



What do mentally retarded individuals residing in group homes in a small western city desire in their sex education program?
by Robert John Ustby

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University
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Abstract:

The problem of the study was to determine what mentally retarded individuals residing in group homes desired in their sex education program.

The author interviewed the mentally retarded population which consisted of six females and thirteen males that ranged in age from eighteen to sixty-two years of age. This population had spent from three to thirty-two years in institutions for the mentally retarded.

Ten members of the population were mildly retarded, five members were moderately retarded, and the intellectual status of four members was unknown.

The interview focused on a questionnaire developed by the author. The questions related to topics presently in use in sex education curricula for the mentally retarded and those topics suggested by authorities in the field.

It was found that: 1) These retarded individuals did have opinions, desires, and ideas about what they would like to talk and learn about in a sex education program. Most of the members (sixty-three to eighty-four percent of the population) indicated that they would like to talk or learn more about (a) handholding, (b) kissing, (c) dating, (d) love, (e) marriage, and (f) babies. About one-half of the participants indicated that they would like to learn or talk about (a) where a baby comes from, (b) caring for babies, and (c) the sexual parts of boys and girls.

2) These retarded individuals had varied interests, desires, attention spans, language problems, and cognitive abilities.

3) An individualized program and teaching on an individualized basis would be necessary when teaching sex education to these mentally retarded people because of their varied interests, desires, attention spans, language problems, and cognitive abilities.

The following recommendations were made: 1) That the mentally retarded be asked about what they would like to talk or learn about in a sex education program.

2) That the subject matter in sex education curricula for the mentally retarded include but not necessarily be limited to the questions, desires, and interests of the retardates.

3) That the sex education programs for the mentally retarded be individualized to meet the varying interests, desires, attention spans, language problems, and cognitive levels of these people.

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WHAT DO MENTALLY RETARDED INDIVIDUALS RESIDING IN GROUP HOMES
IN A SMALL WESTERN CITY DESIRE IN THEIR SEX EDUCATION PROGRAM?

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

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ABSTRACT

The problem of the study was to determine what mentally retarded individuals residing in group homes desired in their sex education program.

The author interviewed the mentally retarded population which consisted of six females and thirteen males that ranged in age from eighteen to sixty-two years of age. This population had spent from three to thirty-two years in institutions for the mentally retarded. Ten members of the population were mildly retarded, five members were moderately retarded, and the intellectual status of four members was unknown.

The interview focused on a questionnaire developed by the author. The questions related to topics presently in use in sex education curricula for the mentally retarded and those topics suggested by authorities in the field.

It was found that: 1) These retarded individuals did have opinions, desires, and ideas about what they would like to talk and learn about in a sex education program. Most of the members (sixty-three to eighty-four percent of the population) indicated that they would like to talk or learn more about (a) handholding, (b) kissing, (c) dating, (d) love, (e) marriage, and (f) babies. About one-half of the participants indicated that they would like to learn or talk about (a) where a baby comes from, (b) caring for babies, and (c) the sexual parts of boys and girls.

2) These retarded individuals had varied interests, desires, attention spans, language problems, and cognitive abilities.

3) An individualized program and teaching on an individualized basis would be necessary when teaching sex education to these mentally retarded people because of their varied interests, desires, attention spans, language problems, and cognitive abilities.

The following recommendations were made: 1) That the mentally retarded be asked about what they would like to talk or learn about in a sex education program.

2) That the subject matter in sex education curricula for the mentally retarded include but not necessarily be limited to the questions, desires, and interests of the retardates.

3) That the sex education programs for the mentally retarded be individualized to meet the varying interests, desires, attention spans, language problems, and cognitive levels of these people.

Chapter 1

INTRODUCTION

The author was involved with parents of mentally retarded individuals while employed as a public health nurse in Wisconsin. During this time parents of the mentally retarded expressed an interest in learning more about sex education for their children. Since attending graduate school, this writer has become aware of the importance of individualized instruction in education. This study developed from an interest in individualized instruction and a concern about sex education for the mentally retarded.

Statement of the Problem

The problem of the study is to determine what mentally retarded individuals residing in group homes in a small western city desire in their sex education program.

Need for the Study

The study is important because the questions and topics most vital to the mentally retarded person's understanding of his/her sexuality may or may not be included in present day sex education curricula. Generally speaking, the curricula are expert, teacher, parent, or administration directed. Adults usually decide the content of sex education curricula for the mentally retarded. Mentally handicapped

people seldom contribute to or have input into decisions regarding curricula content.

General Procedure

The writer interviewed the mentally retarded population residing in group homes in a small western city. A tape recording was made of each interview which focused on the questions of the questionnaire included in Chapter 3. Permission for the interviews was obtained from the members of the population, the local chapter officials of The National Association for Retarded Citizens, REACH, Incorporated (see Appendix A for more information about REACH, Inc.), and the group home counselors. For reasons of confidentiality, the names of the persons interviewed and the city itself are not disclosed.

Limitations and Delimitations

It was necessary to individualize the questionnaire for each participant during the interviews. The writer was unable to follow the questions and phrase the questions of the questionnaire exactly the same for each interviewee because of language and communication problems. Some members of the population had difficulties dealing with incoming auditory information while others displayed difficulties in attention. At times, parts of the questionnaire had to be rephrased, repeated, or explained using vernacular terminology. An

attempt was made to use language understood by the population members.

The size of the population in this study is a limitation. It may be misleading to apply implications from this study of a small number of mentally retarded individuals to the much larger population of all mentally handicapped people.

It is possible that some individuals of the study population have been rewarded for responding with "yes" answers. Yes responses may have been given by a participant out of habit when he/she did not really understand the question or topic. In order to determine if a participant was giving a yes response out of habit, a question such as, "Would you explain that a little more?" was asked after a yes response.

The study was delimited by the background of the population members and the geographical area. The population members were all living in group homes and had previously lived in an institution for the mentally retarded. The geographical area in which the population lived was of a rural nature.

Definition of Terms

The American Association on Mental Deficiency (AAMD) defines mental retardation as

. . . subaverage general intellectual functioning that originates during the developmental period and is associated with

impaired adaptive behavior. . . . Both criteria must be met before a person is to be considered mentally retarded. The criteria of intellectual functioning is measured by one or more standardized tests of intelligence and is considered sub-average when the obtained intelligence quotient (IQ) is greater than one standard deviation below the population of the mean at the age group involved. . . . The developmental period, although not precisely defined, is regarded as being approximately the first 16 years of life. . . . The criteria of impaired adaptive behavior is manifested in the areas of maturation, learning and social adjustment. Maturation refers to the rate of development in the self-help skills of infancy and early childhood. Learning refers to the ability of the individual to acquire knowledge as a result of his experience. Social adjustment is the degree to which the individual is able to maintain himself independently and to conform to personal, social, and vocational standards appropriate for his age group (Heintz, 1971:335).

Educable Mentally Retarded (EMR)

Although criteria for inclusion in classes for the EMR vary from state to state, a majority of school systems employ the following criteria:

(1) Retarded mental development. While the most commonly used IQ range is 50 to 75, there is a general trend toward aligning educational classification with the AAMD Classification. As a result there is a general move toward accepting an IQ range of 55 to 84 as the lower and upper extremes for inclusion in special classes for the EMR.

(2) Inability to profit substantially from regular education programs.

(3) Limited capacity for academic achievement.

(4) Limited capacity for independent social and occupational functioning (Heintz, 1971:335-38).

Trainable Mentally Retarded (TMR)

Mentally retarded children in school programs for the trainable usually fall into the IQ range of 30-50; however, as with EMR children, students vary from state to state, and the national range for children in programs for TMR extends from 25 to 60. Criteria for selection usually include capacity for development of self-help skills, personal and social adjustment in a restricted environment, and limited productivity in a sheltered employment center such as a common workshop for the severely handicapped. Trainable children are not expected to profit from traditional instructional programs; hence, academic instructional programs in the classical sense are not included in the curriculum (Heintz, 1971:338-39).

In Table 1 Heintz (1971:335) gives verbal descriptions and ranges in I.Q. scores for degrees of retardation (see page 6).

Group Home

A group home is a residential facility which provides supervision and training services to developmentally disabled adults. This definition was provided by the Director of REACH, Inc.

Table 1. Verbal Descriptions and Ranges in I.Q. Scores for Degree of Retardation

Degree of Retardation	Range of I.Q. Scores
Borderline	70 - 84
Mild	55 - 69
Moderate	40 - 54
Severe	25 - 39
Profound	25

Summary

A study of the desires of mentally retarded individuals concerning sex education curricula is important because the questions and ideas most vital to a person's understanding his/her sexuality may or may not be included in today's curricula. The needed data was obtained by using a tape recorder to record verbal answers to questions asked from a questionnaire administered by the writer to the mentally retarded individuals. The findings from this study should help parents, teachers, and administrators to know more about what mentally retarded individuals may desire in sex education curricula.

