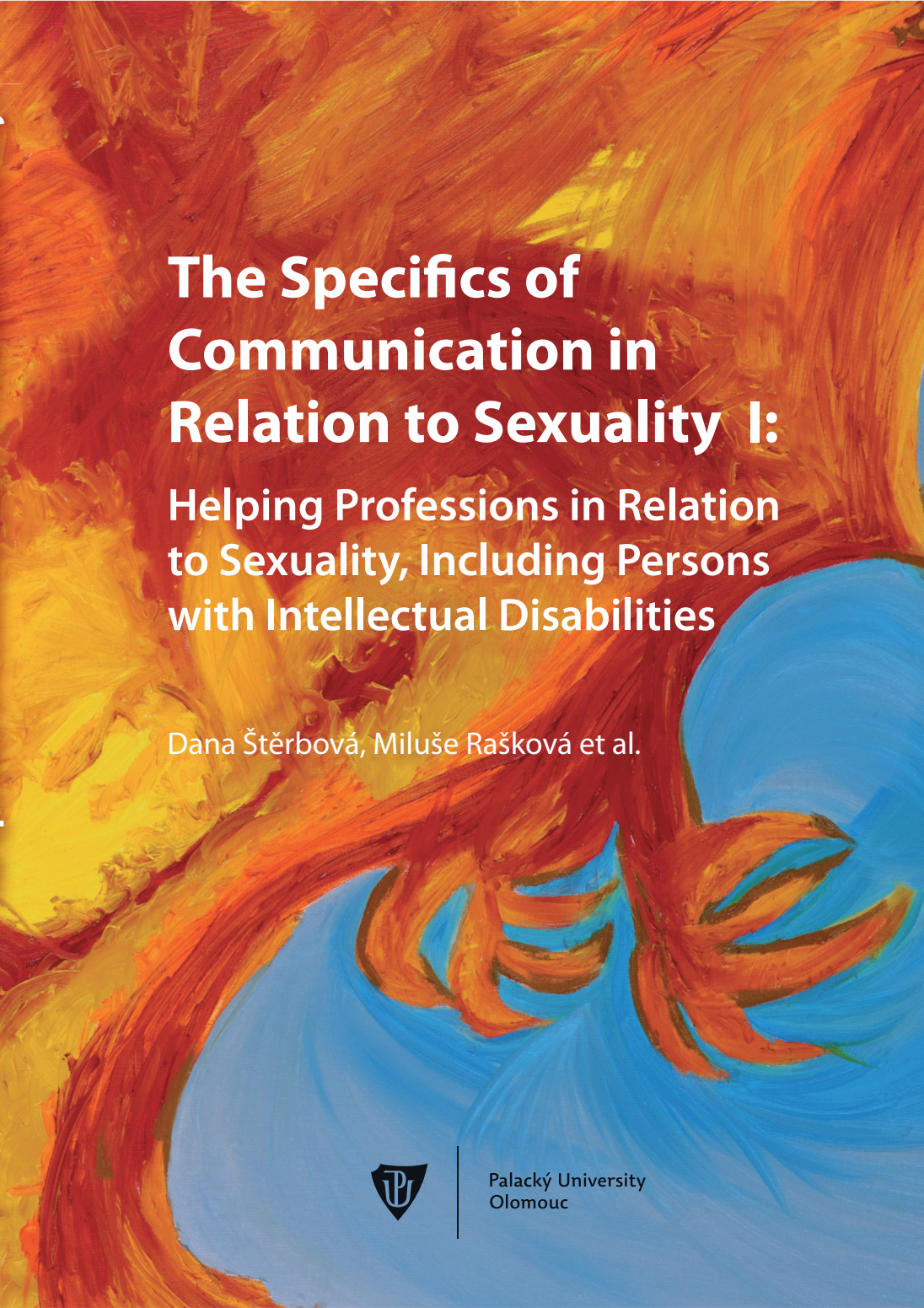

The Specifics of Communication in Relation to Sexuality I:

Helping Professions in Relation to Sexuality, Including Persons with Intellectual Disabilities

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Foreword

In a secondary school class, a debate on HIV approved by the school administration and lead by two young people is ending. In addition to presenting facts, the debate involved practicing skills, especially communication skills how to say no when you do not want to have sex, how to be able to require the use of a condom if you want to protect yourself and how to properly use a condom. Based on the amount of final applause, the debate was beneficial. "Is there anything you would like to ask? We will also be available during the break, or you can send us an e-mail, even an anonymous one." One hand rises with hesitation: "I would like to ask if you agree with providing sex education in schools – I think it would be terrible, your debate was much more interesting." The lecturers look at each other with a speechless expression, searching for words. An answer is running through their heads, but they cannot say it aloud: "...and what we have just done was not sex education according to you?" For the first time ever they are witnessing a complete misunderstanding of the term "sex education", which has never really been understood in the Czech Republic.

If you speak about HIV and preventing unwanted pregnancy, puberty, conception, delivery, miscarriage, abortion, partnership, marriage, parenthood or homosexuality, nothing exceptional will happen; if you speak about sexual abuse prevention, you might warrant compliment. However, as soon as you refer to the above topics as sex education, sooner or later you will hear objections, sometimes very loud ones.

This is a common phenomenon: when the Czech language adopts a foreign word that does not have a Czech equivalent, it is usually because it is attributed a different, either wider or narrower meaning than is possible in a word-for-word translation. Nobody makes such deliberate decisions and it just happens as the language develops. If you tell an American that you are sending something by mail, he or she will expect a paper envelope, but every Czech person will know that you are referring to e-mail. The English term "sex education" does not stir any great emotions – after all, the word sex is listed in everybody's passport and does not cause any public outcry. Nevertheless, if you say *sexuální výchova* (sex education), some people will be embarrassed, some will laugh at you or even attack you. What can we do about it? Go back to the term *pohlavní výchova* (gender education)? In such cases, will we use the other the meaning of the English word sex? *Sexuální vzdělávání* (sexual training)? Probably not.

Our only choice is to patiently explain why sex education and awareness are important and what these terms mean. That they refer to the broad meaning of sex education, including a large portion of interpersonal relationships, health protection not only as a physical condition, but also mental and social wellbeing, both for our own moral and ethical principles and respect for different norms, partnership, marriage and parenthood, the variability of human behaviour and the possibility of free choice.

Traffic education can serve as a good example for comparison when explaining the term sex education. With traffic education, nobody doubts that it means education for observing safe behaviour in traffic where everybody is a pedestrian first, then a cyclist and maybe a motorcyclist later, and once they are an adult, they can drive a car. And just as many drivers still ignore some new rules, newer and newer topics are appearing in sex education, even for adults, and not everybody is willing to accept them.

Everybody who works as a teacher or helping professional will, sooner or later, encounter a sign of affection, relationship, sexuality, anatomy or physiology ignorance in his or her clients and unless such person has received proper training, he or she will be taken by surprise and feel incompetent. Every summer camp instructor, tutor, social worker and personal assistant (I apologize if I missed anyone) encounters signs of puberty and sexuality. Sex education is not just the domain of parents, biology or health science teachers; everybody can find some basic knowledge helpful. At a minimum, we have to know when we ourselves can provide pupils and clients with information in a suitable form and what should be left to the professionals (doctors, psychologists, lawyers and others). We also have to define clear limits when interacting with pupils and clients. It is also important to create a safe social environment in which both clients and workers can confide in a competent person. From our experience, we know that the range of approaches to sexuality of persons with intellectual disabilities is very wide – from complete ignorance of their sexuality, to its prohibition and tabooing, to "sexual freedom" provided in good faith without any education under the pretence of observing human rights when the staff is so insecure that they tolerate sexual harassment from their clients.

The textbook that you are holding in your hands should be another piece of the puzzle for building theoretical foundations for sex education for people working as helping professionals and teachers, their clients and pupils. I wish you a lot of success at work and good luck in your personal life.

Zuzana Prouzová

Introduction

This publication focuses on the issue of sexuality with respect to the communication aspects of helping professionals. It is divided into four basic parts that explores sexuality in general, then looks at sex education, addresses communication and then provides an introduction into the empirical research that was carried out. The issue of sexuality has never been covered or processed in any Czech specialised resources in this manner although such need is dictated by practice and is highly topical. One of the reasons why this issue has not been covered is the certain level of taboo that surrounds sexuality, as well as the existing discrepancies in different opinions about and attitudes towards sexuality in general, including in persons with intellectual disability.

Part I is dedicated to selected terms associated with sexual issues and areas related to sexuality. It focuses on sexual abuse, including the abuse of people with intellectual disabilities. The issue of specific approaches towards persons with addiction is, in our opinion, very inspiring. Next, it explores the topic of helping professionals and the people who work in these professions. Other chapters are dedicated to attitudes, sexuality and families who have a member with an intellectual disability.

Part II deals with the issue of sexuality, education and learning in curricula both at the individual school and national levels. It also describes the specifics about approaches to take towards persons with disabilities.

The authors who contributed with their specialised knowledge to individual chapters are experts in their helping professions and drew information both from specialised texts and form their own long-term experience.

We believe that for some experts, this textbook will create an internal disagreement of opinions, which we see as the impulse for engaging in further professional discussions about sexuality, including the sexuality of persons with intellectual disabilities.

Dana Štěrbová and Miluše Rašková

Part I

ABOUT SEXUALITY – IN GENERAL

1.1 Sexuality and Selected Terms Related to Sexual Issues and Topics

Ivo Procházka

It is not easy to define **sexuality**. Most sexology textbooks (Weiss et al., 2010; Zvěřina, 2003) do not provide a definition and consider this issue to be unclear. According to the Encyclopaedia of Psychology (Psychologický slovník) and the Encyclopaedia of Sexology (Sexuologický slovník), sexuality mainly refers to the set of qualities and phenomena that are given by sexual differences (Hartl & Hartlová, 2000; Caponni, Hajnová & Novák, 1994). Sexuality includes (Hartl & Hartlová, 2000):

- Anatomic, hormonal and reproductive differences between men and women (or males and females);
- A set of behavioural signs and feelings (or reactivity, i.e. a disposition towards a certain type of behaviour and feelings) that result from physical and mental differences between the sexes, including reproductive phenomena and activities;
- The term sexology usually includes erotic behaviour even if it is not sexually specific;
- Different social (gender) roles.

The signs of sexual behaviour refer to phenomena that are related to reproduction, genital and erotic pleasure derived from becoming closer, being close to each other and sexual intercourse (Jandourek, 2001), as well as possibly also autoeroticism, erotic love and attraction. In lay terms, the meaning is sometimes narrowed even more, referring only to the genital and orgasmic areas. Nevertheless, even experts who deal with psychology and medicine largely focus on the aspects of human sexual and reproductive behaviour that are the socially most important signs of sexuality (Baštecká, 2009).

However, in the broader sense of them meaning, sexuality includes more general social aspects. Sigmund Freud was the first person who considered human sexuality an important influence in the shaping of one's personality (Baštecká, 2009). Sexuality is often associated with general

altruism and a tendency to seize power (Foucalt, 1999). A broader concept of sexuality also includes physiological differences based on gender (such as verbal skills, spatial imagination, the ability to think abstractly), social skills and empathy and their application in social relationships. Some of these properties are sexually dimorphous, based on biological predispositions, but many of them are formed, reinforced or weakened by the social environment (such as the notorious sayings that boys should not cry and that pink is for girls and blue is for boys). Deciding whether innate or acquired properties are dominant has caused innumerable disputes between biologists and sociologists (nature vs. nurture).

The original widespread medical and biological approach taken towards sexuality that is especially focused on sex organs, reproductive, hormonal and sexual functions, different sexual orientation and sexual identity is supported by the perspective of various social sciences, especially anthropology, sociology, gender studies, philosophy and political science. This is reflected in social movements (feminism, sexual minorities, father's rights, etc.). Some social systems are defined as sexually-repressive (e.g. the Taliban), while others are permissive (European democracies). We can say that the degree of sexual repression is usually positively correlated to the role of church in any given society.

In the Czech environment, **sexology** is a medical branch that deals mostly with sexuality in a narrow sense of the word and, just like the whole body of medicine; it explores not only healthy sexuality, but also pathologic phenomena and their prevention, diagnostics and treatment. However, even in medical sexology, members of other scientific branches have a major say, mostly psychologists and sociologists. The interference by other branches is also facilitated by the prevailing international approach taken towards sexology where the share of non-medical specialists is much larger (Zvěřina, 2003).

The medical approach is closely related to the term **reproductive and sexual health** (World Health Organisation, 2011). This term (similarly to the general definition of health) is not defined only as the absence of diseases and disorders, but also as the state of one's physical, mental and social welfare in relation to sexuality. People should be able to choose their desired level of responsibility, satisfaction and safe sexual life. They should be able to retain their reproductive function and they should have the right to decide whether they want to use it or not, or when and how often. Another interpretation emphasizes sufficient access to information, the

right to choose safe, effective and available contraception and the right to use professional services. It is important to guarantee people the right to the highest possible chance to have a safe pregnancy and delivery and ultimately healthy children,

Reproductive and sexual health also means respecting those **reproductive and sexual rights** that are not contrary to the rights of others. It is logical that disagreements can exist even in sexually-permissible societies. The term reproductive and sexual health does not apply only to adults, but to all periods of the human life cycle where development stages have to be respected.

A typical problem is the conflict between the parents' rights to decide on the upbringing of their children and the children's rights to comprehensive information about sexuality, especially the prevention of undesirable phenomena, such as unwanted pregnancy and sexually transmitted diseases.

Another ethical issue of even greater importance is a mother's desire to deliver her child at home. In case of health complications, there is a greater risk that help will not be available in time.

A similar situation is the refusal by an HIV-positive mother to undergo perinatal prophylaxis to decrease the risk of transmitting the disease to the foetus and the right of the unborn child to decrease the risk of this transmission. In similar cases, lawyers typically recommend the mother's right be respected given the low degree of risk. In some countries, HIV-positive women are prosecuted if they get pregnant.

The Czech Republic has also had to face a conflict between individual rights and state authorities: the case concerned a homosexual couple who were recognised as parents under US law after a surrogate mother was impregnanted with their sperm. After returning to the country, the child could not be awarded Czech citizenship because Czech law cannot recognise two men as parents. It was not even possible for one of them to become a father and the other one to adopt the child. The practical consequence of this situation is that the child as a foreigner cannot automatically receive free medical insurance even though its factual parents who are raising it are Czech citizens. Whether or not we agree with what the couple, unfortunately, it is the child who is made to suffer because of their acts.

The choice of terminology often expresses the absence of a positive approach towards sexuality. **Sex education** is sometimes hypocritically referred to as family education, emotional education, etc. This is supposed to make the acceptance of sex education easier with lay people who see it only in its

limited form; other times, it reflects the efforts to suppress certain sexual topics (such as sexual orientation, contraception, etc.). Similarly, sexual and reproductive health and rights are sometimes limited only to reproductive ones. This creates the impression that the only purpose of sexuality is reproduction. Although, in reality, there are only very few people who see sexuality in this way, the impression ignores the important emotional and recreational dimensions and the role it plays when helping couples to form a positive relationship.

Sex education combines information about psychosexual and physical development, hygiene and prevention focusing on the mitigation of undesirable phenomena, such as sexual abuse, unwanted pregnancy, sexually transmitted diseases, a healthy lifestyle with education aimed at the development of life's emotional aspects and respect for human rights. Lenka Šulová (Weiss et al., 2010) considers a child's parents to be the most suitable source of sex education; however, parents are usually not sufficiently competent to provide this education and do not have sufficient knowledge and experience, did not receive similar sex education themselves and very often, this results in intrapsychical conflicts. Therefore, it is necessary for schools to assume the primary role in providing sex education. The spread of HIV/AIDS necessitated a greater need for sex education countries and communities, even those that had rejected it in the past. In its 2011 judgment in Dojan and others v. Germany, the European Court of Human Rights confirmed that the plaintiffs were not entitled to remove their children from a sex education class because of their (Baptist) education (ECHR, 2011). Naturally, it is the teacher rather that other subject-matter experts without teaching skills who plays a key role in sex education (Weiss et al., 2010).

The methodology of sex education is to be based on various approaches that differentiated by age. While sex education for the first years of primary school provides information about anatomical differences, sexual hygiene and sexual abuse prevention, the next level has to pay more attention to the prevention of unwanted pregnancy and sexually transmitted diseases.

Important sex education topics are the effort to delay beginning a sexually-active life, which, on the other hand should not result in ignoring reality (abstinence only programmes), and to promote other methods of how to decrease the occurrence of unwanted pregnancy and sexually transmitted diseases (Sather & Zinn, 2002; Weiss et al., 2010; www.siecus.org).

The sensitive topic of homosexuality and different sexual identities should be a part of one's general education of tolerance and acceptance of

differences during the first years of primary school; in later years, greater attention has to be paid to the understanding of this phenomenon, the differences of emotional affection and how to recognise one's own sexual orientation. Naturally, we should not forget about promoting safer sex, which has its own specifics with sexual minorities. However, this topic is entirely omitted in many countries and schools (Smetáčková & Braun, 2009).

The basic topics of sexology

Sexology as a medical branch mainly deals with health disorders and dysfunctions. These include (together with gynaecology) the issues of fertility, sexual dysfunctions, sexual deviations (in modern terminology referred to as paraphilia) and the prevention of sexual offences and sexual violence, counselling associated with sexual orientation and sexual identity, and possibly also the change of sex with transsexuals, counselling on sexual development and the prevention of sexually transmitted diseases. Sexology topics also includes sexuality and reproduction for disabled people, including intellectually-disabled and HIV-positive people.

Infertility

Approximately 10 percent of all couples who try to conceive a child remain childless after one year. Men and women are roughly equally responsible for infertility. Recently, there have been discussions about whether the reproductive potential has been decreasing (especially in men), but results are unclear. Independent longitudinal data on the fertility of the healthy population is missing. An infertile couple is defined as a heterosexual couple that is not able to conceive a child after having unprotected sexual intercourse for at least one year. In such cases, a medical examination is indicated and it begins with the man (because it is easier). Topical issues associated with reproduction include the preservation of the reproductive function during serious (e.g. oncological) diseases and injuries, and the development of reproductive technologies and their greater availability.

Sexual dysfunction

Sexual dysfunctions can be divided into male and female, primary (from the beginning of one's sex life) and secondary, generalized (the disorder is present during all sexual acts) and selective, and based on aetiology,

whether organic or psychogenic. An actual sexual act (whether with a partner or masturbation) follows the human sexual cycle that is described by Masters and Johnson. It includes the phases of arousal, plateau, orgasm and refraction. This enables physicians to identify sexual dysfunctions in humans according to individual phases. An important feature preceding the sexual cycle is sexual interest, where disorders frequently occur. Both sexes can display a reduced sexual interest, as well as rarely also a higher sexual interest (hypersexuality). The reasons for a reduced sexual interest can vary, and include physical (hormonal, severe diseases), mental (depression), partnership, etc. The most frequent disorders for which men seek professional help is erectile dysfunction during the arousal phase. This corresponds to lubrication disorder in women. The inability to reach an orgasm or any difficulties associated with it are more common in men. Men often suffer from early ejaculation (and orgasm). Other disorders include female vaginism (a pain felt during penetration) and dyspareunia (painful sexual intercourse without any organic causation).

Sexual deviations (paraphilia) and their relationship to sexual crimes

A sexual deviation is characterised by a qualitatively atypical sexual motivation. According to the International Classification of Diseases (ICD), sexual deviations mainly include fetishist transvestism (which also affects sexual identity disorders), exhibitionism, fetishism, paedophilia and sadomasochism. A specific disorder recognised in Czech sexology is pathologic sexual aggression. Deviations can be divided according to the object of interest (paedophilia, fetishism) or activity (exhibitionism, voyeurism, pathologic sexual aggression) (Weiss, 2008).

Some deviations are not socially dangerous (fetishism, fetishist transvestism); with sadomasochism, both socially dangerous forms (necrophilia and immobilizing sadism) and tolerated forms (fetishist sadomasochism, BDSM) are distinguished. Many deviant people never put their tendency into use (their share is unknown because these people typically do not seek professional help) or they turn them into socially acceptable forms (e.g. a paedophile can write children's fairy tales).

On the other hand, many sexual offences are related to sexual deviations. The most frequent sexual offence, rape, is typically committed by

non-deviant (healthy) offenders. In addition, sexual abuse most often occurs within a family and the offenders are not sexual deviants.

An important part of sex education is protection against sexual abuse, or the mitigation of its consequences. This especially includes a child's right to refuse unwanted physical contact. If such contact occurs, it is important to let the child know that he or she was not responsible. Passing accountability onto the victim is a frequent defence mechanism used by offenders.

Sexual orientation

Sexual orientation is defined as a life-long and stable condition that is not caused or chosen by the individual that includes an exclusive or prevailing erotic and emotional preference for and attraction to persons of a given sex. In most individuals in all societies, heterosexual orientation (i.e. an attraction towards persons of the opposite sex) is typical; a smaller percentage of people (estimates range from 1 to 10%) reports a homosexual orientation. Homosexual orientation is not considered a health disorder. Any kind of treatment is considered medically and psychologically unjustified, inefficient and risky. An egodystonic sexual orientation is considered a neurotic health disorder. This means that an individual has problems accepting anyone, which results in health issues. Accepting one's minority sexual orientation is referred to as coming out. The existence of bisexual orientation, i.e. a life-long comparable and balanced sexual and emotional attraction to both sexes, is questioned by some experts and others consider it very rare.

From the social-psychological perspective, **sexual identity** (i.e. identification with a certain sexual orientation, in other words how one sees himself or herself) is more important. It is largely dependent on the degree of self-knowledge, but is also affected by cultural and social factors. Self-identification can be either heterosexual, homosexual or bisexual (the last one appears to be more common in women).

Sexual behaviour itself may or may not be reflected in sexual orientation and self-identification. It is largely influenced not only by cultural, but also personality and situational factors. From the professional and research perspectives, suitable sexual behaviour should be related to a certain time unit.

Attitudes towards homosexuality differ substantially in different periods of history and in different cultures. They are affected by many social-demographic factors. The most important is religious beliefs, which often

results in more negative attitudes towards homosexuality, contraception and pre-matrimonial sex, a more restrictive approach taken towards the HIV-positive, IV fertilisation and pregnancy termination. Restrictive sexual attitudes can often be heard from older and less educated people. Sexual conservatism is often related to political conservatism. Opinions are most significantly influenced by the respondent's sex – men tend to show a more liberal attitude towards sexual issues than women, with the exception of homosexuality. The most tolerant towards homosexuals are young people from large cities with populations over 100,000 who have at least a secondary education and are not religious, and are mostly women; on the contrary, older and less educated Catholics from smaller towns, especially men, are the most homophobic. Those who believe that one's sexual orientation is a choice and can be changed are also more restrictive.

Today, homophobic attitudes and bullying are increasingly more common among pupils and students. They can be a reaction to a minority sexual orientation and sexual identity or to the unveiling of certain personality features that are considered homosexual by society. Even (pre-) heterosexual children who are different from the majority often fall victims to such behaviour (Smetáčková& Braun, 2009).

Gender identity

Each person's sex is determined on several different levels. At the biological level, we distinguish between genetic, gonadal, hormonal and genital sex. The genitals are usually decisive when determining sex. Gender identity expresses one's mental sex, i.e. a subjectively perceived feeling of agreement or disagreement with one's body, its primary and secondary sex characteristics and the social role attributed to a given sex. External sexual characteristics are referred to as one's sexual role.

Czech, unlike English, does not distinguish between sex and gender, which leads to the term gender identity (in Czech *sexual identity*), in which the sexual aspect is more emphasized. The most important gender identity disorder is transsexuality, an entirely inverse mental identity with respect to one's biological sex. Transsexual individuals often want to change their sex. Other forms of different gender identity include transvestitism, gender identity disorder in children (GIDC) and subclinical forms of different gender identity, sometimes collectively referred to as transgenderism. The

term queer refers to all manifestations of non-heterosexual identity (i.e. gay, lesbian, bisexual and transgender).

People with a different gender identity are exposed to a greater risk of discrimination and stigmatization than people with a minority gender orientation, although there are many fewer of them in the population. This is because they are more "visible", which can greatly complicate a transsexual's coming out. On the other hand, the general public sometimes thinks that homosexuals are people with a different gender identity. People with a gender identity can be, just like others, both heterosexual and homosexual (Fifková et al., 2008).

Socio-sexology studies

Population and community studies that focus on the knowledge, attitudes and behaviour of people allow us to become familiar with human sexuality, disprove certain myths and notify people of the possible risks that are associated with risky and hazardous sexual practices. They are synonymous with the epidemiological term behavioural surveillance and KAB (knowledge, attitude, behaviour) studies.

The first person to carry out a similar study was Albert Kinsey in the late 1950s. Such studies became more common with the spread of the HIV/AIDS epidemic. In the Czech Republic, regular representative studies covering the entire population are carried out by Weiss and Zvěřiny; ad hoc studies concerning the behaviour of young people and the gay population (Weiss & Zvěřina, 2001).

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1.2 Sexual Abuse, Including the Abuse of Persons with Intellectual Disability

Dana Štěrbová

Sexual abuse is a crime regardless of whether the victim is disabled or not. A person with disability can be both a victim and an offender. "Sexual abuse is a terrible thing. Any form of abuse is particularly dangerous for people with intellectual disability and other vulnerable persons" (Vanier, 2009, 73).

A criminal act is an act that is a judicially punishable act, the preparation and attempt to commit a criminal act, the planning of such an act and the instruction and assistance in committing a criminal act. According to the applicable Criminal Code, a person who forces another by violence or the threat of immediate violence to take part in sexual intercourse, or who abuses the other person's defencelessness for such a purpose is committing a crime. Sexual intercourse usually refers to coitus, but also any other form of satisfying one's sexual needs on the body of another person. The Supreme Court ruled oral sex to be a form of sexual intercourse that is comparable to classical coitus. Even though sex organs are not touching, when the sex organ of one person is replaced by another body part of the other, such as when an offender forces his penis into a woman's hand for masturbation, it is analogous to coitus. This means that the legal interpretation of the term sexual intercourse is wider than is understood by the population (Mitlőhner, 2013).

Lockhart, Guerin, Shanahan and Coyle (2009) say that inappropriate sexual behaviour is one of the factors that limits the integration of persons with intellectual disability into society. The authors suggest the term "sexualized challenging behaviour" for inappropriate forms of sexual behaviour. They state, referring to Emerson (2001), that their behaviour is culturally abnormal to such an extent and with such frequency or duration that the physical safety of the person or other persons is jeopardised; behaviour that will most likely result in subsequent denial of commonly available resources and therefore, it has to be restricted.

"Sometimes it may seem that people with the syndrome show abnormal sexual behaviour (such as when they touch strangers of the opposite sex); however, this is only a consequence of the fact that nobody told them that such behaviour was inappropriate. If you speak with adult persons with intellectual disability, it may seem surprising how little they know about sexual issues" (Selikowitz, 2011, 168).

Doughty and Lindsey (2010) and Lištiak and Mandzáková (2013) mention that the most frequent high-risk situations are those when a person with intellectual disability is exposed to sexual abuse.

The issue of sexual abuse concerns the population as a whole, but a whole range of other factors increases this risk in persons with intellectual disability. "According to Walker-Hirsche (2007), people with intellectual disability may have weak social judgment and difficulties predicting the consequences of their acts. They are often sought out as victims not because they provoke others with what they wear or find themselves in remote locations, but because they are considered less credible when reporting abuse and at the same time, it is less likely that somebody will believe them because they cannot give a convincing statement" (Sobsey, 1994, in Lištiak Mandzáková, 2013, 81).

