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СТАТЕВЕ ВИХОВАННЯ РОЗУМОВО ВІДСТАЛИХ ОСІБ У КОНТЕКСТІ СПЕЦІАЛЬНОЇ ОСВІТИ І АНДРАГОГІКИ

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Зміст статті зосереджено на висвітленні питань комплексної реабілітації осіб з особливими потребами з позицій міждисциплінарного підходу. Основний вектор статті спрямований на розгляд надійного науково-теоретичного фундаменту та змісту організації статевого виховання осіб із розумовою відсталістю у контексті спеціальної педагогіки та андрагогіки.

Втілення принципу гуманізації та нормалізації, як основоположного відповідно до концепції функціонування World Health Organisation (Світова Організація Здоров'я) (2011) у процесі обговорення питань реабілітації осіб з особливими потребами, передбачає досягнення оптимального рівня фізичного, сенсорного, інтелектуального, психічного та соціального розвитку. При цьому реабілітація забезпечує необхідний інструментарій для досягнення можливого рівня незалежності та самовизначення, оскільки її сучасне тлумачення передбачає не лише заходи медичного спрямування, а й соціального, освітнього та трудового, що становлять повноцінне життя індивіда (Reynolds and Fletcher-Janzen, 2000). До базових завдань комплексної реабілітації також входять профілактика та нівелювання негативних чинників, які можуть супроводжувати життя людини з особливими потребами. З огляду на це підґрунтя, особливої актуальності набуває проблема статевого виховання осіб з розумовою відсталістю, яка оптимізує науковий пошук, об'єднуючи зусилля багатьох фахівців: гінекологів, сексологів, урологів, психіатрів, спеціальних педагогів, психологів, соціальних працівників, батьків тощо. Це, зокрема, викликає необхідність детального розгляду існуючих моделей розумової відсталості, їх кореляції із ступенем прояву статево-вікових особливостей розвитку, що дає змогу диференційовано підійти до розробки змісту методики статевого виховання підлітків, а також дорослих із розумовою відсталістю, та репрезентовано у вигляді теоретичної стратегії та конкретних практичних прикладів.

Ключові слова: особи з розумовою відсталістю; гендерні права, потреби, обов'язки та інтереси; статеве виховання; принцип гуманізації та нормалізації.

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ПОЛОВОЕ ВОСПИТАНИЕ УМСТВЕННО ОТСТАЛЫХ ЛИЦ В КОНТЕКСТЕ СПЕЦИАЛЬНОГО ОБРАЗОВАНИЯ И АНДРАГОГИКИ

Содержание статьи сосредоточено на освещение вопросов комплексной реабилитации лиц с особенными потребностями с позиций междисциплинарного подхода. Основной вектор статьи нацелен на рассмотрение надежного научно-теоретического фундамента и содержания организации полового воспитания лиц с умственной отсталостью в контексте специальной

педагогики и андрагогики. Детально рассмотрены существующие модели умственной отсталости, их корреляция со степенью проявления возрастных особенностей полового развития, что позволяет дифференцированно подойти к разработке содержания методики полового воспитания подростков, а также взрослых с умственной отсталостью, что представлено в виде теоретической стратегии и конкретных практических примеров.
Ключевые слова: лица с умственной отсталостью; гендерные права, потребности, обязанности и интересы; половое воспитание; принцип гуманизации и нормализации.

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SEXUALITY AND SEXUAL EDUCATION OF MENTALLY DISABLED PEOPLE – PART OF QUALITY OF LIFE IN REFLECTING SPECIAL EDUCATION AND SPECIAL ANDRAGOGY
The review is focused on the interdisciplinary issue related to complex rehabilitation of disabled persons. The sexuality issues of individuals with mental disability are subject to interest of special pedagogy from the aspect of content and process anchorage of education interventions. The principle of humanisation and normalisation in approaches to disabled persons in application means that the basis thesis that even adult individuals with mental disability have their sexual needs and under certain conditions may lead a relatively good quality partner and sexual life. The review contains description of sexuality of individuals with mental disability and also the possibilities of sexual education that from the competency point of view belongs to the field of special education.
Keywords: persons with mental disability, sexual rights, needs, obligations and interests, sexual education, sexuality of individuals with mental disability, quality of life, normalisation and humanisation as a principle of intervention

Complex rehabilitation and quality of life of people with mental disability

For some years in connection with disability, as well as mental disability the principle «people first» has been applied worldwide upon identification of persons with disability, which emphasises that first of all we are all people, with different traits, features, characteristics, properties and disability may be only one of them. Therefore instead of the generally accepted expression disabled, the collocation a person with disability or the characteristic ... having disability is preferred.

In 1980 the World Health Organisation (WHO) published the international classification of disability that in most of the countries became the basis for determination of disability definition, under the name *International Classification of Impairment, Disability and Handicap* (ICIDH).

This classification was elaborated according to Votava (2003) as a requirement for expression, organisation and classification of diseases and accidents included in the International Classification of Diseases. ICIDH-2 defined and classified 3 basic terms denominating functional changes due to disability:

1. At the level of organ or body system – ***impairment***
2. Functional change at the level of the entire individual, which limits the individual in his entire activity – ***disability***.
3. Impairment and disability in projection into the social level was called ***handicap***.

However, this classification proved to be insufficient since it was based on the morphologic criteria, organ or system impairment and was conditioned by the changes of this system with following limitation to the activities of the person with disability. Therefore in 2001 it was replaced by a new classification that is also used currently. The new version is called *International Classification of Functioning, Disability and Health* –

* *The scientific study presents partial results of the VEGA project No.*

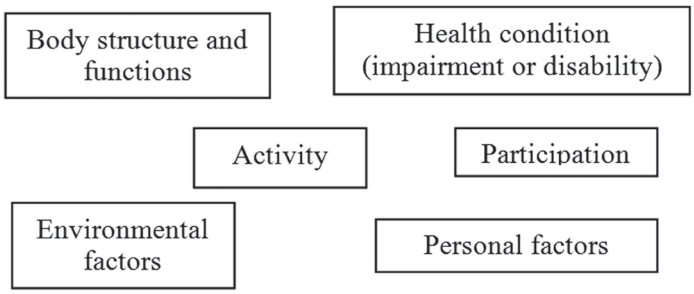
ICIDH – 2. The term *«function»* is an umbrella term for the state of somatic functions of activities and participation. The term *«disability»* includes physical disability, limitation of functions by pathological condition and restriction of possible participation in work and social life of the individual with disability. The new terms *participation* and *activity* also appear in the classification. Participation and life and work activities represent the social element and emphasise the basic characteristics of the bio-psycho-social model of the person and therefore it is a multi-dimensional model of the person with disability.

