed in the group. In addition, it appears that the clients may finish the group feeling that people are not exiting but just beginning to enter their lives.

Facilitator Self-Disclosure

It appears that facilitators of socio-sexuality education groups will be confronted by the decision of whether or not to self-disclose personal information. The

principal investigator suggests that self-disclosures are appropriate when they serve to facilitate the group process and enhance the clients' socio-sexual learning and understanding. The principal investigator found that self-disclosure effectively decreases the clients' anxiety toward socio-sexual material and effectively influences a change in the clients' attitudes toward relationships and sexual behaviours.

However, the context and the content of the self-disclosure will be important. The very nature of the socio-sexual material dictates the limits of the self-disclosures. One of the goals of the group is for the individual with a developmental handicap to develop boundaries and to understand that many socio-sexual behaviours are private. Therefore, facilitators must refrain from sharing personal information that provides explicit details of their own sexual behaviours. The use of anatomically correct dolls and visual tools will suffice to meet these goals.

Facilitation of the Counsellor Group Process

The principal investigator has learned that as a result of the counsellors' participation in a concurrent group, a change in attitudes and development of insight into their behaviours will ensure that the client's developing decision

making, problem-solving and interactional skills will be supported in the group home. The principal investigator has already suggested that the provision of positive feedback about the clients' strengths and competencies and the discussion of attitudes that may have an impact on the clients' lives will result in a change of counsellor attitude and perception. However, it is important that the facilitator also provide the counsellor with factual information.

The principal investigator suggests that the counsellors will come to the group lacking accurate socio-sexual information of potential help to their clients' engagement in healthy and reciprocal relationships. However, myths and misconceptions will begin to fade as the counsellors gain information. As a result the counsellors will begin to more comfortably discuss socio-sexual issues with their clients. It is at this interface that the counsellors' attitudes and perceptions with respect to their clients' sexuality and knowledge will be challenged and altered.

The Role of the Counsellor

The involvement of the counsellor is indispensable in the education of the client with a developmental handicap.

For instance, the counsellors provide information about the client that allows the facilitators to more effectively teach the client participant. The counsellors are excellent resources as they will tend to have a wealth of knowledge with respect to their clients' history, behaviours, rituals and emotional status. Furthermore, the counsellors can identify different slides or material that they believe may result in a reaction from the client. The counsellors may provide the facilitators with feedback about inappropriate public behaviours or questions on the homework that are problematic for the client. As a result, the facilitators will be prepared to emphasise or review specific curriculum topics in subsequent sessions.

Facilitator and Worker Relationship

The partnership between the facilitators and the counsellors will not develop immediately. Similar to the client group, the facilitator can expect that power and control issues will emerge. However, power and control issues will subside when it is apparent that the facilitators will not judge the counsellors' attitudes. Power and control issues will further subside as the counsellors realise that the facilitators are listening to,

respecting and utilising their opinions and their knowledge of their clients.

By keeping the counsellor group informal and resisting attempts to engage the workers in therapy, the facilitator will enhance the growth of a reciprocal relationship with the counsellors and will further facilitate the emerging partnership. The goal of the partnership between the facilitators and the counsellors is the provision and support of the clients' socio-sexuality education and the subsequent increases in knowledge and attitudes.

Location and Timing of the Group Sessions

Location of the group sessions.

The facilitators of a socio-sexuality education program with concurrent groups for clients and workers must be conscious of the location of the group sessions as this will have an impact on both the clients and the counsellors. The location of client group sessions must ensure privacy and confidentiality. It has become apparent that the sessions should not be located in a group home as there are far too many distractions that interfere with the presentation of the didactic material.

The counsellors provided feedback to the principal investigator that it was acceptable to hold their sessions

within the agency but they stressed that the location must provide privacy. However, the principal investigator suggests that future groups should not be held at a group home because the facilitators and the counsellors cannot control for the presence of a resident who is at home and who may disrupt the group.

Timing of the group sessions.

The principal investigator asserts that facilitators utilising this format in the future must ensure that the counsellor group convenes prior to the client group. This provides the counsellors with an opportunity to recognise, confront and work through their own reactions to the material before they engage with the client to complete the homework assignments. It appears that this will allow the counsellor time to separate their own attitudes about and reactions to the material from those of the client and thus allows the counsellor to support and encourage the client's rehearsal of the material, independence and growth. As well, the early provision of the homework ensures that the counsellors will not be surprised by the content and will feel more comfortable and capable when helping their client with the assignment.

The Role of Homework

The homework assignments will play several roles when utilised in a socio-sexuality education group. Firstly, homework assignments are an excellent tool for the careful linking of the socio-sexual didactic material from session to session which allows for the repetition and rehearsal of the material to enhance the group member's memory. Secondly, the homework is an excellent review tool that can be utilised at the beginning of sessions and at home to provide further repetition and rehearsal of the material. Thirdly, when the facilitators abandon the curriculum in the group to attend to group process, the homework assignment and the counsellors' knowledge of the didactic material ensures that the material will be covered in the homework session with the client.

For these reasons, the principal investigator strongly urges the facilitators of socio-sexuality education programs with concurrent groups for clients and counsellors to utilise homework assignments. In addition, the homework assignments will be a catalyst for the development of a caring and reciprocal relationship between the counsellor and the client within their naturally occurring environment. The development of a reciprocal relationship will certainly

have an impact on the counsellors' attitudes and the clients' knowledge and attitudes.

Attitudes and values.

The homework may provide facilitators with information about the clients' attitudes. When the facilitators of this study reviewed the clients' homework assignments, they often noticed that group members had answered questions on the homework differently then they had answered the same question in the group. For example, all of the group members agreed in session that it was okay for people to engage in gay and lesbian relationships but several stated on their homework that it was not okay. When this discrepancy was brought to the counsellors' attention, they enquired if they should attempt to change the clients' attitudes.

This vignette illustrates perhaps the most difficult dilemma facilitators will face during the facilitation of a socio-sexuality education program that involves the counsellor in a concurrently running group. The topic of sexuality is value laden and appears to be even more so value laden when placed in the context of education. The principal investigator struggled with the concept of defining an attitude as negative versus positive or liberal

versus conservative. Moreover, the principal investigator considered the historic dependency that people with a developmental handicap have had on others to make their decisions. One of the goals of the group was to facilitate the development of decision making skills and self-determination and because of this goal it did not appear appropriate to suggest that their attitude was wrong or right and negative or positive. To have suggested otherwise may have further increased the group members' dependency on others.

The principal investigator also wondered how one would define an attitude as negative or positive. For example, "is the person's attitude negative simply because they have it or does it become negative only when they act on the attitude?" In the end the only attitude the facilitators felt was important was their own non-judgmental attitude. The facilitators suggested to the counsellors that the clients' attitudes were personal convictions and therefore, it appeared that it would not be appropriate nor ethical to suggest that their attitudes were right or wrong. The facilitators felt that it was not appropriate to penalise an individual for their personally held attitudes.

Meister (1992) also utilised the SSKAT (Wish et al., 1980) in preparation for socio-sexuality education groups

for people with a developmental handicap. However, he suggests that facilitators utilise the attitude subscales only for the purpose of identifying scoring trends that indicate liberal or conservative attitudes towards sexuality. Meister further suggests that facilitators should not use the attitude subscales as participation criteria because there are no right or wrong answers where attitudes are concerned.

The principal investigator suggests that the SSKAT (Wish et al., 1980) may not be a reliable instrument even when it is utilised for the purpose of tracking liberal and conservative attitude trends within the group. One of the questions in the pregnancy, childbirth and childrearing subscale asks the respondent if they would like to be a parent. The respondent is found to hold a positive or liberal attitude towards pregnancy, childbirth and childrearing if they answer "Yes" and they are found to hold a negative or conservative attitude if they answer "No." However, the principal investigator claims that this question does not take into account group members who have had a hysterectomy. For example, when the topic of pregnancy was taught in group one of the female group members stated that she could not have children because of having had a hysterectomy. At pre and post-test this group

member answered that she did not want to be a parent. Thus, group facilitators should be cautious when solely relying on the test to determine whether or not an individual experiences a change in attitude following participation in a socio-sexuality education group. The principal investigator concludes that a person should not receive a negative attitude label if they answer that they do not want to have children because that answer may reflect the fact that they cannot have children.

The Involvement of the Parent

Kempton (1991b) suggests that one of the strongest influencing factors of an individual's sexual attitudes is the family and more specifically the parents. The principal investigator learned that the parents continue to have a strong influence on their adult child's sexual attitudes and behaviours well after the individual with a developmental handicap has left the parental home.

The principal investigator suggests that parental support for the participation of their adult child in a socio-sexuality education group is imperative. It appears that parents will be supportive of their adult child's participation when they believe that their child will gain knowledge that will protect them from sexual abuse or

exploitation in the community. The principal investigator suggests that parental support will also be more likely when open lines of honest communication exist between the parent and the group home counsellor. Furthermore, facilitators should encourage the participating counsellors to share their observations of their client's positive changes with the parents where there are open lines of communication.

The results of the qualitative analysis indicate that the positive feedback will have the same positive impact on the parents' attitudes and perceptions of their child's knowledge and socio-sexuality as it did on the counsellors' attitudes and perceptions. Therefore, a socio-sexuality education program with concurrent groups for clients and workers appears to have the ability to impact change in not just one, but two of the client's most significant systems. It appears that the client's gain in knowledge and attempts to independently make decisions and engage in relationships will be supported in the two significant systems.

Conclusion

The overall findings of this study suggest that a socio-sexuality program with concurrent groups for individuals with a developmental handicap and their worker can have an impact on the clients' knowledge and attitudes. The quantitative

analysis indicated that there was a significant increase in the clients' knowledge scores between pre and post-test, and indicated a significant difference between the pre and post-test attitude scores of the individual with a developmental handicap on two of the nine subscales of the SSKAT (Wish et al., 1980) while the findings approached significance on five of the remaining seven subscales. However, a qualitative analysis of the facilitators' process notes and information collected in the counsellors' focus group suggest that the participants with a developmental handicap experienced a greater change in attitudes than was captured by the quantitative analysis.

A qualitative analysis of the facilitators' process notes and information collected during the counsellors' focus group identified several factors that appeared to have facilitated the client's increase in socio-sexual knowledge and change of attitude towards sexuality. Adherence to the philosophies and processes of the Mainstream model, concrete activities, visual tools, games, and most importantly, the utilisation of homework assignments and the involvement of the group home worker were reported to have had an impact on the ability of the individual with a developmental handicap to experience an increase in knowledge and a change in attitudes after participation in a socio-sexuality education

group. The flexibility of the format, the facilitation and location of the group and the fact that the client group members received their education in a group of their peers were also factors that were identified as having influenced the individual's increased knowledge and change in attitude.

The facilitators and the counsellors identified specific areas of the program that may have impeded the clients' increase in knowledge and change of attitude. The findings suggest that these areas of the program would benefit from further development. They included: vague and over-technical visual tools and concrete activities; homework assignments that excluded relevant issues or topics or had questions that were too wordy; and a program that may have been too short for effective coverage of all material within the curriculum. In hindsight, these areas may have impeded the counsellors' change of attitudes.

Although the quantitative analysis indicated that there was no significant difference between the pre and post-test attitude scores of the counsellors, the overall findings of this study do suggest that a socio-sexuality program with concurrent groups for individuals with a developmental handicap and their worker can have a significant impact on the workers' attitudes. The qualitative analysis of the facilitators' process notes, a case by case quantitative

analysis of the SMRAI (Brantlinger, 1983) results and information collected during the counsellors' focus group indicated that attitudes did change on both an individual and group level.

A qualitative analysis of the facilitators' process notes and information collected during the counsellors' focus group identified several factors that appeared to have facilitated the counsellors' change of attitude towards sexuality and change in behaviours. It appears that the provision of factual information, the identification of the origin of their attitudes, the involvement in the completion of their clients' homework, the development of safety in the group, the facilitator's provision of positive feedback and the development of mutual aid and sensitive challenging of attitudes all appear to have been factors that influenced a change in a more positive direction of the counsellors' attitudes and perceptions of their client and their client's sexuality. As a result it appears that the counsellors were more willing to foster their clients' independence and self-determination.

Hanley and Parkinson (1994) suggest that social work intervention with people with developmental handicaps should emphasise and uphold the values of individualisation and self-determination. Providing a place for individuals with

a developmental handicap to discuss their difficulties is one way to meet these goals. The provision of socio-sexuality education in a group format provides the opportunity for individuals with a developmental handicap to talk about their experience and difficulties in relationships with respect to sex, dating and love. The participant was provided with new information and an outlook on life that may result in increased self-determination and individual dignity. However, socio-sexuality education program formats have apparently ignored the systems within which the behaviour of people with developmental handicaps is often influenced and controlled by others.

According to Prout and Strohmer (1994) these systemic factors should not be ignored in the provision of services to people with a developmental handicap. They suggest that "...counseling should not occur in isolation from these aspects of the client's lives. Therapeutic interventions will interface with families and those who provide services for persons with mental retardation" (p.9). The program format that was utilised in this pilot project provided intervention and service at the interface of the client's and the group home counsellor's systems. True to systems theory, a change at this system interface resulted in a change in other significant systems. The result is that there appears

to be a better chance that the increase in the client's knowledge and change in attitude toward sexuality and relationships will be supported and nurtured within several systems as a result of the counsellors and the clients participation in this program.

The group home workers began to support the clients' attempts at self-determination and individuality as the they progressed through the program in separate but concurrently running groups. As a result of their participation the counsellors were able to recognise and change attitudes, perceptions and behaviours that had served to control the sexuality and life in general of their client. This certainly impacted on the client's self-esteem and self-confidence and further enhanced the empowerment of the client. It is highly unlikely that these changes would have occurred if the counsellor and the client had not participated in the program together.

Is it possible, even following participation in a socio-sexuality education group, that individuals who have been historically disempowered will be able to have a significant impact on a counsellor or a system in which there is an extreme power imbalance? Immediately following the group experience the person may have increased knowledge, a change in attitude or improved self-esteem, but if the power

imbalance continues it is likely that the power holders would extinguish the individuals changes and new found self-determination over time. Thus, if power holders within the system do not allow the individual with a developmental handicap to use the knew found self-determination, skills or knowledge, then it is highly unlikely it will be generalised and retained.

The principal investigator believes that future socio-sexuality education programs must include the involvement of the group home counsellor or the parent. Recognition of their own disempowering attitudes and behaviours will enable them to help their client realise the goals of increased knowledge, change of attitudes and skills development, self-determination, the experience of intimate relationships and the retention of the knowledge, and increase in self-esteem and self-confidence. Other individuals who live in the group home of the participating individual with a developmental handicap may then benefit as the counsellor begins to support the attempts of these others at relational growth and development.

