

**Socio-Sexual Intervention in a Protective Workshop:
Process Analysis of Action Research**

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of the requirements for the degree of
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ABSTRACT

This dissertation explores an organisational consultation and a socio-sexual training intervention made at a protective workshop. Against an informative background and a literature review, the process is examined in the light of principles of organisational consultation, with special attention to the processes of entry, needs assessment, contracting, the actual intervention and evaluation. The intervention, which took the form of action research, is explored. Particular emphasis is focused on the tensions which manifested because of sexuality as subject matter, personal and interpersonal dynamics, as well as organisational factors relating to consultation. The discussion around the various influences results in recommendations. These recommendations should be useful to the agency involved, and to other mental health workers in the field of sexuality and mental handicap, and also to fellow students.

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INTRODUCTION

In 1992/3 as part of my training in clinical psychology, I conducted a consultation and training intervention at a protective workshop in the Cape. The aim was to train supervisory staff to address socio-sexual issues with mentally handicapped people and their families, to promote the rights of people with mental handicap and thus to assist in preventing sexual abuse of the workers. The intervention took the form of action research, and was modified in relation to ongoing feedback (Schein, 1985). There were many influencing factors. For instance, the inexperience and student status of the psychologist; the process of entry and contracting; the organisational structure of the social work agency involved; the nature of the subject matter; and the interpersonal dynamics.

In order to explore the meaning of particular outcomes, some reflection on the context, nature and process of the consultation and intervention is necessary before the intervention itself is discussed. Writers in the field of organisation consultation suggest it is important to analyze negative and positive outcomes (Schein, 1985; Whyte, 1991b). Morris (1991) points to the inadequacy of quantitative methods in assessment of values and meaning in the context of sex education. The endeavour is particularly suited to qualitative analysis because of the flexibility which is facilitated thereby. What follows is an analysis of the above mentioned consultation and training intervention with the writer as participant observer.

Overview of Dissertation

The first section outlines the process of qualitative participant research and some elements of analysis used to evaluate the consultation and intervention. It also yields background material relevant to the particular organisation; organisational consultation; and the clinical psychology training at the University of Cape Town. Comment is made about the fields of interest - sexuality, people with mental handicap and staff training. Ethical considerations are addressed.

The second section gives a brief resume of the consultation and intervention process.

The third section discusses the process with attention to the reception given to the sexual material and to the material on rights; personal and interpersonal interactions; and organisational factors.

The final section draws on the material presented in Section Three to make recommendations addressing the agency as an organisation; the socio-sexual training of staff; and the trainee experience. The dissertation is necessarily limited in content due to constraints of space.

The major aim of the dissertation is to reflect an understanding of the consultation and intervention process. There are three equally important areas of focus:-

- 1) The difficulties of training people in the area of sexuality and mental handicap.

- 2) The influences of individuals on the process, including the writer's position as a trainee consultant.
- 3) The influences of organisational structures and practices.

As research the document is significant in that it serves to provide practical advice for future work in the field of sexuality and mental handicap; makes recommendations to the agency concerning staff training and the role of the intern psychologist. It also complements previous studies evaluating the training of psychologists at University of Cape Town (U.C.T.) (Dickman 1983; Lazarus, 1985/6; Parker, 1986; Kottler, 1991).

The academic convention of writing wholly in the third person will not be used as it is a device of language that reifies the author as expert and creates unnecessary distance between the author, the text and the reader (Sless, 1986; Schein 1985; Wolcott, 1990). I am presuming my audience to be colleagues in the mental health field.

SECTION ONE - BACKGROUND

Qualitative research

The research process under review is situated in the action research model (Schein, 1985). In this model a theoretical approach is applied to a problem and evaluated in a context. The problem in this case was to find a suitable method to train supervisory staff in socio-sexual issues. The context was a protective workshop associated with a social work agency. The intervention was to train supervisory staff to deal with socio-sexual issues with the expectation that they would in turn educate the workers with mental handicap whom they supervised. In action research the results of an intervention inform future interventions in an ongoing process. The results in this case are an evaluation of process with the researcher as a participant observer (Kirk & Miller, 1987). Whyte called this particular qualitative methodology participatory action research (1991a).

Traditional empirical methodologies seek to reduce the contamination of data by the researcher but fail to do so (Kirk & Miller, 1987). Most qualitative methodologies accept that the researcher influences the data and try to make that influence explicit (Manning, 1987; Schein, 1985; Henwood & Pidgeon, 1993). Control of all possible variables is not possible (Manning, 1987). The observer is "the instrument of research" (Reeves Sanday in Van Maanen 1990, p. 19) applying clinical knowledge (Schein, 1985). The observations of a participant observer have face validity but the interpretive range in qualitative research is limited to that observed (Kirk & Miller, 1987). Interpretations are therefore not generalizable and are offered tentatively (Schein, 1985; Van Maanen, 1990). In rendering my subjective position I hope to preserve the self referent quality

that will make this document amenable to objective analysis and understanding (Niemi in McKeown & Thomas, 1988). Miles (1990) suggests that exposing the researcher in qualitative methods reduces the researcher's biases and arrogance. Qualitative analyses have proved most useful in generating theory and discovering new insights (Manning 1987; Van Maanen, 1990; Whyte, 1991a; Whyte, 1991b; Henwood & Pidgeon, 1993).

Manning suggested that "the reflective relationship" is critical to the enterprise of qualitative analysis but noted that it is "unstandardised" (1984, p. 24). Miles wrote that there are "few guidelines for protection against self delusion" (1990, p. 118). For this reason, Manning (1987) suggested that qualitative research be conducted in teams. This option was not available to the student researcher. For various reasons there was no-one within the agency who was free to become involved, nor did the staff at the workshop engage with the research process. Thus, I was dependent on my supervisor for guidance.

The research data is the process of the consultation and training intervention. This process was documented throughout. I kept detailed field notes and periodically audio-taped meetings and discussions. To analyze the process it is necessary to consider it in detail.

One can look at how the consultation came about; what theory was used; whose problem was addressed (Van Maanen, Manning and Miller in Schein, 1985); whose needs drove the process (Schein, 1985); how members of an organisation communicated (Selancik, 1990) and responded to the consultant (Schein, 1985). Additionally, it is important to look at organisational ethos and how it is received by members (Schein, 1985). The structure of an organisation might also reveal influencing factors (Selancik, 1990). Van

Maanen (1990) suggests that meanings taken for granted should be questioned. Schein (1985) and Miles (1990) point out that qualitative analysis with reliance on the researcher's clinical experience and knowledge, generates anomalous and unexpected findings. Light (1990) and Schein (1985) note that what in qualitative research might be termed a mistake or error can become a source for insight and information. Bhavnani (1990) suggests that critical examination of power issues should be a part of all research endeavours.

The process of analysis involves a degree of abstraction to understand possible meanings of the recorded process (Whyte, 1991a). As meanings are always contextual it is important to elucidate the context first.

The context for this research consists of background information about the social work agency and the protective workshop, the background to my own training, and a review of previous work in the field of sexuality and mental handicap. The context forms the background against which the intervention decision was made. Political aspects of the South African context are not specifically addressed due to space constraints.

Intervention Context

Background Information

The social work agency serves a limited number of people with mental handicap or mental illness in the Cape Town area. It is a regional office concerned with mental health. Services include assessment and placing of people with mental handicap, counselling for mentally handicapped or chronically mentally ill people and their

families, home visits, application for disability grants, administration of special care and training centres for mentally handicapped children and workshops which employ mentally handicapped adults. It depends on government subsidy as well as public and private charity for funding. Some of the agency's projects are financially self supporting. The inadequacy of mental health services in South Africa is well documented (Grover, Cooke, Hollingshead & Rip, 1987; Lea & Foster, 1990; Vogelmann, 1990). Accordingly the agency's resources are stretched.

The agency employs one psychologist on a part time basis and since 1991 has provided a training placement for interns from the University of Cape Town.

A special interest group was formed at the agency to address issues of sexual exploitation of people with mental handicap who are known to be a high risk group (Griffiths, Quinsey and Hingsburger, 1989). This group consists of interested social workers employed by the agency and the clinical psychologist. The psychologist was my supervisor for assessment cases and it was she who facilitated my entry to the group as I had an interest in sex education and was concerned about people with mental handicap and their rights.

After some discussion within the special interest group and with my project supervisor, it was decided that I should explore the possibilities for sex education in the protective workshops with a view to producing guidelines for all the workshops. This put me in the position of a consultant to the special interest group. I was directed to liaise with the workshop coordinator who then chose the project site.

Protective workshops seek to provide a working environment for people with mental handicap which resembles so-called normal working conditions. Mentally handicapped people belong to a highly stigmatised group whose so called deviancy from what is constructed as normal, is "fostered by differential treatment, labelling and segregation" (Chapman & Pitceathly, 1985, p. 227). Recently, there is a worldwide trend toward normalisation of marginalised people such as those with mental handicap. The aim of normalisation is "to help foster more socially appropriate behaviour" by "providing mentally handicapped people with living conditions that are as normal as possible" (Chapman & Pitceathly, 1985, p. 227).