ICIDF – 2 emerges from four levels: the level of bodily and somatic functions, the level of body structures, and the level of activities and participation of the individual with disability in these activities, the level of environmental and personal factors that interfere with the health area. The classification involves findings on the functions and structures of human organisms, on its activities and participation in them and also characterises the environment and its impact on human health condition (Orgonášová, Palát, 2004).

It results from the above said, that the World Health Organisation in the classification (ICIDH-2, 2001) no more focuses only on diagnoses, but also on the limits of functioning that the given disability or impairment causes. This classification concept was developed according to WHO (ICIDH-2, p. 2001), mainly due to practical reasons since disabilities and impairments are not identical in the basic pathology but in manifestation of its appearances. It means that people with different «diagnoses» may have identical limitations in participation in everyday life activities, which significantly affect the global quality of their life, and vice versa.

Scheme 1

Model of disability according to WHO (ICIDH-2, 2001)



The disability model according to WHO is therefore focused on describing the entire dimension of being of an individual with disability. As no disability may exist without its carrier, the person with disability may not be considered without respect to their environment, personality, as well as the ability to participate in the happening in their environment and develop their own activities.

Vančová and Smolianinov (2009) also emerge from such holistic view of the individual with disability in their description according to whom *in case of a person with disability, there is disruption to the integrity of the organ or functional component, or both, which may be shown in temporary or permanent impairment of the scope that intervenes in the bio, psycho and social dimension of being.*

Thus we can observe that even in case of persons with disability based on CNS impairment may we can observe the changes caused by the presence of disability in the

biologic, psychic and social sphere, which significantly affects their education, later their employment and total socialisation.

The term rehabilitation is of Latin origin (*habilis* – able, *re* – restoration) and in general represents processes of restoring abilities upon non-development, loss or damage of certain functions of the person (Jesenský, 2000, p. 136).

The term rehabilitation may be therefore translated as making able again. From this aspect it refers to individuals, who were healthy and gained disability due to a disease or accident and rehabilitation enables them to return to full value life. In case of persons born with disability we should not talk about rehabilitation but habilitation, i.e. «making able» the person with disability to live a relatively full value life. However, this term is not widely used in our country and in case of both groups of people we use the term rehabilitation.

The World Health Organisation defines rehabilitation of people with disability as a process, whose aim is to achieve and maintain an optimal bodily, sensorial, intellectual, psychological and social functional level. Rehabilitation of persons with disability according to WHO (2011) provides tools necessary for achieving independence and self-determination.

It results from the definition of WHO that rehabilitation is currently not strictly perceived only as medical activity but it is rather an interdisciplinary discipline that pursues complex understanding of rehabilitation and apart from medical tools also involves other instruments – social, educational and labour ones.

Rehabilitation is similarly characterised by Reynolds and Fletcher-Janzen (2000) according to whom this term covers any process, procedure or program that enables persons with disability to operate at a more independent and self-satisfactory level. This activity should include all the aspects – bodily, mental, social, educational and labour-life of the individual.

A broad understanding of habilitation/rehabilitation started in the 90s of the last century also in important international documents focused on the support of human and civil rights of persons with disability and their families.

Standard Rules for the Equalization of Opportunities (accepted by the UNO in December 1993, in Slovakia in 1994) in rule 3 Rehabilitation it is defined as a set of programs that are aimed at helping people with all types of disability to compensate the impaired function, develop their independence and self-sufficiency in order to support their complex integration and equality.

Distinguishing medical rehabilitation from the complex understanding of rehabilitation is also applied in the Action Plan of the Council of Europe for enforcement of rights of persons with disability and their full participation in the society adopted in April 2006. Section 3.10 Rehabilitation indicates that *a coherent policy for the rehabilitation of people with disabilities should aim at preventing the deterioration of disability, alleviating its consequences, furthering the autonomy of people with disabilities as individuals and ensuring their economic independence and full integration into society*.

Within the **Convention** on the Rights of Persons with Disabilities approved in December 2006 in chapter 6 both terms are used – habilitation and rehabilitation as well (Repková, 2009).

According to Jesenský (1995) the term rehabilitation is of broad spectre and therefore it should be discussed as comprehensive rehabilitation – compact, complex, global or integral one. In our country the generally used term is complex rehabilitation.

Complex rehabilitation stems from holistic philosophy that deals with the unit and holistic entirety, and does not degrade the unit to a summary of parts but sees a mutual relationship and possibility of influence between them (Pavlíková, 2007, quoted according to Vančová, Prečuchová Štefanovičová, 2012). As mentioned by the authors (also)

the essence of this access is the process of care that represents a systematic intervention and complex solution of the client's problems – it is always focused on the entire being of the individual. The need to approach the person with disability in a complex way is closely related to it, and it emphasises the need of interdisciplinary cooperation and implementation of complex rehabilitation.

Vašek (2003, p. 116) defines complex rehabilitation as a *«summary of activities of multidisciplinary character focused on prevention, mitigation or elimination of adverse consequences of disability (defect) or impairment, and that mainly in favour of optimal socialisation.»*

It is a set of mutually tuned and connected activities of all participating experts in planned sequence or performed simultaneously in favour of socialisation of the individual with special educational needs (Vašek, 2003).