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Figure 1

Gender Composition: Client Group

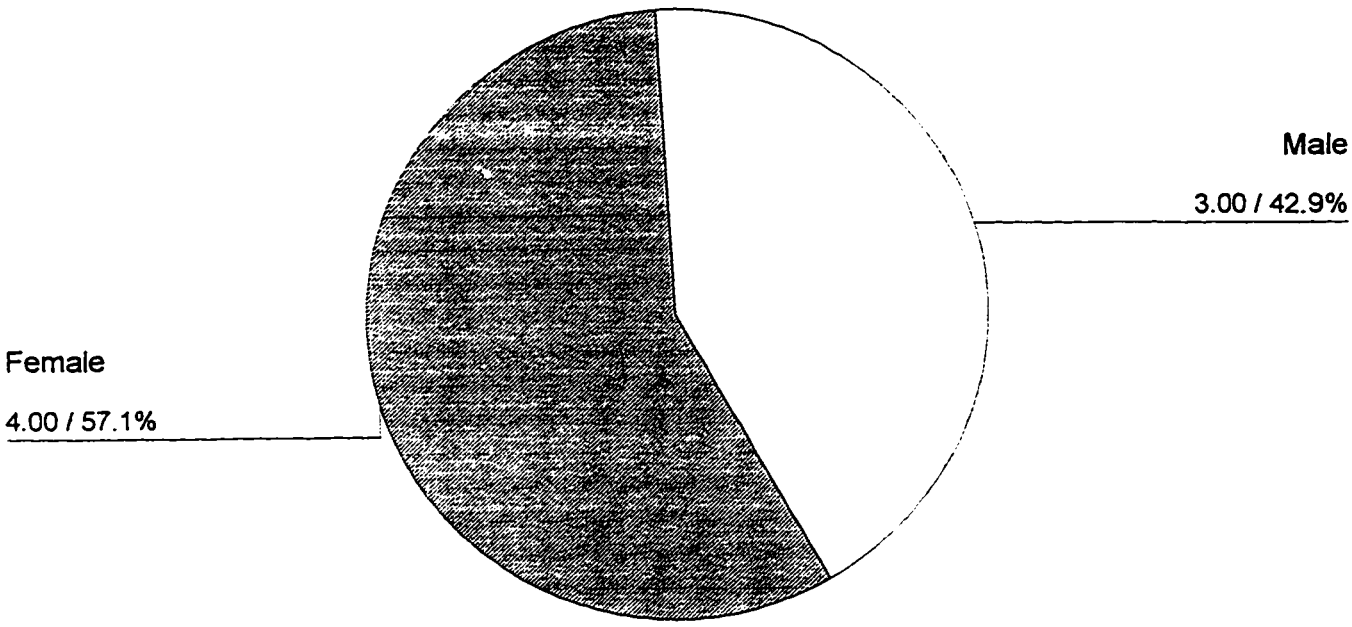


Figure 2

Age of Client Group Participants

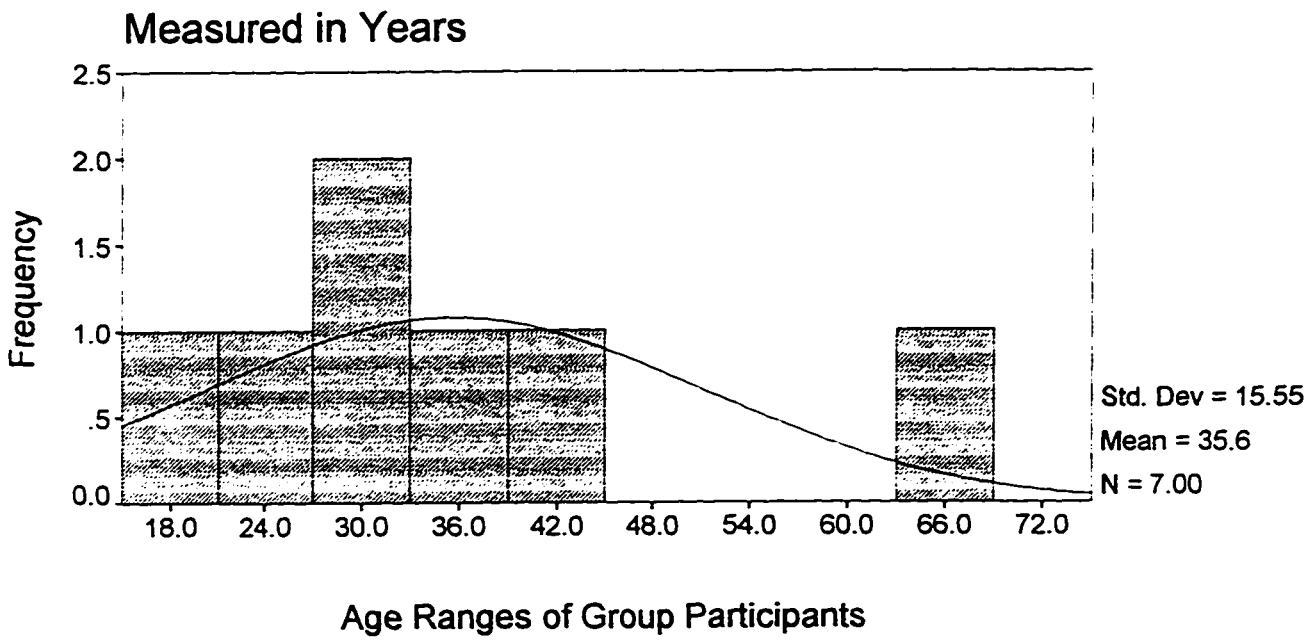


Figure 3

Gender of Group Home Workers

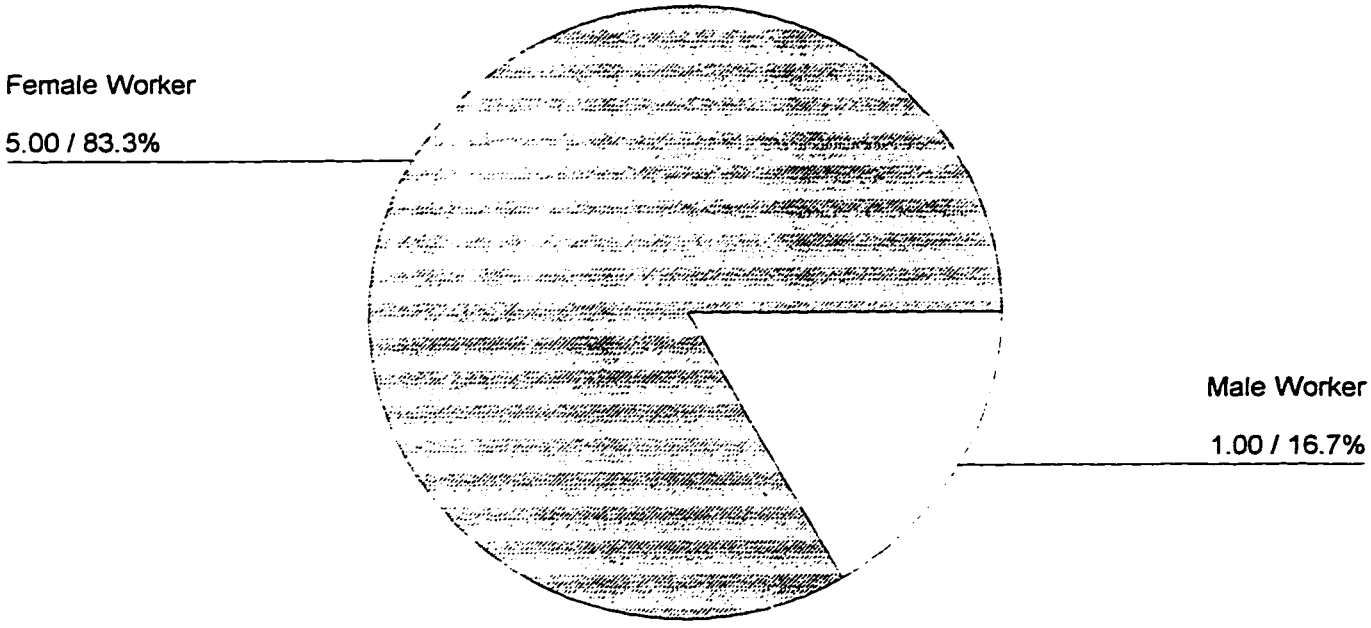


Figure 4

Age of Group Home Workers

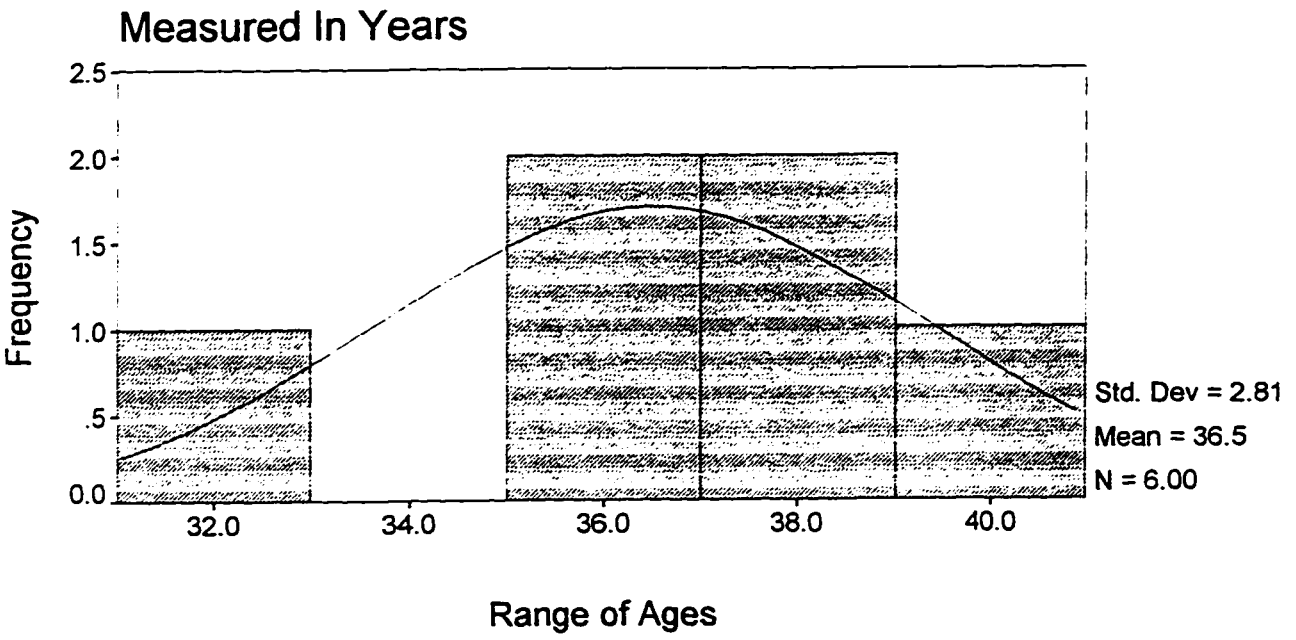


Figure 5

Worker's Educational Attainment

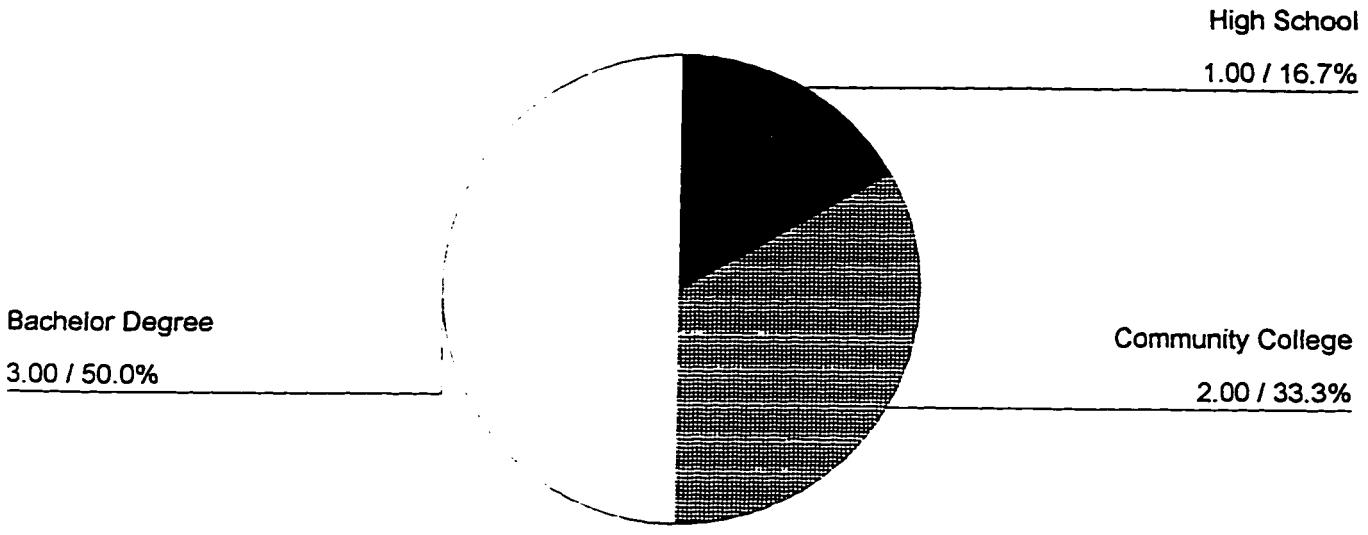


Figure 6

Length of Employment With Population

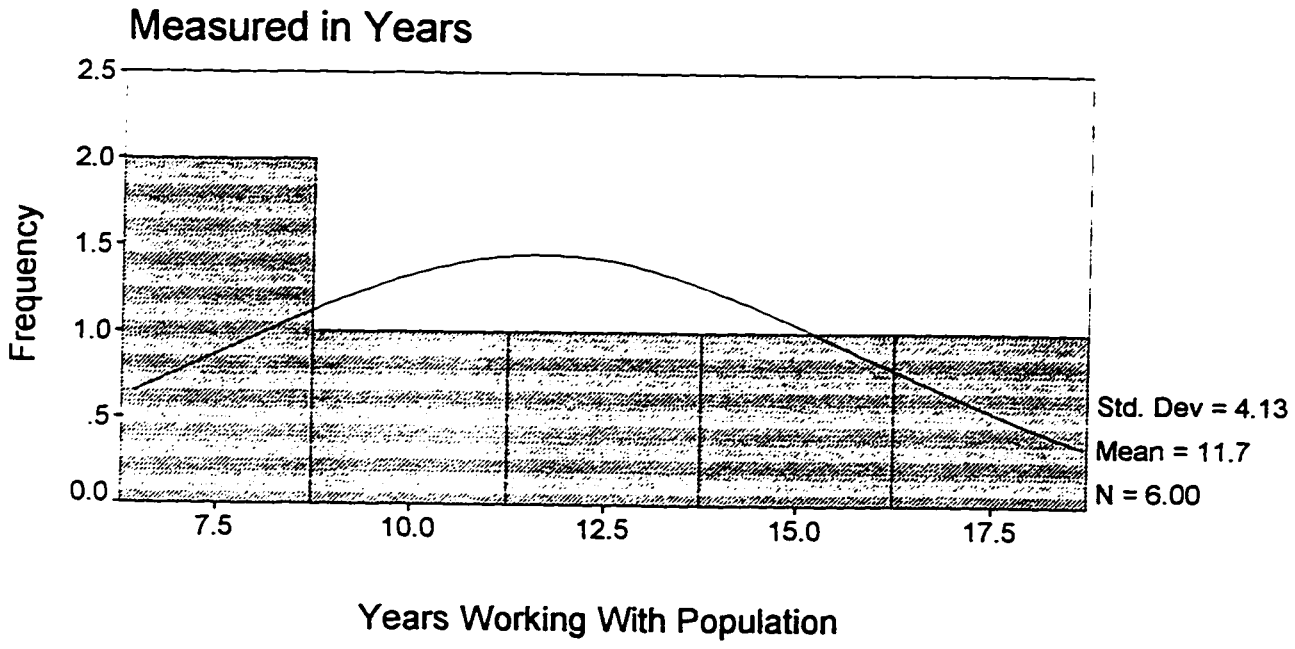


Figure 7

Length of Time Working With Client

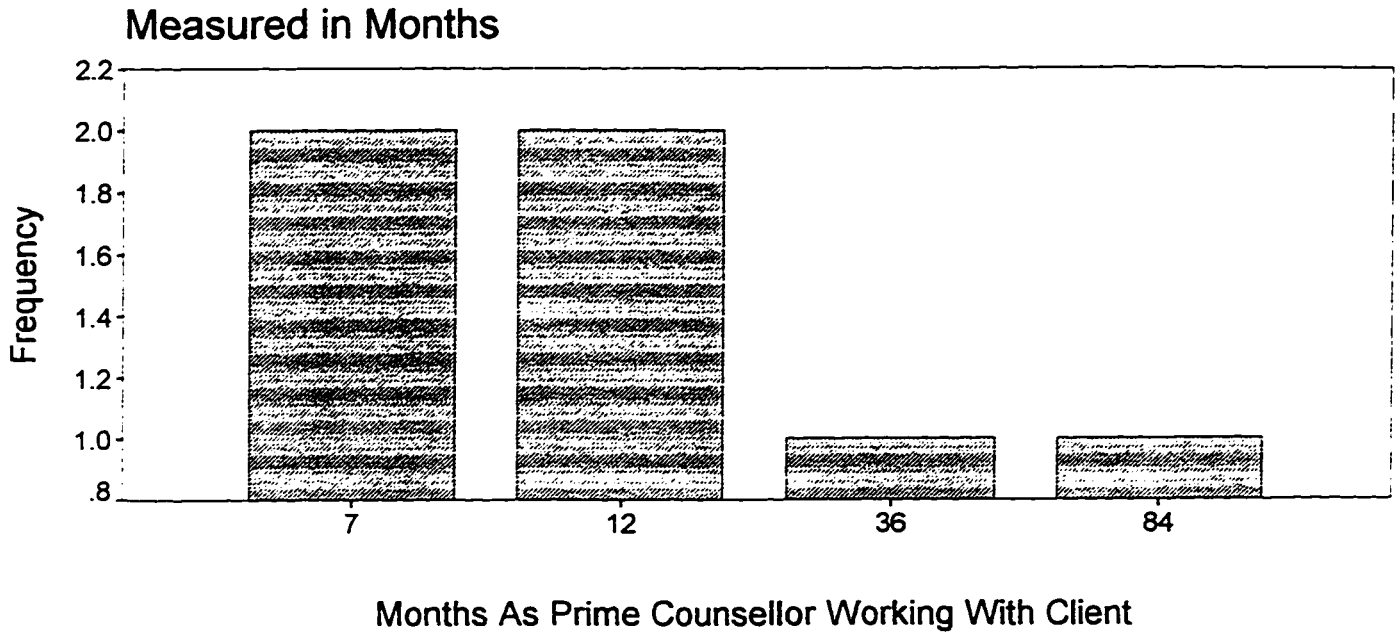
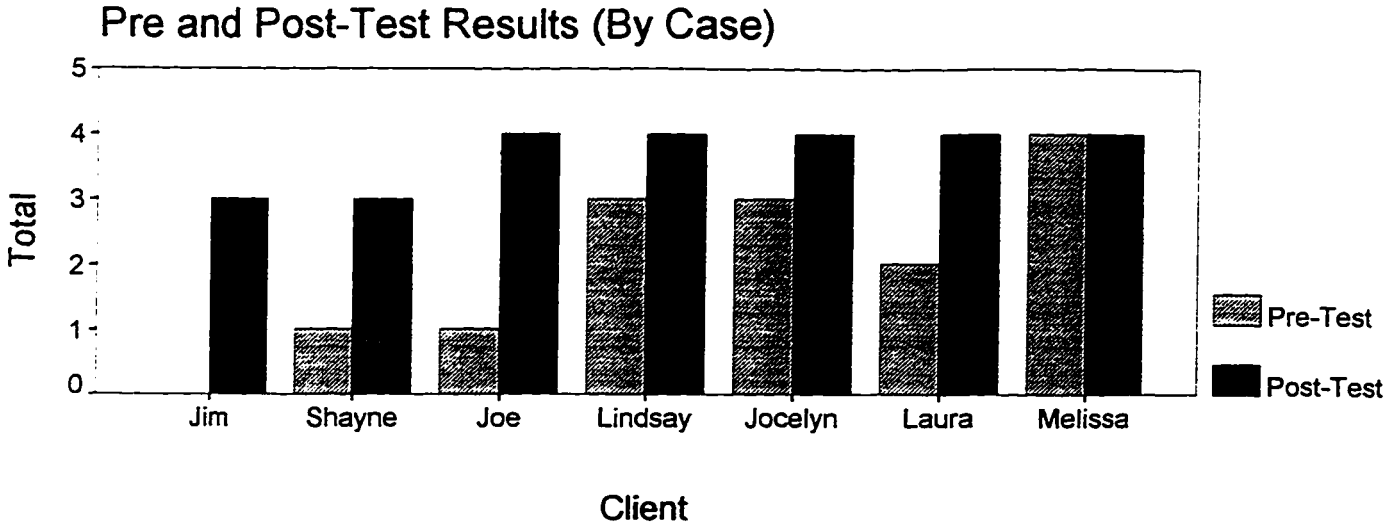