Chapter 2

REVIEW OF LITERATURE

This chapter presents information on mental retardation and education, including sex education. The review of the literature focuses on the following major areas:

Mental Retardation - Prevalance and Causes;

Education of the Mentally Retarded;

Individualized Education - General Population;

Individualized Education - Retarded Population;

Language Difficulties Associated with Mental Retardation;

Rights of the Retarded;

Characteristics of the Subject Matter - "Sex";

Reasons For and Against Sex Education For the Mentally Retarded;

Sex Education Levels for the Mentally Retarded; and

Sex Education Curricula.

Mental Retardation - Prevalance and Causes

Three percent of the total population in the United States is mentally retarded (President's Panel . . . 1963). Based on this figure, it is estimated that the number of mentally retarded individuals in this country is approximately six million people (Heintz, 1971).

Whaley (1974) states that intelligence, like stature, shows a continuous variation. Approximately seventy-five to eighty-five

percent of intelligence is contributed by the small additive effects of polygenes and the remainder by environmental factors.

Fraser and Nora (1974) report that if an individual with an I.Q. below seventy is arbitrarily defined as retarded, then some people will be retarded because they received an assortment of genetic and environmental factors that placed them in the lower portion of the normal distribution of the population without any factor in itself being abnormal. They further state that the causes of mental retardation fall into the same four categories as do congenital hip, heart malformations, and other common familial disorders: 1) mutant genes, 2) chromosomal aberrations, 3) major environmental insults, and 4) multifactorial etiology. Persons in the first three groups tend to be more severely retarded than those in the multifactorial group.

The most seriously affected retardates make up a small proportion of the total population of retarded persons. The most severely retarded have a high mortality rate (Matheny and Reisman, 1969). Mental retardates with an I.Q. below fifty-five exhibit a difference in gender. The sharp increase in the number of males in this group suggests the probability of an X-linked recessive gene effect. Severely retarded persons are almost always infertile (Whaley, 1974). Fraser and Nora (1974) report that intelligence of near relatives of those retarded persons with specific and, therefore, severe types of retardation is like that of the general population. However, the

intelligence of near relatives of children with nonspecific and, therefore, milder retardation tends to be lower than that of the general population.

Matheny and Reisman (1969) are concerned with the group that displays familial retardation. This group represents eighty to ninety percent of the total population of retarded people. Multifactorial or polygenic inheritance refers to genetic variations that are due to a number of genes held in common. The nature of the polygenic model suggests that mental retardation correlates with the degree of genotype similarity. Relatives of this group of retarded people have a higher incidence of mental retardation than that of the general population. Matheny and Reisman identify the following risk factors associated with familial retardation: If both parents are retarded, there is a fifty-five to sixty percent chance that the offspring will be retarded, a thirty-five to forty percent chance they will be borderline or slow, and a four percent chance they will be of average or better intelligence. If only one parent is retarded and the other parent has borderline or below intelligence, there is a thirty-five percent chance the offspring will be retarded and a ten percent chance they will be of average or better intelligence.

In another study of people with an I.Q. less than seventy, Fraser and Nora (1974:243) investigated the risk factors of mental

retardation for children and siblings. Their findings are presented in Table 2:

Table 2. Risk of Mental Retardation in Children and Sibs of Retardates

Parents	Children	Risk for child	Risk Percent
0	--	"	1
1	--	"	11
2	--	"	40
0	1	Risk for sibling	6
1	1	"	20
2	1	"	42

^aF. Fraser and J. Nora, Medical Genetics (Philadelphia and Febiger, 1979), p. 243.

Matheny and Reisman (1969) believe that it is important to point out that not all familial retardation is a result of heredity because often mental retardation can be attributed primarily to poor cultural or environmental factors. Most families with the familial form of retardation tend to be in the lowest economic and social class. Finally, they conclude that the majority of families with familial retardation will not avail themselves voluntarily to genetic counseling.

Jones et al. (1974) revealed a factor unknown to the general population that may increase the incidence of mental retardation. He found that women who were chronic alcoholics during their pregnancy had a high incidence of offspring with mental retardation. Forty-four

percent of the offspring in his study were determined to possess borderline to moderate degrees of mental deficiency.

The pollution of wastes containing mercury into the ocean by Japanese factories had contributed to an increase in mental retardation. Life and Health (1974) related that the residents who ate fish contaminated with mercury developed Minamata Disease. An increase in mental retardation was associated with Minamata Disease.

Infants who eat paint containing lead can develop lead encephalopathy and mental retardation (Begab, 1974; Marlow, 1973).

Bass (1974) reports that the President's Task Force on the Mentally Handicapped estimates that family planning could reduce congenital malformation by twenty percent and Down's syndrome by thirty percent. The Task Force recommends increased dissemination of birth control devices along with making sterilization and abortion more readily available.

In their paper, Anderson and Reed (1973) discuss several findings concerning mental retardation and birth rate figures.

1. There is no correlation between parents' I.Q. and family size.
2. Some retarded have very large families but more than half of them have no children. Thus, the average number of children per retarded individual is less than that produced by a non-retarded individual.

3. Retarded parents produce about seventeen percent of all retarded children.

In response to Anderson and Reed, Murphy (1973) states that the gene pool has long been in a state of near equilibrium with a slow trend toward improvement of the genetic stock. A conservative estimate is that ninety-five percent of all people carry harmful genes; a more reasonable estimate would be ninety-nine point nine percent. The majority of these genes are genes for recessive traits and difficult to detect. Murphy (1973:129) states, "If the human is to reproduce from unsullied stock only, a minute fraction of the population is going to be very busy indeed." He advises that nothing can be done about the gene pool without imperiling adaptability and points out that the carrier state of Tay-Sachs disease is associated with a lower than average risk of tuberculosis. He warns that any interference with the dynamics of the gene pool may cause problems.

Education of the Mentally Retarded

Gunzberg (1974:628) believes that education for the mentally retarded should be modest but realistic, and enable them to function as unobtrusively and competently as possible through the teaching of social competence. It is essential that education ensures, first of all, that the retarded person is adequately prepared for his role in the community. Gunzberg adds that there is considerable concern about

the mentally retarded person's social inadequacy, which makes him a social liability, but nearly all educational work concentrates on his academic weaknesses even though the community tolerates scholastic weaknesses quite well. Gunzberg points out that in normal education the order of emphasis is: academic proficiency, occupational competency, and competency in social adjustment. In the case of the mentally retarded the order of emphasis should be: social competency, occupational or vocational competency, and academic proficiency.

For a long time children with an I.Q. score above fifty were given education and those with a score below fifty were given training. This served as an administrative convenience but also determined the quality of education given them. Gunzberg (1974) reports that in Great Britain the Education (Handicapped Children) Act of 1970 abolished this line of division between educable and trainable retardates. It established that all children, regardless of their mental deficiency, were now the responsibility of the education authorities.

However, there is difficulty in agreeing on the definition of mental retardation. The American Association on Mental Deficiency recognized the need to achieve greater uniformity and developed the interdisciplinary definition the writer used in Chapter 1 (definition of terms). The definition differed from some earlier terms and these differences are important. The definition clearly states that sub-average intellectual functioning must be accompanied by impairment in

adaptive behavior. It also states that the term is descriptive of the individual's current intellectual and adaptive behavior. This is very important because the individual may meet the criteria of mental retardation at one time and not at another.

Labeling may be an important factor in determining whether an individual receives training or education even if the label is inappropriate. Kurtz and Wolfensberger (1974) report that once a label is attached to an individual, those who deal with him often assume that the label is a legitimate characterization of his condition. This may be true even when there is little or no evidence supporting the appropriateness of the label. Whalen (1973:238) reports, "Once labeled, individuals lose their individuality. The mentally retarded are construed as members of a homogeneous group with a standard set of characteristics and deficiencies." Edgerton (1973:245) adds, "One central finding from the studies of mildly and moderately retarded is that through being labeled mentally retarded, such persons suffer an acute loss of self-esteem." As would be expected, this diminished self-esteem is a fundamental problem for the retarded and for all those who must interact with them. Begab (1974) feels mental retardation is not necessarily a permanent legitimate characterization of an individual; for certain groups, especially the so-called cultural familial group, "cure" through behavior change is possible.

The use of I.Q. tests may also contribute to labeling and be a factor in determining whether an individual receives training or education. Murphy (1973:129) discredits the use of I.Q. tests which are often used as tools for labeling the mentally retarded.

They do not lend themselves to any of the classical statistical techniques, such as discriminant analysis or multiple regression, because there is no agreed variable against which they can be validated; if there were, we could use the outcome variable and not the test. If there is nothing to appeal to for validation, then inevitably the construction, the weighting, and the interpretation of the tests must be colored by the standards of the psychologists, for the most part middle-class males of European stock and academic cost. If the birds constructed such tests, we would doubtless get low marks in building nests, hatching eggs, flying, and catching worms. We would be labeled hopeless imbeciles and perhaps be compulsorily sterilized by our well meaning rulers.