Milichovský (2010) defines complex rehabilitation as a society-wide system that represents a coordinated activity of all society components aimed at integrating the person with disability into active social life. Apart from the basic medical, social, pedagogic-educational and labour elements, according to him it also involves psychological, technical, legislative, economic, cultural, organisational and political aspects. The purpose of complex rehabilitation is to achieve minimum decline in the quality of life, achieve maximum independence and ensure active participation in life.

Prophylaxis and elimination of negative effects accompanying the life of a person with disability in the society can also be considered as the basic task of complex rehabilitation.

Recently there have been widespread discussions on the right of individuals with mental disability to partner and sexual life. This topic includes the opinions of individual experts, such as doctors (gynaecologist, sexologist, urologist, psychiatrist, etc.), special pedagogues, social therapists, but also of parents, relatives and last but not least of the actual person with mental disability. Public takes an inconsistent attitude to the sexuality of individuals with mental disability. A part of them is principally against since the governing opinion is that these individuals are asexual and therefore not capable of sexual activity. On the other hand voices are often heard emphasising and supporting the right of people with mental disability to sexual life. Thus if we talk about equalisation of persons with mental disability, we must take into consideration also this important aspect of their life.

At the beginning we will describe different models of viewing mental disability, which according to Lečbych (2012) present the main trends of its definition. The following models of mental retardation are considered. The models in question are the following:

Classification, limiting, medical model – currently the most widely spread in our cultural context. The term mental retardation in it defines individuals as having deficiencies in the field of development of intellectual abilities and adaptation difficulties. Due to orientation to patopsychology, limits and weaknesses of the individual this model is described as limiting and with respect to the effort to distinguish the scope of deficit severity we can mark it as a classification model.

Model of residential social care is philosophically close to the previous one and presents a relatively traditional model preferring a protected environment to a competitive and confrontation environment. The advantage of this model is that it provides care for people that due to any reason cannot live in their own natural environment (family, community) and mainly provides complex care. Specifically the last mentioned advantage is at the same time also the biggest risk mainly in case of people with light or medium level of mental disability since it cause dependence on other people, restricts initiative and may lead to their isolation.

The **descriptive model** was developed as an alternative to the medical model as it tries to prevent from the negative effects stemming from the use of diagnosis for human description. This concerns mainly the so-called putting on stickers, which is connected with stigmatisation, building prejudices by simplified perception of the person. The organisation «People First» mentioned in the introductory part of the chapter also belongs to this model. Its aim is not to understand mental retardation as the most important characteristic of the person but only as one of the many of his personal traits. The advantage of this model is mainly fighting against prejudices and stigmatisation of people with mental disability. The risk of the model is creating misleading and inaccurate descriptions, such as the term of people with special educational needs, unclear descriptions where it is not clear what type of disability it is and therefore even what type of intervention should be provided to this person. The definitions of this model are not united but the effort to see the person first is involved in all of them, in the context of ordinary life and ordinary activities.

Spiritual model of mental retardation is based on a complex, holistic understanding of the person in its physical, psychic and spiritual dimension. Apart from complexity and spiritual orientation, practical principles such as emphasising equality and partnership, support of mutual learning and mutual enrichment are important and emphasis is placed rather or human possibilities than on restrictions. This model is connected with the anthroposophic philosophy of Rudolf Steiner, or the so-called Camphill communities. (Lečbych, 2012).

The **ecologic model** is the last of the aforementioned models of mental retardation. This model also reflects the effort of integration movement aimed at solving mainly practical problems connected with the integration of people with mental disability. The primary prerequisite, as stated by Lečbych (2012), is that each person has the right to participate in the life of the society. This understanding of mental retardation currently dominates in the definition of the American Association on Intellectual and Developmental Disabilities (AAIDD), which defines it as an intellectual disability characterized by significant limitations in both intellectual functioning and in adaptive behaviour, which covers many everyday social and practical skills. This disability originates before the age of 18.

The intellectual function, i.e. intelligence, refers to the general mental capacity, such as learning, thinking and solving problems. One way to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 or as high as 75 indicates a limitation in intellectual functioning. Adaptive behaviour is the collection of conceptional, social, and practical skills that are learned and performed by people in their everyday lives. Conceptual skills include understanding of the language and literacy; money, time, and number concepts; and self-direction. Social skills involve interpersonal skills, social responsibility, problem solving, and the ability to follow rules/obey laws. Practical skills mean activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone. But in defining and assessing intellectual disability, the AAIDD stresses that apart from the above mentioned skills, additional factors must be taken into account, such as the community environment typical of the individual's peers and culture. Finally, assessments must also assume that limitations in individuals often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period (AAIDD, 2012).

Based on the above stated it is clear that in this model mental disability is not understood as an absolute characteristic of the individual but it is perceived in the con-

text of the so-called support system, such as interaction of the individual and environment with further factors and we cannot talk about mental retardation without having paid attention to the environment that the person lives in.

Adulthood specifics of people with mental disability

As it was mentioned above, adulthood may be generally characterised by attributes such as completion of study, getting a job, economic independence or getting married and establishing a family. However, the opportunities of people with mental disability are with respect to their handicap in the adult age often restricted from the aspect of achieving occupational, partner, as well as parent role and they often require a high rate of support for their handling. Adulthood is the period of free decision-making bound with responsibility for one's decisions and the ability to assume and fulfil the respective roles. As stated by Vágnerová (2004), an adult individual with disability creates a certain identity that also involves their disability. If they can count with the limitations brought to them by their disability, they can strive for their further development, which shall enable them to be an equal partner at the psychic level and is not only an object dependent on the care of another person. With regards to mental disability, these people have problems with realising their own role of an adult, which is not always in compliance with the responsibility and obligations that are expected from a mature adult individual. Despite this fact, people with mental disability have the same physical abilities as other people; however, they lack adequate cognitive and adaptive abilities owing to which their environment could consider them to be independent and often they do not even get a chance to show their abilities for independent and productive life in the society.