Figure 8

SKIS: Feelings Subscale

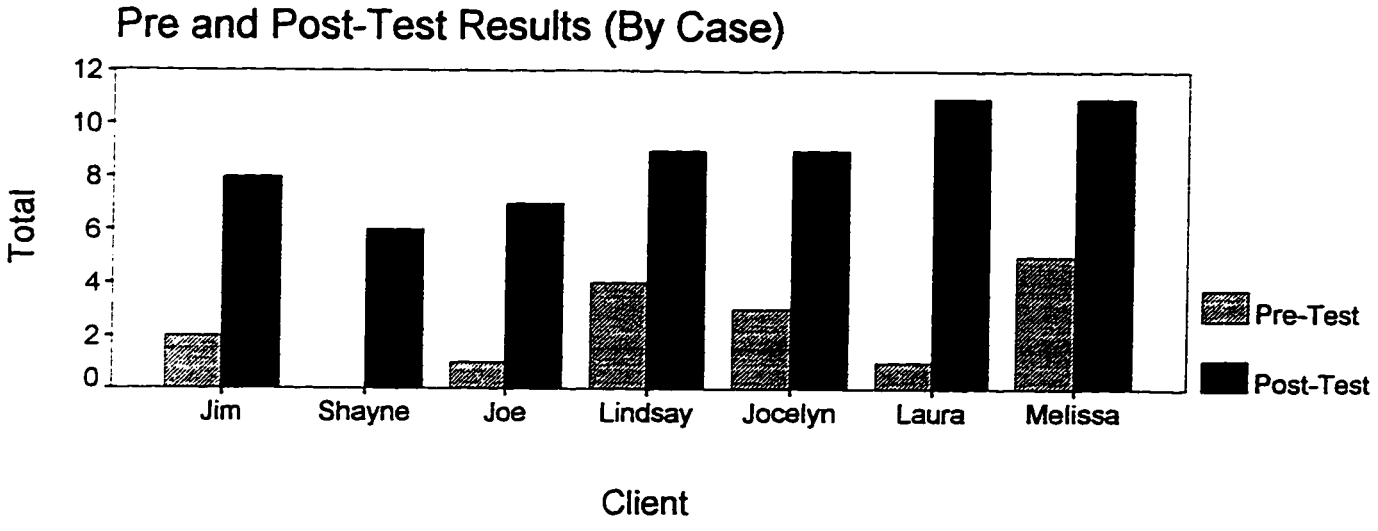


1. Where Total = 0, extreme lack of knowledge

2. Where Total > 0, indication of knowledge

Figure 9

SKIS: Body Parts Identification Subscale

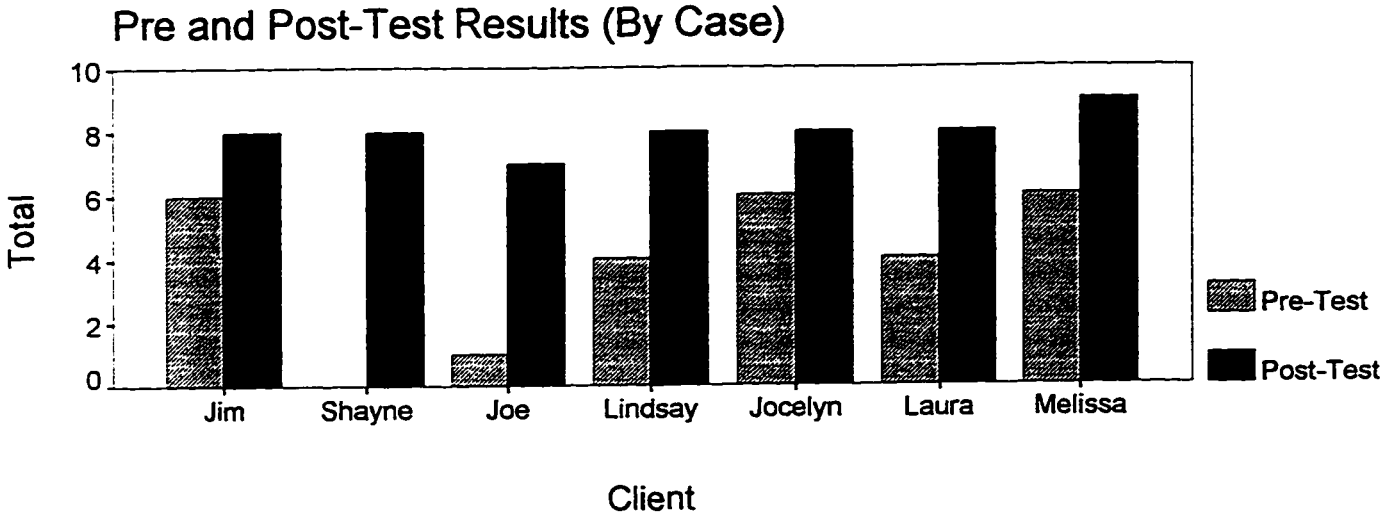


1. Where Total = 0, extreme lack of knowledge

2. Where total > 0, indication of knowledge

Figure 10

SKIS: Body Parts Function Subscale

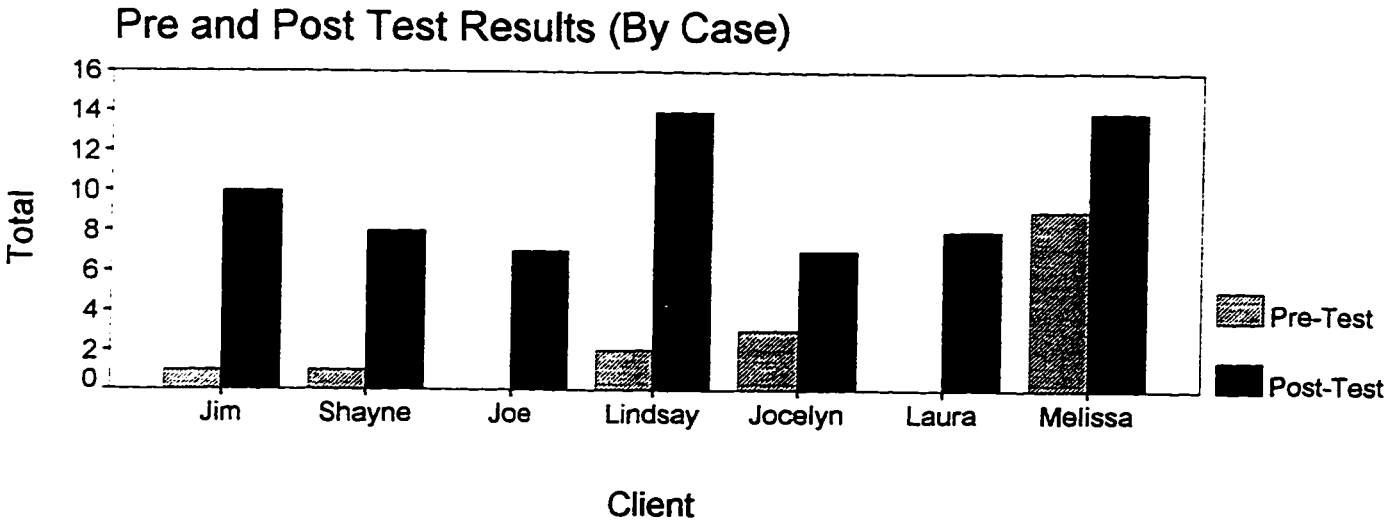


1. Where Total = 0, extreme lack of knowledge

2. Where Total > 0, indication of knowledge

Figure 11

SKIS: General Sexual Knowledge Subscale

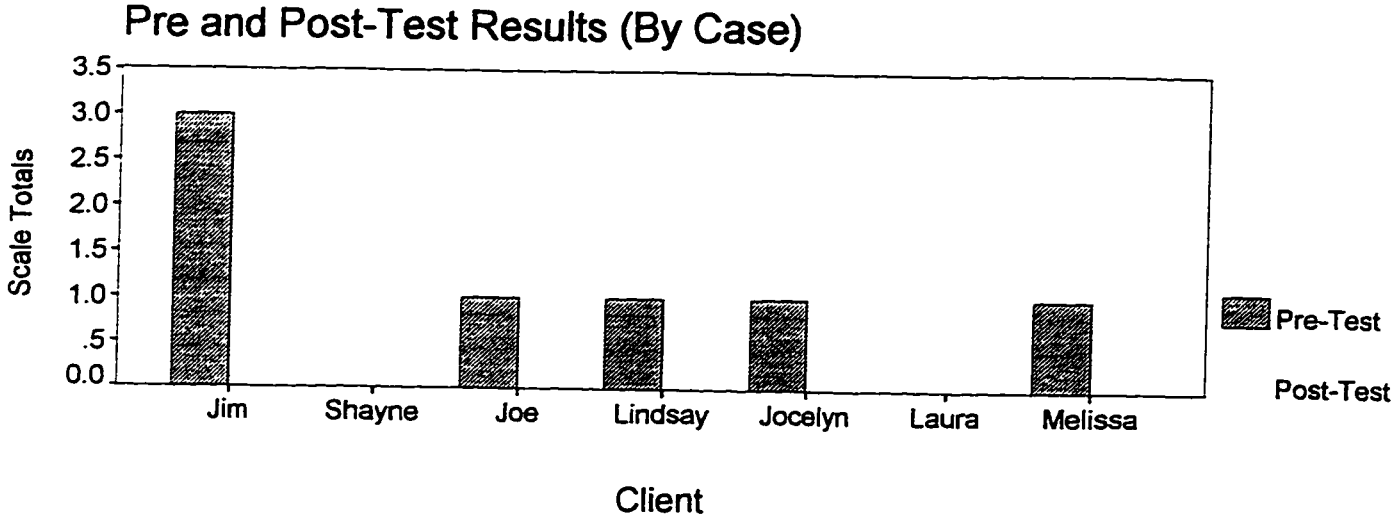


1. Where Total = 0, extreme lack of knowledge

2. Where Total > 0, indication of knowledge

Figure 12

SKIS: Potential Abuse Subscale

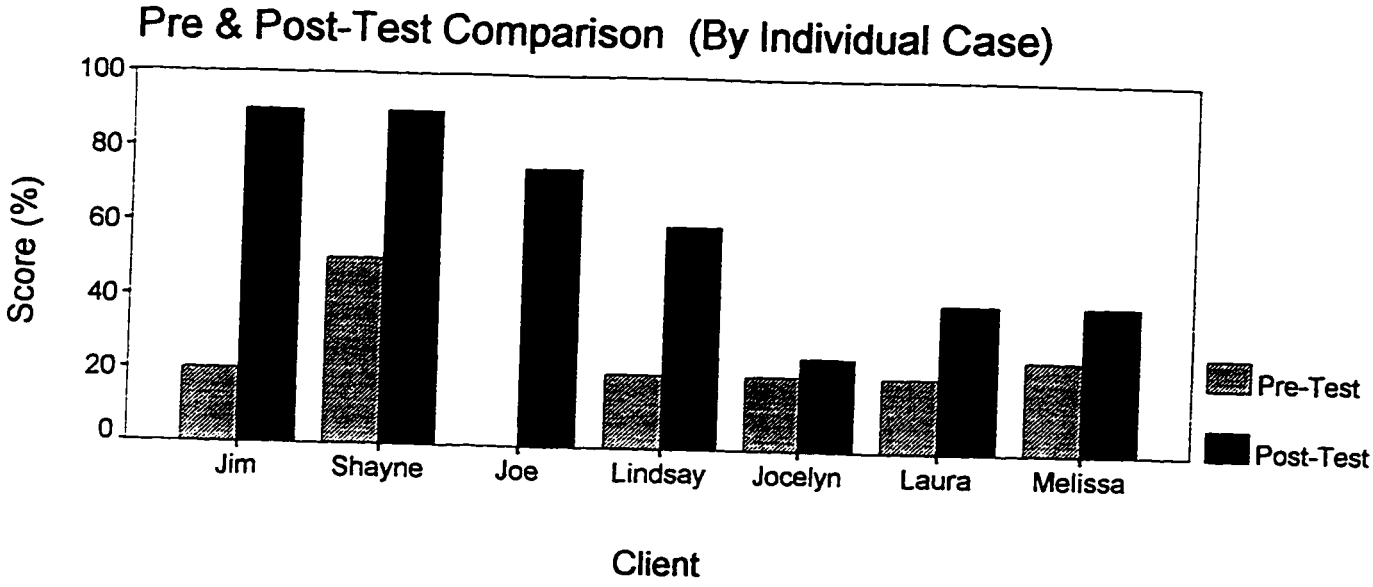


1. Where Score = 0, indicates no or little concern of victimization

2. Where Score > 0, indicates potential to be victim of abuse

Figure 13

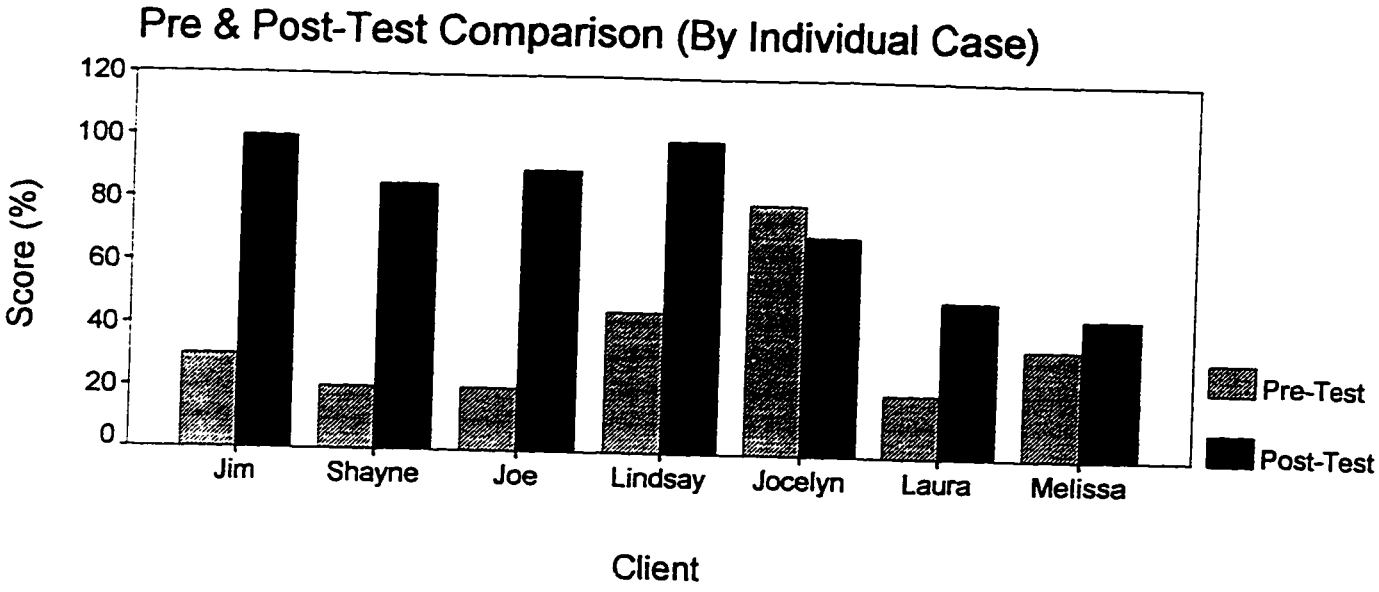
SSKAT: Intercourse Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 14

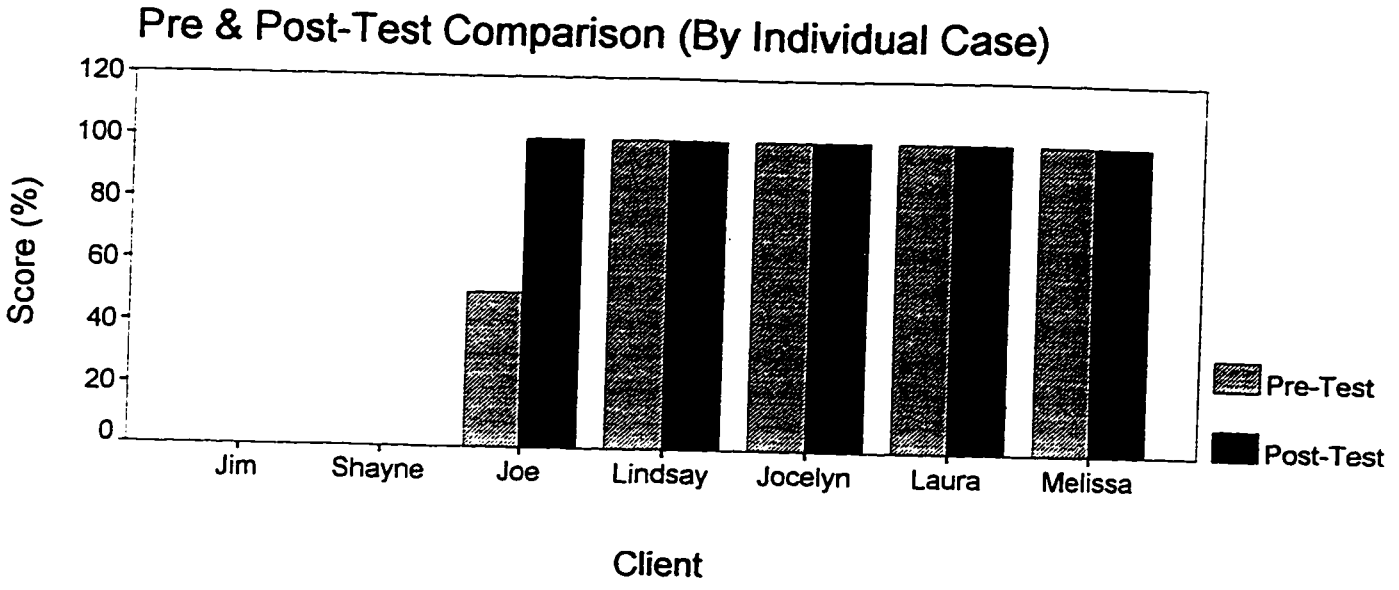
SSKAT: Gay & Lesbian Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 15

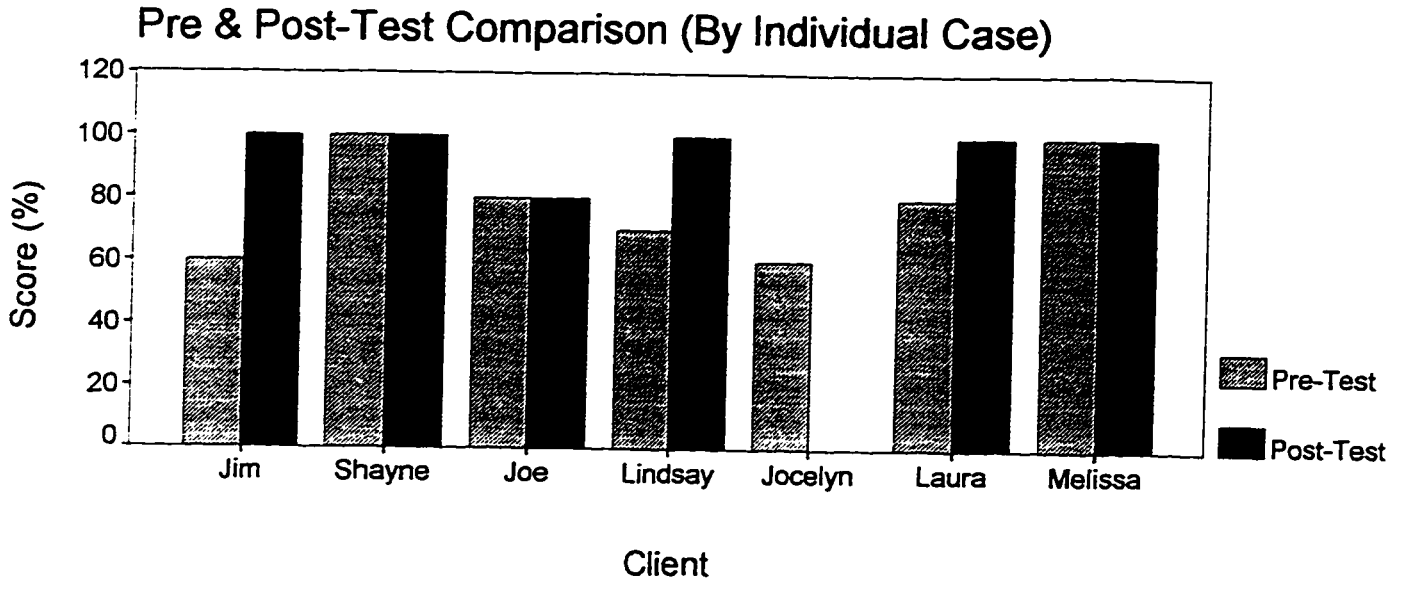
SSKAT: Menstruation Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 16

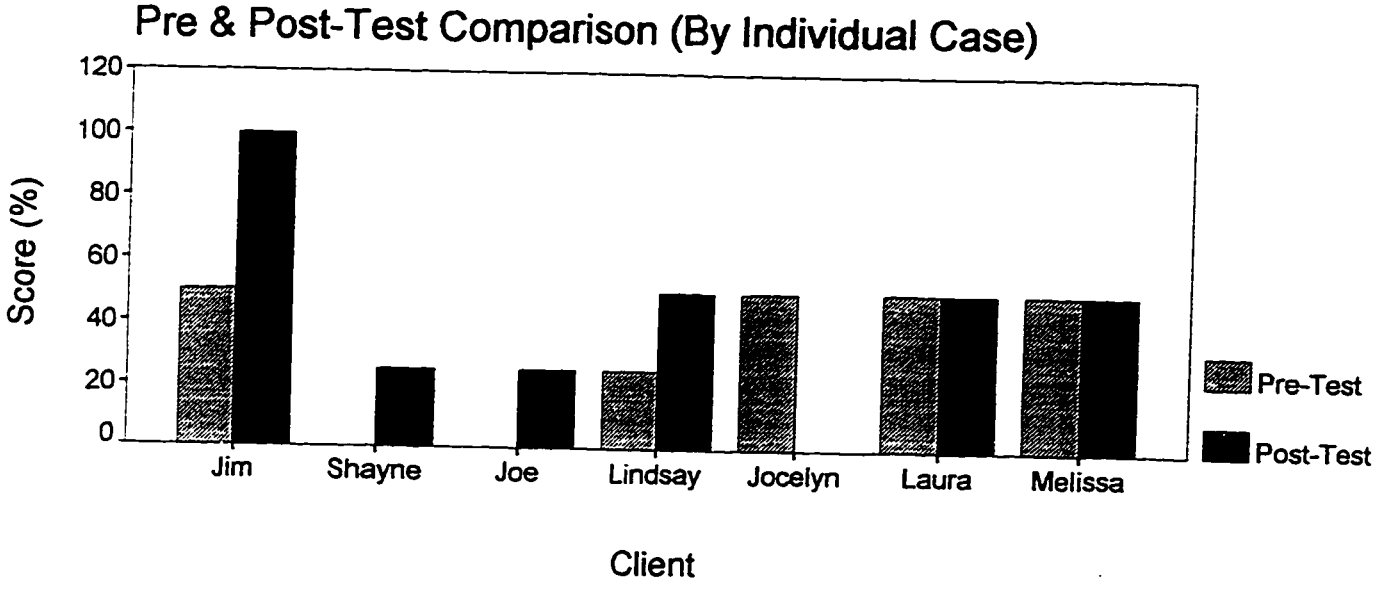
SSKAT: Alcohol Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 17

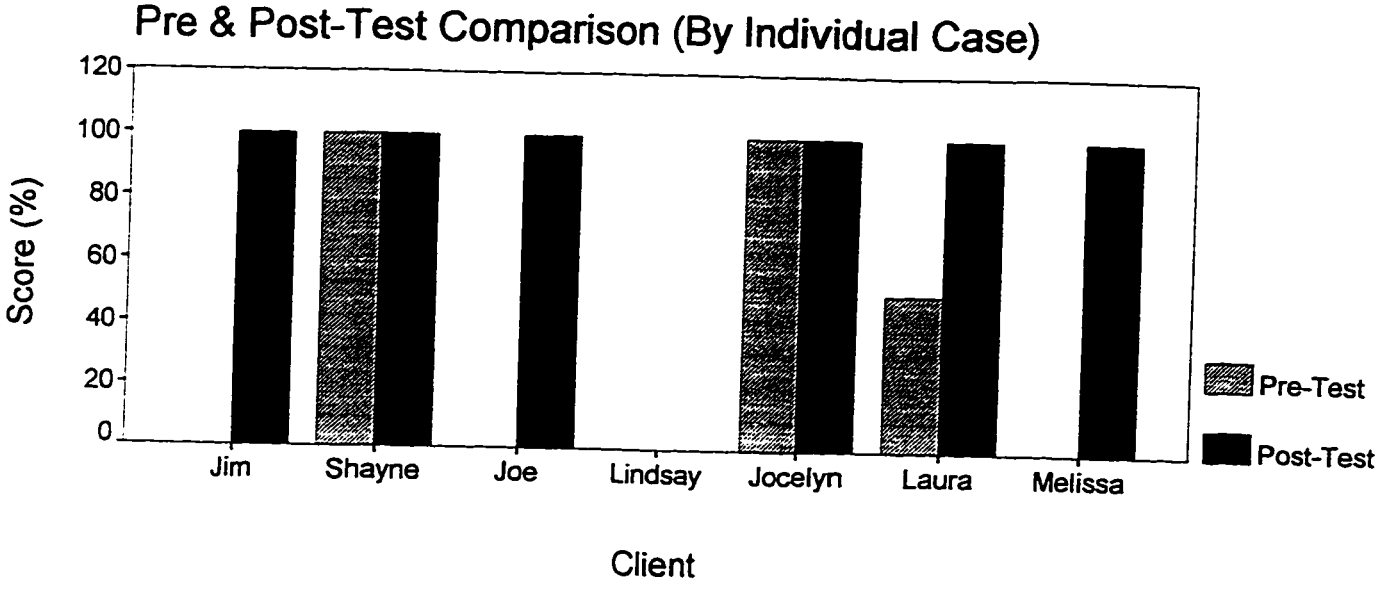
SSKAT: Pregnancy Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 18

