The website http://www.sexualaufklaerung.de focuses on presenting media from the area of sexuality education, contraception and family planning. The web pages provide an overview of publications on current and completed studies, expert papers, examinations, campaigns and pilot projects addressing various target groups.

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The BZgA's regular information service, FORUM Sexuality Education and Family Planning, is also introduced in detail and offered for download. The abridged versions of studies and repeat surveys are also available online. The series Research and Practice in Sexuality Education and Family Planning has published more than 20 items to date and is being continually expanded. Several volumes are no longer available in print, but they are available in electronic form.

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- Women's health and promoting health: literature, data, organizations
- Prenatal diagnostics and an unfulfilled desire for children: information materials, educational brochures, media, measures
- Sexual development and an unfulfilled desire for children: information materials, educational brochures, media, measures
- First experiences and contraception: information materials, educational brochures, media, measures
- Sexual development and preventing pregnancy: information materials, educational brochures, media, measures
- Sexual development and an unfulfilled desire for children: information materials, educational brochures, media, measures

Youth Sexuality and Disability
Results from a survey carried out at special-needs schools in Saxony

Publisher: Bundeszentrale für gesundheitliche Aufklärung
BZgA


Youth Sexuality and Disability
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Study

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Youth Sexuality and Disability

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Results from a survey carried out at special-needs schools in Saxony

Study

Research and Practice in Sexuality Education and Family Planning

Research and Practice in Sexuality Education and Family Planning

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Study

Research and Practice in Sexuality Education and Family Planning

The study series Research and Practice in Sexuality Education and Family Planning documents surveys and expert reports as well as results from pilot projects. The individual volumes reflect the current state of research as well as presenting developments and results. The spectrum of subjects ranges from addressing fundamental questions to discussing selected topics and supporting practical work. Multiples of useful material for their work as well as for initial, advanced and in-service training purposes.

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Results from a survey carried out at special-needs schools in Saxony

by Sabine Wienholz, Anja Seidel, Marion Michel, Martina Müller

With the collaboration of
Monika Häussler-Sczepan, Christina Schiller

Sponsored and commissioned by the
Bundeszentrale für gesundheitliche Aufklärung
Cologne 2013
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With the support of
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Client
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Preface

‘Sexuality education and disability’ has been a new working focus of the Bundeszentrale für gesundheitliche Aufklärung (BZgA) since 2010. The basis for this is a resolution by the Bundestag (the German parliament) to create target-group-specific sexuality education and information material and to focus more on the sexuality education of people with disabilities. In addition the hope is that public will be sensitized to the subject via suitable campaigns and projects. Scientifically based data are indispensable for the development and provision of sex education services as well as target-group-specific sexuality education. However, with respect to sexuality, there are hardly any studies about how well informed young people with disabilities are, about how they experienced their first sexual intercourse, or what contraception they use. There are significant research gaps here, both nationally and internationally.

That is why the BZgA commissioned the pilot study ‘Youth Sexuality and Disability’ in 2010. The study’s central concern is to analyse and describe the attitudes and behaviours of young people with disabilities towards sexuality education, sexuality and contraception. 169 special-needs school students from Saxony with physical disabilities and hearing and visual impairments were surveyed for this pilot study between December 2010 and May 2011. They were between 12 and 18 years of age. With reference to the BZgA’s representative survey on youth sexuality, a similar questionnaire was developed, bearing in mind the criteria of disability-friendliness. Using this tool, the survey determined the young people’s knowledge about sexuality, their current sexual activities, the nature of the sexuality education received in the home and at school as well as the extent of contraceptive use.

The survey results documented in the present publication reveal both the competences and resources as well as the deficits experienced by the young people with disabilities with regard to sexuality education and contraception. The results provide plenty of ideas for practical application. The study therefore makes a contribution to the implementation of the UN Conventions regarding the participation of people with disabilities.

In spring 2012 the research team presented the results as part of an expert symposium in Leipzig. Many experts from advice centres, sexual-education specialists, teachers, representatives of associations, politics and academia as well as the participating schools discussed the results of the pilot study and confirmed them. The lectures and summaries of the workshops that were held, as well as information about the participating experts, can be found online at: www.forschung.sexualaufklaerung.de.

Bundeszentrale für gesundheitliche Aufklärung

Cologne 2013
Introduction

In the past, ‘disabled’ people were often not considered fully human, especially not in their various social roles. Even in the 1990s the opinion that people with disabilities did not have sex lives was widespread. As a result they were perceived as particularly child-like and innocent, as asexual.\(^1\)

Especially boys and men with disabilities were said to have a lack of control over their sexual urges, or they were said to be obsessed with sex.\(^2\)

The dominant image was that of a disabled person without a partner, who was dependent on the care of his/her original family and/or the state, without being him/herself obligated to provide care. The teacher and former director of the Bildungs- und Forschungsinstitut zum selbstbestimmten Leben Behindertes (Education and Research Institute for the Self-determined Life of People with Disabilities), Gisela Hermes, commented on this issue in her dissertation:

‘Sexuality, relationships and parenthood were aspects of life denied to people with disabilities in the past, because it was socially undesirable for a group of individuals considered a burden on society to reproduce.’\(^3\)

The literature often describes close family ties between disabled young people and their parents, to the extent of over-protection and infantilization.\(^4\)

This over-protectiveness has consequences for the development of these young people: young people who felt over-protected reported being less happy, to have less of a feeling of self-worth, to be less popular, and to be more fearful.\(^5\)

All of these factors influence their relationship to sexuality, the way they acquire and process knowledge and, as a result, their sexual behaviour. One aspect associated with this is the inadequate social integration in peer groups. This lack of social integration, symbolic of all aspects of peer relationships, is even considered a problematic health factor.\(^6\)

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2. Alemu/Fantahun 2011
3. Hermes 2003
4. Stevens et al. 1996, Alriksson-Schmidt et al. 2010
5. Stevens et al. 1996
6. Stevens et al. 1996
It is particularly difficult for people with physical disabilities to build and maintain social, intimate and sexual relationships. In addition personal-care dependence on others can be associated with boundary transgressions such as the violation of privacy.

Relationships, sexuality and family planning are subjects which children and young people have to confront as part of development during adolescence. This confrontation is more difficult for girls and boys with a disability, because the conditions for making contact with peers of both genders, for the emotional detachment from parents, and for the acceptance of their own bodies can be tougher as a result of their disability. The parents too pay less attention to this aspect of their children’s development than they do to their educational and professional development. Sigrid Arnade portrays twelve disabled women in her book ‘Weder Küsse noch Karriere’ (Neither Kisses Nor Career). They have in common that girls with disabilities were evidently raised by their parents under the following motto: ‘If you’re not going to have a partner, then at least you need a good job.’ The parents’ ambivalent feelings played a big role. On the one hand mothers of disabled children assume they are the most important reference person for the child. They have a tough time accepting that their child is becoming independent. On the other hand they worry that they themselves will have to bear the additional burden of a grandchild.

1.1 The current state of research/need for research

In the past there was almost no information about the sexual activities of disabled young people, about their attitudes to and knowledge of sexuality, or about the influence of the nature and severity of their disability on their sexual development. It has only been in the past 40 years, as a result of medical progress, that the life expectancy of people with congenital disabilities such as spina bifida and cystic fibrosis has increased to allow sufferers to live to be adults. This explains the late awareness of disabled and chronically sick people as sexual and fertile beings. Even in 1976 Dorner wrote:

---

7 Wiegerink 2008  
8 Hermes 2003  
9 Michel/Häußler-Sczepan/Riedel 2003  
10 Arnade 1992  
11 Spina bifida: lit. ‘split spine’, which can cause paraplegia or partial paralysis and affect motor skills and sensitivity and have an impact on mental performance (cf. Haupt 2006)  
12 Cystic fibrosis: metabolic disease associated with the increased production and viscosity of glandular secretions (lungs, intestines). This can lead to respiratory and metabolic complications (cf. Pschyrembel 2004: 570).
Even now there are still not many surveys addressing the sexuality of young people with disabilities, and this is true at both national and international level. There is not much reliable data, since the people affected were usually excluded from quantitative surveys, studies to date have only had small sample groups, or the surveys look solely at people with mental disabilities.

Young people with disabilities are still largely excluded from scientific, quantitative, written surveys, because the survey designs are not tailored to their disability. People with visual impairments cannot read what is written, people with hearing impairments have a different language understanding from people who can hear and cannot interpret what they read (e.g. the term ‘crisis hotline’), while people with learning disabilities often do not understand the more complex questions.

1.2 Research aims and questions

The goal of the present study, sponsored by the BZgA, is to use a survey tool that meets the requirements of the guidelines on disabled-friendliness to create a data situation on the basis of which statements can be made about the sexual knowledge and contraceptive behaviour of young people with disabilities. This has happened via a survey at nine special-needs schools and two vocational training centres in Saxony where young people with physical disabilities as well as visual and hearing impairments were questioned. The questionnaire used in the BZgA study on Youth Sexuality was to be the basis of this current survey.\(^{14}\)

The study can thus make a contribution to the development of specific sex-education services that meet the needs of disabled young people and support the implementation of the UN conventions on the inclusion of people with disabilities.

\(^{13}\) Dorner 1976: 439

\(^{14}\) Representative repeat survey of 14–17-year-olds and their parents, cf. BZgA 2010
As was the case in the nationwide Youth Sexuality survey, the present survey focused on the following subjects:

- sexuality education (people, subjects, contraceptive knowledge)
- physical development (body image, first period, first ejaculation)
- sexual activity (petting, sexual intercourse, degree of acquaintanceship of the partner, experience, number of partners)
- contraception (measures, application, advice)
- desire for children
- homosexual experiences
- experiences with violence

Specifically, a number of research questions were raised:

- In what manner do disabled young people get their sexuality education? What are their primary sources of information and how does their concrete knowledge express itself within the different disability groups?
- Can distinctive features be identified with regard to the physical development and self-perception of young people with disabilities?
- What sexual experiences do disabled young people report having had? What data is there with regard to the time when the sexual experience took place and the degree of satisfaction about that time, as well as with regard to the level of acquaintanceship with the partner?
- What is the contraceptive behaviour of young people like with regard to implementation and frequency of use?
- What attitudes do disabled young people have regarding teenage pregnancy? How do they express their desire to have children? What experiences do they report?
- What experiences with homosexual contact do they report?
- Are there experiences with sexualized violence?
• In what way can the results be incorporated into specific sex-education services for schools and outside of schools to meet the needs of these groups of young people (e.g. using the internet)?

• Can consequences be drawn for the support of parents of disabled children and young people for the tolerant handling of their children’s sexuality?

1.3 Structure of the Report

The report is subdivided into three parts. In the first part the fundamentals of the study are presented. → Chapter 2 addresses the disability-specific backgrounds pertaining to the subjects’ living environments. It sketches the current view of disability, which has changed over time. It goes into legal aspects, such as the right of participation and general principles of equality, but it also casts light on the perspective of the research community. In addition the specific characteristics of the various types of disability are explained, and different educational forms for children and young people with disabilities discussed. → Chapter 3 deals with the starting situation in Saxony: in addition to statistical data on severely disabled people in Saxony, this chapter introduces the school system in the state and looks at the various school types for students with special educational needs.

In the second part → Chapter 4 first explains the design of the study. Special attention is paid here to the design of the questionnaire, which took the needs of people with different disabilities as its guideline. → Chapter 5 presents the results in detail, structured according to the aforementioned sets of questions. In → Chapter 6 the results of the present study are contrasted with comparable results obtained from non-disabled young people. To do this, the partial sample of the respondents in Saxony from the BZgA’s nationwide representative survey on Youth Sexuality15 was drawn on.

In the third part, recommendations for action are deduced from the results. → Chapter 7 gives recommendations for the contents and availability of sex-education services for children and young people with disabilities, taking parents as well as educational, medical and therapeutic experts into account. → Chapter 8 highlights further areas in need of research and issues recommendations to policy-makers.

15 BZgA 2010
1.4 Important results at a glance

Between December 2010 and May 2011, 104 boys and 65 girls with physical disabilities, or visual/hearing impairments aged between 12 and 18 at nine special-needs schools and two vocational training colleges in Saxony were interviewed in the context of this survey. The questionnaire that was used took into account the requirements of disability-friendliness. It was tested in advance for its suitability for people with different disabilities. It contained questions from the BZgA study on Youth Sexuality as well as a number of disability-specific questions. Below is an overview of the most important results:

**Sexuality education**

- Two-thirds of the young people felt they were sexually educated, although the girls struggled more with estimating their knowledge. The school as a place of passing on sex-education content was the top source, regardless of gender and the nature of the disability. The other media, on the other hand, are used to varying degrees. There is a connexion between the disability and the accessibility of the medium. When asked about their preferred sex-education media, the young people preferred face-to-face situations, digital media and print media (especially free sex-education brochures).

- Sex education in schools is clearly dominated by biologically oriented topics, i.e. teachers focus on the structure and function of the sexual organs, on physical development, the menstrual cycle, pregnancy, sexually transmitted infection and contraception. Socio-ethical subjects such as the diversity of sexual manifestations are much less common. The participants were much more interested in subjects that were not, or only rarely, taught in class. → Chapter 5.2

**Contraceptive advice**

- More than half of the young people have already had a talk about contraception in the home. Condoms and the contraceptive pill are the most commonly suggested contraceptive options; other contraceptives receive little mention at home.

- Around one in three girls has sought advice from a gynaecologist regarding contraception. The Pill was recommended by doctors across all age groups, making it the most commonly recommended contraceptive option, more common even than condoms.

16 BZgA 2010
17 More information about the survey design cf. → Chapter 4
• The ‘morning-after pill’ as a form of emergency contraception is known to the majority of young people with a disability. They primarily obtain their information from school and their family as well as from the media. → Chapter 5.2.6

Body image
• Young people all feel quite positive about dealing with their bodies; they are quite satisfied with them. Overall, older adolescents are somewhat more critical of their bodies than the younger respondents. Those with a hearing impairment had the most positive body image among all the respondents, while those with visual impairments were most commonly dissatisfied with their appearance. The girls got their first period between the ages of 10 and 15, with the most common ages being 12 and 13. The boys experienced their first ejaculation between 7 and 16, with around half of the boys experiencing their first ejaculation before turning 15.

• Only around half the girls have been to a gynaecologist; girls with a physical disability were the least likely to have gone. Three-quarters of the girls were 14 or older when they went to see a gynaecologist for the first time. The most common reason cited for going to see a gynaecologist was contraceptive questions, followed by menstrual and lower-abdominal complaints. → Chapter 5.3

Relationships and sexual activity
• Two out of five of the young people are currently in a steady relationship, excluding the visually impaired boys, where only around a quarter have a steady girlfriend. More than two-thirds of the young people who have already experienced their first sexual intercourse are currently in a steady relationship.

• The proportion of young people who have not yet had any sexual contact with the opposite sex (or the same sex) is around a quarter. The main reasons given for this sexual inexperience are the absence of the right partner, followed by personal shyness and the fear of doing something wrong.

• Around three out of four young people have already kissed. Both older girls and older boys have had significantly more experience with breast and genital petting than their younger counterparts.

• Around one in four 14–18-year-olds with a disability have already had sexual intercourse; in the 15–18 age bracket the proportion is around a third. There are around twice as many boys as girls who have had sexual intercourse experience.
• Young people with a disability struggle to estimate the percentage of peers who are already sexually active. 14-year-olds and older adolescents, especially the ones with sexual-intercourse experience, tend to overestimate the number of sexually experienced peers.

• Regardless of the nature of the disability, more than half of the boys had masturbated in the past twelve months. Among the girls the percentage was under 20%.

• Around one in five girls and one in ten boys with a disability have had homoerotic or homosexual experiences.

• The boys with a disability tend to become sexually active earlier than the girls. While the boys tend to experience their first intercourse in a steady relationship, this is not a requirement for the girls. In the majority of cases the first time happened because both partners wanted it and it was a positive experience. More than half of the young people feel they made their first sexual experiences at the right time.

• More than a tenth of the disabled young people have been affected by sexualized violence. Girls are twice as likely to have been affected as boys; the most vulnerable group are young people with hearing impairments. The perpetrator is usually from the immediate social group. In most cases the attack could be fended off. \textit{Chapter 5.4.4}

\textbf{Contraception}

• Nine out of ten young people used contraception when they had intercourse for the first time. Two-thirds of the respondents used a condom on this occasion, while almost a third used the contraceptive pill.

• The few respondents who did not use contraception when they first had intercourse cited as reasons the spontaneity of the situation as well as the fear of buying condoms, and of the subject of contraception in general. \textit{Chapter 5.4.2}

• During the most recent sexual intercourse only a third used condoms while the percentage using the Pill almost tripled.

• More than half of the sexually active young people always pay very close attention to contraception, while the same is true for less than a third of 15-year-olds. \textit{Chapter 5.4.3}
Prospects for the future and the desire to have children

- Career orientation is a central life goal for disabled boys and girls, followed by having their own flat, having a relationship and having a wide circle of friends. The probability of achieving the goals is estimated to be less than the desire for them, especially with regard to getting the job, the flat and financial security. → Chapter 5.5

- The notion of getting pregnant/fathering a child right now was regarded as a disaster for around half of the young people, especially for the girls. Girls with a hearing impairment were the most tolerant of a pregnancy during the teenage years. Compared with the girls, the boys had an overall more positive attitude to a pregnancy during the teenage years. → Chapter 5.6

Comparison with young people without a disability

- The comparison group consisted of young people between the ages of 14 and 17, residing in Saxony and not attending a special-needs school. In the sample description it becomes clear that the young people without a disability had a higher average age and were more likely to be living with one or both of their biological parents. → Chapter 6

- Talking about sexuality does not cause noteworthy problems for most young people either with or without a disability. When distinguishing by gender it becomes clear that boys with a disability have fewer problems talking about sexuality than boys without a disability. It is exactly the other way around for the girls. At first glance there is no clear difference between the two groups in the choice of confidants either. The best friend is the most important confidant in both groups with regard to sexual matters. The mother is in second place; among the girls with no disability the mother was cited almost as often as the best friend. → Chapter 6.1

- Around a quarter of the 14–18-year-olds with a disability and around four out of ten of the 14–17-year-olds without a disability have already experienced sexual intercourse. There are clear differences between the genders. Among the disabled young people, the percentage of sexually experienced boys is almost as high as that of the girls. Among the non-disabled young people, the girls are the more sexually active. There are differences regarding the age of first intercourse between the groups too. Among the non-disabled young people, three quarters were over the age of 15, among the disabled young people the same is true for somewhat more than half. → Chapter 6.7
• Young people with a disability exhibit a very similar contraceptive behaviour the first time they have intercourse as their peers without a disability. More than four-fifths of the young people with and without a disability used contraception on this occasion time. Condoms were the most commonly chosen contraceptive. Among the disabled girls, four-fifths chose condoms. → Chapter 6.8

• The question about the desire to have children gets different responses from the two genders as well as in the two different survey groups. Around nine out of ten non-disabled girls have an explicit desire to have children. Among the young people with a disability, around one in five did not want children at the time of the survey. Only around half as many disabled young people as non-disabled young people had developed a definite desire to have children. → Chapter 6.9
The Basics

2 Disability-specific backgrounds pertaining to the subjects’ living environments

3 The initial position in Saxony
Disability-specific backgrounds pertaining to the subjects’ living environments

‘It is not just a question of scientific categorization how disability is defined and who is called ‘disabled’. The dominant understanding of disability in society has consequences for the women and men considered ‘disabled’ as well as for their life circumstances. In the general scientific discussion a development is taking place across the disciplines, which can be characterized as a turning away from a purely medical, defect-oriented understanding and a turning towards a perspective that also integrates dependence on society and the environment.’

The change of perspective regarding disability was established in law with the introduction of the International Classification of Functioning, Disability and Health (ICF) in 2000, the SGB IX and the BGG, although elements of the deficit-oriented view of disability can still be found among the general public and also among experts such as medical staff, teachers and the staff of youth welfare and social services offices as well as in institutions working in disability aid. The academic analysis of the changed view of disability occurs largely in the interdisciplinary area of disability studies. It describes disability as a social, cultural and historical construct. Insights emerging from disability studies also provided the foundation for the UN Convention on the Rights of Persons with Disabilities. In this convention, disability is viewed as one mode of existence in the diverse human spectrum. It also makes the demand for an inclusive society. According to the convention’s goals, every person, regardless of his/her disability, should have ‘full and effective participation and inclusion in society’, including ‘in all matters relating to marriage, family, parenthood and relationships’.

19 International Classification of Functioning, Disability and Health
20 Neuntes Sozialgesetzbuch 2001 (Code of Social Law, Book 9)
21 Law on ensuring the equality of disabled persons (Behindertengleichstellungsgesetz) 2002
22 Waldschmidt/Schneider 2007
23 UN Convention on the Rights of Persons with Disabilities 2006
24 Ibid., Article 23
Being disabled usually has far-reaching consequences for the people affected. They partly stem from the cause, nature and severity of the disability and partly from the people’s living conditions. For parents, the birth of a disabled child or the onset of a disability in infancy as a result of a serious illness or accident means the wish for the ‘perfect’ child remains unfulfilled. For the near future they ask themselves how they can cope with the demands of looking after the disabled child, how they can structure their everyday lives etc. In the longer term, the questions focus on how the child will find its way into the adult world and where its place in the world will be. Children with disabilities will develop in an environment that will have a supporting or inhibiting effect on the confrontation with the personal circumstances and on the nature of their participation in life in the community. Similar disabilities can have very different effects on taking advantage of participation opportunities, depending on the concrete living conditions of each individual, because in addition to the biological and medical dimension, disability also always has a cultural, historic and social dimension.

This approach, of defining disability by looking at living environments, does not primarily look at a person’s functional limitations from a deficit perspective anymore; instead it describes resources and the potentials of disabled people in the confrontation with their own life circumstances. Focusing on the living environment is also a central paradigm in the work with children and young people.\textsuperscript{25} It is especially under the aspect of social injustice and the resulting unequal development opportunities that the concept of living environment captures the entirety of the cumulative effects of the plus and minus factors for a child’s socialization. Disability is just one, albeit usually a very significant, part of the living environment or circumstances.

**Definition of living environment**

The living environment is a person’s subjective construction of reality, a construction a person forms in his/her circumstances. The circumstances are defined as a person’s material and immaterial living conditions.\textsuperscript{26} Education science has developed the concept of focusing on the living environment as an action theory to analyse and structure social work in view of social change and the increase in individualization and pluralization.\textsuperscript{27} The goal of social (and educational) work geared to people’s living environments consists in enabling the individual to develop his/her resources and to use them in order to shape his/her life in a self-determined manner. This concept of empowerment is becoming greatly significant, particularly with regard to working with disabled children and young people. ‘The action goal of empowerment practice in social work is to make available to people the tools

\textsuperscript{25} Achter Jugendbericht der Bundesregierung 1990 (Eighth Youth Report published by the Federal Government)
\textsuperscript{26} Thiersch 1992
\textsuperscript{27} Ibid.
necessary for managing their own lives and to open up opportunities to them in which they can acquire experiences of their own strength and where they can test patterns of networking based on solidarity.’

Thiersch states that individuals have to master a large number of tasks in everyday life, which also includes living with a disability. Everyday life is often a balancing act between coping and failing. Life in society entails always understanding everyday life as social action. There are various zones in everyday life. There are, for example, schools and the family, which individuals gather their experiences and learn to master their problems. It is only via these experiences that individuals can find their way around in their living environment. Success goes hand-in-hand with increasing mastery of difficult everyday processes.

In order to support young people in coping with their own living environments, the empowerment concept would suggest for example that teachers make use of the individual resources and build new resources together with the protagonists in the living environment. That way, young people will be able to consolidate and implement their own life concept.

The ‘living environment’, as Böhnisch and Münchmeier emphasize, is not just a natural space; it also has a symbolic significance. The processes of showing separation from, and membership of, groups, subcultures and cliques are conveyed via the social environment and expressed symbolically in it. Participation in these processes is significantly influenced, for disabled people, by the existence or non-existence of barriers in their material and non-material environment. Inclusion or exclusion in the social environment, especially in the peer group, in the classroom, in school and in other social networks has a significant impact on how disabled people manage to confront their own living situations and compensate for deficits. This is particularly true in adolescence.

Identity development and developmental tasks

The search for personal identity, breaking away from parental care, and the gradual implementation of developmental tasks are what determine the transition from childhood to adulthood.

‘Puberty and the changes associated with it necessarily cause girls and boys to perceive their bodies in a new way and to confront their physical nature. This happens on the one hand through physical processes

28 Herriger 2006: 19
29 Thiersch 1992
30 Böhnisch/Münchmeier 1993
31 Havighurst 1972, Dreher/Dreher 1985
(development of the sexual characteristics, first menstruation), but on the other hand it is particularly during puberty that the norms to do with appearance become more significant."\textsuperscript{32}

Disabled young people can hardly fulfil these norms. That presents them with many and various additional challenges in their journey towards coping with developmental tasks.\textsuperscript{33} The acceptance of their own physical appearance, involvement in more mature relationships with peers of both sexes, becoming emotionally independent of their parents, the discovery of their own identity, and engaging in more intimate relationships can be significantly harder for young people with disabilities.\textsuperscript{34}

Disability-related influences on the successful implementation of these developmental tasks can be found at different levels of the young people’s living environments, for example:

- **finding their own identity**: the influence of the nature and severity of the disability and the associated deviation from current ideals of beauty, as well as direct or indirect self-perception and perception by others as a sexual being;

- **mobility**: the influence of the nature and severity of the limitations to mobility and therefore the opportunity of being capable of individually making contact with peers of both sexes as well as of having the first sexual encounters;

- **socialization**: the influence of the parenting style in the family and, associated with this, of preparation for sexuality and relationships, linked to parental fears of negative influences on the disabled young people and to prejudices regarding their suitability for a (sexual) relationship and parenthood;

- **information**: the influence of the nature of the access to information on the subject of sexuality, relationships and family planning, which parents of disabled children and young people may downplay vis-à-vis parents of non-disabled young people;\textsuperscript{35} it was revealed as part of a study on the situation of disabled and chronically ill mothers in Saxony that the women who had obtained their information about sexuality from books and the internet were more likely to have children than women who had received that information by their parents,\textsuperscript{36} which suggests that the information provided by the parents was primarily focused on contraception.