Research shows that of all criminal acts, violent and sexual offences are the least reported ones. Čírtková (2008) mentions that little willingness to report rape and other forms of sexual crimes is mainly related to:

- The victim's relationship with the offender – the existence of a special relationship with the offender is a factor that discourages many women from reporting a crime. "In cases of sexual violence, the offender and the victim very often know each other to a certain extent… The cases of deviant and serial offenders who attack victims that they do not know are statistically less frequent" (Čírtková, 2008, 57);
- Issues with evidence – little willingness to report a rape is also affected by the difficulty in obtaining evidence, especially in cases when no severe bodily injury occurred. Both rape and sexual abuse are criminal acts that typically take play in seclusion. The victim (the injured party) is often the only witness. In situations where "gaps in consciousness" play a role, it is the offender's statement against the victim's. The credibility of the victim is therefore very important when sentencing the offender (Čírtková, 2008, 57);

- Subjective stress resulting from the criminal proceedings – to overcome stress that is related to being interrogated; expert examinations and trials are exhausting for traumatized victims;
- Secondary victimisation and stigmatisation of victims in the form of myths. The author mentions the "good and bad girls" and "true rape" clichés when a future victim provokes a later offender by what she wears and her behaviour, carelessness and naivety.

The above facts are documented by Venglářová and Hrdá (2013). The same applies to people with intellectual disability and without disability. "Long-term abuse is more often perpetrated by close persons who have a long-term relationship with the person with disability and encroach on his or her privacy" (Venglářová & Hrdá, 2013, 165).

Persons with disabilities (including persons with intellectual disabilities and autism) experience the same feelings of pleasure and displeasure as everybody else, but unlike people without disability, they are exposed to higher levels of risk. They are not sufficiently informed (or rather, not informed at all) about topics related to sexuality and therefore, they have a reduced ability to make decisions on their own. They have experience with their body (who, how and when touches them), but often are not aware of having the choice to agree or disagree and of the risk of sexually transmitted diseases. They do not know that "somebody will do something to them" etc., and sometimes they may not even know whether somebody has abused them. Their ignorance is also associated with the signs of sexual behaviour and acts that are inappropriate and can even be criminal. They do not know the borders of how to act towards other people.

Štěrbová (2012) describes the risks associated with the possibility of sexual abuse in persons with an intellectual disability. They are less capable of distinguishing whether other people's behaviour towards them is appropriate, inappropriate or criminal. Behaviour that borders on the criminal is hard to assess, distinguish and prove (especially with people who are closest to them). The "closest ones" may not necessarily mean only close family members, but also paid assistants, teachers, parents or other clients. In situations such as these, the abused person is helpless and exposed to sexual violence. Many people with an intellectual disability do not know how to defend themselves and say "No!" This means that they are dangerous to themselves.

It has been confirmed that an intellectual disability (mental retardation), as Kovář et al. (2008) say, is a risk factor for rape.

In summary, we can say that people with intellectual disabilities:

- Often do not know what to do because they do not have information about who and what may and may not do to their bodies;
- They do not have information about what sexual violence and sexual abuse are;
- They are incapable of recognizing that sexual violence and sexual abuse are occurring.

It is difficult to determine who is the offender and who the victim as the understanding of why they are in these roles is disturbed due to decreased cognitive abilities and a different level of understanding the situation.

Čírtková (2008) points out that disabled people and children are easy victims for offenders because "offenders believe that these individuals are less capable of providing testimony and their statement is generally seen as incredible. Scepticism related to their testimony (fitness competency) is strongly rooted in legal practice" (Čírtková, 2008, 85).

Green (2001) describes the case of a 24-year old woman who was exposed to sexual abuse. The court, using an expert opinion by a clinical psychologist (court expert), determined the woman's ability to engage in a partnership relationship, a serious partnership relationship, to provide informed consent for sexual intercourse, to understand her oath at the court and to understand the judicial proceedings. The author emphasizes the necessity to protect witnesses with intellectual disabilities, warns of the risks of post-traumatic stress disorder and the importance of follow--up care for people with intellectual disabilities that should be provided by experienced clinical psychologists and psychotherapeutists.

It is very important to carry out a quality psychological examination of an intellectually-person with disability when investigating a crime, not only to find out his or her intellectual abilities, communication and social skills, but also to determine whether he or she will need the support of another person as a participant in a judicial proceedings. As Green points out (2001), it is important to examine whether an intellectually-person with disability is aware of the differences between the truth and lies and what consequences a false statement would have in court, i.e. whether he or she is competent to provide reliable testimony.

In relation to the investigation of sexual abuse, it is necessary to remember recommendations for approaching disabled people. The role of a person with disability's parents can be assumed by tutors and direct care employees. People with intellectual disabilities may also defer to them with any uncertainties that they have.

When investigating the sexual abuse of a child (whether with disability or not), the child is confronted with many things that he or she does not understand.

Collaboration with reference persons, especially parents, is very important. The parents should be informed of the course and procedures of the investigation so that they can answer any questions that the child might have (e.g. his or her meeting with an expert). On the other hand, it is important to empathize with the parents' situation. The parents often suffer from feelings of guilt. They accuse themselves of presumed or actual insufficient care of their child.

Mentally stable parents are able to cope with their feeling of guilt. However, unstable parents tend to become aggressive. Aggression triggered by a feeling of guilt is directed towards the offender or the police, since they are the unit that discovered either assumed or actual negligent care by the parents. Such parents are not able to provide help to their child and cooperate during the investigation. Naturally, the same applies to parents who evidently give preference to their own personal interest, do not agree with the investigation and have a negative or complicated relationship with their child. In specific cases, it is advisable to make decisions based on whether or not the parents can provide real support for their child (Čírtková, 2008, 86).

Čírtková (2008) also points out the role of teachers and psychologists who join the interrogation pursuant to the Criminal Procedure Code as being the connoisseur of the children's soul. These should be people who have experience with education and can help conduct the interrogation properly. "Inviting experts is twice as important during an interrogation of children with different disabilities" (Čírtková, 2008, 86).

It is important that all suspected cases of sexual abuse of disabled people be suitably investigated, examined and therapeutically discussed with both the offender and the victim (a person with disability) and that follow-up therapeutic care is offered. Štěrbová (2007, 2009), Venglářová and Hrdá (2013) emphasize the necessity to define clear rules when suspecting sexual violence, sexual assault and physical assault in terms of caring for the victim and the offender.

Based on results from Slovak social care homes (Mandzáková, 2011), most professional staff members in these facilities interviewed their client or notified the management when sexual abuse was reported.

The possible prevention of sexual abuse and sexual violence

The rights of the child were recognized by the UN Convention on the Rights of the Child that was adopted in 1989 and since ratified by most countries. It clearly grants children the right to freedom of expression and freedom to seek, receive and impart information and ideas of all kinds (Article 13); Article 19 concerns the obligation of countries to provide children with a level of education that will protect them against sexual abuse (Standards, 2010).

Štěrbová, M. (2013) describes the results of qualitative research where statements by mothers of teenage children show that families have different attitudes towards sex education in terms of sexual abuse.

Parents warn their children about the risk of sexual abuse at a young age, either generally, telling them to be careful about strangers, or specifically, where parents advise children how to protect themselves and teach them about different "tricks" that stranger who might hurt them could use. These pieces of advice are similar in all families (Štěrbová, M., 2013, 38).

It is obvious that children receive information, but it is not clear whether they are able to use it in practice. It has been proven that disabled people must be trained to be able to protect themselves against sexual abuse.

The drill of practical skills for direct care employees is a requirement for sexual abuse prevention in social care facilities – homes for persons with intellectual disability. Venglářová and Hrdá (2013) list the criteria that can affect prevention:

- *Providers of social services* – The selection of employees, their learning in the sexual needs and signs manifested by specific target groups and the instruction given about how to appropriately treat their clients. "Despite all measures, extraordinary situations may arise; therefore, it is necessary to implement an emergency plan in every organisation" (Venglářová & Hrdá, 2013, 168). As far as sexuality issues in social services are concerned, Štěrbová (2007, 2009), Eisner (2013) recommends that a document be introduced that establishes, among other things, a support system to help social services users exercise their rights, while

respecting the sexuality limits for both the service provider and for the user. This document should also include the rules of procedure when sexual abuse is suspected.
- *Direct work with clients and their close friends and relatives* – Employees are obligated to also receive education on the sexual needs of the people that they care about.
- *Clients* – Clients have to be introduced to the options and rules in a given facility as far as sexual needs and their satisfaction are concerned. "Adequate sex education has to be provided to intellectually-disabled people" (Venglářová & Hrdá, 2013, 168).
- *Parents and tutors* – Information about sexuality, its satisfaction and possible issues must also be provided to persons close to the intellectually disabled.

Regarding the last bullet point, we would like to add that interested employees (social service providers) should be aware that employing a sensitive approach to sexuality and observing the borders of intimacy and privacy are necessary. The requirement to respect one's privacy and intimacy concerns not only people's behaviour, but also the maintenance and provision of information (for more details, see Štěrbová, 2009). A tutor may ask staff about information related to a client's sexuality, although they are not always entitled to such information. It is advisable to have clearly-defined rules, including rules about how to talk to a client and persons close to him or her when dealing with a client with a risk behaviour that might result in his or her sexual abuse.

In other countries, programmes and learning sessions focused on establishing model behaviour for intellectually-persons with disability are used with the aim of eliminating sexual abuse. In the learning programme entitled "Introduction to Practical Sex Education I and II", we use The Whole Truth DVD (Hingsburger & Jobes, 2008) where disabled people themselves provide model situations of sexual abuse and explain how to respond to potential sexual abuse and how to proceed if this kind of threat occurs. This form of communication (information provided by disabled people themselves with regard to model situations) is considered one of the most effective. Its usage is limited by the mental level of the receivers. It should have a positive impact on persons with a light form of intellectual disability or persons on the upper level of medium intellectual disability, who possess a high level of social skills.

Two Australians, Keeling and Rose (2006), describe the importance of special sex education programmes for sentenced offenders with special needs, including people with a border intellectual potential and a light intellectual disability. The programme is also meant for people with serious communication issues and illiteracy. The programme lasts 12 months, takes place four times a week for 2.5 hours, including a 30-minute break. Similar programmes are based on the cognitive-behavioural approach and are conducted on a more general level with a special focus on the development of communication skills, discussions about criminal conduct, problem-solving skills, decision-making, awareness of the victim, emotions, sexual self-control, attitudes and opinions, relationships, defining objectives, relapse prevention, life models, sex education and sexual abuse and learning. Education on sexuality involves basic information about anatomy, contraception, sexuality and sexually transmitted diseases; importance is placed on understanding informed consent. Special attention is placed on practical methods of learning, i.e. repetition and reinforcing.

The contents of the programme have to simpler and complicated terms have to be restructured or possibly even changed so that people with an intellectual disability clearly understand. Role-playing and group work are used during sessions where the expression of emotions, empathy and joint objectives are supported. Simplified words and symbols are used. Trainers work with offenders, their "old selves", forming them into "new selves", or more precisely, with who they were and where they are heading. Suitable strategies are being developed to help make changes trough modelling and drama therapy techniques.

Mandzáková and Horňák (2009) offer activities in sex education that can be used for people with light intellectual disabilities. These include:

- *Feelings about my own body* – the purpose is be able to work in a group, make friendships, be able to distinguish between differences in the body, be able to express how one feels, what he or she thinks about himself or herself and what they can do to feel better.
- *Menstruation exercises* – the purpose is to be able to cope with menstrual pain and manage it.
- *Important people* – the purpose is to be able to openly communicate about one's feeling, say whom we love and give reasons.
- *The roles of men and women* – the purpose is to get to know and explore the roles of men and women.
- *Non-erotic speech* – the objective is to learn to say "no" to a sexual activity and practice "we don't want sexual harassment".

- *What I like about myself?* – the purpose is to learn about certain properties that we like in people and be aware of one's own self and the way other people see us, to get to know properties that we like about ourselves.

All activities are intended to be carried out in a group. In order to achieve the objectives defined in each of the activities, the instructor has to be well prepared and know everybody in the group. People with intellectual disabilities should be at approximately the same level (in terms of severity of their disability, social skills and knowledge of sex issues).

Model situations, practising correct solutions, generalisation of required skills – these are all methods based on a behavioural approach (largely operant). Therefore, people with intellectual disabilities should be motivated so that the desired behaviour that they reach in model situations is reinforced and becomes part of their everyday life.

Lumley and Miltenberger (1997) emphasize that individuals with intellectual disabilities need to acquire three sets of skills:

a) To be able to recognize a situation that is dangerous;
b) To be able to respond in such manner that will enable them to best escape from the situation;
c) To notify a designated person.

The same authors point out (referring to research by other experts) that the risk of sexual abuse increases with:

- The limited imagination of people with intellectual disabilities in relation to sex;
- A higher dependence on the commands by authoritative figures;
- A lower level of social skills that are necessary to report the situation;
- A lesser ability to assess whether a situation is dangerous and to make a correct decision;
- Insufficient communication skills.

Based on the experience that we have obtained from counselling in social services in homes for the intellectually disabled and information provided by employees (participants) at educational events focused on sex education and awareness of intellectually-persons with disability, the risk of insufficient protection of the intellectually disabled by employees increases with:

- A lesser ability to assess whether a situation is dangerous and to make a correct decision;
- Uncertainty as to where and how to interfere in favour of the client;
- Insufficient communication skills – the employees do not know how to provide a person with an intellectual or combined disability with the information they need.

"Employees in facilities that provide social services engage in sex education only when they need to address an issue or a situation when a person with disability's behaviour is assessed as being inappropriate or threatening to others. However, even in those cases, they often do not know how to proceed. In such types of facilities, it is advisable to write a document that regulates attitudes towards sexuality, known as "the sexuality protocol" (Štěrbová, 2012).

It would be wrong to assume that it is sufficient if a facility uses appropriate didactic materials. It is also necessary to teach employees how to work with such materials. However, support for the suitable guidance of clients through the issues of sexuality in practice and related risks is missing.

"Risks resulting from different forms of ignorance affect not only clients, but also their legal representatives (parents, tutors) and experts, as has been stated above. Both parents and their children of different ages are missing *theoretical* and *practical* information. On the other hand, they have their own *experiences,* which they consider the *norm*. It is more than just those situations where a systematic education of people (children, adolescents and adults) with intellectual disabilities is not provided poses major risks; in addition, there are no legal regulations or other protective restrictions for the intellectually disabled in the Czech Republic that concerns their consent with sexual activity. In foreign countries, the following measures exist: a person should be considered incapable of providing his or her consent when he or she cannot make a decision about a given mater because of an intellectual disability or is not able to communicate his or her decision because he or she is unconsciousness or for other reasons. Other applicable criteria say that an individual should be considered incapable to make a decision related to consent if he or she is not capable of understanding the nature of such conduct, foresee and understand its consequences, but makes a decision anyway" (Štěrbová, 2012).

Without a systematic approach, people with intellectual disabilities are not able to participate in medical examinations without problems, with the

exception of anaesthesia. This means that they are exposed to greater health risks. Clients themselves are not able to make decisions for themselves and lack the reinforcement of their own limits.

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1.3 Specific Approaches towards the Addicted and Sexuality

Dagmar Krutilová

With the development of social and addictology services, more attention has recently been also paid to individual planning with clients. Proper individual planning focuses on the different aspects of clients' lives in which they need support and assistance from a social service. However, not all clients' needs can be satisfied through social services; sometimes, it also helps when an employee works with clients to map out certain areas of their lives and to help them find resources that they can use on their own.

Employees who work in social and addictology services (social workers and social service workers) have a difficult task because of the demands placed on their professionalism and skills. They have to be experts on issues that their clients encounter and know various methods of working with clients, be able to respond to specific situations (such as any crisis situations that their clients may experience) and they should be aware of other options and services that might help their clients. It is also important to engage in continuous education in areas in which the worker specializes, e.g. if he or she works with homeless people, he or she should know how to work with these people, which services he or she can offer and what, on the other hand, is counterproductive. If the client is an adolescent or a child, the worker should be aware of his or her development needs, development stages and risks resulting from development specifics.

A very specific area of work with clients is the services provided to users of addictive substances and clients with addictive behaviour. Services for these clients cover social, health, educational and learning issues. In the given context, the word **client** will be used for a person who uses this type of social service (and may also be a user of addictive substances) and the word **user** will refer to a person who abuses addictive substances. Persons addicted to addictive substances and persons with addictive behaviour deal with many problems, ranging from health (drug addiction, abstinence, cravings, etc.) to social problems (how to establish safe and meaningful

relationships, how to communicate, which behaviour is normal and which norms are common in the social sphere, etc.).

Sexuality is an important topic for everybody and sometimes, difficulties in this area may cause a given individual to compensate for their deficiencies and problems with alcohol, drugs or addictive behaviour in other areas. On the other hand, the use of certain addictive substances or addictive behaviour may in fact cause difficulties with sexuality and relationships. There are not many specialized books and research that would explore the effects of different addictive substances on one's sex life. Similar research is often conducted in connection with theses, such as A. Doležalová's thesis from 2010. We will mention some data found in publications and information provided by some former users of addictive substances.

The following describes experience with sex while under the influence of addictive substances narrated by a user of different addictive substances.

"I started with drugs, alcohol and sex relatively early. As a teenage girl, I was convinced there wasn't anything better than drunken sex, sex under the influence of marijuana and later crystal meth. Everything naturally develops, right...? As I realized a couple of years later ...my natural development turned into an almost six-year long addiction on crystal meth and sex. If alcohol is supposed to free inhibition, then I don't know how to describe crystal meth. A girl who used to dislike sex became the biggest nymphomaniac...

I had a boyfriend for a year (a junkie)... First, we couldn't get enough of each other and our sex would last for hours. I say sex on purpose because it was miles apart from making love, so to say. Interestingly, my sexual appetite did not diminish even after coming down from the height ...quite the opposite... I was not able to sleep... I was not able to eat, but constantly felt like having sex. This was true for me anyway; everybody is affected differently and people around me were a good example of it. Some friends experienced a lower libido, some higher. Unfortunately for me, my boyfriend's sex drive dropped. This was followed by arguments, frustration ... alienation and break-up. I never saw myself as a hooker although, in terms of societal standards, I was with a lot of guys. If those years with drugs gave me at least one thing, it was a different view of sex; I stopped being afraid, afraid to admit that I like sex and there's nothing wrong with it. For me, making love and sex on drugs are two different things. Be it sex on crystal meth trip ... (it had the same effects on me, even pot), it was always the

same chemistry and pure selfishness; my reason was defeated ... in such situations, I was not able to think of anything other than myself and MY orgasm. No, I am not a hypocrite and I know that it was a trip that I will hopefully, never experience again. Now I prefer making love. It's about trust and not selfishness. I want to feel what I really feel and not what some drug tells me to do. I am passionate enough and when I meet someone and there is a sparkle, I can be pretty wild even without drugs, as I say. A person who prefers sex on drugs is only selfish (and so was I... and I would have never started with sex without drugs), thinks of himself or herself and listens only to his or her instincts. The easy way may not be the right one. To use and to immediately feel horny … that was my mantra for a long, long time. To get everything for free. But nothing is for free. OK, you can have a great fuck on drugs (sorry about the expression) like never before in your life, but it will never be anything else, such as the love of your life... thank god for my ego, I really believe that I don't need any help to have great sex... it only took me a while to figure it out."

Sexuality in the context of drug usage borders several branches of science and reflects experience and knowledge from psychology, psychotherapy, psychiatry, sexology, sociology, neurology and social work. Therefore, it is very complex and has not been explored in too much detail. The scope of this field poses a challenge for another comprehensive publication that would cover the issue of sexuality in the context of addictive substances. More research covering especially the risks of sexual behaviour by drug users has been carried out abroad. Some research has also been conducted in the Czech Republic and recently, students of some universities, especially those specialising in addictology and psychology, have been dealing with the behaviour of drug users in their papers.

The current research that I am referring to in my text focuses on components of the sexuality issue in the context of the abuse of addictive substances, such as the risk level of users' sexual behaviour, etc. This research is typically based on research samples, especially of young users and users of one type of addictive substance (sometimes combined with other addictive substances) and do not include any information about how former addictive substance users view sexuality after a longer period of time.

Factors that also largely affect research knowledge are different variables, e.g. at what age a user used an addictive substance for the first time, which substance it was, what his or her health and mental condition was,

what his or her social status and environment were, etc. It is a very complicated set of different factors that deserves deeper investigation.

A narration by a former addictive substance user (31 years old) concerning his use of addictive substances. *"I had sex because I was using, or was I using to have sex? The use of hard drugs replaces relationships and sex to an extent. When I was on drugs, the frequency of sex was very reduced. Crystal meth helped me first to overcome my shyness and nervousness, but made them even worse when coming down from the high. During my first experience with crystal meth, I met a woman in a bar. I sat down next to her and we openly talked about what was going through our heads. She was very intrigued by my empathy and listening, opinions and speech. It was a great night. I was in a good mood and it radiated from me. But, because of my intoxication, I didn't feel like sex at all and neither could I perform. A day later, I met her again. That time, I was going through a crash. She was very surprised to see the misery and my reactions had to freak her out. I could not stand what she was saying, her talking was bugging me and I just felt miserable next to her. My reactions were extreme, I was touchy about the slightest detail and very soon I exploded with rage that I released verbally, so she left. If I had sex, it was only to mitigate the crash phase. Shortly after orgasm I was able to go again; the intercourse was longer and so was my orgasm.*

The longer I used, the less I was able to be around people. My social contacts were reduced to a group of junkies with whom I was using. Crystal meth deepened my social phobias and made me paranoid. More than sex, I was interested in who was going to rob me, who was following me and where I would get another fix from.

After sobering up and even abstaining for a long time, I still remember the ecstasy provided by crystal meth, both during normal activities and during sex (how long my orgasm and the sexual act lasted). At first, sex is disappointing for most drug users. This is caused by the extreme euphoria that cannot be achieved without a drug. For many, sex without drugs is new and unknown.

During an intervention, it is necessary to take into account the patterns of addictive behaviour, such as to have everything now and without any effort and in the largest amount possible. Time also plays a role. The client has to see the euphoria with critical eyes. It is important to realize that he or she will never experience it again and to motivate him or her to other, not so intense, but profound and deeply felt feelings. After a few years of abstaining, the ecstasy becomes only a memory that doesn't affect one's sex

life in any way. The client even may replace them and make his or her sex life more interesting with alternative methods, such as Kamasutra, Tantric massage, etc. And even sex can motivate the client to work on himself or herself, on his or her personality development and self-esteem support to acquire healthy social habits."

The areas where workers also encounter sexuality in the context of addictive substance abuse are social and addictology services. Whether sexuality is covered during client counselling or not depends on the type of service. As far as sex is concerned, current issues, such as advice about infectious diseases, is addressed as part of outpatient and low-threshold services. Clients often need counselling on the relationships that are affected by their addiction. In residential and day-care facilities, they also focus on more profound topics that cover a wide range of sex life and relationship issues.

In low-threshold facilities, any communication about sexuality is typically reduced to client instruction about safe sex and protection against sexually transmitted diseases and AIDS/HIV; clients can be provided with basic protection (condoms) and receive written materials that inform them about safe sex in a comprehensive and acceptable manner.

Some organisations, such as Rozkoš bez rizika (Pleasure without Risks), work directly with women who provide sexual services and at the same time cooperate with providers of addictology services to the addicted. It is very common for women who provide sexual services to be addicted and therefore, similar forms of collaboration are very helpful. Sometimes, this means that case workers who specialize in taking care of women providing sexual services work in the field side by side with case workers specializing in addicted people. In this manner, they can immediately respond to the questions and needs of addicted women who provide sexual services and provide them with tailored counselling.

Depending on accessibility (the threshold level), we distinguish between the following services in the Czech Republic:

- **K-centres, field programmes** – these services are used by clients who are not too motivated to change their lifestyle. What they mostly need is health and social services – to exchange needles for injecting drugs, do laundry, consume basic nutritional items (soups, vitamins) and receive advice. If necessary, they can have their lost documents replaced, spend a night in a facility at an affordable rate and get a temporary job. As far as sexuality is concerned, these people often find themselves in

different dangerous situations such as abuse, rape, prostitution (sometimes forced) and promiscuous behaviour. The range of social services offered by such facilities also include the option to provide clients with protection (condoms) and at least partially reduce the health impact of unprotected sex between active addictive substance users. Typically, teams of workers in these programmes are selected from a multidisciplinary pool of social workers, healthcare specialists, psychologists and counsellors. In terms of sexuality in the context of addictive substance abuse, the most important task of these service providers is to establish a good and safe relationship with the clients (the clients have to have the option to stay anonymous and know that the worker will not report what was shared in confidence, etc.). After establishing a confidential relationship, the worker has to focus on high-risk behavioural patterns, such as drug use with a shared needle and unprotected sex. If the client is interested in changing his or her lifestyle, at least in some areas, the worker can direct him or her towards other services where the client can receive counselling and therapy in specific areas of life.

- **Detoxification units** – these are medical services that offer people with an addiction the opportunity to cope with withdrawal syndrome and intoxication in a safe healthcare facility. Abstaining individuals may not be in a state that requires more intensive care. Detoxification units are usually a part of healthcare facilities – hospitals. If a client wants to continue with their treatment, such as through the specialised services in a therapeutic community and follow-up care, he or she has to first stay in a detoxification unit in order to decrease the health risks resulting from sudden withdrawal. Treatment at detoxification units also includes a structured programme with supporting psychotherapy and basic social work. If sexuality is an issue, clients can use counselling or psychotherapy to deal with specific difficulties and questions.
- **Outpatient treatment** – this kind of treatment is provided in both medical and non-medical facilities. Today, non-medical facilities are more common. These are specialized social, AT and psychological counselling centres and psychiatric surgeries. The client can come for regularly--scheduled meetings and address his or her addiction and the issues associated with it. These facilities are attended by clients who are already motivated to change their lifestyle and undergo treatment. If the treatment is to be successful, counselling and therapy first have to focus on areas where the client has failed, where he or she needs support and

where mirroring may help. The most frequently-addressed topics include relationships, whether they are partnerships, family or work relationships, free time, debt, health and possibly also crime. Sometimes, clients also want to addresses issues that they have not previously addressed and that might be one of the causes of his or her addiction. These also include sexuality when it is not known whether one's problems with their sex life resulted in an addiction or vice versa. Outpatient treatment might be long-term, sometimes lasting for several years because if a lifestyle change is to be permanent, long-term support is needed.

- **Day care centres** – these provide services ranging between hospitalisation and outpatient treatment. Clients who use these services are motivated to change their lifestyle and undergo addiction treatment. They need more intense support and contact than can be provided by outpatient care, but at the same time, they do not want to stay in residential facilities for various reasons. They can come to the day care centre every working day for 6 hours. They take part in a structured, intensive programme. Work with clients is based on a combination of individual and group therapy. Some elements of the day care centre programme are similar to programmes and methods used in therapeutic communities and the programme includes both psychotherapy and free-time activities. Clients also deal with very private issues, including sexuality and relationships. An advantage of day care is that in addition to individual therapy, the client also receives feedback on his or her behaviour and lifestyle from other clients in the group.
- **Mid-term hospitalisation** – this treatment takes place in medical facilities for a period of 3 to 6 months. Medical facilities include psychiatric hospitals and addiction treatment units where clients are admitted after detoxification. Mid-term hospitalisation can also include clients with ordered hospitalisation; however, most clients enrol themselves because they want to change their lifestyle and treat their addiction. Facilities use methods and elements used by therapeutic communities, especially in group psychotherapy and detachment. Psychotherapy is less-frequently used and emphasis is placed especially on community elements and work therapy. Clients can discuss topics related to their addiction, including sexuality and their relationship with their bodies. During individual therapy sessions, the clients usually do not have time to address such issues in great depth and is recommended that they seek

psychotherapy and outpatient counselling where topics of individual interest can be addressed.