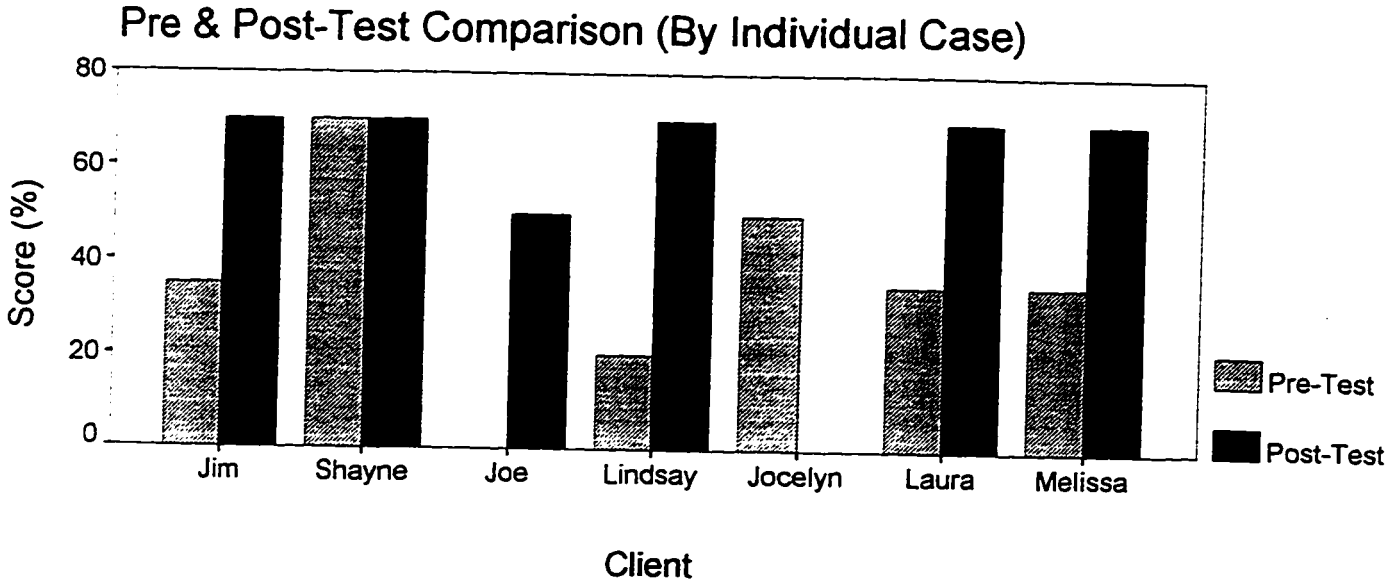
SSKAT: Marriage Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 19

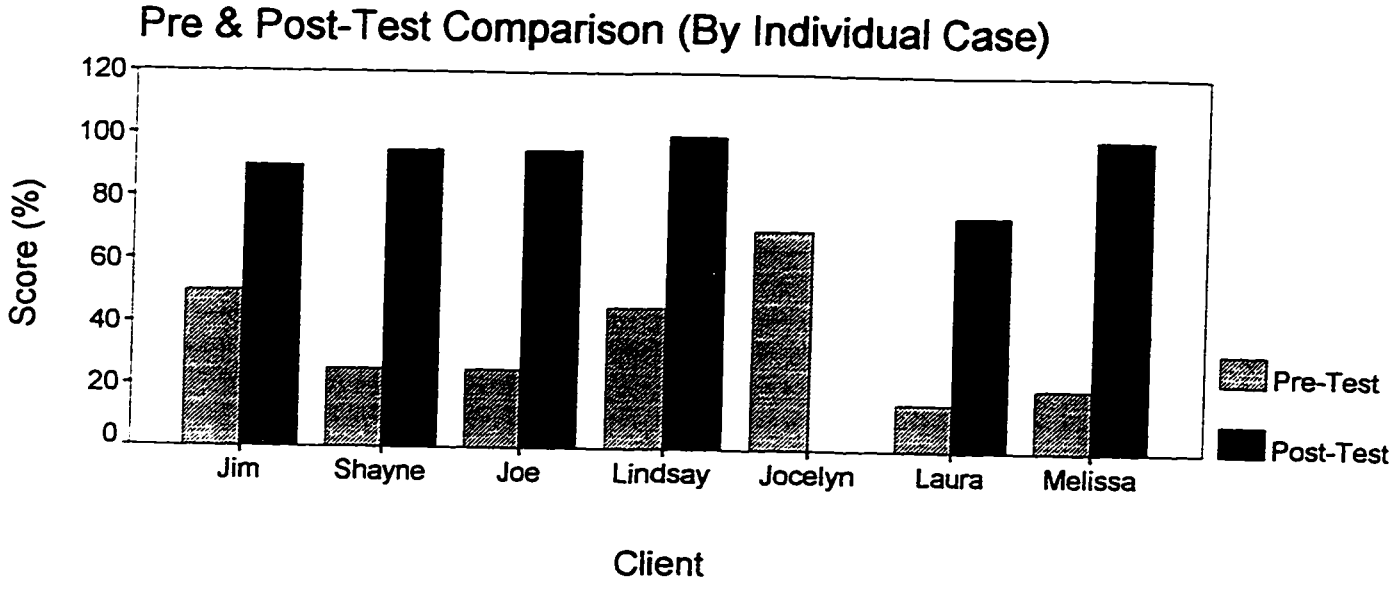
SSKAT: Intimacy Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 20

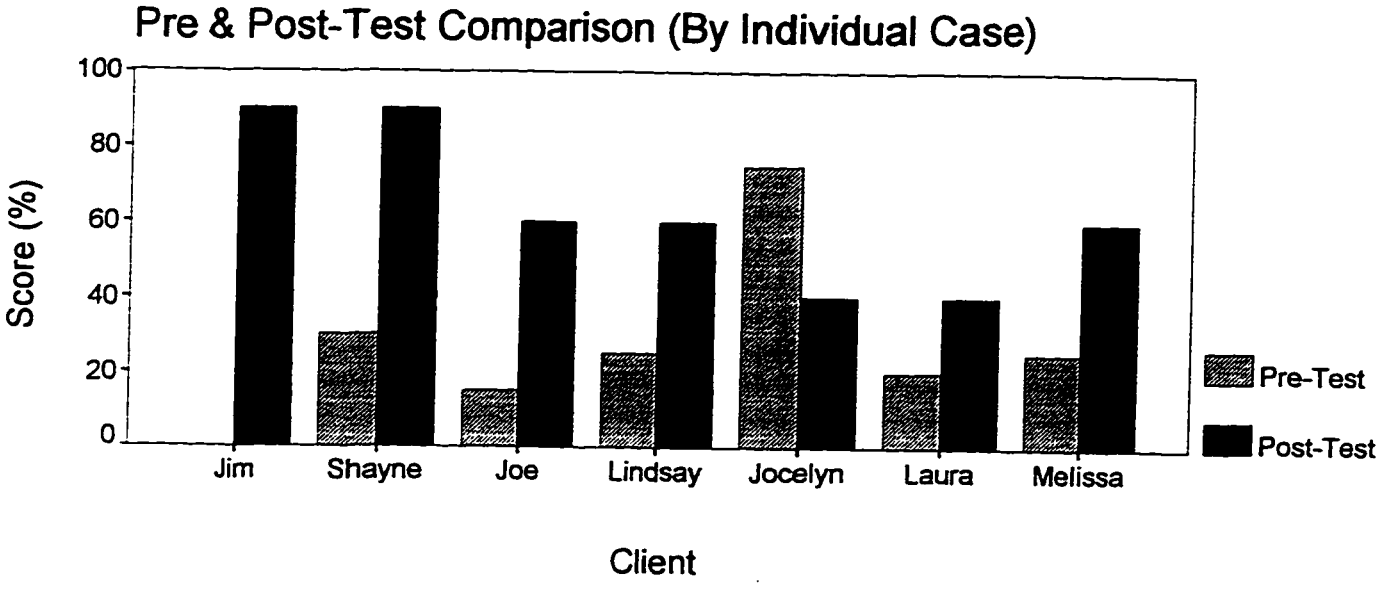
SSKAT: Masturbation Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 21

SSKAT: Dating Subscale



1) 25% = Neg. 2) 50% = Neutral and 3) 75% = Pos. Attitude

Figure 22

SMRAI: Group Home Workers' Scores

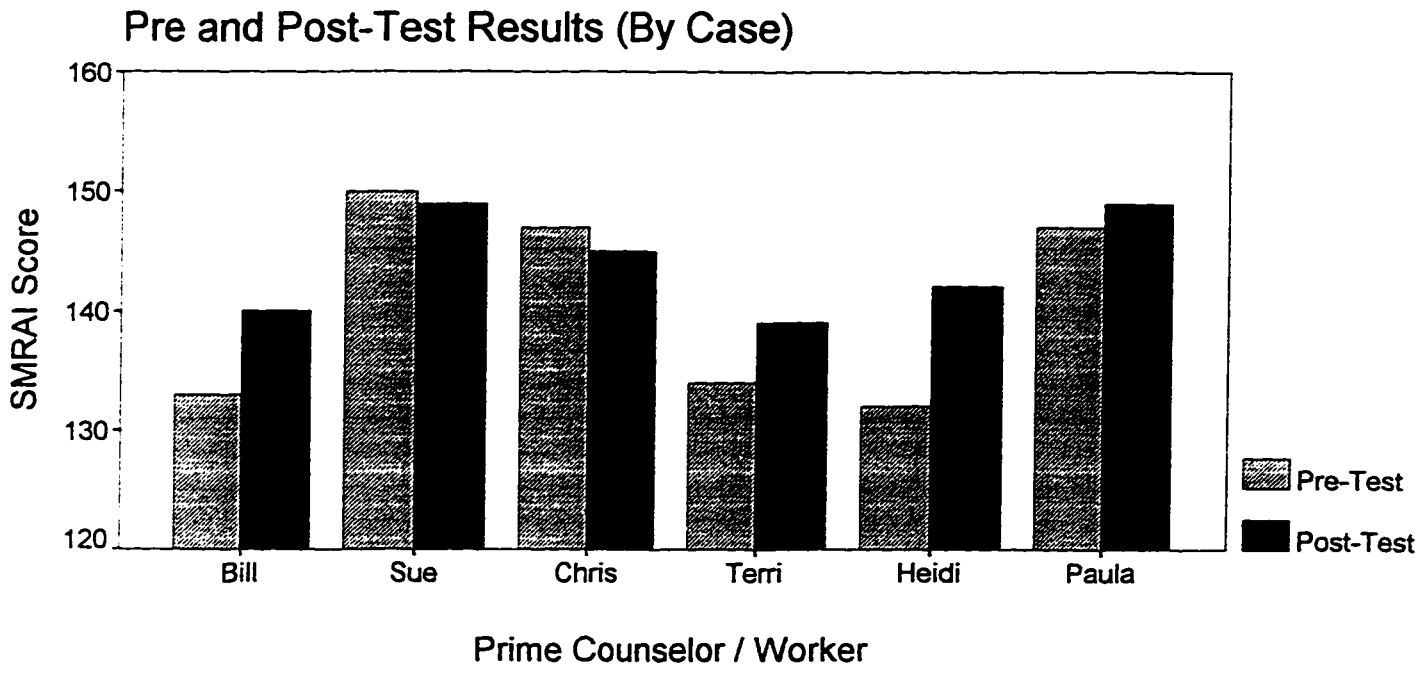
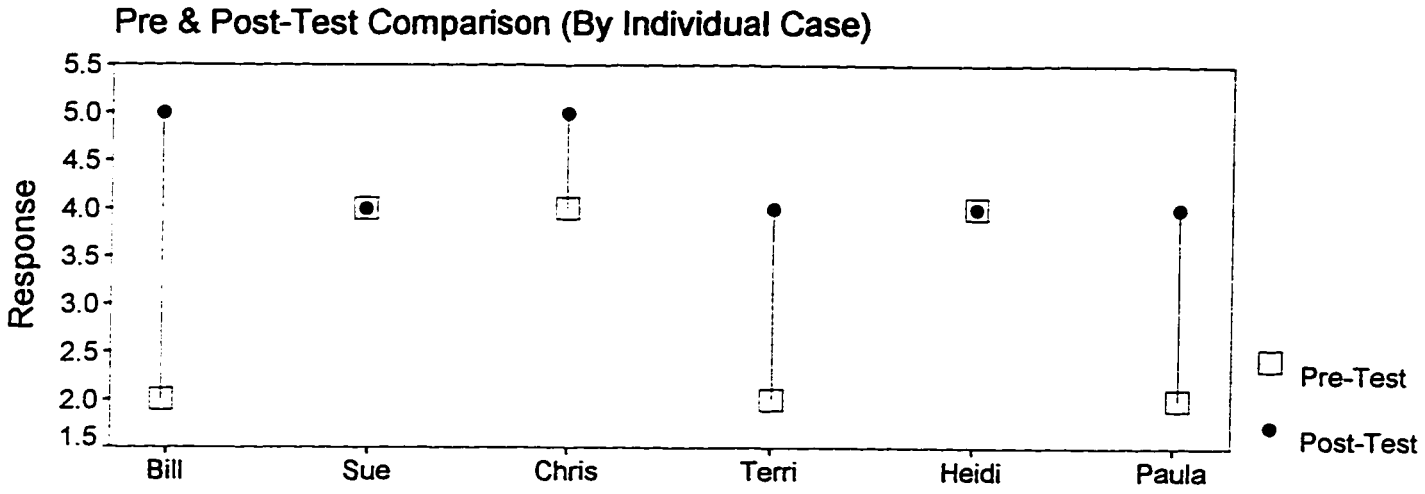


Figure 23

Inability To Make Responsible Decisions



1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 24

Right To Have Own Sexual Life

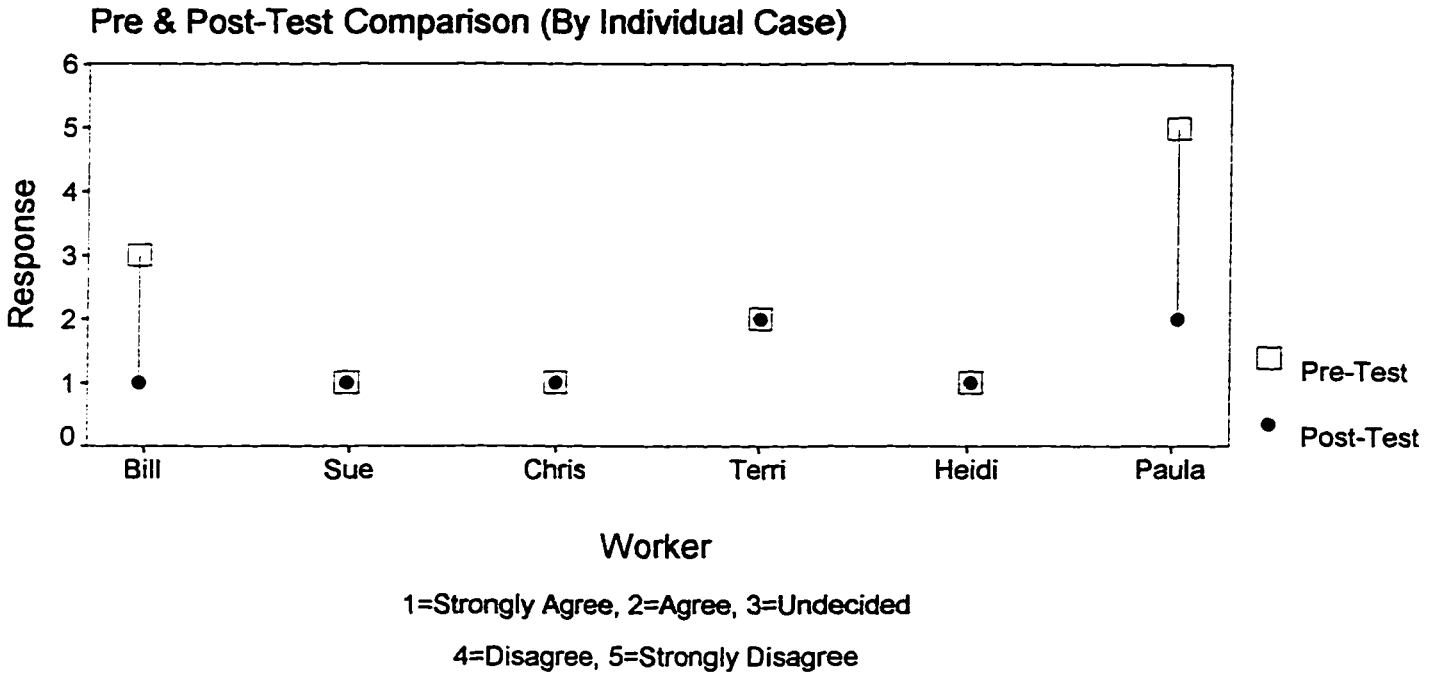
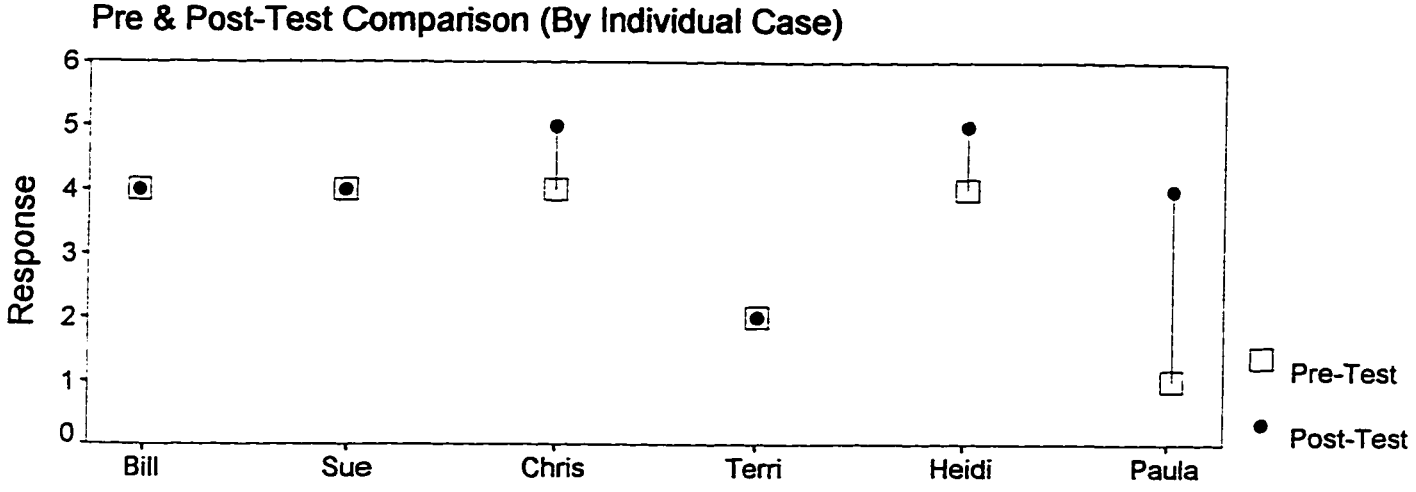