Workers in the protective workshops come from the surrounding area, usually a segregated, Afrikaans speaking, working class area. The intellectual capacity of the workers varies from severely mentally retarded to mildly mentally retarded (DSM-111 R). They do jobs which range from peeling labels off used coathangers, to packaging, to woodwork. They keep normal working hours and are paid wages. However, wages received are minimal so as not to jeopardise their eligibility for disability grants.

The Avon Bulletin (May/June 1987) includes an article on the rights of mentally handicapped people. This article stresses that people with mental handicap have the right to learn responsibility but at the same time have the right to a professional support team.

In the case of the protective workshops, staff are engaged to supervise the workers. Wages are small and the work is arduous. Little training is given to staff on the subject of mental handicap and related fields. At the workshop where the research was

conducted, male supervisory staff were engaged on the basis of their artisan experience, mainly carpentry. Female supervisory staff were not qualified but two of them had a relative with mental handicap.

The protective workshops are required to be financially self supporting but are controlled by workshop coordinators who are accountable to the regional office. The agency is a hierarchical structure but during the time I spent there, there was a concerted effort amongst those in authority to examine ways of empowering both clients and staff in the organisation.

Training Background

The University of Cape Town offers a two year Master's Degree in Clinical Psychology at the Child Guidance Clinic in tandem with Valkenberg Hospital. The training is aimed at producing general practitioners in clinical psychology (Kottler, 1991).

In the first year of training, students are introduced to brief term psychotherapies and psychometric assessment. Limited practical experience is gained in these areas. There has been a systematic programme teaching aspects of community work since 1990. The second year primarily consists of practical experience. Interns are placed within the mental health care system, mostly hospital based appointments, for periods of two to four months. In 1991 two community based placements were introduced in an effort to make the training of psychologists more relevant to the needs of the majority of South Africans (Lazarus, 1985/6; Parker, 1986). Another component of the degree is that of research. Students are required to produce an original, clinically related, minor dissertation.

Inevitably, the multiple demands of the training create tensions which affect the interventions made by trainees. There are tensions between the requirements of rendering service and becoming trained. Another tension could be ascribed to the exposure of the student to multiple models, while this is necessary in a general training it can also be confusing (Kottler, 1991). Schein (1985) suggests that a community consultation requires a certain amount of clinical knowledge and helping skills which may not be part of the trainee psychologist's repertoire. Supervision by a more experienced psychologist is crucial to the training. Students are supervised in assessment, therapy and community work. As the supervisory relationship is potentially evaluative, this can have consequences for the process of supervision (Kottler, 1991).

Mollon comments on psychotherapy: there is a difference between knowing the "characteristics" of therapy and the "culture" (1989, p. 114). The latter requires experience while the former is learnt in books. The comment stands if 'community consultation' is substituted for 'psychotherapy'. Kottler (1991) wrote that such culturalization required time for reflection. She also noted that the demands of the training and trainee fatigue left little time for reflection. In Section Three some of these tensions will be elucidated with respect to the intervention.

My own training commenced in 1991. I came from a nursing background with a special interest in sexuality. During the first year I was exposed to community work in the form of consultation to a working class family. In the second year, my first placement was at the social work agency. I was the fourth intern to be placed there and the role of the intern psychologist was still in the process of being defined. In this placement, interns learn assessment and community consultation. Supervision of assessment is from the

agency psychologist. Supervision of consultation projects is from a clinical psychologist based at the university, but who has three years previous work experience at the agency. My decision to do research at the agency was based on my personal interest in the field of mental handicap and a desire to begin research for my dissertation.

Sexuality

My task was to devise a programme which would aid in preventing sexual exploitation of mentally handicapped workers. A review of previous research in the current literature revealed that no published South African research exists in the field of sex education and mental handicap. Literature from Britain, Australia, America and Canada, based on research conducted in the late seventies and early eighties was consulted and will be reviewed where applicable.

Sexuality is an emotive subject productive of anxiety. Brown suggested this is because people are “confronted by their own feelings and conflicts” (1992, p. 185). Sexuality is considered private and only to be spoken of in particular ways (Brown, 1992). Sexuality is a relationship one has with one’s body, one’s image, one’s gender and with social mores (Brown, 1992). Ambivalence is likely because in sexuality “physical, social, emotional needs are intertwined and inseparable” (Brown, 1992, p. 187). Sexuality evokes feelings about one’s self in relation to social, religious, cultural and economic realities (Brown, 1992). Conflicts exist for each of us.

Sexuality and Mental Handicap

As do all humans, people with mental handicap have the right to sexual knowledge, expression and fulfilment (Craft & Craft, 1983; Chapman & Pitceathly, 1985). This

includes being sexually active or inactive, marriage, cohabitation, and parenthood.

Normalisation for people with mental handicap in the field of sexuality is impeded by the conflictual feelings held by the general public toward people with mental handicap.

These conflicts are evidenced by the historical distortion of sexuality in relation to mental handicap. Brown (1992) describes the over-emphasis of the sexuality of people with mental handicap, the suppression of sexuality through segregation, the withholding of sexual information and the punishment of sexual activity, as evidence of such distortions.

People consider those with mental handicap to be children (Brown, 1992; Craft & Craft, 1983; Craft, 1987). As such, they are thought to be either not sexual or not capable of being responsible for the consequences of sexual activity such as childbirth (Clarke in Chapman & Pitceathly, 1985), or not in control of their sexual impulses (Craft & Craft, 1983). The fear of the sexuality of people with mental handicap has at times resulted in the violation of their rights, for instance, involuntary sterilisation (Craft & Craft, 1983).

The strong feelings and points of view evoked by sexuality and mental handicap are also ambivalent. Caretakers are caught between the desire that people with mental handicap "have the same rights and privileges as everyone else" and the concern that they be "specially protected" (Laubscher, 1979, p. 2). Caretakers "juggle between acknowledging the 'ordinariness' of their issues and taking into account the 'extraordinary problems' they have to face" (Brown, 1992, p. 187). It is not surprising that the same ambivalence is reflected in attitudes toward sex education of people with mental handicap (Heshusius, 1982).

Sex Education

Logically sex education will aid in prevention of sexual exploitation through ignorance. It is recommended that education of people with mental handicap takes place on a day to day basis in small manageable chunks (Craft, 1987; McCarthy & Fegan, 1984; Avon Bulletin, 1987). People with mental handicap have cognitive limitations (Kempton in Chapman & Pitceathly, 1985) and can benefit from informed, practical input rather than cognitive overloading in lecture form. It is logical that daily caretakers such as parents and supervisory staff, should be involved in sex education (Brown 1992). Chapman and Pitceathly (1985) indicate that education of people with mental handicap requires training and access to resources for those involved in the education.

Chapman and Pitceathly consider that successful implementation of educational programmes for people with mental handicap requires a "positive attitude" from all caretakers involved (1985, p. 231). This requires good team work and liaison between all groups of caretakers. Brantlinger (1983) has found that implementing a programme based on the rights of mentally handicapped people is effective in assisting staff in attaining positive attitudes toward sexuality and mental handicap. Johnson and Davies assert that staff require factual knowledge, practical counselling skills and to have explored their own feelings about sexuality in order to "feel adequate in providing sex education and counselling" (1989, p. 20). Brown propounds that effective staff training requires a "coherent model" - educative and practical, as well as self exploration (1992, p. 199).

Some professionals in the field of mental handicap suggest that staff should be carefully selected to deal with sexual matters (Sanctuary, 1983; Brown, 1992). I think that any

person involved with people with mental handicap should receive some basic training in socio-sexual matters with guidelines for action.

Staff in the protective workshop are confronted with socio-sexual matters almost daily. In the year that I visited the workshop the staff were required to deal with public masturbation; jealousy in relationships; impotence; rape; incest; family planning problems; a person in a wheelchair needing assistance to become sexually active; people wanting to marry while parents disapproved; sexual intercourse in the toilet and a mute man with inappropriate sexual habits.

Intervention Decision

Against the above background I decided that the most appropriate method of implementing sexuality training in the workshop was to train staff first in order to establish a positive perspective for the workers. In addition staff could then be educative agents of both the workers and the parents. Another obvious advantage was that sexuality training could conceivably continue after I left.

After discussion with my supervisors, and consultation with the special interest group at the agency, the workshop coordinator and the workshop staff, I proposed to train workshop supervisory staff in socio-sexual issues. The purpose of the psycho-educative training was to address the staff's feelings of inadequacy and embarrassment about sexual issues; to enable them to talk to workers more freely about sexual matters; to transfer advocacy of the rights of people with mental handicap to the staff; and to encourage liaison with workers and parents. It was hoped that the process of addressing training

would be useful in producing working guidelines which could in turn aid administrative planning around sexuality training in the future.

Principles of Organisational Consultation

I have decided to address the intervention made at the workshop through the lens of consultation dynamics. It is at this level of abstraction that the paradoxes and tensions within the intervention arise. Much will be neglected by this focus but space is limited. The ideal situation is described in this section. The real situation is addressed in Section Three.