- **Therapeutic communities** – these are residential facilities that are considered the most effective way to work with addicted clients. Therapeutic communities combine intensive group psychotherapy, work with family members, work therapy and free-time activities. Therapeutic communities admit clients who have undergone detoxification and the length of the programme is adjusted to their needs. The work with clients is divided into phases and the client is supposed to handle certain tasks and gain insight into his or her addiction and the mechanisms that trigger his or her behaviour. Work in therapeutic communities focuses on all areas of the client's life and during psychotherapy, the client gets to address even very personal and profound topics. These also include sexuality, their relationship with his or her body, traumas related to sexuality, relationships and sex and one's own sexual identity. Sometime during the therapy, the client may come to a conclusion that the addiction was his or her response to his or her undefined gender identity or to a conclusion that the addiction opened their eyes to the issue of his or her gender identity. A therapeutic community can provide a very safe and supportive environment to resolve issues. During their treatment in residential facilities, clients are not allowed to engage in sexual or partnership relationships among themselves, especially because they would be distracted from working on themselves and overcoming the difficulties that caused their addictions.
- **Follow-up care** – this service can be used by clients who have undergone treatment in residential facilities. Such clients are exposed to risk when they return to their home environment, former friends and hobbies. Sometimes after residential therapy, they start to address very personal and profound issues that need to be addressed during follow--up psychotherapy. Follow-up care is offered as both residential and outpatient. Some clients prefer to use sheltered housing in facilities; sometimes, they can also choose to work in sheltered workshops and retraining centers. The typical length of follow-up care is 6 months, but it can also be longer according to the client's individual needs. Clients use both individual and group psychotherapy, structured programmes focused on free-time activities and getting new hobbies. With the help of expert workers, they usually map out all areas of their lives and proceed with resolving them. Topics related to sexuality are openly

discussed during individual and sometimes also group activities, and clients receive safe support for their solutions or changes. Some organisations tolerate and accept relationships between clients, especially since the clients are getting ready to re-enter everyday life, which also involves relationships and sexuality. In some facilities, clients can also share housing during their treatment. This gives them the opportunity to try therapeutic health, to be able to function in a relationship and deal with conflicts and issues that may occur between two people receiving addiction treatment. Research focused on follow-up programmes (Růžička & Kellnerová, 2011) shows that a large portion of organisations that offer such programmes prohibit their clients from forming partnerships during the programme. Couples can be together in groups, use couple therapy or couple meditation during the programme and after the programme ends, they can stay in touch with the facility (both individually and as a couple) for therapeutic purposes.

The issue of women and addictive substance use is very specific. Sometimes, the addiction starts with promiscuity, which goes hand in hand with a high-risk lifestyle, unprotected sex and prostitution. Women who provide sex for money often start using addictive substances to be able to cope better with their lifestyle. Addictive substances may help them to relax, detach themselves from reality, stimulate them and increase their "performance". This way, they often find themselves in a vicious circle – a woman provides paid sex and therefore, she sometimes needs a drug; in order to get the drug, she provides sex for money … Some women with a strong addiction provide sex only so they can afford the drug dosage that they can no longer live without. They find themselves in an unenviable situation because they are capable of providing sex to anybody for very low prices and agree to practices that go beyond the scope of "normal" sexual activities. They often fall victim to violence, even very brutal violence, and do not seek help because they are afraid of being judged by those around them and they do not trust outside help.

Compared to the regular population, addicted women are more likely to be promiscuous. Their female self-esteem is reduced and they have a negative attitude towards their body. Sometimes, prostitution is a way to get to drugs or a "patron" who will provide them with drugs. Drugs help women "detach themselves" from their body and see it only as a tool through which drugs, food and accommodation are obtained. Women are very often

dependent on their partners, even those who treat them with violence. They can remain in pathologic relationships much longer than women without an addiction and often do not seek help from any service or organisation. Reasons for such behaviour are very diverse and may be caused by their personality, patterns they learnt during childhood, strong traumas from the past and low self-esteem or a severe addiction to drugs, etc.

The above are different options provided within different services where clients can address their issues related to sexuality and addiction.

Addictive substances have one desired property – psychotropic effects. These change our perception of the world and how we experience it and our bodies. It is one of the reasons why people begin using drugs.

The psychotropic effect also influences the way people experience sexuality during drug abuse. This changes depending on which type of addictive substance is used and in what quantity. Body experience and the perception of reality are affected by crystal meth, a stimulant. Different effects are triggered by heroin, an opiate, which has calming effects and causes a euphoric rush. This is also reflected in the physical and mental experience of sex under addictive substances. Addictive substances can be divided into different categories, which are briefly explored below.

An overview of drugs that affect one's mental state (Kalina et al., 2008):

1. **Sedatives** (narcotics) slow down the psychomotor rate (benzodiazepines, barbiturates, alcohol, opiates and volatile substances);
2. **Psychomotor stimulants** eliminate fatigue, accelerate the mental rate and activate motor activity (crystal meth, cocaine);
3. **Hallucinogens** (cannabis, LSD and psilocybin) cause changes in perception from a merely sharper vision to states similar to schizophrenia.

The most widespread addictive substance in the population is **alcohol**. Our society and culture are closely connected with alcohol. Just think of how many rituals and occasions do not pass without drinking alcohol – toasts on different occasions such as opening nights, book, CD or DVD launch ceremonies, the opening of new structures, etc. When a new child is born, it is common to celebrate by dinking. People drink at weddings and funerals, we drink to drown our sorrows and because of stress, boredom, and anxiety. Sports (both actively played and watching) are associated with drinking beer.

The use of alcohol has many reasons, including reducing one's anxiety and stress. Anxious, uncertain and shy people find it easier to act naturally, meet other people, react spontaneously and do things that they would not otherwise do when they drink alcohol. The effects of alcohol are very fast. Alcohol is easily available and its use is very easy. It enters our boday by drinking (no complicated aids are needed to injest it, such as syringes) and is absorbed very quickly through the digestive tract into the brain. How quick and serious the effects are depends on the quantity, everyone's disposition, the influence of the environment, age, etc.

When used in small doses, alcohol acts as a stimulant; in larger quantities, it has sedative effects. A person who uses alcohol experiences a feeling of euphoria, followed by a good mood, self-confidence, the loss of one's restraints, self-criticism, aggression towards others, sedation and tiredness. This means that it depends on the stage of intoxication experienced by a person who consumed alcohol for the purpose of being able to meet someone more easily or have sex. In most film scenes, intimacy between characters is preceded by a glass of something, which quickly evokes a feeling of relaxation, intimacy and desire. Alcohol stimulates both the body and the mind.

As the quantity of consumed alcohol increases, the situation quickly changes as motor coordination and the ability to understand decrease. This can be accompanied by aggression (just think of all the crimes committed under the influence of alcohol) and can cause hallucinations leading to a consciousness disorder and erectile dysfunction. Severe alcohol intoxication in women can result in a state where all restraints have been eliminated even in terms of sex and a woman agrees to things that she normally would not. In worse cases, an intoxicated woman may become an easy victim of violence and rape. Long-term alcohol abuse also causes physiological damage, especially to the endocrine system as far as sexuality is concerned. This damages the excretion of glucocorticoids and testosterone and eventually may cause impotence.

Another widely used substance in our society is **cannabis**, mainly **cannabis sativa** or **marijuana**. On the international scale, cannabis-derived drugs are the most widely used. The World Health Organisation estimates that they are used by 147 million people, i.e. 2.5% of the world's population (WHO, 2008). In the Czech Republic, it is the third most used drug after alcohol and tobacco. In the Czech Republic, the use of marijuana is not criminal; however, possession and distribution are not allowed. The

consequences of long-term cannabis abuse have not been assessed on a large scale.

Several authors have conducted partial research studies. In 2010, this topic was covered in Alexandra Doležalová Hrouzková's thesis entitled "The Sexuality of Marijuana Users" defended at the Department of Psychology at Charles University in Prague. Our book uses the following findings and research.

The study group was comprised of 202 men, regular marijuana users aged between 30 and 50. 61.7% of the respondents stated that they were fully satisfied with their sex life; 53.9% of the respondents reported that the use of marijuana somehow changed their sex life. 20.8% of the respondents mentioned some kind of difficulties with sex related to the use of marijuana. 10.8% of the respondents have experienced sex with another man; 12.9% of the respondents consider themselves bisexual; 32.7% of the respondents have had experience with commercial sex; and 3.5% of the men had sex for money.

The conclusion of the survey was that regular long-term marijuana users differ from the representative group of the Czech population in many respects, but as far as hazardous sexual behaviour is concerned (active prostitution, the use of condoms, hepatitis C), there are not any differences between marijuana users and non-users among Czech men (A. Doležalová Hrouzková, 2010).

It would be interesting to conduct similar research in women who have been long-term marijuana users, among other things because female physical and mental experiences differ from male experiences.

The most common method of cannabis use is by smoking; the effects are fast and culminate in about 20 minutes and subside in 3 hours. If used per os (by mouth), absorption is slow and irregular. The first effects appear within 30 minutes and culminate within 1 to 5 hours. Oral use poses a greater risk of overdose. The main effects of cannabis include calming down, euphoria, cheerfulness and shaper sensory perception; undesirable effects may be diverse and can include changes in time perception, short-term memory disorders, confusion, worsening of fine motor skills, psychotic experiences, hallucinations, panic attacks and cardiac acceleration (Kalina, 2008).

The following text tells of the experience of a man (31) with sex under the influence of marijuana.

"There's nothing like sex on drugs – this is a very common belief among drug users. It's a very subjective experience for each person. I will divide the sexual act into its length, mutual experience and climax from the man's perspective if he uses marijuana, hallucinogens and methamphetamine. Based on my experience, I can say that it differs according to which drug you use.

Marijuana. It depends on the quantity and your current mental condition. The effects of THC can actually deepen your feeling both during sex and during orgasm; it can even delay premature ejaculation, but it reduces ecstasy during orgasm by deepening it. THC acts as both a relaxant and stressor. Nervousness and stress before sex can cause the inability of a man to get an erection. When using THC, you start seeing it as a serious problem, multiply it and deepen your depression because of a feeling of failure. Feelings are stonger due to THC, both positively and negatively. Feelings of insecurity and nervousness of another failure often occur during the next act of sexual intercourse, even if you are not under the influence of THC."

Psychostimulants – in the Czech Republic, the most common psychostimulant substance is methamphetamine (crystal meth). In most European countries, amphetamine prevails. Cocaine is less abused in the Czech Republic. It is more common in the UK and Spain; crack is also less widespread in the Czech Republic (Kalina, 2008).

Methamphetamine causes overall organism arousal and increases both the user's mental and physical performance. It eliminates fatigue, accelerates mental processes, enhances the feeling of strength and energy and the intoxicated person is more talkative. Because the sympathetic system is activated, the feeling of hunger is supressed and a loss of appetite and reduced food intake frequently occur. If used over a long-term period, weight loss, hallucinations, especially auditory ones, delusions and mental changes may occur. Among users, the mental disorder is referred to as paranoia (paranoid and paranoid-hallucinatory syndrome when a person thinks that he or she is being followed and is in danger and acts irrationally). Withdrawal and addiction treatment is accompanied by fatigue, restlessness and an intense craving for more drugs; depression, irritation and sleep disorders may develop within weeks to months. The primary effect of methamphetamine is significant and pleasant and therefore desirable. Due to increased empathy – the ability to identify with the needs of other people – and a loss of restraint, the use of methamphetamine may be welcome in sex. The

drug stimulates both the body and the mind and therefore, the condition is so desirable for many users that they cannot enjoy sex without the drug.

The following is a narration by a former crystal meth user about his experience with sex under the influence. *"Crystal meth – this stimulant will charge you with energy and give you the feeling of being the strongest bull in the corral... You feel euphoric and self-confident, your attention and concentration increase, but you lose your appetite and the feeling of thirst, which can easily lead to dehydration. If you use crystal meth, your penis contracts because of the drug and dehydration since you do not feel thirsty. If you manage to have an erection, then the act is limited to coitus only, and it can last from several minutes to several hours; however, the quantity is to the detriment of quality. Nerve endings on the head of the penis are blocked and instead of pleasure, you are "stuck" (this can last from several minutes to hours and is typical for crystal meth – the same dance movements, doing a crossword puzzle, the same conversation topic over and over). Orgasms then appear to be longer, lasting from 3 to 5 seconds, but it is important to say that this cannot be objectively assessed and the intoxicated don't pay attention to time. I believe that sex is important during crashing because it helps to mitigate withdrawal."*

The experience of a client who was addicted to methamphetamine and gambling for 8 years; her primary addiction was methamphetamine. She is 25 years old now and has abstained both from addictive substances and from addictive behaviour for 5 years.

"What was sex on drugs like?" That's a rather difficult question for me. Since I started with drugs at an early age, I used crystal meth intravenously when I was still virgin. So I used drugs first and sex followed. I slept with a guy for the first time when I was eighteen. Of course, I tried other things before, like petting, kissing and oral sex, just not normal sex. I liked sex right away and my first sex was on crystal meth. And this continued; I was never "clean" during sex. Naturally, I felt euphoria and I do not think I will experience such pleasure ever again, but those were no real emotions. Everything was false, which I can now only see from a distance. I started to be promiscuous and collected different sexual experiences.

I used drugs and immediately after intravenous application, I felt the urge to have sex. I simply HAD to have it. I did not care with whom or where. My craving for sex did not leave even during the most serious stages of my addiction and during toxic psychoses. I had some of my best orgasms

when I was using crystal meth. Marijuana triggers a mental longing, while crystal meth stimulated my body and so I combined them both.

I have been abstaining now and sex is the only "drug" that is left. It took me relatively long before I learnt that sex without drugs is different, but it can still be a great experience. It's not about being forced by the drug anymore and me going into everything head first; I am enjoying a functioning relationship where I live entirely free and making love is just a bonus …"

Cocaine is less common in the Czech Republic. It is less available because it is more expensive than alcohol, cannabis and methamphetamine. It has euphoric effects that cause mood changes, helps enhance the feeling of strength and mental energy, suppresses fatigue and causes a psychological addiction. Cocaine can be injected or sniffed. Users of this drug may reach a state of complete physical exhaustion where they spend all their time and resources trying to obtain money for more of the drug and often neglect their nutrition. In the past, cocaine was seen as the drug of the privileged, often used by artists and rich people who were looking for more pleasant and quick experiences. Cocaine was also widely used by prostitutes. Today, there is no relevant research that focuses on the relationship between sexuality and the use of cocaine.

Opioids and opiates are substances with strong sedative effects. The most widespread opiate in the world is heroin. In the Czech Republic, heroin became popular especially after 1994. The most important representatives of opioids and opiates are heroin, buprenorphine and methadone (synthetic opioid), opium (poppy seed), and in the past, brown was popular among users. It used to be made from codeine.

Heroin is typically taken with syringes, inhaled through sniffing or smoking. Its effects include calming down, a pleasant euphoria, a feeling of no physical or mental pain, a reduced perception of bodily sensations and a greater feeling of warmth. The user daydreams, relaxes and watches the world around himself or herself rather than being an active player. Long-term use creates both physical and mental addiction, reduces the feeling of pain and one's own needs. The user is exposed to different infections, permanent faintness and sleep disorders. The use of heroin also reduces the necessity for food and sex, causes cramps and menstrual disorders in women. Opiates cause both physical and mental addiction, with heroin being the most dangerous one. Drug tolerance quickly increases and the addicted needs higher and higher dosages. To satisfy his or her need for a higher dose, the individual often engages in illegal and criminal activities,

sometimes even prostitution even though the addicted does not really need sex and the drug is more important to him or her.

Hallucinogens are drugs that include a wide range of natural and synthetic substances. These substances alter perception and distort one's objective reality. They can affect the perception of time and space, the user might "see sounds and hear colours", and his or her mood changes from euphoric to depressive. Hallucinogens are widespread all over the world and their use can be detected far back in human history where they were used for different rituals and purposes. Natural hallucinogens include mescaline, psilocybin (in magic mushrooms), datura, panther cap and fly agaric. Synthetic hallucinogens include LSD (lysergamit), popular today in the form of "trips" on the music scene and dance parties.

Because the effects also distort one's perception of reality and affect physical performance (higher blood pressure and its follow-up decrease, increased cardiac activity, vertigo, digestive disorders, nausea, faster breathing, no need to sleep, have sex or eat) no experience have been reported with sex under intoxication.

A former user of this drug reports on his experience with sex when he was intoxicated. *"If you take these drugs, sex is the last thing you are interested in. Experiences are very strong and unpredictable. I am totally carried away by my thoughts and my own reality and there is no room to think about sex; physiologically, the veins contract, so are the larynx and penis."*

The social context within which drugs are used is also important for the issue of sexuality in addicted people. As we know from history, certain cultures and social groups sometimes used certain addictive substances for their rituals and customs. Sometimes, the use of such addictive substances was also associated with sexual activities that were received by the group as their norm. In the 1960s, during the era of hippies, different types of addictive substances experienced a boom. This happened hand in hand with relaxed morals in terms of sexuality – having multiple partners and changing them quickly and group sex. Given the social changes, the elimination of certain taboos, development of social relationships and opposition to the establishment, we can say that the link between sex and addictive substances was in line with the context of that time.

In the Czech Republic, several surveys focusing on the prevalence of drugs among primary and secondary school pupils have been conducted. One research concerned special school pupils' experience with drugs. The

researchers were O. Šmídová and students of the 3rd year of the Faculty of Social Sciences at Charles University in Prague in 1995; the research was commissioned by the Public Health Authority of the Capital City of Prague.

As far as sexuality is concerned, the research showed that boys and girls like to gather in mixed gangs of 10 to 20 people. Some members of the gang used drugs, others did not. Together they would engage in different activities, such as skating, and would also go to bars, to Vítkov Park and other places. The pupils openly admitted that they were interested sex long before they were 15 years old and often had vast sexual experience. They liked to watch porn films, girls did not have any difficulties quickly meeting unknown men and strangers in public places (underground, bars and parks). Together they would go to discotheques where they would dance, smoke and meet other people. The peer influence was enormous and through their friends, others would try drugs, receiving information from the more experienced ones (Nožina, 1997).

Another set of research concerned the population of secondary school students and was conducted in Prague in 1992 by a group of employees of the Faculty of Social Studies at Charles University in Prague, led by P. Kuchař. The research showed that there is a strong connection between the use of drugs and the subjects' love life. As far as erotic relationships are concerned, drug users had more experience than regular secondary school students. Drug users had 1.5 times more experience with petting, kissing and erotic playing than others. As far as sexual intercourse was concerned, drug users reported twice as much experience. In other words, the research showed that drugs play a role in eliminating barriers in erotic relationships and also form part of the lifestyle of certain groups of young people.

The issue of sexuality in persons addicted to substances or their effects is very vast and diverse. There have been many other research studies and connections that deserve to be mentioned. I would like to thank to Vašek, Zuzka and other drug users who were willing to share their experience from this area.

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1.4 Helping Professions – the Professional's Personality, Sexuality and the Client

Jana Harvanová

Today there is an ever-growing list of requirements that helping professionals have to meet. This is followed by descriptions of the failures, risks and negative models that are associated with these professions. Less information, both in specialized texts and in the media, is dedicated to what helps these professionals overcome the difficulties they encounter in their demanding professions. Very often, helping professions are performed by those who help themselves and who, more or less, do not receive any help from others. However, the ever-growing psychological accents that society has been delegating to helping professionals require (while naturally maintaining the proper degree of professionalism and specialisation) the development and deepening of the social-psychological aspects of the helping professions' skills. This concerns both the preparation of pre-graduate and follow-up specialization programmes that are being designed as a part of lifelong learning. The psychological aspect of this work acquires a new definition and generates a unique demand for the development of the employees' professionalism (Štětovská, 2011). Society has been placing more pressure on performance and at the same time, direct contact between people, not burdened with structures, that allows for a simple direct experience with open communication and interaction has been diminishing. This results in a society flooded with information (with questionable credibility and maximized changeability); society is fragmented with regard to knowledge and relationships. Society is characterised by the disintegration of direct communication links, its values are relativized without being replaced by new systems or structures (Hoskovcová & Štětovská, 2006). What people in the past used to acquire naturally through life experience within their community is no longer developed or is modified (moderated) by the media. The overpressure of fast and effective (sometimes rather easy to measure and acquire) performance, anonymity and the hectic pace of

everyday life are also more and more related to the disintegration of natural communities (neighbourhoods, interest and other groups, etc.). The pervasive growing feeling of danger makes clients and their parents strive for structured and organized free time without the option to naturally interact with their peers. The number of children in families has been decreasing, as has the amount of time families spend together (Gillernová, 2006). Opportunities and space for natural socialization and the continuity of relationships in society have been diminishing. Thanks to new communication options in the interpersonal sphere and communication in general, opinions have emerged that education is not really needed and everything can be resolved through access to information. On the other hand, demand for a qualified guide to the chaotic world of partial information has been growing together with a requirement for a qualified "survival" strategy and orientation in the system and hierarchy of information (Hoskovcová & Štětovská, 2006).

The environment in which work with a client takes place is where moments of mutual socialization occur. It is a place where the concepts of authority and authenticity, rivalry and cooperation is tested, new relationships are made and communication (or more generally, social) skills are trained and behaviour in conflict situations is shaped. However, a professional in this type of environment does not take over the socialization tasks because of his or her own omnipotence. The most discussed fact remains that society delegates many important powers to professionals, often without considering their capacities or options. Helping professionals are supposed to prevent all kinds of hazardous social and health phenomena and act as facilitators and mediators in difficult situations. Many of them lack examples or do not have direct experience with the issues of safety, self-respect and self-esteem. These professionals often have to address completely new social phenomena that have not been sufficiently explored (either directly or indirectly). They also face demands on the relationship level because insufficiently mapped hazardous phenomena often force them to confront their own authenticity. The situation of helping professionals may also be affected and complicated by their ethical attitudes towards a given issue. The professional s find themselves in a relatively complicated situation – on the one hand, they face high expectations, while on the other hand, they are constantly reminded of not having sufficient skills, proper education or being easily adaptatable to change. Helping professionals are

the main actors of change, but their working conditions do no always reflect that (Prokop, 2005).

There is no question that the requirements for these professionals' skills has been increasing. However, helping professionalss themselves often lack any direct experience with what they should cultivate and develop with their clients (Bučková, 2002). Psychological skills have been increasingly identified with the ideal norm. Professionals are supposed to act as an understading and professional authority, but also see their client as an equal partner. This by itself is, wihout any question, a difficult task full of internal contradictions. This means that a hidden component of the profession is working on oneself and further personal and professional development.

It is relatively hard to define where the work process begins and where it ends for helping professions. Similarly unclear is the relationship level and to a certain extent, the professional s' responsibilities. Some professional s prepare for complicated life situations so that when they get close to a client, they try to help him or her with their family problems.

Naturally, any professional is also a member of his or her own peer (generation) group. At the same time, he or she has to be able to communicate with his or her clients regardless of their generation of (who are often much younger). The professional has to understand their vocabulary and to a certain extent share (although not necessarily accept) their problems so that he or she can use these moments for motivation. In addition to their own specialization, professional s constantly have to learn new skills, changes in values, communication, etc. This whole situation changes with each new generation of clients.

Another specific characteristic of helping professions is the success rate. The question is when a professionals sees quick and clear results of his or her work at a time and in a society that requires such results. Most results that are accomplished by this profession are not visible, happen over a long period of time and it cannot be clearly clearly attributed to the professionals's efforts. One specific feature of helping professions is that they see themselves in the context of other professionals. A helping professionals only rarely becomes the centre of media attention and is often portrayed in negative cases. Qualified experts very often provide critical feedback without stressing any successful moments. The question arises how this critical understanding coexists together with the expectation that a helping professional will help to shape self-confident clients when he or she himself is not received in that manner. At the relationship level, the professional

is forced to be constantly alert while also being the centre of everyone's attention (even if he or she does not want it). When working in his or her profession (with exceptions) the work is performed alone without a partner who might help, give advice or share responsibility.

The above ethical dimension of the work is often associated with many myths related to helping professions. Positive myths are as equally bad as negative ones for the profession. It seems to be an obvious fact that there is somebody like an "ideal" helping professional to whose services the client is automatically entitled, who never fails to resolve any situation, can help anybody at any time, etc. The issue is that many professional s willingly accept this ideal norm and expose themselves to a risk of significant professional stress associated with unrealistic and unrealizable expectations. A specific feature of helping professionals is that they can also help get through their mistakes if they know how to work with them.

It is not a new phenomenon that a professional becomes a social model for his or her client (sometimes rejected, sometimes accepted), as this naturally results from his or her own professional role. The professional may feel a need to escape from this situation or accept it. Regardless of their choice, he or she remains a model against which clients confront the world of social norms, values and conventions.

The democratisation of social relationships, which in helping professions corresponds to the gradual transformation of relationships between a helping professional and a client, changes their mutual communication and social activities. However, many professionals are afraid of or concerned about such changes because it deprives them of the ability to authoritatively control what their client does. The client is exposed to types of behaviour for which he or she many not feel sufficiently prepared, such as conflicts, sexuality, addiction, xenophobia, relationship with money and the media, etc.

The profession is increasingly placing a number of new demands on helping professionals on the social, communication and relationship levels, and is making them work with themselves and their personality to an extended degree. All of this results in specific demands on the professionals' motivation, their abilities and skills and certain personality traits. The professional remains the only one who knows how to act in the "bouncer zone" of social changes. The professional repeatedly moves forward to deal with other changes that he or she can manage through his or her work (Štětovská, 2011).

The above indicates that a helping professional's personality plays a decisive role in his or her work (Kohoutek, 2003). When studying the personality of a professional, two main approaches are applied – the normative and analytical approaches. The purpose of the normative approach is to determine what a professional should be like and which properties he or she should have to be successful in his or her work. The analytical approach determines which specific, real personality traits a professional actually has. The following components are important for the professional's personality: mental resistance, insight into the substance and nature of problematic situations, adaptability and adjustability, the ability to acquire new knowledge, learn and effectively respond to one's inner and outer activities (Mikšík, 2007).

However, the personality of a helping professional may not be understood as just a mere list of properties. It is more suitable to imagine it as a whole made up of different layers – missions (*Why am I here?*), identity (*Who am I? Who do I think I am?*), beliefs (*What is my personal opinion?*), skills (*What can I handle?*), behaviour (*What do I do, How am I doing?*) (Mareš, 2013). An important aspect of a professional's personality is the idea of who he or she is and believes to they are. It is important to understand that throughout his or her life, the professional constantly constructs and reconstructs his or her identity and that this identity has at least two other layers – the personal identity related to the special traits of his or her personality; and the social identity related to his or her different roles in society. There is also the professional identity that concerns his or her work. The professional's identity is made by many partial identities and the professional must make sure that they are not mutually contradictory and that they form, if possible, a coherent unit. His or her identity may change throughout their life, at least some aspects of it; some others change as the professional gains more experience, re-evaluates how he or she sees himself or herself and things that have occurred. The professional's identity is also affected by his or her contact with other people and the relationships that the professional has with them. The professional creates his or her own professional identity by dealing with co-workers, superiors and clients. He or she forms his or her identity by overcoming conflicts between people and coping with how the people around him or her see them (Mareš, 2013).