Figure 25

Segregate Genders For Sex Education

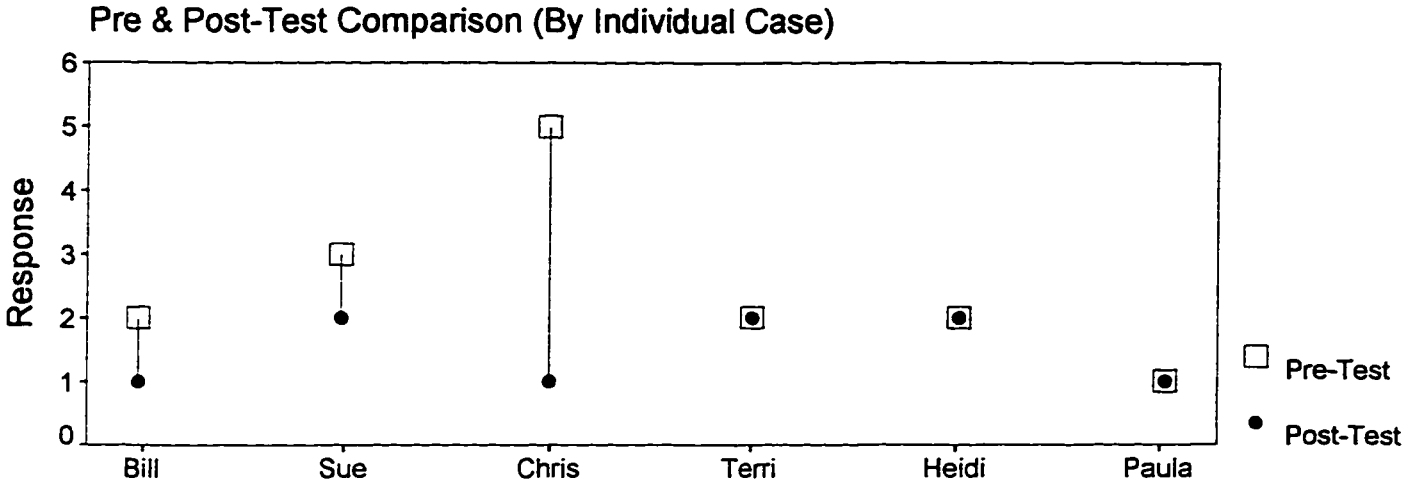


1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 26

Teach About Drugs, Sex & Alcohol



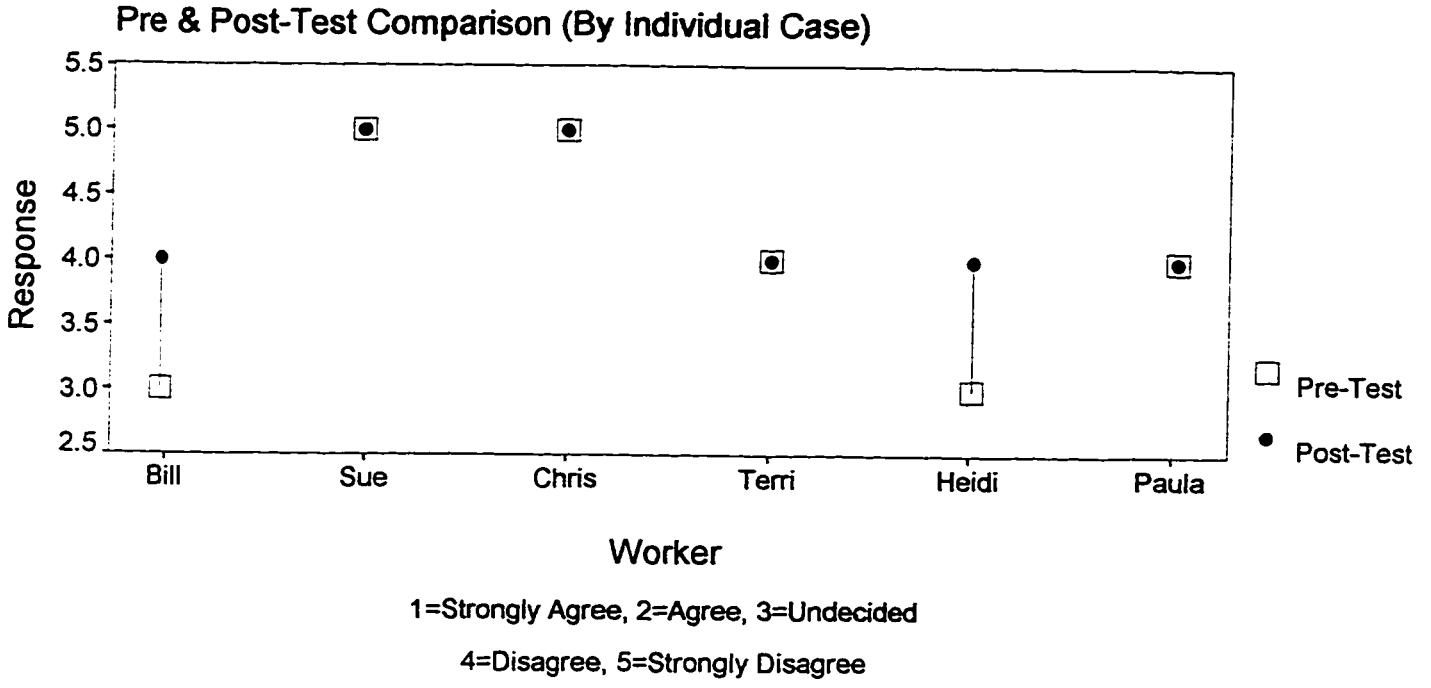
Worker

1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 27

People With A D.H. Have A Stronger Sex Drive

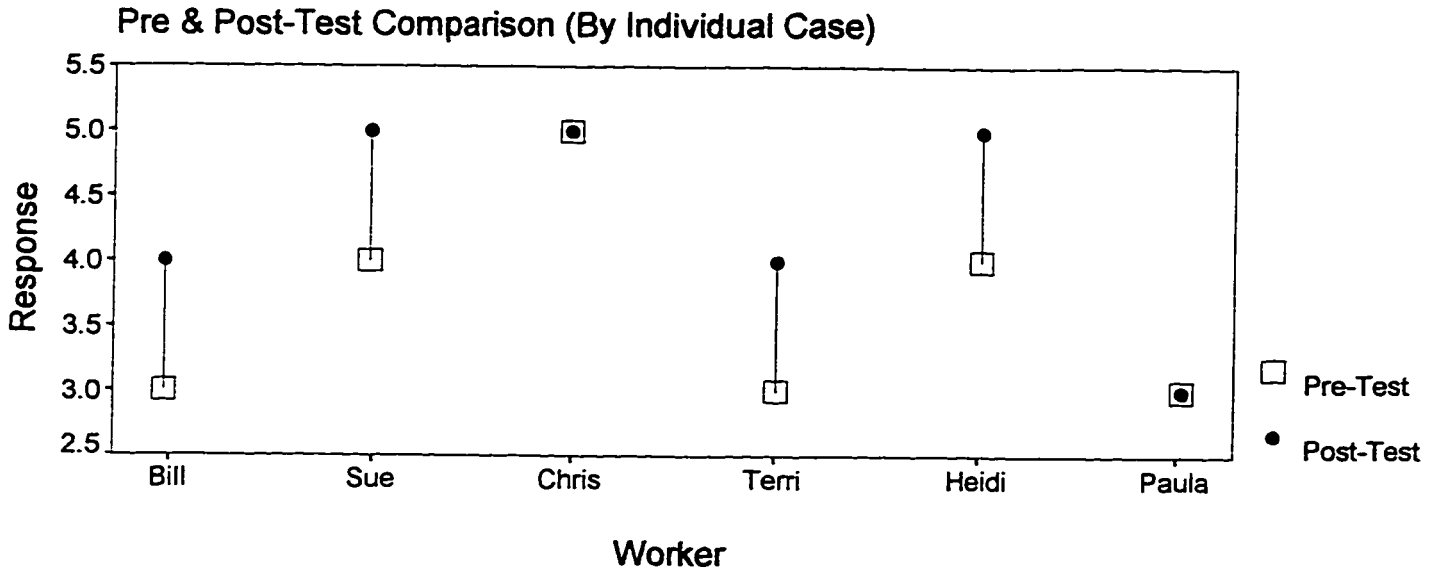


1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 28

Men Have Stronger Sex Drives

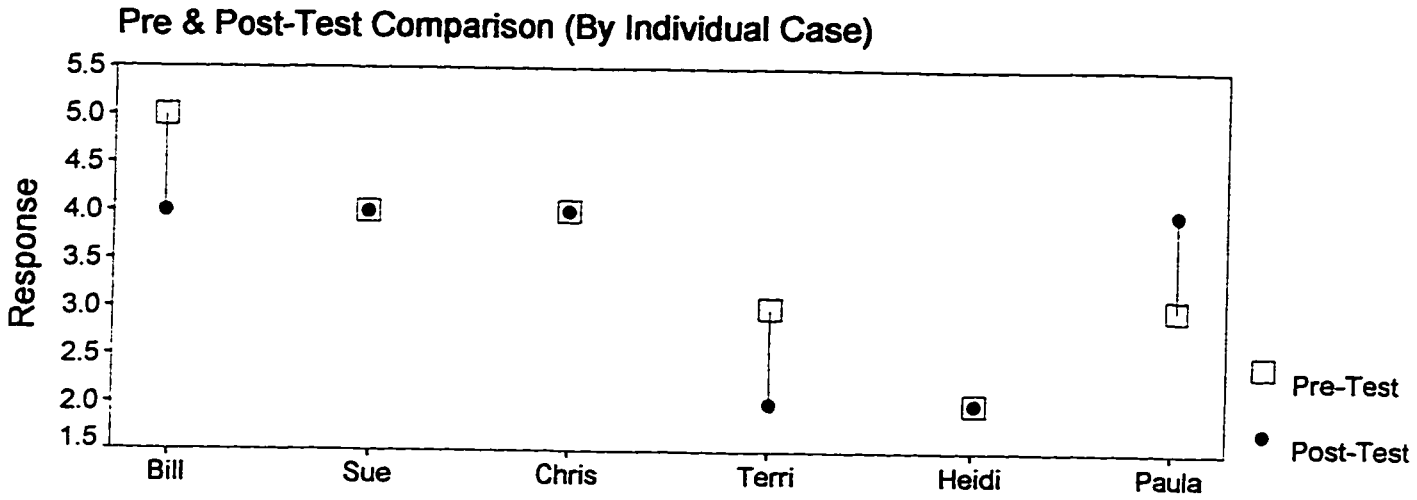


1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 29

Should Not Marry If Cannot Support Self

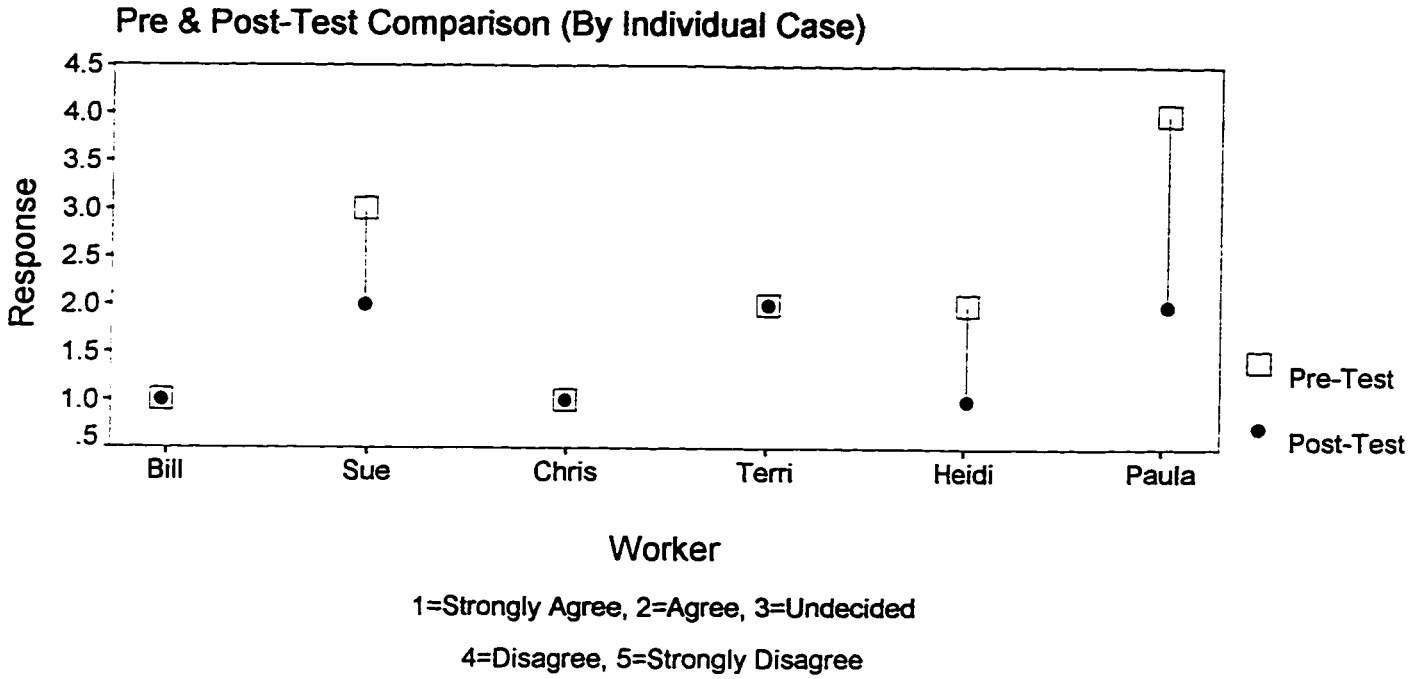


1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 30

Facilities For Married Individuals With A D.H.



1=Strongly Agree, 2=Agree, 3=Undecided

4=Disagree, 5=Strongly Disagree

Figure 31

The Right To Have Children

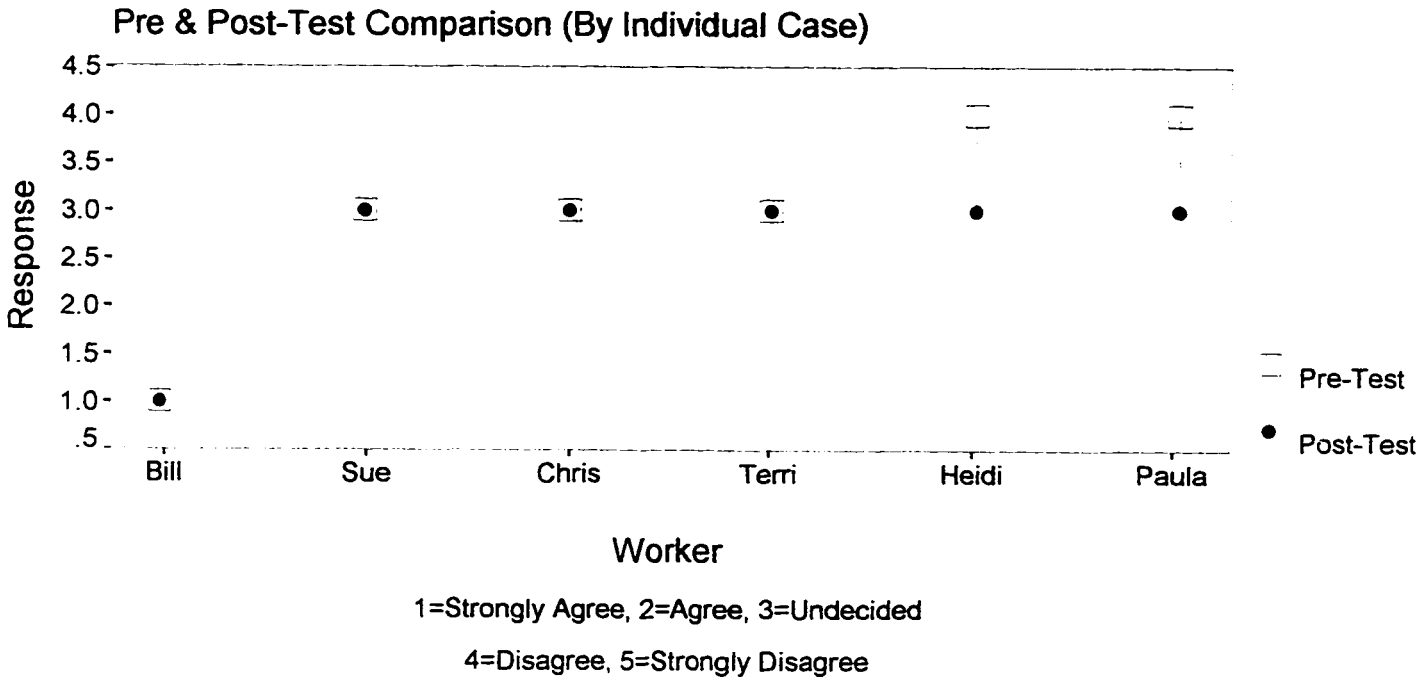
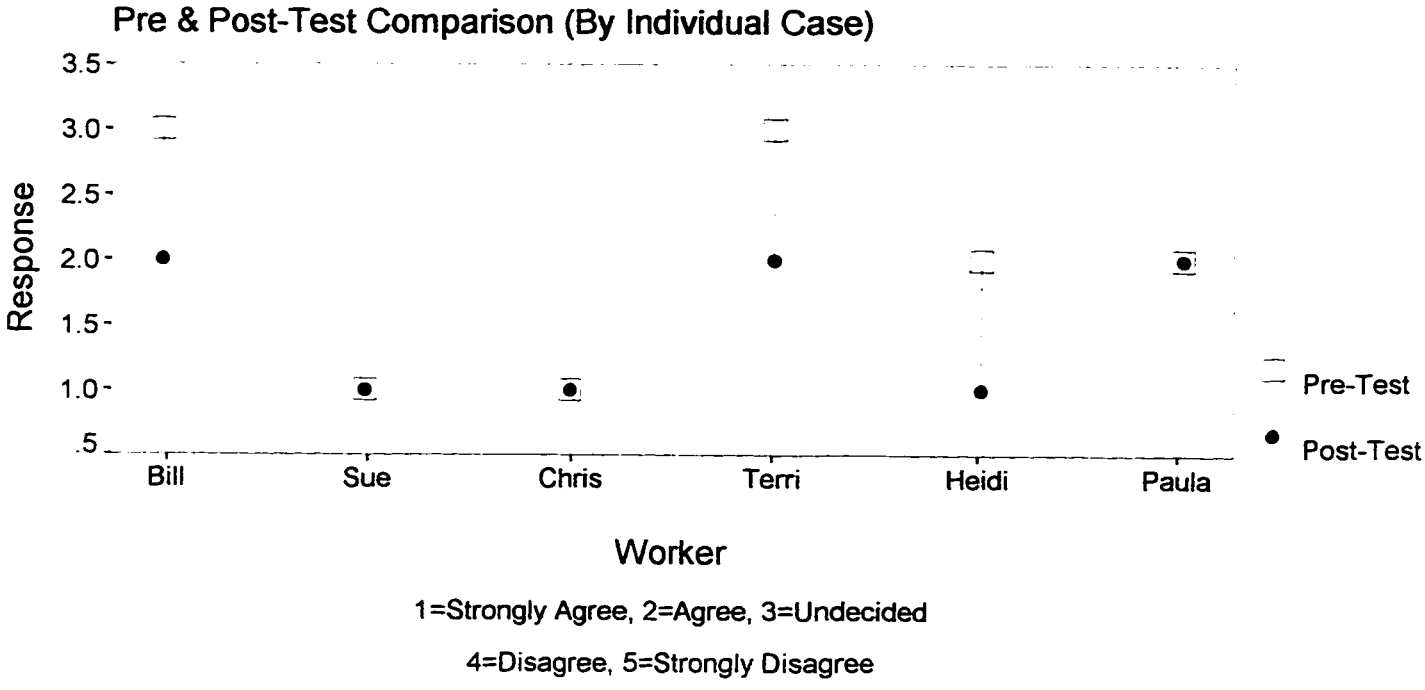


Figure 32

Gay & Lesbian Relationships Should Be Permitted



Appendices

Appendix A

Client Consent to Participate in the Group

In this group we will talk about body parts, private and public behaviour, how to act with people, what dating is, what marriage is, what pregnancy is, and how to be safe. Some people call this talking about sex or relationships. Sometimes talking about sex and relationships can be uncomfortable and sometimes we remember things that hurt our feelings. This may happen to you or someone else in the group and although it is a risk of being in the group, we will try to make it not so hurtful if it happens to you.

The other group members will be close to your age. There will be two leaders in the group: a man and a woman. We will meet one time a week for eight weeks. It is your choice to be in the group or not to be in the group. But, to be in the group you must answer some questions with pictures so we can know how best to help you. If the questions or pictures make you feel uncomfortable at any time, you can stop and do not have to continue if you do not want to. Once you start the group you do not have to come back if you are not happy and it will not count against you.

What you say in the group is secret unless you tell us something that would hurt you or someone else. We also do not want you to tell other people's secrets outside the

group, and we will talk more about that in the group. It is called confidentiality.

Before the group starts we will show you some pictures and ask you questions. We will repeat this when the group finishes and again three months later.

There is homework after each group to be brought back to the next group. It will take you about 15 minutes to one-half hour to complete. The homework will consist of short questions about our discussion that day.

I would also like to tell you about myself. I am student at Wilfrid Laurier University and because I am a student I will sometimes need help deciding how to best work with you and the other group members. Dr. Anne Westhues is one of my teachers and she will be helping me by being my supervisor. Although you might not meet her you can talk to her if you have any questions about the group. Her phone number is at the bottom of this form.

The purpose of the group has been explained to me by the group leaders. I want to participate in the sexuality group.

I acknowledge receiving a copy of this informed consent.

---------- Date:
Participant

---------- Date:

Investigator: David Morrow, M.S.W Candidate
Faculty of Social Work
Wilfrid Laurier University
(519) 884-0492

Supervisor: Anne Westhues, D.S.W.
Faculty of Social Work
Wilfrid Laurier University
(519) 884-1970

Appendix B

Client Consent to Participate in the Research Study

There is another part to the group called research. The purpose of this research is to find out if the group helped you, and how it helped you so we can help others. I understand that I am being asked to participate in a research study which is being conducted by David Morrow, Dr. Anne Westhues and the Faculty of Social Work of Wilfrid Laurier University.