The areas of consultation addressed are:-

- 1) Permission and entry.
- 2) Needs assessment and contracting.
- 3) Intervention.
- 4) Evaluation.

Permission and Entry

It is preferable for any community, organisation or group to ask for assistance, thereby ensuring “voluntary cooperation” (Whyte, 1991a, p. 240) and “active agents” for change (Whyte, 1991b, p. 177). Gershenfeld suggested that a consultant “asking to be let in” is less likely to be successful in diagnosis and intervention (1986, p. 213). Thus skills in entry, engagement and negotiation are essential tools for the consultant. Schein (1985) noted that consultation is often called for by persons in authority and that this creates

tensions for any interventions made at a lower level.

Needs Assessment and Contracting

Needs Assessment

The most fundamental job of a consultant is needs assessment. The aim is to diagnose what is required by the community, organisation or group and negotiate a way to bring about change. Needs assessments may be complicated by the inability of a community to express its needs or by the inability of the assessor to perceive the needs (Vogelman, 1990). An analysis of whose needs drive the process is necessary.

Contracting the intervention

Intervention is contracted through negotiation with relevant parties. A plan for change is made taking into consideration time and resources available as well as the feasibility of the project. When consulting with an organisation there are many persons or groups who could be considered “the client” and part of negotiating the contract is making this explicit (Schein, 1985). Schein suggested that the “psychological contract” could be different from the explicit contract and might need to be explored (1988, p. 33). In Section Three, it will be shown that the contracting process affected the intervention process in major ways.

Implementing the Intervention

Any therapeutic intervention is not value free, it is an “educative and socialising process” (Turton, 1986, p. 97). Some analysis of professional roles, formal status, gender, age, nationality and colour are important (Schein, 1985; Bhavnani, 1990). The researcher as clinician must be alert to styles, skills and verbal behaviour, to “misinformation, lies,

deceptions, fronts, evasions” (Adler & Adler in Manning 1987, p. 18). The communicative behaviour of people in their interactions and within the organisation must be noted (Selancik, 1990). It is important to look at organisational ethos and how it is received by members (Schein, 1985).

Community clinical interventions require then, similar skills, attitudes and awarenesses to those required for therapy (Schein, 1985). Tension, particularly for a trainee, lies in the increased complexity and number of influencing factors, for example the number of people and complex organisational structure. In addition there is tension between meeting the research and training demands and providing a service to clients.

In Section Three, aspects of the intervention are reviewed with attention to the material on sexuality, personal and interpersonal dynamics and organisational influences.

Evaluation

It is important to evaluate and record community clinical interventions and the process of action research in order to extend the body of theoretical and practical knowledge in the area of consultation. Hence this dissertation.

Continuous appraisal and reappraisal of process is necessary to monitor the effectivity of a given plan. A contract can be subject to change after negotiation amongst relevant parties. According to Schein (1985) such evaluation presumes open and honest communication within the organisation and with the consultant.

Later, in Section Three, the intervention is evaluated in the light of its aims. Timing of

evaluation is reviewed and the importance of using qualitative methods in discovering covert meaning is noted.

Ethical Issues

A short note on my ethical position is necessary. I have attempted to protect individuals and groups with whom I have worked through anonymity. This is because of the sensitive nature of that revealed to me both wittingly and unwittingly. Those reading this document may recognise themselves and others. I ask the readers to treat the material herein with respect and a degree of confidentiality. I have attempted an impartial analysis but have also attempted to reveal my biases.

I am extremely grateful to those who kindly assisted in the project and emphasize my view that all persons have behaved responsibly within the constraints of their circumstances. Some details here may be uncomfortable for some readers. I remind them of these words from Adler and Adler:-

In the context of qualitative analysis

“Older rules about secrecy, trust and mutual trust, protection of one’s subjects’ worlds and even to some extent the editing of field reports to save the face of the researcher and the research subjects no longer hold” (in Manning, 1987, p. 19).

O’Neill writes “we have no special ability to predict the future and can never anticipate all negative outcomes” (1989, p. 377). The interpretation of the intervention process is

offered with sincerity and respect, but is open to debate and is not considered definitive.

Finally, I would like to emphasise that information contained herein is dated and only applies to 1992-1993. Organisations and persons change and so observations may not be accurate at the time you read this.

SECTION TWO - BRIEF SUMMARY OF PROCESS

A brief overview of the process is necessary to provide a frame for the analysis. A chronological record of contacts can be found in Appendix A. For the purposes of description I have divided the process into four phases.

Phase One - Preparation, Planning and Contracting

The first placement in my internship year was at the social work agency. Because of my interest in sexuality and mental handicap I made contact with the special interest group at the agency which was concerned with monitoring sexual abuse. Together, it was agreed that I would pilot an intervention at a protective workshop, aimed at preventing sexual abuse through sex education. After library research, I gained permission to proceed from the special interest group, the senior personnel at the agency and my supervisors.

I then liaised with the workshop coordinator who suggested a possible site for my project. She agreed to facilitate my entry at the site but mentioned that she was extremely busy and would probably be unable to assist me further. When the agreed upon time came for the visit she was unable to attend due to the constraints of her work. She had omitted to inform the workshop supervisory staff that I would be arriving. Nevertheless I proceeded to engage the workshop staff and workers in conversation, saying I had been sent by the agency and was interested in sex education and research. I spent two lengthy sessions at the workshop talking to the staff and the people with mental handicap who were employed in the workshop about differing sexual matters. It

became apparent that the workers were ignorant about sexual matters and that the staff were anxious about their competence to advise on sexual matters.

An intervention was designed (see below) and accepted in principle by the supervisor and agency staff.

A contract meeting was set up with the workshop staff and the workshop coordinator. At this meeting the supervisory workshop staff agreed to proceed with a training programme designed to aid them in exploring socio-sexual issues with workers and staff by addressing their anxiety and improving their knowledge and counselling skills. They also agreed to take part in my research. At that stage it was not clear exactly what the research component would involve. It was a pilot study and my role was that of participant observer. Data was to be recorded in note form and on audio-tape. The analysis, however, would not begin until a later stage.

We contracted to have nine 1,5 hour sessions between March and May. The sessions were to be held approximately weekly making allowances for illness and holidays. They were to be completed by the time I finished my placement at the agency at the end of May 1992. We planned to meet as a group and to cover:-

- 1) How people are sexually educated and how much knowledge they had.
- 2) What made people uncomfortable when talking and thinking about sexuality.
- 3) Perspectives on sexuality and mental handicap with particular emphasis on human rights.

- 4) Areas of interest, for example, homosexuality, masturbation, sexual abuse, taboos.

The special interest group at the agency requested that some guidelines be drawn up. The guidelines were to focus on how to deal with socio-sexual issues in the workplace, with particular emphasis on sex education and prevention of sexual abuse. The guidelines were to form the basis of a policy that might be adopted by the agency and the other workshops.

The second part of the intervention was also contracted at this time. After my placement at the agency was complete (May 1992), we would meet once a month from June 1992 to January 1993. This was called the problem solving phase. Staff would work on 'cases' arising in the workshop, counselling the workers involved. The group meetings were to address any problems.

Phase Two - Weekly Group Meetings (Intervention Part One)

In the first four sessions we explored how each person had learnt about sexuality and the differences between men's and women's experiences. Sexual language was explored and interesting discussion was generated on cultural and religious influences. Group members were initially embarrassed and uncomfortable. Their feelings were accepted and explored. Sexuality was then framed as being part of human relating and not just a separate functional activity.

The fifth session was used to outline the rights of people with mental handicap. This session served as the basis for the four following sessions where guidelines were

generated and reviewed in discussions about relationships and people with mental handicap. The guidelines can be found in Appendix B. They cover the socio-sexual rights of people with mental handicap as well as some preliminary ideas in how to proceed with sexuality education. The staff group were concerned to involve the parents of the workers and also the workers themselves in further construction of guidelines and in sexual education of the workers.

In the sixth and seventh sessions mental handicap was discussed in relation to marriage, pregnancy, masturbation, impotence, rape and familial expectations. Some areas of importance were not discussed, for example, sexual abuse, sexual difficulties. We agreed that these matters would be discussed if they arose in the problem solving phase. The last session was spent evaluating the process thus far and planning the presentation of the guidelines to the workshop coordinator and then to the parents.

Notes were kept in and after each session and all except three sessions were audiotaped and later transcribed. Some of these tapes were used in supervision. Notes cross check with tape transcriptions and may thus be considered reasonably reliable.

Phase Three - An Interim Phase

Guidelines were presented to the workshop coordinator who expressed verbal support. Two of the staff had worked on an Afrikaans copy of the guidelines which was said to require further work. The coordinator contracted to set up a meeting with other workshops for presentation and review of the guidelines.