Individualized Education - General Population

Bolvin and Glaser (1971:270) remind us that in 1925 the National Association For Study of Education declared, "It has become palpably absurd to expect to achieve uniform results from uniform assignments made to a class of widely differing individuals." Individualized instruction emerged to deal with the problems mentioned by the National Association For Study of Education. There has been a movement in education in recent years toward individualized instruction (Deshaw, 1973; Bishop, 1971; Dunn, 1971).

Individualized instruction provides a program for each student that is based on his/her characteristics as a learner and includes

his skills, abilities, interests, learning styles, motivation, goals, rate of learning, self-discipline, problem-solving ability, degree of retention, participation, strengths, weaknesses and prognosis for moving ahead in various curriculum areas and projects.

(Dunn, 1971:31). For many people it implies instruction segregated from the rest of the class, for others independent study. Still others believe it implies one child and a tutor or one child and a machine. This is not the case according to Bolvin and Glaser. Individualized instruction is instruction that is adapted to an individual's needs, characteristics, and interests and may include the use of small group instruction, teaching machines, programmed instruction, tutoring, project work, or independent study. Seigel (1967) reports that for instruction to be most effective, it must be tailored to the needs, capabilities, and histories of individual learners.

Conley and O'Rourke (1973:591) believes that instruction might be improved by a process of obtaining baseline data on students involved in sex education courses; they state,

In educational circles, it is axiomatic that an assessment of students' needs and interests should proceed instruction efforts. This assignment should help in obtaining desired educational outcomes. Too often, instructors assume a prior knowledge of the student wants without validating such assumptions.

Individualized Education - Retarded Population

Weisgerber (1974:33) wrote,

Much has been written about the principles and practices employed in individualized learning for regular students and

for the most part these systematic procedures are equally appropriate for handicapped students. The handicapped child warrants individual attention and educational experiences adapted to meet his unique needs.

Gunzberg (1974:653) when speaking of education for the retarded states, "It would be a retrograde step if education for all were interpreted as meaning the same education to different degrees. The guiding principle is to each according to his needs."

Gunzberg believes that education should respect the choices, wishes, and desires of retarded people. Mentally subnormal people are seldom encouraged to participate actively in decisions and arrangements concerning them though normal people claim the right of having a say in issues relating to them.

Shindell (1975) believes that all instructional procedures for the retarded must be geared to the level of the individual, including sex education.

Borthick, Fisher and Krujicek (1973) believe that when teaching sex education to the mentally retarded, eliciting information is just as important as giving information. They believe that the first and most important step in making available sound sex education for the developmentally disabled person is to talk to that individual. By talking with an individual one can gain insights to his developmental level, needs, interests, questions and concerns. Mattison (1973) suggests that before teaching sex education to the mentally retarded

it is important to listen to them and find out where they are in their own psychosexual development, their emotional level, interests, and questions.

Language Difficulties Associated with
Mental Retardation

Mittler (1974) reports that for language functioning to be effective, the subject has to:

1. be able to receive stimuli produced in sequential order;
2. maintain a sequential impression of the message so that its components can be integrated into a pattern;
3. scan the pattern from within to categorize the data and compare it with an existing store; and
4. respond differentially to perceptual impression.

According to Mittler these are the very disabilities that have been shown to be severely impaired in the mentally subnormal. They have particular difficulties in dealing with incoming sensory information, and many of their learning difficulties can be regarded as stemming from a disorder in attention. Information processing of auditory material is particularly difficult, but it is also seen in dealing with visual material. Mittler (1974:535) states that the subnormal

Frequently lack the social and behavioral skills which would allow them to indicate to the speaker that he was not being understood, thus depriving the speaker of the kind of cues which would enable him to modify his utterance accordingly.

A normal child learns as he gets older to give signals that he does not understand something by frowns, puzzled looks, or asking for something to be repeated. Mittler feels these are essential social skills in a communication situation which a child may acquire without conscious effort but which may need to be taught to the mentally retarded child.

Muller and Weaver (1964) studied the psycholinguistic abilities of institutionalized and non-institutionalized trainable mental retardates. They found that institutionalized people were inferior in language development.

Spren (1965) documents the relationship between I.Q. and both speech and language disorders. He reveals that the frequency of language disorders is one hundred percent in those with an I.Q. below twenty, around ninety percent in the I.Q. range twenty-one to fifty, and about forty-five percent in the mildly retarded group.

Johnson (1973) sees the retarded as having a language barrier when dealing with sex education. First of all, they face the frustration of being unable to decode some important verbal messages because of the unfamiliar vocabulary or the complex style in which it is used. The retarded are not skilled in medical terminology. He thinks the reluctance of the educator to use vulgar language is another barrier. Chadsey and Wentworth (1970) in the Gosset Webster Dictionary define vulgar as common or ordinary. This language is understood by all, but

its use is not accepted. Money (1973) supports the use of pictures and films for explicit teaching to the mentally retarded, but observes that our culture has a great inhibition to pictures of sexual organs.

Rights of the Retarded

The Mental Disability Law Reporter (1976) reveals that Florida recently enacted a "Bill of Rights of Retarded Persons" (Chapter 75-259, approved June 29, 1975), which spells out and guarantees basic rights for the clients of the state mental retardation system. The clients' rights enumerated in the new law (effective July, 1975) include dignity, privacy, and humane care; religious freedom; an "unrestricted" right to communication and visitation; possession and use of personal belongings and clothes; education and training services (though not at any particular level), including sex education; behavioral and leisure time activities; physical exercise; humane discipline; and compensation for labor in accordance with applicable federal regulations.

Public Law 94-142 (1975) deals with the educational needs of the more than eight million handicapped children in the United States. Some of its important provisions are:

1. assurance of an effective policy guaranteeing the right of all handicapped children to a free, appropriate public education, at no cost to parent or guardian;

2. assurance of special education being provided to all handicapped children in the "least restrictive" environment;
3. assurance of regular parent or guardian consultation; and
4. assurance of the maintenance of an individualized program for all handicapped children. (The emphasis is not in the original copy.)

In the definitions of this law, it states

The term "individualized education program" means a written statement for each handicapped child developed in any meeting by a representative of the local educational agency or an intermediate educational unit who shall be qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of handicapped children, the teacher, the parents or guardian of such child, and, whenever appropriate, such child, which statement shall include (A) a statement of the present levels of educational performance of such child, (B) a statement of annual goals, including short-term instructional objectives, (C) a statement of the specific educational services to be provided to such child, and the extent to which such child will be able to participate in regular educational programs, (D) the projected date for initiation and anticipated duration of such services, and (E) appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether instructional objectives are being achieved.

Burt (1973) reports there are several kinds of state laws that limit the freedom of those labeled mentally retarded to engage in sexual relations, to marry, and to rear children. In a number of states, "mentally retarded" individuals can be compulsorily sterilized, denied marriage licenses, or lose the custody of their children. However, in recent years these laws have rarely been invoked. Burt firmly

believes that any law that singles out "mental retardates" for special restrictions in sexual or family life violates the United States Constitution.

Goodman (1973) reports on the legality of providing contraceptive information to all people. The public welfare provisions of the Social Security Act Title IV amended in 1967 maintains that states must make available on a voluntary basis family planning information to any person of child-bearing age asking for it, regardless of marital status or age, including the mentally retarded.

The Wisconsin Association for Retarded Citizens Board of Directors adopted the following resolution on sexuality on November 8, 1975, as reported in the Wisconsin ARC News, March, 1976.

RESOLUTION ON SEXUALITY

WHEREAS, persons who are mentally retarded have the same sexual feelings, thoughts and needs that other people have, and
 WHEREAS, factual and accurate information on human sexuality decreases the incidence of sexual problems and inappropriate behaviors, and
 WHEREAS, persons who are mentally retarded are in need of special training and education in their learning process, and
 WHEREAS, non-mentally retarded adults have the right to freedom and privacy in expressing themselves sexually, and
 WHEREAS, non-mentally retarded persons have the right to obtain birth control devices and/or to birth control methods,
 THEREFORE, persons who are mentally retarded have the right to privacy, to sexual expression that does not impinge upon the rights of others and that is within legally defined limits, to sex education and information, and to information and training in the use of effective birth control, and to obtain such birth control devices.

THEREFORE, WARC seeks to ensure the rights of person who are mentally retarded by encouraging legislation which protects their rights, by recognizing their sexual rights, by promoting the gathering together of sex education resource materials for families and educators, by supporting the training of persons in the field of human sexuality and by encouraging the implementation of sex education programs.

Characteristics of the Subject Matter - "Sex"

Warren Johnson (1973) feels that the prime characteristic of the subject matter of sex education is that it is different. It is not treated as educational subject matter in the same sense as chemistry or nutrition. No polling is done of the public or school officials to determine whether mathematics or history should be taught in the schools. The strange taboo system of sexual morality and attitudes present in today's society was laid down by Old Testament Jews. The early Christians added to the Jewish regulations a frank hatred of sex and women. Johnson (1973:61) states,

The influential St. Augustine wrote that the gateway to hell lay between a woman's thighs; and it was he who permanently fixed the sex-in-guilt association in the Christian mind.