Dr. Westhues is the Wilfrid Laurier University faculty supervisor and advisor for David Morrow. Although she will not directly participate in the groups or research study, Dr. Westhues will be informed and hence involved in all processes directly and indirectly related to the socio-sexuality education groups and the research study.

It is your choice to be in the group or not to be in the group. But, to be in the group you must answer some questions with pictures so we can know how best to help you. If the questions or pictures make you feel uncomfortable at any time, you can stop and do not have to continue if you do not want to. Once you start the group you do not have to come back if you are not happy and it will not count against you. If you agree to participate in the research, we will

ask you to complete the picture and questions test again three months after the group finishes.

The reason for this is we want to find out if the group helped you to learn about sexuality and relationships and if we can help you to remember the things you learned. We also want to find out if it is a good thing for us to carry out groups like this one for other adults like you. Your agreement to participate in the research will help us to provide the best service possible, both to you and to other adults. In that way, you will be helping others.

We will not put your name or anything that would identify you, your family or your group home in the final report. We may include something only you said word for word, but nobody will know you said it. If we want to use something you said word for word and we think people might know it was you who said it, we will call you and ask your permission before we use your words.

Participating in the research part will only involve two extra meetings; immediately following the group and than three months after the group. Someone will come to your group home for the meetings when it is a good time for you.

All of your answers to the questions will be kept in a locked file and nobody else will ever see them. They will be destroyed after the data has been used.

We want you to be very comfortable right from the very beginning so it is important for you to know that you have the right to ask the researcher or the advisor any questions about the group and the research. You will find the researcher's and the advisor's phone number below. You may need your counsellor's help, but you can call any time you have a question about the group that is important to you.

Two to three months after we show you some pictures and ask some questions for the last time, we will invite you to come and talk about what we learned from having you and others participate in the group and the research.

I acknowledge receiving a copy of this informed consent.

---------- Date:
Participant

---------- Date:

Investigator: David Morrow, M.S.W Candidate
Faculty of Social Work
Wilfrid Laurier University
(519) 884-0492

Supervisor: Anne Westhues, D.S.W.
Faculty of Social Work
Wilfrid Laurier University
(519) 884-1970

Appendix C

Primary Counsellor Consent to Participate In The Research Study And A Concurrent Socio-Sexuality Education Group

I understand that I am being asked to participate in a research study which is being conducted by David Morrow, Dr. Anne Westhues and the Faculty of Social Work of Wilfrid Laurier University.

Dr. Westhues is the Wilfrid Laurier University faculty supervisor and advisor for David Morrow. Although she will not directly participate in the groups or research study, Dr. Westhues will be informed and hence involved in all processes directly and indirectly related to the socio-sexuality education groups and the research study.

The purpose of this study is to better identify and understand some of the systemic variables that effect the ability of an individual with a developmental handicap to retain the knowledge and attitude change they may experience as a result of participating in a socio-sexuality education group. A key variable in this study is the attitude of the primary group home counsellor with respect to the sexuality of individuals with a developmental handicap. The data collected in this research will be used to promote this understanding.

As a participant you will be asked to participate in a socio-sexuality education program that will cover the same socio-sexuality material that your charge will be concurrently learning. The group will meet one night a week for 8 weeks. You will be asked to discuss the topics with your charge and to help them with their homework if they wish you to. You will also be asked to fill out a sexuality attitude inventory before and immediately after the group and again three months after the group finishes. I understand that the proposed length of my participation in this study is approximately 17 hours.

I understand that the following risks are involved:

-exposure to sexually explicit material

-exposure to differing opinions with respect to sexuality

The following are benefits which I may derive from my participation in this study:

-to learn first-hand about research in social work

-to gain knowledge pertaining to the variables effecting the ability of an individual with a developmental handicap to retain knowledge and attitude changes as a result of participating in a socio-sexuality education group

-a safe environment in which to explore my own attitudes about the sexuality of individuals with a developmental handicap

-to gain knowledge pertaining to the topics and methods of leading a socio-sexuality education group for individuals with a developmental handicap.

I understand that my participation is voluntary. I may refuse to participate in this study without penalty to me. I may also withdraw from the study at any time without penalty or loss of benefits to which I would ordinarily be entitled. I may omit the answer to any question.

I understand my research records will be kept confidential and that I will not be identified in any publication or discussion.

I understand that direct quotations may be used in reporting the data. The use of these quotations will be limited to those that do not disclose my identity. The researcher will obtain my consent to use quotes that may disclose my identity.

I understand that I have a right to all questions about the study answered by the researcher or research advisor in sufficient detail to clearly understand the answer.

I understand that I can receive feedback on the overall results of this research by a face to face meeting with the principal researcher, and that this will be made available to me within two to three months of the follow-up test date.

If I have any questions about the research, the procedures employed, my rights, or any other research related concerns I may contact the investigator and/or their supervisor.

I acknowledge receiving a copy of this informed consent.

---------- Date:
Participant

---------- Date:

Investigator: David Morrow, M.S.W Candidate
Faculty of Social Work
Wilfrid Laurier University
(519) 884-0492

Supervisor: Anne Westhues, D.S.W.
Faculty of Social Work
Wilfrid Laurier University
(519) 884-1970

Appendix D

Focus Group Questions and Guidelines

Attitude: Question #1

WHAT WERE YOUR ATTITUDES ABOUT THE SEXUALITY AND THE RELATIONSHIPS OF YOUR CLIENTS BEFORE YOUR INVOLVEMENT IN THIS GROUP?

PROBES:

A. Individual Client

i) Socialization Skills: -ability to be in relationship
-ability to socialize (interact)

ii) Behaviours including hygiene and sexual preferences (masturbation; teasing; gay/lesbian)

iii) Ability to learn new material and to retain

iv) Self-esteem/Self-image/Body Image

v) Community awareness/Protection Issues

vi) Anxiety about relationships

vii) Fantasy/Reality (i.e.: marriage)

viii) About helping client (could you help any more)

ix) Dependency

B. Individuals with developmental disabilities in general

i) Myths

ii) Marriage/Pregnancy

iii) Effective and loving relationships

iv) Self-esteem/Self-image/Body-image

v) Community awareness/Protection issues

vi) Age and how enter group homes

vii) Dependency

C. Socio-Sexuality Education Programs

D. Opposite Genders with respect to counsellor and individual work with

ATTITUDE: QUESTION #2

HAVE YOUR ATTITUDES ABOUT THE SEXUALITY AND THE RELATIONSHIPS OF YOUR CLIENTS CHANGED AS A RESULT OF BEING IN THE GROUP? IF SO, HOW?

PROBES:

A. Behaviours i) Social (interactional)
ii) Relational
iii) Sexual

B. Marriage/Pregnancy

C. Ability to learn and retain material

D. Fantasy/Reality

E. Your ability to help with respect to sexuality and relationship issues

F. Community Awareness and Self-protection

G. Indivduals with a developmental disability in general

H. Socio-Sexuality Education Programs

I. Privacy and Interactional issues: how model pub and private at home. Boundaries.

QUESTION #3

WHAT CHANGES DID YOU SEE IN YOUR CLIENTS AS A RESULT OF BEING IN THE GROUP?

PROBES:

A. Self-esteem/Self-image/Empowerment

i) Confidence in general (empowerment)

ii) homework (can do)

iii) Relationships

B. Behaviour

i) Interactional/Social/Relational

ii) Sexual

iii) Fantasy

C. What changes surprised you the most?

i) Retention of knowledge

ii) Behaviour

iii) Interactional/Social/Relational

iv) Empathy/Depth of Emotion

v) Self-esteem/Self-image/Body-image

vi) Knowledge already present

vii) Comittment to group

viii) Parental/Other staff interest

D. Anxiety: Relationships? Sexuality?

E. Did changes generalize?

F. Changes you identified or experienced that you did not think were positive

QUESTION #4: THE FORMAT OF THE SOCIO-SEXUALITY PROGRAM

4A. WHAT DID YOU FIRST THINK WHEN YOU HEARD THE FORMAT OF THE PROGRAM?

4B. HOW DO YOU FEEL ABOUT THE FORMAT? IS THIS A GOOD APPROACH?

PROBES:

I. Homework

i) Commitment to

ii) How affect relationship (doing together)?

iii) Organizational issues (consistency; staffing)?

iv) What did you learn about client (attitudes: sexuality bad)?

v) Assist in learning and retention of knowledge?

II. Gender Composition: Client group being co-ed

III. Male and Female Facilitator

IV. Counsellor Involvement

i) Impact on attitudes

ii) Client retention

iii) Modelling of behaviour

iv) Interaction with client

v) How did you benefit

vi) Were you a factor in the program development

vii) Were client goals met

viii) Assist with retention of knowledge

ix) Group vs. individual involvement

x) The impact or involvement of other systems

i.e.:-parents
-group home: staff
housemates

4C. WOULD YOU SEE IT AS BEING USEFUL TO HAVE ONE OR MORE JOINT SESSIONS WITH THE CLIENT?

4D. WOULD YOU SEE IT AS BEING USEFUL TO HAVE PARENTS PARTICIPATE IN YOUR COUNSELOR GROUP?

QUESTION #5

WHAT WOULD YOU DO DIFFERENTLY IF YOU WERE TO DESIGN THIS PROCESS AGAIN?

i) Homework

ii) Counsellor-facilitator meetings

iii) Parental/Other caregiver (staff) involvement

iv) Time Frame

v) Model: Mainstream?

Group?

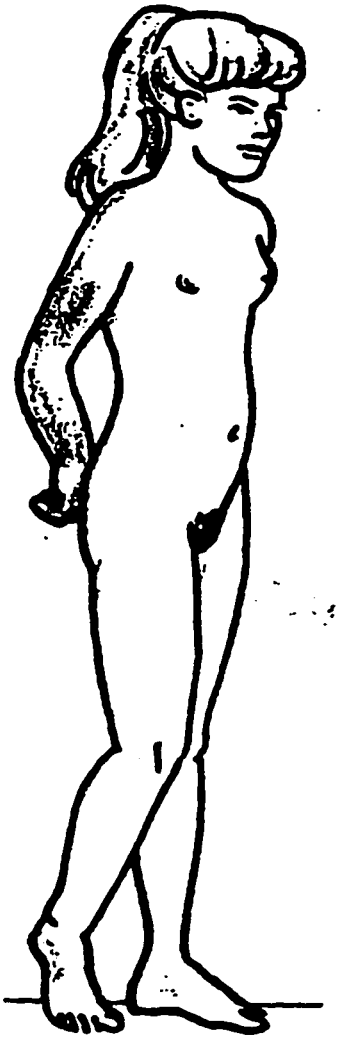
Appendix E

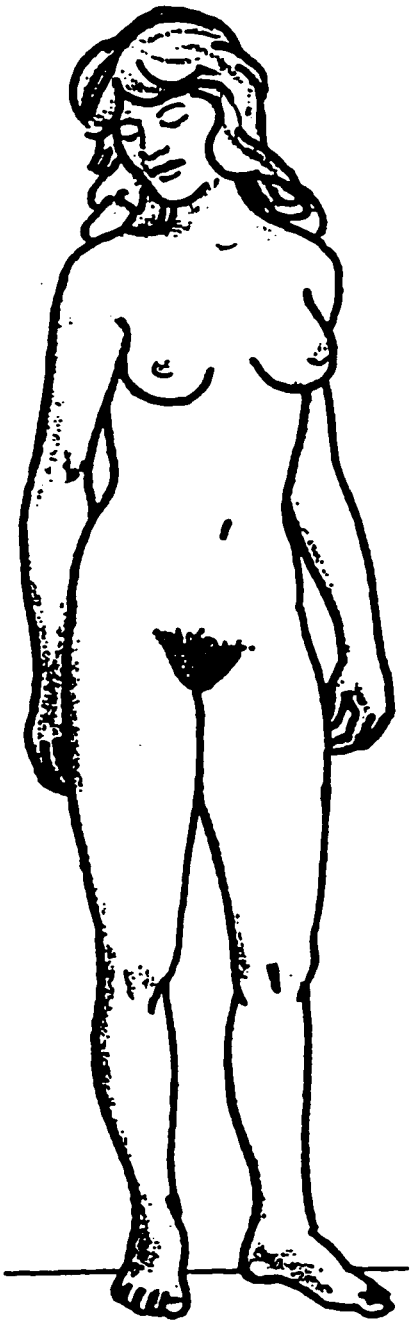
ANATOMY HOMEWORK: MAY 9, 1996

1. The body changes when girls grow older and become women.

   Are you a girl or a woman?

2. Circle the parts of the bodies that have changed since this girl became a woman.



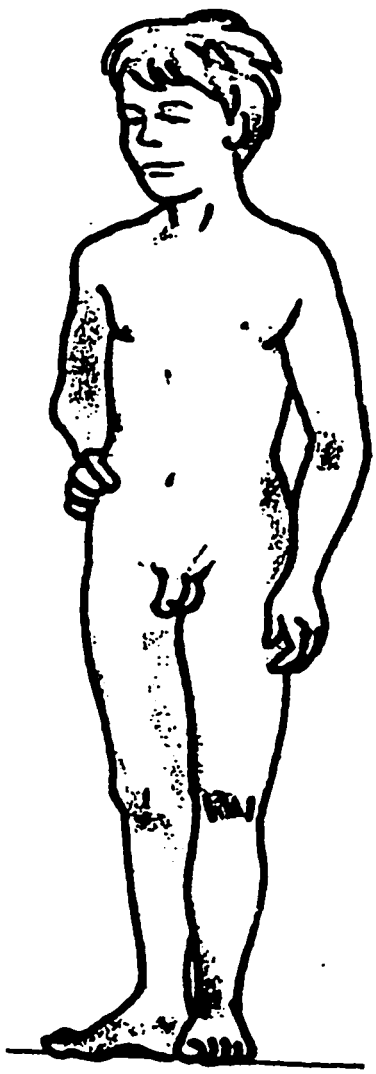


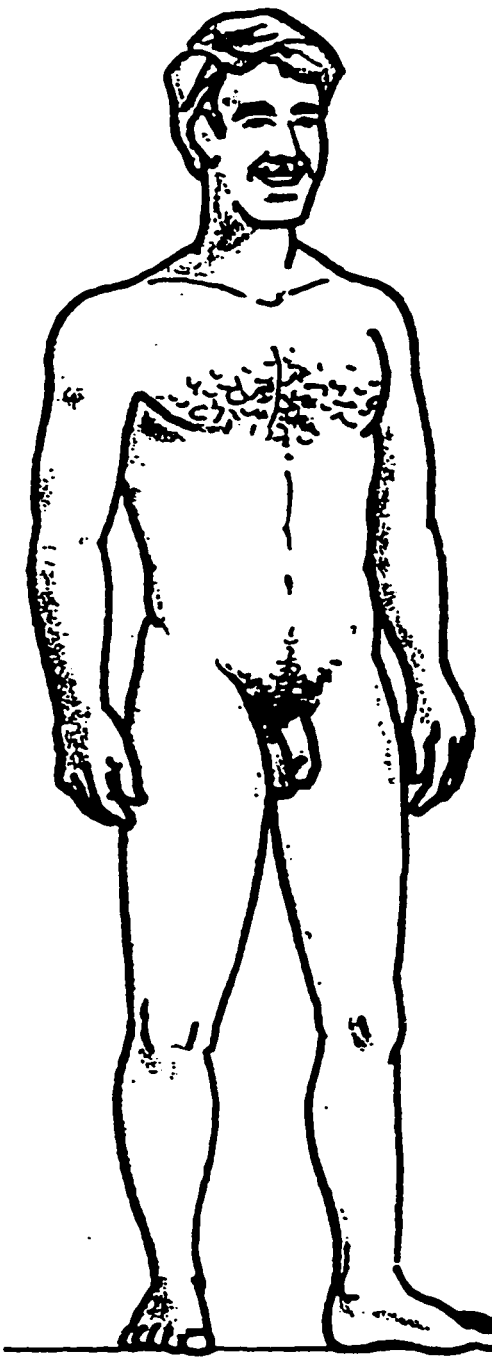
ANATOMY HOMEWORK: MAY 9, 1996

1. The body changes when boys grow older and become men.

   Are you a boy or a man?

2. Circle the parts of the bodies that have changed since this boy became a man.





ANATOMY HOMEWORK: MAY 9, 1996

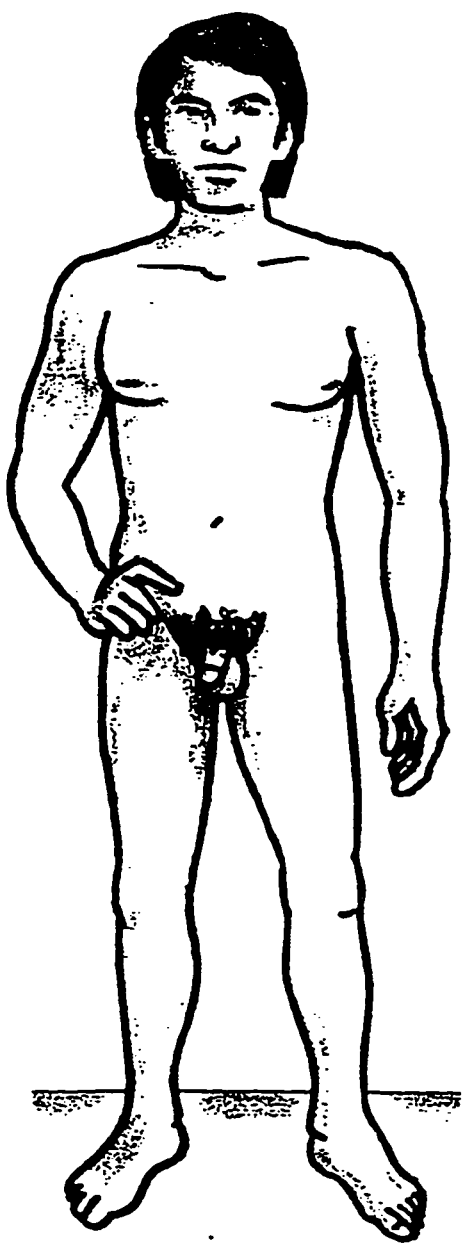
1. Can you name 3 public places?

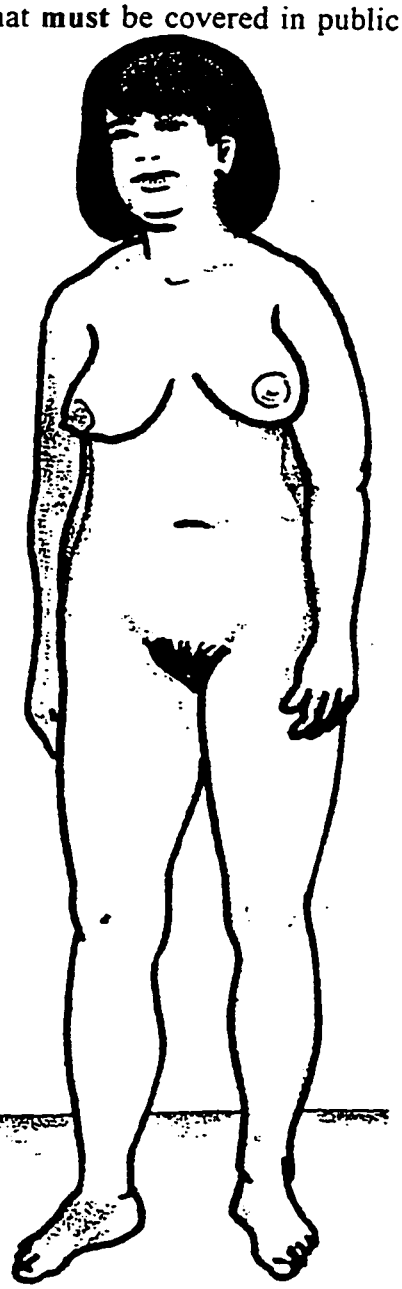
   i) ii) iii)

2. Can you name three private places?

   i) ii) iii)

3. Pretend you are going to work, a dance or even a hockey game. Use a marker, pencil crayon or crayons to put clothing on the man and woman that will cover their private areas. Make sure to cover all the body parts that **must** be covered in public!!