The protective workshops hold regular staff/parent meetings during the year. After the presentation of the guidelines to the workshop coordinator, it was agreed that the socio-sexual rights of people with mental handicap should be discussed at the next staff/parent meeting. Normally the coordinator would be present but as she would be on leave that day, the staff agreed to organise the next meeting. Few parents come to the meetings. Those present on the 11th July 1992 were pleased to get the input, and a lively discussion about people with mental handicap and sexuality ensued. Some particular problems relating to sexual responsibility were brought up and the parents of workers involved managed some effective problem solving. Parents were asked if they would like to be involved in planning sex education policy in the workshops, that is, extending the guidelines. No one was interested.

An audiotape was made of the meeting with the workshop coordinator and detailed notes were kept of the staff/parent meeting.

Phase Four - Problem Solving (Intervention Part Two)

In the monthly meetings supervisory staff were assisted in problem solving in the workshop context. This phase was seen as partial assessment of the effectivity of the weekly groups, as well as the "learning how to counsel" phase.

"Cases" were chosen. Staff identified workers who were involved in what seemed to be complicated relationships. Sexuality alone was not the main focus. Rather 'cases' were identified on the basis of socio-sexual complications, for example, a boyfriend and girlfriend who were not allowed to visit with each other because of differing parental

values, or where two persons were sexually active and wanting to marry. Working in pairs the staff approached the relevant workers and the parents of the workers to find out what was actually happening in the relationship. Some "problems" ceased to be problems once those involved had talked. Staff coped well in approaching parents but became uncomfortable when a case of incest came up. They were also concerned about the amount of time that such counselling took out of their working day and/or private time. After October the production demands of the workshop prevented further meetings in 1992. We met in January and February 1993 but by then the impetus for the project had waned. No further progress was made in presenting the guidelines to other workshops. The workshop coordinator was unable to set up a meeting between different workshop staff as she had contracted.

Two of the six monthly sessions were taped. Detailed notes were kept of remaining sessions.

The above brief overview of the process serves to orient the reader to the following analysis. In Section Three aspects of process will be analyzed in relation to principles of organisational consultation.

SECTION THREE - ANALYSIS

Following the proposal in Section One (Principles of Organisational Consultation), I have chosen to focus on four aspects:-

- 1) Permission and Entry - how the process of entry affected the intervention.
- 2) Needs Assessment and Contracting - how needs were evaluated and the contract negotiated.
- 3) Intervention - how the intervention was affected in its different phases by interpersonal dynamics, the sexual subject matter and by organisational practice.
- 4) Evaluation - how evaluation took place continually over time and was not discrete from the process.

The above division is for the convenience of writing. The actual process was not as discrete.

Permission and Entry

The social work agency could be said to follow a mental health model. In this model expertise is applied in the field. Psychology interns can provide a degree of expertise. The agency, in accepting the placement of psychology interns, have contracted that the intern will have work to do within the agency and thus trainee psychologists are at once a resource and a responsibility.

At the outset it was contracted that I would be supervised in this project by a psychologist from the university. Being placed at the agency but supervised at the

university created a paradox. The supervisor at the university was quite removed from the actual process. To an extent the special interest group at the agency also undertook the responsibility of some supervision in that the group monitored progress in regular feedback sessions.

A difficulty arising from the above structure was that while I experienced the agency staff and the supervisor as supportive, on the ground I was quite alone except for the other group members. The supervisor was dependent on my own interpretation of events. As a trainee I still had a lot to learn, this was my first group experience and there was probably a lot that I omitted to bring to supervision through ignorance. However the process was a valuable one for me, allowing me to gain experience and to grow into the "culture" of consultation and intervention in a mental health setting (Mollon, 1989).

My approach to the protective workshop was negotiated through the appropriate hierarchical channels. It is quite common in organisations that intervention is sought by people higher up for people lower down the hierarchical chain (Schein, 1985). I presented an area of expertise which was accepted as useful by the agency and the special interest group. This expertise was then applied in a particular setting - the workshop. The tension of this top-down arrangement lies in that the people who would become involved in the intervention were not really in a position to say no to any proposal accepted by those higher up in the hierarchy.

Another complication in this hierarchical approach was accountability. I was primarily accountable to the special interest group. To some extent this disempowered me on the ground. Should I have wanted to change what I was doing I would have had to refer

back up the hierarchy. Given limited time and the amount of energy required this was not an option. I was also accountable to the staff group, but to a lesser degree as they did not have the same power of permission as those higher in the hierarchy.

One person who might have contributed more was the workshop coordinator. She was a person with a lot of experience and much knowledge of the protective workshops. The original meeting with her was pleasant and she was very helpful, agreeing to introduce me to the workshop. She did ask however that she not be "loaded with extra work". The implications of this only became apparent later. It became clear to me over time that she had a huge workload. Staff at the workshop described her as busy and reported that she was very difficult to contact. I noted also that she was ill quite often, possibly pointing to high levels of stress.

As a result the intervention did not have her active support. She was not present at my initial contact with the workshop and had not informed them of my potential visit. Feeling impatient I introduced myself anyway. If I was a more cautious person or had more experience I may not have done this. I said I was interested in sex education. I became known as "the sex expert" and was allowed to talk to all staff and workers. These discussions lead to some expectations that I would teach the workers, which then had to be ironed out during contracting. However, the interaction also pointed to the level of trust that was established. One member of staff said, "If she (the coordinator) said it was O.K., it's O.K. with us". It seemed staff were not in the habit of questioning orders. This was also apparent in the contracting process. On the surface the coordinator's absence did not seem to affect my entry but may have given a covert message undermining the importance of the intervention.

Needs Assessment and Contracting

Needs Assessment

Needs assessment is not discrete from entry nor does it stop when an intervention is begun. It is an ongoing process. The heading is used here to facilitate introduction of the various needs driving the intervention process and thus acting as filters to what was negotiated and contracted.

The mental health model is a particular body of knowledge which proposes how mental health can be attained. The model prescribes how things should be and has a kind of moral rectitude that can at times be taken for granted especially by a trainee clinician. It is from this body of knowledge that I drew the literature on which the intervention was based. The mental health model has a normative agenda and thus lacks flexibility to absorb information outside of the agenda (Schein, 1985). For instance when I talked to the staff and workers at the workshop I discovered exactly that which was mentioned in the literature and was blind to any other possible needs. I found that the workers experienced themselves as ignorant about sexual matters and supervisory staff were anxious about their ability to advise on sexual issues. I did not comprehend until much later the degree of stress and overwork experienced by the staff.

Owning knowledge puts one in a position of power. When that knowledge is adopted by the hierarchy it gains the additional impetus of that structure. Thus when time came for the contract to be clarified I had the balance of power on my side: I was knowledgeable and had permission from higher structures. The staff did not have the necessary information to argue with me, or even to question the intervention. When they did

question why it was necessary to address their own sexual issues before addressing those of the workers, I used the literature to justify it. The imposed agenda may in part account for the differential motivation of various staff members and for the passive resistance experienced during sessions (See below).

It can be seen above that the 'needs' or requirements of the mental health model were in part driving the process. My own needs were also influential. For example I needed a project in my placement and I wanted a research topic. Sexuality was my field of interest and I was impatient to start. The drive of these needs was increased by the needs of the special interest group to move into the field of prevention of sexual abuse. As mentioned previously, the fundamental job of a consultant is to diagnose the needs of the particular group or organisation where intervention will be made (Schein, 1985). In fact I was my own client, I was consulting to the special interest group but the delivery of service was to the workshop staff and thence indirectly to the workers. While it can be argued that inservice training in the area of sexuality was necessary given the levels of abuse in the mentally handicapped workers, it may not have been a priority for the staff. In this process the needs of the workshop were probably the least influential, possibly confirming Kaslow's notion that a consultant "asking to be let in" makes a less successful diagnosis (1986, p. 213).

The staff being on the lower rungs of the hierarchical ladder were not in a position to refute my research needs or those of the special interest group. Even if the staff group were aware of their needs they did not have a free forum in which to discuss them. The hierarchical structures within the workshop and agency did not facilitate expression of individual or staff group needs. A pattern of organisational relating that I noted in my

interactions with various workshop staff was that orders were seldom questioned or challenged overtly.

This is not to say that the staff were not powerful. For example the staff through passive resistance were able to re-negotiate meeting times. The workshop coordinator had decided that the best time to hold the weekly meetings would be Friday afternoons as they were frequently “free”. The afternoon sessions were marked by tardiness in arrival and early anxiety to leave. There were frequent interruptions for toilet purposes and telephone calls, while some group members just did not arrive, offering excuses like “my car’s in the garage”. They were unable to actively refuse the time suggested by the coordinator but could do so passively. At one session it emerged that the staff were always tired on Friday, they were concerned to do their weekly business and felt that the sessions impinged on their free time. When sessions were changed to mornings during working hours they settled down to work for the full 1,5 hours. It is this kind of serendipitous finding that occurs with qualitative research and which is particularly important in informing action research (Schein, 1985; Miles, 1990).

Contracting

A principle of clinical work is that of “informed consent” (Schein 1985, p. 21). Schein stated that in consultation and intervention clients initially do not understand the ramifications of the commitment they make. It is the job of the consultant to educate the client as quickly as possible. Because this was action research, I could not outline all possible consequences of the intervention and especially not the research angle. This made the staff group feel anxious because the process was open ended. Initially, I merely outlined the plan for the intervention and described the literature it was based

on. I obtained permission to tape sessions and to use the material as research data, promising a degree of confidentiality.