\textsuperscript{32} BZgA 2010: 92
\textsuperscript{33} Cf. Bretländer/Schildmann 2004
\textsuperscript{35} Michel/Häußler-Szepan/Riedel 2003
\textsuperscript{36} Michel/Wienholz/Jonas 2010
A disability is always an intrusion into human integrity. It results in a different perception and a different attitude to life than in a life without disability. A disability is permanent, it is not generally reversible. It need not, however, always and fundamentally be equated to suffering. No life can be looked at exclusively under the perspective of suffering and endurance. But a disability 'shows one to one's place in society' and it is often defined as a negative personal characteristic.

This is true in all areas of life, but especially in the area of work and income as well as with regard to sexuality, relationships and parenthood. Girls and women with disabilities experience these exclusions and violations regarding their perception as sexual beings even more clearly than men. Some of these experiences start in the home. The subjects of sexuality and relationships are often left out of the socialization process, usually from a desire to give the disabled child even more protection. This protective instinct also seems to be the problem affecting disabilities across the board. When a child is born with a disability, all the things the parents had taken for granted, along with all of their expectations, now have a question mark over them.

When the ideal of the ‘dream child’ does not come true for parents, they feel unsettled; they can even feel shocked and sad. This results in parents’ seeking to protect their child and keep it away from frustrating experiences. The children’s ability to experiment is limited because of existing barriers and their lack of mobility. This is particularly fateful when it comes to exploring and discovering their own sexuality. Parents can hardly be considered advising and supporting partners here. At the same time contacts with friends, both disabled and non-disabled, can be limited, depending on the nature and severity of the disability.

Sexuality and the desire for a relationship and for parenthood are very significant for women and men with disabilities. This is confirmed by many academic works and reports (mostly) based on women who are physically disabled or have a sensory impairment. It also applies to mentally disabled women and men, who are also confronted with reservations about their suitability as parents and about their sexuality. Parenthood and dealing with sexuality can, however, also be learned by people with mental disabilities.

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37 Cf. Joester 1993
38 Michel/Häußler-Szepan 2005
39 Michel/Häußler-Szepan/Riedel 2003
Disabled young people need the support of their social environment to do this. As already mentioned, parents are often overwhelmed by the subject. For this reason services offered in and out of school are highly significant in supporting the young people as well as their parents in recognizing sexuality as an important part of life, instead of seeing disabled people as sexually neutral, thereby devaluing their sexuality.

A disability as the result of an attribution process necessarily leads to an alteration, and therefore an impairment, of a person’s identity. Identity, including sexual identity, is a complex system of abilities of modern humans. Goffman writes:

‘Society creates the means to categorize people along with the complete set of attributes considered usual and natural for the members of all of these categories. The social institutions establish the categories of people that one would presumably encounter there. The routine of social communication in existing institutions permits us to deal with other people we expect to meet there without particular attention or thought.’

In the context of a (visible) disability there tends to be a stigmatization with regard to the person’s sexuality and their attractiveness as a sexual partner, which can make it significantly harder for them to accept their own bodies. The fear that others could disregard us because of our external characteristics is not limited to disabled people. Non-disabled people, and especially young people, perceive this situation as precarious. A latent fear of being disregarded causes the person affected to be insecure in his or her contact with other people. Confrontation with one’s own body will be especially tricky when, in addition to the typical insecurities of adolescence, there are additional problems as a result of visible features (e.g. conspicuous gait, facial deformities) or behavioural deviations (e.g. as a result of a hearing impairment, a speech impediment or a psychological impairment). It is important for the perception of a disability – including perception by non-disabled people – that the disability is visible. Physical disabilities and visual impairments are visible, while hearing impairments are invisible; it is at best the hearing aids that are visible. This has an impact on the development of identity and therefore also on the development of young people’s sexuality.

42 Cf. Goffman 1975
43 Goffman 1975: 10
44 Goffman 1975
2.1 Physical disability

The term ‘physical disability’ is the umbrella term for a broad spectrum of functional impairments of different origins. They range from the loss or impairment of the functioning of the extremities, the spine and the torso to chronic internal illnesses. The causes are equally varied. They range from genetic causes and complications during birth to illnesses and accidents. In the context of sociological considerations pertaining to the body, Waldschmidt and Schneider see the body as a starting point and emphasize how the body can be perceived as a limitation when it is disabled or impaired in its function.

Sexual activity is bodily activity and ‘dependent’ on certain abilities. Physical disabilities are therefore significant in two ways for the development of sexuality and sexual activities, namely with regard to perceiving the person as a sexual being and with regard to the physical requirements needed for performing sexual activities. For young people with a physical disability the following questions are therefore the most significant for the development of their sexuality:

- what is my body scheme? how do I perceive my own body? what is the attitude of myself and others towards my appearance and by bodily functions?
- what are the reactions towards me in the context of standard ideas of beauty and attractiveness? what are my motor skills and physiological abilities (e.g. with regard to masturbation)?
- how do I evaluate my own abilities?
- how does this fit into society’s focus on performance, not least with regard to sexuality?

In addition to the cited effects of the stigmatization of (visibly) disabled people, experiences with one’s own body play a significant role when it comes to accepting this body. A physical disability is often associated with operations, interventions and other medical procedures. They go hand-in-hand with fears, pain and negative bodily perception on the one hand, and on the other with hopes and expectations; not least they can be time-consuming. If extensive care is needed, physically disabled girls and boys often feel their modesty is violated and taboos are broken. One’s own body is experienced less as a source of pleasure, and associated much more with physical and psychological violations.

When it comes to coping with the challenges associated with a child’s disability, parental sex education and the children’s confrontation with their own bodies, often
get left by the wayside – there is not enough time and space available. In addition, the parents of physically disabled children often feel insecure about the issues of sexuality, pregnancy etc. and do not know what their own child will be able to do/cope with.

Environmental factors also play an important role in determining whether physically disabled young people can make contact with young people of both sexes independently and develop their sexual identity during the process of implementing their developmental tasks in adolescence. Especially when mobility is limited because of the disability and/or when there are unfavourable environmental conditions (e.g. no disability-friendly public transport), young people have almost no way of gathering experience with peers of both sexes outside of school and therefore of confronting their own sexuality and their perception as sexual beings. Ortland and Czerwinski describe the situation as follows:

‘As a result of their impairment, children and young people with physical impairments often have no or only limited or altered opportunities to have sexual experiences. They often have only inadequate opportunities to experience their bodies as beautiful and lovable. Instead, their bodies are the object of often painful medical examinations or corrective physiotherapeutic measures. The exploration of their own body and its pleasurable opportunities is often hardly open to them, if at all, because of their motor limitations.’

2.2 Sensory impairment

People who can see and hear well often have the notion that people with sensory impairments compensate for their impairment with the help of their other senses. Although this is not incorrect, neither is it an adequate description of the relationship of people with sensory impairments towards their senses. The world of perception and imagination of people with sensory impairments is very different, especially for people who were born blind or deaf, but also for those who become blind or deaf later in life. Certain sensory concepts such as colours and sounds are given a different significance: e.g. a sensation of warmth or cold for certain colours and the sensation of music through vibrations of the abdomen or the nose. Tactile stimuli or smells also have a special significance when it comes to perceiving the environment. That means it is particularly important for the development of children and young people with sensory impairments to support their ability to under-
stand the environment via other senses. The guidelines under the heading ‘vision’, published by Sonderpädagogik e. V. state:

‘Individually tailored support aims at overcoming dependencies and barriers so that children and young people actively expand the spectrum of their perception and learning opportunities and are able to acquire self-confidence and trust in their own abilities.’

Learning with all of the (available) senses is fundamental to these young people’s confronting their impairment, coping with disability-related limitations and finding their place in society.

2.2.1 Visual impairment and blindness

Visual impairments mean a reduction in the ability to use the sense of sight. The reduction of visual perception is due to damage to the organ of sight or to the connection between the eye and the brain; blindness is defined as the better eye having a residual vision of less than 0.02 (1/50) of normal acuity (maximum light-dark perception), or a limitation to the field of view to less than five degrees. Severe visual impairment is deemed to exist when the acuity in neither eye is more than 0.05 (1/20), even when both eyes are tested together.

Visual impairments have very diverse causes and are overwhelmingly associated with a gradual reduction in the ability to see. According to Renz-Polster et al.,

‘around 150 to 200 children are born blind in Germany [every year], while another five times as many are born with a severe visual impairment.’

As with hearing impairments, the data situation regarding visually impaired children and young people is insufficient, because the official statistics only list the most severe impairment, while other visual problems do not receive enough mention.

Even though most young people with sight problems fall into the categories ‘visually impaired’ or ‘severely visually impaired’, it is blind young people who receive far more attention in the literature. In school routine, the visually impaired also tend to be considered less problematic than the blind. Röder says it is generally assumed that the problems of visually impaired people are inversely proportionate to their residual vision. According to this understanding, blindness (no remaining
vision) is a big problem with little coping. The reverse implication is that a large amount of residual vision means a small problem with maximum coping with the situation.

This simple equation neglects the differentiation of visual impairments in respect of their progress, the aesthetic impact, the living and environmental conditions and the processing of the situation. How an individual copes with and accepts the impairment is described in the literature as a process that occurs in stages, as a mechanism that can also be applied to the coping processes involved in other types of impairments/disabilities.\textsuperscript{53} Röder\textsuperscript{54} refers to the one-dimensional view taken by these models, which neglect the fact that a progressively worsening impairment or changing environmental conditions require frequent, new confrontations with the impairment. Changes to the living conditions (e.g. changing schools to attend special-needs school) or social support systems (family, peer group, teachers) can have a supportive function during such periods of confrontation.

The use of aids makes the impairment visible. The acceptance of the corrective aid may also be influenced in a negative manner, if the visually impaired person has experienced negative discrimination for example.\textsuperscript{55} Being excluded as a result of the visible impairment creates hurt feelings in the young person, which have a particularly negative effect during adolescence and could lead to that person withdrawing from the (non-disabled) peer group. It is possible that as a result of the exclusion experienced, the impaired person will choose for aesthetic reasons not to wear the aid. Withdrawing to a special-needs school could then even be experienced as helpful. The consequence of this is, however, a separation from friends and siblings who could act as support networks. Therefore acceptance is not a uniform process; instead, it is typically something ambivalent during which progress and emotional setbacks can occur simultaneously. This is particularly true during adolescence, when young people’s perception of themselves and others focuses strongly on physical appearance and is associated with the activation of very strong emotions.\textsuperscript{56}

One of the very important developmental tasks of adolescence is accepting one’s own body and therefore also one’s own appearance.\textsuperscript{57} A visual impairment as an impairment that is visible in the face, which could indeed be associated with a further worsening of the condition during this sensitive phase in life, makes mastering this task even more difficult. This is even more true when the people affected are aware that the visual impairment is not just a passing problem in puberty, but will stay with them for the rest of their lives.

\textsuperscript{54} Röder (n.d.)
\textsuperscript{55} Cf. Michel/Häussler-Sczepan/Riedel 2003
\textsuperscript{56} Röder (n.d.)
\textsuperscript{57} Cf. Havighurst 1972, Dreher/Dreher 1985
The other developmental tasks are also lastingly influenced by the visual impairment. The ‘fledging’ process is more difficult when mobility is limited. Connecting with peers also remains restricted because of limited mobility and time constraints, e.g. long travelling times to a special-needs school. Meeting places for young people such as clubs, discos and cinemas are difficult to access by those with a severe visual impairment. Making contact with people through eye contact is more difficult as a result of the visual impairment, as is the awareness of other people’s glances.\textsuperscript{58}

Like the physically disabled, young people with a visual impairment face the problem of their perception and acceptance as sexual beings during the development of their sexuality, especially when the impairment is associated with aesthetic impacts.

In addition, Prerowsky\textsuperscript{59} refers to two further problem areas: the pre-stages to making contact with potential sexual partners, and communication. The visually impaired find it very difficult if not impossible to emphasize or alter their appearance, e.g. through make-up, on their own. That is why visually impaired girls and women tend to do without. As a result of the visual impairment, communication is primarily verbal or tactile. This can lead to significant misunderstandings or be difficult or impossible in a noisy environment (e.g. a disco).

In summary, as a result of the visibility of the impairment and the resulting behaviours a visual impairment, like a physical disability, can make the development of the sufferer’s sexual identity as well as his or her sexual experiences significantly more difficult.

\subsection*{2.2.2 Hearing impairment}

Hearing impairments are a much more widespread phenomenon than generally assumed and the causes can be very diverse. The percentage of people with hearing impairments increases with age. Since the introduction of the neonate ear test in 2009, it has been possible to diagnose and treat hearing impairments at a very early stage. The extant data indicates that two to three children in a thousand newborns are affected.\textsuperscript{60} Statements about the 14+ population are based on an initial scientific analysis by Sohn and Joergenshaus.\textsuperscript{61} According to this analysis, 19 % of the population resident in Germany have a hearing impairment, which translates into 13.3 million people. Around a million of them are classed as severely hearing-impaired, while 213,000 people are deaf or borderline deaf.

\begin{footnotesize}
\begin{enumerate}
\item[58] Cf. Prerowsky 1996, Michel/Häussler-Sczepan/Riedel 2003
\item[59] Prerowsky 1996
\item[60] Deutsche Kinderhilfe e. V. (n.d.)
\item[61] Sohn/Jörgenshaus 2001
\end{enumerate}
\end{footnotesize}
Nevertheless, hearing problems are significantly underestimated in society and are not addressed anywhere near enough. Furthermore

‘(…) there is no other group in the literature that in the past was stigmatized so much as a result of their handicap – of not hearing or not hearing well – as the group of the hearing impaired, and especially the group of deaf people.’

Ears as ‘receivers’ are an important component in the communication chain. In a world that very much relies on speech, it is through our ears that we make contact with other people. The majority of human communication is done via speech, and understanding is dependent on hearing. If this connection is broken, it has serious consequences. Hearing is the most complicated sensory function we have. A hearing impairment is not visible, but perceptible and apparent.

Deaf people define themselves as members of a linguistic and cultural minority – they are neither disabled nor sick. Their mother tongue is sign language. The history as well as the culture of the deaf is different from the history and culture of the ‘hearing’. The two ‘worlds’ of the hearing and the deaf are only converging very slowly. This convergence is happening in part because progress in medical technology is creating an increase in the number of deaf people who are able to communicate through spoken sound communication, e.g. the group of children, young people and adults wearing a cochlear implant and who communicate both through spoken sound and sign language. A small group of people (3,000 to 6,000 nationwide) are deaf-blind – they too have their own systems of communication.

By far the largest group in the hearing-impaired category are the hard of hearing and those who have become deaf, who are generally able to communicate through speech and who, in contrast to those born deaf, do not use sign language. People who have become deaf tend to use signing that accompanies spoken language.

The more complex the impairment, the less possible it is to compensate for it with hearing aids, nor does wearing a hearing aid or a cochlear implant mean that we do not have to take special consideration when communicating with the hearing-impaired.

Special-needs schools for the hearing-impaired are attended by an incredibly heterogeneous mix; different groups of children and young people with a hearing impairment and speech impediment as well as with learning difficulties and/or behavioural problems go to one class. This also includes children and young people.

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62 Hintermair 2005: 17, cf also Grohnfeldt 1976
63 A cochlear implant (CI) is an implanted device that can be used for people with inner-ear deafness where the auditory nerve is intact. The devices are electronic receivers implanted in the inner ear.
64 Disability Commissioner for Bavaria 2011
with auditory processing disorder or with retrocochlear hearing loss. Children and young people with auditory processing disorder have a normal function of the ear, but there are problems doing tasks that make demands on higher auditory processing levels. It is characteristic that they often have trouble taking in and storing what they hear and often cannot remember multi-step instructions. They hear less well when there is background noise, confuse words that sound different and can be hypersensitive to noise. In addition they often have difficulty perceiving, processing, and understanding or categorizing the meaning of sound events in a differentiated manner. This disorder is diagnosed by a screening test conducted by a paediatric audiologist.

As a result of more and better aids, the group of hard of hearing young people who primarily communicate in whole or in part with spoken language is growing. It is also noteworthy that schools for the hearing-impaired are seeing an increase in students with learning difficulties and behavioural problems. The heterogeneous composition of the classes requires an adaptation to the different linguistic and cultural approaches while maintaining the specific conditions of perception. Under these circumstances, raising children by communicating both in sign language and spoken language is a major priority.

For young people with a hearing impairment, it is immensely important to them that they identify with a cultural and linguistic group. The development of identity very much takes place via the use of a shared language. Social recognition and membership are fundamental requirements for a sense of identity.

Regarding the development of a sense of self among hearing-impaired young people, Hintermair among others noted that young people with an open orientation, who circulate in the world of the hearing as well as the hearing-impaired, benefit because they possess a repertoire of appropriate behaviours as well as increased social flexibility. These abilities also impact on the development of a positive sexual identity.

The following causes were given for the assumption that students with hearing impairments have sexual experiences earlier and more often than other disabled young people.

65 An auditory processing disorder or central auditory processing disorder is one where there is a problem processing what is heard, even though the peripheral hearing is intact. The causes of such an auditory processing disorder could be frequent middle ear discharges among toddlers or also brain damage at a young age.
66 An expert in speech disorders, voice disorders and children’s hearing problems
67 Hintermair 1999, Hintermair 2005
• In the sign language community, the culture focuses on the body. It is part of their communication to engage in physical touch and to speak with the whole body. This can also lead to an open approach to sexuality.

• Young people with a hearing impairment do not have any motor function limitations, and are just as mobile as young people who hear well. Contacts with peers, and the first sexual contacts, can be made unhampered by transport options, while visually impaired and physically disabled young people often rely on their parents to drive them around.

• People tend to look for relationships in their own peer group (and they find them too). Young people with hearing impairments spend a lot of time with their peers, e.g. on group trips or in camps, although these groups have now become very heterogeneous.

Michel et al. 68 were able to prove that hearing-impaired young people had significantly larger circles of friends than visually impaired or physically disabled young people, but ‘friend’ is evidently defined as ‘member of the sign language community’. In addition hearing-impaired children are particularly likely to experience early institutionalization in specific special-education facilities and even vocational training centres.

Evidently as a result of this experience, the hearing-impaired young people in this study were less likely to think it realistic that they would one day be able to live independently in their own home 69 Even though the physical mobility of hearing impaired people is not restricted, their communicative limitations impact their social mobility and participation. The communicative limitations, which vary in severity, can therefore also carry the risk of the hearing-impaired person retreating into his or her ‘own linguistic community’. Breaking free from this linguistic community is also made more difficult for those with more severe hearing impairments if there are conflicts in this linguistic community.

2.3 Special-needs schools v. integrated schools

The socialization of disabled children and young people takes place in the family, in school and in society, just as it does for non-disabled children. Over the course of adolescence, contact to peers becomes increasingly important. At the same time the young people have to find their own identity and achieve emotional independ-
ence from their parents. As a result of the special situation, this process is slower and more difficult for disabled children and young people. This is particularly true when the children require a high degree of support because of the nature and severity of their disability and when they cannot make contact with their peers without outside help. As a result of the limited opportunities of disabled young people to make contacts with their peer group, their class or school holds a special position. The school environment is not just there to teach school subjects, but to enable the implementation of the principle of the peer group, peer support and peer counselling.

The history of peer counselling started in the United States in the mid-1960s. The idea was that people with disabilities would help each other, share their experiences and see themselves as experts on themselves.

‘Over the years peer counselling became an incredibly important tool in empowering disabled people within the movement for self-determined living in the United States. More and more people with disabilities took their lives into their own hands and campaigned for their interests. Disabled people who demand full social participation as a human right call their goal “self-determined living”.

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<th>Fundamental assumptions of peer counselling</th>
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<td>• People are able to solve their problems themselves.</td>
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<td>• Shared experiences favour the counselling situation.</td>
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<td>• Counselling takes place on equal terms.</td>
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<td>• ‘Behind the experiences of the counsellor and the counselled are all the gathered experiences of disabled people all around the world.’</td>
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<td>• ‘The stage belongs to the counselled.’</td>
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Peer support refers to the entire process of support by people who in the same position or on an equal footing. The philosophy of peer support states that supervision, help and a role model function, when provided by a person with personal experience and knowledge relating to disability, reach other disabled people much better than support services provided by people without these experiences.

70 Havighurst 1972, Dreher/Dreher 1985  
71 Michel/Häußler-Sczepan/Riedel 2003  
72 Van Kann/Doose 2004: 19 f.  
73 Ibid.  
74 Ibid.  
75 Cf. Rensinghoff 2008
This is particularly true for the development of sexuality, an area of life that has up until now been taboo and that has been kept away, consciously or subconsciously, from the experience of disabled children and young people. Peer counselling and peer support can be implemented in special-needs schools because the disabled young people will have contact to disabled peers here. Therefore, schools should not just make room for professional sex education classes, but also to peer counselling and peer support.

However, special-needs education still constitutes a separation that also keeps alive prejudices with regard to the sexual attractiveness of disabled young people. Integrative education can counteract this. What is meant by this is that special-needs education should also take place in regular schools. To what extent the creation of integrative conditions is more time-consuming and more expensive than segregation is always a matter of controversy. The principle of special-needs schools is still dominant in Saxony. Their design is comparable to that of a whole-day school, since the children and young people spend a large amount of their free time in school by way of afternoon therapy sessions.76 The choices of leisure activity are also significantly more restricted because of the long travel distances involved.

‘Overall, the relationship between disabled and non-disabled children can be seen as very productive. They build relationships with each other, give each other valuable impulses for their development, they experience pain and sadness just as much as tenderness and friendship; they learn to get on quite well with each other, even though the individual starting positions can be very different. In principle the chance exists that children with and without disabilities can come together before the judgements of society make unselfconscious interaction more difficult. Therefore integration should start as early as possible, even before the children start school. Integration must then continue, in order to counteract alienation through “separate paths” in primary school and special-needs school. If children experience people with disabilities from earliest childhood, they will develop skills and abilities together and learn appropriate ways of dealing with each other. We can assume that this will make attribution processes and stigmatization increasingly difficult: integration is a way of de-stigmatizing disabled people.’77

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76 The reference here is to the practice, still quite common in Germany, whereby school finishes at lunchtime. By ‘whole-day school’ is meant a school which has lessons or other activities in the afternoon.

77 Markowetz 2007: 257
3.1 Severely disabled young people in the statistics

According to the Sächsisches Landesamt für Statistik (Office of Statistics, Saxony), Saxony was home to 325,328 officially recognized severely disabled people on 31 December 2007. A nationwide comparison in 2007 revealed that Saxony, at 7%, had the lowest percentage of severely disabled residents in Germany. In the age group of 6–24-year-olds, Saxony had an official severely disabled population of 13,708, which constituted a percentage of 4.2% of all severely disabled people in Saxony (table 1). Disabilities are particularly prevalent among older people: more than half of the severely disabled people are 65 and older. In the young age groups, disabilities are more common among the male population.

Among children, adolescents and young adults, people with mental disabilities are the largest group, while across all age groups the most common problems are diseases of the inner organs and physical disabilities.

In most cases, i.e. in more than 80%, the disability was caused by a disease. Only 4.4% of all disabilities were congenital (i.e. had existed since birth) or developed during the first year of life. Among the 6–24-year-olds the percentage suffering from a congenital disability was 29%. This includes deformities that developed in the womb as well as damage that occurred during delivery. According to the perinatal statistics of the state of Saxony, congenital problems (ones that developed in the womb) account for 1.5% of all damage.

78 People classed as severely disabled are ones who have a degree of disability from 50–100%.
79 Statistisches Bundesamt 2009 (Federal Office of Statistics)
80 Statistisches Bundesamt 2009 (Federal Office of Statistics)
81 Project office for quality control, Medical Association of Saxony 2007
3.2 Students with special educational needs

Even though the number of school students in Saxony has dropped since 2004/2005 by 17% and the number of those attending special-needs schools is also declining, the number of school-students with special educational needs has remained relatively constant over this period, at around 6%. The percentage of school-students with physical disabilities and visual impairments has even gone up slightly (table 2).
Table 2: Student numbers by nature of the disability, in Saxony, over time

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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Visually impaired</td>
<td>215</td>
<td>206</td>
<td>218</td>
<td>230</td>
<td>231</td>
<td>234</td>
</tr>
<tr>
<td>Hearing impaired</td>
<td>395</td>
<td>368</td>
<td>363</td>
<td>365</td>
<td>378</td>
<td>392</td>
</tr>
<tr>
<td>Physically disabled</td>
<td>743</td>
<td>757</td>
<td>740</td>
<td>745</td>
<td>775</td>
<td>798</td>
</tr>
<tr>
<td>Students with</td>
<td>12,315</td>
<td>11,468</td>
<td>10,702</td>
<td>10,060</td>
<td>9,854</td>
<td>9,904</td>
</tr>
<tr>
<td>learning disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of</td>
<td>21,628</td>
<td>20,848</td>
<td>20,094</td>
<td>19,223</td>
<td>18,875</td>
<td>18,821</td>
</tr>
<tr>
<td>students at special</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>schools</td>
<td>Total</td>
<td>363,284</td>
<td>340,715</td>
<td>321,472</td>
<td>307,771</td>
<td>301,610</td>
</tr>
</tbody>
</table>

Source: Drucksache 3025, Statistisches Landesamt Sachsen

Among the physically disabled school students and those with sensory impairments, the average number over the past five years is made up of around 800 boys and around 550 girls, who together make up 0.47% of the total number of students in Saxony. The smallest group of the special-needs school students are the ones with visual impairments, followed by those with a hearing impairment. By far the largest group of students at special-needs schools, making up more than 50% of the whole, is that with learning difficulties. The student figures for secondary schools in Saxony make it clear that around a third of the physically disabled students and those with a sensory impairment also have additional special educational needs, which is why the percentage of school-students requiring special educational support rises to more than 50%.  

Criteria for acceptance at a special-needs school

The classification of special-needs students is carried out by the school that diagnoses a child’s special educational needs. On this basis, the teachers, psychologists and parents will decide what school will be the most suitable for the child. If there are several schools to choose from, factors such as proximity to the home, transport costs and the school’s capacity come into play. However, the personal decision of the parents also affects the choice of school. If two or more special educational needs were diagnosed (e.g. as a result of a physical disability and a learning disability),

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83 Statistisches Landesamt des Freistaates Sachsen 2010 (State Office of Statistics for Saxony)
then the school chosen will be the one that can provide support for both (e.g. a school for the physically disabled that has a focus on learning disabilities). If such a school is not available, the selection is made depending on what area of support is the more pressing.