Tradition plays an important factor in our society. An example of this, according to Johnson, is the disavowal of the report of the President's Commission on Pornography and Obscenity which found no evidence that pornography produces ill effects on the beholder, child, or adult. Johnson (1973:62) concludes,

Historical, moral, legal, and linguistic traditions profoundly affect all efforts at sex education and often hinder attempts to educate in this area. Especially impeded, perhaps, are any efforts to educate the mentally retarded.

Deisher (1973) reports that there has been a progressive change in public awareness of the importance of sex in people's lives.

Reverend Tyrer (1973:xii) states,

We of this generation are living in an hour of transition from the day when sex was considered as something to be hidden, something that had undefined relation to impurity . . . , to the cleaner sweeter day that is dawning . . . , it will be exalted as the most important thing in the world.

Reasons For and Against Sex Education for the Mentally Retarded

Maddock (1974:374) feels the heart of the issue of sex education for the retarded is found in this question,

At what ages, under what circumstances, with whom, and in what forms shall genital activity be considered appropriate for the person with special needs--and with what consequences for the individual and for society?

Maddock gives reasons of why people oppose sex education for the mentally retarded: (1) fear of uncontrolled reproduction; (2) fear of an undisciplined sex drive; and (3) denial of the sexuality of the retarded person. Hoyman (1974) reports that some people feel that sex education will lead their children toward premature sexual permissiveness. Hoyman does not specifically mention retarded children, but speaks of children in general.

Maddock (1974) points out the obvious by saying that the sexuality of the retarded is a fact. Shindell (1975) reports that retarded and normal individuals have similar sex interests and desires.

Hammer, Jensen, and Wright (1967:625) concur, "According to parental observations, the sex drives, curiosity, and interests of this group of mildly defective children differed little from that of their normal siblings and age mates." Gebhard (1973) in his study reports that the retarded with I.Q.'s of fifty or less experienced less heterosexual and homosexual activity than those with higher I.Q.'s but orgasm in sleep was more prevalent for the former group. Johnson (1973) reports that like the so-called normal person, the retarded person is likely to, but not necessarily, have a strong interest in sex. He feels the mentally handicapped, like most people, are interested in sex primarily for its potential sensual gratifications and that it may have little or nothing to do with a motivation to procreate or form a permanent relationship.

Deisher (1973) recognizes that society has increasingly recognized the rights of the retarded to be educated, to work and to fit into society in a way commensurate with their abilities. But, society has almost entirely neglected the rights of the retarded to be sexual individuals, to enjoy sexual pleasure, and to experience feelings that are of a sexual nature.

Kempton and Forman (1971:Forward), in referring to the mentally retarded, declare,

Until their parents, the professionals working with them, and members of the community face the fact that all handicapped persons are sexual beings, and until programs are developed to help them understand their sexuality and enjoy it appropriately, we have not truly progressed in our efforts to help them, nor indeed have we acknowledged their rights.

Maddock (1974) believes that many people who feel the exceptional person should be protected from knowing what normal people know about sex are in a way protecting themselves from the sexuality of the retarded person.

Sex education for the mentally retarded may help to decrease the incidence of venereal disease among the mentally handicapped. Kempton, Bass, and Gordon (1971), in their book Love, Sex, and Birth Control for the Mentally Retarded, relate that a child is more likely to have sexual problems when he/she does not know much about sex and that there is less promiscuity and venereal disease among those with more information. Levine (1967) portrays sex education as a possibility for reducing the incidence of venereal disease because gonorrhea and pregnancy rates decrease when sex education is introduced into public schools.

The incidence of this disease is growing. According to Baker (1974), gonorrhea has the greatest incidence of any communicable disease required by law to be reported; syphilis is number four. An

added difficulty is that eighty percent of the women and fifteen percent of the men with gonorrhea have no symptoms. Subak-Sharp reveals that there are at least two hundred and fifty thousand and perhaps as many as one million cases of the venereal disease herpes simplex II in the United States. As of yet there is no proven cure for this disease. Bass (1974) reports that venereal disease is three times higher in the retarded than in the normal population.

The incidence of venereal disease nationwide, the prevalence of this disease among the retarded, and the fact that sex education may help decrease the incidence of venereal disease, are important reasons which support sex education for the mentally handicapped.

Maddock (1974) gives other justifications for sex education for the retarded:

1. The role of the body in human development is important and sex education can provide an opportunity for the retarded to focus attention on their body and physical expression.

2. The interpersonal aspects of sex must not be forgotten. The retarded often lack an opportunity for sexual expression (physical, interpersonal, and symbolic) and this leads to less effective social, emotional, and intellectual functioning.

3. Parents desire help in the sex education of their retarded offspring.

Barker, Hall, and Morris (1973) in their research on sixty-one non-institutionalized mildly and moderately retarded adolescents show that in certain areas (contraception, conception, and venereal disease) the adolescents were lacking in accurate information, and parents were unsure of the knowledge their children possessed. The mentally retarded adolescent had a more liberal attitude than expected by the parents. Sex education was not being given in the home. The parents expressed concern that assistance be given in this area. Social class, race, and religion did not correlate with the test measures, and this suggests the need for sex education for the mentally retarded is demonstrated in all strata of society.

Hammer, Jensen, and Wright (1967) in their study of fifty retarded adolescents reported that parents felt more comfortable about coping with sex education for females than males. The onset of menarche helped to initiate sex education for the females. However, because physical changes were not as demonstrative for the males, the parents tended to delay or avoid sex education for their sons. Parents indicated they would only answer questions when asked, and if none were asked this was interpreted by the parents as a lack of interest in the topic by their children. Goodman, Bunder, and Lesh (1971) found that parents with retarded children living at home have limited knowledge of sexual functions and make only minimal efforts to give sex instruction.

Presently there is a movement to return institutionalized mentally retarded people back to the community. Shindell (1975:88) states that "no normalization process can be considered complete and/or successful without consideration for its socialization component." Gordon (1975) predicts that there will be a great move back to the institutions if no sex education and contraceptive education is given to the mentally retarded. Gunzberg (1974) states that in the past the relationship of the sexes had been considered only in terms of keeping them apart but now people realize that this task has to be dealt with through preparatory training. No normalization program can be successful without dealing with the topic of sex education.

Sex Education Levels for the Mentally Retarded

Kempton (1971:65) reports that when teaching sex education to the trainable mentally retardates (TMR) one should remember the following:

1. The TMR group does not have as rational an approach in expressing their sexuality.
2. Many TMR people have difficulties in expressing themselves to the opposite sex, and do not express their feelings in an "organized" manner.
3. The sexual behavior of many TMR persons may be auto-erotic.

4. Learning for this low level is best accomplished visually, accompanied by short simple statements with simple pictures or hand demonstrations. Experimenting with new methods may also be helpful.

5. Most trainable retardates cannot discuss facts rationally so the education process may be acting out a simple social situation to demonstrate what is appropriate.

Alcorn (1974) reports that there is a tendency to generalize the sexual attributes of the trainable mentally retarded or exclude TMR people from any discussion of program needs. He reports TMR children as showing little inclination toward sexual activity and minimal curiosity about sex, those having done so being more likely to demonstrate interest in the manner of a normal preadolescent who talks about a boyfriend or girlfriend at school and who might hold hands with a partner at a party. He quotes a parent as saying,

Retarded children vary in their abilities to comprehend situations and interpretation of sexual matters, and, like any other thing, sex education must be geared to their level of understanding. Some, like ours, can not even comprehend simple concrete things without difficulty, and sex education is not a prime consideration.

Kempton (1971) believes that sex education for the educable mentally retarded people should be much the same as for the normal population, but it should be more simply and concretely stated and with much more repetition. Meyers (1972:1) states, "The sex education

needs of the educable mentally retarded are basically the same as those individuals of normal intellectual ability."

Sex Education Curricula

There are those who question the validity, adequacy, and nature of sex education curriculum for the mentally retarded. Balester (1971) pointed out that very little research is available concerning the structure, content, and results of sex education programs. Blom revealed the neglect of sex education in special education:

While guidelines and curricula exist at various grade levels for sex education, there is some question about the adequacy of many of them. My impression is that most of the curricula have been based on what adults think children want to know, or should know at different ages; less often on what is known about the psychology of children--their interests, questions and cognitive capacities (Blom, 1976:360).

The sex education programs for the retarded are, for the most part, teacher-directed, not student-directed. The mentally retarded students do not decide what they will study because it has already been decided for them by experts, parents, teachers, or administrators.

Meyers (1972: Table of Contents) in his curriculum guide for teachers incorporates three levels of sexual and social development for the educable mentally retarded. There are primary, intermediate, and advanced levels and lesson plans for each area.