Part of contracting is establishing who the client is. Initially there were three potential clients: myself as a researcher, the special interest group, and the workshop as a whole (including workers). At contracting it was clarified that I would work with the staff at the workshop and that we would construct guidelines for the special interest group and the workshops in general. The staff were initially surprised that I would not be teaching the workers. Schein wrote of a "psychological contract" (1985, p. 33) and in this case the staff may have presumed that I would engage with the workers based on the fact that I had talked to the workers in the process of needs assessment. I then had to explain that there were too many workers to reach in so short a space of time, and that the staff themselves would be more effective if they taught the workers on a daily basis.

The contract with the special interest group had consequences for the supervisory staff group. The request for working guidelines came from the interest group and the construction of the same was imposed on the staff group. The differing levels of accountability had consequences for the development of the guidelines.

The staff group were wary of the responsibility. They said such guidelines might not be well received by other workshops. They insisted that parents and workers should also be involved. In order to save time I drew up the guidelines from the group discussions. They were altered by the staff and two members attempted translation into Afrikaans. They struggled with the high level language. The coordinator said she would assist with the language but this never materialised. One group member was particularly concerned

to reach other workshops but this process was not facilitated as promised by the workshop coordinator.

The confusion of responsibility lies partially in the various bodies involved. The special interest group suggested the necessity for guidelines but were not involved. The staff group were interested but not responsible for establishing policy. The coordinator appeared interested and was involved in all the bodies but she did not have the time to carry the responsibility. I was merely consulting and that only temporarily, so the responsibility could not be mine.

Schein (1985) suggests that contracting is a process which is negotiated by relevant parties which is subject to change depending on appraisal of process. This presumes open and honest communication within the organisation and with the consultant (Schein, 1985). It appeared to me that communication within the organisation was not open or honest but opaque and hierarchical. Communication with me was initially accommodating. The staff were agreeable and tried to please. This may have been because I was perceived as being higher up in the hierarchy. Only when they were very stressed by workload and were distracted from the group process was I able to ascertain that the sessions drained too much of their time. I think it safe to assume that open and honest communication was not the norm. I was grateful when the staff group began to trust me enough to speak of their distress. I was then able to make adjustments in the programme and timetable.

Intervention

The factors influencing the intervention process can be divided into three areas:

- 1) Sexuality as a subject.
- 2) Personal and interpersonal factors.
- 3) Organisational elements.

Sexuality as a Subject

Early on in discussions with the staff it became clear that they viewed the workers as “children” and considered them to be “oversexed”. This concurs with the findings of Chapman and Pitceathly (1985).

The staff initially adopted a religious perspective on what would be appropriate sexual behaviour for people with mental handicap. They gave The Bible or the Imam as a source of authority. After some discussion of their own behaviour and beliefs it was decided that, in regards to sexuality, a wider perspective might be more realistic. Change in perspectives was effected by exploration of their own feelings and experience.

Initial discussions were marked by nervous giggling and blushing. Some group members used humour to defend their discomfort. Slowly talk became more cohesive. This was facilitated when discussion moved from personal discussion to discussion about workers. Interestingly, they were more able to share from a personal perspective when the talk was ostensibly about workers.

Sexual ignorance was only revealed later in the weekly sessions. People expressed ignorance about female masturbation, homosexuality, family planning and tubal ligation for example. Originally the staff had told me they felt they knew about sex, sexual reproduction, and sexual development. I took this at face value and thus did not commence the intervention with an educational phase. From about the seventh session it became clear from feedback given to me that there was some ignorance of basic sexual facts such as what homosexuality was or what a tubal ligation was. When the ignorance came to my attention I would have liked to address that but was constrained by time. I attempted to redress the issue by leaving copies of a good basic text but this was not read, probably because the group members were not in the habit of reading. As one group member said "I prefer it if other people do the work for me".

In the process of group discussion, one woman in particular seemed more progressive in her knowledge. This complicated the group process in that she reported feeling conspicuous in the group. Other group members were intimidated by her knowledge.

It seems that the different genders interacted differently with sexual material. In the initial sessions the men were quite boastful about their sexual prowess and spoke more freely while the women were shy about using sexual language. Towards the end of the weekly meetings the men had toned down their language and the women were chatting more freely about sexual issues. This may have been the result of contextualizing sexuality within relationships. The suggestion was made by my supervisor and proved useful in normalising talk.

Language and identity are associated. As sexuality constitutes part of an individual's identity (Brown, 1992), the language used in discussion aimed at changing a person's perspective is likely to be influential (a subject for future research). During the intervention the language used was English. Permission was given to speak in Afrikaans but this was a rare occurrence that happened only in the second phase of the intervention. The staff assured me that they were comfortable in English but only when they started speaking openly and honestly to me about the cases they were working on in the second phase did Afrikaans become part of the transaction. On reflection I think my English accent and my poor Afrikaans probably reduced the level of rapport and changed the possible level of influence of the material in unknown ways.

Personal and Interpersonal Factors

In this section I will examine how status, roles, gender, age, colour and nationality influenced the process (Schein, 1985; Bhavnani 1990). I will look at aspects of personal styles, verbal behaviour and individual skills (Manning, 1987). These all affect the dynamics.

It was mentioned above that the sessions were conducted primarily in English. I am from Zimbabwe originally and was not schooled in Afrikaans. The staff group members were Afrikaans and Xhosa speaking but were competent in English. However the adherence to my home language reflected the predominant power dynamic and also served to accentuate and reinforce the differential. My language also contains much jargon gained in tertiary education thus marking my greater knowledge. Two group members referred to my superior education and said that they felt inadequate in comparison, they felt they "lacked training".

The language used served to mark me as an outsider. The fact that we were not speaking the language used commonly by group members meant that my access to the real meaning of that which was happening in the room was limited. The fact that I grew up in Zimbabwe, was “white” as opposed to “black” or “coloured” also made me different, and probably meant that some of the meaning of verbal interactions were lost to me. I know on one or two occasions jokes were made that were meaningless to me. My inquiries as to the meanings were greeted with laughter but no explanation. This poor access to meaning is a limiting factor as described above and could influence the reliability of the data interpretation.

As a trainee psychologist I was not confident in my ability and thus I took refuge in the role of “sex expert”. Listening to the taped sessions it became apparent that, at least initially, I adopted a didactic style. I was unable to utilise the group fully, due to my lack of experience and tended to engage in diadic conversations. I was confused about which models I should adopt and anxious to do well in my training. When I become anxious I tend to try and control all possible variables. This anxiety is reflected in the didactic controlling style I adopted. My supervisor alerted me to this after listening to one of the early tapes. Thus, I was able to change parts of my style, but I still experienced tension between the need to facilitate feelings and discussion and the need to cover a certain amount of information.

Age had some effect on group dynamics. All group members except one were over forty. The youngest member was frequently teased. My younger age was less influential because I was “married” and thus “one of us”.

From my position it seemed that I established better rapport with the women group members. They would hug me in greeting and chat to me after sessions. The men appeared busy before and after sessions but would chat if I made an effort. This gender difference must have affected the group dynamics. Certainly the women were more interested in the material and contributed much, especially in the monthly sessions of the second phase intervention. Their greater interest may also have been a result of the fact that two of the three had relatives with a mental handicap.

One male group member was remarkable for his almost complete silence in group sessions. Initially other members would berate him about it but then it was accepted. What was interesting, was that when the manager was absent from sessions he became more vocal. The manager was quite critical of his behaviour and thus may have dampened this man's enthusiasm.

The manager of the workshop was also concerned about his role. He was very cooperative but would defer to his superiors. In the sessions the staff would often refer tricky questions to him, especially the women. He emphasised his position by remaining in his "place" behind his desk during group interactions and by asking the workers to do tasks for him. He became upset if meetings got "out of order" and if people spoke when he spoke. He was however very conscientious about doing homework. Looking at the staff dynamics, it appeared that there was no democratic forum for addressing staff differences.

Organisational Factors

Fortunately during 1992 the workshop coordinator's parents, who had previously

managed the workshop, were available to assist in the supervision of workers while the other staff were in their training meetings. This raised the question of what would happen about in-service training if and when the couple were not available?

Staff group members became involved in home visits during the second phase of the intervention. One member found this extremely enjoyable. She said, "This is what I like, to talk to the parents". Other members could see the usefulness of doing the home visits but were most concerned about the amount of time it took out of their off duty time. It emerged that they felt torn between the production work and the potential counselling. They agreed that they could do the counselling work but they felt that their current work demands were already excessive.

It was previously mentioned that the production demands of the workshop took precedence over training meetings after October. Christmas contracts which constitute the larger portion of the workshop's income had to be completed. The manager was most concerned about this. He mentioned that he felt the workers had a right to more counselling but that this would mean a lot of time out of production which would be against the workshop ethos.