The consequence of this is that Saxony’s special-needs schools are not just attended by students with a disability or illness in line with the school’s special educational focus; they are also attended by students with other limitations (e.g. a learning disability) or with a limitation without its own special educational focus (e.g. autism). As a result, classrooms can be very heterogeneous.

The special-needs schools for the visually impaired have very few students diagnosed with learning disabilities. These students can largely be found in the special-needs schools for the physically disabled in the administrative regions of Chemnitz, Bautzen and Leipzig, and in the special-needs schools for the hearing impaired in the administrative regions of Dresden and Leipzig. Among the hearing-impaired students with learning disabilities, the majority are children with an auditory processing disorder, which is associated with an increased need for special needs support.

**Special-needs schools in Saxony’s education system**

The following depiction of Saxony’s education system illustrates the two-tier arrangement of special-needs schools in the primary and secondary sectors as well as the vocational institutions such as vocational training colleges and special-needs vocational schools (fig. 1). There is also the option to graduate from a Gymnasium (academically oriented secondary) school as an integrative student; however, there are no dedicated such schools for special educational needs students in Saxony.

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84 Autism is defined as a ‘social interaction disorder where the sufferer retreats into his own mind and isolates himself from the outside world’ (Pschyrembel 2004: 171).

85 Cf. Chapter 2.2.1
With the ‘Empfehlung zur sonderpädagogischen Förderung in den Schulen in der Bundesrepublik Deutschland’ (‘Recommendation on Special-needs Education in German Schools’) of 6 May 1994, it was agreed that special educational support would also be provided in regular schools. However, it remains the case that there are hardly any special-needs students in Saxony who are educated in regular schools. In 2008 the figure was 18.4 %, i.e. around one in five special-needs students received an integrative education.

86 Standing Conference of the ministers of education 2010
In other states such as Hesse and Brandenburg, information from the respective state offices of statistics suggested that the proportion of ‘integrated’ students was up to 75%. The majority of the integrated students were primary-school children. Only around a quarter (23%) attended a regular secondary school. The decision on whether to send a child to special-needs school or to choose the integrative path also depends greatly on the child’s special-needs focus.

Table 3: Percentages of students with special educational needs in special schools and regular schools, by area of support, 2008 (figures in %)

<table>
<thead>
<tr>
<th>Area of support</th>
<th>Special schools</th>
<th>Regular schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning</td>
<td>43.5</td>
<td>44.8</td>
</tr>
<tr>
<td>Seeing</td>
<td>1.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Hearing</td>
<td>2.8</td>
<td>4.4</td>
</tr>
<tr>
<td>Language</td>
<td>9.5</td>
<td>15.6</td>
</tr>
<tr>
<td>Physical and motor development</td>
<td>6.3</td>
<td>7</td>
</tr>
<tr>
<td>Mental development</td>
<td>19</td>
<td>2.9</td>
</tr>
<tr>
<td>Emotional and social development</td>
<td>9</td>
<td>22.4</td>
</tr>
<tr>
<td>More than one area of support/no classification</td>
<td>6</td>
<td>0.7</td>
</tr>
<tr>
<td>Illness</td>
<td>2.5</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Standing Conference of State Education Ministers, 2010

Students whose special-needs focus lies on their mental development are comparatively unlikely to be educated in regular schools, while students with emotional and social problems as well as language problems are the most likely to be integrated in regular schools. Students with physical disabilities and visual impairments are educated in roughly equal proportions in regular schools and special-needs schools in Saxony.

The guidelines on special-needs diagnostics distinguish three degrees of severity. If the support requirement is low, it can be covered in regular schools (particularly in primary school). If the support requirement is moderate, there will be a lasting special educational needs support in an integrated classroom, where the students will be expected to achieve the same educational outcomes as their peers. If the

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87 Staatsministerium für Kultus und Sport Sachsen 2005 (State Ministry of Education and Sports in Saxony)
support requirement is high, then this requires lasting and extensive special-needs support in an integrated classroom or a special-needs school. According to the Schulintegrationsverordnung (SchIVO, ‘School Integration Regulation’), an integrative education is dependent on the objective, spatial (disability-friendly) and staffing (teaching hours, integration teachers) constraints of the receiving schools.\(^{88}\)

### 3.3 Sexuality education at special-needs schools in Saxony

Sexuality education at schools in Saxony is governed by section 36 (family and sexual education), clauses 1 and 2, of the state’s Education Law (SchulG)\(^{89}\), as well as by the state curricula\(^{90}\) for the subjects of science/nature study, religious education, ethics and biology. The parents are informed about the information given to the students via a letter from the state education ministry. The schools themselves do not have guidelines regarding sexuality education as such.

At the special-needs schools for the physically disabled and visually and hearing impaired, the sex-education guidelines are the same as those for primary and secondary schools.\(^{91}\) However, since there is always an integrated special educational needs focus at the schools for the physically disabled and the visually and hearing impaired, the syllabuses for regular secondary schools come into play as well as those for special educational needs.

In the primary-school sector, sexuality education takes place as part of the nature-study classes, in secondary school and in special educational needs school as part of biology, ethics and RE classes. In addition, some subjects are addressed in home economics classes in the special educational needs schools. The learning area ‘my body and my health’ is addressed in years 1 and 2 as well as in year 4. The learning contents focus on two core areas: getting to know the sexual organs in connexion with changes that occur during puberty, and the dangers of sexual abuse. The specific content focuses on information about physical development, hygiene, and getting rid of fear and embarrassment. On the other hand, the students even at this age are already to be shown how to protect themselves from sexual violence by being told about advice centres and by learning to say ‘no’, which also aims to boost their sense of self-worth. In the secondary sector, students at schools for the physically disabled and the visually and hearing impaired, but not in need of special educational support, are educated according to the regular syllabus of secondary schools in Saxony (cf. table 4).

88 SchIVO 2004  
89 Schulgesetz für den Freistaat Sachsen SchulG (as of 16 July 2004), (Saxony’s education law)  
90 Sächsisches Staatsministerium für Kultus und Sport 2005/2010 (State Ministry of Education and Sports in Saxony)  
91 Sächsisches Bildungsinstitut 2011 (Saxony’s Education Institute)
<table>
<thead>
<tr>
<th>Year group, Subject</th>
<th>Learning area</th>
<th>Educational content/goals (mandatory)</th>
<th>Remarks (recommendation, explanation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Ethics</td>
<td>Human beings and their social behaviour</td>
<td>Getting to know selected social problems and suitable ways to help</td>
<td>Sexual abuse</td>
</tr>
<tr>
<td>5 Biology</td>
<td>Mammals in their habitats</td>
<td>Learning about mammalian reproduction, using humans as an example: fertilization of the egg, parent-child relationship, problem of sexual abuse</td>
<td>Behaviours in dangerous situations, prevention (re. sexual abuse)</td>
</tr>
<tr>
<td>5 Religious Instruction (Protestant)</td>
<td>Our own lives and our world</td>
<td>Getting to know behaviours that are damaging personally and to the group</td>
<td>Sexual abuse, preventive measures</td>
</tr>
<tr>
<td>7 Biology</td>
<td>Structure and function of the human body</td>
<td>Using knowledge about reproduction: significance of sexuality and reproduction, female cycle, formation of sperm cells, pregnancy and childbirth, keeping the sex organs clean and healthy; learning about contraception and sexually transmitted infections</td>
<td></td>
</tr>
<tr>
<td>7 Religious Instruction (Protestant)</td>
<td>Our own lives and our world</td>
<td>Learning about the special aspects of growing up: physical and psychological changes, sexuality, generational conflict, significance of friendships, falling in love</td>
<td>Puberty</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Marketing of sexuality</td>
</tr>
<tr>
<td>9 Biology</td>
<td>Biology of behaviour</td>
<td>Getting to know selected human behaviours: sexual behaviour</td>
<td></td>
</tr>
<tr>
<td>7 Religious Instruction (Protestant)</td>
<td>Our own lives and our world</td>
<td>Thinking about behaving responsibly with regard to friendship, love and relationships</td>
<td>The term ‘love’, ideas and desires, sexuality</td>
</tr>
<tr>
<td>9 Ethics</td>
<td>Human life – one way</td>
<td>Assessing the significance of friendship, love and sexuality for a flourishing life: sexual orientation, behaviours, responsibility, characteristics of friendship and love, being in love and love, the connexion between body, soul and mind, development of a sexual identity, friendship, love, sexuality as a fundamental human need, mutual affection and respect, partner’s consent, preventing pregnancy, protecting against AIDS and sexually transmitted infections</td>
<td>Behaviour in dangerous situations; forestalling (e.g.) abuse</td>
</tr>
<tr>
<td>9 Ethics</td>
<td>Semi-elective (!) True love and love as commodity</td>
<td>How is the human body portrayed in the media?</td>
<td>A collage about the problem that ‘love’ can be bought and sold as a commodity</td>
</tr>
</tbody>
</table>

Source: Standing Conference of State Education Ministers, 2010
Year 5 focuses almost entirely on forestalling sexual abuse, year 7 on the other hand deals primarily with (developmental) biological, functional subjects. In year 9 more attention is paid to the experience of sexuality – with regard to the aspects of arousal, relationships and identity.

Some of the students attending schools for the physically disabled and the visually and hearing impaired also have special educational needs, which is why the syllabus for special educational needs students comes into play. This syllabus focuses more strongly on sex education in the context of the students living environment (cf. table 5).

**Table 5: Curricula of schools with special learning focuses**

<table>
<thead>
<tr>
<th>Year group Subject</th>
<th>Learning area</th>
<th>Educational content/goals (mandatory)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/6 Biology</td>
<td>General (no designated learning area)</td>
<td>Forming and developing responsible, healthy, environmentally conscious behaviour:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• developing socially adequate attitudes and behaviours about sexuality and human reproduction</td>
</tr>
<tr>
<td>5/6 Biology</td>
<td>Basics of life</td>
<td>Transferring knowledge of reproduction and development in mammals on to humans:</td>
</tr>
<tr>
<td></td>
<td>Light and warmth</td>
<td>• sexuality and language</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• physical and psychological changes during puberty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Structure and function of the sex organs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transferring knowledge of human reproduction on to developing a healthy, responsible way of life; assessing abnormal sexual behaviour towards children</td>
</tr>
<tr>
<td>7 Ethics</td>
<td>Semi-elective (!):</td>
<td>Insights into the changed friendship relationships between young people</td>
</tr>
<tr>
<td></td>
<td>Friendships change</td>
<td></td>
</tr>
<tr>
<td>7 Religious Instruction (Protestant)</td>
<td>Living in a community</td>
<td>Developing a sense of responsible actions in the community:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• friendships between girls and boys</td>
</tr>
<tr>
<td>7 Religious Instruction (Protestant)</td>
<td>Semi-elective (!):</td>
<td>Developing an understanding of one’s own ideas about love and sexuality, gaining insights into biblical ideas</td>
</tr>
<tr>
<td></td>
<td>Love, sexuality and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>intimacy</td>
<td></td>
</tr>
</tbody>
</table>
In addition to biological processes and psycho-physiological changes, teachers pay attention in particular to values and norms. Core issues are a self-determined, responsible relationship to sexuality and the body (including contraception) and the respectful treatment of others. But the emotional aspect of sexuality, including relationships and identity, is also addressed from years 5/6 onwards.

Sexuality education therefore takes up a lot more time in special educational needs schools in the secondary sector than in the regular secondary schools. Subjects focusing on the students’ living environments are given particular attention.

Remarks (recommendations, explanations)

- expert language, slang, swear words
- respect for the opposite sex, factoring in experiences of the body
- genital hygiene – gender-specific differentiation
- hygiene during menstruation
- physical and social consequences of an early pregnancy, jobs and responsibilities of parents
- natural curiosity – recognizing sexual dangers – being able to say no
- coercion, abuse, rape, child pornography and prostitution, listing sources of help

Changes in friend relationships and romantic relationships

Characteristics of a friendship, being in love, intimacy

- images, slogans, figures of speech
- forming gender-specific groups
- Song of Songs, Psalms
- beauty of the body, the gift of sexuality
- perception of one’s body

continued on next page >
<table>
<thead>
<tr>
<th>Year group</th>
<th>Learning area</th>
<th>Educational content/goals (mandatory)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Ethics</strong></td>
<td>Familiarity with different types of relationships and ethical consequences</td>
</tr>
<tr>
<td></td>
<td>Living in a community</td>
<td></td>
</tr>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Religious Instruction (Protestant)</strong></td>
<td>Considering biblical ideas of relationships and family:</td>
</tr>
<tr>
<td></td>
<td>Living in a community</td>
<td>• friendship, intimacy, sexuality and devotion as God’s gift</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• freedom and responsibility in a relationship</td>
</tr>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Religious Instruction (Protestant)</strong></td>
<td>Knowing the dangers of abuse</td>
</tr>
<tr>
<td></td>
<td>Semi-elective (!): the dangers of abuse</td>
<td></td>
</tr>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Biology</strong></td>
<td>Forming and developing responsible, healthy and environmentally friendly behaviours: confronting human sexuality as a significant part of life</td>
</tr>
<tr>
<td></td>
<td>General (no designated learning area)</td>
<td></td>
</tr>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Biology</strong></td>
<td>Insights into the different types of interpersonal relationships:</td>
</tr>
<tr>
<td></td>
<td>Conscious life</td>
<td>• responsibility in relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• homosexuality/heterosexuality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• risks associated with frequent partner change</td>
</tr>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Biology</strong></td>
<td>Learning about the consequences of a pregnancy in adolescence:</td>
</tr>
<tr>
<td></td>
<td>Semi-elective (!): when children have children</td>
<td>• social consequences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• psychological consequences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• physical consequences</td>
</tr>
<tr>
<td></td>
<td>Taking a stance about responsible sexual behaviour</td>
<td></td>
</tr>
<tr>
<td><strong>8/9</strong></td>
<td><strong>Home economics</strong></td>
<td>Learning about healthy behaviour during pregnancy</td>
</tr>
<tr>
<td></td>
<td>Semi-elective (!): a baby is on the way</td>
<td></td>
</tr>
</tbody>
</table>

Source: Saxon State Ministry of Education and Sport 2005/2010
### Remarks (recommendations, explanations)

**•** marriage, family  
**•** living together, same-sex relationships, being single  
**•** responsible behaviour with one’s own sexuality, life and family planning  
**•** terminating a pregnancy

**•** ideas and expectations, self-love, love in a relationship, distance and closeness, homosexuality  
**•** marriage, getting married, the feeling of belonging together, the pain of breaking up  
**•** fidelity, feeling happy, freedom and commitment  
**•** responsible attitude to sexuality, life and family planning, abuse, terminations

**•** different kinds of abuse  
**•** sexual perversion

**•** endangering graduation and job training, limiting leisure options, financial security  
**•** casual relationships  
**•** responsibility, feeling overwhelmed  
**•** complications in pregnancy and during childbirth  
**•** health problems, emotional and legal problems of a termination  
**•** frequently changing sexual partners, unprotected sex – transmission of diseases

### Dealing with an early pregnancy and future life planning:

**•** graduation, responsibility, support services  
**•** acceptance and tolerance  
**•** sexually transmitted infections, HIV, hepatitis  
**•** precautions

**•** endangering graduation and job training, limiting leisure options, financial security  
**•** casual relationships  
**•** responsibility, feeling overwhelmed  
**•** complications in pregnancy and during childbirth  
**•** health problems, emotional and legal problems of a termination  
**•** frequently changing sexual partners, unprotected sex – transmission of diseases
II

The design and results of the study

4 Methodological implementation

5 The results in detail

6 Selected results in comparison with young people without disabilities
The main issue for implementing the research goal was to get access to the sample group. The special-needs schools in Saxony were a good choice because the proportion of ‘integrated’ school students in Saxony was just 18% of all the students with special educational needs (cf. Chapter 3.2). In addition, special-needs schools, with their normally central location, have a large catchment area. The schools that were chosen were those for the physically disabled and the visually and hearing impaired, of which there are nine in Saxony, and the two vocational training centres in the state.

4.1 Recruiting the sample

Before it was possible to conduct a survey in the special-needs schools and vocational training centres, the Saxon education agency had to give its permission, as it has to do for all surveys in schools. The application was made to the education agency at the end of August 2010 and was approved in mid-October 2010. After that we were able to hold preliminary talks with the head teachers, who had previously received written notice of the research project. These talks took place between October 2010 and March 2011. The goal of the talks in situ was to firm up the research project, to request cooperation and to agree on how to conduct the survey. During the talks the head teachers informed us of the number of students between the ages of 14 and 17. It quickly became clear that the actual number of students was far smaller than expected. For that reason the sample was expanded by making it independent of age; instead the students were asked class by class. Since the students at special-needs schools often tend to be slightly older than their counterparts at regular schools, we set the range for the survey from year 6 to year 10. That means that there were also some 12-year-olds included. As for any survey done with minors, the parents had to give their written consent. Two to four weeks before the scheduled interview date in the schools, the parent letters,

92 Schulaufsichtsbehörde (Education Authority)
93 See appendix
which were formulated using a BZgA template, were sent to the schools, where they were handed out to the students. The parents were informed about the voluntary nature of the participation, as were the students. The signed consent forms were collected and passed on in time for the interview date. The main reason why not all students could be reached by the interview date is because some of them were sick or on a school trip. In one of the schools for the physically disabled, only some of the students came to the appointment because many could not get to school as a result of adverse weather conditions in winter. A new appointment was then not possible for organizational reasons, according to the head teacher. As a result there are big differences in the sample size and the participation quota (cf. table 6).

Table 6: Return percentages for the survey

<table>
<thead>
<tr>
<th>Institution</th>
<th>No. of students</th>
<th>Parental consent</th>
<th>Percentage</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>School for the hearing impaired 1</td>
<td>40</td>
<td>30</td>
<td>75.0 %</td>
<td>28</td>
<td>93.3 %</td>
</tr>
<tr>
<td>School for the hearing impaired 2</td>
<td>36</td>
<td>27</td>
<td>75.0 %</td>
<td>25</td>
<td>92.5 %</td>
</tr>
<tr>
<td>School for the hearing impaired 3</td>
<td>30</td>
<td>19</td>
<td>63.3 %</td>
<td>17</td>
<td>89.5 %</td>
</tr>
<tr>
<td>School for the physically disabled 1</td>
<td>54</td>
<td>16</td>
<td>29.6 %</td>
<td>8</td>
<td>50.0 %</td>
</tr>
<tr>
<td>School for the physically disabled 1</td>
<td>60</td>
<td>25</td>
<td>41.7 %</td>
<td>19</td>
<td>76.0 %</td>
</tr>
<tr>
<td>School for the physically disabled 1</td>
<td>30</td>
<td>26</td>
<td>86.7 %</td>
<td>25</td>
<td>96.2 %</td>
</tr>
<tr>
<td>School for the physically disabled 1</td>
<td>38</td>
<td>16</td>
<td>42.1 %</td>
<td>13</td>
<td>81.3 %</td>
</tr>
<tr>
<td>School for the visually impaired 1</td>
<td>40</td>
<td>20</td>
<td>50.0 %</td>
<td>20</td>
<td>100.0 %</td>
</tr>
<tr>
<td>School for the visually impaired 2</td>
<td>30</td>
<td>9</td>
<td>30.0 %</td>
<td>7</td>
<td>77.7 %</td>
</tr>
<tr>
<td>Job training centre 1</td>
<td>22</td>
<td>5</td>
<td>22.7 %</td>
<td>5</td>
<td>100.0 %</td>
</tr>
<tr>
<td>Job training centre 2</td>
<td>30</td>
<td>2</td>
<td>6.7 %</td>
<td>2</td>
<td>100.0 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>410</strong></td>
<td><strong>195</strong></td>
<td><strong>47.6%</strong></td>
<td><strong>169</strong></td>
<td><strong>88.6%</strong></td>
</tr>
</tbody>
</table>

Source: BZgA, data set 'Youth Sexuality and Disability in Saxony', 2011
From a total number of 410 students, around half got their parents’ consent to participate. Of these 195 students, 169 were actually surveyed. The participation quota was therefore 41.2%.

In our experience, a high participation quota very much requires the support of head teachers, who pass on their openness towards the subject of sexuality education to the teachers responsible, and at the same time emphasize the necessity of the survey. In addition it seems that a co-operative relationship between the school and the parents positively influenced the parents’ willingness to participate in the study.

In the vocational training colleges, of which there are two in Saxony, it was a lot harder to recruit young people. The students at the vocational training colleges tend to be quite a bit older, which is why 17-year-olds were the exception. For that reason the sample group was expanded to include 18-year-olds. Since they were not asked in their classes here, the young people who fit the criteria were made aware of the survey by the college directly; however the participation rate was very low, not least because of the voluntary nature of the survey.

### 4.2 Development of the questionnaire

The first step was to select questions from the original BZgA Youth Sexuality survey questionnaire\(^\text{94}\) that seemed relevant and appropriate for surveying young people with a disability. In a second step it was supplemented by disability-specific questions which had already been used in a previous study.\(^\text{95}\) After that the questions were put into ‘Simple Language’ (‘Leichte Sprache’), a specific form of expression for people with limited language comprehension. The translation of the questionnaire into Simple Language mainly served the purpose of meeting the special communication requirements of young people with a hearing impairment. As a result, two versions of the questionnaire were available for the survey: in ordinary and Simple Language. The translation was done following the rules of the Netzwerk Leichte Sprache\(^\text{96}\), to which the authors of this study also belong. According to the rules of Simple Language, we posed the questions as simple main clauses. Every sentence is to contain just one statement, while we largely make do without foreign words, technical terminology and abbreviations. Technical terminology was put into everyday terms and/or was explained. In the questionnaire we used terms from everyday language and, if necessary, we put the corresponding technical terms in brackets at the end. We reduced the number of nouns and used verbs instead. We deliberately made do without introductory sentences as well as superfluous and

\(^{94}\) BZgA 2010  
\(^{95}\) Cf. Michel/Häussler-Sczepan/Riedel 2003  
\(^{96}\) Cf. www.leichtesprache.org (accessed: 10 Sept 2012)
possibly misleading or redundant information in the questionnaire. To improve readability, compound words of more than seven letters were divided by hyphens (e.g. ‘Frage-Bogen’ instead of ‘Fragebogen’). A larger font and a larger line spacing also made the questionnaire clearer and simpler to understand.

Unfortunately the translation of the original questions into Simple Language created a slight shift in one case, which had a bearing on the evaluation. The question, ‘Who were or are the most important people for you regarding information about sexual matters?’ became ‘With whom can you talk best about sexual matters?’ in the Simple Language version. This is a mistake: two questions with different intentions were equated, when they actually aim at different aspects, namely at the person providing education on the one hand, and the confidant on the other. There were clear differences in the evaluation, when the two versions were compared. For that reason the focus was on evaluating the data about the confidant, because a lot more students filled in the questionnaire in Simple Language.

After the questionnaire was complete, the texts were checked by test readers from the group of people with learning disabilities. The questionnaire was presented to staff at the workshops for disabled people of the Diakonie am Thonberg in Leipzig, our partner in creating texts in Simple Language. After intensive work, the intelligibility of the questionnaire was deemed to be good by the test readers and after minor modification and additional shortening, it could be sent to a school for the hearing impaired as a pre-test.

In a further step, the checked survey questionnaire was adapted to the requirements of young people with visual impairments. This included making do without images and symbols, because they cannot be processed by people who are severely visually impaired, and the braille terminal and the computer’s text-to-speech system cannot read them out. The hyphens added when the questionnaire was put into Simple Language were removed again, since the text-to-speech system tends to read them out and they are also obstructive when reading with a braille terminal. When putting the questionnaires on paper, attention was paid to the font being large enough and the contrast being clear. The questionnaire was subsequently given to employees at the German Central Library for the Blind in Leipzig, our partner in the inclusive project of producing disability-friendly media, who checked its legibility. Its comprehensibility was described as good. We were merely told to put the tables in the reading direction to ensure that the answer ticks could be put in the right places. The questionnaire was then used with minor modifications.
4.3 Conducting the survey

The survey was conducted from December 2010 until May 2011. The pre-test was done in a school for the hearing impaired, and revealed a need for only minor modification to the questionnaire. The main points of criticism only became clear during the further course of the survey.

The participants filled out their questionnaires in their class under group conditions (with the exception of the vocational training centres). This manner of conducting the survey had already proved reliable during a study on the living situation of disabled children and young people. As is standard for sex-education events, the teachers were not supposed to be present. If teachers were present, then with the justification that their students had a special relationship of trust with them and that they would be available to help them understand the questions. This occurred primarily in the schools for the hearing impaired. Usually the presence of a teacher was unproblematic, and generally unnecessary, since the students could either turn to us or to a sign-language interpreter who had been made available. This interpreter participated in the surveys at the schools for the hearing impaired, signing the instructions on how to fill in the questionnaire and signing responses to the deaf students’ comprehension questions.

Since the subject matter is a very sensitive, personal one and shared knowledge can make students vulnerable, the students were urged to keep a certain physical distance from each other. This suggestion was not considered necessary at every school, at the request of the young people. Often we saw the young people discussing the questions with each other, which could have an effect on how they answered them. For that reason, a physical distance should be insisted on without fail when conducting a survey in group conditions.

In the special-needs schools for the hearing impaired, all bar two students used the Simple Language questionnaire and the same is true for the special-needs schools for the visually impaired. Here, however, the students had the option of filling in the questionnaire at the computer, an option taken up by around half of them. In the schools for the physically disabled, both versions of the questionnaire were used; 35 out of 65 students opted against the Simple Language questionnaire.

In most cases the survey took place during regular school hours. In just three cases an extra appointment was arranged for the students. This did not, however, have an impact on their willingness to participate. At four schools the survey was done in two rounds, at the other schools it was done in one go. Filling out the questionnaire took a minimum of 15 minutes and a maximum of 45 minutes. On average it took half an hour. During the survey the students largely worked quietly and in a disciplined manner.

97 Michel/Häussler-Sczepan/Riedel 2003
4.3.1 Experiences in the individual schools

Structured according to the respective special needs focuses, the following special features became clear during the survey phase.