Lesson Plans

Primary

- | | |
|--------------------------------------|--------------------------|
| 1. Realistic Body Image | 7. Sexual Encounters |
| 2. Proper Toilet Habits | 8. Growth |
| 3. Differences between Men and Women | 9. Differences in People |
| 4. Male and Female Roles | 10. Negative Feelings |
| 5. Self Concept | 11. Living Things |
| 6. Love | 12. Human Reproduction |

Intermediate Level

- | | |
|--|-------------------------------------|
| 1. Embryo and Fetal Development | 4. Facial and Body Hair, Acne |
| 2. Sociograms and Peer Relationships | 5. Reproductive Organs |
| 3. Adolescent Physical and Emotional Changes | 6. Menstrual Hygiene for Girls |
| | 7. Sexual Feelings and Masturbation |

Advanced Level

- | | |
|--------------------------|--------------------------------|
| 1. Personality | 5. Dating |
| 2. Feelings and Emotions | 6. Premarital Sexual Relations |
| 3. Authority | 7. Heredity |
| 4. Peer Groups | 8. Environment |

- | | |
|---|----------------------|
| 9. Planning for Marriage
and Family Life | 14. Sexual Deviants |
| 10. Motivation for Marriage | 15. Venereal Disease |
| 11. Family Planning | 16. Alcohol |
| 12. Communication in Marriage | 17. Smoking |
| 13. Meeting Conflicts in
Marriage | 18. Drug Education |

Gordon (1973) suggests that the retarded (and perhaps normal people) do not need to know many facts about sex. The information given to them can be done in a few minutes, though it must be repeated many times, and for different levels of understanding. According to Gordon (1973:69) the only concepts which need to be taught to the mentally retarded are:

1. Masturbation is a normal sexual expression no matter how frequently it is done and at what age. It becomes a compulsive, punitive, self-destructive form of behavior largely as a result of suppression, punishment, and resulting feelings of guilt.
2. All direct sexual behavior involving the genitals should take place only in privacy. However, since institutions for the retarded are not designed or operated to ensure privacy, the definition of what constitutes privacy in an institution must be very liberal. Bathrooms, one's own bed, the bushes, and basements are private domains.
3. Any time a girl and a boy who are physically mature have sexual relations, they risk pregnancy.
4. Unless both members of a heterosexual couple clearly want to have a baby and understand the responsibilities involved in child-rearing, they should use an effective method of birth control.

5. Until a person is about 18 years old, society holds that he or she should not have intercourse. After that age, the person can decide for himself.
6. Adults should not be permitted to use children sexually.
7. The only way to discourage homosexual expression is to risk heterosexual expression.
8. In the final analysis, sexual behavior between consenting adults (regardless of their mental age and of whether their behavior is homo or hetero) should be no one else's business --providing there is little risk of bringing an unwanted child into this world.

Consideration should also be given to achieving greater acceptance of 1) abortion as a safe, legal, and moral alternative to bringing an unwanted child into this world, and 2) voluntary sterilization as a protection for those retarded persons who could function well in a marriage if they did not have children.

Kempton, Bass, and Gordon (1971) in the book, Love, Sex, and Birth Control for the Mentally Retarded--A Guide for Parents, include the following chapters:

Preparing for Puberty	Contraceptive Methods
What About Masturbation	Vasectomy and Tubal Ligation
What are the Merits of Dating	Abortion
Sexual Intercourse	What About Marriage
Venereal Disease	What if She Wants Children
Birth Control	

Kempton, Bass, Gordon, and Meyers specify the curriculum to be studied.

However, there are some authorities who suggest that the mentally retarded should be included in deciding the sex education

program content. Gunzberg (1975) believes that education should respect the choices, wishes, and desires of the mentally retarded. Mentally subnormal children are seldom encouraged to participate actively in decisions and arrangements concerning them though normal people claim the right of having a say in issues relating to them.

Borthick et al. (1973) report that much literature is available about the sexual development of the mentally handicapped, and curricula are available that list the prescribed sequence in which the handicapped individual is expected to learn facts and concepts about sexuality. He believes suggestions for eliciting information from the mentally retarded is just as important as suggestions for giving information. He suggests using a picture book and talking with the mentally retarded person to gain information on their sexual feelings, desires, and interests and knowledge levels. Mattison (1973) suggests that before teaching sex education to the mentally retarded, it is important to listen to them and find out where they are in their own psychosocial level and what they want to know.

Summary Based on Review of Literature

Three percent of the total population in the United States are mentally retarded. Those people with specific causes of mental retardation tend to be more severely retarded, but the vast majority of

retardates have a multifactorial etiology and are not as severely retarded as the former group.

The topic of sex has many traditional taboos, values, and preconceived opinions. Only recently have we arrived at the point where we can talk and think about sexuality as something which is a normal part of human behavior, and which, perhaps, deserves the same study and research as many other types of human behavior.

The retarded are sexual individuals with the same feelings, thoughts, and needs that are possessed by other people. Factual and accurate information on human sexuality decreases the incidence of sexual problems. Sex education aids in helping people gain a wholesome attitude toward sex and an understanding of sexual attitudes, roles, and relationships.

For a long time children with an I.Q. score above fifty were given "education" and those with a score below fifty were given "training." The term, "mental retardation," is a descriptive term of an individual's present intellectual and adaptive behavior. The individual may meet the criteria of the definition at one time and not at another. However, all too often, a label is attached to an individual, and those who deal with him often assume that the label is a legitimate characterization of his condition, even when there is little, if any, evidence supporting the appropriateness of the label.

Public Law 19-142 provides that all handicapped children have a right to a free, appropriate, public education at no cost to the parents or guardian. It does not say for all those with an I.Q. above fifty. It applies to all handicapped children. It also stipulates the maintenance of an individualized program for all handicapped children.

Individualized instruction has gained popularity in the field of education. Individualized instruction provides a program for each student that is adapted to the individual's needs, characteristics, and interests. It may include small group instruction, teaching machines, programmed instruction, tutoring, project work, or independent study. The handicapped person surely warrants individual attention and educational experiences adapted to meet his unique needs. All instructional procedures must be geared to the level of the individual, including sex education.

It is important when teaching sex education to elicit information from the retarded that indicates their desires, interests, needs, questions; and cognitive levels. When eliciting information, one must remember that the retarded are often faced with a language barrier. Often the retarded have not learned the social skills that allow them to indicate to the speaker that they do not understand something. Oftentimes the material is presented in a complex way or by using

medical terminology not understood by the retarded. Vulgar terms are understood by most persons, including the retarded, but there is a reluctance on the part of educators to use vulgar terms.

Adults often think they know what should be taught to children or what interests them, but this is not often a true representation of the situation. Blom (1970) sees most curriculum as being based on what adults think children should know or want to know about sex, rather than on the expressed interests and questions of the students. This leads to the question to be dealt with in the next chapter: What do the retarded desire in a sex education program?

Chapter 3

PROCEDURES

This chapter outlines the procedures used in investigating the question: "What do mentally retarded individuals desire in a sex education curriculum?" The following sections are included in this chapter: population, method of collecting data, questionnaire, method of organizing data, analysis of data, and a summary.

Population

One distinct population was involved in the study which took place in a small western city during the fall of 1976. All mentally retarded persons, regardless of age, sex, or I.Q., residing in group homes in this city were considered for possible inclusion in this study. Nineteen out of a total population of twenty-one individuals were included in the study. Two individuals declined to participate. All people in the study population were involved with Recreation, Education, and Adult Counseling for the Handicapped (REACH), Incorporated.

REACH, Inc. is a legally recognized, non-profit organization which is currently providing services to developmentally disabled adults in this small western city. A more detailed description of REACH, Inc. is included in Appendix A.

Method of Collecting Data

The writer had the good fortune of belonging to the National Association for Retarded Citizens (NARC) and had been involved with this organization for two years before the study was begun. This enabled the writer to gain valuable insight into the lives of retarded people, their families, and those associated with them.

The author became a member of the local chapter of NARC in the city where the study took place. Through the help of this organization and the people the writer met at the local chapter meetings, the population for this study was identified.

Permission to interview the population was obtained from the local chapter of NARC, REACH, Inc., the group home counselors, and the retarded individuals involved in this study. For reasons of confidentiality, the city and the names of the people involved in this study have been withheld.

A questionnaire to be used during the interview was developed by the writer. The questions relate to the topics presently in use in sex education curricula and those topics suggested by authorities in the field. The writer also discussed the questionnaire content with Dr. William Serdahely (health educator who teaches sex education), REACH, Inc., and various people involved with the local chapter of NARC.

The questionnaire was divided into three main parts: introduction and warm-up, open-ended questions, and specific content questions.

The introduction and warm-up were designed to explain to the participant the purpose of the interview, to develop a more comfortable relationship with the participant, and to reduce any anxiety held by him/her. At this time the writer also attempted to assess the participant's general level of verbalization and his/her understanding of the interview process.

An open-ended question was included at the beginning of the questionnaire to ensure that the participant had an opportunity to express questions or comments about sex education curriculum content without being influenced by the specific content questions asked in the questionnaire. An open-ended question was also included at the end of the questionnaire to give the participant another opportunity to ask questions or comment about sex education curriculum content.

Specific content questions were included in the questionnaire. These specific content questions dealt with material presently in use in sex education curricula or material recommended by experts in the field of sex education for the retarded (included in Chapter 2).