Bartoňová et al. (2007) describes the most common problematic areas that people with mental disability must face:

- **Taking a decision about themselves** – it means insufficient competencies for independent decision-making, individuals remain in the position of a dependent child even in adulthood.
- **Independent housing** is enabled in the form of protected housing.
- **Establishing partner relationships** either does not have to take place or there are no conditions created for establishing contract with the other sex. Mainly persons living in a family have this opportunity hindered, mainly by their own parents.
- **Sexuality need** is usually saturated by auto-stimulation. There might appear striking behaviour as sexual aggressiveness and there is also the possibility of being sexually abused by other people.
- **Parent role** is usually not fulfilled and regulation of parenthood is often recommended.
- **Pursue of profession** on the free market is not common. As a suitable form of pursuing a profession protected workshops are mentioned.
- **Economic independence** is usually not achieved; persons with mental disability are in general economically dependent on their families and the state.

It stems from the character of mental disability that not all people, with regard to insufficient competences for independent decision-making, are able to decide on life and work and even in adulthood they remain to a certain extent dependent on their relatives and on the society. The rate of dependence or independence of the person with mental disability is affected mainly by the level of mental disability. The development of social competences takes place mainly in childhood and adolescent age, however, they may also be developed in adult age, mainly within the framework of well-selected work activities during which they acquire new experience, establish new social relationships and achieve lifelong learning. Even if the persons with mental disability are mostly not able to fully assume the role of an adult and fulfil social roles expected from them, it

is necessary to support them in these efforts to the maximum extent in all areas and hereby to normalise their lives. *«Normalisation refers to employment, partner and family life, good quality spending of free time, opportunities of further education, offer of social services of different types, support of protected housing of persons, who even in adulthood are to a certain extent dependent on another person»* (Pipeková, 2006, p. 71). However, as it is pointed out exactly in the above mentioned areas people with mental disability experience certain limitations, which are given on one side by the depth of disability, as well as by the approach of the society that they live in.

Sexuality of individuals with mental disability

Sexuality of individuals with mental disability according to Marková and Truhlářová (In collective of authors, 2009) is characterised by certain differences:

- mutually from each other;
- in their levels;
- from one individual story to another individual story;
- as well as within the individual stories of these persons.

If we talk about the differences based on the level of disability, we can characterise sexuality of individuals with mental disability as follows:

Psychosexual development of *people with light disability* is disturbed to such extent that despite the disability it enables to create a partner relationship, which must operate well outwards. However, in case of parenthood there is the possibility of neglected and insufficient care for the child. People with light level of mental disability may lead a relatively normal sexual life in adulthood.

In case of *individuals with a medium level of mental disability* large individual differences appear; some of them are communicative, capable of integration and establishing interpersonal relationships and others find it hard to adapt in the social environment, and in some cases social situation is completed by the symptoms of autism. In general we can talk about two groups:

1. group – there is no effort to grow together; if the early stage of sexual development persists, the instinctive tension is discharged pregenitally (overeating, masturbation), it must be regulated in order not to limit or endanger other activities. Sexual behaviour of persons is of instinctive character and its aim is not to satisfy the psychical needs but the physical needs.

2. group – with the same rate of disability, the effort to establish relationship is visible, often connected with violent and aggressive behaviour, oriented rather to physical contact than to creating a psychic connection. Prevention of violence against the partner, forcing of sexual contact, (minimisation of stress, humiliation, and deprivation), development of interest, social skills in the manifested affection is important.

Different variants of interests and realisation of sexual life also stem from the individual differences:

- Division of the sexual and relationship component. Sexual instinct may be extinct or weakened; individuals do not need sexual life;
- Realisation of sexual needs in the form of auto-erotica. The need of sex and partnership is not interconnected;
- The effort to grow together, interest in sexual activities in a couple. It is a variant that ensures experiencing several positive qualities of human life.

People with hard and deep mental retardation usually do not have the need of an erotic relationship; they might satisfy their sexual needs only instinctively. Within the framework of their self-satisfaction it is suitable to ensure privacy and monitor whether there is no self-destruction; in case of sexual contact with another person it is necessary to monitor whether it is no undesired contact in case of either of the parties.

(According to Venglářová, Brožová, 2009; Švarcová, 2011).

If we also stem from the context of fertility, already Drobný, Drobný (1987) have stated that in case of serious mental disability there is infertility. According to whether individuals with mental disability are able to reproduce or whether they have or do not have children, we can divide them into two parts. The border between these two groups is represented in IQ values – it is in the range of between IQ 35 and 39.

According to Šustrová (2008), most of individuals with mental disability, just like in the general population, have their sexual organs developed. The desire for friendly and later also sexual relationship with their partners is also related to this. Most of the women are fertile and are able to conceive and deliver their child. In case of young men, save for some exceptions (boys with Down syndrome), sexual activity is also preserved.

Already in earlier literature (Kvapilík, Černá, 1990) it has been stated that currently certain sexual life is being counted with among people with mental disability; however, there differences compared to the general population, which depend on the level of mental disability, age and diagnosis. In general it is valid that the lower the disability, the more sexual development approached the normal one and the deeper it is, the less sexuality will appear. It is necessary to realise that people with mental development in sexual life these do not have to be only activities expressly of sexual character, such intercourse and masturbation but also mutual cooperation and better quality interpersonal relationships between men and women, temporary or permanent affection.

Man is a sexual being, regardless of the presence of mental, psychic, physical or sensorial disability. Expressions of sexuality are a natural and important part of human life. Sexuality of persons with mental disability develops in the general way. In the field of physical, biological sexuality they are usually at the level of the intact population, however, the emotional area of sexuality in case of people with mental disability is usually delayed or mistaken. Sexual development starts with the development of sexual identity that determines the rate to which each of us feels to be a man or woman, homosexual, bisexual or heterosexual (Valenta, Müller, 2005).

An important role in the development of sexuality among people with mental disability is represented by sexual education performed from early age and it should be focused on regulating the expressions of sexual behaviour, as well as on incidental sexual life with emphasis placed on contraception and protection from sexually transmitted diseases.