Schools for the hearing impaired
We had very different experiences in the schools for the hearing-impaired. In one school we came across a large number of hearing students who did not need sign language, while at another school many of the students were profoundly deaf and used our sign-language interpreter strikingly often. Often there was a great deal of interaction among the young people, regardless of what class they were in, and especially so among the girls. The profoundly deaf and those with severe hearing impairments communicated with each other in sign language. In contrast to the other schools, the atmosphere was somewhat more unsettled, as a result of the involuntary sounds made by the profoundly deaf young people and those with severe hearing impairments.

Schools for the visually impaired
The experiences at the schools for the visually impaired were quite similar. Except for one participant, everyone could see at least something and was therefore capable of filling in the questionnaire either on paper or at the computer. The blind student was helped with filling it in by his carer. Some of the young people filled in the questionnaire at the computer, which greatly increased legibility thanks to the magnification option. The desire of the majority of the students to fill in the questionnaire at the computer was also due to the communication with them that took place in advance, during which this method was favoured. In retrospect the paper version proved to be better suited, since the rate of error during the filling-in process was smaller. Therefore we preferred the paper questionnaires during the subsequent sessions. Although all the students in the schools had a visual impairment, nobody was dependent on a braille terminal or a text-to-speech system. It would also appear that filling in the questionnaire while using a braille terminal was more difficult. One student used this method and only made very slow progress, and as a result failed to complete the questionnaire. During the survey it was very quiet because the students worked individually. The visually impaired young people were generally very quick at filling in the questionnaires and there were hardly any comprehension issues.

Schools for the physically disabled
One thing that was striking about the schools for the physically disabled was the very different participation rates. At one school the rate was almost 100 % and here the interest of the teaching staff in the subject matter was also obvious. In the other two
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schools the rate was only around a third, partly because of student absence (e.g. because of poor weather conditions or a school trip). Since getting an appointment to begin with had been difficult and the students’ interest was very low, we chose not to have a second appointment. One survey took place right after lunch break, so that it started in a very hectic, chaotic manner. During the filling-in process the students worked very conscientiously and were very concentrated, particularly so the students with learning disabilities. If students were restless while filling in the questionnaire, they were admonished by others to be quiet. There was just one group consisting of only boys that was very restless. There were many comments and several comprehension questions, e.g. about the degree of the disability. The group that used the questionnaire in ordinary language was finished significantly faster, at maximally 35 minutes, than the group with the questionnaires in Simple Language. Students with motor restrictions in the upper extremities also participated in the study, but irrespective of that, all of them were able to fill in the questionnaire themselves.

4.3.2 Structural problems of the questionnaire

A further problem relating to content only became clear during the course of the survey. Many students had problems with the principle of a filter question, especially those using the Simple Language version. During the design of the questionnaire we deliberately made do without lots of filter questions, but this was not possible when asking about the students’ experience with sexual intercourse. Despite highlighting the instructions on how to fill in the questions by making the writing larger, many students did not adhere to the rules of how and when to skip sections. As a result there was a data revision process for the filter questions when the questionnaires were being evaluated. The answers to the question about sexual intercourse experience were only taken into account where the students also answered the follow-up questions about their first time and about contraception, for example.

This resulted in the possibility that the actual percentage of students with sexual intercourse experience was distorted, because all those who said they had had sexual intercourse experience, but who for whatever reason did not answer the follow-up questions, were excluded. Presumably this group is very small. Generally speaking data about sexual experiences collected under group conditions is always to be treated with some caution, because incorrect statements can be made because of social desirability or embarrassment.

Problems with the questionnaire for the hearing-impaired

When working with the hearing-impaired students, it became clear that they had problems with the semantics of some of the words, such as the term ‘Zärtlichkeit’ (tenderness). The word ‘Samenerguss’ (ejaculation) also had to be explained because the (female) teachers present thought that the boys knew the process
but not the word. One rule for putting texts into Simple Language says that the subjunctive mood should be avoided if possible. Some students, especially girls, evidently had problems with the question about a current potential pregnancy, which was in the subjunctive mood, and therefore they left it unanswered. When the answers did not apply, the students on several occasions created their own answer categories, such as ‘not yet’. Another feature of note was that the hearing-impaired young people had a slightly different linguistic understanding. The comprehension issues that arose, and the responses given in the questionnaire, which had an altered sentence structure, e.g. quotes from the students in response to the last question (question 57 \( \rightarrow \) Appendix) suggest that the hearing impaired students could have read the questions differently from the hearing students.

Problems with the questionnaire for the visually impaired

In the version for the visually impaired students, it turned out that because of an unfavourable choice of format, there were several displacements in the questionnaire. A few participants did not type in an ‘X’ in the answer box as the instructions said, but instead copied the one/three crosses shown as a visual aid, or moved them into the respective boxes so that they did not fully answer questions where several responses were possible. Often the crosses were not put inside the appropriate boxes, but were placed in front of or behind them. Unfortunately it was the case here too that some of the respondents did not answer the question about a current potential pregnancy, although it is not clear whether this was because of how the question was phrased or because of how it was depicted, since this question, compared with the previous ones, was visually less conspicuous.

Problems with the questionnaire for the physically disabled

One factor of note among the physically disabled students is that people with cerebral palsy may be limited in their spatial perception, which can make reading tables more difficult.

4.4 Definition of the evaluation groups

There needs to be an explanation of the concepts at this point, since the surveyed students with special educational needs were not just physically disabled or suffering from a hearing or visual impairment as might be believed; they formed an incredibly heterogeneous group. Students with different special-needs focuses are educated within the special-needs school system. The manner in which students are allocated was already described in detail in \( \rightarrow \) Chapter 3.2. The consequence of this is that the group of special-needs school students within a certain type of school is very heterogeneous. Schools for the hearing impaired do not just educate children
and young people with a hearing impairment; they also educate students with the special-needs diagnosis ‘hearing’. This could stem from the aforementioned auditory processing disorder, but the group in any case includes students with a diagnosed dysphonia, language disorder, speech impediment or hearing impairment.

Often students will have a combination of several impairments, i.e. a multiple disability such as a hearing impairment and a learning disability. Generally speaking, the areas with which the students need special support are also the ones the schools focus on; from time to time students are taught who cannot be clearly categorized into a specific support focus (such as autism). All of these students just have in common that they attend a school for the hearing impaired, but only some of the student body are exclusively hearing-impaired.

It was decided for the data evaluation that the young people’s disability or impairment should be expressed in terms of the school they attended. Therefore the correct term would not be ‘hearing impaired’ or ‘young person with a hearing impairment’ but ‘student at a school with a special-needs focus on hearing’. Analogously, the term for young people with a physical disability should be ‘students at a school with a special-needs focus on physical and motor development’ and for young people with a visual impairment ‘students at a school with a special-needs focus on vision’. While for the purposes of readability and comprehension we have subsumed different disabilities and diseases under the terms physical disability, visual impairment and hearing impairment, it is actually the different types of school that are meant.

4.5 Recommendations for future surveys

For future surveys it would be important to ensure a quiet atmosphere during the filling-in process and to pay attention to the necessary time frame. If necessary, a second date could be set if the students could not be present at the first date because of illness or unfavourable weather conditions. The support of the schools’ head teachers, who prepare the teachers for the survey, is particularly important. This has a favourable impact on the students’ willingness to participate. In our experience, whether under-age young people participate in a survey is less down to parents’ consent than to teachers’ preparation. This is something that should be pointed out during the first consultation with a school.

The following suggestions can be made for future surveys of young people with hearing impairments: the Simple Language questionnaire should be used if possible. Words, especially technical terms or compound words, should be simplified as much as possible and if necessary, be explained in the margins. Only the present and past tenses should be used and filter questions should also be avoided as much as possible. The text should be supplemented by self-explanatory pictures if possible. The survey can be conducted in groups, but there should be adequate physical spaces between
the participants. During future surveys about intimate subject matters, it would be important to ensure favourable conditions such as the presence of a physical distance in order to avoid the abovementioned effect of false statements as a result of social desirability or embarrassment. To reduce comprehension issues, it would be a good idea to read the question out loud or use sign language where appropriate.

It is a good idea for all events with sex-education content that the teachers are not present; instead a person who is independent of the school and competent at sign language should be used. Another good idea is to have the questionnaire checked in more detail by hearing-impaired people, preferably by a person with a combined learning disability and hearing impairment.

For future surveys of visually impaired young people, the following suggestions can be made. If the young people have sufficient sight, it would be better if they used the paper questionnaires. The font size should be varied depending on the requirement. The digital version of the questionnaire would have to be very well prepared, e.g. as a form with fixed answer fields, but not as a PDF or Word document. There should also be a spoken version as well as the option of an oral interview. The best option should be determined on the spot, depending on the abilities of the student. Therefore it is a good idea to have all options ready. As with the hearing-impaired students, it is a good idea to use the questionnaire in Simple Language with easy words and few tenses.

As a result of the different syllabuses of regular schools and special-needs schools regarding sex-education topics (cf. →Chapter 3.3), the young people in this current survey have a varying degree of knowledge. If the special-needs school students are young people with and without learning difficulties, who have different syllabuses available to them, it would be a good idea to determine, in future surveys, from what syllabus the survey participants are being taught.
The results in detail

104 male students and 65 female students with a physical disability, hearing impairment or visual impairment between the ages of 12 and 18 and attending nine special-needs schools and two vocational training centres in Saxony were surveyed in the context of this study during the period from December 2010 to May 2011.

5.1 Social demographics

According to the severe-disability statistics, disabilities and chronic diseases affect more boys than girls, as is reflected in the current sample. Almost two-thirds of the participants were male (cf. table 7). The age groups on the other hand were quite evenly distributed, including within the disability groups. Only among the 15-year-olds was there a slight bulge. The distribution of the students by type of school did not entirely match the statistical distribution by type of disability, since with our survey we were best able to reach young people with a hearing impairment.

98 Statistisches Bundesamt 2009 (Federal Office of Statistics), cf. table 1
99 In-depth information about the methodological problems in Chapter 4
Table 7: Description of the sample

<table>
<thead>
<tr>
<th>Number of cases</th>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating young people</td>
<td>65</td>
<td>100</td>
</tr>
<tr>
<td>Boys</td>
<td>104</td>
<td>61.5</td>
</tr>
<tr>
<td>Girls</td>
<td>65</td>
<td>48.5</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–13 years</td>
<td>28</td>
<td>16.6</td>
</tr>
<tr>
<td>14 years</td>
<td>30</td>
<td>17.8</td>
</tr>
<tr>
<td>15 years</td>
<td>42</td>
<td>24.9</td>
</tr>
<tr>
<td>16 years</td>
<td>36</td>
<td>21.3</td>
</tr>
<tr>
<td>17–18 years</td>
<td>33</td>
<td>19.6</td>
</tr>
<tr>
<td>Students attending a school for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical disabilities</td>
<td>65</td>
<td>38.5</td>
</tr>
<tr>
<td>Visual impairments</td>
<td>31</td>
<td>18.3</td>
</tr>
<tr>
<td>Hearing impairments</td>
<td>73</td>
<td>43.2</td>
</tr>
</tbody>
</table>

Source: Schwerbehindertenstatistik Sachsen on 31 Dec 2007, Statitisches Bundesamt 2009

It is striking that there is a very heterogeneous age distribution in the individual (school) year groups, which is a specific feature of special-needs schools and is true of all types of disabilities. The largest spread occurred in school-years 7, with students aged between 12 and 16, and 8 (age range 13 to 17); this reflects the different developmental level of the students, which could be caused, for example, by long hospital stays.

Self-perception of their own disability
The image of the heterogeneous disease and disability patterns at the various schools (cf. →Chapter 4.4) is confirmed when looking at the self-perception of the students attending special-needs school with a support focus on physical and motor development (school for the physically disabled) regarding their own disability (cf. table 8). A similar picture is revealed by the evaluation of the students attending schools for the visually impaired and for the hearing-impaired.
The results at hand confirm that the special-needs schools with a special-needs focus on physical and motor development do not just educate physically disabled children and young people, but also children with other or multiple disabilities, with chronic illnesses and children and young people without their own specific special-needs focus (cf. Chapter 4.4). The same is true of the groups with visual and hearing impairments.

### The respondents’ living situations
The living situations of young people with disabilities cannot be adequately described in the current survey. With their central locations, Saxony’s special-needs schools have a large catchment area, which is why every school has a boarding school or residential home attached to it. However as far as age was concerned, our survey results revealed no or only minor differences regarding the question whether the young people lived largely at home or at the boarding establishment.
More than half of the young people lived with both parents (51.2 %), a third with one parent (33.3 %, some of them with step-parents), and only very few lived in boarding school (7 %). It seems likely that the living option ‘boarding school’ only becomes relevant for many young people when they start job training. There were some minor differences among the young people depending on their type of disability: a fifth of the visually impaired young people lived in boarding school (20 %) and 12 % of the physically disabled young people lived with adoptive parents or foster parents.

The time at which the disability/disease occurred hardly varies at all between the sexes. Almost two-thirds of the respondents had their disability from birth (63.9 %), most commonly so among the physically disabled young people (78.5 %). Overall, every tenth respondent was unable to say when the disability started (10.7 %), especially among the hearing impaired. Around a quarter of the young people became disabled/sick at a later date, or it developed gradually (24.8 %). The span here goes from one to eleven years, the average age was five years.

Conclusion: In summary our sample exhibits an excess of male respondents, a small percentage of visually impaired students, the majority of the young people lived in the parental home, and the majority had grown up with a disability right from the start.

### 5.2 Sexuality education

This education tends to start in kindergarten and is continued in school. The parental home also plays a crucial role. The following section will present the results about the sources of sexuality education, distinguished by media and people, as well as information about the level of information and the young people’s information requirements.

#### 5.2.1 Participants’ subjective assessment of their own level of sexual education

In both regular and special-needs schools, sexuality education is a requirement in Saxony, so that every student comes into contact with the subject matter in some form. How much knowledge the children and young people ultimately end up with depends on their prior knowledge, on the different information avenues, and not least on the interest of the individuals. For that reason the respondents were asked to evaluate the level of their own sexuality education to start the survey.
In response to the question ‘Do you know a lot about sex’, more than two-thirds answered ‘yes’ (70.8 %) and only 6.5 % with ‘no’. Around a quarter of the young people were not able to assess their own level of knowledge, therefore opting for the answer ‘don’t know’ (22.6 %). One boy in five and one girl in three were not able to assess their own level of sex education (18.4 % v. 29.2 %).

Within the disability groups half of the visually impaired and more than a third of the hearing-impaired girls chose ‘don’t know’ (cf. figure 2).

Figure 2: ‘Do you know much about sexuality?’ by gender and type of disability (figures in %)

![Figure 2: ‘Do you know much about sexuality?’ by gender and type of disability (figures in %)](image)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

Among the boys it was the ones with a hearing impairment who were the most likely to say they were sexually educated, among the girls this applied to the physically disabled. At the same time the group of physically disabled girls also contained the greatest percentage of respondents who said they did not know a lot about sex.
The influence of age was weakly perceptible for all the young people: the older the young people were, the more sexually educated they considered themselves (cf. table 9). However, the percentage who could not assess themselves remained relatively constant across the age groups.

**Table 9: ‘Do you know much about sexuality’, by age (figures in %)**

<table>
<thead>
<tr>
<th>number of cases</th>
<th>12–13 years</th>
<th>14 years</th>
<th>15 years</th>
<th>16 years</th>
<th>17–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 28</td>
<td>n = 30</td>
<td>n = 42</td>
<td>n = 36</td>
<td>n = 33</td>
</tr>
<tr>
<td>yes</td>
<td>64.3</td>
<td>63.3</td>
<td>70.7</td>
<td>80.6</td>
<td>72.7</td>
</tr>
<tr>
<td>no</td>
<td>10.7</td>
<td>3.3</td>
<td>9.8</td>
<td>2.8</td>
<td>6.1</td>
</tr>
<tr>
<td>don’t know</td>
<td>25</td>
<td>33.3</td>
<td>19.5</td>
<td>16.7</td>
<td>21.2</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

Overall, there is a gender and age effect when it comes to the young people’s subjective assessment of their own sex education. In contrast to the boys, the girls struggled to assess their sexual knowledge, and younger students had a harder time making an assessment than older ones. Among the different disabled groups, the visually impaired young people were the least likely to say they knew a lot about sex.

### 5.2.2 Communication about sexuality

More than half of the young people surveyed said it was unproblematic to have conversations about sex (54.5 %). A third only spoke about this topic with a few people (33.3 %) and a small proportion felt discomfort about the subject generally (12.1 %). There were significant differences between the disability groups as well as between the sexes. While the boys tended not to have a problem talking about sex (62.4 %), the girls preferred to do this with just a few people (43.8 %). Few boys and girls said they were loath to talk about the subject at all (10.1 % and 14.1 %).

An age effect was not discernible. Distinguishing by type of disability, the ones preferring to talk about sexuality with just a few people were the visually impaired among the boys and the physically disabled among the girls (cf. figure 3). These were also the groups who were the most likely to say they had just one or two confidants in sexual matters (cf. Chapter 5.2.4).
The groups most likely to say conversations about sexuality were unproblematic were the visually impaired girls and the physically disabled and hearing-impaired boys. Hearing-impaired young people constituted at the same time the largest group that was loath to talk about the subject.

Consequently, boys are overall more open in their choice of who they talk to, while girls are more selective. In addition, communication about sexuality is closely tied to the number of confidants for sexual matters – the fewer confidants there are, the less openly the young people communicate about sex.

5.2.3 Sources of sexuality education

Subjects relevant to adolescents are now provided in very different forms and also communicated to them in different ways. But do the standard media also get used by young people with a disability? Or is school the sole source of sex-education topics?
This latter suspicion is indeed confirmed. Three-quarters of the young people said their school was the main source of knowledge on this matter (cf. table 10).

Table 10: ‘Where did you learn most about sexuality, reproduction, contraception etc.?’ by type of disability (figures in %)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number of cases</th>
<th>Total</th>
<th>Physical disability</th>
<th>Visual impairment</th>
<th>Hearing impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>School</td>
<td>82.8</td>
<td>89.2</td>
<td>74.2</td>
<td>80.8</td>
</tr>
<tr>
<td>2</td>
<td>Youth Magazines</td>
<td>46.2</td>
<td>46.2</td>
<td>25.8</td>
<td>54.8</td>
</tr>
<tr>
<td>3</td>
<td>Computer programs/games/internet</td>
<td>35.5</td>
<td>27.7</td>
<td>29</td>
<td>45.2</td>
</tr>
<tr>
<td>4</td>
<td>Television films/DVDs</td>
<td>30.8</td>
<td>23.1</td>
<td>22.6</td>
<td>41.1</td>
</tr>
<tr>
<td>5</td>
<td>Personal experience</td>
<td>23.7</td>
<td>16.9</td>
<td>25.8</td>
<td>28.8</td>
</tr>
<tr>
<td>6</td>
<td>Free sex-education brochures</td>
<td>16.6</td>
<td>20</td>
<td>19.4</td>
<td>12.3</td>
</tr>
<tr>
<td>7</td>
<td>Lectures/information events</td>
<td>5.9</td>
<td>6.2</td>
<td>12.9</td>
<td>2.7</td>
</tr>
<tr>
<td>8</td>
<td>Radio/audio books</td>
<td>3.6</td>
<td>3.1</td>
<td>6.5</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

The second-most important source of information was youth magazines, followed by computer programs, games and the internet. Regarding the youth magazines, there was a significant difference among the different disabilities: visually impaired young people were significantly less likely to use youth magazines than those with other types of disability. The same was true of television films and DVDs, which were significantly most used by hearing-impaired young people. Gender differences will be discussed later.

Computers and the internet were used more commonly for sexuality education the older the young person was. Further media were free sex-education brochures, which were used more rarely by the hearing impaired. There was an age effect here too, as with increasing age the sex-education brochures were used significantly more often than they were by younger students (12/13 years: 3.6 % v. 17/18 years: 33.3 %).
Around a quarter of the respondents obtained their knowledge of sex from their own experiences. Again an age effect was discernible; differences could also be made out among the different types of disability: the physically disabled young people were less likely to refer to their knowledge from personal experience than the visually and hearing-impaired. Lectures and information events were not really a source of information for any of the respondents, and the same is true for radio and audio books. The latter two were most popular with the visually impaired young people.

The young people were asked what sources of information they would prefer most in addition to the media actually used if they wanted to obtain more information about sexuality. A small percentage of the respondents did not want any further information (13.2 %). More than half of the students wanted to learn more about sexuality and sex education in school and more than a third wanted further information from youth magazines (cf. table 11).

Table 11: ‘Where would you like to get more information from?’ by type of disability (figures in %)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number of cases</th>
<th>Total</th>
<th>Physical disability n = 65</th>
<th>Visual impairment n = 31</th>
<th>Hearing impairment n = 73</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>School</td>
<td>55.7</td>
<td>63.1</td>
<td>46.7</td>
<td>52.8</td>
</tr>
<tr>
<td>2</td>
<td>Youth Magazines</td>
<td>35.9</td>
<td>38.5</td>
<td>23.3</td>
<td>38.9</td>
</tr>
<tr>
<td>3</td>
<td>Computer programs/games/internet</td>
<td>23.4</td>
<td>18.5</td>
<td>23.3</td>
<td>27.8</td>
</tr>
<tr>
<td>4</td>
<td>Free sex-education brochures</td>
<td>22.2</td>
<td>24.6</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>Television films/DVDs</td>
<td>19.2</td>
<td>16.9</td>
<td>13.3</td>
<td>23.6</td>
</tr>
<tr>
<td>6</td>
<td>Public exhibitions</td>
<td>11.4</td>
<td>4.6</td>
<td>20</td>
<td>13.9</td>
</tr>
<tr>
<td>7</td>
<td>Lectures/information events</td>
<td>9.6</td>
<td>10.8</td>
<td>13.3</td>
<td>6.9</td>
</tr>
<tr>
<td>8</td>
<td>Comics</td>
<td>8.4</td>
<td>9.2</td>
<td>3.3</td>
<td>9.7</td>
</tr>
<tr>
<td>9</td>
<td>Sex-education games</td>
<td>6.6</td>
<td>7.7</td>
<td>3.3</td>
<td>6.9</td>
</tr>
<tr>
<td>10</td>
<td>Radio/audio books</td>
<td>4.2</td>
<td>6.2</td>
<td>6.7</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
As was the case for the media actually used, computer programs/games and the internet as well as television films and DVDs were the media of choice, particularly for the hearing impaired young people. Free sex-education brochures were used more rarely by them, since they might not be available, but a quarter (25%) of the hearing-impaired young people preferred them as a source of information. There was an age effect here: the older the young people were, the more commonly they wanted to have free sex-education brochures (14 years: 10% v. 17/18 years: 36.4%).

Public exhibitions, lectures and information events were cited particularly frequently by the visually impaired young people as sources of sex education, possibly because of events that had been held close to the time of the survey. Physically disabled young people on the other hand hardly opted for this medium at all; the reason for this could be buildings that were not disability-friendly. The visually impaired young people were less likely to choose visual information options, but the radio and audio books were also not a preferred medium of sexuality education for them. They generally were less forthcoming about where they would like to obtain information about sex in the future.

Suggestions for unconventional media with an innovative character in the realm of sexuality education, such as comics or sex-education games did not get much support from the young disabled people. Only the 17 to 18-year-olds could conceive of sex education in the form of comics (18.2%). However, there was not much demand for the radio or audio books either. The young people primarily wanted face-to-face situations, digital options and print media.

While comparing the already used and the desired sources of information, it became clear that both the boys and the girls cited fewer desired media than media they were actually using. Only the free sex-education brochures, lectures and information events were desired somewhat more than they were already being taken advantage of (cf. figure 4).
There were significant differences between the boys and girls surveyed with regard to the use of computer programs/games and the internet. These media were preferred more strongly by boys, while girls got their information about sexuality and sex education largely from youth magazines and also preferred these media significantly more often. According to information by the Bundesprüfstelle für jugendgefährdende Medien (Federal Review Board for Media Harmful to Minors) regarding gender-specific media use by children and young people\textsuperscript{100}, these differences are not just observed in the area of sexuality education. A similar gender relationship, also with a significant result, is evident in the use of the medium film.

**Conclusion:** While schools take the top spot for conveying sex-education contents to young people, regardless of their gender or disability, the remaining media were used to varying degrees.

On the one hand, a correlation can be discerned between the disability and the accessibility of the medium, which is also reflected in the preferences. As would be expected, the physically disabled and hearing-impaired young people had learned about sexual subjects from visual media such as magazines, films and computer

programs much more often than the visually impaired, and also wanted to use these most for their future sexuality education. On the other hand, the boys’ great interest in technology and computers also became clear in their sexuality education, while girls clearly preferred youth magazines. Finally, age had an effect when it came to using the internet and free sex-education brochures. These sex-education media are of particular interest to older teenagers.

5.2.4 Confidants and people providing sexuality education

Confidants for sexual matters
Adolescent boys and girls go through lots of changes, not least sexually. That is why it is very important for young people of this age to have a confidant available to them for their questions. Almost every girl and boy in the survey with a disability had at least one confidant (93.3 %). With increasing age the likelihood that a confidant was present increased. On average two people were cited. The following overview shows who they were (figure 5):

Figure 5: ‘Who can you talk to best about sexual matters?’ by gender (figures in %)

n = 132; only the questionnaires in Simple Language were evaluated. Further explanation in Chapter 4.3.2
Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
For both boys and girls, by far the most important confidant is the best friend. 54.2% say they give their best friend this trust; among the girls it is no less than 64.7%. That means that peers take on a more important role in sexual matters than the parents. The mother is the second-most important confidant for both sexes (38.9%), while boys also cite their father (19.1%). The girlfriend/boyfriend becomes increasingly relevant to the boys and girls with increasing age (26.7% overall).

The young people’s answers differ according to their gender: it is the same-sex siblings (for boys a brother: 14.8%; for girls a sister: 21.6%) and young people in the peer group (other boys: 14.5%; other girls: 5.3%) who are a confidant for sexual matters. While boys are more likely to use other boys as confidants, girls are more likely to approach their sisters than other girls. Siblings and the peer group tend to play a subordinate role, as do teachers (12.2%).