I would like to comment briefly on the staff's working conditions as they are germane to the process of in-service training. Working with people with mental handicap can be very taxing (Craft & Craft, 1984). One member reported that, "at lunch time you need a rest" and another said it was hard to be with the workers eight hours a day. All members complained of being tired and were frequently ill (See Appendix A). The stress levels were clearly high: There appeared few opportunities to review people's

feelings; staff were paid very little and staff were undertrained for their jobs. They were not informed about the special difficulties of people with mental handicap. Members who had been working in the field for years asked to be taught how to approach parents. It can be seen that in-service training is essential but that the time constraints and staff overload make it impractical unless changes can be made in the existing structure.

I have mentioned that staff at the workshop were hired on the basis of their ability to supervise particular tasks, not their interest in mental handicap. The men in particular are hired for their wood working ability. This may be an explanation of the differing levels of interest in learning about training in sexuality between male and female staff.

In February 1993, I asked male and female workers if their level of knowledge had improved during the year. Most of the women felt they had learnt a lot and appeared more knowledgeable but only the male workers who had worked in the female section of the workshop had developed any new sexually related knowledge. Male workers from the male section of the workshop had not spoken as much with their supervisors about socio-sexual matters. This may have been a result of the male staff being uninterested in teaching but, it could also be explained by the fact that the male section was noisy and thus talk was not facilitated.

Evaluation

Evaluation is an ongoing process that occurs throughout any intervention. In this way evaluation can inform and change an intervention. It has already been mentioned that an evaluation of my personal style led to changes in how I interacted with the staff

group. An example of an evaluation that informed but did not change the intervention was that of discovering the sexual ignorance of staff group members. Reading matter was introduced unsuccessfully and time constraints made further changes in the intervention difficult. The writing up of this document is a form of evaluation that will hopefully inform future work in the field.

In this section I would like to emphasise how time affected the intervention, indicating the need for longitudinal evaluation in research. In addition I will evaluate the intervention in relation to achievement of aims.

As Turton remarked any intervention is an “educative and socialising process” (1986, p. 25). In the mental health model, success is measured by the adoption of certain values. The aims of the training intervention were to address the staff’s feelings of inadequacy; to enable them to talk more freely about sexual matters with the workers; to promote advocacy of the rights of mentally handicapped people to the staff; to encourage liaison with workers and parents; and to produce guidelines for workshops on socio-sexual issues.

In this particular intervention the perspectives of the staff toward the workers shifted. By the end of the weekly sessions they had stopped calling the workers “children”, indicating a raised consciousness. In addition they responded particularly to the material on human socio-sexual rights presented in the fifth session. One member said that before that discussion he “never gave them (people with mental handicap) a chance”. In the monthly sessions staff were able to think of people with mental handicap having sexual relations, being involved in the decision to have a baby or not, getting married

and were encouraging parents to do the same. The perception that people with mental handicap were oversexed was replaced by the understanding that they had not received appropriate socio-sexual behaviour training.

After the weekly sessions the staff reported feeling comfortable talking amongst themselves and with the workers about sexual issues. Previously this had been taboo. One staff member said "you've motivated some vibes". I was impressed when the staff were able to conduct the staff/parent meeting and facilitate discussion. Some of the staff were engaging the parents in socio-sexual talk about their offspring.

The content of the guidelines in Appendix B are a testament to the amount of work the staff did in their weekly discussions. They were able to point to many important factors in promoting the socio-sexual rights of people with mental handicap. An example of this was that I had tended to look at people with mental handicap as a homogenous group, the staff pointed out that workers meeting at the workshop were not always of the same class and that this led to tensions in relating.

The resource network of the workshop had also been extended. They were introduced to reading material and videos. There was some resistance to reading but they were keen to use the video material.

If this project had been evaluated for success in July 1992, the findings would have been unequivocally favourable. The aims of the intervention had been achieved. The staff were involving parents and wanting to present their guidelines to other workshops.

However, in the face of the production demands at the end of 1992, the enthusiasm for creating guidelines and promoting the socio-sexual rights of people with mental handicap waned. The shift in perspective on talking about sexuality, and people with mental handicap having socio-sexual rights remained. However the time and commitment required to continue to promote the rights of people with mental handicap was too great. Only one person remained enthusiastic about approaching parents and counselling workers. One other was angered that the guidelines were being ignored. These findings emphasise the importance of longitudinal evaluation and could possibly link with two effects commonly reported in organisational consultation literature. Farson (1966) reported that organisations and people are remarkably able to resist change and ascribed this to the fact that improvements in a system can make life more complex. It is also reported that organisations are able to absorb and transform interventions into familiar tasks (Manning, 1987; Selancik, 1979). The waning of interest from the staff members may be a result of reverting to familiar practice, or it may reflect resistance in the face of increased complexity.

This section attempted to make sense of the intervention process in terms of entry, planning and contracting, intervention and evaluation. Particular attention was paid to various influencing factors such as sexuality as subject matter, personal and interpersonal factors, and organisational effects.

SECTION FOUR - RECOMMENDATIONS

In the previous section, examples of the intervention process were reviewed in an attempt to make some sense of where the workshop intervention was successful and of where it fell short. In this next section I will summarise the previous discussion in order to justify the recommendations made. It is important to keep in mind that the consultation and intervention was participant action research and that it was intended to inform future intervention in the field. I will address organisational aspects first, and then sexuality training. Finally I will review my learning process in this intervention.

Thoughts about the social agency and the workshop system

In coming to a close, I find myself returning to a beginning in that I am compelled to think in terms of needs assessment. The most striking need in the workshop appears to be for some relief of the stress the staff are under. The frequency of staff illness and their constant reports of fatigue point to a real need. If the agency and/or the workshops are going to empower their staff and workers through education and democratic process as has been proposed, then some creative solutions will have to be found.

Farson (1966, p. 1) describes a healthy organisation as one which solves “the problems it sets out to solve”, achieves “the goals it sets out to achieve”, makes “an impact in its own field and on the community”. The social work agency involved in this intervention needs to assess whether or not the workshop system is doing the above. Farson (1966, p. 1) suggests that a “healthy organisation” is one in which people feel “honestly related to

each other and to the organisation itself; they feel influential; they are committed to the organisational goals and achieve personal growth and fulfilment in the course of contributing to them". Is this the case at the workshop?

The workshop staff are undertrained and overstressed. Basic information about mental handicap as well as basic counselling and problem solving skills need to be taught. A new system for staff training could usefully consist of more comprehensive and structured in-service training. The intervention described in this paper was initially framed in "spare time" and this was resisted. Once it became part of everyday duties it was better accepted. Without such structured training any future interventions made by interns are likely to repeat the pattern of initial enthusiasm and longitudinal loss of interest which is of questionable value. (Note: A new system of staff training was introduced in early 1993).

Some consideration should be given to the wishes of the staff as to how they would like to develop and in which areas. In this intervention the person who benefitted most from the training was the person who was most interested in the subject matter and thus most motivated. Other personnel benefitted (in the mental health model) in that they were exposed to material that caused a shift in their perspectives on both sexuality, and sexuality and mental handicap but, their motivation was externally imposed. They also learned some basic counselling skills. However, they did not seem to have a democratic forum where their needs could be explored and expressed.

The workshop system should possibly examine the ethos which appears oriented to "production", as reflected in the hiring of staff. Due to the inadequacy of facilities for

people with mental handicap there are many training deficits evident amongst the workers. Should the workshops not become more service oriented? A suggestion was made that a staff member should be freed from the constraints of production work in order to deal with counselling the workers and their parents. If a decision was made to free a staff member to work with socio-sexual issues this would entail that they receive support in the form of training and access to resources (Chapman & Pitceathly, 1985). Sanctuary (1983) and Brown (1992) suggest that in the field of sexuality staff should be selected to work in the area based on interest and suitability.

I commented in Section One that the agency resources were stretched over a wide range of activities. In Section Three this was exemplified in how the production of working guidelines was discontinued because of the difficulties of accessing the workshop network. The network was large and diverse. Meetings were difficult to set up because of the demands on each workshop and on the workshop coordinator. It could be said that control of satellite bodies by a central office disempowers the members of the satellite bodies. Perhaps, if some satellite bodies were more independent, then the number of meetings required to coordinate actions would be fewer, and more responsibility could be taken by them.

Thoughts about sex education in the workshop setting

The intervention described here was successful in addressing aspects of staff training in sexuality. Group discussions and exploration of personal feelings served to reduce the anxiety experienced by staff in talking about socio-sexual issues as was suggested by Johnson & Davies (1989). The material on human rights was very effective in altering

staff perspectives on sexuality and mental handicap, thus confirming the findings of Brantlinger (1983). Some counselling skills were taught in both phases. The practice gained in the second phase of the intervention served to build the confidence of the staff in their ability to relate to workers and their parents, concurring with research by Johnson & Davies (1989). However it might be advantageous for staff to receive training in the specifics of counselling at a later stage.

The programme was also useful in that at least some of the workers had benefitted indirectly from it. Sexuality had become a subject for discussion, at least in the female section of the workshop. Some gender consciousness raising may be in order. The segregation of the work within the workshop by gender may be an area for future change.