An important factor affecting the expressions of sexuality among persons with mental disability is apart from the age and sex also the level of disability. *«In general it is valid that the lower the disability, the more sexual development approached the normal one and the deeper it is, the less sexuality will appear.»* (Kvapilík, Černá, 1990, p. 74).

Even the methods used by them to satisfy their sexual needs depend mainly on the level of disability. People with serious and deep mental disability incline to auto-stimulation, while people in the zone of light or medium serious level of mental retardation are able to realise the role of man and woman in a relationship, as well as the terms of parenthood and marriage (Pipeková, 2006). People with a light form of mental disability do not have a markedly different sexual development from the general population, they do not even have specific problems in establishing contact and in adulthood they may actually lead a normal sexual life (Švarcová, 2011). However, the sexual needs of people with mental disability are different, and many of them find satisfaction even in a purely platonic relationship. The positive elements of partnership are pointed out by Valenta and Müller (2005) according to whom experience shows that people with disability living in a partnership are more mature, balanced, and independent and cooperate better. The desire for establishing a partnership among people with mental disability appears in the same way as with people free of any disability, while the partnership is often a confirmation of being full-valued and «normality».

The actual idea of partnership in case of people with mental disability is different, in many cases infantile. The partnership of people with mental disability does not have a standard character in each case, and often it is expression of the desire for a close person. The need of partnership does not always have to appear and an adult person with mental disability may lead a fully saturated relationship with the mother or other members of the family. Many relationships include only rare social activities, most often within the employment or leisure time facility that they attend. Currently some of the facilities enable for adults with mental disability to live in a partnership with respective contraception and social support. In families it is usually not the case and in most of the cases parents try to present their child from a partnership, mainly due to the reason that it seems inappropriate to them and are afraid of undesired pregnancy (Vágnerová, 2004). Plesníková (2004) dealt with the opinions on sexual issue from the aspect of parents of adults with mental disability. The research results showed that from the sample of 173 parents 84 % agree that persons with mental disability have the right to sexual life, 54 % think that their child should live in a certain partnership relation, 30 % of the parents were willing to accept marriage of their child and only 6 % of them think that their child should become a parent and have a child.

Regulation of parenthood in this case is considered suitable also by Vágnerová (2004) since people with mental disability usually do not have the ability to assume the parent role and no necessary responsibility may be expected from them. As stated by Valenta and Müller (2005), in the question of persons with mental disability there are many discussions conducted with different opinions, ranging from completely liberal to restrictive ones. The basic fears include the already mentioned distrust in taking care of the child at a good quality level and fear from heritability of the disability. However, as they state, the incidental fears of parenthood should not in any case make implementation of a partnership relation impossible.

The problem of sexuality of people with mental disability includes the opinions of individual experts from the field of medicine, such as neurologist, gynaecologist, sexologist, psychiatrist, but also special pedagogue, social therapists and last but not least of parents of these individuals. Mandzáková (2011) in her research monitored the attitudes of the interdisciplinary team of experts to the sexuality of people with mental disability. The research results show that experts are partly and with certain limitations able to accept their sexuality and implementation of sexual education in case of persons with mental disability. They are partly able to recognise sexual rights to them and self-control over their sexual behaviour, as well as the possibility to satisfy their sexual needs, however, without the possibility of reproduction. A negative attitude to parenthood of persons with a more serious form of mental disability within the reviewed group of experts, except for gynaecologists, was assumed by psychologists, psychiatrists and professional employees of social care facilities. A similar research was conducted also by Spilková (2004) among the employees of social care facilities for people with mental disability. The right to sex was recognised by 83 % of respondents, 82 % accepted the possibility of partner relationship, marriage was accepted by 48 % of the respondents and parenthood of people with mental disability only 5 % of the respondents.

The opinions of respondents in these researches on the examined questioned are basically identical. We hold the opinion that for appropriate fulfilment of needs in this area of the life of people with mental disability preparation for sexual life and prevention of sexual abuse of these persons is important in the form of adequate sexual education. Brožová (quoted according to Švarcová. 2011) defines four basic areas that sexual education should deal with:

- What is sexuality;
- How to handle it;
- What ways are suitable and what are unsuitable;
- How to cope with threat in this field.

In our opinion, in sexual education attention should be paid to the actual creation of partnership, where apart from the lack of opportunities mainly in case of individuals living in a family, the problem is insufficient self-confidence and difficulties in communication. Another problem in this field is inability, unpreparedness of these individuals to assume the role of a partner and maintain an adequate partner relationship. And right here sexual education plays a significant role within which it is necessary to provide people with mental disability with appropriate support in the partnership field, train conduct in different situations, help in creating the necessary habits and competences for handling the partner role.

According to Šustrová (2008) in sexual education it is necessary to include people with mental disability into education groups according to their individual cognitive abilities so that the group joins individuals at approximately the same level of mental, social and related sexual development and not according to the physical age, while in case of each person with mental disability it is always necessary to find out their individual development need.

In sexual development of people with a light or medium level of mental disability we place emphasis on education in the social area. The ability to talk together, understand each other and solve conflicts. Information must be provided to client in short, very certain form and use easy terms. The best way of learning is through playing and experience from playing. Appropriate topics are: male and female difference, maintaining body hygiene, cultivation of sexual instinct (learning the principle that sexual behaviour is an intimate matter and should not be expressed in public), orientation in who is a stranger and who is a friend, when it is necessary to hinder expressions of affection and how to protect themselves from sexual violence, friendship, and love. The most suitable methods of sexual education include the dialogue methods (free or directed dialogue), staging methods (thematic and role plays, puppet and hand puppet show), labour methods (handwork, cooking, working in a workshop, cleaning works), music therapy (dancing, playing musical instruments) and sports (Mokrá, 2013).

The situation of persons with a medium to serious level of mental disability is difficult, as also stated by the above mentioned author. Only few of them achieve such level of independence that enables them to live in a natural partnership, without the supervision of parents or caretakers. In most of the cases they do not incline to coital sex and if a behaviour resembling masturbation or onanism occurs, then it is only contact with their sexual organs, accompanied by pleasant experience but it is not a goal-targeted and specifically realised behaviour.