A pre-testing of the questionnaire was done with two mentally retarded individuals. This pre-testing revealed the importance of a warm-up because initially one person demonstrated a reluctance to

verbalize. But later, after the warm-up, the individual was quite willing to discuss the questions on the questionnaire. Scientific or socially accepted terminology was not readily understood by the two individuals. However, slang or vulgar terminology was better understood in some instances. The writer experienced difficulty in understanding some responses of the persons participating in the pilot testing.

Two members of the writer's graduate committee members and the writer's graduate class listened to a tape recording of the pre-test interview. They suggested the use of vernacular terminology which was better understood by the participants and also recommended patience in waiting for a response.

During the interviews an attempt was made by the writer to follow the questions on the questionnaire closely to maintain a uniform interview for all participants. But, it was difficult to follow the questionnaire uniformly and to use the same language for all participants.

Mittler (1974) reports that the mentally retarded have particular difficulties in dealing with incoming sensory information, and that many of their learning difficulties can be regarded as stemming from a disorder in attention. During the interviews the author found instances of difficulties in dealing with incoming auditory information and difficulties in attention. At times, participants did not

understand a question or concept regardless of the terminology used or the way in which it was presented. Sometimes responses were totally unrelated to the question or topic of discussion. This may have been due in part to the participant's inability to understand the question or a difficulty in attending to that particular question or topic.

Mittler (1974:535) speaks of another language problem of the mentally retarded that was evident during the interviews. They

frequently lack the social and behavioral skills which would allow them to indicate to the speaker that they were not being understood, thus depriving the speaker of the kind of cues which would enable him to modify his utterance accordingly.

At times cues such as a frown, puzzled looks, or asking for something to be repeated were used by the participants. However, there were also times when participants would look at the interviewer for a considerable length of time with no response or indication that they did not understand the question or topic of discussion.

The language abilities of the participants were varied and no two individuals demonstrated the same degree of comprehension or verbalization.

A language barrier was evident in some instances. Vernacular terms were much better understood than socially accepted scientific terminology. Vernacular terms were used when the participant demonstrated confusion or unfamiliarity with socially accepted words. If the participant did not respond, an attempt was made to determine if

the question was understood. The question was then re-explained in another way or repeated with different terminology. If the participant's response to a question was unclear, an attempt was made to obtain a clear response. This was accomplished by asking, "Would you explain that a little more?" Or a similar phrase was used.

The following questionnaire was used to interview the participants involved in this study.

Questionnaire

Introduction: My name is Bob Ustby. I'm going to talk with you for a while about things you would like included in a sex education class. By talking with me you will help me decide what to include in this new class. Some of the things we talk about may be difficult to understand but that's okay. If you don't understand something, I'll explain it a little more or else we'll just skip over it. What we talk about will be a secret between you and me.

Warm-up: First of all, I would like to know you a little better.

Okay?

What's your name?

What things do you like to do?

Do you like to watch T.V.?"

Other questions of this nature were also used.

Open-ended Question: If you could learn or talk about anything at all concerning girlfriends (boyfriends), dating, kissing, love, sex, marriage, babies, and things like this, what would you like to learn or talk about?

Specific Content Questions:

1. Would you like to learn and talk more about hand-holding?
2. Would you like to learn and talk more about kissing?
3. Would you like to learn and talk more about dating a boyfriend (girlfriend)?
4. Would you like to learn and talk more about love?
5. Would you like to learn and talk more about marriage?
6. Would you like to learn and talk more about babies?
7. Would you like to learn and talk more about how to care for babies?
8. Would you like to see a baby being born?
9. Would you like to learn and talk more about where babies come from?
10. Would you like to learn and talk more about sexual intercourse?
11. Would you like to learn and talk more about contraceptives?
12. Would you like to learn and talk more about venereal disease?
13. Would you like to learn and talk more about masturbation?
14. Would you like to learn and talk more about homosexuality?

15. Would you like to learn and talk more about abortions?
16. Would you like to learn and talk more about the sexual body parts of men and women?

Open-ended question: Anything else you would like to learn or talk about?

No special training was required by the participants to respond to the questionnaire. The writer personally interviewed the mentally retarded individuals. The interviews took place during the months of September and October of 1976. A tape recorder was used to record the writer's questions and the participant's responses. This was done to improve the writer's understanding of what was said by the participants. This was especially helpful in analyzing the data because a certain section could be played back if a response was not understood. This was also a means of having an accurate, permanent record of the interviews.

It was the writer's opinion that the participants thoroughly enjoyed the individual attention received during the interview. Many participants were extremely eager to talk with the writer. In one instance some of the population members hurriedly formed a line awaiting their turn to be interviewed. At times during the interview other topics (not pertaining to sex education) initiated by the participants were discussed. However, there were some individuals who were quite

shy and reluctant to speak. The warm-up portion of the questionnaire seemed to help these individuals to be a bit more verbal.

Method of Organizing Data

The data for this study was organized into tables. The tables show the desires of mentally retarded individuals regarding sex education curriculum content as could be established in the areas investigated.

Analysis of Data

The data collected for this study describe some of the personal desires of a group of mentally retarded people. These desires pertain to sex education curriculum content. Percentage is the means of analysis of these data.

Summary

The population of this study was interviewed to determine what topics mentally retarded individuals desire in a sex education curriculum. The data for the study were generated through the use of a verbal questionnaire administered to each member of the population. The data were organized into tables, and analysis of data was done in percentages.

Chapter 4

RESULTS AND ANALYSIS OF DATA

The following data arranged in tabular form with accompanying comments is an effort to report the participants' responses to the question: "What do mentally retarded individuals desire in their sex education program?"

For reasons of protection of individual confidentiality of records, the populations' backgrounds as to age, sex, and I.Q. range were supplied for the group as a whole to the author by REACH, Inc. Even if such information was available, the data would not have been grouped according to age, I.Q., or sex. The author believes that this grouping could lead to labeling or misleading conclusions applied to a specific group which would hinder efforts to provide and improve individualized sex education to the mentally retarded. The responses of the participants are shown in tables using percentages; however, the writer does not wish to imply that these responses are characteristic of the entire population of mentally retarded individuals.

The population interviewed consisted of six females and thirteen males. The age groupings are presented in Table 3. These individuals have spent from three to thirty-two years in institutions for the mentally retarded. The intellectual range of the group is shown in Table 4.

Table 3. Age Groupings of Population Members at the Time of the Interview

Age	Number	Age	Number
18	2	31	2
20	3	35	1
23	1	36	1
27	3	37	1
28	1	42	1
29	1	62	1
30	1	Total	19

Table 4. Intellectual Range of Population Members at the Time of the Interview

Intellectual Range	Number	Percentage
Mild Retardation*	10	53%
Moderate Retardation*	5	26
Unknown	<u>4</u>	<u>21</u>
Total	19	100%

* See Chapter 1 (definition of terms)

In the following tables some of the comments of the interviewees have been included to reflect the understanding and behavioral evidences which the questions elicited. Since it is possible that these respondents have been taught to respond with "YES" answers and have been rewarded for those responses, the content of the comments may provide more evidence of interests, desires, and understandings than the "YES/NO" answers. In order to determine if a participant was

giving a "YES" response out of habit, a question such as, "Would you explain that a little more?" was asked after a "YES" response.

Those responses in the "UNSURE" category of the tables consisted of such responses as no replies, shrugs, replies unrelated to the question asked, or a lack of understanding of the topic or question asked.

Results of the Questionnaire

The first section of the questionnaire consisted of an open-ended question, and it was designed to ensure that the participant had an opportunity to express questions or comments about sex education curriculum content without being influenced by the specific content questions asked later in the questionnaire.

Response to open-ended question: If you could learn or talk about anything at all about girlfriends (boyfriends), dating, kissing, love, sex, marriage, babies, and things like this, what would you like to talk about? This general introductory question elicited a wide variety of responses. These are listed below.

Comments

"Holding hands."

"Ya. I'm going home." Laughter.

"I don't kiss. I don't do that. I would just like to sleep with cats at night when I'm so lonesome."

"My girlfriend's name is Cheryl." Laughter. "How do girls get babies out of the little seed?"

"My teacher is not here. She went out."

"Well at the workshop . . . Boats."

"Ya shucks." Laughter.

"I have a boyfriend. He's engaged with me tomorrow. He's going to take me to the movies tonight at three o'clock."

"Work. I'm happy." Laughter.

"Cats."

"Becky my girl." Smile.

"I'm not doing that."

"Babies and feeding them."

"No, it isn't worth it. I don't think so."

These responses demonstrate evidences of interests in various topics, denials of doing things related to the open-ended question, replies totally unrelated to the question and laughter. The response, "No, it isn't worth it. I don't think so," may be related to the past experiences the individual has encountered concerning the topic of sex. "Well at the workshop--boats" is a reply that did not relate to question asked. This could have been due in part to a short attention span or misunderstanding of the question asked.

Table 5. Would You Like to Talk or Learn more about Handholding?

YES	NO	UNSURE	TOTAL
14	2	3	19
74%	10%	16%	100%

Comments:

"Ya sure."

"I took her to a show and she held my hand."

"A nice girl. I love her."