The term identity of helping professionals may also be replaced with the term of professional's self-understading. What does this include? The understanding of oneself (i.e. identity) has both retrospective and current

sources. Retrospective sources of identity have four forms. The first one can be referred to as self-image – a description of oneself as a helping professional that reflects any previous assistance and characterizes the quality of professional contact with clients in the past. Secondly, identity can be expressed as self-esteem and self-respect. The professional retroactively assesses himself or herself, thinks about how successful his or her work has been to date, appreciates himself or herself or alternatively, has doubts, considers himself of herself weak and despises himself or herself. Third, the identity of a helping professional can be briefly characterized as professional motivation. The professional revisits the circumstances surrounding his or her decision to choose the profession. He or she remembers the changes that has shaped his or her professional motivation over the years, sums up how he or she has coped with their lower social status, looked for the positives in the helping profession and compensated for its negatives. Fourth, the professional's identity can be understood as a task; a set of goals that the worker defines for himself or herself together with requirements that he or she has in relation to his or her clients and colleagues. The current sources of a professional's identity also have four forms that are more or less identical with the previous text. In addition, the current dimension of the professional's identity reflects any resolutions that the professional has made through a retrospective analysis and any changes that he or she has tried to implement (Mareš, 2013).

The previous text outlined that a substantial part of a professional's multilayer personality is his or her identity, including any experiences and self-assessments and, based on that, a certain prediction of his or her perspectives. Every human has a certain notion of oneself, what he or she is and is not capable of. In his social cognitive theory, A. Bandura used the term *self-efficacy* to summarise this concept – it refers to one's perceived strength and abilities. Bandura's social cognitive personality model searches for connections between a person's reflections and perceptions on the one side and his or her acts on the other side. In his theory, he says that a person is successful if he or she is predisposed to do certain work and at the same time expects to manage it without any problems while also expecting to achieve a desired result through this work and therefore, personally believes it (Bandura, 1997). The basic theory is the *reciprocal determinism model.* Each part of the system (behaviour, cognition and environmental impacts) affects all other parts. People are nor free initiators of their environment, but do not just passively respond to its pressures either. One's perceived

efficacy mean the person's beliefs in his or her ability to act to what he or she has control over and to the events that affect his or her life. The belief in one's efficacy forms the basis of human activity. The less a person believes that he or she can achieve a result through what he or she does, the lower is the motivation to do something. Helping professionals with high self--efficacy work with the belief that through their special strengths, they can achieve the effects that they have defined. On the other hand, a professional with low self-efficacy believes that he or she can achieve only a little.

Perceived self-efficacy is only one of the personality traits that identifies good professional work by helping professionals. Other key traits and skills include empathy, understanding, a willingness to help, a positive emotional relationship and connection to a wide range of social skills. Such characteristics together with a degree of perceived self-efficacy are important, especially when communicating with clients and in their mutual relationships. The relationships also reflect to what extent the professional has or has not developed his or her own social skills, whether he or she can properly and timely recognize changes in their clients' mental conditions and attitudes and have adjusted his or her further steps and behaviour as a result (Hoskovcová & Šírová, 2011). The basic social skills that are prerequisites of effective performance of all of a professional 's activities include the acceptance of their client's and co-workers' personalities; authenticity of the professional 's behaviour (to openly or genuinely show emotions, express opinions and attitudes); empathy (the ability to feel for others but remain oneself); listening to and distinguishing between feelings, reflections and judgments from opinions both in himself or herself and in others; support of self-control and self-regulation; the development of self-confidence and self-confident behaviour; respect and tolerance towards different views; and the development of responsibility for oneself and the social environment in which he or she lives (Gillnerová & Krejčová, 2012).

Self-reflection and self-assessment are important for further developing the above skills as they help to provide a self-critical evaluation of one's professional work. A professional who uses self-reflection focuses on their clients and pays attention to their needs, acts as a facilitator and strives for feedback, further education and professional improvement. A professional who does not use self-reflection is focused on himself or herself or their work, relies on personal experience, passes on information, makes rash conclusions and generalisations without exploring the causes of the given phenomena, is influenced by prejudice and dogmatism and routine prevail

in his or her work and he or she does not feel any need for further education (Dytrtová & Krhutová, 2009).

All of the above aspects of the personality of helping professionals are key in relation to his or her attitudes to their clients' sexuality. Štěrbová (2007) says that it is important to create specific conditions to provide sex education, which means creating a framework and a set of internal rules and regulations that given institutions should follow. The framework is supposed to enable helping professionals to act quickly and properly in difficult situations. A professional who intervenes in different ways in sex education should be sufficiently skilled (continuous education, awareness of one's obligations, knowledge of relevant legislation); he or she should be able to work and communicate with co-workers and specialized workplaces, cooperate with parents and also see the ethical borders of his or her personal statements. Sexual topics in the work of helping professions include more than just the provision of information, attitudes towards sexual ethics and support of personality autonomy (Recommendation by the Ministry of Youth, Education and Sports Regarding Sex Education at Elementary Schools, 2010). A professional does more than just provides facts; he or she shows attitudes towards sexual ethics, supports personality autonomy and teaches the ability to satisfy one's own sexual needs (Rašková, 2008). In addition to the general objectives, these are also ethical principles. These include gender equality in sexual ethics, the rejection of racial discrimination, violations of personal freedom through mental and physical pressure and aggression and respect for the position of homosexuals in society. The above list of ethical principles is not exhaustive. There are other principles that definitely are not marginal and are related to inappropriate sexual liberalization because certain behaviours are not acceptable and cannot be tolerated (e.g. attacks, aggression, abuse, etc.), to the existence of sexual relationships with different groups of people where nobody may abuse anybody else for his or her own satisfaction (Rašková, 2010).

The ethical principles of helping professionals also include the knowledge of one's limits. As has been mentioned above, an helping profession does not automatically mean perfection at all levels. The effort to succeed in one's role does not automatically mean they have to be competent in all situations to which a professional is exposed.

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1.5 Sexuality, Attitudes and Communication, Including Persons with Disabilities and Persons with Autism

Dana Štěrbová

In her description of sexual development, Spilková (2013) says that basic gender-related characteristics are already formed in children's brains and that children are capable of basic sexual emotions – sexual arousal, orgasm and erotic fascination by another individual. Therefore, they masturbate. "…children's sexual manifestation does not have any of the erotic character that we see in adults" (Spilková, 2013, 27).

The views of modern psychoanalysts are complemented by psychological views. For instance, Jungian analyst Guggenbühl-Craig (2010) mentions conception, which reflects religious views. He describes mainly the attitude of the Catholic Church where it has for a long time been the moral rule time that sexuality and reproduction go hand-in-hand. "Modern theology has shown an increasing understanding for sexuality that is not just an activity associated with reproduction. Regardless of the theological view, from the psychological perspective, human sexuality cannot be seen just in relation to reproduction. Rather, sexuality much better expresses a relationship between two people" (Guggenbühl-Craig, 2010, 46).

The author also says that a physical relationship between a man and a woman, or their sexual connection, is one of the most intensive connections between male and female principles.

Reproduction means multiplication, while sexuality is the contrary –the merging of two bodies. However, I am not concerned with the biology, but rather the psychology of sexuality. The fact is that a majority of human sexual activities takes place without the slightest intention to conceive a child. We cannot even claim that a woman might unconsciously think of conceiving a child during a sexual act. This would be a dogmatic claim that cannot be verified by any psychological material (Guggenbühl-Craig, 2010, 46).

Based on their attitudes towards sexuality, people sometimes find themselves in communication traps.

"In a simplified manner, communication can be understood as the process of exchanging information between two or more communication entities. It is the practical basis of all human relationships. It is the process of communicating (and sharing), transferring and exchanging meanings and values, which includes not only information, but also other expressions and results of human activity, such as goods, forms of behaviour, works of art, etc." (Pokorná, 2010, 11).

An example that might be controversial and may provoke the above feelings is the assumption that a child is polymorphously perverse, i.e. both heterosexual and homosexual.

Children's sexual games involve peers of both the same and the opposite sexes. Throughout development, the heterosexual component becomes more important while the homosexual is less predominant, i.e. subdued and forced out. "In many people, the homosexual aspect lies very close to the surface and under certain conditions, it may become predominant. Many psychologists believe that homosexuality is always close to the surface and that it has to be sublimed in a way" (Guggenbühl-Craig, 2010, 52).

Although homosexuality has been considered an equal form of sexuality for many years, it still provokes different feelings in people (both non-professionals and experts). Dixon-Woods et al. (2002) say that research has identified that both medical students and physicians may have negative attitudes towards homosexuality and certain forms of sexual behaviour. The present authors point out that only a few studies focus on the wider issue of attitudes and values that shape the behaviour of health care professionals. It is important for medical students to start the process of reflection early on and to identify how their attitudes and values may affect their care for their patients. Therefore, learning programmes are recommended to help students develop communication skills for sex consultations.

There is a greater disproportion in people with intellectual disabilities than in people without any disability, as the period of maturation takes longer and an individual takes more time to achieve true psychosocial maturity.

The development of intellectual skills is not proportionate to physical development or sexual maturity. A correction is often needed and therefore, problematic sexual behaviour is seen more often in people with intellectual disabilities (Spilková, 2013, 32).

Problematic sexual behaviour may jeopardise both the safety of a person with intellectual disability and the safety of people around him or her. Some displays of sexual behaviour can be considered hazardous and their consequences may be criminal. Different attitudes towards the sexuality of persons with intellectual disabilities are formed due to assessing the behaviour of people with intellectual disabilities. In practice, we can see elimination, or tolerance of sexuality in persons with intellectual disability.

Štěrbová (2011) lists the basic classification of attitudes towards the sexuality of persons with intellectual disability according to Burdová (1988):

a) The elimination of sexuality in people with intellectual disability;
b) Tolerance of sexuality in people with intellectual disability;
c) Acceptance of sexuality in people with intellectual disability;
d) Cultivation of sexuality in people with intellectual disability.

The most frequently-adopted elimination of sexuality in persons with intellectual disability and autism can be found not only by the lay public, which does not have sufficient information, but also by uninformed specialists. It is associated with uncertainty, which is one of the repeated registered feelings that accompany elimination and tolerance. We can also see it in students of helping professions and those who are trained at universities to work with persons with disabilities in subjects dedicated to the sexuality of persons with intellectual disabilities. Their attitudes were mapped based on their final papers (Štěrbová & Harvanová, 2013):

"I think that the majority of society more likely expects asexual behaviour from these people. The general public is not able to imagine that people with intellectual disabilities also have their needs. I don't mean just sex as such, but ordinary things such as love and partnership. The problem is that people with intellectual disabilities are seen more like children than adults. … Who can be competent to advise persons with intellectual disabilities? … We can pretend that we accept sexual life in people with intellectual disabilities and that we want to help them develop it, but I think this is just a social attitude. Most of us, maybe not expressly disagree with it, but cannot imagine a sexually-active person with intellectual disability. Nevertheless, society is developing and becoming more open to "new things". Perhaps, within future integration and inclusion, the sexual life of persons with intellectual disabilities will be accepted as absolutely normal" (female student, 22 years).

A lack of self-reflection with respect to the sexuality of persons with disabilities is a risk factor not only during pre-graduate studies of students of helping professionals, but also in practicing experts. Their attitude towards sexuality is subsequently reflected in the way that they communicate with patients with disabilities.

The specifics of their attitudes are reflected in the way they approach different situations and problems related to the sexual behaviour of clients with intellectual disabilities and clients with autism; this can range from refusal to helpfulness when addressing such situations and problems. The feeling of uncertainty is accompanied by other feelings, such as anger, rage, resistance, sorrow, joy, etc. If such feelings are predominantly negative, then it is difficult to address a situation and an escape strategy is more likely chosen ("I prefer not to see the problem"). However, this increases the risk for all participants; all of them are exposed to stress and more or less incapable of reacting to it. Risks can be also found in approaches that operate with alleged protection, including the failure to provide any information as a part sex education that might be expressed as follows: "If they do not know anything, then there are no risks involved for them." Parents (legal representatives) should always be involved in the decision-making of whether and how sex education will be provided to children/pupils and adult individuals with intellectual disabilities and autism. Their attitudes can largely affect the attitudes adopted by the surrounding environment. If a positive feeling towards sexuality prevails, then there is a greater chance to create a tolerant and accepting attitude.

It is obvious that a person whose attitudes were shaped while he or she was developing unfavourable opinions of sexuality may unconsciously distort some information or complete it so that it suits him or her, while intentionally avoiding information that is not part of his or her value system. A person cannot be forced to accept the values and opinions of others; however, at the same time, it is necessary to use modern scientific knowledge if we want to educate, cure, rehabilitate and generally help in terms of sexuality.

People often present their attitudes towards homosexuality under the influence of the rational element. They seem to be telling themselves that homosexuality "is not harmful" as long as "it does not affect me". Their emotions are alert and people experience discomfort, concerns, displeasure and at times even hatred.

We believe that everybody should adopt Howlin's idea: "Although the disabled are aware of their limits, the need to be loved and accepted with understading is very strong. In such cases, a conflict can arise between the desire for an intimate relationship and the knowledge of problems that come along with such close relationships" (Howlin, 2005, 248).

Different values and attitudes, as mentioned above, affect the scope of information by either narrowing or widening the issue of sexuality.

Vanier (2009) aptly describes the differences in approaches to the sexuality of persons with disabilities based on the Christian view of humanity, which is very different from industrial society's perspective. The approaches and communication fully reflect the character of an individual and demands that should be adequate to the requirements for providing support during insecure moments. Vanier (2009) speaks about people who accompany persons with intellectual disabilities during consultations and education and who should be sensitive and kind to be able to face pain, confusion and injuries.

The accompanying person also has to know the limits of his or her own role. It is not necessary to know everything. What is necessary is to respect privacy and the hidden secrets in everyone's life. It is correct to intervene when it is certain that the other person is in danger or is confused. The basic rule remains the same – to establish a close relationship that enables dialogue and where fear slowly, but surely disappears. To establish such a relationship sometimes requires a lot of time (Vanier, 2009, 52).

Since attitudes towards different areas of the life of the normal population differ, the more specific opinions of sexuality in persons with intellectual disabilities appear. Vanier (2009) points out the fact that persons with intellectual disabilities are more affected by values and opinions of the relationship between men and women and of sexuality than are proclaimed by the media and family. "All of that forms imagination and therefore, we cannot wonder that they are confused to a certain extent" (Vanier, 2009, 104).

Adolescents with cognitive disorders, such as mental diseases and mental disorders, often lack the skills required to understand social "allusions". They are less capable of getting involved in social interaction in the same way as their peers, which decreases their ability to make new friends. Cognitive and language issues create difficulties when making relationships and building intimacy (Freeman & Kasari, 1998). Adolescents with questionable social behaviour and limited social understanding may fail in understanding the duties and expectations that are required to maintain a friendship (Doll, 1996).

The following topics (issues) are those that form the attitudes of (not only) the professional public.

Does a person with intellectual disability have the right to be a full sexual being? Cognitive disability and communication problems may cause difficulties both during the process of interaction and in the development of a relationship with a counterpart. However, this does not mean that relationships between people with disabilities should not be fostered. Gordon, Tschopp and Feldman (2004) mention how much the young with disabilities are affected when they realize the differences between them and others and how deeply this feeling is reflected in their self-perception of sexual beings, i.e. their sexual development. With reference to other authors, they emphasize how difficult it is for adolescents with disabilities if they are seen by the ones close to them as asexual.

"In the past, the sexual needs of people with Down syndrome were often ignored" (Selikowitz, 2011, 167).

A young adolescent with or without disability can be internally split, unbalanced and unable to find the right relationship boundaries; such person either seeks a close physical relationship too soon, which is dangerous both to him or her and their partner because sooner or later it will result in rejection, or he or she will hide behind the protective barriers that he or she has built over the years and refuse any relationships. This may cause a deeper gap between genital sexuality and the heart, between the search for sexual satisfaction and the search for a deep, authentic relationship with another person. The most important thing that we can do when confronted with such suffering is to accept the person and continue living together with him or her, respect his or her pain, but maintain hope. Each of us carries wounds inside that will never be healed, which means that relationships are complicated for all of us, especially physical, sexual relationships. We are never entirely healed and entirely free (Vanier, 2009, 21–22).

About the relationships between a man and a woman with intellectual disability

A young man and a young woman who both have intellectual disability may be attracted to each other to a certain extent, but that does not mean that we should encourage them to start a sexual relationship or enter into marriage. If they are not mature, their relationship would lack the required responsibility. Encouraging a sexual relationship may only deepen their immaturity (Vanier, 2009, 71).

"It is natural that many teenagers and adults strongly long for a sexual partnership. This desire is enhanced by the knowledge that "everybody has a girlfriend or a boyfriend" and not having a partner makes the label of being different and incapable even worse" (Howlin, 2005, 247).

"Gerald is a 22-year old boy with a light intellectual disability who keeps telling everybody that he needs to find a girlfriend because he wants to get married before he turns twenty-fine and that time flies. He does not realize which role he would play in such a relationship and what problems are associated with relationships in general. His only argument is that his brother got married when he was twenty-five and he does not want to be left behind" (Howlin, 2005, 248).

A man does not always provoke the best in a woman just like a woman does not always provoke the best in a man. The presence of men might provoke the desire to flirt and to pit one man against another and cause a disagreement. A woman can provoke true sexual obsession in men (Vanier, 2009, 65).

It is not obvious whether Vanier (2009) is always right when he says that based on his experience with persons with intellectual disabilities he discovered that "…the deepest desire of each person is to make a relationship with another and live with him or her in a family. People wish to live with the other in truly friendly relationships" (Vanier, 2009, 63).

One of the reasons is the fact mentioned by Selikowitz (2011): "The claim that people with Down syndrome have low sexual needs is not reliably supported by any research and seems not to be true for many people with the syndrome. The opinion that people with Down syndrome are "excessively sexually active" or that they have tendencies to hurt others because of their sexual desires is also not correct. Similar assumptions were probably based on previous opinions that deny that individuals with the syndrome have any sexual desires whatsoever and consider any normal signs of sexual interest deviant" (Selikowitz, 2011, 167–168).

Can a couple in which both the man and the woman have intellectual disability have children?

Based on their experience, O'Toole and Doe (2002) say that with rare exceptions, nobody asks people with disabilities whether they want to have children. The silence surrounding sexuality concerns both persons with disabilities and their parents and assistants, teachers and most health care professionals. And the same people sometimes approve forced sterilisation.

The authors also mention that the world of "normal" people creates problems for future parents who themselves have disabilities.

Vanier (2009, 156) responds to that as follows: "It is a complicated issue. We quickly forget that some women with intellectual disabilities want to become mothers more than anything else. The misery of infertility is unbearable for them. If the people around them support them to engage in sexual relationships while at the same time prevent them from conceiving a child, their profound desire for motherhood remains misunderstood."

Regarding the question of whether to have or not to have children, Vanier (2009) adds: "Nevertheless, we have to admit that some people with intellectual disabilities should not have children. We definitely should not support the conception and birth of a child if there is a risk that the child would have a severe disability or would not be accepted, loved or cared for. This is not just an issue of heredity. A much more delicate issue is the fact that a person with intellectual disability will not be able to look after his or her child, even if the child does not inherit the disability. Naturally, a mother with intellectual disability is able to look after her child and enjoy it, but there is a risk that when the child is irritated and anxious, some mothers may become insecure and anxious themselves. At such moments, they might abandon or even torture their child. A mother can bring up her child only if she is secure, free and internally calm, of which some women with intellectual disabilities are not capable. It would be irresponsible to agree with them having children, if evidently, they are not capable to duly bring a child up" (Vanier, 2009, 156).

Kelly (2001) says that persons with intellectual disabilities seem to be one of the most oppressed groups of people (with disabilities) in connection with the (historic) focus on concerns about congenital defects, which in the past resulted in forced sterilisation. This brings us to the issue human rights violations.

Masturbation in persons with intellectual disorders

Masturbation is a delicate topic. The issue of masturbation is usually a taboo in families (*in families without children with intellectual disabilities – author's note)*. Parents do not speak about masturbation with their children and do not know which approach they should assume in this respect. Mothers seem to be taken by surprise by this question. They do not consider masturbation a part of sex education. Although they do not consider it anything bad, they do not know how to initiate this topic in conversation. If

masturbation were reported in a family, it was children masturbation and no further explanation was provided (Štěrbová, M., 2013, 42).

However, the situation is the same in families with children with intellectual disabilities. The issue of masturbation in persons with intellectual disability has to be addressed according to where and under what conditions it takes place. Based on that, it may be classified as behaviour that is appropriate and desirable, or as behaviour that is inappropriate because it takes place in public or in relation to other persons. Emerson (2008) lists self-harm among the problematic behaviour of public masturbation.

During puberty, other behavioural issues usually occur, because it is a time of big changes. Just like healthy children, teenagers with autism have difficulties understanding and coping with the changes to their body. When is it going to end? What else is going to change? The first epileptic seizure usually happens during puberty. It seems to be a neurological disability that affects a large number of young people. During adolescence, their body needs more physical activity, but unfortunately there are very few educational programmes and options for relaxation for this age group. Under such conditions, masturbation becomes a form of repetitive behaviour because relaxation cannot be achieved through any alternative way (Peeters, 1998, 121).

Vanier (2009) says that masturbation can be a lonely act to supress a fear of relationships with other people. It is a vicious circle: masturbation deepens isolation and contributes to loneliness which results in anxiety that the person tries to eliminate through masturbation. The purpose of education is to help the client out of this dead-end alley.

"If masturbation starts at a young age, it brings about the risk that a person will get caught in the trap of genital sexuality, which does not head towards community with others and giving oneself to others, but towards self-satisfaction" (Vanier, 2009, 77).

Vanier's attitude towards masturbation and the attitudes of other authors differ radically. "It is very hard for tutors to recognise the sexual needs of their clients with more severe disabilities. Problems usually concern masturbation in public, exposure, touching other people in appropriate places, etc. Sometimes they also fall hard for one of the staff members. If appropriate measures are not taken in time, such behaviour can exclude the disabled from a number of activities as other clients do not want to spend time with them" (Howlin, 2005, 252).

Masturbation is associated with a wide range of problems as this issue is not sufficiently explained and understood, such as when and where it is or is not allowed. Masturbation at an inappropriate time and in an inappropriate place is a mistake of time management. Young people with autism have to learn that even though masturbation is allowed, it is allowed only in certain places and at certain times. It is not allowed in workshops, during meals or in public. However, it is allowed in bedrooms. These are the answers to "when" and "where". For some clients, symbols can be used (an image or an item) for masturbation and these can be included into their daily programme. "Not now. Later. Look at your timetable" (Peeters, 1998, 122).

Fig. 1 Teaching material – information about positive feelings during masturbation (Adopted from Keeling, 2005, 98)

"Josh got into a stage when he would masturbate almost non-stop. Once he caused a huge uproar when he undressed in front of a group of young

mothers with infants at a public pool. After this incident, all co-workers from the day care centre were banned from the swimming pool" (Howlin, 2005, 252).

Problematic behaviour – aggression associated with sexuality

The medical history of persons with intellectual disabilities and aggression reported beating others with their hands, verbal aggression, beating others with objects, anger and cruelty, pulling hair, pinching and biting.

Research conducted on persons with light to moderate intellectual disabilities (light or moderate mental retardation) showed that clients are able to provide credible information about how they feel and what they perceive and recognize. Focusing their attention on themselves and their thinking may help to reduce self-harm, aggressive and stereotypical behaviour, and more complicated processes of self-control, including anger management training and skills when dealing with social problems may eliminate aggressive, disruptive, stereotypical and self-harming behaviour (Emerson, 2008, 124).

Contraception

In his research, McCarthy (2010) explored the issue of contraception in women with intellectual disabilities. 23 women aged 20 to 51 years with light to moderate intellectual disability who were able to provide information on the use of contraception were asked questions in a semi-structured interview. Conclusions show that 14 out of 23 women did not understand how contraception works. Only five women decided to use contraception on their own; parents and staff made the decision for the remainder of them (18). Other results are presented in a form that may serve, among other things, as a manual to support the understanding of information for more than only persons with disabilities.

Fig. 2 Almost all women reported that the use of contraception was a decision made by someone else; usually by physicians, staff or parents.
(Adopted from McCarthy, 2010, 296)

Fig. 3 Most women could not remember what their physician told them about contraception. Most women said that the physician did not ask any questions.
(Adopted from McCarthy, 2010, 297)

Fig. 4 Physicians are very busy. They have many patients. This means that they often do not have enough time to speak sufficiently long and properly with women with intellectual disabilities. (Adopted from McCarthy, 2010, 297)

Opinions by women with intellectual disorders were not taken into consideration and in a way, their right to make a choice about themselves was violated. We believe that if similar research were conducted in the Czech Republic, the results would be the same.

A physician communicating with a patient with an intellectual disability requires sensitivity and tact, the ability to make the patient feel relaxed and use suitable language. The scope of requirements and expectations is obvious.

Dixon-Woods et al. (2002) report that physicians should adopt a therapeutic, non-discriminatory attitude towards human sexuality, but to also remember that research shows that there are negative attitudes shown towards gay, lesbian and bisexual patients and co-workers and some forms of sexual behaviour both in medical students and in physicians.

Sexual abuse

In relation to the clients of social services, Spilková (2013) says that risky sexual behaviour may be influenced by a long-term unfavourable health condition, social isolation or less experience with interpersonal

relationships. "With some disabilities, the issue of communication skills, fixation to one's known environment and disorientation in everyday life become more visible" (Spilková, 2013, 33).

In relation to communication aspects, Čírtková (2008) mentions work by Australian linguists M. and R. Brennan from 1994, who advocated their principle in a manual for policemen assisting the disabled that everyone has to be heard in a language that he or she understands. They also mention communication skills that the victim or the offender are able to use to describe their case. Communication skills in persons with intellectual disabilities are at different levels.

We must not forget about suggestibility and inappropriate approaches towards persons with intellectual disabilities when a suspicion of sexual abuse arises.

"Persons with intellectual or physical disability, including children, are labelled as especially vulnerable. However, increased vulnerability does not automatically mean incapability to testify" (Čírtková, 2008, 85).

Direct care workers in facilities providing social care, a parent, psychologist or teacher might be someone who can influence the testimony of a person with intellectual disability by asking inappropriate questions. Therefore, not only the police, but also people working in helping professions should be trained on how to approach persons with disabilities (both children and adults) when sexual violence is suspected. For more information, see chapter 1.2.

Where does eroticism and fantasy belong?

"However, it is obvious that a sexual impulse not associated with authentic love and a true desire for the other person to live and grow both at the human and intellectual levels may be very dangerous. Erotic literature, films and commercials try to evoke impulses that can take control over people and make them behave in a perverse and dangerous way when they use their partner for their own sexual pleasure" (Vanier, 2009, 74).

"Too strict bans in connection with punishment may result in a greater feeling of guilt and fear. This can further deepen the inner block and promote a secret search for sex and escape to erotic fantasies. This complete freedom of social activities may cause confusion" (Vanier, 2009, 52).

Appropriately chosen erotic literature may help the development of erotic fantasies and promote behaviour that helps a person reach self-satisfaction and eliminate sexual tension. Stanway (2000) considers sexual

and erotic fantasies a universal part of human experience and a kind of adult psychological game.

What is so fascinating and revealing about sexual fantasies is the fact that they often relate to early development stages of life when a person was facing diverse psychosexual problems that he or she had to cope with and absorb to become a successful sexually-active adult individual (Stanway, 2000, 15).

The use of erotic literature and erotography with persons with disabilities has to be carefully considered since such people are not always able to distinguish between reality and fantasy. It is often the environment that has to assume the responsibility for providing erotographic materials.

A huge clinical issue that can be very confusing for some individuals occurs when they try to distinguish between fact and fantasy. Sometimes I meet a woman who does not know whether she was abused in childhood or not. Her memories are very vivid and she cannot decide whether they are based on real experience or she made it all up. Given the power of the unconscious to penetrate into sexual experience, it may be virtually impossible to decide what is true without lengthy therapy. Nevertheless, the question whether a fact or a mistake is involved may only be academic in many similar cases because fantasy is so realistic that it might very well be true. The distinction may be impossible, but if such experience causes difficulties, the person has to deal with its consequences, whether real or imaginary (Stanway, 2000, 19).