ANATOMY HOMEWORK: MAY 9, 1996

1. This woman is touching her vagina in a special way. What is the name we use for what she is doing?

2. Is it okay to do this?

3. What **must** she do when she is finished?

4. Where should she do this? **Hint:** Remember public and private!!

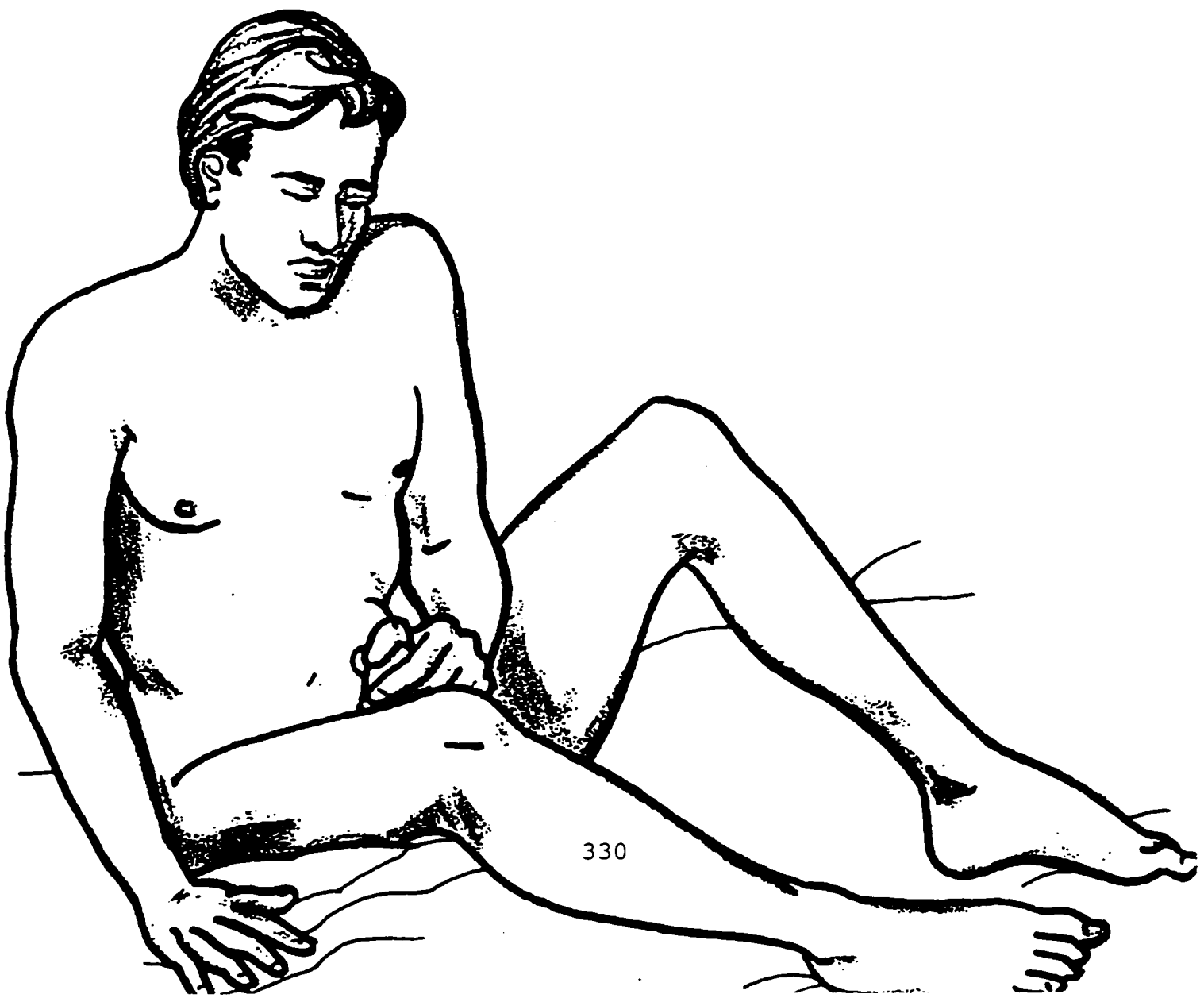
ANATOMY HOMEWORK: MAY 9, 1996

1. This man is touching his penis in a special way. What is the name we use for what he is doing?

2. Is it okay to do this?

3. What **must** he do when he is finished?

4. Where should he do this? **Hint:** Remember public and private!!



ANATOMY HOMEWORK: MAY 9, 1996

1. Circle either male or female to indicate if the body parts are those of a man or a woman.

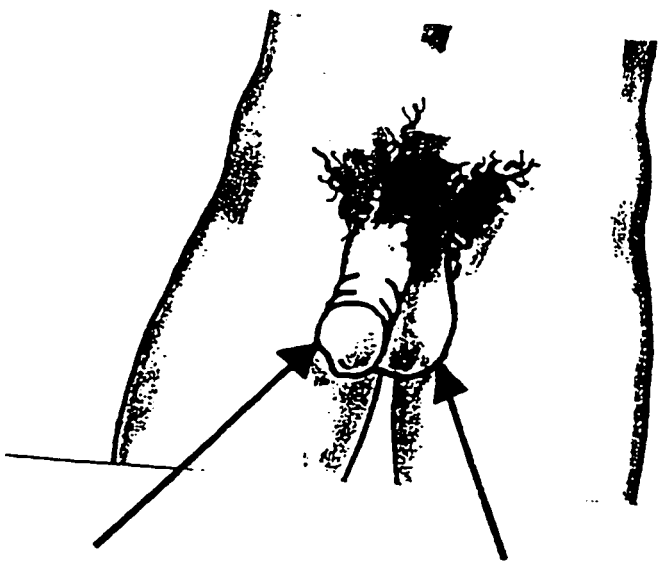
2. Name the parts of the body the arrows point to.

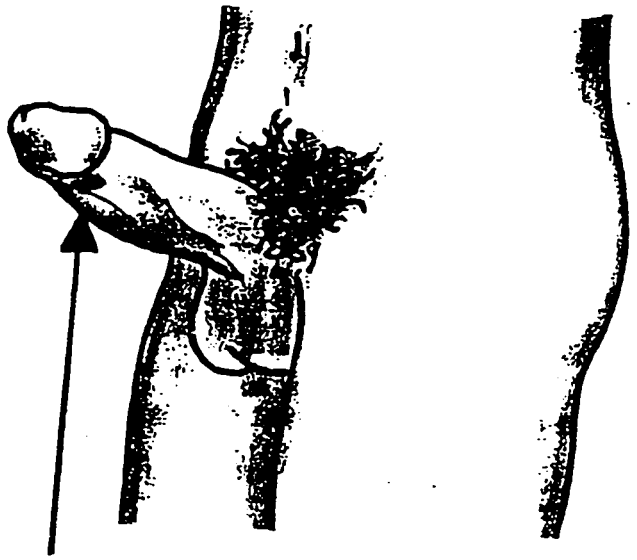
3. Sometimes a man's penis gets hard. What do we call it when the penis gets hard?

   Is it okay for a man's penis to get hard?

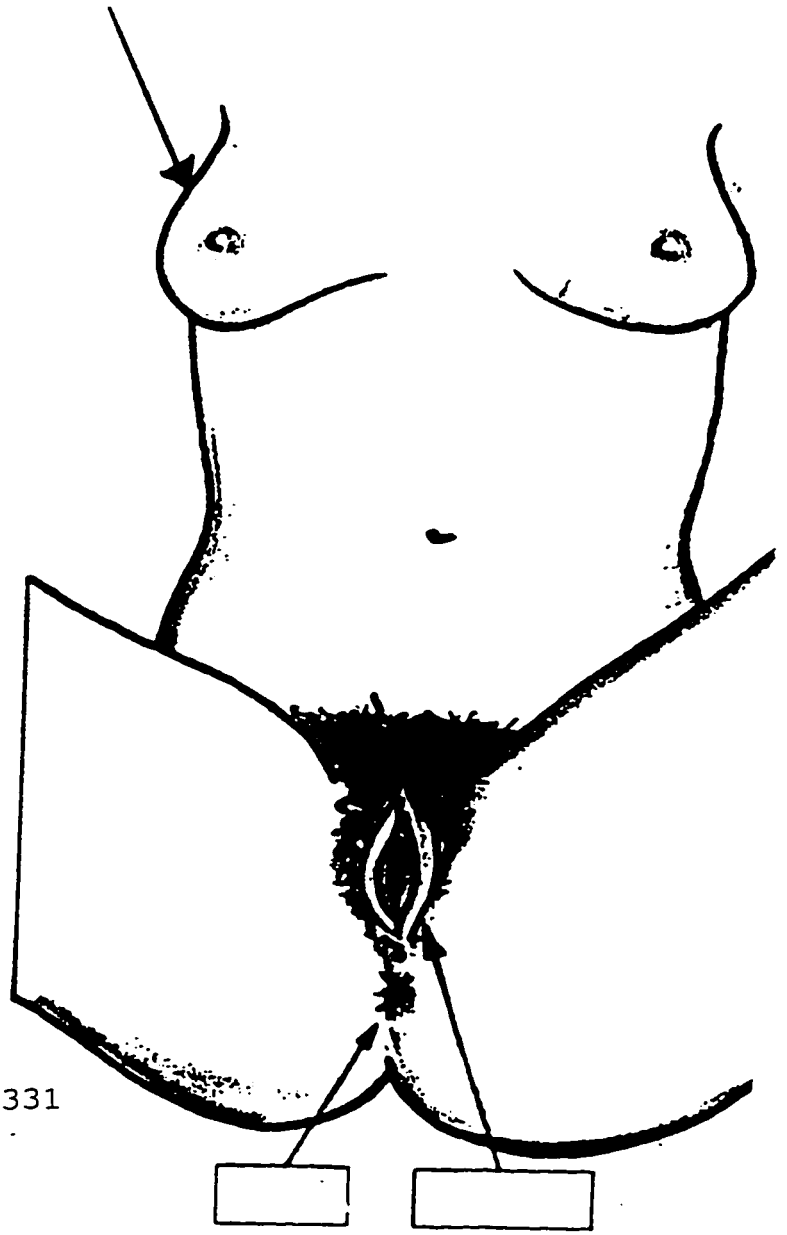
   When might it get hard?

MALE OR FEMALE?





MALE OR FEMALE?



Appendix F

RELATIONSHIPS HOMEWORK: MAY 15, 1996

1. We all want to be treated well by someone we care about. How you behave in your relationship with a boyfriend or a girlfriend and how they treat you will tell you if it is a good relationship or a bad relationship.

Read each statement or have your counselor read each statement listed below. Circle the statements that you think are part of a good relationship and put a big X through the ones that are part of a bad relationship.

YOUR PARTNER...

...tells you that you are fat, lazy and stupid.	...shares some of the same interests as you.	...never thinks you are right
...puts your friends down.	...has a sense of humour.	...is honest.
...likes to embarrass you in front of others.	...is easy to talk to.	...trusts you and you trust your partner
...gets jealous easily.	...spends all of their free time with you.	...becomes angry easily and hits you.
...is flexible about plans.	...is a good friend.	...forces you to do things sexually that you do not want to do.
...makes all of the decisions.	...can laugh with you.	...threatens to hit or hurt you if you do not obey.
...criticizes what you wear and what you do.	...talks to you about things bothering them.	...will not let you talk to other people or friends.
...spends time with you and with their own friends and family.	...accepts that sometimes you may be tired or moody.	...accepts that you may not always agree.

RELATIONSHIPS

There are many different kinds of relationships that you can enjoy. Having a friendship with one of your parents or a housemate is a relationship. Please look at the pictures below. Write the kind of relationship you think the picture is about (father and son, friends, etc.)

Circle your favourite picture and prepare to talk about the picture at our next group. Please feel free to bring in one of your own photographs to talk about if you want to. The photograph you bring in should be a picture of you with at least one other person.

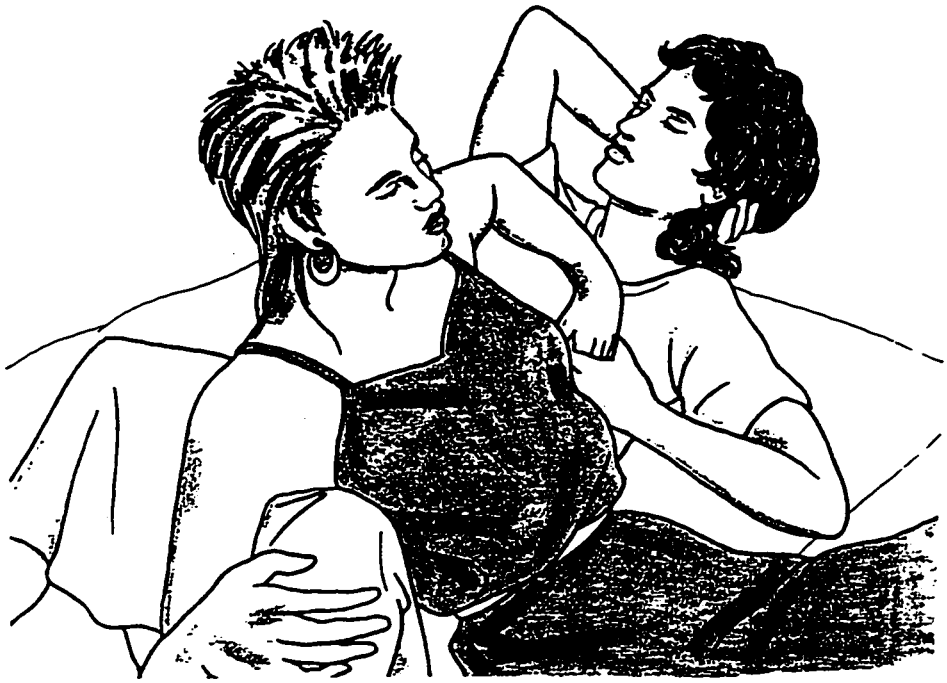
GAY, LESBIAN AND HETEROSEXUAL RELATIONSHIPS

This is a picture of two men. They care very much for each other. Gay is the correct term we use for two men in a loving relationship. This means that they do not date women. They only date other men and would be considered boyfriend and boyfriend.

1. Is it okay for two men to go out on a date?

2. Is it okay for to men to have a loving relationship?

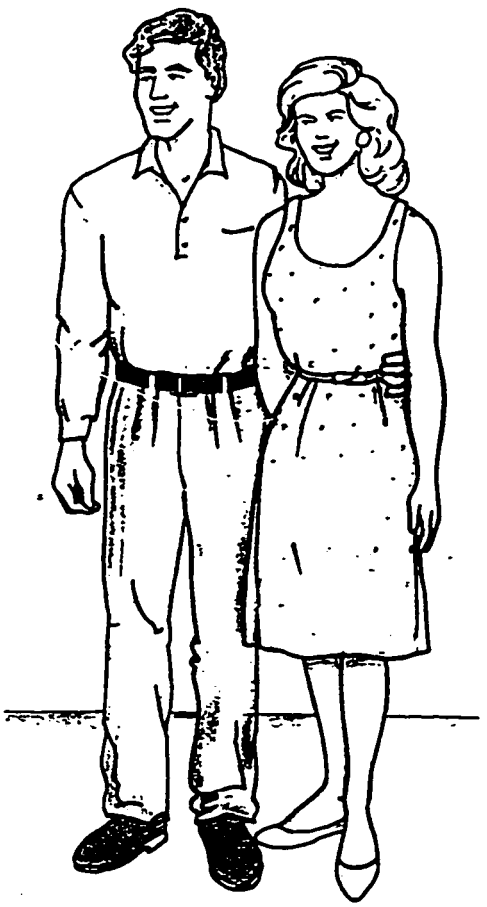
This is a picture of two women. They care very much for each other. Lesbian is the correct term we use for two women in a loving relationship. This means that they do not date men. They only date other women and would be considered girlfriend and girlfriend.



1. Is it okay for two women to go out on a date?

2. Is it okay for to women to have a loving relationship?

This is a picture of a man and a woman. They care very much for each other. Heterosexual is the correct term we use for a man and a woman in a loving relationship. This means that a man would only date a woman and a woman would only date a man. They would be considered boyfriend and girlfriend.



1. Is it okay for a man and a woman to go out on a date?

2. Is it okay for a man and a woman to have a loving relationship?

Please look at the picture below and answer the following questions:

1. What do think is happening in this picture? Hint: look closely at the man's face, the woman's face and her hands.

2. Is it okay for this man to touch the woman when she does not want to be touched by him? (circle the correct answer)

   yes no

3. What do we call his behaviour if he continues to touch her after she says no? (circle the correct answer[s])

   illegal appropriate sexual assault rape

4. What will happen to him if he continues to touch her when she has told him not to touch her? (circle the correct answer[s])

   nothing arrested by police go to jail

5. Is it okay for you to touch someone who does not want to be touched? (circle the correct answer)

   yes no

6. What could happen to you if you do touch someone who does not want to be touched? (circle the correct answer[s])

   nothing arrested by police go to jail

SEXUAL INTERCOURSE HOMEWORK: MAY 23, 1996

Sometimes when people are attracted to each other they spend a lot of time together. They may go out on many dates and eventually they come to **trust** each other. When this happens they may decide to have an **intimate relatioship** and will do things with each other that we call **sexual play**.

1. List two activities that you think are sexual play. (Hint: one you do with your lips)

   i) ii)

It is important to talk to your partner to find out what sexual play and touching they enjoy. It is also important that your partner knows how you like to be touched and what sexual play you enjoy. Your partner will become **sexually aroused** when you hug, kiss and touch them during sexual play.

2. List 2 ways you can tell that a woman is sexually aroused.

   i) ii)

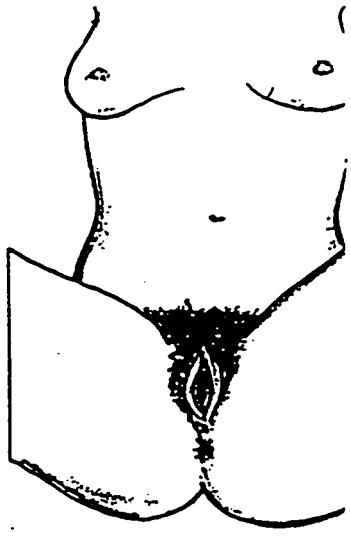
3. List 2 ways you can tell that a man is sexually aroused.

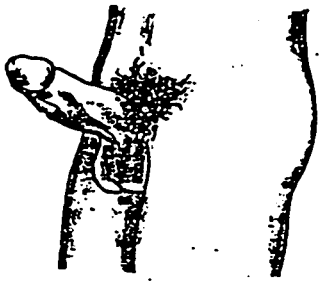
   i) ii)

Only when you and your partner both say yes and you want to, will you use your personal body parts during sexual play. Look at the pictures of the man and woman's personal body parts below.
The man's penis is hard and this means that he is sexually aroused.

4. What is it called when the man's penis is hard?

5. When the man and woman become sexually aroused he will want to put his penis in her vagina and if it is okay with the woman she will let him. Please draw a line from the man's penis to the woman's vagina.





6. What do we say the man and woman are having when the man puts his penis in the woman's vagina and moves it in and out?

Look at the picture below. This is a man and a woman having sexual intercourse. The man is on the top and the woman is on the bottom.

7. Does the man always have to be on the top for them to have sexual intercourse?

8. Does the man's penis have to be hard for the man and woman to have sexual intercourse?

9. What should both the woman and man do shortly after they finish having intercourse?

10. Can a man sexually touch another man and have intercourse with him?

11. Is it okay for a man to sexually touch another man if they both want to sexually touch each other?

12. Can a woman sexually touch another woman and have intercourse with her?

13. Is it okay for a woman to sexually touch another woman if they both want to sexually touch each other?

14. Is it okay to sexually touch or have sexual intercourse with a child?

HUMAN REPRODUCTION HOMEWORK: MAY 30, 1996

Please look carefully at the picture below and use the arrows to help you answer the following questions.