There are only minor differences, or none at all, between the disability groups. In comparison with the other disability groups, the hearing-impaired young people were the most likely to confide in a teacher or a sister, and least likely to confide in other girls. The visually impaired young people were the least likely to cite their father as a confidant and the physically disabled young people were the least likely to cite their boy/girlfriend. As a result, the visually impaired boys and physically disabled girls were also the ones who were most likely to communicate with the fewest people about sexuality (cf. Chapter 5.2.2).

**Conclusion:** In summary it can be said that most of the disabled young people surveyed possessed a confidant for sexual matters and, in addition to someone the same age, clearly preferred a same-sex person in this role. One exception is the mother, who was a frequently cited confidant for the boys.

**Reference people for sexuality education**

As explained in Chapter 4.3.2, the responses to the Simple Language question about preferred sex-education providers could not be evaluated. Therefore no clear results can be presented here about people providing sexuality education. There are, however, trends that make it clear that it makes sense and is vital that a distinction be made between confidants on the one hand and sex-education providers, particularly teachers, on the other.

A total of 37 students (out of 169) used the questionnaire that was not adapted into Simple Language, 35 of them were physically disabled. That means the following results refer primarily to the statements of the physically disabled, and cannot be applied to all young people with disabilities.
In contrast to confidants, teachers played a central role in providing sexuality education – an indication that sexuality education was imparted to a great extent through schools (cf. table 12). Physically disabled girls also got their sexuality education from their circle of friends, while physically disabled boys preferred their parents. After teachers, the mother was the most important person for sex education across all the ages. The peer group only became interesting and relevant for sexuality education from 15 onwards. Just one in ten students had had no sexuality education from one specific person, and instead had taught him/herself.

**Conclusion:** The results make it clear once again that young people make a real distinction between people providing sexuality education and confidants for sexual matters. This is particularly obvious when it comes to teachers, who are only a confidant for around one in ten of the respondents, but are the main person providing sexuality education for every second student. The other people cited are confidants and people providing sexuality education to approximately the same extent.
5.2.5 Subjects in sexuality education

As illustrated in →Chapter 3.3, the syllabus in Saxony envisages sex-education subjects to be dealt with early on. It then depends on the teachers what themes they address with what intensity. In addition there are varying themes for the learning-difficulty support focus compared to syllabuses with the other support focuses, which explains why the knowledge of the young people participating in this survey varied widely at times.¹⁰¹

Subjects addressed

The responses to the question about what subjects had already been dealt with in class reveal that biologically oriented subjects take precedence in the schools’ sexuality education programmes. The structure of the sex organs (83.9 %), the female cycle (67.3 %), the development of the unborn (57.7 %) and physical development during puberty (56.5 %) are classic topics discussed in biology class. When comparing the disability groups, it becomes clear that the physically disabled students were the most likely to have received biologically-functional sex education (cf. figure 6).

The differences are at times significant. However, it is also the physically disabled young people who were significantly more likely to have discussed sexually transmitted infections (63.7 %) and contraception (55.4 %) in class. All young people are very much less likely to have discussed socio-ethical subjects as well as the diverse way in which sexuality manifests itself; these issues were discussed most commonly among the hearing-impaired young people.

¹⁰¹ An explanation can be found in →Chapter 3.3.
Figure 6: ‘What topics have already been discussed in class?’ by type of disability (figures in %)

- **Sex organs**: 17.4% (Hearing impaired), 54.6% (Visually impaired), 77.4% (Physical disability)
- **Female cycle**: 51.6% (Hearing impaired), 62.5% (Visually impaired), 80% (Physical disability)
- **Sexually transmitted infections**: 51.6% (Hearing impaired), 55.6% (Visually impaired), 78.5% (Physical disability)
- **Pregnancy**: 50% (Hearing impaired), 58.1% (Visually impaired), 66.2% (Physical disability)
- **Physical development**: 51.6% (Hearing impaired), 59.7% (Visually impaired), 66.2% (Physical disability)
- **Contraception**: 41.7% (Hearing impaired), 64.5% (Visually impaired), 66.2% (Physical disability)
- **Love and intimacy**: 22.6% (Hearing impaired), 34.7% (Visually impaired), 36.1% (Physical disability)
- **Homosexuality**: 16.1% (Hearing impaired), 26.2% (Visually impaired), 36.1% (Physical disability)
- **Sexual violence**: 24.6% (Hearing impaired), 22.6% (Visually impaired), 27.8% (Physical disability)
- **Terminations**: 12.9% (Hearing impaired), 27.8% (Visually impaired), 27.8% (Physical disability)
- **Sexual practices**: 18.5% (Hearing impaired), 22.6% (Visually impaired), 25% (Physical disability)
- **Relationships**: 15.4% (Hearing impaired), 22.6% (Visually impaired), 26.4% (Physical disability)
- **Gender roles**: 15.4% (Hearing impaired), 22.6% (Visually impaired), 23.6% (Physical disability)
- **Masturbation**: 12.3% (Hearing impaired), 12.9% (Visually impaired), 18.1% (Physical disability)
- **Prostitution**: 7.7% (Hearing impaired), 15.3% (Visually impaired), 15.3% (Physical disability)
- **Pornography**: 6.5% (Hearing impaired), 11.1% (Visually impaired), 11.1% (Physical disability)
- **No topic was discussed**: 12.5% (Hearing impaired), 12.5% (Visually impaired), 12.5% (Physical disability)

Source: BZgA, data set 'Youth Sexuality and Disability in Saxony', 2011
Sexuality education is a process, and that is made clear by the comparison between the youngest and oldest survey groups. The percentages of students who had discussed the above-mentioned subjects in class increased with increasing age (cf. table 13).

### Table 13: ‘What topics have already been discussed in class?’ by age group, significant differences only (figures in %)

<table>
<thead>
<tr>
<th>Topic</th>
<th>12/13 years</th>
<th>17/18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 28</td>
<td>n = 33</td>
</tr>
<tr>
<td>Contraception</td>
<td>39.3</td>
<td>69.7</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>28.6</td>
<td>87.9</td>
</tr>
<tr>
<td>Terminations</td>
<td>14.3</td>
<td>39.4</td>
</tr>
<tr>
<td>Intimacy and love</td>
<td>10.7</td>
<td>54.5</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>10.7</td>
<td>51.5</td>
</tr>
<tr>
<td>Prostitution</td>
<td>3.6</td>
<td>33.3</td>
</tr>
<tr>
<td>Pornography</td>
<td>7.1</td>
<td>24.2</td>
</tr>
<tr>
<td>Gender roles</td>
<td>10.7</td>
<td>36.4</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

The subject ‘relationships and marriage’ was cited more by the higher age groups and year groups, while the subject of homosexuality was equally distributed among the year groups.

Here too there are gender differences: the subjects of masturbation and prostitution were hardly cited by girls. Quite generally the girls were more reserved about the number of subjects already discussed in class than the boys, and were more likely to say that none of the subjects had been discussed. Since boys and girls get the same sex-education classes, it would be worth investigating why the girls’ responses were so different from the boys’. There is possibly a connexion with the extent of the girls’ interest in the various subjects, which could impact on their memory of the individual subjects.

**Conclusion:** In summary it can be said that biologically oriented subject areas also dominate sex education in special-needs schools, while practical and socio-ethical subjects were secondary. There were differences between the disability groups and the sexes. The differences between the sexes become even clearer when the topics already discussed in class are compared to the need for further information.
Need for further information

From the list of topics already discussed in class, the young people were also asked to indicate how interested they were in each topic. Using a scale from 1 to 3, the young people were to say whether they would like to know more about the topic (1), whether they already knew enough about the topic (2) or whether they were uninterested in the topic (3). The averages were subsequently compared. The lower the value, the greater the young people’s interest in a topic. The following table shows the averages for all the young people as well as the comparison between the girls and the boys, with the relevant rankings (cf. table 14).

The boys showed the greatest interest in subjects such as sexually transmitted infections, love and affection, sexual practices and contraception (ranks 1 to 3). However, most of the male respondents chose ‘I already know enough about it’, in line with their self-assessment of their own knowledge about sexuality (cf. Chapter 5.2.1). This affected the middle rankings 4 to 10 with the subjects of relationships and gender roles, physical development and structure of the sex organs, pregnancy and terminations, masturbation and pornography. The boys were least interested in the subjects of prostitution, the female cycle, and homosexuality (ranks 13 – 11).
Table 14: ‘What topic would you like to know more about?’ gender averages (figures in %)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Boys</th>
<th>Rank</th>
<th>Girls</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted infections</td>
<td>1.76</td>
<td>1</td>
<td>1.65</td>
<td>4</td>
</tr>
<tr>
<td>Love and intimacy</td>
<td>1.79</td>
<td>2</td>
<td>1.65</td>
<td>4</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>1.92</td>
<td>5</td>
<td>1.58</td>
<td>3</td>
</tr>
<tr>
<td>Contraception</td>
<td>1.82</td>
<td>3</td>
<td>1.72</td>
<td>5</td>
</tr>
<tr>
<td>Terminations</td>
<td>2</td>
<td>8</td>
<td>1.48</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>1.99</td>
<td>7</td>
<td>1.54</td>
<td>2</td>
</tr>
<tr>
<td>Relationships</td>
<td>1.90</td>
<td>4</td>
<td>1.73</td>
<td>6</td>
</tr>
<tr>
<td>Sexual practices</td>
<td>1.82</td>
<td>3</td>
<td>1.87</td>
<td>9</td>
</tr>
<tr>
<td>Physical development</td>
<td>1.92</td>
<td>5</td>
<td>1.77</td>
<td>7</td>
</tr>
<tr>
<td>Gender roles</td>
<td>1.98</td>
<td>6</td>
<td>1.73</td>
<td>6</td>
</tr>
<tr>
<td>Structure of the sex organs</td>
<td>2</td>
<td>8</td>
<td>2.02</td>
<td>11</td>
</tr>
<tr>
<td>Female cycle</td>
<td>2.16</td>
<td>12</td>
<td>1.82</td>
<td>8</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>2.13</td>
<td>11</td>
<td>1.88</td>
<td>10</td>
</tr>
<tr>
<td>Masturbation</td>
<td>2.03</td>
<td>9</td>
<td>2.10</td>
<td>12</td>
</tr>
<tr>
<td>Prostitution</td>
<td>2.18</td>
<td>13</td>
<td>2.16</td>
<td>13</td>
</tr>
<tr>
<td>Pornography</td>
<td>2.08</td>
<td>10</td>
<td>2.49</td>
<td>14</td>
</tr>
</tbody>
</table>

1 = I would like to know more about it; 2 = I know enough about it; 3 = The topic doesn’t interest me

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
The girls were the most interested in subjects specific to women, such as terminations, pregnancy and sexual violence (ranks 1 to 3). The girls were more interested and open to sex-education subjects than the boys. The focuses among the girls were on the answer categories ‘I know enough about it’ and ‘I would like to know more about it’. This affected the middle rankings 4 to 11, with the subjects of sexually transmitted infections and contraception, love and affection, relationships and gender roles, physical development and the female cycle, sexual practices, homosexuality and the structure of the sex organs. The girls were least interested in the subjects of pornography, prostitution and masturbation (rankings 14 to 12).

When comparing the averages between the sexes, significant differences existed more for subjects relating particularly to women, such as pregnancy, terminations, the female cycle and sexual violence. However, the subjects of homosexuality and gender roles were also more interesting to girls than to the boys. The visually impaired young people wanted to know significantly less about masturbation than the physically disabled and hearing impaired young people, and they were also less interested in the subject of prostitution than the hearing-impaired students. An age effect existed to the extent that a significantly greater number of 15+ students wanted to know more about the subject of affection and love than younger respondents. This is very probably connected to their own personal experiences.

If we only compare the response ‘I would like to know more about it’ with the subjects already addressed in class, it becomes clear that there is more interest in the subjects that were addressed less in class. This effect is particularly clear among the girls (cf. figure 7).
As has been shown above, the teaching contents mainly focus on biological subjects and contraception. The girls’ interest in these subjects was therefore less pronounced and focused more on areas with an ethical aspect, such as terminations and sexual violence.

This effect of shifted interests can also be seen among the male respondents, albeit not to the same extent (cf. figure 8). The biggest differences between supply and demand exist for the subjects of sexual practices, terminations, pornography and prostitution. There was very little perceived need for information about the structure of the sex organs and the female cycle, which most of the boys had already heard about in class.

Figure 7: Topics addressed in class and the need for more information in comparison, girls only (figures in %)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
**Conclusion:** In summary it can be said that the level of interest in certain sexual subjects depends greatly on the gender of the respondents and their sex education to date. Overall, the boys thought far more often that they already knew enough and therefore showed less interest than the girls in (almost) all of the subjects.

**Sex-education subject: emergency contraception**

Around one in ten of the young people were not informed about the ‘morning-after pill’ (12 %), and almost twice as many boys as girls did not know about it (cf. figure 9). Among the non-informed, around a fifth were 12/13 years old (18 %), but a fifth were also 17/18 years old (21 %), so that the respondents’ age did not seem to correlate with their level of knowledge.
Almost nine out of ten young people had already heard about this form of emergency contraception (88 %), and more than half of them through their school (55.4 %). Among this group, the ones who were significantly most likely to have heard were the physically disabled students (70.3 %), while the hearing-impaired were the least likely (44.4 %). While school was the primary source of information for the boys, the majority of the girls were told about it by their mothers.

Sex education through media such as the television, radio and newspapers as well as through sex-education brochures also seems to work for young people with a disability. Further important reference people were, similar to all sexually relevant subjects, peer groups such as friends, the boy/girlfriend, and siblings. It was mainly the 17 and 18-year-olds who received sex-education information from health funds and advice centres. For all other sources of information there were no significant differences between the disabilities and age groups.

**Conclusion:** This means that disabled young people are also sufficiently educated about the ‘morning-after pill’, even though we cannot comment on the extent the young people actually make use of it. It could merely be shown that the majority of them were informed about it and that they largely obtained their information from school or their families as well as the media.
5.2.6 Contraceptive advice

One very central subject of sex education is providing education about the function of contraceptives and how they work. The intention is to give young people information about how they can protect themselves effectively from unwanted pregnancies and sexually transmitted infections.

This education takes place in part in school, as part of biology, ethics, RE and nature-study classes. Other important institutions for providing information are the parental home and gynaecologists. Therefore, one object of research is to determine to what extent young people talk with their parents about contraception and whether the girls sought advice about contraception from a doctor.

Parents’ recommendations

More than half of the young people had conversations in the home about contraception (59.4 %), more so among the girls (66 %) than among the boys (57 %). The hearing-impaired boys and girls were particularly likely to receive contraceptive information from their parents (boys: 65.9 %; girls 78.6 %), which makes them stand out significantly from the other young people. Two thirds of the visually impaired girls received such advice in the home, compared to one in two physically disabled girls (66.7 % v. 51.9 %); the results are similar for the boys (50 % v. 47.4 %). In addition, the percentage of young people who had already had sexual intercourse and who had received contraceptive advice in the home was higher than for the sexually inexperienced young people (72 % v. 57 %). This suggests that the parents seem to know about their children’s sexual activities and react by providing information.

The most commonly recommended contraceptive method by far was the condom (cf. figure 10), which is most effective and makes most sense for adolescents, since the periods of getting to know each other are short and partners change frequently, and it is the only contraceptive that is entirely uncomplicated to use and protects not just against unwanted pregnancies but also against sexually transmitted infections. Most parents therefore seem to be familiar with the advantages of condoms. Condoms were the number one parental recommendation for both boys and girls, but the boys were significantly more likely to be given it. The girls on the other hand were significantly more likely to be told to use the contraceptive pill; and this was particularly true for the hearing-impaired girls (86.4 %).
Only a few girls received absolutely no recommendation. Only a very small number of respondents said they had been recommended long-acting hormonal injections or chemical contraceptives. Consequently, contraceptives with significant side effects, such as hormonal injections, and unsafe methods such as chemical contraceptives come last among the recommended contraceptives for young women with a disability. Parents recommend contraceptives that are best suited to young people.

**Doctors’ recommendations**

One in three girls had already been to see a gynaecologist to get advice about contraceptive methods (35.4 %); girls with experience of sexual intercourse were significantly more likely to have done this (36 % v. 14 %). These figures correlate with the statements about having been to see a gynaecologist (cf. Chapter 5.3.3). This suggests that the start of the girls’ sexual activity is also cause for seeing a gynaecologist in order to obtain information about contraception.

Among the disability groups, one in two hearing-impaired girls had sought advice from a doctor (46.4 %) – compared to around one in three visually impaired girls (30 %) and one in four physically disabled girls (25.9 %). There was a clear age effect regarding receiving such advice from a doctor: it was not just that the percentage of girls who had received such advice increased with age (12–13 years: 18.2 % v. 17–18 years: 42.9 %), the recommendations also changed. The older the young woman was at the time of the survey, the less likely it was that she had been recommended the use of condoms. Doctors recommended the Pill across all age groups; this was a more common recommendation than condoms (73.9 % v. 69.6 %), (cf. figure 11).
Figure 11: ‘What did the doctor recommend to you as the best form of contraception?’ by type of disability (figures in %)

It was only the physically disabled girls who were 16 or older who said that the doctor’s recommendation regarding the most suitable contraceptive was hormonal injections. Therefore doctors rarely suggested it as the contraceptive of choice to young disabled girls. Further contraceptives were not cited.

**Conclusion:** Condoms and the Pill are not just recommended as the best contraceptive choices for adolescents by parents, but also by doctors.
5.3 Participants’ experiences with their own physicality

Children and young people with disabilities grow up with an understanding that they are in some way different from other children. This ‘being different’ affects either the physical, the sensory or the cognitive area. On the other hand, the disability corresponds to the children’s reality and is therefore integrated into their perception of themselves. For this reason we were interested in finding out how happy they are with their own body, to determine whether young disabled people tend to have a negative or positive self-image.

5.3.1 Body awareness

In general, the young people responded positively to questions about how they dealt with their body and how happy they were with it. Half of the young people liked styling themselves (50 %) and said they felt good in their own body (50.9 %). Only around a tenth of the respondents would like to change themselves surgically (7.9 %) or thought they were too thin (9 %). Around a third of the young people were happy with their own body and considered it attractive (31.1 %), two-fifths thought they were physically fit (43.5 %). Around a fifth of the respondents said they were too fat (21.2 %).

The boys’ responses were very similar to the girls’. However, the girls were significantly more likely to use cosmetic products (63.1 % v. 41.6 %), while the boys were somewhat more likely to feel happy in their own body (57.8 % v. 40.0 %) and think of it as attractive (36.4 % v. 23.1 %). According to the present results, a positive body image is also connected to age: the younger the respondents were, the more likely they were to agree with the statement that they felt happy in their own body (12/13 years: 64.3 % v. 17/18 years: 30.3 %). In general, older teenagers were somewhat more critical about their bodies than the younger respondents. Even greater differences could be found between the different disability groups (cf. figure 12).
Figure 12: ‘How happy are you in your own skin?’ only ‘agree’ responses, by disability (figures in %)

Among the young people surveyed, the hearing-impaired had the best body image. They were much more likely to take part in sports than the physically disabled and the visually impaired, and were also much more likely than the other survey groups to say that they were happy with their appearance. More than half of the physically disabled young people also felt happy in their own body; this group was also the most likely to use cosmetic and styling products. The visually impaired young people had the least positive body image. They were also the most dissatisfied with their weight and therefore with their appearance and their sense of wellbeing. It seems likely that the reasons for this result are to be found in the pre-set answer choices given in the questionnaire. They were primarily focused on the visual appearance. Visually impaired young people have real limits here and appearance loses some of its significance.
5.3.2 Sexual maturity

A physical or sensory disability does not really have an effect on the physical development and therefore on sexual maturity. The average age at which the young people experienced their first period or their first ejaculation was 12.5 in the current sample. Among the participating girls, the ages ranged from 10 and 15. Three out of four girls started getting periods before they were 14 (72.3%). A period before the eleventh birthday was the absolute exception (cf. figure 13). The majority of the girls were either 12 or 13. A fifth of the girls had their first period when they were 14 or 15 and only a very small percentage of the respondents (particularly among the younger ones) had not had a period yet. There were no differences between the disability groups.

Figure 13: ‘How old were you when you had your first period/your first ejaculation?’ by gender (figures in %)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

In contrast to the first period, the first ejaculation seems to have been a less dramatic and therefore a less memorable event. As was mentioned in >Chapter 4.3.2, some students had problems understanding the term ‘Samenerguss’ (ejaculation). Some did not know the word, others had difficulties distinguishing between an ejaculation they brought about alone (through masturbation) and one as a result of sexual intercourse.
As a result, the results here do not have great validity and are to be regarded with caution. They also reflect the ambiguity of the semantic understanding. According to statements by the participating boys, the age range of the first ejaculation was from 7 to 16. Around a fifth said they had never ejaculated, including many 15 to 17-year-olds. To what extent these were paraplegic boys, for example, cannot be determined with certainty here, but merely presumed.

A significant difference between the disability groups could not, however, be determined. Around one in two boys experienced his first ejaculation before the age of 14 (47.1 %). Ejaculating before the age of eleven was not all that rare either (12.6 %). The majority of the boys were either 12, 13 or 14. A very small percentage of the boys experienced their first ejaculation at 15 or 16. 9 % were unable to remember their exact age.

**Conclusion:** A correlation between early sexual maturity (defined here as 11 years and younger) and sexual activity could not be found for young people with a disability. Among the sexually experienced young people there were significantly more young people who had reached their sexual maturity at age 12 and older than young people who might be regarded as precocious in this respect (81.1 % v. 18.9 %). This was true of both the boys and the girls.

There were also no gender differences in the responses to the question whether the young people had been prepared for their first period/ejaculation. More than half of the young people were informed about it (53.0 %), almost a third were only partially informed (31.1 %). 15.9 % of the respondents were unprepared, including more than half of the physically disabled young people and more than half of the hearing-impaired young people.

### 5.3.3 Seeing a gynaecologist

In general, after the onset of menstruation, which at the time of the survey had occurred in more than 90 % of the girls at the time of the survey, as stated in Chapter 5.3.2, the girls also tended to see a gynaecologist for the first time. However, this was only true for every second girl (47.7 %). The other half had not yet been to see a gynaecologist.

The girls with a physical disability were the least likely to have been to see a gynaecologist (37 %). The corresponding figures for the visually and hearing-impaired girls were 60 % and 53.6 % respectively. With the increasing age of the respondents, the percentage of them who had already been to see a gynaecologist ought to increase. This was not, however, the case with the present sample. Regardless of the disability, the 16 to 18-year-olds were the most likely to have said they had already seen a
gynaecologist. This was also true for all the visually impaired 14-year-old girls too (figure 14). It is striking that very few 15-year-olds had already been to a gynaecologist, regardless of the type of disability.

Figure 14: Percentage of girls who have been to see a gynaecologist, by age (figures in %)

There was also a connexion between an appointment with a gynaecologist and the onset of sexual activity. The girls who had already had experience of sexual intercourse were significantly more likely to have been to a gynaecologist than those who had not (25.8 % v. 5.9 %). However, this data does not permit the conclusion that both events took place at around the same time.

Just over half of the girls were 14 or older when they saw a gynaecologist for the first time (54.3 %) and only around one in eight were 11 or younger (13.4 %). When asked about the reasons for going, the 31 girls most commonly cited contraception (11 mentions), followed by menstrual and lower abdominal complaints (8 mentions each), check-ups (4 mentions) and HPV vaccinations102 (3 mentions). Further reasons, given by just one or two girls, were lower abdominal surgery and a suspected pregnancy. For four out of five girls, regardless of their disability,
the first appointment with a gynaecologist was the way they imagined it would be. If the girls evaluated the visit as more pleasant than expected, it was because of the doctor's helpfulness and friendliness; if it was less pleasant than expected, the girls' fears and embarrassment/modesty were the main reasons.

5.4 Sexual experiences

In addition to the question about disabled young people’s access to sex education and advice, the study wanted to learn more about the young people’s experiences in the sphere of sexual activities. This included questions about the formation of relationships, sexual experiences with and without intercourse, experiences with masturbation and experiences with homosexual contacts as well as a question about the reasons for a lack of sexual experience.

5.4.1 Types of sexual contacts

The existence of a relationship
The existence of a relationship is not a requirement for having sexual experiences, but it opens up a broad spectrum for making sexual experiences. It is not just the availability of a partner that is advantageous. The emotional bond also makes the explorative approach of the first sexual experiences easier. This is true for all relationships with or without disabilities.

Two in five young people were in a steady relationship at the time of the survey, apart from the visually impaired boys, of whom only around a quarter had a steady girlfriend (cf. figure 15).
There is a significant correlation between the existence of a relationship and the first experience of intercourse. While only a third of the respondents without sexual intercourse experience were in a steady relationship, more than two-thirds of the respondents who had already had such experience were in a steady relationship (31.2 % v. 68.4 %). This confirms the theory that the existence of a relationship increases the probability of having sexual intercourse for disabled young people too. Age and gender did not have an effect.

**Sexually inexperienced young people**
Around a quarter (25.6 %) of the respondents had not yet had any sexual contact with the opposite or the same sex. The percentage was slightly higher for the boys than for the girls (27.2 % v. 23.1 %).

Age is crucial for the development of sexual activity. The percentage of the sexually inexperienced rapidly decreased among the 16-year-olds. Around two-fifths of the 12 to 15-year-olds had not yet had any kind of sexual encounter with the same or the opposite sex (37.2 %), the same was true for only a fifth of the 16 to 18-year-olds (19.3 %). There were also clear differences between the disability groups: while the percentage of sexually inexperienced young people decreased with age among the physically disabled, it remained relatively constant across all age groups among the visually and hearing-impaired (figure 16).
**Figure 16: ‘Have you ever kissed a boy/girl or been intimate with a boy/girl?’ only ‘no’ responses, by age and type of disability**
(figures in %)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Physically disabled (n = 65)</th>
<th>Visually impaired (n = 31)</th>
<th>Hearing impaired (n = 73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13 years old</td>
<td>44.4</td>
<td>33.3</td>
<td>23.1</td>
</tr>
<tr>
<td>14 years old</td>
<td>37.5</td>
<td>57.1</td>
<td>13.3</td>
</tr>
<tr>
<td>15 years old</td>
<td>50</td>
<td>0</td>
<td>22.2</td>
</tr>
<tr>
<td>16 years old</td>
<td>0</td>
<td>18.8</td>
<td>16.7</td>
</tr>
<tr>
<td>17/18 years old</td>
<td>16.7</td>
<td>57.1</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

In comparison to the hearing-impaired young people, the physically disabled young people claimed to have the least sexual experience (33.8 % v. 19.2 %). Among the visually impaired respondents around a quarter had had no kind of sexual experience (23.3 %). However, there was no kind of linearity across the age groups here.