It is very difficult for persons with intellectual disabilities to know whether a given experience was a fact (it happened) or fantasy (it did not happen). If the experience is traumatic, it is necessary to address it therapeutically.

Communication, attitudes and sexuality of persons with disabilities

It is good to remember that the following messages also apply to communication about sexuality. These messages become even more important for persons with intellectual and combined disabilities.

Anytime we speak with other persons, our mutual communication carries six messages, as Pokorná (2010) explains:

- What we wanted to say?
- What was actually said?

- What the other person(s) actually heard?
- What the other person(s) think that they heard?
- What the other person(s) say to what we thought that they had heard?
- How do we perceive what the other person(s) said about what we thought that they had heard?
  (Pokorná, 2010, 16)

A list of communication deficiencies of persons with intellectual disabilities include especially the following (according to Čírtkova, 2008, 85):

- limited vocabulary,
- limited attention span,
- difficulties understanding questions,
- memory problems,
- insufficient abstract thinking and mentalisation,
- inapt or inconsistent answers to asked questions,
- increased suggestibility.

Štěrbová (2012) mentions another obstacle to problem-free communication with a person with disability: insufficient skills of employees to use alternative and augmentative forms of communication (hereinafter referred to as AAC) and the ability to recognize whether a person with intellectual disability understands the AAC system. It often happens that staff providing services do not know what the level of receptive and expressive elements of the user's speech is. Problems may occur especially in clients whose ability to understand is disturbed, either by the depth of their intellectual disability or other diagnoses and disorders (PAS, hearing impairment, visual impairment, physical disability, etc.). The AAC system involves signs, symbols, objects, photographs and vocal outputs of different communication aids. Signing is recommended as a supportive means of communication for persons with diagnoses including cerebral palsy, autism and intellectual disabilities.

We recommend a book that describes the in-depth experience of a mother whose son is disabled. It is called *Nebij mě, můj milovaný synu* (Don't Beat Me, My Beloved Son) (Hrabáková, 2011). The author explores all areas of life with a disabled child. "Míša can imitate well, but he still only signs if he is asked to. And very often, I am not sure if he really wants what he is signing, or whether he is just making one of the gestures that he thinks he is supposed to show" (Hrabáková, 2011, 99).

Everybody who deals in practice with clients with severe intellectual disorders combined with an autism spectrum disorder should read this book. We have selected a paragraph about the emphasized choice of an adequate form of communication that will enable to people communicate information needed to reach a mutual agreement and to identify and satisfy needs.

"I found a course on alternative communication that will, hopefully, show me how to teach Míša to communicate more. I also discovered the Makaton sign language for persons with a disability. I've seen a Míša's classmate use some gestures before, but I didn't know what it was. For an unknowing spectator, it looked as if she were playing with fingers and fidgeting. Only her mother explained to me that this was her way of saying that she wants a piece of candy, a cookie or an apple. At that time, I thought it was stupid or entirely impossible, but now I found an online manual on how to sign a drink, food, toilet, etc. I tried using the sign for drink first and voila! Míša started to imitate my gestures relatively well and quickly and soon he was able to tell me that he was thirsty. But only if I ask him what he wants" (Hrabáková, 2011, 99).

Helping professionals are experts and parents should have an opportunity to rely on them. Overall, we can say that if a person does not know what and how to communicate about their sexuality, he or she should approach the issue of sexuality only in relation to oneself, as this is the safest attitude. When communicating about sexuality with persons who require a specific approach (including persons with disability), it is necessary to have clear attitudes, values and opinions both of sexuality in general and of sexuality in persons with disabilities. This is one the main ways to prevent discrimination.

Regardless of the attitudes, Czech legal regulations do not provide sufficient protection for persons with disabilities. McCarthy and Thompson (2007) analysed the 2003 Sexual Offences Act that sets the age of 16 for homosexual and heterosexual relationships under certain measures and restrictions. "Restrictive" measures include sexual touching including (but not limited) oral, anal and vaginal penetration of an individual with intellectual disability who does not have a choice and therefore, is limited:

- by his or her insufficient mental capability to make a choice;
- whether he or she agrees with being touched;

- whether he or she is able to determine and deduce the consequences of what will be done and under which circumstances;
- his or her inability to communicate about such choice or agrees with being touched because he or she cannot grant a valid (informed) consent because the person/member of staff who provides him or her with services is a person whom he or she trusts.

The 2000 Adult with Incapacity Act (Scotland) and the 2005 Mental Capacity Act (England and Wales) addresses the framework for deciding about oneself – the ability to make one's own decisions. A person is not able to make decisions about himself or herself if he or she is not able to:

a) Understand information relevant to the decision,
b) Retain this information,
c) Use or consider this information as part of the decision-making process, or
d) Communicate his or her decision because he or she does not speak, use sign language or for other reasons.

Štěrbová (2011) recommends making an alternative decision in the *client's best interest* in the event that or she is not able to make specific decisions. Under such conditions, the clients' past and present opinions and wishes are considered, what is important for his or her life, including the family, so that any choice made *restricts* his or her freedom *as little as possible*. This means that the *least restrictive alternative is chosen.*

People with intellectual disabilities can be supported in sexual relationships with other people only if they are able to make decisions about themselves and are capable of being responsible for their behaviour.

Válková (2012) talks about the independent life theory and referring to Sherill (1998), about managing oneself when an individual is able to make a decision; has a vision of the future and his or her goals; is able to regulate and control oneself; feels responsible for oneself and others, for the environment in which he or she lives; and feels satisfaction about his or her efforts. We would like to say that this idea is important for the entire area of the sexual life for persons with disabilities.

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1.6 Families and Individuals with Intellectual Disability

Dana Štěrbová

This chapter briefly explores the functioning of families with health disabilities with respect to sexuality. The issue of families with disabled children is covered by Štěrbová (2013). Not every family with disabled children go through the same cycles as described by Fergusson (2001).

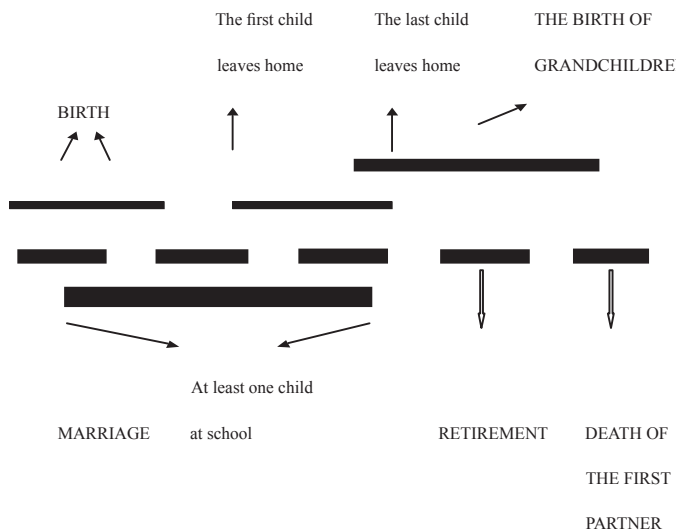

Fig. 5 An overview of the life cycle of a nuclear family
(Fergusson, 2001, 387, transl. Štěrbová, 2013, in D. Štěrbová, 2013)

In some families, development seems to stop. The child does not leave the home and parents do not become grandparents. The flow of life and the anticipated changes of social roles do not occur. Expectations regarding parenthood are changed. The relationships between siblings and the interaction between parents and adolescents with intellectual disabilities

are different and the adolescents' ability to make their own decisions is disrupted. Individuals rely on their own ability and resources to select social relationships and roles (in line with historic circumstances and experience (Demo, Aquilino & Fine, 2005). This cannot be fully accomplished in families with children who suffer from more severe intellectual disabilities and autism.

Whem a child with an intellectual disability is present, the family identity forms and changes not only within development cycles, but also with respect to how the family is seen by others and how it is shaped by external societal influences (Štěrbová, 2013). The personal identity, i.e. that everyone in the family is respected as a unique individual, how much space he or she has to develop his or her personality, identity, interests and dispositions, can take different forms. Another component is intimacy which, according to Plaňava (2000), includes emotional quality, a feeling of mutual closeness, signs of interest and warmth, cohesion, support and mutual dependency. Intimacy within family can be conjugal, parental and between siblings. In families with disabled children, all relationships are reflected in the sexual area of the family life.

An important period for families with a disabled family member is the development stage when the disabled child enters adolescence. Research conducted in families with deafblind adolescent children (Štěrbová, 2013) proved that these families are exposed to a large amount of stressors that put them at risk and make them very vulnerable. The overall level of satisfaction with life was close to the lower average value. Adult family members (fathers and mothers of children with disabilities) were less satisfied with their marriage, themselves and their sexuality. Families with deafblind children face a great number of stressors and their resistance to stress is not boosted by using healthy habits. They decrease their stress level by having fun and joking, thereby making the stress less important. One qualitative research project identified that the concern about their family member's health and its continued degeneration is a constant uncertainty, drains their mental strength and creates constant stress in families. Future expectations are associated with a feeling of uncertainty (Štěrbová, 2013). Similar feelings affect families with intellectual disabilities and autism.

Spilková (2013) says that parents see their adult children "as eternal children without any sexual rights" (Spilková, 2013, 32).

The same concerns that were identified through research in families with deafblind adolescents were reported in families with adolescent and

adult children affected with intellectual disabilities and autism. The concern is that they might meet professionals who will not be able to help them. Another fact that applies is that sexuality is a taboo in families with deafblind adolescents. The following approaches and attitutes towards sexuality are seen in such families:

- The elimination of sexuality. Parents do not show any deep interest in the sexuality of their child (a teenager) and do not address it. They see their teenage child as being much younger. In relation to their child's sexuality, they feel insecure.
- The right to sex (in a broader sense of word) including certain conditions and restrictions. Parents leave the issue of sexuality to others.
- The right to sex (in a broader sense of word) according to the needs of the persons with disability. Parents notice the issue of sexuality and are mostly concerned about secondary sex characteristics, masturbation, menstruation (and related behavioural changes), intimacy and privacy (nakedness, clothing and hygiene) and touching. They also express their concerns about drug abuse.

When asked how they see the sexuality of their child, one mother replied (adopted from Štěrbová, 2013): *"It is a problem. It depends on the type of intellectual disability. In my opinion as a mother … to watch or not to watch … How is the child going to respond? Is it going to produce the desired reaction. That's another problem. I'm sure you can explain and correct it with a client. But the experience itself, that's a question. Well …everybody has a right to it. But to address a negative situation can be very problematic. Negative, I mean negative feeling. Or negative consequences. Such a shocking reaction from the client, helplessness. How to explain these things? I think a professional should do it. A medical specialist. This must be extremely complicated with respect to the client. From my perspective anyway. Development is a natural thing and we all have hormones. If the disablement is light or moderate … And then prevention with the more severe cases? Although it's questionable, everybody has a right. So should we focus on the disability or the person? What is more important? The person. If a person has feelings, then they should be not be controlled and should be allowed to be expressed."*

Štěrbová (2011, 2013), Bazalová and Huliáková (2004) emphasize the importance of information provided to persons with intellectual disabilities in their surrounding environment. The reason is that people with health disabilities perceive and understand only certain information from the

environment in which they live. People with health disabilities should not be deprived of their right to information. It is important how and when parents provide information about sexuality. However, families with disabled children do not have supporting materials to educate their children and often do not know what to tell them.

However, some parents do request information. *"A 16-year old boy with low functioning autism and a moderately severe intellectual disability. He gets an erection when he sees small children and likes to be close to his younger sibling. He walks around home naked. He practices self-satisfaction the way in which he knows how, in other words, it is not masturbation as such... he does not know how to do that."* The mother asks how to explain the concept of masturbation to her child and that it needs to be practiced in suitable places and at suitable moments, i.e. where it does not offend anybody, such as in his room. "*We are afraid that he might hurt his younger brother and that our friends will not understand it. We are afraid to take him outside anymore. Since he is mentally disabled, we are afraid that he could do it any time in public or in front of our guests and so on.*"

Parents of disabled children find themselves in different phases of being able to cope with the disability as the family and the disabled individuals develop and they are often not interested in the sexuality of disabled children or they understand it in their own way. The reason is that they want to maintain their own securities. As the child gets physically older (usually during adolescence), some parents do not want to admit that the child is growing up in all aspects, i.e. also sexually. Not much happens in terms of providing the child with instructions. Some parents believe that the sexual development of their child will be delayed, that the child will develop more slowly because it is disabled. Often, they do not see their disabled child as being capable of having sexual relationships, getting married and having children (Moss & Blaha, 2001). They are often afraid of their child's autoerotic sexual behaviour and any signs related to the child's sexuality, physical development during puberty, genital hygiene, unwanted pregnancy, sexually transmitted diseases, and embarrassing and hurtful situations in the family (Ballan, 2004). It is difficult for them to speak with their children about sexuality and they experience anxiety associated with concerns about how their child will cope with sexuality in a normal social life, which even increases their fear of their children's sexuality (Schwier & Hingsburger, 2003).

Some parents understand that their child is developing sexually and can express his or her sexuality. However, they are not always sure whether and how to support the child in this respect. Many of them report not having enough information that they need to provide proper sex education to their children and they are not sure whether to ask for professional help. If they do ask for professional help, they expect to receive specific pieces of advice on how to proceed. Very often, they find out that specialists (sexologists, gynaecologists, psychiatrists, psychologists, podiatrist, GPs and teachers) do not have sufficient experience with the behaviour or severely intellectually- disabled children. Therefore, it is hard to expect any professional recommendation or reassurance that the given approach that they would like to choose towards the sexuality of their children is both possible and suitable. The parents' uncertainty is associated with the issue of hygiene, masturbation, exposure, appropriate touching, etc. Nevertheless, not every parent seeks specialised help. This is because they are ashamed to talk about sexual issues. Parents often seek professional help about sexuality only when their child is labelled as problematic and a solution is needed. Parents instinctively feel that they should do something about it, but do not know what to do. They are exposed to negative reactions from their surroundings, which only increases their helplessness (Štěrbová, 2013).

According to Howlin (2005), potential problems should be prevented during childhood (Howlin, 2005, 253–254): "The correction of behaviour that might be potentially triggered in adulthood has to start as soon as in early childhood. Behaviour that is considered inappropriate, harassing or dangerous in adults, such as public exposure and touching women's breasts and legs, is often forgiven or even encouraged in childhood. A person with autism usually continues with such behaviour at a later age because either he or she is not aware of its social inappropriateness, or on the contrary, he or she want to get attention."

Firm and systematic restrictions placed on such behaviour that were defined in early childhood are the most effective prevention of future problems. Clear and uniform rules on public exposure that can be openly discussed with strangers and the rules on when and where to masturbate have to be introduced as soon as possible (Howlin, 2005, 254).

A mother describes the behaviour of her adult son: *"But other than that … I mean when we are outside, then no. Although, true, he puts his hand into his pants, but he's only playing … but no, he doesn't take it out. Well, it's not a*

problem yet, it only happens here at home or inside. It's not a public problem yet. No. When there is someone new, he needs to touch them. But that's not sexual."

To protect their child and prevent their behaviour from being seen as unsuitable, parents often devalue the information and do not consider it important.

However, it is not just the risk of inappropriate behaviour that disabled people may be guilty of. A disabled child (and later a disabled adult) are often exposed to risks, especially in terms of sexual abuse and sexual harassment. Foreign literature describes a high percentage of sexual abuse and harassment of people with intellectual disabilities and it is up to society whether a person with disability is protected or not. Concerns that a child (or an adult) with an intellectual disability will be abused are also documented by previous experience that families have had. It is a sad reality that in the majority of such cases, people never seek out any specialist. There are not many specialists in helping professions who deal with the issue of sexuality of the disabled.

"*This started when he lived in* Š. *(a town) and where he had a room to himself and his caretaker. He was about 15 or 16 then. Others were jealous that he had a room to himself. So they put him together with the other boys. I don't know whether they abused him … I had to take him out of there immediately. They didn't know what to do about him, he was depressed. Then he came home with a bruise. That's when it started. I know that one day he came home and had … a bruise over half of his butt, a huge one. Where he got it from, I don't know. But it was really big … I think that somebody there … somebody must have hurt him.*"

Parents are most disappointed when they turn with hope to "their" practitioner. Physicians often expect that parents will prepare a teenage child for the first examination themselves. This might by a gynaecological examination, prostate, rectal or breast examination, etc. Although they do not address the issues associated with their children's problematic sexual behaviour, parents are exposed to the stress caused by a physician's poor attitude that appears during a basic medical examination. In certain cases, anaesthesia is needed, which means more stress for the family.

The family plays a key role in the sexuality of disabled children. It would be helpful if more information about disabled children's sexuality were provided to family members so that they also had the right to information and education. In the Czech Republic, some non-profit organisations offer discussions, courses and education for parents of disabled children.

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Part II

ABOUT SEXUALITY – LEARNING AND EDUCATION

2.1 A general overview of sexuality education in general public

Miluše Rašková

We often hear or read about the words sex, sexuality, sexual behaviour, sexual practices and other similar words. We cannot deny that they are part of our lives, as are love, partnership, marriage, parenthood, family, relationships between people, and others. We are people and we must understand that we do not work or rest in isolation. We can only exist in a group of other people with whom we share our personal and working life; we also communicate with each other and establish relationships among each other. And we need education to be able to live with each other in a civilized way.

Before we start to focus specifically on sex education, we must recall the relationship with education in the general meaning of the word. Education is a social and historical phenomenon that has existed since the establishment of society, and from society's perspective, its task is to provide overall cultivation of one's character. The process of focused formation and cultivation of one's personality is maintained although the goals, content, conditions and means of education. Education is therefore determined by society; it originated because of societal needs, serves to society and develops within society.

According to Koťa (1994, 19), education can be understood as "…a specific human activity whose essence is based in initiating and managing intentional changes and processes in one's personality". The aforementioned author stresses the interpretation of education as a specific type of socialization that is characterized by deliberate and managed influencing of a personality (and thus it is differentiated from coincidental impacts that influence a person. According to Průcha, Walterová and Mareš (2003, 277), education can be defined as a "…process of deliberately influencing a person's personality with the aim to attain positive changes in their development".

According to Hartl and Hartlová (2004, 680–681), education is "…a deliberate and more or less systematic development of a person's emotional and intellectual skills, the forming of his or her attitudes and behaviours in compliance with the goals of a given group, culture, etc." According to

Krause and Poláčková 2001, 41), education is "…a regulated, deliberate and targeted intervening in the life-long process of an individual's socialising that takes place within a certain particular cultural and social system". The aforementioned authors propose the unity of the four components that form the life of society, including:

- the value-normative component (values, standards, belief, ideologies);
- the interpersonal relationship component (interaction, communication, work activities);
- the resultative component (material, spiritual and organizational products);
- the personality component (individual people updating, developing and overcoming the system through their way of life).

The aim of education is the universal development of a personality at all levels, i.e. intellectual, moral, aesthetic, physical and work. According to Průcha, Walterová and Mareš (2003, 29), the aim of education is defined as "…on the most general level, a comprehensive picture (ideal) of a person's anticipated and desired characteristics that can be gained through education". Personality development occurs over time (in all stages of a person's life) and occurs through an educational process defined as a managed social activities comprising sub-stages and sub-goals. The goal of education, as one of the components of the educational system, setting the direction of educational influence, differs with different cultures and periods of history.

Sex education as a part of education in the general sense must be understood comprehensively and in a broader context (Hariss, 1974; Janiš & Marková, 2007; Janiš & Täubner, 1999; Pondělíčková-Mašlová, 1973; Rašková 2007, 2008, 2009; etc.). Sex education as a complex education includes not only the transfer of information, but also attitudes towards sexual ethics and support for personal autonomy. We must realize that sex education does not focus only on interpersonal relationships (Borrman & Schile, 1977) as in such case, emphasis is placed exclusively on the formation of interpersonal relationships even in terms of sexuality so that before relationships are manifested by physical sexual activities, they should be manifested at the emotional and spiritual levels. From this perspective, sex education facilitates knowledge, helps a person to navigate values and helps a person to control his or her own behaviour. Through developing and fostering sexual awareness, it is supposed to prepare and adapt an individual to submit his or her sexuality to sexual love and moral decision-making.

Sex education represents more than just the process of transferring knowledge about human physiology and biology (i.e. a discourse about life events, development and relationships towards the surrounding environment, etc.) and human reproduction (Borneman, 1995; Steinberg, 1989). If sex education is only interpreted as the process of transferring knowledge about human physiology and biology and human reproduction, then it only provides information about sex, the genitals, reproduction, pregnancy, contraception, etc. mainly through verbal instruction.

Comprehensive sex education teaches people about moral principles, it helps them form their activities and attitudes towards sexual issues and develops their emotions in relation to their future sexual desires and needs. It includes not only the transfer of facts, but also the attitudes towards sexual ethics; it supports an individual's personal autonomy and teaches him or her the skills necessary to satisfy his or her sexual needs.

Examples of sex education defined as complex education include:

"Sex education means the instillation of moral principles and forming human behaviour and attitudes towards sexual issues. It requires the development of the individual's emotional sphere in relation to his/her future sexual desires and needs" (Pondělíčková-Mašlová, 1973, 34.) "Sex education is not identical to processes, such as instruction and learning. The goal of education is related to learning and understanding. Sex education cannot be the mere transfer of facts; it should include one's attitudes towards sexual ethics, and support for one's personal autonomy is an important goal. Sex education should basically teach the skill to satisfy one's sexual needs and to provide greater autonomy in decision-making." (Harris, 1974, 18.) "Sex education is a targeted, formative and planned activity focused on the long term and provided by a tutor (teacher, parent, etc.) to the person being taught (pupil, child, inmate, etc.) and in cooperation with such person; in sex education, the educated individual is gaining subjectively and socially desired knowledge, attitudes and behaviour from the broadest sphere of sexual behaviour" (Janiš, Täubner, 1999. 8).

The goals of sex education (curricular documents for education, Standards for Sexuality Education in Europe, 2010) are based on the age and individual specifics of the persons of a certain age (Vágnerová, 2000; etc.). The fundamental goals of sex education include passing on appropriate knowledge about the anatomy, physiology, psychology and sexual ethics,

providing assumptions for establishing one's system of values, as well as for helping people to responsibly regulate their life. Another necessary goal is to teach children to understand sexuality as an integral part of human life and to respect the complexity and variety of attitudes.

Sex education is designed for the current and future life of people aiming to lead a content life, mainly with regard to partnership, marriage and parenthood, and should operate within societal principles and standards. Sex education must have a positive impact on the individual, mainly with regards to receiving and understanding the needed information, forming of one's beliefs and attitudes towards the broadest area of human sexuality, and forming skills, habits and behaviour within interpersonal relationships.

We must mention that in addition to the general goals, there are also ethical principles of sex education (curricular documents for education, Standards for Sexuality Education in Europe, 2010; Zvěřina, 1994). Every educator should follow ethical principles as they are related to each educated individual. The list of ethical principles includes, for example, accepting sexual moral equality between men and women (Zvěřina, 1994), denial of racial discrimination, refusal of breaching one's personal freedom through psychological or physical pressure or aggression and respecting the position of homosexuals within society (Kaňka, 2004; Kaňka, Štěpánová & Bretl, 2003; Procházka, 2013; Weiss, 2003). The aforementioned list of ethical principles is not exhaustive. There are other principles that definitely are not marginal and are related to inappropriate sexual liberalization because certain behaviours are not acceptable and cannot be tolerated (e.g. attacks, aggression, abuse, etc.), to the existence of sexual relationships with different groups of people where nobody may abuse anybody else for his or her own satisfaction. In education, it is recommended to positively value the faithfulness between partners as sexuality in a partnership relationship is more valuable than in an occasional sexual intercourses. We should not forget about the issue of pornography (Pondělíček, 1997; Weiss, 2001; Uzel, 2000; etc.) and the depiction of sexuality – not only in the arts where we appreciate the author's specific view of sexuality, its original interpretation and the message that must not be in contradiction to the humanistic concept of the artwork (Fišerová, 2013) unlike in pornography that is refused for dehumanisation with view to its impure content, which represents the sex life in a vulgar way.

In relation to applying ethical principles to sex education, educational influence should also support sexual and reproductive rights (Rašková,

2007; Sovová, 2004) concerning individuals and couples as established in a document by IPPF (International Planned Parenthood Federation). The document, called the Charter of Sexual and Reproductive Rights, which was signed in 1995, defines its goal as the support and protection of sexual and reproductive rights and freedoms in all political, economic and cultural systems throughout the world. It defines 12 rights (Charter of Sexual and Reproductive Rights, 1997, 13–28) that are all included in international documents on human rights. As the leading worldwide voluntary organization for family planning, IPPF engages in worldwide efforts to implement laws in real life. Sexual and reproductive rights are defined in the context of human rights. IPPF and its member associations strive to implement the rights established in the Charter in their programmes, as well as in their work with other organizations.

Within the Czech Republic is the non-governmental organization called the Association for Family Planning and Sex Education (Společnost pro plánování rodiny a sex education – SPRSV), which obtained the status of a full member in the International Planned Parenthood Federation (IPPF) in 1997 and espouses the commitments ensuing from the Charter of Sexual and Reproductive Rights. According to the opinion of the former executive director of SPRSV and the current Honorary President of SPRSV Radim Uzel (1997, 6–7), it is important that all 12 rights exist in human life even though at first sight it may seem that this fact is obvious. He also mentions the issue of superiority of some people who, as parents, subordinate the basic right of their children to access to true information to their parental rights, which is in contradiction with the conclusions of European Community bodies.

We are now going to focus on learning in the general sense of the word. The term learning is understood as those activities conducted by people through which an individual learns and simultaneously somebody or something (especially a technical facility) facilitates such learning to (i.e. teaches) the individual. In the educational process, the result of which is called education, an individual acquires knowledge, skills, attitudes and personal experience, creates his or her own views, etc. In this sense, learning represents a system of knowledge that should develop the cognitive and practical activities of the individual, cultivate his or her characteristics and influence his or her attitudes. In this relation, we should not forget to mention that overall, education represents both education and learning. When we talk about education or the educational process, we always mean

the educational and learning processes. Learning is a term that is also used in fields other than pedagogy, mainly in relation to economic, social and political issues in society, in the media, etc. The term learning can also indicate another meaning than the one represented by the general term; it is determined by specific education that is usually defined in the legislature and it is implemented by professional educators, etc.

It has long been known that learning and the learning process include both curricular and extra-curricular activities. It also plays an indispensable role in economic decision-making, social politics and in helping professionals. In relation to learning, we cannot omit its efficiency and quality. In the economic concept of learning, efficiency is the relationship between costs and outcomes and it should be considered that the more outcomes that are reached at the lowest possible costs, the better efficiency has been produced. There are currently in place sophisticated mathematic formulae to calculate the economic efficiency of learning that assess investments in learning (known as the return on learning). Success on the labour market is also tracked in relation both to short-term results and long-term effects. However, the quality of education should not be omitted, and according to Průcha (2000, 70), it can be theoretically defined as follows: "The quality (of learning processes, educational institutions and the educational system) is the desired level of functioning and/or the product of these processes or institutions that can be objectively measured and assessed." It is clear that the responsibility of educators in educational facilities is related to the quality of learning and in these economic terms, we are talking about accountability. It means responsibility for the quality of learning in the form of educational services, the method and the attained outcomes of learning, as well as the responsibility of educators towards their clients, funding bodies, etc. Educators should also be able to appropriately communicate with the public and should definitely be aware of their accountability for the quality of education provided.