Laughter and giggling was demonstrated by four people.

"I don't care." Smile.

This was an area in which most (about three-quarters of the population) demonstrated a favorable response. They seemed to understand this concept quite well. This was evident by the expressions on the participants' faces, the attention given by the participants, and the lack of responses unrelated to the question asked.

Table 6. Would You like to Talk or Learn more about Kissing.

YES	NO	UNSURE	TOTAL
15	2	2	19
79%	10.5%	10.5%	100%

Comments:

"Kiss Dennis. I'm going to get married tomorrow."
 "I kiss my girl goodbye."
 "Kissing all the time."
 "Sometimes girls kiss men too."
 "I kiss Becky. Vickie got kissed. She kisses me." Laughter.
 "I kissed Roxanne." Smile.
 "Kissing is loving and holding hands and dates and everything."
 "Chucky don't care." Laughter and smile.
 "Kiss one of my girlfriends." Giggle.
 "Kiss Ginger." Smile. "Kiss Mike."
 "Not hugging either. Cause not about the boy's either cause they can be so rough. Cause I don't want to be . . . because if there are rough boys they will fall on me and turn me into a bowling ball. I don't want that."

Kissing was another area in which the great majority expressed an interest, and this concept seemed to be understood by almost all individuals. There were no responses unrelated to the question asked and there was no evidence of any lack in attention span. One individual related kissing and hugging with "rough boys" and subsequently becoming pregnant, i.e., "turn me into a bowling ball." However, for most of the participants, kissing seemed to be associated with a more pleasurable experience.

Table 7. Would You like to Talk or Learn more about Dating Girlfriends or Boyfriends?

YES	NO	UNSURE	TOTAL
13	1	5	19
68%	5%	26%	100%

Comments:

"Go to the movies, to the dances."

"How to make dates. Call up girls. Movies, bowling, and the Dairy Queen."

"I like to take a girl out, movies, drive-ins, and everything."

"Kiss girls. Dating."

"Dancing and the Halloween Party."

"To the movies."

"I haven't got any girls."

"Dating for what?"

"My mom and dad told me about deer and elk."

"No I don't do that. I get so shivering."

Dating was another area in which almost seven out of ten of the population expressed an interest. One respondent denied doing any dating although the question of whether she did any dating was not asked of her. This person may have picked up the idea that dating was not allowed or maybe she did not care for dating. "My mom and dad told me about deer and elk," is a reply that appears to be unrelated to the question asked.

Table 8. Would You like to Talk or Learn more about Love?

YES	NO	UNSURE	TOTAL
13	0	6	19
68%	--	32%	100%

Comments:

"Don't know much about love. Sometimes girl fall in love with guys.

Girls want to know about men too . . . Fall in love, marriage."

Laughter.

"Love, when you're married."

"I went to church and they marry them. I love her."

"Well I like girls, kissing, and loving."

"I know that. I know that."

"Kiss girls."

Big Smile

"Love means you get a hug."

"Going home on Thanksgiving."

"Loving a kitty and that's all I want to do."

Responses ranged from the simple "Love means you get a hug," to the more complex "Love, when you're married." Almost seventy percent of the population members expressed a desire to talk and learn more about love.

Table 9. Would You like to Talk or Learn more about Marriage?

YES	NO	UNSURE	TOTAL
12	1	6	19
63%	5%	32%	100%

Comments:

"Fall in love. Marriage. Engagement ring and wedding."

"Some girls get married."

"Well I take care of marriage to get a woman and love and take her out to dinner, movies, dancing, and everything."

"Oh ya. No me I didn't get married, my brother did."

"I wanta get married! I wanta get married!"

"The wedding, kissing, love. She's my girlfriend."

"I would like to get married so I can have kids, so can have a baby, so I can be a baby sitter. Take her to the show, honeymoon, and church."

"I'm going home in a week."

The author still remembers the excited reply, "I wanta get married. I wanta get married." Over sixty percent of the respondents were interested in talking and learning more about marriage. "I'm going home in a week" appears to be a reply unrelated to the question asked.

Table 10. Would You like to Talk or Learn more about Babies?

YES	NO	UNSURE	TOTAL
16	2	1	19
84%	10.5%	5%	100%

Comments:

"Ya babies."

"Mother has a baby."

"I don't know. See my football shirt . . . I don't have a baby no more. I gotta shave."

"I guess I wouldn't mind."

"I know how to take care of babies but I don't know how to change diapers though. I don't know how to give them milk."

"I like babies."

"They are little. They are small."

"Oh I don't know."

"Ya babies and when they are little."

"I don't want to baby-sit."

Babies were of interest to almost all individuals of the population. Many participants seemed happy when talking about babies. They often smiled or even pretended they were holding a baby.

Table 11. Would You like to Talk or Learn more about Caring for Babies? Would You Like to See a Baby being Born?

YES	NO	UNSURE	TOTAL
9	1	9	19
47%	5%	47%	100%

Comments:

"Feed them. I don't want to change diapers. Know how to baby-sit."

"I don't know."

"Ya. Fine."

"How to care for them and feed them."

Would you like to see a baby being born?

YES	NO	UNSURE	TOTAL
6	1	12	19
32%	5%	63%	100%

Comments:

"Because he's born from a mother."

"I would like to see a baby being born."

"Would like to see where the baby comes from, egg in the womb."

"At the hospital. Through the glass."

The large number of "UNSURE" responses could be due to a reluctance to discuss this topic or a lack of understanding of the concepts involved. The positive responses varied from concepts that involved babies being born at the hospital to concepts that involved babies being born from an egg in the womb.

Table 12. Would You like to Talk or Learn more about Where a Baby Comes From?

YES	NO	UNSURE	TOTAL
10	3	6	19
53%	16%	32%	100%

Comments:

"Ya babies, heaven, God."

"Out the back-end. They are born."

"From here the stomach. I don't know how they get there."

"From your stomach. My teacher is going to have a baby."

"From the woman's stomach."

"They come from the hospital."

"They come from the stomach. Some girls get married."

"They come from the mother. Women get pregnant. They go to the hospital and see if okay normal and then put in incubator."

"Fucking a girl, then have a baby. Guy gets on top of the girl."

Responses varied from babies coming from heaven and God or from the hospital to "Out the back-end" or "From the woman's stomach." One individual was concerned about the normality of a newborn baby.

Table 13. Would You like to Talk or Learn more about Sexual Inter-
course?

YES	NO	UNSURE	TOTAL
6	4	9	19
32%	21%	47%	100%

Comments:

"I'd like to learn about that."

"I'm not going to say. I'm not going to say."

"Oh ya. You get a girl pregnant."

"Ya. You get a baby."

"Not very much. Keep the doors locked."

"I don't like that. I don't like that at all. It makes me jealous.
Cause most of the time I want to be around someone I like. Not
someone who is rushy."

"Not while I'm here. I can't swear."

Some respondents indicated a reluctance to talk about this topic and this could be a reason for the increased number of responses under the unsure category. This was evident by smiles or laughter which may have been an indication that they understood the concept. However, many did not reply to the question. "I'm not going to say" and "Not while I'm here. I can't swear," are responses which indicate a reluctance to talk about this topic.

It is possible that these retarded people are no different from many other people in that they did not desire to discuss this subject, or that they have learned from others that talking about sex is taboo.

This question was asked using vernacular terminology in most cases. One person's response demonstrates the need to use language understood by the participants. This person did not understand the word sexual intercourse, however, when the interviewer used the word "fuck" the interviewee replied, "Oh ya, you get a girl pregnant."

Table 14. Would You like to Talk or Learn more about Contraceptives, Venereal Disease, Masturbation, Homosexuality, and Abortions?*

Would you like to talk or learn more about contraceptives?

YES	NO	UNSURE	TOTAL
1	1	17	19
5%	5%	90%	100%

Comments:

"Rubber go over cord."

Would you like to learn and talk more about venereal disease?

YES	NO	UNSURE	TOTAL
1	0	18	19
5%	--	95%	100%

Comments:

"You get sick. Maybe you get sick to your stomach."

Would you like to talk and learn more about masturbation?

YES	NO	UNSURE	TOTAL
0	1	18	19
--	5%	95%	100%

Would you like to talk or learn more about homosexuality?

YES	NO	UNSURE	TOTAL
0	0	19	19
--	--	100%	100%

Table 14 (continued)

Would you like to talk and learn more about abortions?			
YES	NO	UNSURE	TOTAL
0	0	19	19
--	--	100%	100%

* Responses are arranged according to subject

Table 14 represents questions in which the majority of answers were listed under the "UNSURE" category. This could be attributed to the more complex nature of the topic subjects or a reluctance of the participants to discuss these topics. The cognitive level of many of the participants was such that the inability to comprehend these topics was a very likely possibility.

These topics were rephrased using vernacular terminology, but the participants still did not respond to these questions in a way that indicated whether they would or would not like to talk or learn more about these topics.

Table 15. Would You like to Talk or Learn more about Sexual Body Parts of Boys and Girls?