When asked about the reasons behind their lack of experience, the young people tended to give two. The most important one was a lack of the right partner. More than two-thirds of the young people picked this reason: both the boys (69 %) and the girls (71.4 %). Both sexes also agreed on the second-most significant reason: shyness. This was cited a bit more by the boys (48.3 %) than by the girls (42.9 %). The third-most common reason was the young people’s fear of doing something wrong. This reason was primarily cited by the boys who had never kissed or cuddled a girl before (44.8 % v. 21.4 % for the girls) and increased with age. The girls, on the other hand, were more worried than the boys that their parents could find out (21.4 % v. 10.3 % among the boys); although this was a greater concern for the older teenagers. Last but not least the boys were more likely to explain their lack of experience by citing lack of interest (17.2 % v. 7.1 %), particularly among the under 14-year-old boys. A few believed they were too young. There were hardly any differences between the different disability groups.
**Conclusion**: In summary, the lack of the right partner and shyness were the two main reasons why young people did not engage in sexual activities with the other or the same sex. In addition, the boys were worried about doing something wrong during intercourse. The girls, meanwhile, were concerned about their parents finding out.

**Sexual experiences without intercourse**
The survey distinguished between various sexual activities that did not involve intercourse, namely kissing, breast petting (boy strokes girl’s breasts), male-active genital petting (boy touches girl’s sex organs) and female-active genital petting (girl touches boy’s sex organs). Kissing was by far the most common form of intimate physical contact between the young people. Around three out of four young people had already kissed, the girls somewhat more often than the boys (76.9 % v. 72.8 %). Having experience with kissing was not necessarily a question of age: while the different ways of petting became significantly more common with age, the percentage of 12 and 13-year-olds who had kissed already was similarly high to that of the 14 and 15-year-olds. It was only from 16 onwards that the percentage of young people who had kissed before rose significantly above that of the younger age groups.

Compared with the boys, all the girls, except for the 14-year-olds, had more experience with kissing (cf. figures 17 and 18). When asked about experience with genital petting, this relationship was reversed.
Figure 17: ‘What have you done or experienced already?’ only girls, by age (figures in %)

n = 65
Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
In contrast to kissing, other sexual activities without intercourse are very much age-related. The older boys and the older girls were both significantly more likely to have had experience with breast and genital petting than their younger counterparts. The same percentage of boys had engaged in breast and genital petting across the age groups, while among the girls a larger percentage had only experienced breast petting. Overall, the 17 and 18-year-olds were the ones who had the most experience of sexual activities without intercourse, as was to be expected. It was merely with kissing that the 16-year-olds had a higher percentage than the 17 and 18-year-olds.

There were only significant differences between the disabilities among the boys: while every second to third boy with a hearing impairment had already experienced breast petting (46.7 %) as well as male and female-active genital petting (46.7 % and 33.3 % respectively), the same was only true for 10 % to 20 % of the physically disabled and visually impaired young people. The girls’ experiences with petting were similar across the disability groups.

The reasons why the young people stopped short of intercourse were diverse and differed depending on gender and type of disability. The boys and girls had in common that they still felt too young for sexual intercourse (table 15).
Table 15: ‘Why haven’t you had sex yet?’ (figures in %)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Boys</th>
<th>Rank</th>
<th>Girls</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of cases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m still too young for that</td>
<td>27</td>
<td>2</td>
<td>41.8</td>
<td>1</td>
</tr>
<tr>
<td>I haven’t met the right boy/girl for that</td>
<td>43.2</td>
<td>1</td>
<td>14.5</td>
<td>5</td>
</tr>
<tr>
<td>I’m scared of doing something wrong</td>
<td>24.3</td>
<td>3</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>I’m too shy</td>
<td>18.9</td>
<td>4</td>
<td>14.5</td>
<td>5</td>
</tr>
<tr>
<td>I don’t want to</td>
<td>8.1</td>
<td>7</td>
<td>23.6</td>
<td>2</td>
</tr>
<tr>
<td>I’m scared of a pregnancy</td>
<td>9.5</td>
<td>6</td>
<td>21.8</td>
<td>3</td>
</tr>
<tr>
<td>My parents could find out</td>
<td>13.5</td>
<td>5</td>
<td>10.9</td>
<td>6</td>
</tr>
<tr>
<td>The boy/girl refused</td>
<td>6.8</td>
<td>8</td>
<td>1.8</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

Around half of the 12 and 13-year-olds still felt too young for sexual intercourse. Among the 14-year-olds this reason was only cited by a quarter. The fear of doing something wrong and the lack of a relationship were the most common reasons among the 17 and 18-year-olds. More girls than boys were worried about their age. Among the boys, the absence of the right partner was the main reason, followed by feeling too young and the fear of doing something wrong.

In response to the question why the respondents had never kissed or cuddled before, significantly more boys than girls answered with the fear of being clumsy; and more girls than boys were worried their parents could find out about it (see above). When asked why they did not go further and have sexual intercourse, these differences were not present anymore: here the boys and girls were equally worried about doing something wrong and their parents finding out.

Alongside insufficient maturity, a lack of interest and concern about becoming pregnant were, for the girls, the main reasons for staying away from further sexual activities. The 15-year-olds and the visually impaired young people were least worried about a pregnancy. The latter group also said most often that they did not have the right partner.
The physically disabled young people were the shiest. They were also most worried about their parents finding out. The hearing-impaired young people were on the one hand the most sexually active, on the other hand they were the disability group that said most often they had not had sexual intercourse because they lacked interest and because they felt too young. The fear of being clumsy was expressed to roughly the same extent by all the young people, regardless of their disability.

**Conclusion:** In summary, the majority of the boys cited external reasons for not having had sexual intercourse, such as the absence of a partner, while a smaller percentage also included personality factors, such as lacking maturity and the fear of being clumsy. The girls primarily invoked internal factors such as lacking maturity, lacking interest and the fear of a pregnancy, which reveals that a lot of girls still want to wait before having sex for the first time.

**Experiences with sexual intercourse**

As shown in Chapter 4.3.2, only a portion of the responses regarding sexual intercourse experience could be incorporated in the evaluation. According to the responses, only around a quarter of the 14 to 18-year-olds with a disability had already had sexual intercourse (23.2 %), while the percentage was around a third among the 15 to 18-year-olds. Twice as many boys as girls said they had already had sexual intercourse (28.2 % v. 15.4 %).

There were hardly any differences between the disabilities. The percentages varied between 11.1 % and 20 %. Among the male respondents there were significant differences: while around one in two of the hearing-impaired boys had already had sexual intercourse (44.4 %), the same was only true for every fifth visually impaired boy (20 %) and one in ten physically disabled boys (13.2 %). As a result, the hearing-impaired young people were not just the ones with the most kissing and petting experience, but also with the most sexual intercourse experience. Among the young people with a disability, they were the most sexually active, which presumably has to do with their being the least restricted in their mobility compared to the other young people surveyed. That way they can move about freely in the circle of their peers, while physically disabled and visually impaired young people are often dependent on a companion or on an assisted-transport service.

As with the sexual activities without sexual intercourse, the percentage of those who had already had sexual intercourse increased with age. This was unequivocally true for the female respondents (cf. figure 19).
Among the male participants there was no such linear increase. Among the boys, the 15-year-olds were the group with the most sexual intercourse experience. However, this average value is not valid for all the disability groups, because two-thirds of the sexually experienced 15-year-old boys were hearing-impaired.

**Conclusion:** This survey found that the young people with the most sexual intercourse experience were male, 15 and hearing-impaired.

**Estimated percentage of peers with sexual intercourse experience**

Young people often have a wrong idea about how widespread sexual relationships are in their age group. For that reason the boys and girls were asked to estimate how many of their peers had already had sex.

The young people’s assessments differ less by gender and disability and more by the respondents’ age and whether they themselves had already had sexual intercourse. Generally speaking, the disabled young people aged 14 and older tended to overestimate the percentage of their peers who had already had sex (table 16).

103 Cf. Bundesministerium für Familie, Senioren, Frauen und Jugend 2011
Table 16: Estimated and actual percentage of peers who have had sex (figures in %)

<table>
<thead>
<tr>
<th>Age-group</th>
<th>Actual % of those with SI experience</th>
<th>Correctly estimated proportion</th>
<th>Underestimated proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/13-year-olds</td>
<td>0 % ('A few')</td>
<td>60 % 'A few'</td>
<td>40 % 'A third', 'Half', 'Most of them'</td>
</tr>
<tr>
<td>(n = 28)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-year-olds</td>
<td>0 % ('A few')</td>
<td>24.1 % 'A few'</td>
<td>75.9 % 'A third', 'Half', 'Most of them'</td>
</tr>
<tr>
<td>(n = 30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-year-olds</td>
<td>31 % ('A third')</td>
<td>7.7 % 'A third'</td>
<td>61.5 % 'Half', 'Most of them'</td>
</tr>
<tr>
<td>(n = 42)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-year-olds</td>
<td>34.3 % ('A third')</td>
<td>31.4 % 'A third'</td>
<td>48.6 % 'Half', 'Most of them'</td>
</tr>
<tr>
<td>(n = 36)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17-/18-year-olds</td>
<td>33.3 % ('A third')</td>
<td>20.7 % 'A third'</td>
<td>68.8 % 'Half', 'Most of them'</td>
</tr>
<tr>
<td>(n = 33)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

Three out of five young people in the youngest age group made the right assessment about their peers and another quarter opted for the next-highest category. Among the 14-year-olds around a quarter chose the correct answer (‘not many’). The remaining 75 % overestimated the percentage of peers who had already had sex, sometimes very much so. They most commonly said ‘half of them’ (34.5 %). The 15-year-olds are very interesting: around a third of them had already had sexual intercourse, but not even a tenth of the respondents was right about this percentage. Instead they either assumed that half or most of their peers had already had sex (35.9 % and 25.6 %). A third underestimated the percentage, saying only a few peers had already had sex (30.8 %). The assessment of the 16-year-olds was much more accurate: in this group around a third had already had sexual intercourse and the same number correctly judged the percentage of peers who had already had sex.
Around half of the 16-year-olds overestimated the percentage, while a third even chose the answer category ‘most of them’ (31.4 %). 20 % of the 16-year-olds assumed that only few of their peers had already had sex. The 17-year-olds were also more likely to overestimate the percentage than underestimate it. The answer category ‘a third’, which corresponded to the actual (response) figures, was only chosen correctly by a fifth of respondents in this group. Instead, more than two-thirds of the 17-year-olds believed that half or most of their peers had already had sex (37.5 % and 31.3 %).

Even though the actual percentages of young people with intercourse experience were fairly identical for the 15 to 18-year-olds at around a third, with increasing age, the respondents were also more likely to think that the percentage of experienced peers was higher (figure 20).

**Figure 20:** ‘What do you think, how many girls and boys your age have already had sex?’ only ‘a few’ and ‘most of them’ responses, by age (figures in %)

That means the older young people were particularly likely to develop incorrect ideas about how widespread sexual activities were within their age group. But age was not the only factor influencing their assessment. So too was their own sexual experience. While those who had not yet had sex were significantly more likely to choose ‘only a few’ rather than ‘most of them’ (34.7 % v. 19.8 %), the figures were
reversed among those who had already had sex. In this group the majority of the young people chose ‘most of them’ and only around a tenth said ‘only a few’ (35.9 % v. 10.3 %).

**Conclusion:** The results show that the assessments of peers’ sexual intercourse experiences are largely connected with the respondents’ age and their personal experiences with sexual intercourse.

**Experiences with masturbation**

The assumption that masturbation is a common practice among young men is also reflected by the data. Regardless of the nature of the disability, more than half of the boys had masturbated in the past twelve months (cf. figure 21). Those over the age of 15 with sexual intercourse experience were significantly more experienced with masturbation than those under the age of 14 and with no sexual intercourse experience. The percentage of girls who were experienced with masturbation was a lot lower. Those who were 15 and older had masturbated somewhat more often, but here too only around one in five girls said they engaged in the practice.

**Figure 21:** ‘Have you masturbated in the past twelve months?’ by gender, age and sexual-intercourse experience (figures in %)

---

Boys: n = 104, Girls: n = 65, Sexually experienced: n = 39, Sexually inexperienced: n = 130, 14 and younger: n = 58, 15 and older: n = 111

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
**Conclusion:** In summary it can be said that masturbation is primarily a common practice among older boys who have already had sexual intercourse.

**Experiences with homosexuality**
Sexual encounters with the same sex are not uncommon in puberty and are rooted in the adolescents’ curiosity about the variety of encounters available. Around one in five girls (20.3 %) and one in ten boys (9.8 %) with a disability had already had a homoerotic or homosexual encounter. The girls were significantly more open to sexual experiences with the same sex. It should be kept in mind, however, that the young people could have had difficulties assessing whether this was temporary curiosity or an actual manifested sexual orientation. In addition it is conceivable that the young men were worried about being stigmatized as ‘gay’ by others. In what manner homosexual encounters took place varied between the sexes as well as the disability groups (cf. figure 22).

**Figure 22:** ‘What have you done/experienced with a girl/boy or woman/man before?’ by gender and type of disability (absolute figures)

<table>
<thead>
<tr>
<th></th>
<th>Kissing</th>
<th>Touching genitals</th>
<th>Sexual intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls: n = 13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys: n = 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physically disabled: n = 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visually impaired: n = 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing impaired: n = 13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Girls: n = 13, Boys: n = 10, Physically disabled: n = 5, Visually impaired: n = 5 Hearing impaired: n = 13
Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
Conclusion: Kissing a member of the same sex was the most common exchange among all of the respondents, followed by touching genitals. Around one in five girls and one in three boys had had sexual intercourse with the same sex. Girls were more likely to report homosexual encounters, but they generally focused on exchanging affection. Boys have fewer homosexual contacts, but when they do, they were more likely to involve petting and sexual intercourse. The latter is more true for the young people with a hearing impairment, who, as explained in the section on experiences, were also the ones with the most sexual-intercourse experience overall.

5.4.2 The first experience of sexual intercourse

The following section will look at the results to all of the questions about the first sexual intercourse. The data includes the age of the sexual partners, the level of familiarity with the partner, initiative, the subjective experience and retrospective assessment of the timing, contraception and reasons for no contraception, and other people’s knowledge of the event. Since the absolute number of sexually experienced disabled young people in the survey is small, where necessary we will give ratios instead of the normal percentages. The depictions make do entirely without figures to avoid the possibility of drawing conclusions about individuals. For detailed analyses by age group, nature and severity of the disability etc. larger samples would be needed than the ones available here, so that the evaluation focuses primarily on the gender differences.

Age at first intercourse

The age range during which the young people first had sexual intercourse was between 12 and 17. A correct evaluation of the age of first intercourse would have to take place retrospectively, i.e. in adulthood, when the probability of engaging in sexual encounters is highest. Overall, three out of four young people had not yet had sexual intercourse; nor indeed had two out of three 17 and 18-year-olds. Therefore no representative information about when young disabled people first have intercourse could be obtained from the age groups surveyed. There are tendencies however, such as that the boys were sexually active earlier than the girls. Among the hearing-impaired boys, there was a very high percentage of 15-year-olds who had first had intercourse when they were 14. Among all the respondents, they were the sexually most active and experienced group. The girls tended to wait a little longer before becoming sexually active. They were most likely to be 15 or older when they had their first time, regardless of the nature of their disability.

With regard to the partner’s age, the girls clearly preferred an older partner. On average, he was two years older. Around a third of the girls first had intercourse with a partner who was the same age as them, with all others the partner was older than
the girl herself. Among the boys, the pattern was less obvious. Although around half the boys first had intercourse with an older girl, one in three had a partner who was the same age and approximately one in five had one who was younger.

**How well known was the partner?**

Three out of four boys were in a steady relationship with the partner they first had intercourse with. The others at least knew their partner well, regardless of the age of the boy and the nature of the disability. None of the boys said they did not know their partner well or at all. Most of the boys met their partner at school, but they also met during activities after school, through friends and online. The physically disabled boys were most likely to meet a partner in their group of friends, the visually impaired in school and the hearing-impaired during activities after school, at school or online. In comparison with the physically disabled and visually impaired young people, the hearing-impaired are more mobile and less restricted in their ability to get to know members of the opposite sex. Only in one of around four cases was the partner also disabled; but if she was, she was most likely to have the same disability as the respondent.

Among the girls, only one in two were in a steady relationship with their partner. The other half, which primarily consisted of girls aged 16 and older, knew their partner well, regardless of the type of disability. None of the girls said they had not known their partner well or at all. They met their partners in their group of friends as well as during after-school activities and online, but most commonly at school. For this reason one in two girls first had intercourse with another disabled partner, but he tended not to have the same disability or illness as the girl herself. This is possibly to do with the variety of impairments that are accommodated within a particular type of special school (cf. Chapter 3.2). However, as a result of the small sample, it could also be a purely chance result.

**Conclusion:** Boys generally first had intercourse within a steady relationship and with a non-disabled person. This is surprising, because young people with a disability often stay within a homogeneous group. Therefore, the question arises as to how the young people define the term ‘disability’ and whether young people with less visible disabilities are more able to get involved with non-disabled young people and to become sexually active sooner than young people with more noticeable disabilities. For the girls, their first experience of intercourse did not necessarily take place within a steady relationship, and their partners were just as likely as not to be disabled. How well they knew their partner did not correlate with the existence of a disability or illness.
Initiative for the first time

In the majority of cases, the respondents had intercourse for the first time because both partners expressed the desire. However, among two out of five young people the answers were somewhat non-committal, in that they answered with ‘it just happened that way’. Only a very small percentage went through with it only because of their partner’s wishes, and in these cases it was always because of the male partner’s wishes. While there was a shared desire among the younger respondents, the arbitrariness of the timing increases with the respondents’ age (cf. figure 23).

Figure 23: ‘Why did you first have intercourse?’ by gender and age (absolute figures)

![Figure 23](image)

It was characteristic of the boys surveyed that they said there had been a shared desire to experience intercourse for the first time, while every second girl described the initiative for the first time with ‘it just happened like that’, and one in five girls thought the one-sided desire of her partner was the trigger. Almost all the young people with a physical disability described a certain chance nature of the events leading to their first experience of intercourse. In comparison, the same was true for only one in four young people with a hearing impairment.

Conclusion: It was particularly the younger boys who first experienced intercourse as a result of mutual desire, while the girls and the physically disabled respondents
were more likely to say ‘it just happened like that’. Only the girls described any dominance on the part of their partner.

**Subjective experience of the first act of intercourse**
The disabled young people described their first intercourse as something extremely positive. Three out of four young people experienced it as something pleasant. Around a fifth of the young people described it as nothing special; this was expressed somewhat more by young people who were 14 or younger at the time. Only approximately a tenth of the respondents felt their first time had been something unpleasant, or reported that they subsequently felt guilty about it. The boys were more likely to describe their first time as something pleasant. Girls as well as the visually impaired were just as likely to describe their first time as ‘something pleasant’ or as ‘nothing special’. The majority of the young people with a physical disability or a hearing impairment experienced their first time as ‘something pleasant’.

Those who had experienced their first intercourse as a result of the one-sided desire of their partner gave it a negative connotation. Those who merely knew their partner ‘well’ also tended to feel guilty. If there was a steady relationship, the first time was experienced as something pleasant.

**Conclusion:** These results suggest that the positive interpretation of the first act of intercourse is associated with a steady relationship and the mutual desire of the two partners. Boys apparently experienced this combination of circumstances more often.

**Assessment of the timing**
More than half of the young people thought they had first had intercourse at the right time (51.3 %). A third thought it was a bit early and 7.7 % thought it was much too early, while another 7.7 % thought it was really rather late. Interestingly, the boys’ assessments do not differ from the girls’. Nor did relationship status and the subjective experience have an influence on how the young people felt about the timing. Rather, the age when they first had intercourse, and the nature of the disability, were much more significant (cf. figure 24).

The younger the respondents were when they had sex for the first time, the more likely they were to say that the timing had been somewhat or very much too early. If the young people were 15 or older, they were much more likely to say it was just the right time.
The hearing-impaired young people had a similarly critical perspective to that of the ‘early bloomers’. While the majority of the physically disabled young people and almost all the visually impaired young people judged the timing to be appropriate, around half of the hearing-impaired young people said the timing had been somewhat or very much too early. Given the fact that the hearing-impaired young people reported having a lot of sexual activity, and at an early age, this result might be seen as surprising, because this activity was largely the result of mutual desire and was also associated with a positive subjective experience.

**Contraception the first time**

Almost nine out of ten young people used contraception the first time they had sex, regardless of the age at which it happened, their gender and the nature of their disability. Two-thirds of the respondents used a condom the first time they had sex. Around a third (in the case of boys, their female partner) used the contraceptive pill. A fifth used a combination of both of these. The percentage who used a hormonal injection was less than the percentage of those who did not use any contraception at all the first time they had sexual intercourse. The (reported) contraceptives were used.
distributed relatively equally between the genders, except for the statement that the Pill had been the sole contraceptive. This was stated only by the male respondents (cf. figure 25). This is probably because some of the boys surveyed had older partners. It is likely that the latter were already on the Pill at the time in question, so that there was no need for additional contraception.

While around half of the young people with a physical disability or visual impairment used condoms, the same was true for three out of four of the hearing-impaired young people. The Pill was predominantly used by the physically disabled young people (or, in the case of boys, their female partners).

**Figure 25: ‘What contraception did you use the first time?’ by gender**

(absolute figures)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

Around three out of four young people who were recommended condoms as the best contraceptive by their parents also used it the first time they had intercourse (either on its own or in conjunction with the Pill). By comparison, the Pill was only used by a third of those who were recommended it by their parents. That reveals that condoms were the method of first choice when it came to using contraception at the onset of sexual activity.
The few respondents who did not use any contraception the first time they had sex said this was because of the spontaneity of the situation, as well as because they were scared to buy condoms and to raise the issue of contraception in general.

**Other people's knowledge**

On average, the young people told two other people that they had had sex for the first time. The number of people ranged from one to six. Very few respondents had not spoken to anyone about it.

If the young people were 14 or younger when they had sex for the first time, then they told three or more people about it. Among those who were 15 or older, they only told one to two people. Boys communicated more with two people, while girls were most likely to share their experience with one person, and most commonly with their best (girl) friend (cf. figure 26). The second most likely confidant was the mother and the (current) partner – a sister or other young people were not informed very often.

**Figure 26:** ‘Who did you talk to about the first time?’ by gender, multiple responses possible (figures in %)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011
Among the boys, the favourite confidants were less clear, but more widely scattered. The best (male) friend was also in first place, followed by the (current) partner, a brother and other boys. Only the older boys said they had not spoken to anyone about having had sex for the first time. A further age effect was that the ‘early bloomers’ were more likely to communicate with their parents as well as with peers. The differences between the disability groups were almost negligible. The one thing worth mentioning is that none of the physically disabled young people went to their (current) partner as someone to talk to about the experience.

**Conclusion:** In summary it can be said that young people tend to inform a third party about having had intercourse for the first time, but depending on their gender and the age when this event took place, they inform varying numbers of people. It would be interesting to find out in this context how much time passed between the first act of intercourse and the time when the young people told others about it, and whether there are differences among the different groups.

### 5.4.3 Sexual experience

**Amount of sexual intercourse and number of sexual partners**

Even though the percentage of sexually experienced boys was still clearly above that of the girls (cf. *Chapter 5.4.1*.), further evaluation revealed that the girls were nonetheless the more sexually active. Compared with the boys, the girls in our sample had had sexual intercourse more often in their lives. More than two-thirds had already had sex more than once and two out of five girls more than ten times (figure 27).
Among the boys, around a third had had sex just the once, and another third had had sex two to ten times. The remaining third had had sex more than ten times already.

The age when they first had sex did not play a significant role in our sample with regard to the amount of sex the respondents had had so far. The nature of the disability also only had a minor influence on sexual activity. For the physically disabled young people, sex was primarily a one-off experience so far, while the visually and hearing-impaired had already had sex more often. Young people who were currently in a steady relationship had also already had sex more often than young people without a steady partner.

There was a high correlation between the amount of sex so far and the number of sexual partners to date. The girls and boys with disabilities were not very different in their sexual relationships (cf. figure 28). The percentages that had had more than three partners were almost identical and there were only marginal differences between the girls and boys regarding those who had only had up to three partners.
The younger the respondents were the first time they had sex, the greater the number of sexual partners to date. All the ‘late bloomers’ had had a maximum of two partners; two-thirds of the early bloomers had had three or more partners. The latter group primarily consisted of hearing-impaired boys.

**Conclusion:** While the amount of sexual activity was very much linked to gender, the number of sexual partners also depended on the age at which the young people first became sexually active.

**Contraceptive behaviour during the most recent sexual intercourse**
As against the first time, the percentages of the various contraceptives used had shifted somewhat. For the first time, every second young person had used a condom, but during the most recent sexual intercourse, this figure had dropped to a third. The percentage of Pill-users had tripled from one in ten to three in ten young people. The use of hormonal injections had dropped, as had the use of the Pill in conjunction with condoms.

Overall, the young people’s contraceptive behaviour changed somewhat over time. The girls used contraceptives a little less often compared to their first time, while the boys tended to use contraception a bit more often (cf. figure 29).
Figure 29: **Comparison of the contraceptive behaviour the first time and the most recent time, by gender (absolute figures)**

Condoms remained the method of choice for boys, even during their most recent sexual intercourse experience, especially if the boys were among the younger age groups at the time of the survey. Hardly any of the girls cited having used condoms during their most recent sexual experience. Instead, they opted for hormonal contraceptives, particularly the Pill, regardless of their age. Boys were also proponents of the Pill, often also in combination with condoms.