Communication between staff and parents was improved by the personal approach taken in the second phase of the intervention. However this was demanding on the staff and possible alternatives and accommodations should be explored.

A serious omission in the intervention under discussion was the lack of a basic sexual information programme. I recommend that a programme introducing essential concepts be given in future, regardless of the overt disclaimers about being sexually knowledgeable. In this way all persons involved in group discussions would at least be operating from a similar knowledge base. The people who are too shy to reveal their lack of knowledge will emerge early in the intervention. Johnson and Davies (1989) suggest that factual knowledge is a necessary requirement for staff to be able to teach others.

The programme under review, which consisted of exploration of sexual knowledge and feelings in a group setting, and practical hands-on learning of counselling was effective in training some staff to deal with socio-sexual issues in the workshop situation. The addition of a factual information package in the beginning would probably have made it more effective. The workers in the workshop were given access to sexually educative material and in this way were able to bring problems to the staff. It is hoped that through their improved knowledge of aspects of sexuality they will be able to avoid some exploitative situations.

It seems logical that any future intervention should be undertaken or coordinated by someone who can make a larger time commitment than a year to the agency or satellite body. It took eight months for the staff at the workshop to trust me sufficiently to stop pleasing me and to express their own needs and difficulties. An intervention carried out by a temporary agent, such as an intern, will have little effect on the overall system unless someone within the system is invested in continuing the work.

Thoughts from the student position

Coming from the mental health model, I had a prescribed normative agenda in this intervention which served to filter the process of consultation and intervention. In future I hope to be less prescriptive and thus become a better consultant (Farson, 1966; Schein, 1985; Whyte, 1991b).

Taping and transcribing the sessions allowed me to learn more about myself and allowed me to change and develop as a clinician. Reading and reflection allowed me to become

more certain of which models were applicable and the limitations of each. This was a good learning experience, but I regret that the service delivery to the staff group was not optimal, due to my undeveloped skills and inexperience. However, the best way to learn the “culture” of clinical consultation and intervention is to practice and in so doing make mistakes (Mollon, 1989, p. 114).

The supervision structure for interns at the agency placement bears some thought as it is both problematical and advantageous. The advantages in being supervised by the university staff are that the academic and critical aspects of one’s work are reviewed. In addition, supervisors are aware of one’s clinical development and can enhance this.

A problem arises in that the supervisor is not really in touch with what is happening in the organisation. In this intervention, this was ameliorated by the fact that the supervisor had insight based on her longitudinal perspective gained through consecutive supervisions and three years service at the agency. She was however dependent on material presented by myself. The paradox was that as a trainee, I was unaware of what I did not know and to which I was not paying attention. In addition, training demands did not allow much time for reflection (Kottler, 1991). Research of this nature should be conducted in teams if at all possible or at least with a partner (Manning, 1987). Team work would assist in the reflective process and in guarding against “self delusion” thus increasing the reliability of the data (Miles, 1990).

Postscript to fellow students

I would like to say that the work has been both enlightening and frustrating. I recommend the area of sexuality and mental handicap as an area which requires much

research, particularly in the South African context. When you make interventions reduce your expectations of what can be achieved and expect things to go wrong. If you are contemplating using a qualitative methodology please read “Doing Qualitative Research: Circles Within Circles” (Ely, Anzul, Friedman, Garner and Steinmetz, 1991) BEFORE you start.

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APPENDIX A - DIARY OF CONTACT

Thursday 30th January 1992

Met with university supervisor to discuss internship placement at agency. Possibility of working in area of sexuality and mental handicap introduced.
No record kept.

Wednesday 5th February 1992

1) Meeting of special interest group at agency. Proposed to become involved at one of the protective workshops in sex education with a view to assisting in prevention of sexual abuse. Informed of channels for processing of proposal and gaining permission.
Minutes kept.

2) Immediately following on the above meeting. Meeting with the workshop coordinator. We discussed the possibility of exploring sex education and promotion of the socio-sexual rights of mentally handicapped workers. She suggested the venue and agreed to meet me there the next day and introduce me to the staff.
Notes kept.

Thursday 13th February 1992: 2,5 hours

Visit to Workshop. Coordinator absent.

Introduced myself to the staff. Five permanent staff members in all.

Informal interviewing of female workers to ascertain level of sexual knowledge.

Notes kept.

Monday 17th February 1992: 1,5 hours.

Return to workshop. Informal interviewing of staff and male workers.

Notes kept.

Tuesday 18th February 1992

Supervision with supervisor.

Notes kept.

Thursday 20th February 1992

Telephone call from myself to workshop manager. Arranged contract meeting for 28.2.1992 in liaison with workshop coordinator. (Later changed to 6.3.1992).

Notes kept.

Friday 28th February 1992

Supervision. Explored the manner of analysis of research. Considering a questionnaire.

Notes kept.

Thursday 5th March 1992

Telephone call from myself to workshop coordinator. Progress report and confirmation of meeting the following day.

Notes kept.

Friday 6th March 1992: 14.30 - 15.30.

Meeting in female workroom at workshop. All staff present as well as a new staff member. Coordinator and assistant present. Proposal outlined. Contract re time commitment and subject matter. Aim of working toward socio-sexual guidelines for all workshops set. Staff agreed to be part of research process.

Notes kept.

Tuesday 10th March 1992

Supervision.

Notes kept.

Wednesday 11th March 1992

Presented a synopsis of research proposal to the special interest group at agency.

Permission given to continue.

Minutes kept and synopsis.

Tuesday 17th March 1992

1) Supervision. Decision made to use qualitative research methods (PAR) and not experimental methods.

Notes kept.

2) Supervision with both supervisors. Review of research proposal. Suggestions made for further resources.

Notes kept.

Thursday 19th March 1992: 08.30 - 09.30

1) Attended the introductory session at Workshop. Decision made to meet in manager's office. Started on time but had to finish early (09.05), as workers arrived for work. Discussed why sex education necessary and explored individual's experience of sex education. People were uncomfortable and norms of confidentiality and openness were discussed.

Taping was introduced but the machine did not work. Notes kept.

Tuesday 24th March 1992

Supervision.

Notes kept.

Thursday 27th March 1992: 08.30

Visit to Workshop. Three staff members ill and at home. Two staff members present also ill. Meeting cancelled. Informed that a sister from the family planning clinic would be coming to give lectures at the workshop in April.

Monday 30th March 1992

1) Supervision. Advised to contact workshop coordinator to delay the family planning talks.

Notes kept.

2) Telephone call coordinator. Requested permission to delay the Family Planning input until June. I asked about the availability of video equipment - to be loaned from other Workshop. Notes kept.

Thursday 2nd April 1992

1) Telephone call to coordinator. Confirm which agency Social Worker worked at the workshop.

2) Telephone call from myself to workshop staff. Inform that family planning lectures should wait until June.

Friday 3rd April 1992: 14.00 - 15.00

Second session at workshop. Started 15 minutes late, finished late. One staff member had resigned. All other staff present. Discussed menstruation and virginity. Religion and sexuality. Gender differences in perspectives were noted.

Notes kept. Tape machine not working.

Friday 10th April 1992: 14.00 - 15.00.

Third session. Commenced half an hour late. Two staff members were called away to an emergency manager's meeting. Meeting proceeded anyway. Sexual language was discussed. People were uncomfortable again. Agreement made that those present would feed back to those absent. Photocopies of chapters in "Sex Education and the Intellectually Handicapped" by Fegan and McCarthy (1984) given out

Audio-taped. Notes kept.

Tuesday 14th April 1992

Supervision with both supervisors. Proposal discussed with attention to data collection. Notes kept.

Tuesday 21st April 1992

Telephone call to workshop to remind them of meeting and the importance of reading before then.

Notes kept.

Friday 24th April 1992: 14.00 - 15.00

Started 15 minutes late. One group member absent. Other staff were required at a meeting at another workshop at 15.00 hours so the meeting was cut short to 14.45.

No-one had done any reading. Staff requested feedback from the evaluation sheets.

There were complaints that no progress was being made. Nothing from the agenda was covered. Time of meetings changed to Thursday mornings.

Tuesday 28th April 1992

Supervision. Possible I was overinvolved i.e. controlling.

Notes kept.

Thursday 30th April 1992: 08.15 - 09.15

Fifth session at workshop. All staff present but one member very ill. Three group members had done some reading. Socio-sexual rights of people with a mental handicap were read and discussed with a view to guidelines.

Audio-taped and notes kept.

Wednesday 13th May 1992

Presented a progress report to the special interest group.

Documented.

Thursday 14th May 1992: 08.15 - 09.15

Sixth session. Discussed how to approach workers in the context of current problems at the workshop e.g. masturbation, public touching, aggression. Discussed how to approach parents. Concerns about time mentioned. Went over time by 15 minutes.
Notes kept.

Thursday 21st May 1992: 08.15 - 09.15

Seventh session. Fifteen minutes late. Discussed the problems of relationships for people with mental handicap and how to involve parents in education.
Audio-taped, notes kept.