In the zone of deep mental retardation it is apparently out of question to consider any sexual education. In case of some disabled persons we can see experiencing of delight, for example as a reaction to touches, however, it is disputable whether and to what extent it concerns expressions of sexual instinct. Due to the deep level of mental disability the expressions of sexual instinct are usually permanently latent – Mokrá (2013).

Each individual, just like an individual with mental disability, is a bio-psycho-social-spiritual being and as in case of such basic components of good quality human life should be respected, which are:

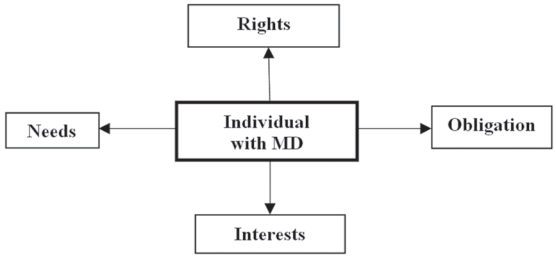
- needs,
- rights,
- obligations,
- interests.

From the aspect of sexuality of individuals with mental disability, the *right* to partnership is anchored in the Universal Declaration of Human Rights (Article 16) where it is stated that «Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family.»

(Available at: WWW: http://www.amnesty.sk/article_files/file/UDHRvSVK.pdf, cited 13.9.2012, 21:35).

Scheme 2

Components of the quality of life of an individual with mental disability



It means that individuals with mental disability have the some right to establish relationships with the opposite sex, live in a partnership relation, and have a sexual life. In case there is condemnation of the sexuality of people with mental disability or if it is made impossible, it is an illegal conduct.

According to Mitl hner (In collective of authors, 2004) these problems are addressed in the Charter on Sexual and Reproductive Rights, adopted in Valencia, which covers all human beings, not excluding even individuals with mental disability.

The Charter on Sexual and Reproductive Rights of the International Planned Parenthood Federation (IPPF) is a reaction to the need to have sexual and reproductive rights defined in the context of human rights. The entire charter defines 12 rights – all of them appear in international documents on human rights, including the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women and Convention on the Rights of the Child. All these rights are taken over from sources that are of international character:

- The Right to life;
- The Right to Liberty and Security of the Person;
- The Right to Equality, and to be Free from all Forms of Discrimination;
- The Right to Privacy;
- The Right to Freedom of Thought;
- The Right to Information and Education;
- The Right to Choose Whether or Not to Marry and to Found and Plan a Family;
- The Right to Decide Whether or When to Have Children;
- The Right to Health Care and Health Protection;
- The Right to the Benefits of Scientific Progress;
- The Right to Freedom of Assembly and Political Participation;
- The Right to be Free from Torture and Ill Treatment;

(The Charter on Sexual and Reproductive Rights IPPF, available at WWW: http://www.rodicovstvo.sk/ippf_charta.htm, cited 19.9.2012, 14:36)

The World Health Organisation (WHO) considers it important to respect the following sexual rights:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;

• consensual sexual relations;
• consensual marriage;
• decide whether or not, and when, to have children; and
• pursue a satisfying, safe and pleasurable sexual life.

(Available at: WWW: http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/, cited 17.9.2012, 22:02)

On 1st December, 2006 the UNO adopted Convention on the Rights of Persons with Disabilities and its Optional Protocol (hereinafter referred to as «Convention»). The President of the Slovak Republic signed the Convention and the Optional Protocol on 26th September, 2007. The Slovak Republic hereby manifested its will to become in the future a contracting party to the Convention and to ratify the Convention. The purpose of the present Convention is «to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.»

(Convention on the Rights of Persons with Disabilities, 2009, p. 3 – 5)

Thus it is important, based on the Convention, to respect all rights of individuals with mental disability, also the right to partnership and sexual life. In Article 23, inter alia, it is mentioned that States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;

b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;

c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

(Convention on the Rights of Persons with Disabilities, 2009, p. 37 – 38)

Needs in general represent one of the motives and drives of our behaviour and activity.

Murray (quoted according to Jesenský, 2000) distinguishes the following needs that also include the need of sexual activity:

Table 1

Division of needs according to Murray

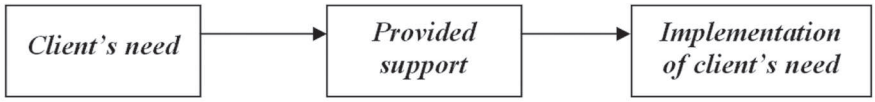
a. biogenic needs	need of	need to avoid
	oxygen	harmful substances
	water	heat
	food	cold
	impressions	accident
	secretion (sexual, lactation)	
	breathing out carbon dioxide	
	urination	
	defecation	
b. sociogenic needs		

Švarcová (2011) indicated that sexual needs are one of the normal human needs also in case of people with mental disability. The expressions of their sexuality, however, may be perceived by their environment as undesirable since in the foreground they see disharmony between their «childish» thinking, behaviour and sexual needs.

Each individual with mental disability has different needs as far as partnership and sexual life is concerned. It is necessary to respect it and provide support upon its implementation, as we can see in the following scheme according to Koz kov (In Collective of authors, 2004):

Scheme 3

Support upon the implementation of client needs



Obligation as a component of the quality of life of individuals with mental disability must be understood as an activity, action, which enables to the disabled person to really utilise their abilities in favour of the society so that they take them for their own. Each intact member of the society is confronted with everyday obligations that they must meet. If we want individuals with mental disability to live as normally and good quality life as possible, they should participate in functioning of the society (certainly with respect to the severity of their disability).

According to Šprunk (1998), the term obligation has two meanings:

1. It identifies what is mandatory, i.e. Behaviour, action having the quality «to be obliged», and/or is the subject of obligation.
2. Identifies the property that makes something mandatory.

In the sexuality context of individuals with mental disability we can talk about obligation towards:

3. Themselves – respecting their own bodily integrity, sexuality;
4. Their partner – respecting their bodily integrity, sexuality;
5. Society – respecting and compliance with moral, ethical and legal norms.