In general, it can be said about the young people’s contraceptive behaviour that more than half of the sexually active young people always paid very close attention to preventing a pregnancy, regardless of age. A quarter of them usually or almost always paid attention to birth control, while one in five young people never or rarely paid attention to it. The most negligent were the 15-year-olds, where only a third paid very close attention to preventing a pregnancy. This behaviour was also reflected in the attitudes towards a potentially occurring unexpected pregnancy: almost all of the respondents who never or only rarely paid attention to birth control had a positive attitude towards an unexpected pregnancy. Among those who said an unexpected pregnancy would be a disaster or very unpleasant, more than four-fifths always paid very close attention to contraception. → Chapter 5.5 addresses the other ideas young disabled people have about their future; their desire to have children is addressed in → Chapter 5.6.
5.4.4 Experiences with sexualized violence

According to a current study by the Bundesministerium für Familie, Senioren, Frauen und Jugend (Federal Ministry for the Family, Senior Citizens, Women and Youth), one in three to one in four disabled women are affected by sexual assaults in childhood and adolescence at the hands of adults, children or peers; women with a hearing impairment were the most vulnerable. In our study, we too asked the young people about their experiences with violence. More than a tenth of the respondents had already been affected by sexualized violence (14.2 %). Twice as many of them were girls rather than boys. One in four girls had therefore already been affected by sexualized violence, especially the hearing-impaired girls (figure 30). Among the boys and the visually impaired young people, the percentage who made no response to this question was relatively high. This could indicate a large number of unreported cases as a result of feelings of shame and guilt. Among the male respondents, the hearing-impaired were the most likely to report experiences with violence, mirroring the girls’ results.

104 Cf. Bundesministerium für Familie, Senioren, Frauen und Jugend 2011
Figure 30: ‘Has a boy or man ever tried to be intimate with you or have sex with you against your will?’ by gender and type of disability (absolute figures)

The perpetrator was most likely to have come from the young people’s close social surroundings. While the girls were most likely to experience sexual assaults by an ex-partner as well as in equal measure by a male friend, a male classmate or an unknown man, the boys were most likely to have been assaulted by a male friend or male classmate and less likely to have been assaulted by a man they were dependent on (coach, teacher etc.). In most cases the attack was staved off so that no (further) sexual acts followed. It was very rare for sexual intercourse to be performed. Somewhat more frequently the victims were forced to kiss and touch the genitals. Around a quarter of those affected subsequently turned to an adult, mainly the parents, while around a third told a friend about the experience. A similarly high percentage, namely almost two-fifths of those affected by sexual violence, told nobody about it. The question remains open whether these young people actually had someone they could have talked to, or whether fear and shame prevented a conversation about it.
5.5 Prospects for the future

Children and young people with disabilities grow up with the understanding and the experience that their lives will be limited in some areas, while other areas will be entirely closed to them. From the study ‘Lebenswelten behinderter Kinder und Jugendlicher in Sachsen’\(^{105}\) (‘Living circumstances of disabled children and young people in Saxony’) we know that children and young people with disabilities have similar desires and ideas about the future as their non-disabled peers. For that reason we asked about the importance and achievability of their future goals in this study. The following table ranks their future goals in order of importance (cf. table 17).

Table 17: ‘How important is it to you to have the following things in your future?’

<table>
<thead>
<tr>
<th>Rank</th>
<th>Future goal</th>
<th>Percentage 'important'</th>
<th>Average boys (n = 104)</th>
<th>Average girls (n = 65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Having a job</td>
<td>93.4</td>
<td>1.93</td>
<td>1.91</td>
</tr>
<tr>
<td>2</td>
<td>Having my own flat</td>
<td>86.1</td>
<td>1.88</td>
<td>1.78</td>
</tr>
<tr>
<td>3</td>
<td>Having a partner</td>
<td>77.8</td>
<td>1.71</td>
<td>1.75</td>
</tr>
<tr>
<td>4</td>
<td>Having lots of friends</td>
<td>70.5</td>
<td>1.71</td>
<td>1.55</td>
</tr>
<tr>
<td>5</td>
<td>Having lots of money</td>
<td>59</td>
<td>1.61</td>
<td>1.42</td>
</tr>
<tr>
<td>6</td>
<td>Having children</td>
<td>35.4</td>
<td>1.07</td>
<td>1.23</td>
</tr>
<tr>
<td>7</td>
<td>Having a fulfilled sex life</td>
<td>32.9</td>
<td>1.22</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Important = 2, somewhat important = 1, not important = 0
Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

Almost all the respondents expressed the desire to have a job in the future, making the disabled young people’s career orientation their central life goal. They are therefore no different from the young people with and without disability in the aforementioned study ‘Lebenswelten behinderter Kinder und Jugendlicher in Sachsen’\(^{106}\). The rankings of the other future goals were also identical to the results of 2003. These goals included having their own home, having a relationship and having lots of friends. It was merely the importance of a relationship compared with the importance of a big circle of friends that was ranked more highly here than in

\(^{105}\) Michel/Häussler-Sczepan/Riedel 2003
\(^{106}\) Cf. Michel/Häussler-Sczepan/Riedel 2003
the 2003 study. The current results can also be equated with the results of the current Shell Youth Study. Here too the importance of the goal ‘having a career’ is ranked more highly than the goal ‘family’. The lowest priority goals in our study were ‘starting a family’ and ‘sexual satisfaction’, which were even classed as unimportant by around a quarter of the respondents in both cases (starting a family 22 %; sexual satisfaction 23.8 %), while all other future goals were below the 6 % mark in the answer category ‘unimportant’. A fulfilling sex life and having children were ranked as ‘fairly important’ by more than 40 % of young people (sex life 43.3 %; children 42.7 %). A third of the young people also thought it was fairly important to have a lot of money one day (35.5 %) and around a quarter said the same about having lots of friends (24.1 %).

The boys differed significantly from the girls in that they placed a greater importance on a fulfilled sex life. Girls were somewhat more likely to want their own family. In all other areas the girls’ rankings were similar to those of the boys or showed only minor deviations.

The hearing-impaired young people achieved the highest values in all categories. They gave the two future goals ‘having lots of money’ and ‘having children’ significantly more importance than the physically disabled and the visually impaired (figure 31) and this is true for both the boys and the girls in the hearing-impaired category. Regardless of the kind of disability, personal independence in the form of a job and a flat/house was ranked most highly by all the young people, followed by the existence of a social network.
At the same time the young people were asked to estimate how realistic they thought these future goals were. Here too having a job, a flat/house, a wide circle of friends and a relationship came out on top (table 18).
Table 18: ‘How achievable do you think these goals are?’

<table>
<thead>
<tr>
<th>Rank</th>
<th>Future goal</th>
<th>Percentage ‘achievable’</th>
<th>Average boys ( n = 104 )</th>
<th>Average girls ( n = 65 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Having a job</td>
<td>76.8</td>
<td>1.72</td>
<td>1.78</td>
</tr>
<tr>
<td>2</td>
<td>Having my own flat</td>
<td>73.2</td>
<td>1.69</td>
<td>1.9</td>
</tr>
<tr>
<td>3</td>
<td>Having a partner</td>
<td>70.3</td>
<td>1.67</td>
<td>1.8</td>
</tr>
<tr>
<td>4</td>
<td>Having lots of friends</td>
<td>69.1</td>
<td>1.66</td>
<td>1.62</td>
</tr>
<tr>
<td>5</td>
<td>Having children</td>
<td>39.6</td>
<td>1.24</td>
<td>1.20</td>
</tr>
<tr>
<td>6</td>
<td>Having lots of money</td>
<td>39</td>
<td>1.34</td>
<td>1.28</td>
</tr>
<tr>
<td>7</td>
<td>Having a fulfilled sex life</td>
<td>33.3</td>
<td>1.21</td>
<td>1</td>
</tr>
</tbody>
</table>

Achievable = 2, somewhat achievable = 1, not achievable = 0
Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011

At the bottom end of what the young people thought was realistic were starting a family and sexual satisfaction, which is similar to the question about how important these things were. They were considered ‘not achievable’ by around a fifth of the respondents (starting a family 17.1 %; sexual satisfaction 20.1 %), while all other goals were below the 8 % mark in the category ‘unachievable’. For the goals of children, wealth and a fulfilled sex life, many respondents chose the category ‘fairly realistic’, which was therefore the most common response within the category (a lot of money 53.7 %; fulfilled sex life 46.5 %; children 43.3 %).

There were only small differences between the various disability groups. The hearing-impaired young people were the most likely to think achieving financial wealth was feasible, in line with the importance ranking (cf. figure 32).

When looking at the averages, there was a significant difference for the boys regarding how achievable they thought a fulfilled sex life was; young people with a physical disability were the least likely to think it was an achievable goal (average: 1.00). There was another interesting difference: the physically disabled girls were significantly less likely than the hearing and visually impaired girls to think that they would be able to live in their own home one day. The existence of physical barriers is still a huge challenge for the physically disabled, and it limits their scope of action. In addition, conversion work is expensive. This could be a reason why the physically disabled young people were the least likely of all the groups to think financial wealth was an achievable goal.
A comparison of the averages between the importance and achievability of the goals listed makes it clear that in most categories the achievability was thought to be lower than the importance (cf. figure 33). In the categories work, own home and financial wealth, the difference is statistically significant.
However, the differences cited only affected the boys. There were no significant differences among the averages of the girls’ statements, which suggests that for the girls, the importance of an event is also linked to its achievability. This was not the case for the boys: work, a flat/house and financial wealth were ranked more highly in importance than in achievability; this relationship was reversed for the goal ‘children’. More detail on this in the following chapter.

5.6 A desire for children

As described in chapter 5.5, the importance and achievability of having children was less strongly developed among young people with any disability (cf. also figure 33). We know from comparative studies that the desire for children still has to establish itself in this age group, so that we should assume the importance and achievability of having children is an effect of their age rather than of their disability. None of the young people already had a child at the time of the survey, and only one boy stated that a girl was currently pregnant with his child.
Around half of the young people said it would be a disaster if they became pregnant or fathered a child right now (47.9 %) and this was true for a lot more girls than boys (58.8 % v. 41.8 %). Nine out of ten physically disabled girls and more than four-fifths of the visually impaired girls would feel negatively about a current pregnancy (physically disabled girls 92 %; visually impaired girls 85.8 %), while around a quarter of the hearing-impaired girls would feel it would be unproblematic or even positive (26.3 %) (cf. figure 34).

Figure 34: ‘What would it be like to get pregnant/get a girl pregnant now?’ by gender and type of disability (figures in %)

Around one in three boys, regardless of the type of disability, would feel positively about a pregnancy. That means that the boys were significantly more positive about a pregnancy during adolescence than the girls, and were more tolerant about it. The question remains to what extent the boys’ attitude was shaped by an insufficiently developed sense of responsibility and lack of self-awareness. There was no age effect. The only thing that could be determined was that young people who had already had sexual intercourse felt a bit more positively about a pregnancy than those who had not had sex before (31.4 % v. 24.3 %). In general it can be said that most of the young people did not currently want a pregnancy.
To conclude, we will compare the group being studied here with the youth population of Saxony who were surveyed in 2009 as part of the BZgA’s Youth Sexuality study. This comparison is considered particularly important for work in sex education. One of the study’s central goals was, however, to analyse the attitudes and behaviours of young people with disabilities with regard to sex education, sexuality and contraception. The following section will present the results where there were differences between the two groups under investigation. The results are available in their entirety online at www.forschung.sexualaufklaerung.de.

The comparison group consisted of young people aged between 14 and 17 who were resident in Saxony and who did not attend a special-needs school. In the description of the sample it becomes clear that the non-disabled young people tended to be older and were more likely to be living with one or both of their biological parents (table 19).
Table 19: **Social demographics of the two research groups**  \((n=475)\)

<table>
<thead>
<tr>
<th>Number of cases</th>
<th>Young people with disabilities in Saxony</th>
<th>Young people without disabilities in Saxony</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>(%)</td>
</tr>
<tr>
<td>Young people surveyed</td>
<td>169</td>
<td>100</td>
</tr>
<tr>
<td>Boys</td>
<td>104</td>
<td>62</td>
</tr>
<tr>
<td>Girls</td>
<td>65</td>
<td>38</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12–13 years old</td>
<td>28</td>
<td>16.6</td>
</tr>
<tr>
<td>14 years old</td>
<td>30</td>
<td>17.8</td>
</tr>
<tr>
<td>15 years old</td>
<td>42</td>
<td>24.9</td>
</tr>
<tr>
<td>16 years old</td>
<td>36</td>
<td>21.3</td>
</tr>
<tr>
<td>17–18 years old</td>
<td>33</td>
<td>19.6</td>
</tr>
<tr>
<td>Student at a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>special-needs school</td>
<td>162</td>
<td>95.9</td>
</tr>
<tr>
<td>junior high school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>academic high school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>comprehensive school</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>vocational college</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>vocational training institution</td>
<td>7</td>
<td>4.1</td>
</tr>
<tr>
<td>Residing with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>biological parents</td>
<td>86</td>
<td>51.2</td>
</tr>
<tr>
<td>one parent + one step-parent</td>
<td>27</td>
<td>16.1</td>
</tr>
<tr>
<td>only mother</td>
<td>24</td>
<td>14.3</td>
</tr>
<tr>
<td>only father</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>adoptive/foster parents</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>boarding school/residential home</td>
<td>12</td>
<td>7.2</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
6.1 Communication about sexuality

While there was no difference between the two groups with regard to dealing with sexuality on the communicative level, the differences between the sexes are clearer. Young men with a disability were very much more likely not to have a problem talking about sexuality than boys without a disability (figure 35). The percentage of those preferring to avoid this subject was highest among the girls with a disability and lowest among the girls without a disability.

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
6.2 Confidants

The most important confidant for sexual matters was the best male friend for half of the boys and the best female friend for two-thirds of the girls (table 20). The mother came in second place. However, it is noticeable here that the non-disabled girls rank the mother’s importance particularly highly. The father is only a confidant for sexual matters for the boys, while the disabled girls said their partner and their sister were important. 16 % of the non-disabled boys said they did not have a confidant.

Table 20: Confidant for sexual matters, by research group and gender (figures in %)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Boys with a disability n = 80</th>
<th>Boys without a disability n = 161</th>
<th>Girls with a disability n = 51</th>
<th>Girls without a disability n = 145</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Best friend</td>
<td>46.9</td>
<td>52.2</td>
<td>64.7</td>
</tr>
<tr>
<td>2</td>
<td>Mother</td>
<td>38.3</td>
<td>36</td>
<td>39.2</td>
</tr>
<tr>
<td>3</td>
<td>Father</td>
<td>25.9</td>
<td>26.1</td>
<td>7.8</td>
</tr>
<tr>
<td>4</td>
<td>Partner</td>
<td>24.7</td>
<td>6.8</td>
<td>29.4</td>
</tr>
<tr>
<td>5</td>
<td>Other boys</td>
<td>23.5</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>Sister</td>
<td>2.5</td>
<td>6.8</td>
<td>21.6</td>
</tr>
<tr>
<td>7</td>
<td>Brother</td>
<td>14.8</td>
<td>13</td>
<td>5.9</td>
</tr>
<tr>
<td>8</td>
<td>Teacher</td>
<td>13.6</td>
<td>6.2</td>
<td>9.8</td>
</tr>
<tr>
<td>9</td>
<td>Other girls</td>
<td>3.7</td>
<td>1.9</td>
<td>7.8</td>
</tr>
<tr>
<td></td>
<td>Nobody</td>
<td>5.0</td>
<td>16.1</td>
<td>7.8</td>
</tr>
<tr>
<td></td>
<td>No information</td>
<td>24</td>
<td>-</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
6.3 Sexuality education

With regard to the sources of sexuality education, there are hardly any noteworthy differences between the groups. However, the subjects of sex education differ in nature and intensity. Generally speaking, more young people without a disability remember the subjects of their sex-education classes (figure 36). The clearest discrepancies exist for the subjects of contraception, physical development, relationships, role models, sexually transmitted infections, pregnancy and terminations.

Figure 36: Topics of sex education, by research groups (figures in %)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
### 6.4 The need for information

The girls with a disability exhibited the greatest need for information with regard to sexual subjects (table 21). They have the most interest in the subjects of pregnancy and birth, love and affection and relationships, as well as sexual violence. It should also be noted that subjects with a strong preventative character, such as sexually transmitted infections, sexual violence and terminations, are of great interest to all young people.

#### Table 21: Sexual subjects – information deficits, comparisons of averages for the sexes and the research groups

<table>
<thead>
<tr>
<th>Topic</th>
<th>Boys with a disability $n = 104$</th>
<th>Boys without a disability $n = 161$</th>
<th>Girls with a disability $n = 65$</th>
<th>Girls without a disability $n = 145$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexually transmitted infections</td>
<td>1.8</td>
<td>1.8</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Love and intimacy</td>
<td>1.8</td>
<td>1.7</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>1.9</td>
<td>2.1</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Contraception</td>
<td>1.8</td>
<td>1.8</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Terminations</td>
<td>2.0</td>
<td>2.3</td>
<td>1.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>2.0</td>
<td>2.1</td>
<td>1.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Relationships</td>
<td>2.0</td>
<td>2.1</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Sexual practices</td>
<td>1.8</td>
<td>1.7</td>
<td>1.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Physical development</td>
<td>1.9</td>
<td>2.0</td>
<td>1.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Gender roles</td>
<td>2.0</td>
<td>2.0</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Structure of the sex organs</td>
<td>2.0</td>
<td>1.9</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Female cycle</td>
<td>2.2</td>
<td>2.1</td>
<td>1.8</td>
<td>1.9</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>2.1</td>
<td>2.3</td>
<td>1.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Masturbation</td>
<td>2.0</td>
<td>2.0</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Prostitution</td>
<td>2.2</td>
<td>2.2</td>
<td>2.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Pornography</td>
<td>2.1</td>
<td>2.1</td>
<td>2.5</td>
<td>2.3</td>
</tr>
</tbody>
</table>

1 = I would like to know more about it; 2 = I know enough about it; 3 = The topic doesn’t interest me

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
6.5 Contraceptive advice and recommendations

The statements about the parents’ contraceptive advice reveal to what extent young people are also given sex education by their parents. Approximately the same percentage of boys (approx. 60%) with and without a disability were given such information by their parents, whereas there was a discrepancy among the girls. Two-thirds of the girls with a disability were given contraceptive advice by their parents compared with four-fifths of girls without a disability. Almost every boy with a disability and four out of five boys without a disability were recommended condoms as the best form of contraception. Between 24% and 31% of the boys were told that the Pill was the best form of contraception. By comparison, three out of four girls with a disability were recommended condoms in conjunction with the contraceptive pill as the best form of contraception, while for two-thirds of the girls without a disability the Pill was clearly favoured; condoms were favoured by four out of ten girls.

6.6 Relationships

40% of the young people without a disability and one third of the young people with a disability were in a relationship at the time of the survey. Around twice as many disabled as non-disabled boys had a steady girlfriend. The distribution was similar for the girls.

As would be expected, not all of the under-18s were sexually experienced. The reasons why the young people had not yet engaged in sexual intercourse hardly varied between the genders or the survey groups. The only major difference was partner availability: more than half of the non-disabled girls with no sexual intercourse experience, compared to 15% of the disabled girls, said they had not found the right partner. The latter group primarily explain their abstinence by referring to their young age.
6.7 The first act of sexual intercourse

Around one in four of the disabled 14–18-year-olds (23%) have already had sexual intercourse, as have around four in ten of the non-disabled 14–17-year-olds (39%). There are clear differences between the genders here (figure 38): while there are around twice as many boys with such experience (28%, n = 29) as girls (15%, n = 10) in the disabled group, the girls are the more sexually active in the non-disabled group. 43% of the non-disabled girls (n = 62) had already experienced sexual intercourse, compared with 36% of the non-disabled boys (n = 58).

There are also differences regarding the age at which the young people say they first had sex: the majority of the young people were 15 or older (70%), but this is true of far more young people without a disability (76%) than of disabled young people (51%). More than half of the disabled boys first had sexual intercourse before their 15th birthday (52%); the same was true of only four in ten of the disabled girls, which is comparable to the percentage among the non-disabled boys (figure 37).
There were also different responses regarding the partner during the first sexual intercourse experience: while three in four boys with a disability were in a steady relationship with their partner, the same was true of just half of the non-disabled boys. One third knew the girl well, while 15% only knew her slightly or not at all. The picture is similar for the girls without a disability. Among the disabled girls, half were in a steady relationship, the other half knew their partner well.

6.8 Contraceptive behaviour

Young people with a disability exhibited a very similar contraceptive behaviour the first time they had intercourse as their non-disabled peers: 87% of the disabled young people and 84% of the non-disabled young people used contraception on this occasion. 67% of the disabled young people and 58% of the non-disabled young people used condoms. There was a difference in that disabled girls were somewhat more likely to use condoms, in line with the parental recommendation and as a medication-related alternative to the Pill (figure 39). Around one in five non-disabled boys failed to use contraception. A further
point is the subordinate role of unsafe contraceptive methods such as coitus interruptus and of contraceptive options with major side-effects, like hormonal injections, among both the disabled and non-disabled young people.

Figure 39: Contraception used the first time, by research group and gender (figures in %)

When it comes to their general contraceptive behaviour, the disabled young people’s statements are very ambivalent. Half of the sexually active disabled young people said they always paid very close attention to contraception, and the girls somewhat more than the boys. But around a quarter of the disabled young people rarely or never paid attention to contraception (23%), and again, the girls somewhat more than the boys. The young people without a disability are more conscientious, regardless of their gender: two-thirds of the non-disabled young people consistently use contraception, girls somewhat more than the boys, and only around 5% never or rarely pay attention to preventing a pregnancy.
6.9 The desire to have children

The question whether the young people would like to have children one day is answered very differently by the genders and by the two different survey groups. The non-disabled girls are the most certain: around nine in ten of them have an explicit desire to have children (figure 40). The picture is similar for the non-disabled boys. Around two-thirds would like to have children one day. The situation is very different for the disabled young people. Around one in five did not want children at the time of the survey, compared with maximally 6% of the non-disabled young people. 43% were undecided. Only around half as many disabled young people as non-disabled young people had developed a clear desire for children.

Figure 40: The desire to have children, by research group and gender (figures in %)

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
### 6.10 Sexual violence

At the end, we wish to take a look at a negative aspect of sexuality. The girls in particular had experienced sexualized violence. They were affected almost five times as often as boys. Among both the boys and the girls it was the young people with a disability who were most likely to be victims here (figure 41). One in four girls in this group had experienced sexualized violence. The disabled boys were the most likely to refuse to give an answer.

**Figure 41: Experiences with sexualized violence, by research group and gender (figures in %)**

[Bar chart showing experiences with sexualized violence by gender and disability status]

- **Boys with a disability (n = 104)**: 76.9% Yes, 24.6% No, 7.7% No indication
- **Boys without a disability (n = 306)**: 98.8% Yes, 15.4% No, 82.8% No indication
- **Girls with a disability (n = 65)**: 73.8% Yes, 7.7% No, 15.9% No indication
- **Girls without a disability (n = 145)**: 82.8% Yes, 15.4% No, 76.9% No indication

Numerical values for percentages less than 1.5% are not shown.

Source: BZgA, data set ‘Youth Sexuality and Disability in Saxony’, 2011/BZgA, TNS Emnid, data set ‘Youth Sexuality 2010’
III

Recommendations for action

7 Recommendations for contents and the provision of sex-education services

8 Recommendations for research and government
Recommendations for contents and the provision of sex-education services

‘In order to be able to assert the right to marriage, partnership and sexuality, people with disabilities need age-appropriate and barrier-free information about sexuality, reproduction and family planning,’

according to the Federal Government’s first State Report on the implementation of the UN Convention on the Rights of Persons with Disabilities. The study on Youth Sexuality and Disability is named explicitly in this context. As a result, the subject is being given considerable attention, which should also find its way into recommended actions.

The focus should not be entirely on children and young people with disabilities, but also on parents, (sex-)educational experts, social workers, medical staff and carers, scientists and politicians as well as those who create information material on sexuality education. The goal consists of empowering young people with disabilities by equipping them with the necessary knowledge about issues such as sexuality, relationships and family planning, by supporting them in their character and by enabling them to develop a sex life that is in line with their abilities and needs. This also implies protecting them from sexual abuse and from writing off disabled people as asexual beings, because sexuality education forms an important foundation for a sexually self-determined life.

108 Bundesministerium für Arbeit und Soziales 2011: 52
7.1 Sexuality education that matches the need

Young people want and need information and education and not just about the conventional sex-education topics, but ideally also information that takes into account the special considerations applying to disabled people. This is something Wazakili et al.\textsuperscript{109} refer to. They believe the lack of information is an infringement of the right to freely live one’s sexuality.

The results of the present study show that young people with disabilities receive sexuality education both at school and at home. They usually have someone they can talk to about sexual matters and who can give them the necessary information.

There are also manifold ways to access information material about sexuality, if not as part of the educational programme at school, then in the form of digital communication methods (internet) and the print media (youth magazines). These ways also do justice to the young people’s informational needs and correspond most closely to the way in which young people obtain information. In addition, they are available everywhere, even when people have limited mobility or are in a region with a low level of specific advice services.

Access to information available online can increase self-assurance and counteract isolation through online networks.\textsuperscript{110} Online services are therefore a source of information that is largely anonymous and has a low access threshold. It is, however, important that these websites are disability-friendly and safe. Users also have to be protected from unreliable information and services. Young people should be made aware of the dangers and be educated in how to use the internet safely, especially with regard to sexuality.

In order to cover the young people’s need for information, the spectrum of available information has to be quite wide, ranging from information and instructions about how to meet other people despite sensory disabilities, via contraceptive advice that takes the special features of disability/chronic illness into account, and all the way to information about techniques that will allow disabled people to have a fulfilled sex life despite the existing conditions.

It is still difficult to assess the young people’s available sexual knowledge and no reliable statements can be made on the basis of the data at hand. It was possible to determine to what extent existing knowledge also led to corresponding action, e.g. with regard to contraceptive behaviour or finding sexual contacts.

\textsuperscript{109} Wazakili et al. 2009
\textsuperscript{110} Cf. also Potgieter/Khan 2005
It should be noted in connexion with this that some of the young people surveyed, especially the 14-year-olds and the hearing-impaired young people, said they had had intercourse for the first time had happened somewhat/much too early, that some of the girls had intercourse for the first time because their partner wanted it, and that a relatively large percentage of the girls had experienced sexual assaults. Strengthening their self-confidence and self-worth can help them wait to have sexual experiences until they feel personally ready. It helps young people to articulate boundaries clearly and to protect themselves from abuse that way.