Thursday 28th May 1992: 0815 - 0915

Eighth Session. New staff member - a temporary but possibly permanent supervisor. He joined the sessions, invited by the other staff. Guidelines, written up by myself based on the previous discussions, were read and altered. Much discussion was generated about how to involve parents. Relationships amongst people with mental handicap were discussed again, focusing on marriage, family planning, motivating parents and respecting individuals.
Audio-taped and notes kept.

Thursday 4th June 1992: 0815 -0915

Ninth Session (last in first series). Manager absent, had to get the workshop car fixed. Discussed plans to introduce guidelines to parents, to workers and to other workshops. Practical preparation for discussion with coordinator. Explored fears of how guidelines would be received.
Audio-taped and notes kept.

Tuesday 23rd June 1992: 10.30 - 11.30

Presentation of guidelines to coordinator and social worker. Lively discussion. Permission given for staff to do home visits and to get involved with counselling to the level they were both able and comfortable with. Coordinator agreed to coordinate a meeting of staff from all workshops for further presentation of guidelines. Audiotaped and notes kept.

Friday 26th June 1992: 14.00 - 15.00

I arrived late (14.30) due to a patient crisis in my placement but had telephoned. Meeting was set up to choose video to show parents. Crossed wires. Staff anxious to leave as it was end of month. Staff agreed to organise agenda for parents meeting without me and to choose a video without me.

Tuesday 7th July 1992

Telephone call from me to workshop to discover where meeting was. Video selection was discussed and manager brought me up to date on the expected agenda.
Notes kept.

Saturday 11th July 1992 : 15.00

Meeting started one hour late as venue was locked and everyone had to return to the workshop. Coordinator was on holiday. Two staff members were absent. Social worker present to meet parents. Manager greeted and introduced the topic and video called "Loving Parents" about the pros and cons of sex education. A staff member read the socio-sexual rights of people with mental handicap. This was generally well received but 5 people fell asleep during the video. Parents began to discuss their own difficulties with educating their sons and daughters and requested more information. None of them were drawn to the idea of being part of the working team that drew up permanent guidelines. Meeting ended at 17.45.

Notes kept.

Tuesday 21st July 1992: 08.15 - 09.15

First of problem solving meetings. One person ill. Reviewed parent meeting, feedback generally supportive. Team divided into pairs and chose to work with particular couples or persons exhibiting relationship difficulties from amongst the workers.

Notes kept.

Tuesday 25th August 1992: 0815 - 0915

Second problem solving meeting. All staff present. Discussion of how approaches to parents and workers of chosen cases had gone. Next steps decided on.

Notes kept.

Tuesday 22nd September 1992: 0815 - 0915

Third problem solving meeting. Four out of five staff members felt ill. Progress reported. One case dropped due to changed circumstances. Discussion of sexual abuse. Audio-taped and notes taken.

Tuesday 13th October 1992

Supervision. Production demands at workshop noted.

Notes taken.

Tuesday 20th October 1992: 08.15 - 09.15

Fourth problem solving meeting. Very late start - 20 minutes. Little progress made on case work due to ill health on the part of staff. Process reviewed, feelings and problems of the attempts to do case work discussed at length. Production demands looming as well as prospective move to new premises. Staff member to be transferred out. Next session postponed until January. Agreed to visit socially before Christmas.

Friday 18th December 1992

Telephone call from myself to manager. Workshop closed so I could not visit. He would call me in January.

Thursday 29th January 1993

Telephone call from myself to manager to set up termination meeting for 2.2.1993.

Tuesday 2nd February 1993: 08.15 - 09.00

Termination session. Moved to new building. I brought banana loaf for all the workshop members. They gave me a spice rack as a Christmas gift. We reviewed the workshops from last year. Each person gave an account of what was useful and what

was problematical. Plans were made to present guidelines to other workshops and to start teaching the workers about their rights. I chatted informally with some of the workers.

Audio-tape became inaudible once workers arrived. Notes kept.

Monday 1st March 1993

Telephone call to manager. No progress made with guidelines. Staff member ill.

APPENDIX B - WORKING GUIDELINES FOR SEXUALITY TRAINING

We, the sexuality working group at Workshop, accept that people with mental handicap have the same rights as other human beings. We think it is important to emphasize the sexual and relationship rights of adult persons with mental handicap, in order to improve their quality of life. We have identified sexuality training as necessary for people with mental handicap because: a) issues relating to sexuality are part of the daily living problems that we as protective workshop staff encounter everyday amongst the mentally handicapped workers; b) sexuality training is an area that is often neglected for people with mental handicap; c) sex education is a preventative measure that is necessary in protecting people with mental handicap from sexual abuse, sexually transmitted diseases, and unwanted pregnancy.

We believe that people with mental handicap have the following sexual and relational rights:-

- the right to opportunities to love and be loved.
- the right to be taught about their bodies and to be helped to an understanding of what is appropriate social-sexual behaviour.
- the right to knowledge about sexuality that takes into account their own level of development and comprehension ability.
- the right to socio-sexual training that will allow them greater social contact and more opportunities for relating but, which will help them to avoid exploitative situations and relationships.
- the right to learn to be responsible for their sexual behaviour in such a way that is acceptable to other people and to the law.
- the right to be helped to find appropriate sexual expression. (This will vary from hand holding to mutual sexual fulfilment)
- the right to information and help with birth control which meets their *personal* needs and circumstances.
- the right to marry or live together, and to receive support for maintaining that relationship.
- the right to be involved in a decision to have a child or not with the appropriate advice, guidance and information. We note that supporting parents also have rights in this area.

- the right to supportive services with the goal of achieving realistic personal development.

We understand that these rights are not being promoted in our particular community of people with mental handicap. As a result, we have noticed that our workers are having relationship difficulties and are vulnerable to sexual exploitation and abuse. We have decided that steps must be taken to change this. A primary goal is to educate workers in a useful way about sexuality and relationships.

It has been shown that people with mental handicap learn best from people they care about. They need to be taught regularly on a day to day basis, small amounts of information at a time. Learning is facilitated when the experience is real and in the present.

Who should be involved?

We feel that we, as staff who work with mentally handicapped people on a daily basis, should be involved in promoting these rights.

We feel that the mentally handicapped people themselves should be informed of their rights and helped to implement them.

We feel that parents who are often the primary caretakers of people with mental handicap, and who also have rights, should be involved in socio-sexual training.

It would be useful for members from all three of the above groups to be involved in drawing up a policy statement on sexuality training. Such a process may require the presence of a person representative of CMHS as well. A common language (terminology) must be established to avoid conflicting messages being given to the mentally handicapped worker.

Problem...

Sexual issues are not discussed freely and openly on a day to day basis. This can be changed by conscious effort once permission has been given for such talk. This has to be motivated from the example set in other countries where human rights are promoted.

Thoughts on approaching parents....

- they are likely to be resistant to thinking about their "children" as adult sexual beings: A strategy of prevention of abuse and pregnancy might be motivating.
- feelings and fears of parents will have to be accepted and discussed.
- many may not even be interested, but even a few are enough to start with.
- they will come from differing religious and cultural backgrounds and this must be respected.
- parents may not have the socio-sexual knowledge necessary and may need to be educated themselves.
- efforts toward sex education and assertion of rights will have to be coordinated between parents and staff so as not

to confuse the worker (refine)

- working parents may not have time to attend meetings or workshops, perhaps home visits would suffice

Thoughts about workers.....

- they need education on their rights
- their special needs must be taken into account
- sometimes parents or other caretakers will be accountable for the actions of a mentally handicapped worker and thus mutual responsibility should be negotiated.
- socio-sexual behaviour and training should be recognised as part of the daily programme to avoid creating "problem" situations.
- privacy does not seem meaningful to the workers and may have to be taught

Thoughts about staff....

- do we have enough time to get involved? we are already.
- do we have permission to get involved?
- do we need more training before getting involved in training others? i.e. in the areas of sex education, counselling, skills training.
- we have experienced some anxiety about sexual issues and about talking about sexuality. This has reduced with practice.
- what are our rights in the situation?
 - to refuse to get involved in socio-sexual training if preferred
 - to have more in service training
 - to receive more responsibility and trust from parents and the hierarchy of the agency.
 - to receive support from the agency
- perhaps we need to emphasise that workers have a right to supportive services in order to motivate for more staff with functions that are not only production related.
- we can be important agents in advocating the rights of people with mental handicap.

Practical guidelines....

- rather do a little work thoroughly than a lot of work badly
- use other resources

Direct problem solving.....

- deal with crisis as best you can
- deal with the problem when it happens
- before doing anything else including reacting emotionally yourself, assess the whole situation e.g. what has happened

from the perspective of all concerned? is this really a problem? what is the meaning of the problem for all concerned? what other factors are influential here?

- acknowledge people's feelings
- ask others how they would like to solve the problem generating as many solutions as possible.
- negotiate around that
- separate the behaviour from the person i.e. a person who behaves badly is not necessarily bad
- once drawn up - use policy statement and the rights of mentally handicapped people as the basis for judgements and decisions.

Please note that this is a working document that is subject to alteration with further exploration.