Sex education is not an "invention" of our modern times, but has its roots in the 19th century. Sexologists A. H. Forel (1848–1931) and H. H. Ellis (1858–1939) are considered the pioneers of sex education. Swiss A. H. Forel considered sex education to be the primary method to prevent disorders in sexual life, while Englishman H. H. Ellis focused on the fight against the purists' opinions regarding gender (mainly in relation to women and sex education). The importance of sex education started to be emphasized in developed countries after World War I. A more intense effort

to introduce sex education in schools became an institutional issue after World War II, although at the beginning of the 1950s, most of the European governments voted against introducing sex education into scholastic curricula. An exemption was Sweden, where the introduction of sex education in elementary schools dates back to 1942. It was not until the beginning of the 1960s when the application of sex education in school systems fell on fertile ground.

Taking into account the resulting historical development of the implementation of sex education into our country's school system, we can claim that during the 20th century, important changes took place that brought about a certain amount of progress in sex education.

Looking back at the overall historical development of the implementation of sex education in the school system throughout the last century, we can conclude that as early as at the beginning of the 20th century, the idea of the need to introduce sex education into school education (although only for older pupils) occurred with the reasoning that it is not appropriate for adults to conceal knowledge from pupils. Over the course of the 20th century, opinions regarding the initiation of sex education to pupils were changing with regard to the right age to start, and it was only in the 1970s that sex education was included in school education. In addition to the priority status of family, it was mainly the teacher who increased his/her position within sex education, thus replacing health care professionals and doctors. The concepts of sex education also underwent various changes that were successfully completed in the 1990s. The conceptual changes started with the inclusion of sex education in school education through various laws, decrees and methodical guidelines and culminated with its position as an integral part of education towards one's well-being and a healthy lifestyle. A meaningful concept of sex education was created in the 1990s (Mellan & Brzek, 1995; Smolíková & Hajnová, 1997). It was historically completed in the 2006/2007 school year and became the basis for designing sex education in the Czech school system in the following (modern) period.

Throughout the years, sex education has undergone frequent conceptual changes, including searching for an adequate name. In the Czech school system, other names have existed in addition to "sex education" (e.g. education on parenthood, education on marriage and parenthood, family education and sex education). Changes in the name have also occurred in other European countries over the years (mainly in the 1970s). More general terms were used to emphasise the broader attitude towards the issues

of intimate cohabitation, mainly with regards to ethics and morals (e.g. to learn to live together, human reproduction – Norway; education on family life – Finland; education on partnership and the family – Germany, etc.). In the 1980s, foreign school systems returned to the name "sex education" as a result of criticism regarding not only the existing names (without the adjective "sexual"), but also the focus on the psychological, ethical and social issues of marriage and parenthood to the detriment of information about sexuality.

Discussions concerning sex education in the Czech school system have currently reappeared. The name sex education (Rašková, 2013), as well as draft changes related to the inclusion of sex education in the school system (Hřivnová, 2013) have been brought into focus. Within the consultation procedure regarding changes to the curricular structure on the internet, Czech critics of the name sex education claimed that the name was not defined in any way whatsoever and that the public could not in fact imagine what sex education included. They proposed the name "education on the mature integration of sexuality" instead of the original "sex education", but their idea to change the name was not accepted (in fact, it also was not defined). Sex education as a pedagogical term in the Czech school system is still preserved, is duly justified, defined (Harris, 1974; Janiš & Marková, 2007; Janiš & Täubner, 1999; Pondělíčková-Mašlová, 1973; Pšenička, 1995; Rašková, 2008; Täubner, 1997; etc.) and conforms to the context of development both within and outside of the Czech school system.

Through modern curricular documents, sex education became a part of school education in the Czech Republic, as well as in foreign countries, even in those countries with a more significant influence by the church. However, it differs in its overall concepts, content, form and age of pupils who are educated in these issues. In many foreign education systems, sex education has already lost its unique sense which involved a warning against unwanted pregnancy and AIDS prevention, and it developed in other forms of awareness and public education with a duly expressed requirement that teachers should be professionally qualified (Rašková, 2008, 2011, 2012).

Sex education currently has an interdisciplinary nature (Štěrbová, Rašková, Procházka & Prouzová, 2012) and it is greatly supported by the World Health Organization, which ordered the WHO Regional Office for Europe and the Federal Centre for Health Education to establish the Standards for Sexuality Education in Europe in 2010 as a framework for

the creators of plans, educational and health bodies and specialists. This 2010 document, which has not been officially translated into Czech and only exists in English, is aimed at helping to introduce mainly holistic sex education to schools and to ensure that it transfers unbiased and scientifically-correct information on all aspects of sexuality and simultaneously to help one develop the skills needed over the course of one's life.

It is worth mentioning that according to the WHO, sex education is a part of general education and thus it influences the development of a child's character. Its preventive nature not only contributes to the prevention of negative consequences related to sexuality, but it can also improve the quality of life, health and overall well-being. It is in this way that in the WHO's opinion, sex education generally contributes to improving health. By issuing this document, we can also oppose all current critics of sex education in the Czech school system (mainly the Committee for the Protection of Parenthood Rights), as it was drafted with the advice of Western European professionals from various areas ranging from medicine to psychology and social science, all who have many years of experience in sex education in both theory and practice.

The entire document is divided into two main parts. The first part provides an overview of the fundamental philosophical perspective of sex education and it contains a definition and the basic principles associated therewith. It states a broader concept of complex sex education and advocates its necessity from a young age. The second part of the document is designed to be used in sex education in pedagogical practice and it contains topics that can be used for pupils at various ages – in the form of information, skills and attitudes. There is no doubt that the document can become a valuable base for teachers and for creating a vision of sex education within its implementation in school educational programmes. The standards for sex education in Europe have been espoused in the editorial plans of the Czech Association for Family Planning and Sex education (www.planovanirodiny.cz), which would like to issue the document in the Czech language for all who need it and want it.

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2.2 Sex Education and Persons with Intellectual Disability and Autism

Dana Štěrbová

In the introduction, I will briefly define the term and scope of sex education. Sex education should start in childhood and continue in adolescence until adulthood and should be appropriate to the students' age. In its approach towards tuition on sexuality and to relationships, sex education should provide objective information that supports and protects healthy sexual development. Children and adolescents are entitled to be provided with sex education. The aim of sex education is to equip adolescents with the skills, attitudes and values according to which they behave in their sexual life. Information alone, however, is not enough. Adolescents must independently develop positive attitudes and gain life skills (Standards, 2010).

Janiš and Täubner (1999) define the meaning of sex education in the preparation of children and adolescents for partnership, family and parental life in the broadest sense of the word, i.e. also for one's sexual life with health protection and education about maintaining good interpersonal relationships. Sex education should help to cultivate partnerships, the sense of accountability and mutual respect. "The main goals are to benefit the young generation, to prevent undesired pregnancy, to decrease the risk of sexually transmitted diseases including AIDS, to fight child abuse and sexual crimes, to cultivate interpersonal relationships and partnerships, and last but not least, to teach respect for sexual minorities" (Uzel, 2006, 22). Sex education in the family, however, is unable to ensure all of the foregoing because families differ in their attitudes, knowledge and values. Rašková (2008, 2013) speaks about other participants in the sex education process and considers teachers in kindergartens and elementary schools to be the key persons who significantly work with the family to provide sex education to individuals in certain stages of their lives.

Šilerová (2003) proposes that both a child's family and school are very important in the field of sex education. "The knowledge, findings and detailed information about sexuality and their systematic transfer to children and adolescents is a part of learning" (Šilerová, 2003, 23).

In a survey of mothers of pubescent children, M. Štěrbová (2013) discovered that parents do not always have a clear and complex idea of the content of sex education. They are often aware to a certain extent what the content of sex education should include. In the parents' opinions, sex education should include preparation for a partnership (information on partnerships) and in relation to that, respect for oneself and for other people; information about sexual contact, how it works and the associated consequences; information about one's body; cognition of one's body; information about sexual maturity and how to take care of one's body; and also information concerning partnerships (Štěrbová, M., 2013, 33–34).

We are facing parents' expectations that can often remain unfulfilled though, as they are not implemented by the family. M. Štěrbová (2013) refers to topics deliberately discussed within the family – menses, sexually transmitted diseases and protected coitus, and sexual abuse.

During the process of maturation and adolescence, children gradually gain knowledge and develop their own imaginations, values, attitudes and skills related to the human body, intimate relationships and sexuality. Therefore, they use a wide range of information resources. The most important, mainly during the initial stages of development, are non-formal resources, including parents, who are the most important when the child is at their youngest age. The role of medical, pedagogical, social and psychological professionals is usually not mentioned in this process, which is understandable since we usually only look for the assistance of professionals when we encounter a problem; an issue that only a professional can help to treat. Nevertheless, the generally-increasing emphasis placed on the prevention of problems in Western cultures that expands the scope of intimacy in human sexuality has increased the need of a more proactive participation by professionals in this area (Standards, 2010, 10).

Here, we must mention that families with a child with disability do not share such information. According to Trávník (2000), sex education should be consistent with the child's age (this point is agreed upon by many authors) and their psychological maturity, and the educator should assess the child's openness and tactfully lead the child towards the right expressions.

Can we apply this approach even to persons with intellectual disability? Štěrbová (2011) proposes that experience from interpersonal relationships in the majority of society of people without disability cannot be transferred and that the situations faced by families and professionals are related to a sense of helplessness, insecurity and powerlessness. Awareness in the area

of sexuality of persons with disability is the basis for the safe provision of information or a greater level of consultancy provided to legal representatives and persons with disability. Persons with disability often have much more experience than their mental level and the anticipated knowledge and beliefs of the educator would suggest. This is related to the following facts.

Although various discussions regarding sex education have been currently occurring that include extremely different attitudes and values not only in relation to sex education, but also to particular areas (e.g. sexual or intimate assistance), we find that there is a lack of discussion of how to approach sexuality and sex education when with persons with intellectual disability with autistic symptoms or sex education of persons with autism.

Hart and Douglas-Scott (2004) perceive sex education as a life-long process during which we acquire attitudes, values and relationships towards sexuality within social principles and an ethical framework and propose the following key principles.

1) Sex education should be perceived as one of the components of health care education within the promotion of broader health and beneficial health.
2) Sex education should contribute to the emotional, moral and spiritual development of all young people.
3) Education on sexuality and relationships should reflect the cultural, ethical and religious influence from home, school and the broader community.
4) Sex education should be non-discriminatory and sensible to the diverse settings and needs of young people.
5) Sex education is informally initiated in the early stages of a child's development by their parents and continues until adulthood with the participation and influence of school life.

"It would be ideal if tuition were carried out individually and if all the participating individuals proceeded uniformly. If the parents, teachers, educators and all other persons who were in touch with the person with disability were to maintain certain rules, a person with autism would find it easier to learn the necessary skills and would assume what is and what is not admissible" (Howlin, 2005, 255).

"It is absolutely necessary to continually strengthen the set rules" (Howlin, 2005, 255). When educating people with mental handicap and

autistic features or persons with a diagnosis of a pervasive developmental disorder, it is necessary to know what their diagnosis comprises.

With regards to persons with mental handicap (the diagnosis of mental retardation), we must respect their level of understanding of the consequences of their behaviour. Their behaviour (including sexual) can be indicated as problematic, inappropriate or sometimes even on the borderline of an offence. In our publication, we accept the opinion regarding persons with mental handicap in the meaning of Emerson (2008) based on Grossmann et al. (1983).

"Mental retardation was defined as a significantly below-average general intellectual functioning (IQ lower than 70) that either leads to a concurrent deterioration in the adaptive behaviour or is related to the same. It occurs in the course of the individual's development" (Emerson, 2008, 12).

Later this definition was supplemented with "… a significant limitation of the actual functioning. It is characterized with a significantly below--average functioning of intellect (IQ lower than 75) concurrently with the related limitation of two or more of the following usable areas of adaptive skills – communication, self-service, life at home, social abilities, usefulness in the community, decision-making about oneself, health and security, functional educability, free time and work. Mental retardation expresses itself prior to 3 years of age" (Luckasson et al., 1992, 5, in Emerson, 2008, 12).

People with disability have poorer sexual knowledge, they often suffer from negative feelings in relation to sexuality and some have never experienced sexual contact (McCabe, Cummins & Deeks, 2000). Education in the area of sexuality helps to prevent unplanned pregnancy, and to protect against venereal diseases and sexual abuse.

Diverse concepts of sexuality in persons with autism are also taken into account by helping professionals with regard to the fact that in most cases, the level of mental ability is reduced to the area of mental retardation and concurrently, other components of the personalities of such persons with disability also show significant deterioration.

People with autism have similar sexual feelings as anybody else, but understand them much less. In many cases, they need protection against sexual relationships as they do not understand them rather than complete freedom that is not related with a realistic sense of responsibility. Expressed in terms of social relationships, people with autism behave differently and they surely also differ with regard to possible sexual relationships. The

inability to imagine anything more than what they really feel is a big problem for them. It is immediately clear what problem this will cause in the area of sexuality. For them, sexual organs are not more taboo than other parts of the body. How can a person who takes everything word for word understand the phrase "make love"? Understanding social reciprocity usually causes difficulties. What meaning can a long-tern sexual relationship have for somebody who has a problem understand the intentions, emotions and ideas of somebody else (Peeters, 2008, 121)?

"Sex education in adolescents with autism is often overlooked. They learn a bit from their peers (a typical resource of information for children); many children, however, learn nothing at all. Parents usually have a lot of other problems and tend to neglect this area. In light of the congenital deficiencies in social relationships, the sex education of clients with autism is very important, even more important than of healthy children. The problem is that the methods and aids used for healthy and young people are not suitable for adolescents with autism. Many mothers could relate stories about their autistic offspring loudly repeating passages from sex education the whole day long and even in a bus in a supermarket full of other people" (Howlin, 2005, 254).

Most children with autism do not have a sufficiently-developed sense of social norms for guilt or shame. It is not a question of a lack of good will, but the result of their persistent "virginity" in this area. In healthy children, the sense of shame and guilt develops between two and three years of age. But in children with autism, this area is one of the most difficult points of their uneven development profile. It is therefore necessary that they follow strict rules when and where, for example, masturbation is allowed. These rules should be visualised (it is clear that this can be most effectively done in such educational settings where all programs and rules are visualised). Sex education that is separated from other forms of education is inefficient. Young people whose verbal skills are insufficient will probably be less nervous when we teach them about various parts of the body – what function they have and what the differences are between the male and female body (including the explanation of sexual organs just like other parts of the body; the taboo is our problem and not theirs). The advantages and disadvantages of this form of sex education must be assessed individually (Peeters, 2008, 122).

Before we continue in our discussion about the sex education of children with autism, we must mention a few words about "echo behaviour" and "echo examples". If the cognitive style is the basis of problems in communication, imagination and social behaviour, it is logical that the echo effect shall appear in activities such as echolalia in words. Inflexible associations are usually replaced by flexible thinking. People with autism form their social understanding and behaviour through the tools they have. However, those differ from our tools (Peeters, 2008, 122).

Melone and Lettick (1983) described a very useful, simple and practical programme of sex education for people with moderate to severe disability. The programme was successfully tested in several residential facilities in the USA. It focused on important topics: cognition of simple body parts and how to behave during menses, how to cope with masturbation and learn the basis of sound personal hygiene. It contains a part about social behaviour, it advises people on how to behave towards familiar adults and to unfamiliar people, how to dress properly and how to use public toilets. One chapter is dedicated to examinations at the doctor's office so that the client knows what to expect during a routine examination and how to behave (Howlin, 2005, 254).

For those who have a more serious disability, we can use programmes for children with mental retardation or adapt the programmes for autistic persons. Most of the materials only teach persons with disability to know what behaviour is appropriate and what is not and what situations can be dangerous; how to say NO and how to avoid diseases or undesired pregnancy. All materials elaborate on the topics, such as body science, menses and menopause, masturbation, sexual relationships (including how to say NO), sexual health, AIDS prevention and the prevention of other infections. It is very important that these materials also include the development of other social skills, such as improving one's self-consciousness, decision--making, understanding social roles and the art of making friends and understanding feelings. Manuals accompanied with videos and pictures provide instruction to thematic exercises and group discussions, suitable practical advice and examples of resolutions to problems. The publications are supplemented with a detailed bibliography (Howlin, 2005, 254–255).

From the legal and psychological perspectives, there is no doubt about the controversy of a person with intellectual disability providing consent during a sexual activity. Such persons must have basic knowledge about sexuality,

must understand the consequences of such sexual activity and know how to protect himself/herself in the case of impending danger (Kennedy & Niederbuhl, 2001). For a more detailed identification of the level of abilities and skills, Kennedy (1999, in Kennedy, 2003) advises using the measurement tool called "The Sexual Consent and Education Assessment" (SCEA), which contains two scales: "The Knowledge of Human Sexuality Scale (the K-Scale)" and "The Safe Practices Scale (the S-Scale)". Understanding masturbation and coitus and all items regarding the client's safety can be used as legal criteria. Basic knowledge is included in items 1–6 of the K-scale, while more advanced knowledge is found in items 9–12.

The K-scale (knowledge of human sexuality) – a person with metal disability is asked about his or her knowledge through the use of pictures and dolls (puppets) mainly to determine the correct anatomy parts.

1. Determines the basic parts of the body.
2. Determines his or her own gender.
3. Differentiates what belongs to a man and to a woman (differentiates male and female parts).
4. Recognizes male and female genitals (in a picture).
5. Is able to demonstrate knowledge and basic functions related to male and female genitals.
6. Demonstrates an understanding and knowledge of masturbation.
7. Demonstrates knowledge of coitus.
8. Can differentiate between significant consequences of sexual activity.
9. Shows knowledge of birth control.
10. Shows knowledge of HIV/AIDS and of other sexually transmitted diseases.
11. Differentiates between appropriate and inappropriate places for sexual activity.
12. Understands and has an idea about unlawful sexual activities.

The S-scale (knowledge of safe practices) – is usually required by the service provider; a person with metal disability shows skills in the following items.

1. Demonstrates a preference of some people over others.
2. Is able to make choices based on preferences.
3. Is able to carry out an efficient personal security practice.
4. Is able to efficiently tell another person that he or she does not want to participate in an activity.
5. Is able to refuse unwanted offers or advances.

None of the facilities in the Czech Republic has in place a system for determining in what area and whether a client is capable of sexual activity (and in what form) and whether he or she is able to protect himself or herself against possible sexual abuse and whether or not he or she bothers other clients (service users) or staff. In facilities abroad, such ability assessments are carried out once per year.

Education in the area of sexuality in persons with intellectual disability helps to increase their ability so that they can make their own decisions about their sexual lives and are able to establish sexual relationships.

"It is necessary to focus our attention on the differences between theoretical and practical knowledge. It is often the case that in persons with disability, "academic" knowledge is broader than practical knowledge, which can confuse the educator. It most often happens when a person has knowledge of himself or herself and their social and sexual abilities differ a lot from real practice – e.g. intimate hygiene, touches his or her own genitals in public or masturbates in the presence of others. Therefore, such persons should be educated by a professional, a person with a learning and practical experience with persons with disability who is sensible towards the client, can "give" precise orders and knows whether the client is able to fulfil them. Individual education must be specific, brief and clear, visual with the use of imitations and games, with the use of video (recordings in real settings), with playback and discussions and explanations of social situations using contact with peers. An educator should assess the client's ability to use abstract thinking to select appropriate didactic materials" (Štěrbová, 2012).

Another risk lies in the unresolved question of competences – whether and who should systematically deal with the education of pupils/people with disabilities?

Taking the "rules" (or rather rights) related to ensuring security in the area of sexuality in Denmark, it could definitely be one of the social supports for the family that asked for advice for their son with autism:

- People with autism should have the right and option to enjoy a sexual life in compliance with their desires and needs and with what they are able to achieve.
- People with autism are entitled to consultancy and support when resolving sexual problems.

- Teaching suitable social behaviour in relation to sexuality should take place in compliance with the social rules and standards of the home.
- Such rules should be established as soon as possible in relation to the anticipated scope of possible problems of an individual in a given setting.
- Sexuality must be perceived in context, sex education and learning should not be focused only on the skills of masturbation leading to orgasm, but also to support an understanding of the physical and emotional changes in relation to sexual desires and needs.
- If a person with autism directs his or her sexual attention to other persons, it must be decided to what extent this form of contact should be supported (sexual contact should include tenderness, care, empathy – relationships with other persons are problematic for persons with a diagnosis of autism.)
- Systematic individual education of people with autism should be first approved by a team of educators and simultaneously by the person with autism with the provision that the goal of this education is to protect such person from sexual abuse, to teach him or her sound sexual habits and to strengthen his or her self- confidence.

If we want to enter the process of sex education, we should be aware of the impediments related to it. Belote (1997) proposes the following impediments related to sex education.

1. We often become unsettled when talking about sexuality.
2. We do not feel comfortable when discussing sexual issues, mainly with our children – clients.
3. A lot of adults were taught that such issues should only be discussed in privacy.
4. We are often uncomfortable in relation to our own sexuality. It is natural that we transfer some of our feelings and beliefs in what we teach.
5. Issues related to sexuality are very personal and therefore, if we feel any discomfort regarding the taught topic, it is clear that the client will also feel it.
6. The level of our discomfort regarding sexuality is influenced, among other factors, by the setting in which each of us was taught, including the cultural factors, religion, family dynamics and relationships. Our own positive or negative experience from past relationships is reflected in our attitude towards sexuality.

7. We do not feel to be competent to teach this subject.
8. Most of us are not specialized with regards the "subject" of sexuality and do not try to supplement our knowledge or understanding.
9. If we have only gained knowledge from what we have been taught, we should suspend taking further steps and obtain additional knowledge in this area.

The most important factor regarding sex education is the existence of a **confident relationship between the parent and the child**, between the teacher and the pupil and between the parent and the educator.

Teaching is most effective when the pupil perceives the teacher as a trusted person who provides accurate information in a positive and safe setting. When selecting sexual educators, it is necessary to keep in mind that a relationship of trust is the most important component. Questions about sexuality are often very personal, the pupils must feel comfortable and satisfied in the relationship with the educator and vice versa – the teacher must feel comfortable with the pupils. In addition, it is also necessary to take into account negative feelings, concerns and uncertainty by the parents.

A well-trained professional must respect the opinion of the parent (legal representative or caregiver) in relation to the development and cultivation of the individual client's sexuality. It is appropriate for the professional to teach the parents and thus the parents will gain the competence and certainty and can be the persons who provide their child with disability with initial information about everything that concerns sexuality. It is the parent who should be best aware of his or her child's feelings and problems related to sexuality; such awareness is, however, often repressed.

Sex education programmes and teaching

The content of sex education programmes corresponds to the following topics.

1) General development – the names and functions of body parts; changes to the body during adolescence; differences between small children (infants and toddlers), older children, adolescents and adults.
2) Personal and social security – differentiation between familiar people and unfamiliar people; inappropriate touches from others and inappropriate touching of others; behaviour in public places; abuse prevention.

3) Public and private places – recognition of personal private places; differentiation between private places at school and private places at home; behaviour corresponding to public and private places.
4) Body care, health and hygiene – washing and showering; self-care during menses; self-care at the toilet; washing of hands; disease prevention; STDs (sexually transmitted diseases), preparation for medical checks.
5) Kind (tender) expressions – appropriate welcoming of familiar people, friends, teachers, etc.; expressions of friendship; selection and differentiation between friends and familiar persons.
6) Sexual expression – masturbation; coitus and pregnancy regulation; safe alternatives to coitus; safe and risky behaviour in relation to sexually transmitted diseases; identification – skills to recognize a partner agreeing with the offered sexual activity; creation of a positive self-value; self-esteem; responsibility for one's actions; ability to resolve problems; ability to meet with a partner; development of long-term partnerships; pregnancy and planned parenthood; slang expressions; alternatives to pregnancy; childbirth.

Education regarding sexuality issues means repeated advice appropriate for the age and level of understanding provided to every child with intellectual disability. To this purpose, some information can be supplied in a group setting, however, it is necessary to provide individual education as well (Evans & McKinlay, 1988).

The Recommendation by the Ministry of Youth, Education and Sports Regarding Sex Education at Elementary Schools (ref. No. 26 976/2009-22) dated April 2, 2010 states that each school should:

- Specifically work with the information provided to pupils, mainly with a view to the individual abilities of pupils with SVP (in the area of sex education, it means providing information to pupils in a way that they are able to obtain, process and, where applicable, apply it appropriately with regard to their disability and in particular situations); respect the specifics of disability and the appropriate ways of communicating (for example, texts in Braille, appropriate signs in sign language, tactile aids, comprehensibility of communication);
- Pay attention to the right terminology and replace slang words and vulgarisms;

- Prefer working in small groups under the supervision of a teacher with the option of immediate communication and illustration; the teacher should divide the individual activities into smaller steps and continuously verify the pupils' understanding using feedback (for example by a step-by-step demonstration of safe solutions when pupils learn about behaviour patterns in critical situations);
- In their instructions and manuals, respect the fact that the pupil is able to make his or her own choices and to be accountable for them.

Marková and Mandzáková (2011) focus on interesting issues related to sex education. For example: How can we teach persons with intellectual disability about social interactions in privacy? How can a person with intellectual disability learn to flirt with romantic attractiveness? How can he/she say to somebody that he/she wants to hug that person? How can he/she communicate with a person who wants to kiss him/her when he/she does not want to kiss?

We find the model entitled "The CIRCLES®" by Walker-Hirch (2007) to be very inspiring and well-thought out by these authors of a series of educational strategies that are used abroad. This method is also mentioned by Štěrbová (2009), which according to Burdová (1998), is known as the Circles method.

It is a widely-used technique focused on presenting the social world's rules to young and adult persons with intellectual disability in a form that is fun to learn. The CIRCLES® is a multimedia programme used by many educational strategies when teaching about the abstract understanding of expected relationships in a concrete and funny form. The educational programme uses videos, mini-stories with visual support, discussions, associative learning in pairs, expressive creative techniques and role-playing to cover the basics of the complex spectrum of relationships and positive and safe interactions. The life dimension of the role is represented by the rainbow paradigm of CIRCLES, which creates a safe setting for social interaction learning.

The CIRCLES methodology takes into account the abstract concept of personal space and borders within relationships and makes them concrete and specific. Every person is in the centre of all circles, similar to the Sun and its planets. A rainbow is drawn around every person the entire time, although it is not visible. Everybody is important. The most important centre of the circle is represented by the autonomy of every person with

intellectual disability, autonomy – *it is only for you. You are the most important person in your life in CIRCLES and you are always the centre of all circles.*

The centre of the circle is purple, as it is the regal colour. *You deserve that they treat you like a queen.* A purple icon is assigned to the **personal purple circle.** *Your body is your own and it is private. You decide who can come closer and who cannot. You decide who will touch you and who will not.* This is the personal domain of every person and they should learn to approach it as one of the most important things for everyone. Ideas, emotions and experience can also be personal. Every person has aspects that the others will never get to know.

Around the circle and the things touching it is another circle. It is not very big, but it copies the private purple circle. It is a **blue circle of hugging.** It is the dimension of hugging. The icon is shown as a hug. There are only a few persons who can be that close to us. For most people, the blue circle of hugging is full of loving family members. When we are adults and if we are lucky, a loving person might come into this circle and fill the free space. Every person should be able to list all the people who are the closest to them. Each of us has a blue circle of hugging and relationships and each of us has different people in this circle. We are all different.

There is one more circle around this circle, which is a bit less intimate, a bit more remote and includes more people – usually a friend, our extended family or people who behave like family members are in this circle. This is the **green remote circle of hugging.** It creates expectations for the friend and the extended family circle; their touches and discussions will help us recognise a threat and a potential attack before there is any harm.