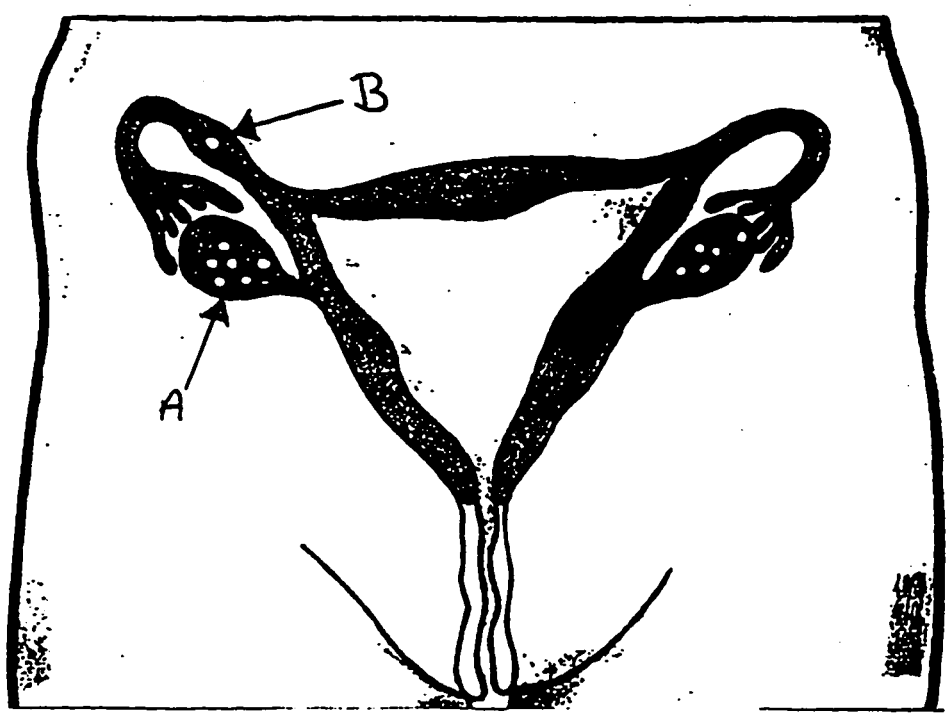
1. What do we call the white dots that arrow A is pointing to in the picture? (circle the correct answer)

   balls testicles eggs

2. Please look at arrow B. What is happening? (Where is this egg going?)

3. Are the eggs produced in a man's or a woman's body? (circle the correct answer)

   man woman



The man gently places his penis in the woman's vagina when they agree that the time is right to have "sex" or "sexual intercourse." The man and woman work together to move the penis in and out of the vagina. Eventually some fluid will come out of the man's penis and go in to the woman's vagina. Please look at the picture below and answer the following questions.

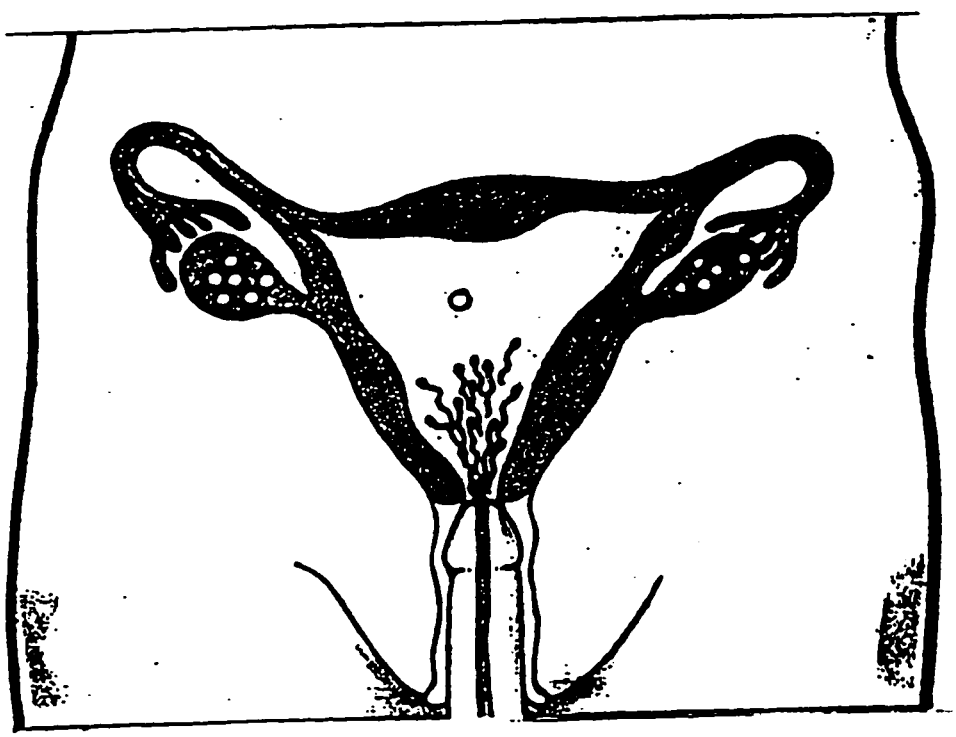
4. Draw a circle to show where the man's penis is inside the woman's vagina.

5. What do we call it when the fluid comes out of the man's penis and goes in to the vagina? (circle correct answer)

erection urination ejaculation

6. What are there many million of in the fluid that comes out of the man's penis? (circle correct answer)

urine blood sperm



The man and the woman are now finished having sexual intercourse. The man has taken his penis out of the woman's vagina but the sperm stays in her vagina. Look at the picture below and answer the following questions.

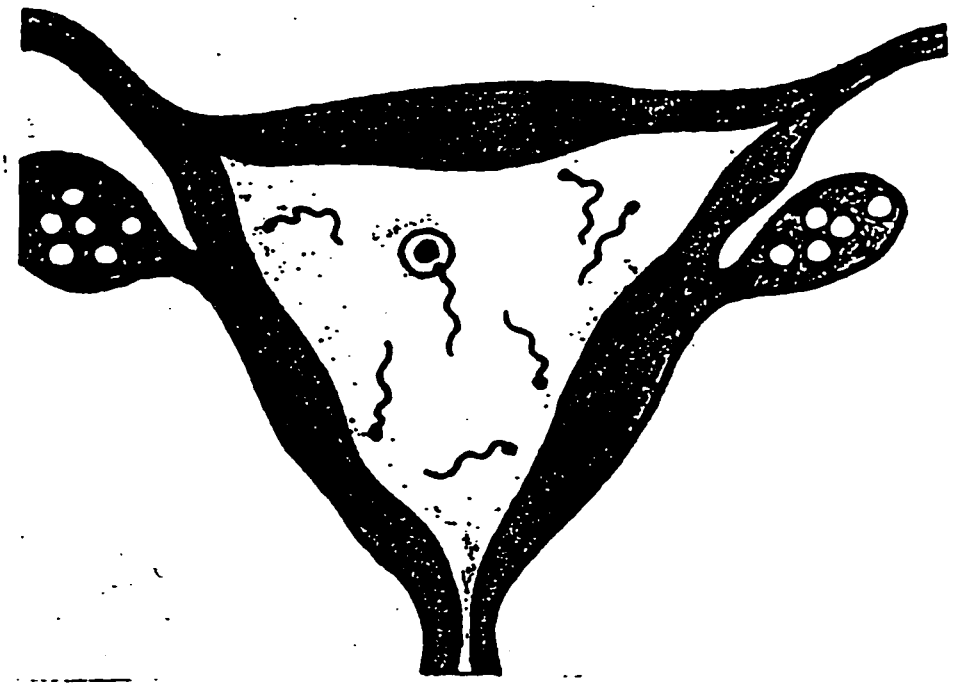
7. You will see that one of the sperm has found the egg. What is the sperm trying to do? (circle correct answer)

move the egg stop the egg get inside the egg

8. What do we call it when the sperm enters the egg in the woman's vagina? (Hint: not a hard concept)

9. Is the woman pregnant when the sperm enters the egg? (circle correct answer)

yes no

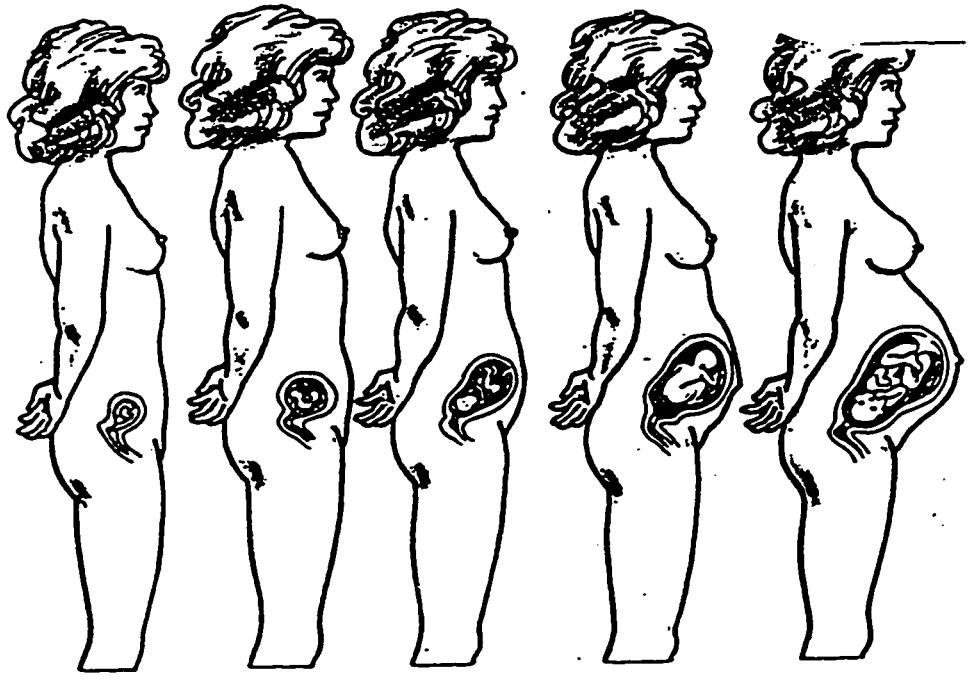


Look at the picture below and answer the following questions.

10. Is this woman pregnant?

11. How does the woman's body change so that you would know she is pregnant?

12. The baby is growing inside of the woman's uterus for approximately 9 months. Where does the baby come out of the mother's body when it is ready to be born?



Look at the picture below and answer the following questions.

13. What kind of pill do you think this woman is taking? (circle the correct answer and remember that we have discussed pregnancy)

aspirin tylenol birth control

14. Why would a woman take a birth control pill?

15. Does a woman need to see a doctor before she can get birth control pills?

16. Where can a woman go to get birth control pills after she has seen a doctor?

Look at the picture below and answer the following questions.

17. What is the man putting on his penis?

18. Why is he putting a condom on his penis? (remember that we have talked about pregnancy)

19. Does a man or a woman have to see a doctor before they can get condoms?

20. Where can a man or a woman purchase condoms?

Appendix I

SEXUALLY TRANSMITTED DISEASE HOMEWORK: JUNE 6, 1996

1. What words are the letters S.T.D. a short form for? (circle correct answer)

   a) Sex Treatment Doctor

   b) Sexually Transmitted Disease

   c) Sexuality Teacher's Device

2. What is a Sexually Transmitted Disease? (briefly describe)

3. Is it possible for a person to catch a Sexually Transmitted Disease by having sexual or anal intercourse with a partner? (circle correct answer)

   Hint: Remember that sexual intercourse is when the man's erect penis is in a woman's vagina and anal intercourse is happening when a man's penis is in either a woman's or a man's anus (bum).

   yes no

4. Is having sexual or anal intercourse the only way to catch a sexually transmitted disease from a partner? (circle correct answer)

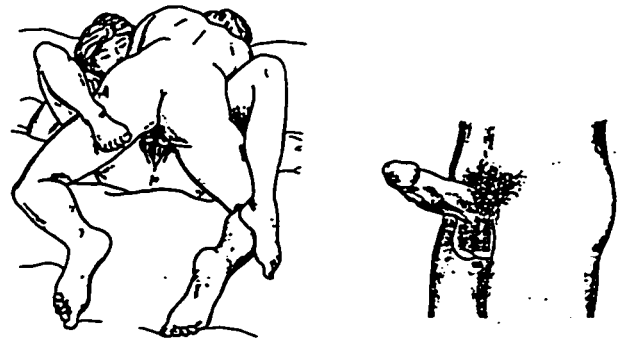
   yes no

5. Look very carefully at the pictures below. Draw a circle only around the pictures that show the behaviours which can result in a person catching a Sexually Transmitted Disease.

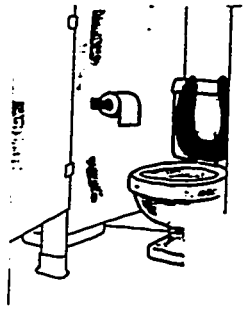
   Under all of the pictures write one word or a short sentence to describe what you see or what is happening in the picture.

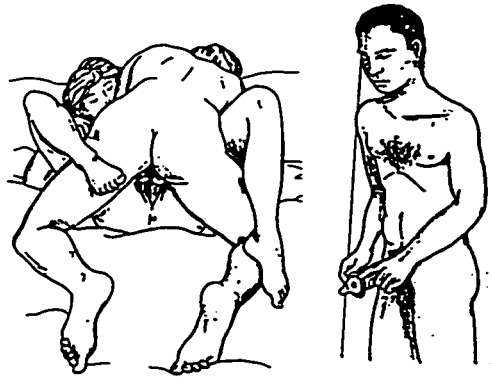
6. Look very carefully at the pictures below. Draw a circle only around the pictures that show the behaviours which can result in a person catching a Sexually Transmitted Disease.

Under all of the pictures write one word or a short sentence to describe what you see or what is happening in the picture.



Hint: They are having sexual intercourse but the man is not wearing something

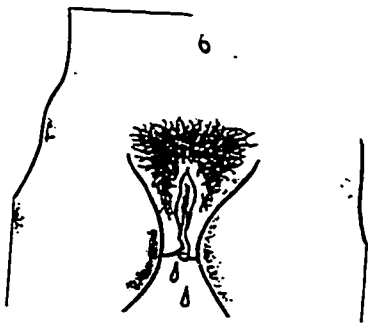


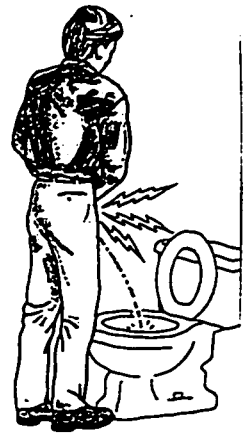


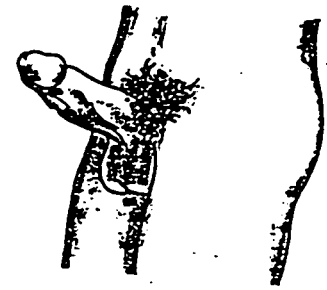
Hint: They are having sexual intercourse and the man is wearing something

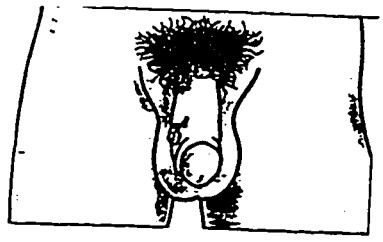
7. How can you tell if you or another person has a Sexually Transmitted Disease? (Look very closely at the pictures below)

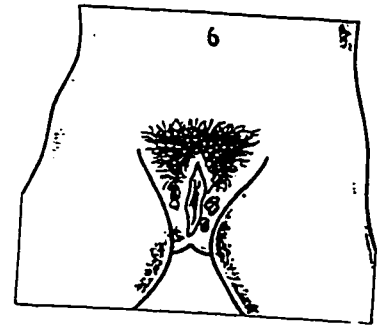
Circle the pictures in which you think the person in the picture has a Sexually Transmitted Disease. Write one word or a short sentence about how you know the person in the circled picture(s) has a Sexually Transmitted Disease.

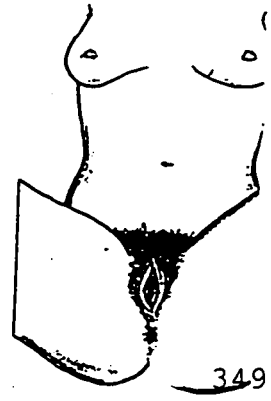


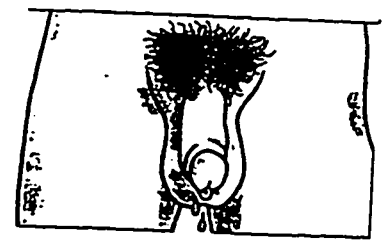












8. Who can you tell if you think you have a Sexually Transmitted Disease? (circle correct answer[s])

postal worker	nurse	police officer
counsellor	bus driver	medical doctor

Catching or having a sexually transmitted disease can make a person very sick and in some cases a person can even die. It is very important to tell your counsellor, a nurse or a doctor as soon as you think you might have a sexually transmitted disease.

There is medicine you can take for some sexually transmitted diseases and because of the medicine you will get better and the disease will go away. Unfortunately there are some sexually transmitted diseases for which there is no good medicine and no cure.

Do not let sexually transmitted diseases make you afraid of sexually touching or having sexual intercourse with someone you care very much for, you have known for a long time and you trust. There are ways you can protect yourself from catching a sexually transmitted disease!

9. Can you list three ways to protect yourself from catching a sexually transmitted disease?

1)

2)

3)

Appendix J

COMMUNITY AWARENESS AND SEXUAL ABUSE PREVENTION HOMEWORK: JUNE 13, 1996

1. Should you open the door to let a stranger in if you are at home alone? (circle correct answer)

Yes No

2. Should you let a stranger in to your house to use the telephone if you are at home alone? (circle correct answer)

Yes No

3. Is it okay to get into a car with a stranger? (circle correct answer)

Yes No

4. Is it okay for someone to touch your body if you do not want them to? (circle correct answer)

Yes No

5. What do we call a person's behaviour if they continue to you after you have said no? (circle correct answer[s])

illegal appropriate sexual assault rape

6. What will happen to a person if they continue to touch you after you have told the person to stop touching you? (circle correct answer[s])

arrested by police nothing go to jail

7. Is it okay for you to touch someone that does not want to be touched? (circle correct answer)

Yes No

8. What could happen to you if you do touch someone who does not want to be touched? (circle correct answer[s])

arrested by police nothing go to jail

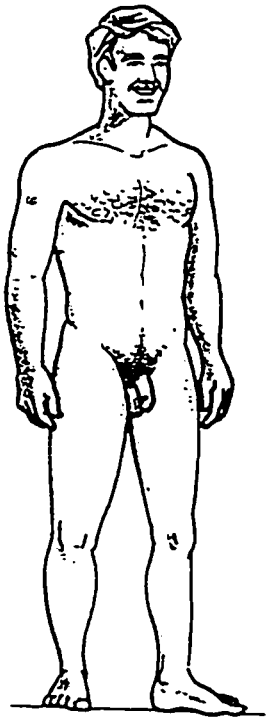
9. Is it okay for your boyfriend or your girlfriend to sexually touch you or to make you do something sexual if you do not want to? (circle correct answer)

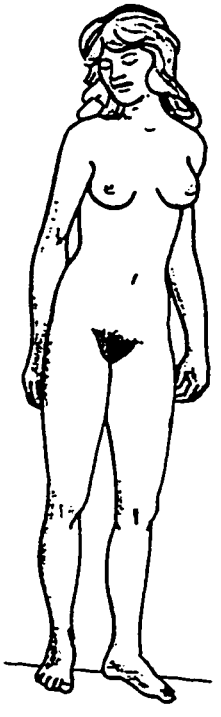
Yes No

10. Is it okay to let someone sexually touch your body if they give you money or buy you a gift? (circle correct answer)

Yes No

11. Please look very carefully at the pictures and draw a circle around the man's and woman's private body parts.





Although people should not touch any part of your body unless you say it is okay, there are people who should never sexually touch your vagina and breasts if you are a woman or your penis if you are a man. Look carefully at the pictures below and draw an X through the picture of the people who should never touch your private body parts when you are an adult man or woman.

Mother/Father

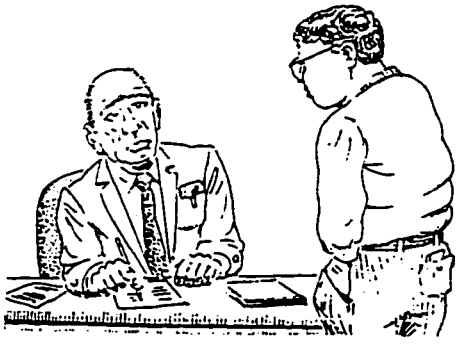
Dentist

A Stranger

Counsellor

Nurse

Brother/Sister



Teacher

Doctor

12. Now carefully look at the pictures that you did not put an X through and draw a circle around them.

The people you circled may have to touch your private body parts but only when they absolutely have to in order to help you.

13. When would it be okay for your Doctor to touch your breasts, vagina or penis?

14. When would it be okay for a nurse to touch your breasts, vagina or penis?

15. Should a Doctor or a nurse ever touch your private body parts in a sexual way?

Yes No

16. Please look carefully at the pictures one last time. Should you touch the private body parts of the people in the picture?

Yes No

17. What should you do if a person is trying to sexually touch you or make you sexually touch them and you do not want to be sexually touched or do not want to sexually touch them? (Circle correct answer[s])

a) sexually touch them even though you do not want to

b) let them sexually touch you even though you do not want them to

c) Yell or shout: Stop!! No!! and then run away from the person and tell someone you trust.

d) If you cannot get away from the person yell or shout: Help!! or Fire!! or blow a whistle if you have one.

18. If a person has been sexually touching you or making you sexually touch them and you know it is wrong and want it to stop, who can you tell and why would you tell that person?