YES	NO	UNSURE	TOTAL
9	0	10	19
47%	--	53%	100%

Comments:

"Baby girl and baby boy."

"Girls have long hair and boys have short hair. Boys like girls."

"Girls are different. Dress nice."

"I don't know. If I looked at a boy I'd tell him you're a cowboy."

"They are nice."

"Girls have a cunt and men don't. Men get women pregnant. Women can't get man pregnant."

Responses ranged from the more superficial difference of long and short hair to the more complex difference of the genital anatomy of females and males.

Response to the final open-ended question: Anything else you would like to talk about?

Comments:

"Ya. What's your name?"

"Ya. I have two sisters."

"I took a bath tonight."

"Learn about hospitals. I would like to learn more about retarded. Some babies born retarded and some not. It don't make sense. Why some babies born retarded and some not? . . . Sterilization to tie cords together so a girl don't get pregnant."

"I would just be . . . loving everybody. Going to play basketball instead of football, it's a yucky game. . . . Behaving when on a date."

"We watch the Brady Bunch."

"Holding hands. Praying at church."

"Girls and man . . . I can't say it. Dating, loving, kissing."

"Holding hands."

"Can I go to the movies tonight? My sister has a baby."

Sterilization was mentioned, and it was not included in the questionnaire. The question, "Why some babies born retarded and some not," was something that greatly interested one individual. This question could be of interest to others and demonstrates the importance of an open-ended question when eliciting information from individuals.

The participants demonstrated a difference in ability to understand language, in a willingness to talk, and in ability to speak clearly. The interviewer had difficulty in understanding the speech of some interviewees; this could have been in part due to the interviewer's unfamiliarity with their speech. The investigator was able to understand the speech of many of the participants without any difficulty.

Some participants were reluctant to talk, and even if they did speak it was done very quietly and not much was said. Others, however, were very verbal and enjoyed talking with the writer.

Socially accepted terminology was understood quite readily by some participants, while others in some cases understood only the vernacular terms.

Other differences regarding communication levels were demonstrated by the participants. Frowns, puzzled looks, or asking for something to be repeated were clues given by some retardates to the writer that they did not understand a concept or question. Others gave no clues of incomprehension when it was evident that they did not understand the question or topic. In some cases an interviewee just stared at the writer for a considerable length of time without saying a word after he/she was asked a question.

Chapter 5

SUMMARY, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to determine what mentally retarded individuals residing in group homes desire in their sex education program.

The study was based on data collected from nineteen mentally retarded individuals residing in group homes. These people were interviewed by the investigator. A tape recording was made of each interview which focused on the questions of a questionnaire developed by the writer. The content of the questions relate to topics presently in use in sex education curricula for the mentally handicapped and those topics suggested by authorities in the field. An open-ended question was used at the beginning and at the end of the questionnaire to ensure that the participants had an opportunity to express questions or comments about sex education curriculum content without being unduly influenced by the specific content questions.

Findings

In an effort to describe what these mentally retarded individuals desired in a sex education program, the researcher sets forth the following findings from this study:

1. Most of the participants (sixty-three to eighty-four percent of the population) indicated that they would like to talk or learn more about the following:

- a. handholding
- b. kissing
- c. dating girlfriends or boyfriends
- d. love
- e. marriage
- f. babies

Meyers (1972) in his curriculum guide for teachers of the mentally retarded includes primary level lesson plans that relate to love and human reproduction. In advanced level lesson plans he includes dating and marriage. Kempton, Bass, and Gordon (1971) in their book for parents of the mentally handicapped include chapters on dating, marriage, and children. It appears that these expressed interests of the study population may be included in some of the present-day sex education curricula guides for the mentally retarded.

2. About one-half of the participants indicated that they would like to talk or learn more about the following:

- a. caring for babies
- b. where a baby comes from
- c. sexual body parts of boys and girls

Meyers (1971) includes primary level lesson plans on reproduction and differences between men and women. Kempton, Bass, and Gordon (1971) include chapters on dating and sexual intercourse. Gordon (1975) suggests that mentally retarded individuals, who are thinking of having a baby, should first work for a month in a day care setting taking care of mentally retarded children. It appears that the above expressed interests of the study population are included in some curricula guides or recommended by some experts in the field.

3. About one-third of the participants indicate that they would like to learn or talk more about the following:

- a. sexual intercourse
- b. see a baby being born

However, two-thirds of the population gave responses which were listed under the "UNSURE" category. These responses listed under the "UNSURE" category were such responses as no replies, shrugs, replies unrelated to the question asked, or an inability to understand the question asked.

The high number of responses under the "UNSURE" category may be due in part to a reluctance of some participants to talk about sexual intercourse. Also, some participants may not have understood the concept of sexual intercourse, even after it was re-explained using vernacular terminology.

Kempton, Bass, Gordon, and Meyers all suggest that sexual intercourse be included in sex education curricula for the mentally retarded. The writer has not found any curricula guides for the mentally retarded that include showing the birth of a baby.

4. Almost all or all of the participants gave responses to some questions related to the topics listed below that were listed under the "UNSURE" category. It could not be determined from this study whether the participants did or did not want to talk or learn more about the following topics:

- a. contraception
- b. venereal disease
- c. masturbation
- d. homosexuality
- e. abortions

Kempton, Bass, Gordon, and Meyers all suggest that the above topics be included in sex education curricula for the mentally retarded.

It is the writer's opinion that most of the participants of this study did not understand the preceding topics or they were reluctant to talk about them, or both.

5. The population members demonstrated varying degrees of interests, desires, attention spans, and speaking abilities. They also differed as to language comprehension of socially accepted and

vernacular terminology. Differences were also noted in the tendency to verbalize and in the understanding of topics or questions.

Weisgerber (1974), Gunzberg (1974), Shindell, Borthick, Fisher, and Krujicek (1973), and Mattison (1973) support the fact that mentally handicapped people are unique individuals. Mittler (1974) reports that mentally retarded individuals vary as to their speaking skills and general language abilities.

Conclusions

It was found that:

1. These retarded individuals did have opinions, desires, and ideas about what they would like to talk and learn about in a sex education program. Most of the members (sixty-three to eighty-four percent of the population) indicated that they would like to talk or learn more about (a) handholding, (b) kissing, (c) dating, (d) love, (e) marriage, and (f) babies. About one-half of the participants indicated that they would like to learn or talk about (a) where a baby comes from, (b) caring for babies, and (c) the sexual body parts of boys and girls.
2. These retarded individuals had varied interests, desires, attention spans, language problems, and cognitive abilities.
3. An individualized program and teaching on an individualized basis would be necessary when teaching sex education to these mentally

retarded people because of their varied interests, desires, attention spans, language problems, and cognitive abilities.

Recommendations

The following recommendations are made:

1. That the mentally retarded be asked about what they would like to talk or learn about in a sex education program.
2. That the subject matter in sex education curricula for the mentally retarded include but not necessarily be limited to the questions, desires, and interests of the retardates.
3. That the sex education programs for the mentally retarded be individualized to meet the varied interests, desires, attention spans, language problems, and cognitive levels of these people.

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APPENDIX

Appendix A

REACH, INC. - PROGRAM SUMMARY

This information, provided by the Director of REACH, Inc., gives insight into the environment of the study population.

REACH, Inc. is a legally recognized, non-profit organization which is currently providing services in a small western city. REACH administers and operates three group homes and provides daily living and training services. Additionally, REACH administers and operates a work activity center and a day activity program. It is the intention of REACH to teach and train developmentally disabled individuals to achieve maximum independence. REACH, Inc. strives to help clients to exercise their constitutional and statutory rights. Their ultimate goal is that the mentally retarded clients may live as normally as possible.

The daily living services provided in the group homes include supervision and support to the mentally retarded residents. Additionally, a minimum of four hours of formal structured training is provided on a daily basis by the group home counselors. Baseline data are recorded to determine individual skill levels, target behaviors are identified, and specific objectives are established to reach specific goals. Emphasis on training includes, but is not limited to, the following: Personal care skills which include appropriate dressing, grooming, bathing, use of toiletries, washing and combing hair and

taking care of one's living area and personal belongings. Housekeeping and kitchen skills which include vacuuming, dusting, mopping, using kitchen appliances and utensils, operating the washer and dryer, preparing food, and acquiring table manners. Community functioning skills are recognizing safety, warning, and information signs, identifying businesses and their functions, constructively using leisure time, purchasing of items, managing money, and acquiring appropriate socialization skills.

The work activity center operates five days a week from 8:30 a.m. to 3:30 p.m. This program is designed to enhance the quality and effectiveness of client abilities to support themselves and to function as independently as possible, while providing meaningful work, productivity, and remuneration.

The day activity program operates five days a week from 9:00 a.m. to 3:30 p.m. The program provides services in the areas of functional academics, recreation, and leisure time activity. Community functioning skills, arts and crafts, and socialization skills are given special consideration.

The population of this study were all involved with various REACH programs, which included the daily living services, work activity center, and day activity center. Some individuals are involved in part-time or full-time employment in the community. The program was

individualized so that people did not spend the same amount of time in each area.