According to Pružinská (2005, p. 68) *interests* may be characterised as a tendency to selective activity. According to the author, interests can be divided into three groups:

• interests in ideas, thoughts (scientific, literary, aesthetic perception and expression);
• interests in people (contact – meeting people for some profit, social – interest in people as such);
• interests in things – collecting and sorting material, working with things, dealing with animals and plants).

Upon practical evaluation of human interests it is relevant to find out:

• width (wide – wide interests);
• depth (superficial – deep);
• durability (durable – temporary);
• activeness (active – passive);
• isolation – relation with other sides of the personality (with abilities and temperament).

(Pružinská, 2005, p. 69).

Even despite their disability, individuals with mental disability have the right to their interests and their implementation. It often happens that they are interested in such activities that are not suitable for them with regard to the type and level of their disabil-

ity. Here the role of parents, social therapists, and personal assistance is important, or in the preparation of children, the role of teachers and educators is important in order to help the person with mental disability to select a suitable activity, which would enable them to adequately fulfil their interests.

Interest in friendship, partnership and the related sexual life are typical for each person. The width and depth of this interest is closely related to the level and type of mental disability of an individual.

In connection with socialisation and sexuality of adult individuals with mental disability, at the end we present some recommendations according to Matulay (1986), also valid at the present (adjusted by Prečuchová Štefanovičová):

• Complex rehabilitation must be applied not only in case of children and youth but also in case of adults with mental disability.

• To train adults with mental disability to the highest possible rate for work in protected workshops, or at a protected workplace.

• An important part of complex rehabilitation of adults with mental disability is also development of motor skills and participation in recreation and sports.

• Education of adults with mental disability must be lifted up to the present level of technical progress.

• Passive charity must be replaced by active methods of how to accept the adult individual with mental disability into the society.

• To influence the society to better understand adult individuals with mental disability and take them as they are.

• Until recently, the society anxiously tried to avoid the question of sexuality and erotica of persons with mental disability, although it concerns natural human needs. It is necessary to pay higher attention to this topic.

• Common stay of both sexes in a social care facility showed to be useful. Mutual social contact brought satisfaction of institutional conditions, enhanced socialisation as well as the possibility of more frequent leaving of the facility.

• Special pedagogues and social therapists shall be given an increased task to explain the questions of sexuality so that people with mental disability are prepared for life also from this aspect.

• Training of all employees in the questions of sexuality of persons with mental disability should be natural.

• Cooperation with parents is highly desirable.

Sexual education of individuals with mental disability

Sexual education of persons with mental disability is an important part of preparation of these individuals for active sexual life without any physical and psychic risks.

As stated by Šustrová (2008), sexual hygiene and sexual life are issues that in the past the society tried to avoid as sensitive issues, even if they form a part of full quality life. Sexual hygiene and sexual education of people with special needs should be in principle the same as of people without this disability; it just has to be adjusted to their understanding and level of disability.

In general there are four basic areas of questions that sexual education should deal with:

1. What is sexuality.
2. How to handle it.
3. What ways are suitable and what are unsuitable.
4. How to cope with threat in this field.

(Brožová, quoted according to Švarcová, 2011)

According to Popper (2002) sexual education of people with mental disability should be oriented to four groups:

1. Group – future trainers and teachers of sexual education of individuals with mental disability, while courses should be focused on the following topics:

- Equality and human rights;
- Knowing one's own body;
- Increase of self-respect and self-confidence;
- Creating friendly and partner interpersonal relationships;
- Masturbation and non-coital activities;
- Pregnancy, delivery, family;
- Protection from undesired pregnancy, sexually transmitted diseases and HIV;
- Resisting sexual coercion and abuse;
- Gender specifics;
- Particularities of the sexuality of people with mental disability where it is necessary to respect mainly the level of disability and biologic, psychological and social age of individuals in the target group.

2. Group – staff, taking care of people with mental disability, while McCarthy and Thopmson (1997, quoted according to Šustrová, 2008) emphasise that education in the field of sexuality is useful not only for the actual people with special needs but also for the staff and due to these reasons:

- they better realise that even people with specific needs are sexual beings, that their sexuality in principle does not differ from the sexuality of anybody else;
- they will support and enable sexual education of people with specific needs;
- unlike until now, they will not be afraid of the consequences of sexual life of people with specific needs;
- they will be better informed on the particularities related to the mutual partnership relations and sexuality of people with mental disability, which are different from their own experience;
- they will further spread optimal strategies (health care policy) and methods of working with people with mental disability in the field of sexuality and where none exist, point out the need of their creation;
- they will increase their self-confidence in case they undertook sexual education of people with specific needs.

3. Group – parents of people with disability. They should also participate in programs of sexual education in order to understand the sexual needs of their children, not to be afraid of their expressions of sexuality but on the contrary to be able to provide them with adequate support. (Popper, 2002).

4. Group – individuals with mental disability, who form the most important target group of sexual education. The topics of sexual education are similar to the ones in case of the target group of future trainers and teachers of sexual education of individuals with mental disability. According to the sexologist (Procházka, In Collective of authors, 2009) sexual education in case of sexually healthy persons with mental disability should also include the following points:

- Count with lower understanding but select concrete terms, and explain (repeatedly).
- Vulgar expressions lead to emotional reactions and loss of attention.
- Count with faster fatigue (distribute into several blocks).
- Count with internationalised negative attitudes to sexuality and overcome them.
- Use tools, non-verbal communication.
- Integration of sexuality into social relationships, creation of conditions for the sexual life of clients (privacy, tolerance, openness in communication).
- Masturbation is possible but not the only possibility of sexual discharge (pollution, orgasm in sleep).

• They may experience anything but must behave responsibly.
• An individual with mental disability may fall in love with the caretaker, social therapist, but the responsibility is always on the worker.
• Sexual tools represent a risk – seizure in the cavity, injury, hygiene.
• Cognitive handicap does not mean an emotional handicap.
• Strive to present moral principle without moralising.