Sometimes, when it is time to fill in the names of friends, we encounter a situation where we have nobody to fill in. It is sad to hear that a person has no friends. On the other hand, it can be the first step in detecting the obstacles that are impeding the establishment of friendships and resolving them.

There is another circle around this circle. **The yellow circle of shaking hands.** It represents the social distance for acquaintances. *A person whose name you know and a person who knows your name belong in this circle. We can shake hands, but hands are the limits of our touching. Simultaneously, there is more remote conversation and less trust. There are usually a lot of people in this circle. They are those people whom you only know a little bit.*

Around this circle there another circle – **the yellow wave circle.** In this remote circle, there is no physical contact or touching. *On the street you meet friendly faces that only wave at you. The best thing to do is to wave back at children who you do not know well. It is their parents' decision who can touch their children.*

Around this is a **red foreign space.** Most people belong in this space. Most people are not familiar to us, we do not touch them, do not talk to them and do not trust them. And they do not talk to us, do not touch us and do not trust us. The community of helpers also belongs in this space. The community of helpers can be recognized by their badges or the uniforms they wear and their special jobs. *You can talk business with the community of helpers. It is important to recognize where the limits of a business touch, a business discussion and trust for various communities of helpers are.*

The programme of circles can be modified according to the age and adaptability of the individual. The book accompanying the programme provides proposals for activities that support large groups of terms that can be addressed through circle terms.

The last two components are important for the sex education of people with intellectual disabilities with a focus on social abilities and sexual powers and opportunities. These areas are still very controversial and this is probably why they are still outside the scope of interest of many schools and facilities (Marková & Mandzáková, 2011, 113–115).

The education of people with disability should be initiated in childhood together with parents, staff in medical facilities, providers of social services and school facilities. Judges and social workers should also be aware of the sexuality issues of persons with disability. The Association for Family Planning and Sex education offers certified (accredited) courses focused on sexual awareness and education of people with intellectual disability for pedagogues and social service workers. In these courses, they also use their experience from abroad mainly with the aim to increase their client's ability to recognize the signs of sexual abuse or behaviour with the signs of a criminal act; to increase the awareness of sexuality; to increase the use of appropriate sexual expressions; to recognize sexual abuse and gain knowledge and skills on how to protect oneself; to improve the appropriate social contact with other people so that the person with disability is not accused of sexual harassment or abuse.

With regards to professionals who deal with the sex education, development and cultivation of sexuality of users with intellectual disability, the need to share with others is becoming increasing important. They need mutual consultations in a team and consultations with independent professionals. They need to have a supervisor who is experienced in the area of sexuality of persons with intellectual disability. In light of the unclear conditions regarding the issues of sexuality, these professionals are exposed to inappropriate pressure and caseloads and they are forced to take responsibility for the clients and their legal representatives or caregivers. More information regarding these issues can be found by these authors – Kozáková, 2004; Mandzáková a Horňák, 2009; Štěrbová and Prouzová, 2006; Štěrbová, 2007, 2008, 2009; Kovář et al., 2008.

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2.3 Sex education in school programmes for pre-school and elementary education

Miluše Rašková

In kindergarten and basic school, sex education is an integral part of education towards health. The education process within education towards health should lead to the pupils' understanding of health in all its aspects, learning about the basic practical skills and behaviours related to one's health care, look and condition, and learning to recognize the dangers to one's health and to behave safely in various situations and when talking to unfamiliar people. Another goal is to make them aware of their responsibility for their behaviour, gain the necessary knowledge about addictive substances and mainly about their impacts on health, gain fundamental information about the body parts associated with and the fundamental aspects of human sexuality, understand the basics of physical and mental hygiene and most importantly, understand the importance of family and home.

Education towards health in kindergartens and elementary schools have common aspects with regard to the conceptual and contextual perspective. Education towards health is interdisciplinary and is mainly composed of the following areas – health, illness, daily routine, personal hygiene, first aid, healthy food, prevention of the use of addictive substances, basic family and sex education and personal security. Its concept and content are defined in various school documents (Framework Programme for Preschool Education, 2001; Framework Programme for Basic Education, 2005). Although the opinions of various professionals (mainly doctors, psychologists and pedagogues) regarding the content of sex education differ significantly, there is a form that can be accepted at a certain age for each child. Education towards health must be based on the experience a child's own experience and become a part of it.

Both framework programmes (Framework Programme for Preschool Education, 2001; Framework Programme for Basic Education, 2005),

together with the National Programme for Education, represent the national level in the system of curricular documents; the school level is represented by school educational programmes (in short SEPs), according to which education in individual schools takes place. The National Programme for Education, the framework educational programmes and the school educational programmes are public documents accessible both by pedagogues and the general public. Although we are currently going through a period of curricular change review, we cannot forget that the starting point for significant changes occurring was the school system reform after 1989. School system reform includes more than just reform of the curricula in the Czech Republic. In relation to the general understanding of reform as an effort to make changes or improvements and increase efficiency, we cannot forget to properly prepare teachers, since through their pedagogic activities, teachers give meaning to the theoretical basis of the curriculum in pedagogical practice.

The concept of pre-school and school education is aimed at teaching child from an early age and later as primary school pupils to learn the basic key competences. The key competences are the set of knowledge, skills, abilities, attitudes and values necessary for one's personal development and the role of each member of society. The sense and goal of pre-school and school education is to equip all children/pupils with a set of key competences at the highest level that they can attain, thus preparing them for further education and their role in society. The educational content, including the activities that take place at kindergartens and basic schools, aim to shape and develop children.

The Framework Programme for Preschool Education (in short, FEPPE) sets the common framework, establishes the basic educational foundation to which basic education can refer and defines the rules for the institutional education of pre-school children, including the main requirements and conditions. The FEPPE document was created in compliance with the professional requirements of curricular reform. In education, it accepts the natural developmental specifics of pre-school children and enables the development and education of every child to the extent of his or her individual abilities and needs in the context of and with emphasis on educational quality, including the specific use of didactic tools.

At kindergartens, the education towards health educational process should aim to teach children to understand their health in all its aspects, to learn

about the basic practical skills and behaviours related to one's health care, look and condition, to learn to recognize the trends that endanger one's health and to behave safely in various situations and when talking to unfamiliar people.

The content of pre-school education according to the aforementioned FEPPE document is clearly divided into five basic areas – biological, interpersonal, social, cultural and environmental. The content arrangement leaves out the traditional educational components; it is based on the natural development of a child's abilities and expands his or her communication with their surrounding world. The particular areas of education are:

1. The child and his or her body.
2. The child and his or her psyche.
3. The child and others.
4. The child and society.
5. The child and the world.

These areas are connected to and influence each other. As an example of the anticipated outcomes, let us introduce the area of education called "The child and his/her body" with relation to education towards health (selecting what a child can usually do):

- Name the body parts, some organs (including the genitals), know their functions, be aware of the body and its development (at birth, body growth and its changes), know the basic terms used in relation to health, movement and sports;
- Differentiate what is good for health and what damages it, behave so that in common situations known to the child, he/she does not endanger his/her own or others' lives, safety or well-being;
- Be aware of the significance of care, cleanliness and health, and of the importance of active exercise and healthy food;
- Be aware of some ways of protecting one's personal health and safety and where to seek help in case of need (where to go, whom to call and how, etc.).

The aims of education towards health in basic schools are fulfilled in all taught subjects and the starting point for their use in all taught subjects is the thematic area entitled *Humans and their World* (i.e. teaching about the environment and society with respect to basic science, natural science and geography). Concerning the contextual perspective, education towards

health is based on a child's previous knowledge and experience. It is necessary to provide children with the information and skills that are adequate for their age, and to deepen, supplement and explain them. Because it concerns a rather long and specific stage of the child's development, the content of education towards health in young school children is supplemented with other important topics with which children might have experience with or that can be used to prepare the children for the future. The current integration concept of education towards health in kindergartens and basic schools leads to the selection of common or very similar suitable methods and specific didactic tools (Rašková, 2009). Enabling independent and creative activities has a significant impact on the personal development of a child in the area of education towards health and beyond.

As a specific example, let us present an overview of anticipated competences in the thematic area entitled *Humans and their World* with a view towards education towards health:

- Is aware of the significance of the environment (nature and society) for the humanity, understands that the way he or she lives influences his/her own health and the environment;
- Can name the human body parts, some organs (including the genitals), knows their basic functions, is aware of how the body grows, its development and changes;
- Shows fundamental hygienic and health prevention habits in relation to health, movement and sport;
- Applies the principles of safe behaviour at school and during hobbies so that he/she does not endanger his/her or others' health;
- Behaves warily when meeting unfamiliar people, can refuse communication he/she does not like, in case of need, he/she can ask another person for help (for him/herself or for another child);
- Is aware what is or can be dangerous in his/her surroundings, tries to avoid know dangers (that can be anticipated).

The area of education called *Humans and their World* is the only area of education called FEPBE that has been conceptualized only for the first stage of basic education. This complex area defines the educational content concerning persons, family, society, home country, nature, culture, technique, health, safety and other topics. It applies an historical and present perspective and is aimed at skills and practical life. Through its broadly-defined synthetic (integrated) content, it co-creates the mandatory basic education

at the first stage. Thus, this area of education prepares the fundamentals for specialized education in the areas of education called *Humans and Society*, *Humans and Nature* and in the field of education called Education Towards Health. The area of education called *Humans and their World* is divided into five thematic areas:

- The place in which we live.
- The people around us.
- People and time.
- Diversity in nature.
- Humans and health.

The last thematic area called *Humans and health* has the following anticipated outcomes in the 1st stage (i.e. the 1st to 3rd year of elementary school), when the pupil:

- can apply basic hygienic, routine and health-prevention customs with the use of elementary knowledge about the human body and shows his/her relationships to health through appropriate behaviour and activities;
- observes the principles of safe behaviour so that he/she does not endanger his/her own or others' health;
- behaves warily when meeting unfamiliar people, can refuse communication he/she does not like, in case of need, he/she can ask another person for help for him/herself or for another child;
- applies the basic rules of a user of the road;
- adequately reacts to the instructions of adults under extraordinary circumstances.

The anticipated outcomes of the 2nd stage (i.e. the 4th to 5th grade of elementary school) in the thematic area are as follows and the pupil should:

- use their knowledge of the human body to explain the basic functions of the particular organ systems and to support his/her own healthy way of life;
- differentiate the particular stages of human life and understand the development of a child before and after his/her birth;
- purposefully plan his/her time for learning, fun and rest in compliance with his/her own needs with a view to the justified claims of other people;
- apply purposeful behaviour in situations that endanger health and in model situations simulating extraordinary events;

- in model situations, he/she can show well-learnt simple ways of refusing addictive substances;
- applies the basic skills and customs related to the support of health and its preventive protection;
- can treat small wounds and search for medical aid;
- applies friendly behaviour towards the other gender and is aware of the basic sexual behaviour differences between boys and girls at the given age.

The FEPBE document establishes the curriculum for the anticipated outcomes for the Humans and health thematic area as a binding standard of the educational program in the following form:

- Human body – life needs and signs, basic structure and function, sexual differences between a man and a woman, basic knowledge of human reproduction, development of an individual;
- Partnership, parenthood, basic sex education – family and partnership, biological and psychological changes during adolescence, ethical sexuality issues, HIV/AIDS (ways of transmission);
- Health care, healthy food – daily routine, drinking habits, exercise regime, healthy food; illness, small wounds, personal, intimate and spiritual hygiene – stress and its risks; effects of advertisement;
- Addictive substances and health – refusal of addictive substances, slot machines and computers;
- Personal security – safe behaviour in risky environments, safe behaviour in road traffic when a pedestrian or on a bicycle, critical situations (bullying, abuse, sexual abuse, etc.), brutality and other forms of violence in the media, professional aid services;
- Public emergencies.

We know that sex education as a part of education towards health, which is usually related to the term "sexual and reproduction health", owes its prominent and legal position in education because of the curricular reform of the school system. Sex education also "survived" the hectic period during the FEPBE consultation process with regards to proposals of amendments in the area of education called Humans and their World in which sex education is conceptually included in the 1st stage of elementary school (Rašková, 2013).

With reference to FEPPE, FEPBE and mainly to the meaningful concept of sex education created in recent years (Mellan & Brzek, 1995; Smolíková & Hajnová, 1997) and with a view of the pedagogical and psychological specifics of pre-school-aged and young school children (Čáp & Mareš, 2001; Langmeier & Krejčířová, 2006; Vágnerová, 2000; etc.), we can specifically define topics that are suitable for pre-school-aged children and young school children. It mainly concerns the following items.

Pre-school age (Smolíková & Hajnová, 1997):

- Life origin and childbirth;
- Relationships between men and women (partnership, parenthood);
- The difference between genders with regards to their bodies, psychology and social life;
- Emotional and social relationships among people (friendship, comradeship, relationships in the family);
- People's privacy and natural shyness;
- The care of human health and its cleanness.

Younger school age (Mellan & Brzek, 1995):

- Family, partnership, expression of emotions and love, married life, parenthood, ethical and legal standards;
- Relationships among people, friendship, comradeship;
- Cultural vocabulary;
- Differences between genders, differences between a man and a woman;
- Relationships with the other gender, amorousness, love, respect, gender sensitivity;
- Sexual behaviour among people, caressing, hugging, kissing;
- Protection against sexual abuse and other forms of child abuse;
- Sexuality and violence in the media;
- The human body, its parts, the significance of physical and spiritual hygiene;
- Adolescence, changes during adolescence, physical appearance, menses, nocturnal emissions;
- Human reproduction fundamentals (the origin and development of an individual before and after birth);
- Planned parenthood, conception, pregnancy, childbirth, new-born, breast-feeding;
- Risks of sexually transmitted diseases, including HIV/AIDS.

New discussions regarding sex education in the Czech school system are currently being held. The name sex education (Rašková, 2013) and proposed changes related to the inclusion of sex education especially in the Framework Educational Programme for Basic Education were the central focus. We have already experienced the procedure of FEPBE consultation through a proposal of changes in the area of education called Humans and their World. The field of education called Humans and health (which is still the valid name) was commented on within the aforementioned area of education where one proposal newly included "education towards a healthy integration of sexuality" to replace the original name "sex education".

We have not found a definition for the new name "education towards a healthy integration of sexuality" in professional literature and we have not found any relevant substantiation to justify changing the name. There is a question whether it really concerns a meaningful change at all. It must mainly be clear why such change has to take place, which has not been sufficiently justified. In our opinion, sex education should remain a pedagogical term, as it has been justified and defined in the context within the development of the Czech school system.

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2.4 Education towards Sexual and Reproductive Health in the Curriculum of the Second Stage at Elementary School

Michaela Hřivnová

Since September 2007, the educational and learning process in the Czech Republic has complied with the new curricular documents according to the Framework Educational Programme for Basic Education (FEPBE). The FEPBE has subsequently undergone several reviews, with the last review valid from 1 September 2013.

The FEPBE defines the main goals and key competences for pupils that should be attained after completing basic education. To reach these goals and key competences, it is necessary to proceed coherently and in a complex way, with the use of updated professional and educational knowledge.

Sex education concerning reproductive health is a part of the educational and learning process within the basic school system or at the 2nd stage at elementary school. This topic is included in several areas and fields of education, mostly in the area of education called Human and Health and particularly in the field of education called Education Towards Health. This fact is also confirmed by school directors claiming that education concerning sexual and reproductive health has been fully implemented in the Education Towards Health (23% of schools) or in the Education Towards Health, as well as in other fields of education, such as Natural Science and Education Towards Citizenship (71% of schools) within the School Educational Programme (SEP) (Hřivnová, 2013c, 119–120). School directors also believe that it is necessary to maintain education concerning protection of sexual and reproductive health in FEPBE, i.e. even in SEP (Hřivnová, 2013b, 301; Hřivnová, 2013c, 119).

The aforementioned updated version of the Framework Educational Programme for Basic Education brings about newly-defined anticipated

outcomes and an selection of curricula for various fields of education, i.e. as well as for the field of education called Education Towards Health.

The anticipated outcomes for Education Towards Health are defined for a graduate of the 9th grade of elementary school, i.e. they indicate what cognitive, affective and psychomotor goals should be fulfilled (what a pupil should be able to explain, describe, determine, use, apply … in the area of education towards health) respecting the biological, psychological and social levels. Education Towards Health includes 16 anticipated outcomes, including:

Pupil:

- VZ-9-1-01 respects the accepted rules of cohabitation among pupils and other peers and contributes to the creation of good interpersonal relationships in the community.
- VZ-9-1-02 explains the role of community members (family, class, fellowship) and provides examples of positive and negative influences on the quality of social climate (community of peers, family setting) with regards to its benefits for health.
- VZ-9-1-03 explains (with examples) direct relationships between one's physical, spiritual and social health; explains the relationship between satisfying basic human needs and the value of health.
- VZ-9-1-04 assesses various behaviours of people with regards to the responsibility for their own health and others' health and derives personal accountability on behalf of the active support for health.
- VZ-9-1-05 within his/her abilities and experience strives to actively support health.
- VZ-9-1-06 expresses his/her own opinion regarding the issue of health, discusses about it with peers, family and with those nearest them.
- VZ-9-1-07 understands the relationship between food composition, diet and the development of diseases and applies healthy eating habits within his/her abilities.
- VZ-9-1-08 applies the learnt preventive ways of decision-making, behaviour and acting in relation to current and contagious, diseases, diseases of affluence and other diseases; talks about his/her health problems and can find professional aid in case of need.
- VZ-9-1-09 shows a responsible relationship towards him/herself, to his/her growth and rules of a healthy lifestyle; voluntarily participates in health support programmes at school and in the municipality.

- VZ-9-1-10 independently uses learnt compensation and relaxation techniques and social skills for body regeneration, overcoming tiredness and preventing stressing situations.
- **VZ-9-1-11 respects changes during adolescence, suitably reacts to them; behaves in a pleasant way towards the other gender.**
- **VZ-9-1-12 respects the significance of sexuality in relation to health, ethics, morals and positive life goals; understands the significance of discretion in adolescence and of responsible sexual behaviour.**
- VZ-9-1-13 puts into context healthy and psychological risks related to the abuse of addictive substances and the life perspective of a young person; applies his/her social skills and behaviour models in contacts with social and pathological phenomena both at school and out of school; searches for professional help for him/herself and others in case of need.
- VZ-9-1-14 based on his/her knowledge and experience assesses the possible manipulative influence of peers, media and sects; applies the learnt skills of communication defence against manipulation and aggression.
- VZ-9-1-15 shows responsible behaviour in risky situations in road and railway traffic; actively prevents situations endangering their health and personal security; provides advice and adequate first aid in case of need.
- VZ-9-1-16 applies adequate behaviour and protection in the model situations of thread, danger and extraordinary situations (FEPBE, 2013, 76).

Upon the outcome analysis, it might seem that only two anticipated outcomes (AOs), i.e. AO 11 and 12, are directly related to the issue of education towards sexually reproductive health. Upon a detailed analysis and identification of the particular AOs we will, however, find out that these issues are also a part of AO 3–6, AO 8–9 and also AO 13 and 14 (to be explained in more detail in the text about Standards of Education Towards Health).

To attain the anticipated outcomes, a number of conditions must be fulfilled from the use of updated scientific knowledge from many disciplines (pedagogy, medicine, psychology, sociology, addictology, etc.) to the application of adequate forms and methods of education with use of the modern apparatus of educational tools (Hřivnová, 2013d, 54).

An integral condition to attain the determined AOs is also the fulfilment of the curriculum specified in FEPBE for the field of education called

Education Towards Health. The curriculum is divided into six thematic blocks with the specified sub-topics, i.e.:
Relationshi[s among people and forms of cohabitation:

- **Relationships in a couple** – comradeship, friendship, love, partnerships,
- **Relationships and the rules of cohabitation in the community setting** – family, school, a group of peers, municipality, fellowship.

Changes in a person's life and their reflection:

- **Childhood, pubescence, adolescence** – physical, spiritual and social changes.
- **Sexual maturation and reproductive health** – reproductive system health, sexuality as a part of personality shaping, discretion, premature sexual experience, promiscuity, pregnancy problems and juvenile parenthood, gender identity problems.

A healthy way of life and health care:

- Food and health – principles of healthy eating, drinking regime, influence of living standards and the way of eating on health; eating disorders.
- Influence of the exterior and interior environment on health – quality of air and water, noise, lightning, temperature.
- **Physical and spiritual hygiene, daily routine** – principles of personal, **intimate** and spiritual **hygiene**, body hardening, daily regime, balancing of work and relaxation activities, significance of exercising for health, exercise regime.
- **Protection against transmissible diseases – basic ways of disease transmission and its prevention**, respiration infections, diseases transmitted by food, acquired in the country, transmissible by blood and **sexual contact**, transmissible by insect stings and through contact with animals.
- Protection of chronic non-transmissible diseases and accidents – prevention of cardiovascular and metabolic diseases; preventive and medical care; responsible behaviour in accidents and life threatening situations (accidents at home, in sports, at work, during transport), basic knowledge of first aid.

Life threatening risks and their prevention:

- Stress and its relationship to health – compensation, relaxation and regeneration techniques to overcome tiredness and stressful situations and to strengthen spiritual resistance.
- **Self-destructive addictions** – psychological diseases, violence against oneself, risky behaviour (alcohol, active and passive smoking, guns, dangerous substances and things, **dangerous internet**), **violent behaviour**, difficult life situations and coping with them, criminal activities, doping in sports.
- **Hidden forms and levels of individual violence and abuse, sexual crimes** – bullying and other forms of violence; **forms of sexual abuse of children**; juvenile delinquency; communication with professional helping services.
- **Safe behaviour and communication** – communication with peers and unfamiliar people, safe movement in risky settings, **a risk of communication through electronic media, self-protection** and mutual help in risky situations and endangering situations.
- Observation of safety rules and health protection – a safe environment at school, health protection in various activities, safety during transport, risks of road and railway traffic, relationships among road traffic participants including coping with aggression, procedures in the event of a traffic accident (emergency calls, ensuring safety).
- **Manipulative advertising and information** – influence of advertising, influence of sects.
- Personal protection upon extraordinary circumstances – classification of extraordinary circumstances, warning signals and other ways of warning, basic tasks of public protection, evacuation, activities for extraordinary circumstances, prevention of extraordinary circumstances.

Values and health support:

- **Holistic concept of a human being in health and disease** – health components and their interaction, basic human needs and their hierarchy.
- **Health support and its forms** – prevention and intervention, affecting changes in the environmental quality and an **individual's behaviour, responsibility of an individual for their own health, support of a healthy lifestyle, programmes of health support.**

Personal and social development:

- **Self-knowledge and self-identity** – relationship with oneself, relationships with other people, healthy and balanced self-identity, building awareness of self-identity.
- **Self-regulation and self-organization of activities and behaviour** – learning of self-reflection, **self-control, self-discipline and dealing with problematic situations; determining personal goals and the particular steps to attain them; learning valuable attitudes and decision-making skills to resolve problems in interpersonal relationships; helping and pro-social behaviour;**
- **Psychological hygiene** in the social ability to prevent and cope with stress, searching for help in case of problems.
- **Interpersonal relationships, communication and cooperation – respecting oneself, healthy relationships, active listening, dialogue, efficient and assertive communication and cooperation in various situations, the impact of one's behaviour and acting** (FEPBE, 2013, 76–78).

Note: Thematic blocks and sub-topics related to education towards sexually reproductive health are emphasised with bold letters.

When we compare the existing version of FEPBE with the previous version (compare with the Overview of Changes in the Amended FEPBE, 2013), we will discover that the curriculum in the area of sex education has changed. Regression can be seen in some topics, while other topics have been newly added, for example in the section entitled *"risks endangering health and their prevention"* under the item entitled *"secure behaviour and communication"* the *"risk of communication through electronic media"* topic has been included, which has an immediate relationship to sexting risks, etc. (Hřivnová, 2013a, 5).

The creation of standards seems to be currently very actual in relation to the valid version of FEPBE 2013. Standards for basic education are defined in FEPBE as: *"Appendix to the Framework Educational Programme for Basic Education. The standards include indicators specifying the particular anticipated outcomes"* (FEPBE, 2013, 141).

Standards of Education Towards Health are currently available only in the draft version. The draft version as of 30 April 2013 can be found on the web pages, but it was already updated on 30 June 2013 and the final version is still being processed. The work group appointed by the

Ministry of Education, Youth and Sports is comprised of members from the Ministry, the National Institute of Education, the National Institute of Further Education, the academic sphere for the area of Education Towards Health and representatives from elementary schools and professional associations.

The aim of the standards is to "refine and specify in more detail" the anticipated outcomes. The Standards of Education Towards Health should define approximately 5 indicators for each anticipated outcome. Indicators using active verbs indicate what a pupil at the end of the elementary school education should be able to do within the field of education called Education Towards Health. The indicators must also cover the entire wording of the anticipated outcomes and not only their particular parts. "Non-doubling" of indicators among the individual AOs must be ensured and they must be defined with a view to the three components of personality (bio-psycho-social perspective) in light of the cognitive, affective and psychomotor goals of education within Education Towards Health. They must be clear, comprehensible and unambiguous. They must also ensure covering of the offered curriculum determined in FEPBE 2013 and based on actual scientific knowledge.

Example tasks enabling people to control fulfilment of the determined indicators and thus of the anticipated outcomes must then be created in relation to the selected indicators. The battery of example tasks to the given AOs will gradually be increased – 1–2 example tasks are currently offered for every AO. The example tasks must be conceptualized so that they cover the fulfilment of the cognitive, as well as the affective and psychomotor goals of education. The level of sophistication of the defined standards should be currently set at the minimum level, i.e. the success rate of the given indicators should be reached by most of the pupils in the 9th grade (over 80 %).

Examples of the draft version of Standards of Education Towards Health (as of 30 June 2013) for anticipated outcomes 11 and 12 with an immediate relation to education towards sexually reproductive health:

Field of education	Education Towards Health
Year	9.
Thematic area	
Anticipated outcome of FEPBE	• **VZ-9-1-11** The pupil respects the changes that occur during adolescence, suitably reacts to them; behaves in a civilized way towards the other gender.
Indicators	1. The pupil can characterise the particular periods of human life. 2. With use of appropriate terminology, the pupil can describe the physical and physiological changes that occur during adolescence. 3. The pupil can characterise the start of reproductive functions, the mechanism of conception and pregnancy. 4. The pupil can provide examples of how to properly react to changes in the psychosocial area during adolescence. 5. The pupil can apply respect to others and to the same gender and the basic ethical code in practice (in class, at school and throughout the community).
Example task	

Say whether the following statements are correct:

Statement	YES	NO
The menstrual pattern takes approximately 28 days.		
The male hormone testosterone also influences the growth of facial hair and originates in the testicles.		
Ovulation means the same thing as menstrual bleeding.		
Pregnancy lasts approximately for 280 days, i.e. 40 weeks.		
Intimate hygiene only applies to women.		
Alcohol consumption during pregnancy can seriously harm the foetus.		
The secondary sexual characteristics of a girl include hair at the external genitals and in the armpits and the growth of breasts.		
The greatest probability of pregnancy is during ovulation.		
Female sex hormones include oestrogen and testosterone.		
Before and after the insertion of a menstruation tampon it is necessary to wash your hands.		
The fluid produced by the male genitals and emitted during coitus is called erection.		
Fertilization (i.e. also the connection of a sperm and an ovum) takes place in the vagina.		
The main sex cell is called sperm.		
A woman can become pregnant from pubescence until the end of her life.		
The development of an embryo and foetus takes place in the uterus.		
During pubescence the girl's pelvis grows and the hips and buttocks form.		
During pubescence voice mutation occurs in boys, which is caused by the growth of the larynx.		