According to Šustrová (2008), it is necessary to inform on the sexual education of people with special needs parents and other relatives. The ones who are in daily contact with people with special needs, might be helpful in their sexual education. Emphasis must be placed also here on individual approach and in the form of conversation the ability of understanding the given topic must be monitored continuously. It is necessary to repeat again in sexual education that violence in mutual relationships and sex is inadmissible.

Example of implementing sexual education under the conditions of social care facility

Sexual education under institutionalised conditions conceals several hazards. Certain conditions of sexual education implementation should be fulfilled, e.g. co-educational character of the facility, possibility to establish social contacts with the broader environment, integration of clients into the society, reduction of the number of clients in the rooms, enough privacy and respecting of the intimacy of clients.

We present one of the possibilities of sexual education implementation under institutional conditions.

Sexual education in the Social Care Facility of prof. Karol Matulay for children and adults in Bratislava

Targets of sexual education:

• By expression tools, such as movement, gesture, haptics, explain the topic of human sexuality and emotional affection to clients.
• Take into consideration the needs and imaginations related to the behaviour of men and women, support individual attitude to own sexuality.
• Teach the clients that within their possibilities they have the right to freely develop and make decisions for development of their personality.
• Assumption of responsibility for own sexual life and behaviour – «Only as many rights as responsibilities!»

Criteria for the selection of clients:
• Approximately the same mental and social age
• Willingness of parents to communicate and cooperate in the given topic
• The same number of boys and girls
• Small community (max. 8 clients)

Criteria for lecturer selection
• The graduate from the training Sexual Education for People with Specific Needs.
• Experience in working with clients with mental disability.
• Man – in all facilities of social services the male model is absent.
• In case of some topics, the partner will be the female employee of DSSpKM.

Thematic plan – Sexual education
November:
• **Monthly topic:** «GETTING TO KNOW THE GROUP»
• Initiation, mutual getting to know each other, expression of trust
• Forming social and personal rules, group secret

• Distinguishing the sexes MAN – WOMAN, common and different signs
• Creating a mosaic from pictures (man, woman, child) – 1st common group activity

December:
• **Monthly topic:** «MY BODY»
• Perception and experience from own body (feelings and their expression)
• MAN – WOMAN – identification (own) – body signs, expressions, clothes, gesticulation
• Creation of a Man and Woman collage – 2nd common group activity

January:
• **Monthly topic:** «FEELINGS AND NEEDS»
• What is pleasant and what is unpleasant
• What they like wearing MAN – WOMAN
• What presents are suitable
• Own identification

February:
• **Monthly topic:** «ADULTHOOD»
• MAN – WOMAN – CHILD
• I am an adult – and now what?
• Love... the most pleasant thing in life

March:
• **Monthly topic:** «I LIKE»
• Love – Feelings – Sex
• I also like
• Careful with people that I do not know

April:
• **Monthly topic:** «HYGIENE»
• MAN – WOMAN – body, sex, hygiene
• Do I take care of myself, how?
• I want to appeal to others
• Protection from diseases and abuse

May:
• **Monthly topic:** «SEXUAL SIGNS»
• Secondary sexual signs
• Sexual organs of a man and woman
• I also have a sexual organ

June:
• **Monthly topic:** «EVERYTHING HAS ITS TIME»
• LADY – GENTLEMAN
• Group games – playing the role of a doctor, friends, partners, parents, etc.

(Arpáš, Kruzslíková, 2011)

At the end we present the problematic areas that might occur upon the implementation of sexual education under institutional conditions, as published by Kozáková (In Collective of authors, 2004).

a) Problem areas related to possible risks of a «residential facility»:

• Big «residential facility» (risk of loss of privacy, isolation, abuse, confusion of roles, necessity to adjust to the regime, needs of other inhabitants).

• No co-educational types of facilities (often pseudo-homosexual relationships).
• Lack of privacy of clients.
• «There is no time» to solve «such problems».
• Conduct not always in the interest of the client (often own comfort).
• Unnatural character of institutional care (e.g. in facilities with stay all the year round lack patterns from the family).
• Insufficiently treated «basic rules» of partnership and sexuality of persons in facilities – unity is substantial in the procedures and approach to staff.

b) Problem areas related to the specifics of teaching individuals with mental disability:

• The general specifics of teaching persons with mental disability are reflected into sexual education.
• Interpretation is not enough, they are not able to transfer experience to the type situation, forms of work used with the intact population are not sufficient, necessary to have a higher level of specification and demonstration, adequate information but also training of social skills.
• The imaginations of clients without sexual education and possibilities of natural contact with the opposite sex are often idealised, unreal, the patterns are often romantic films.
• Clients are often not able to enforce their rights.
• Often problems when getting to know persons, which are in many cases supported by limited contact with the world around.

c) Problematic areas related to the attitudes of staff and parents:

• Own inhibitions of the person, shame.
• Shyness to discuss incidental problems with the parents of the child.
• Prejudices, taboo issues, «closing eyes» before the problems – trying to solve them «quietly» and as fast as possible.
• Approaches that situate the client into the role of a lifelong child.
• Punishment (without explanation) for sexual expressions (masturbation).
• Evaluation based on our perception of «normality» – we do not stem from the needs of the client but from what we consider to be «normal».
• Application of our own values and attitudes.
• Insufficient preparation of the staff working with the clients – how to react and adequately solve the problems.
• Lack of literature, specialised trainings, training of psychosocial skills.
• Unwillingness to take interest in the problem.
• Attitudes of the facility in conflict with own attitudes.
• Disagreement in the wishes and attitudes of the parents and the facility.
• Cooperation with the family that does not want to hear about the problem.
• Unsuitable presentation of sexuality by the media.

Conclusion

The quality of life of people with mental disability also has a dimension concerning sexual life and sexual education. Sexuality of people with mental disability is a natural phenomenon, which despite its differences has an important functionality in the life of individuals. However, there are still many questions in this field that must be responded to in the future with satisfactory answers in order to achieve the highest possible quality of the sexual life of individuals with mental disability. Special education also has its place of application, targets and tasks in this area.

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