Notes to the example task	VZ-9-1-11.2 VZ-9-1-11.3

Field of education	Education Towards Health
Year	9.
Thematic area	
Anticipated outcome of FEPBE	VZ-9-1-12 The pupil respects the significance of sexuality in relation to health, ethics, morals and positive life goals; understands the significance of discretion in adolescence and of responsible sexual behaviour.
Indicators	1. The pupil can characterize human sexuality as a combination of the physiological and psychosocial component of one's personality (describes the significance of will, reason, sensibility and instinct in sexuality). 2. The pupil can differentiate which behaviour corresponds to and which behaviour exceeds sexual standards (as regards age, rights, ethics, moral, socio-cultural environment, etc.). 3. The pupil can assess the risks of premature sexual contact during adolescence for physical health (the risk of sexually transmitted infections, possible adverse effects of contraception, the risk of premature pregnancy), for psychological health (disturbance of the developmental task of identity formation, incorrect motivation for having sex, etc.), for the social dimension of health (insufficient development of sexuality to the mature level). 4. With use of model examples, the pupil can identify possible ways of dealing with risky situations in the area of reproductive health of human sexuality. 5. The pupil can describe the relationships between reproductive behaviour, faithful relationships, marriage, partnership and a possible life perspective.
Example task	

<table>
<tr><td colspan="2">Choose five of the following factors influencing the choice of the future life partner that you find the most important and justify your choice.</td></tr>
<tr><td>Selection of future partner's characteristics</td><td>Choice of future partner's characteristics</td></tr>
<tr><td>Character traits</td><td rowspan="3">1.</td></tr>
<tr><td>Financial situation</td></tr>
<tr><td>Health</td></tr>
<tr><td>Ethnicity</td><td rowspan="3">2.</td></tr>
<tr><td>Physical attraction</td></tr>
<tr><td>Sense of humour</td></tr>
<tr><td>Faith and membership in a religious group</td><td rowspan="3">3.</td></tr>
<tr><td>Sexual performance</td></tr>
<tr><td>Comrades and friends with whom he/she meets</td></tr>
<tr><td>Education and job</td><td rowspan="3">4.</td></tr>
<tr><td>Faithfulness</td></tr>
<tr><td>Social position</td></tr>
<tr><td>Trust</td><td rowspan="3">5.</td></tr>
<tr><td>Material security (house, car, etc.)</td></tr>
<tr><td>Relation to animals</td></tr>
<tr><td>Notes to the example task</td><td>VZ-9-1-12.5</td></tr>
</table>

To conclude, we can claim that the issues of education towards sexually reproductive health in the curricular documents for the 1st stage at elementary schools (Rašková, 2013) and also in relation to the 2nd stage at elementary schools have their foundation and are fully explained in the expected outcomes and in the curriculum of the newly drafted Standards of Education Towards Health within the Framework Educational Programme for Basic Education in the area of education called Man and his health, in the field of education called Education Towards Health.

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2.5 Sex education in school educational programmes – specific attitudes towards education at practical and special elementary schools, one-year and two-year practical schools

Dan Blaha

The attitude of people towards sexuality is genetically determined and it is to a large extent influenced by the family setting and culture in which an individual lives and grows. The family setting and the parents' example influences how a person deals with various life situations, as well as the children's future partnerships. Schools can only partially affect this attitude, but they can add professional dimension to the pupils' attitudes and facilitate comparison with other pupils, which can be important for the perception of variations and the creation of tolerance. Sex education is an important and irreplaceable chapter of education towards health. The transfer of professional knowledge in the area of sex education so that the pupil can use it in their practical lives, to protect his/her health and to navigate through difficult life situations is the main goal of education towards health that is included in SEP at schools. Pupils learn a lot of information about how to protect their health and they have heard about the transmission of sexual diseases, but they cannot apply this information in specific life situations. Schools, in cooperation with the family, can do a lot for the healthy development of pupils in this regard.

Specific attitudes towards education

Pupils with intellectual disability who, due to their limited abilities, are unable to retain the curriculum taught in common elementary schools, mature in the same way as their peers and engage in practical life. To ensure that

their future life is healthy, safe, happy, accountable and of high quality, they need real information about sexual life in addition to theoretical knowledge. This information and knowledge can be gained within the subject entitled Education Towards Health that is freely incorporated into other subjects, e.g. natural science, civics, substantive learning and family education.

Information about sexuality that is important for the future life and health of children is usually not given much attention in families. The majority of pupils do not talk with their parents about the issues concerning their bodies and sexuality and parents rarely provide them with the necessary information in this area. Most advice is gained from older siblings or from peers. The environment in which children grow has a significant impact on their opinions as they consciously and unconsciously copy their parents. Children who are knowledgeable about sexuality usually are pupils who have average grades and they usually indicate that their family, siblings and peers/friends are their source of information. In specialized subjects, pupils obtain information about maturation and about sex education while they show interest and do not feel embarrassed. Girls are usually more embarrassed while boys accept it more easily, or at least pretend to. If pupils are provided with the information professionally and in relation to the health, social and legal perspectives, they react friendly and with interest. It is striking during this current period of repeated growth of sexual diseases and of people still dying from diseases related to AIDS, pupils hear some information in this area for the first time at school and not at home. When we acknowledge this fact, it is very important how such information is presented to pupils. Embarrassment is caused by an unprofessional attitude, inaccurate terminology and familiarity. On the contrary, it is beneficial when a teacher approaches their pupils with the terms they know from the street and which they find vulgar. Such words must be explained to the pupils in relation to and with their etymologic origin and thus get rid of the vulgarity that pupils relate them with. Pupils like playing with words; they are content to hear that the words are not essentially vulgar and that they often come from Latin and are made vulgar by people using them in certain situations. Paradox situations happen with Roma pupils where some pupils and their parents strictly refuse to listen to information about sexuality, contact teachers to claim that such things are not allowed to be discussed in their ethnic group and that talking about menses and condoms is offensive for them – even though there are often instances of minor mothers and fathers in these families.

For pupils at elementary schools who are educated through the learning programmes contained in practical and special elementary schools, information concerning sex education for practical life is very important. The majority of information related to the development of a human being, maturity, personal hygiene, prevention of sexually transmitted diseases, human sexuality and basic legal information with regard to partnerships is gained at school. If the appropriateness of the information is respected and the pupil's legal representatives are acquainted in advance with the educational topics, such education does not cause any problems. Pupils are interested in the topics that are taught, they overcome their embarrassment more easily and they often actively participate with their own experience. Education towards health poses a significant challenge with regards to the pedagogues' personality, as not everyone possesses natural authority in front of pupils.

The book for the 2nd stage of the practical elementary school – Výchova k občanství (Civics Education), part 3, Parta publishing, Prague 2010, by Oldřich Müller, the thematic unit entitled Humans in Society – describes human sexuality very clearly and sensitively. The divisions in the following chapters (Significance of friendship – boys and girls; adolescence; love; sexual life; danger of sexual diseases; interpersonal relationships in society – national minorities) draw on the knowledge gained by the pupils in other vocational subjects, introduces this area of human life to the pupils in its entire context, including the anatomical, physiological, health, emotional and social aspects of the given issues and connects them with the knowledge gained from the family and with their own knowledge.

Sex education in educational programmes (SEP) – practical and special elementary schools, one-year and two-year practical schools

1) Practical elementary school:

Education Towards Health 8th grade

Curriculum – critical situations – bullying, maltreatment, sexual abuse.

Outcome – to apply purposeful behaviour models in cases of bullying, maltreatment or sexual abuse.

Education Towards Health 9th grade
Curriculum – Sex education
- The meaning of sex education
- Facts about sexuality
- The anatomy of the female and male genitals
- Vocabulary
- Intimate hygiene for each day, hygiene during menses, coitus hygiene
- Paediatric gynaecology
- Premature sex education and its risks (the decision-making tree)
- Sexual orientation
- Need of feelings and love in for persons with a physical and sensual disability
- Conception, pregnancy, birth
- Contraception
- Diseases transmissible through sexual intercourse, HIV/AIDS
- Ways of transmission
- Risky behaviour and protection against diseases, promiscuity
- Professional help
- Ethical issues of sexuality
- Ways of expressing love
- Discretion and sexual shame, inappropriate behaviour with regard to sexuality
- Sexual abuse
- Real and unreal information about sexuality in the media
- Sexuality from the perspective of different cultures and religions
- Sexuality and the law

Outcome – the pupil should know basic information about sexuality; be able to describe the physical, physiological and psychological changes that occur during adolescence; learn about the terms from the area of sexuality; know and respect the basic rules of hygiene for each day and during menses; know the basic rules of hygiene upon coitus; specify the arguments to postpone beginning one's sexual life until full maturity and describe why the organism of an adolescent girl is not biologically mature for a healthy pregnancy and birth; understand the differences in the sexual behaviour of various individuals (homosexuals, bisexuals, …); describe conception and the development of a foetus, understand the course of a birth; name the ways of protecting against unwanted pregnancy and understand the

ways and appropriateness of their use; describe the risks of unprotected sexual intercourse and the changing of partners; name the most common sexual diseases and describe how to protect against them; describe how the HIV virus is transmitted and what happens after the a person is infected; understand the treatment of HIV and AIDS and justify the preventive measures used in the fight against the spreading of HIV; how to contact professional aid in case of need; justify the inappropriateness of publicly speaking about intimate matters; express their opinion regarding the programs in the media where love and parenthood are shown in a distorted way; respect different attitudes towards sexuality influenced by different cultures and faith; know the laws related to an individual's sexual life and be aware of the legal matters concerning child abuse.

Natural science 8th grade
Curriculum – the reproductive system, an individual's development.
Outcome – to learn about the prevention of unwanted pregnancy; to describe a child's developmental periods; to gain brief information about the essence of inheritance; to describe with simple examples the effect of inheritance on an organism's development of; to become aware of the risk of sexual diseases.

2) Special elementary school – part 1:

Civics 9th grade
Curriculum – relationships at school, interpersonal communication, the equal status of men and women.
Outcome – to learn about the values of friendship and relationships between people.

Education Towards Health 9th and 10th grade
Curriculum – relationships in a couple, comradeship, friendship, love, partnerships, marriage and parenthood; physical hygiene, principles of personal and intimate hygiene. Outcome – to know about the importance of peaceful cohabitation among peers and family members; to understand the fundamental life needs and their how to apply them in compliance with health.

Factual education 4th to 6th grade
Curriculum – how to protect oneself and one's body against harassment and abuse; inappropriate behaviour and consequences – theft, bullying, abuse, maltreatment.
Outcome – recognize inappropriate activity and the behaviour of peers and adults in one's surroundings.

3) Special elementary school – part 2:

Intellectual education 1st to 10th grade
Curriculum – awareness of one's body with help of touching (using of a mirror); comparing one's body with another person's body; gradual connection and description of the particular body parts beginning with the easy ones (the head, body, arms, legs) to more detailed descriptions; using example materials (dolls) during education, using pictures, different methods of work; using PC programmes with the given issues; cognition of one's body and its basic needs, learning of communication that leads to the satisfaction of life needs in an adequate way (verbally, non-verbally); recognition of one's own comfortable and uncomfortable feelings and how to differentiate them, connecting uncomfortable feelings with health difficulties and their expressing them in compliance with the pupils' individual skills.

Outcome – describe the particular parts of the body or point to them; recognize and satisfy basic life needs, communicate one's emotions and notify parents/guardians of any health problems.

4) One-year practical school:

Civics 1st grade
Curriculum – searching for a life partner, sex education, conception, pregnancy, birthing, significance of friendship and comradeship.
Outcome – to differentiate between partnership and friendship.

Education Towards Health 1st grade
Curriculum
1. Health and measures of protection
– Protection against transmissible and non-transmissible diseases
– Prevention of risky sexual behaviour
– Disease, HIV/AIDS prevention
2. Relationships among people

– Safe behaviour in social contact with peers and unfamiliar people, forms of sexual abuse, bullying, violence
– Relationships and rules in the cohabitation of people
– Relationships in couples, comradeship, friendship, love, marriage and parenthood
– Interpersonal relationships and communication, respecting oneself and others, behaviour supporting good relations

3. Health care
– Deepening knowledge about human health
– Personal hygiene of children, adolescents and adults

4. Risks threatening life
– Prevention against disease and HIV/AIDS

Outcome – to observe the principles of safe behaviour in a way that the pupil does not endanger his/her or others' health; to apply the communication skills learnt to protect against manipulation, bullying, aggression and sexual abuse; to understand the importance of peaceful cohabitation for the creation of common moral principles and rules of behaviour in the family; to correctly name the basic parts of the human body; to identify any health problems within one's abilities.

Family education 1st grade
Curriculum – sexual maturing, contraception, premature sexual experience; risky sexual behaviour and its prevention; prevention of sexually transmitted diseases, sexual identity disorders, abortion.
Outcome – to respect the rules of cohabitation among peers and partners; to apply a certain amount of discretion in one's emotions; to understand the possible risks in selecting a partner; to know the consequences of risky sexual behaviour and unwanted pregnancy.

5) Two-year practical school:

Civics 1st grade
Curriculum – **People in society –** interpersonal relationships in the family and in society; basic rules of social behaviour, public appearance, behaviour in society, interpersonal communication, personal freedom, freedom of others, equality and national minority equality, vandalism, bullying and domestic violence, maltreatment, abuse.

Outcome – to respect the moral principles and rules of social cohabitation; to apply appropriate ways of social behaviour; to recognize inappropriate behaviour and the breaching of social standards.

Civics 2nd grade
Curriculum – **People in society –** the rights and duties of pupils, relationships at school, the responsibility of parents for raising children. Basic rules of social behaviour, interpersonal communication; respect for human beings, interpersonal relationships.
Outcome – to recognize inappropriate behaviour and the breaching of social standards; to be tolerant towards diversity and the interests of minority groups in society.

Education Towards Health 1st grade
Curriculum – **2. Relationships among people –** relationships between partners, sexual relations; planned parenthood, conception, pregnancy, birth.
Outcome – to respect the adopted rules of cohabitation; to learn the terms in the area of sexuality.

Education Towards Health 2nd grade
Curriculum – **1. Health and measures of protection –** infectious diseases and sexually transmitted diseases – ways of spreading disease, gonorrhoea, syphilis, AIDS – prevention.
– 2. Relationships among people – sexual relations; promiscuity, sexual disorders and deviances.
Outcome – to have a basic awareness about infectious and sexually transmitted diseases; to learn the terms in the area of sexuality.

Family education 1st and 2nd grade
Curriculum – **Sex education –** sexual deviations; danger of sexual abuse; sexual identity disorders; sexually transmitted diseases; sexual abuse; pregnancy; premature sexual intercourse and dangers related to it; sex life; pregnancy, medical care of a pregnant woman; birth and care of a child; sexual life, contraception.
Outcome – to correctly recognize inappropriate and risky behaviour; to know the dangers related to dangerous customs; to understand the

responsibility for one's sexual behaviour and to know the consequences of risky sexual behaviour; to be able to protect oneself against sexually transmitted diseases.

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Conclusion

No overview of sexuality-related topics is ever complete and can never be complete, but it can provide a view that makes it clear how important it is to write and speak about sexuality, deal with it on an expert theoretical level and share practical experience. All areas covered by this publication are a part of human sexuality for all people, including people with intellectual disability. The detailed chapters on the risk of sexual abuse and the risk of abuse of and addiction to addictive substances are very enriching. Persons both with and without disability are exposed to these risks in today's society without being provided with sufficient information by helping professionals. In families with children with disabilities, both topics are taboo. We cannot exclude the idea that persons with disabilities who live in a regular environment (i.e. an environment of integration and inclusion) or in an environment where they receive special support (facilities providing social services) might become users of psychoactive substances. Venglářová (2013) mentions that we can see people addicted to alcohol, stimulants and opiates in healthcare and social facilities and that there is a "risk of sexual abuse to users of addictive substances" (Venglářová, 2013, 206).

Including specific features of communication means providing support for the practical aspects of what helping professionals do for safety in terms of sexuality. Helping professionals are those who educate, recommend, treat and give clients the right direction. There are not many specialised sources dealing with sexuality that would explain how to communicate with people with disabilities or how to provide them with support in the development of their relationships and the protection of their sexual rights. This publication lays the foundation to help people form attitudes not only towards the sexuality of individuals with disabilities, but also towards sexuality in general and how to view it.

We believe that future helping professionals will accept the importance and necessity to receive education in the area of sexuality, which will then mark the beginning of people forming positive attitudes towards sexuality.

Dana Štěrbová and Miluše Rašková

Afterword

Society in the Czech Republic and Slovakia has not yet coped with the provision of sex education. This is the conclusion made by not only non-governmental organisations, but also by many experts in science and research, education and social services, and parents and young people of different target groups. The position and importance of sex education is still not getting the kind of attention that it deserves. Moreover, ideological disagreements about the topic, a lack of interest by competent bodies (not just schools) and the lack of educational opportunities in this field of education all cause the level of sex education to lag behind most other EU member states and not meet the human and legal standards of the UNO or recommendations by the CEDAW Committee on the availability of sex education within the school system.

The perception of sexuality and related sex education has changed over the years. While in the past, sexuality was seen as an instinct and its naturalistic perception as a human need with the aim to reproduce prevailed, today, more emphasis is placed on its social and cultural aspects. The existence of different approaches to its narrower and wider definitions indicate different interpretations. In the narrower sense of the meaning, it is a biological dimension associated with reproduction; in the broader sense of the meaning, sexuality is a basic part of our identity. It involves our attitudes, values, beliefs, activities, and biological and emotional processes. It is an important factor in all personal relationships and has both personal and social dimensions – it is emotional, physical, cognitive, spiritual, based on values and not associated only with love, intimacy and romanticism, but also power, conflict and violence, and what is more important, it has been manifested throughout human life in all its variability and diversity.

In the Czech Republic, the conceptualisation of what is taught as sex education has been influenced for a long time by conservative Christian morals (the observation of traditional values and regulations), more than forty years of a totalitarian government, its change in 1989 and subsequent societal development and recently also by ideological and political pressure. Sex education (especially its name and some topics included in it) is the "hot potato" in the hands of politicians, conservative forces and churches, and its introduction in schools is problematic and more or less formal. The strategies surrounding how to implement it has been the subject of

never-ending discussions. However, the strategies definitely do not reflect the pedagogical considerations of its educational objectives! They are often accompanied by an inadequate defamation associated with the dissemination of absurd and distorted information and demagogy concerning its procedural aspect! However, the stakeholders of the given process forget about one fact – children, the youth and adults, including all vulnerable persons in these target groups, perceive personality, experience it and, at a certain level, reflect and manifest it. This happens without any relevant systematically organised information or support. Risks, abuse, protection and prevention are neglected. For a long time, competent persons and institutions have been ignoring the changing concept of childhood and the related emerging needs of the new generation of children and young people, vulnerable social groups from marginalised Romany communities and socially-disadvantaged environments and children and adults with differences (intellectually and physically disabilities) and needs that are related to perceived sexuality. They ignore the fact that the variability of sexuality causes sexuality to have different values for different people, not only instrumental, but also autonomous!

The accentuated Christian value system excludes the education of persons with other than a heterosexual orientation and at the same time neglects the fact that people are authentic and free beings and their sexuality (often also due to health reasons) is not related to marriage or human reproduction. Many current topics included in sex education (sexual orientation, sexual abuse and sexual violence, planned parenthood, abortion, new sexually transmitted diseases, lifestyle changes in young people, gender issues and the satisfaction of sexual needs of persons with disability) are intentionally omitted or referred to as a dangerous threat that might disintegrate traditional values, families and entire communities. Options to satisfy sexual needs of intellectually and physically disabled persons are not discussed. Society pretends that they are asexual beings without the right to satisfy their sexual needs.

An important obstacle to quality and systematic sex education of different target groups is the insufficient professional formation of teachers and helping professionals in this crucial area of education. These professionals are often confronted with problems related to unhandled sexuality and are not systematically prepared to adequately respond or intervene in a proactive manner.

Everybody should be aware of their basic human rights in order to be able to make informed consents, which allows him or her to lead a fully--fledged and meaningful life. The knowledge and observation of human and reproductive rights helps people to feel satisfied and relaxed in their own bodies so that they can recognize when their rights are not being observed and are able to live in satisfied and happy relationships and to make informed decisions related to their sexual life.

The ambition of a quality, holistic sex education is to provide people not only with basic knowledge, but also to develop the skills, attitudes and values that they need to be able to control their sexuality and enjoy it at the cultural level both from the personal perspective and in a relationship.

To conclude, I would like to express the optimistic belief that one day, competent persons and institutions will be sensitively reasonable and reasonably sensitive and will be able to make and accept decisions that promote progress towards a more modern holistic sex education that respects the human and legal attitudes. Accomplishing such a goal might help to improve information about sexual and reproductive rights, prevent risky sexual behaviour and eliminate the stereotypes and prejudices associated with sexuality. It would also result in greater responsibility for one's sexual health and safe and responsible sexual behaviour through which people (even those with disabilities) can satisfy their sexual needs at an acceptable level. What is expected from competent persons and institutions in practice is readiness, openness, helpfulness and support, optimal professional and human skills and the will to help children, young people and adults from different target groups incorporate sexuality into their lives as a value with a significant ethical dimension. The necessity to address specific challenges and recommendations in order to achieve positive changes in this situation is also clearly the responsibility of the government, ministries, school founders, non-governmental organisations, the professional community and donors.

Lenka Rovňanová

Note:
Translation from the Slovak original by Mgr. Petra Jurkovičová, Ph.D.

Summary

The theme of sexuality and communication has not yet been grasped among Czech helping professionals even this need arises from actual practices. Previously mostly ignored and neglected problems are related to taboo of sexuality and the existing diversity of opinions and attitudes toward sexuality in general, and especially in people with intellectual disabilities.

Sexuality refers primarily to a set of characteristics that reflect sexual and gender differences. As sexual expressions are usually understood the acts of reproduction, genital and erotic pleasures, intimacy or close emotional feelings, masturbation and erotic self-imagination, erotic love and attraction. Psychological and medical approach to sexuality focused mostly to the most serious manifestations of sexual and reproductive behavior but the broader concept of sexuality involves more social aspects.

Our attention is paid to the selected concepts and terms related to sexual issues and topics in Part I. We have focused on a phenomenon of sexual abuse, including sexual abuse of persons with intellectual disabilities, and neglected issue of approach toward sexual needs of (1. among persons with dependency, 2. handicaped persons). Furthermore, we are interesting in the issues of attitudes and ability to communicate about sexual issues among helping professionals including ability to intervene in families where at least one member is a person with disability.

The issue of sex education and sexuality in the concept of school curricula can be found in in Part II. Special part is about the specifics of sex education for persons with cognitive disorders.

Authors contributed their expert knowledge and co-worked in each chapter, have a deep knowledge in the social and psychological sciences for helping professions and are prominent leaders in this field with many years of professional experience.

Ivo Procházka

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KATALOGIZACE V KNIZE – NÁRODNÍ KNIHOVNA ČR

Štěrbová, Dana, 1964–
The specifics of communication in relation to sexuality I : helping professions in relation to sexuality, including persons with intellectual disabilities / Dana Štěrbová & Miluše Rašková et al. ; translation Tomáš Vacek. -- First English edition. -- Olomouc : Palacký University Olomouc, 2021. -- 1 online zdroj
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– pomáhající profese
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– kolektivní monografie

613 – Hygiena. Lidské zdraví [14]

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The Specifics of Communication in Relation to Sexuality I:

Helping Professions in Relation to Sexuality, Including Persons with Intellectual Disabilities

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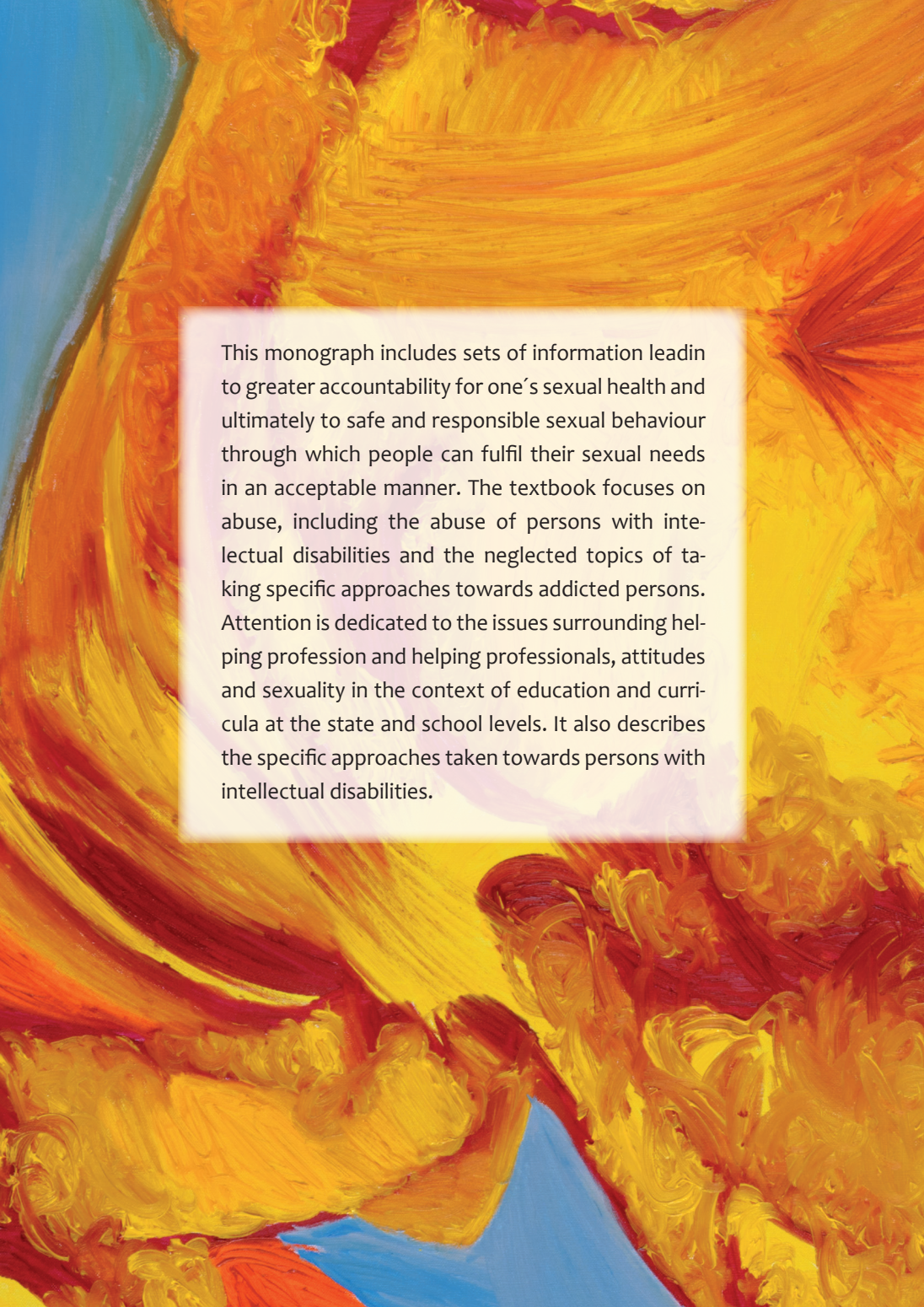

This monograph includes sets of information leadin to greater accountability for one´s sexual health and ultimately to safe and responsible sexual behaviour through which people can fulfil their sexual needs in an acceptable manner. The textbook focuses on abuse, including the abuse of persons with intelectual disabilities and the neglected topics of taking specific approaches towards addicted persons. Attention is dedicated to the issues surrounding helping profession and helping professionals, attitudes and sexuality in the context of education and curricula at the state and school levels. It also describes the specific approaches taken towards persons with intellectual disabilities.