It would therefore be a particularly useful for young people who struggle to develop their own identity in adolescence to develop services that are resource-oriented and aim to strengthen their personalities and to help them accept what their body is like as a result of their disability. This could be done through specific services, such as through the concept developed by Gisela Hermes\textsuperscript{111}.

### Focuses

- A confrontation with the disabled young people about how their bodies reflect their uniqueness, and that as a result they are not worth less than young people without a disability;
- Critical reflection of the beauty ideal presented in the media and by society: beauty is felt and determined subjectively and statements by the visually impaired young people illustrate the relativity of appearance;
- Highlighting charisma and inner values as factors for (sexual) attractiveness;
- Colour and style advice to allow disabled young people to play with colours, fashion and accessories so that they can identify with their own body;
- Teaching self-confidence and inner strength in the face of prejudice on the part of society and the media.

\textsuperscript{111} Hermes 2001
7.2 Recommendations for parents and for work with parents

Addressing the parents of disabled children, Diehl stresses ‘that sexuality education always includes promoting the recipient’s identity, that sexuality education as total education is a strengthening of the recipient’s personality and is therefore a necessary preventive measure to combat sexual abuse, that the discussion of sexuality is not just about deficits, but also about positive experiences with one’s own body, and that when a young disabled person experiences his/her sexuality, it is also an experience of himself/herself becoming mature and independent.’\(^{112}\) This insight should become the foundation for all sexuality education activity, not just for parents, but also for educators, regardless of whether this is in special-needs schools or integrative schools.

<table>
<thead>
<tr>
<th>Young people’s subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents can only have a limited supporting function in this process. It is particularly important for young people with a visible, evident handicap that their school and home talk with them and address their topics and discuss</td>
</tr>
</tbody>
</table>

- dealing with conflicts;
- dealing with feelings of shame and guilt;
- the family situation, maintaining the family ‘refuge’, and breaking away from the home;
- the parents’ fear that their child could be abused and exploited;
- the parents’ difficulties in understanding and accepting their own child as an adult, sexual being;
- the notion that a disabled body is also a sexual body;
- support in the intimate and hygienic area;
- questions about relationships.\(^{113}\)

A positive attitude, especially from the environment (the personal context and the social network), regarding sexual diversity is important for disabled children’s and young people’s development of a personal sexual identity. This is particularly true when the young people are very limited in their mobility, when they experience their body as a barrier, when a lot of physical contact with their own body has to be executed by someone else, when support is necessary in very intimate areas, \(^{112}\) Diehl 2001: 19  
\(^{113}\) Cf. also Diehl/Reuter 1995
and when the line at which the disabled people and their carers feel something becomes embarrassing is reached or even crossed. The tension between the desire for autonomy on the one hand and dependence on another person on the other is always present in such a situation. Anne Ott from the Bundesverband körper- und mehrfachbehinderter Menschen e. V. (Federal Association of People with Physical and Multiple Disabilities) points out in connexion with this that disabled people’s having gender at all is still not given enough attention:

‘Often the disability is in the foreground during encounters with disabled women and men. They are perceived as gender-neutral or still seen and treated as boys/girls even when they are adults. The conventional role requirements are noticed by men and women with a disability, but they cannot always fulfil them, or they are not granted to the disabled person. Gender-specific life circumstances and needs are often not recognized as such by the environment. This is not dealt with in a sensitive manner.’  

Parents need support in order to support their children, not just regarding their professional development, but also to accompany them into the adult world and to accept that even a disabled child has the right to a self-determined life as an adult. The parents’ desire to protect their disabled children from disappointments when looking for a partner, and from sexual abuse, is legitimate, but it is most successfully supported when the children are able to develop into self-confident young adults in their sexual identity and sexual needs too. Parents need the support of educational, medical and other experts, so that they themselves can deal with this subject openly.

Experts play an active role in education and sharing information, since parents often feel helpless and overwhelmed when it comes to their children’s sexual education. One way of dealing with parents’ feeling of being overwhelmed is by disconnecting sex education from other educational measures by having professional sex-educators. Parents, and also teachers as well as experts in the fields of medicine and social work, are not excluded from the children’s sex education, quite the reverse. While sex education teaches basic knowledge about aspects of sexuality such as organ function, reproduction, contraception, preventing sexually transmitted infections, emotions and other subjects, parents are required to raise their children to become self-confident, self-determined and sexually competent people. They should talk more and more openly with their children about sexuality. And they have to learn to let their growing children go, to give them the opportunity for example to go to a doctor’s surgery or an advice centre on their own. To do this, the parents of disabled children and young people need a certain amount of support and education by experts or others in the same boat.

114 Ott 2011: 152
115 Cf. Michel/Häussler-Sczepan/Riedel 2003
Support can be provided by

- talking with other parents and possibly adults who have similar disabilities to their own child, to allay their fears about their child’s budding sexuality and to pass on important information about ending the taboo of this subject;
- training courses and workshops about parents’ specific questions, such as about personal modesty, sexual violence and sexual assistance;
- low-threshold advice and information services that parents can access and that address their fears and ideas and take away their fear and embarrassment when it comes to dealing with the subject of the sexuality of their disabled children.

7.3 Recommendations for educational staff

‘A positive and self-determined experience of sexuality is not inborn. It has to be learned, just like loving does. How we ultimately experience sexuality depends on the other aspects of our lives. Sexual behaviour is as individual as our living environments. Generalizing statements, including ones regarding young people’s sexual experiences, therefore cannot be made.’\(^\text{116}\) Because of the described distinctive features in developing a sexual identity and obtaining sexual experiences among children and young people with physical/sensory disabilities, there are concrete requirements for sex-education classes in special-needs and integrative schools to the effect that disability has to be addressed as part of the children’s sex education.

As in regular schools, the curriculum for disabled students contains information about the structure and function of men’s and women’s sexual organs, about reproduction and about contraception. Biologically oriented subjects dominate sex education in school while practical and socio-ethical subjects are secondary. There are no systematic distinctions between subjects with regard to the situation of the disabled students. However, the information taught is not enough to support the disabled young people with the development of their sexual identity or to promote their acceptance of their physical condition and help them exercise their rights to sexual self-determination. Although the existing services meet the specifications of Saxony’s state curriculum, so that young disabled people are informed about bodily processes to the same extent as non-disabled young people, they learn virtually
nothing about the special aspects that involve their disability or chronic illness, their sexual self-image and responsible interaction. This knowledge is important, however, so that the disabled young people can ask the right questions in an advice situation, for example.

Ortland and Czerwinski say sex education is a primary task of the school as part of its educational remit. They point out that ‘supportive, competent and inclusive sex education can fundamentally improve this situation [e.g. the increased danger of becoming a victim of sexual violence, or protection from hurt and disappointment when searching for a partner because of stigmatization: note by present author], not least for the protection of the children and young people affected.’

Sex education in school is a co-operative undertaking, which has to be conducted together by teachers at the schools, external sex-education experts, and parents. In the final report of the research project on the development of competent, integrated sex education for people with physical problems at special-needs school (KISS), Ortland and Czerwinski cite the following modules, which can also be applied to the classes with young people suffering from visual and hearing impairments:

- teaching materials tailored to the students’ needs, which promote the ‘identification, reflection and focus on the personal living situation’

- parent-information evenings so that parents can be reached as well;

- networking with advice centres;

- in-service training options for educational staff, assistants as well as carers ‘regarding making care situations more positive for intimacy and sexuality’.

In addition to compulsory subjects, the final report of the KISS project also suggests elective subjects for students from year 8 on which should find their way into the sex-education curriculum (cf. table 31).

117 Ortland/Czerwinski 2009: 7
118 Ortland/Czerwinski 2009: 11
119 Ortland/Czerwinski 2009: 57
Table 22: Elective topics for the sex-education curriculum

<table>
<thead>
<tr>
<th>Middle years</th>
<th>Final years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternatives to sexual intercourse</td>
<td>Sexual assistance</td>
</tr>
<tr>
<td>Masturbation, self-determination, contraception</td>
<td>Parents with disabilities</td>
</tr>
<tr>
<td>HIV and AIDS</td>
<td>Contact with self-help groups</td>
</tr>
<tr>
<td>Distance, closeness, gender role expectations,</td>
<td>Discrimination</td>
</tr>
<tr>
<td>clichés</td>
<td></td>
</tr>
<tr>
<td>Relationships, family, breaking up</td>
<td>Unwanted childlessness, adoption, foster</td>
</tr>
<tr>
<td></td>
<td>parenting, terminations</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>Pornography, prostitution, reflecting on</td>
</tr>
<tr>
<td></td>
<td>power and dependency conditions</td>
</tr>
<tr>
<td>Advice centres and other services</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ortland/Czerwinski 2009, p. 50 f.

One element of sex education consists in reflecting on one’s own body and sexuality. For this reason the sex-education curriculum should also contain aspects of personal independence and self-determination alongside discussions about mutual respect and love in a relationship. In addition to anatomical knowledge, physiological knowledge and the specificities of sexual function for the various disabilities, sex education should include the components of family planning as well as sexually transmitted infections and their prevention.

As part of the sex education work, it is, however, also very important to discuss feelings and emotions about the students’ sexuality in connexion with their disabilities. This area should be given a lot of space for individual tailoring, depending on the students’ personalities and the non-disabled people present. To avoid violating their sense of modesty, it has to be decided on a case-by-case basis whether conversations about this topic make sense within the students’ own disability group.

In order to achieve, on the basis of an egalitarian recognition of sexuality, a dismantling of taboos, services that do not emphasize any distinctiveness could also be successful. As part of inclusive leisure and educational services, sex education together with non-disabled young people is also laudable, allowing commonalities between the young people to be featured and to promote a more open approach to the subject of sexuality.
As part of such activities, the young people could be taught, for example, how they can flirt without making eye contact, what role the senses play when meeting people and what misunderstandings can arise during the different ways of meeting people. However, for inclusive services and for shared services for (hard of) hearing and deaf young people, it is very important to pay attention to a shared language, especially for a subject as sensitive as sex education. Young people communicating through sign language must be given access to sign language, and bilingual classes should be given priority. The individuals without hearing problems must adapt to the communication needs of those with hearing impairments if the communication is to remain largely free from misunderstandings. To make a conversation successful, there are specific requirements, such as using a lot of gestures, articulating clearly, moving one’s lips clearly, being face-to-face if possible, reducing white noise and generally paying attention to the space and its configuration. Respecting experiences of frustration, paying attention to one’s gestures and facial expressions and taking time and slowing down are all ideas that do not just help the hearing-impaired; they are conducive to good communication quite generally.

A self-determined sex life also includes the topics of pregnancy and family planning. The study revealed that disabled young people are largely reserved about an early pregnancy. On the other hand they expressed concerns about their ability to achieve their dreams for the future such as living independently and having a relationship and children, resulting from their experiences in coping with everyday life and their existing need for help and support. This means that sex education for disabled children and young people also always has to include the living-environment aspect of disability and attempt to develop realistic options for the future. This is not just a task for sexuality education. It affects all areas of social participation. In an inclusive society such as the one envisaged by the UN Convention on the Rights of Persons with Disabilities, the future options for disabled young people will be much better, and a self-determined life will be just as normal for them as for the non-disabled. However, we are only at the beginning of a long journey there.

Sex education also has to contribute to young people acquiring skills that are necessary for self-determined decision-making. Sexual competence should be the goal, which will allow the adolescents to engage in self-confident and autonomous sex lives. This involves the development of competencies for making responsible decisions about the birth of children. Disabled and chronically ill people are capable of making self-determined decisions about parenthood. An important aspect of this is that they are assisted in obtaining the networks and resources necessary for the care of children already during their sex education. In addition young people should be taught that a disability could make it necessary to make long-term plans regarding a pregnancy in order to switch medications on time and to make

120 Cf. also von Walter 2001
121 Wazakili et al. 2009
changes that are harmless for the mother and baby during pregnancy, but which still deal with the problems caused by the disability (e.g. epilepsy). Interdisciplinary sex education therefore seems to be key to a self-determined and informed sex life for young people.

### 7.4 Recommendations for medical and therapeutic staff

In the literature, young people often cite medical and therapeutic staff as their reference option of choice. Doctors, therapists and carers combine the necessary familiarity and detachment in order to give advice on sexual matters. They are usually familiar/very familiar with the disability and the associated functional limitations, and they enjoy the necessary trust of the young people to be able to talk about sexuality. To fulfil this task, they have to be prepared for conversations about sexuality, especially with regard to the disability-specific features of those affected and their families. As reference people, the experts need to have the right sex-education skills and competencies, such as knowledge about how to communicate successfully, which is indispensable when it comes to an area fraught with so many taboos. They also need to have special knowledge about the functional peculiarities of the respective disability. They have to be prepared to deal with these problems in order to contribute to the development of a healthy sexuality in these people.\(^{122}\)

A special responsibility lies with the medical staff in the area of contraceptive advice. The data from the present study about the contraceptive choices made when the young people first and most recently had sexual intercourse revealed that hormonal injections are not a common contraceptive for young people with physical and sensory disabilities. They are therefore used more for people with mental disabilities, in order to compensate for deficits in their hygiene behaviour and to achieve reliable protection from an unwanted pregnancy. People with physical and sensory disabilities are quite capable of successfully using other contraceptives with less of an impact on physical processes. Nevertheless, gynaecologists’ clear preference for hormonal contraceptives should be critically challenged. Young people with unstable relationships should prioritize condoms, at least as a supplementary contraceptive, even if that is not part of the gynaecologists’ normal advice. In addition, it should always be scrutinized whether the hormonal contraceptives are harmless when used by people with chronic illnesses and disabilities. This is particularly true when the young people are dependent on regular medications as a result of their illness. More medical research must be done in this area (e.g. with regard to women with dwarfism or Crohn’s disease\(^ {123}\)).

\(^{122}\) Moura/Pedro 2006

\(^{123}\) Crohn’s disease: synonymous with regional enteritis, chronic inflammation of the bowels associated with colic, pain, diarrhoea, weight loss and bouts of fever (cf. Pschyrembel 2004, p. 491)
The subjects of sexuality, fertility and disability should form part of the curricula for medical, therapeutic and care staff so that these experts can give good advice on these matters to disabled people.

7.5 **Recommendations for the development of disability-friendly information materials**

Sex-education services are passed on to people via a multitude of avenues (workshops, discussion groups, advice sessions, the internet, print media etc.). Both the specific services for disabled people and the general services should be able to be used by everyone. When designing sex-education services for young people with disabilities, it is not just the design aspects that have to be taken into account; additional disability-specific information also has to be included.

**Ground rules for implementing services**

Generally speaking, the premises for workshops, forums, lectures and advice sessions must feature disability-friendly accessibility and the events must have media support for the hearing and visually impaired participants. The following ground rules need to be followed. They are based on the resources available to the participants:

- important subjects such as sexualized violence, fears, dealing with shame and conflicts with parents must be addressed appropriately; after a general information event there should be time for individual conversations in a calm atmosphere;
- when addressing the body and self-perception, there must again be space for individuality and trusting conversations;
- conditions should be tailored to the participants: by using sign language or writing interpreters, using audio-visual media, working with subtitles if necessary, providing services in Simple Language as well as using very clear visual aids;
- using computers, supported communication etc. in conversational situations in order to promote the cognitive abilities and linguistic accesses; a workshop with a group of hearing-impaired young people has shown for example that their interests are not very different from those of hearing young people if the material provided is disability-friendly.
Digital and print media can be the way into sex-education services or be used exclusively for information and to get a deeper understanding of the information acquired. So far there are only very few materials available for disabled people in a usable form. In addition to the content aspects already mentioned, digital and print media should take into account the following recommendations.

### Recommendations for the design of media

- **digital media** have to conform to the requirements of the Barrierefreie-Informationstechnik-Verordnung – BITV 2.0 (Disability-friendly Information Technology Regulation) – (2002)\(^{124}\) and therefore be usable by visually and hearing-impaired people as well as people with learning difficulties.

- **print media** fulfil the criteria of being disability-friendly under the following conditions:
  - formulation in Simple Language for people with learning disabilities, with hearing and visual impairments, non-native speakers and people with some other restricted ability to read;
  - design in large print, relief print, braille for people with visual impairments; the use of costly relief print can allow severely visually impaired people to access pictures too;

- **other disability-friendly media** include:
  - audio CDs in the DAISY format, a special MP3 format that allows users to navigate in the medium just like in a printed book; this way the visually impaired and the sighted students can work with the same learning materials; the target group are visually impaired people, but also people with a limited ability to read.
  - sign-language videos for hearing-impaired people.

The production of the media listed here is not just time-consuming but also expensive, because there is a considerable backlog demand. Using the existing resources (e.g. German Central Library for the Blind in Leipzig or the nationwide network Simple Language) and taking advantage of synergies during the development and manufacture of suitable media as well as bring in sex-education experts with a lot of experience working with disabled people, ways should be found to create such materials for sex-education.

\(^{124}\) BITV 2.0 2002
Recommendations for research and government

8.1 Recommendations for further research

The present study looked at young people between the ages of 12 and 18 with physical and sensory disabilities. They were attending special-needs schools in Saxony as well as vocational training centres. The study built on the general questionnaire conceived for the BZgA’s Youth Sexuality study. As a result, we generated responses that can be compared with those of non-disabled young people. These are to be compiled in a separate step. It is only then that we can make statements about whether and how the sexual knowledge and sexual behaviour of disabled and non-disabled young people differs. However, some disability-related questions remained unconsidered in the present study.

Disability-specific aspects that were not considered in the questionnaire include the following:

- bodily perception and awareness in connection with the disability;
- violations of personal boundaries, discriminatory statements and actions that have an impact on the development of sexual identity;
- disability-specific ways in which sexuality can be experienced;
- potentially limited fertility (as far as known);
- problems with potency and sensation;
- questions about sexuality and incontinence;
• disability-related amenorrhea\textsuperscript{125} (e.g. Turner Syndrome) or other developmental delays;

• questions about sexuality in the event of institutionalized care;

• the causes of the higher rate of sexual assaults among hearing-impaired young people.

These questions had to remain unconsidered during the present study. That they are significant, however, is clear from the analysis of the literature and the results of our work as part of the competence centre for disabled and chronically ill parents. For that reason it would be advisable, in further studies on the subject of youth sexuality and disability, to include a section with questions that are equally relevant for disabled and non-disabled young people, as well as an additional questionnaire tailored specifically to the type of disability.

The question of the cause of the differences between the groups has remained unanswered. The level of variation among the disabilities in the sample group was immense, which needs to be kept in mind when interpreting the results. Because of the heterogeneity of the defined disability groups, both the disability itself as well as other character traits could be influencing factors.

This accommodates the assumption that individual behaviour cannot be reduced to the existence of a disability. The method used here, based on comparing three different disability groups or school types, assumes that differences are based on the nature of the disability/school. But valid insights are only available if people with and without disabilities are studied to the same extent, so that categories can subsequently be formed, which then characterize disability-specific behaviour. Qualitative studies are best suited for this.

There is also a need for further research regarding medical questions about sexuality and fertility. Children who in the past only had a short or limited life expectancy as a result of their disability (e.g. hydrocephalus) or chronic illness (e.g. muscular dystrophy\textsuperscript{126}, cystic fibrosis) now reach a fertile age. Research has not kept up with this development in many areas, so that we still only have limited knowledge of the sexuality and fertility of these women and men. In order to give young people answers to their questions about their very personal situation and to give them individual advice, more insights are needed here. This is also true with regard to contraception. There is still only limited knowledge about the reduced fertility associated with certain disabilities and chronic illnesses (e.g. absent vasa deferentia among boys with cystic

\textsuperscript{125} No periods (cf. Pschyrembel 2004: 58)

\textsuperscript{126} Progressive skeletal muscle weakness
fibrosis, or probable infertility among women with Down’s syndrome. Knowledge about these limitations could lead to better advice for young people with these disabilities, so that contraceptive advice would be tailored to the specific situation.

8.2 **Recommendations for government**

The recommendations for government can be summarized very briefly because they emerge from the previous presentation. The political will to implement the UN Convention on the Rights of Persons with Disabilities should not just focus primarily on the areas of work, care and leisure, but, in line with article 23 of this convention, should also pay attention, in political decision-making, to the right of disabled people to sexual self-determination. In the context of the present study, it means integrating the sex-education work (in the sense depicted here) into educational services for disabled young people, developing suitable services and materials, training and further-training experts in sex-education work with disabled young people, and promoting scientific work in this area (not least financially) and contributing to people with disabilities being be respected and accepted as part of human diversity by implementing suitable measures (Article 3, section D of the UN Convention on the Rights of Persons with Disabilities).

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127 Chromosomal abnormality resulting in the abnormal development of almost all tissues and organs, which grow slowly, remain immature, age more quickly and can exhibit deformities. Often significant but individually variable, non-static mental disability (cf. Pschyrembel 2004: 419).
Further reading


Projektgeschäftsstelle Qualitätssicherung bei der Sächsischen Landesärztekammer (PGS Sachsen): Qualitätsbericht Geburtshilfe. Jahresauswertung 2007


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\textsuperscript{128} The expression ‘difficult language’ comes from the perspective of those affected, the users of Simple Language.

\textsuperscript{129} Inclusion Europe is a group of people with mental disabilities and their families in Europe: http://inclusion-europe.org (accessed on 12 Sept 2012). Translator’s note: an attempt has been made to reflect the style of the German questionnaire. However, this is only for the benefit of readers of this report. No claim is made for its suitability in an equivalent English-speaking context.
QUESTIONNAIRE

For girls

School number: □ □ □
Student number: □ □ □
Date: □ □ □

Picture source: www.shutterstock.com
About you:

1. How old are you?
   ________ years

   What year are you in (in school)?

   Year ________

2. Where do you live most of the time?

   PLEASE ONLY 1 CROSS

   1  □  with my real parents
   2  □  with my real father and step-mother
   3  □  with my real mother and step-father
   4  □  only with my father
   5  □  only with my mother
   6  □  with adoptive parents or foster parents
   7  □  with other relatives
   8  □  in boarding school or a residential home
   9  □  in a children’s home or youth home
   10 □  with someone else, namely: __________________________
3. What disability do you have?

**YOU CAN CROSS SEVERAL ANSWERS**

1. physical disability
2. deaf or hard of hearing
3. blind or visually impaired
4. illness of the inner organs
5. attacks such as epilepsy
6. mental or psychological illness
7. learning disability
8. other disability, namely: ___________________________

3a. Do you wear a hearing aid or a CI (cochlear implant)?

1. yes
2. no

4. What degree of disability do you have?
   (You can find this information in your disabled ID.)

Degree of disability: ________
1. I don’t have a degree of disability.
2. I don’t know.

5. Since when have you had your disability?

1. since birth
2. since the age of ________
3. it developed over time
About sex education:

6. Do you know a lot about sex?

1 □ yes
2 □ no
3 □ don’t know

7. Where did you mostly learn about sex, reproduction, contraception etc.?

YOU CAN MAKE SEVERAL CROSSES.

1 □ school
2 □ presentations or information events
3 □ youth magazines
4 □ free sex-ed brochures
5 □ DVDs and videos
6 □ television programmes
7 □ radio
8 □ computer programs or computer games
9 □ internet
10 □ from personal experience
11 □ somewhere else, namely: ________________________________
**8. With whom can you talk best about sexual things?**

*YOU CAN MAKE SEVERAL CROSSES.*

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<td>leader of a youth group</td>
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<td>12</td>
<td>☐</td>
<td>experts at advice centres</td>
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<td>13</td>
<td>☐</td>
<td>carer</td>
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<td>14</td>
<td>☐</td>
<td>someone else, namely: ____________________________</td>
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<tr>
<td>15</td>
<td>☐</td>
<td>I don’t have anyone I can talk to about sexual things.</td>
<td></td>
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</tbody>
</table>
9. What subjects have already been talked about in class?

**YOU CAN MAKE SEVERAL CROSSES.**

1. [ ] men and women’s sexual organs
2. [ ] sexual practices and reactions and climax (orgasm)
3. [ ] periods, ovulation, a woman’s fertile days
4. [ ] contraceptives, how to use them, their safety and their side effects
5. [ ] sexually transmitted infections, such as HIV
6. [ ] physical and sexual development in young people
7. [ ] development of the unborn, pregnancy and birth
8. [ ] about terminations (abortions)
9. [ ] marriage and relationships
10. [ ] affection and love
11. [ ] female and male homosexuality (gays and lesbians)
12. [ ] masturbation among girls and boys
13. [ ] sexual violence and sexual abuse
14. [ ] prostitution
15. [ ] porn
16. [ ] roles of men and women in the family
17. [ ] another subject, namely: ____________________________
18. [ ] none of these subjects were talked about in class
10. What subject would you like to know more about?

**PLEASE MAKE 1 CROSS IN EVERY LINE.**

<table>
<thead>
<tr>
<th></th>
<th>I’d like to know more about it.</th>
<th>I know enough about it.</th>
<th>The subject doesn’t interest me.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men and women’s sexual organs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sexual practices and reactions and climax (orgasm)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Periods, ovulation, women’s fertile days</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Contraception, how to use it, safety, side effects</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Sexually transmitted infections such as HIV</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Physical and sexual development of young people</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Development of the unborn, pregnancy and birth</td>
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<tr>
<td></td>
<td>I’d like to know more about it.</td>
<td>I know enough about it.</td>
<td>The subject doesn’t interest me.</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
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<td>-------------------------</td>
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</tr>
<tr>
<td>Pregnancy terminations (abortions)</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Marriage and relationships</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Affection and love</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Female and male homosexuality (gays and lesbians)</td>
<td>❑</td>
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<tr>
<td>Masturbation among girls and boys</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Sexual violence and sexual abuse</td>
<td>❑</td>
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<tr>
<td>Porn</td>
<td>❑</td>
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<tr>
<td>Prostitution</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>Roles of men and women in the family</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>
11. Where would you like to get more information from?

**YOU CAN MAKE SEVERAL CROSSES.**

1. [ ] school  
2. [ ] lectures and information events  
3. [ ] free sex-ed brochures  
4. [ ] youth magazines  
5. [ ] crisis hotline  
6. [ ] sex education games  
7. [ ] DVDs/videos/television programmes  
8. [ ] radio or audio books  
9. [ ] comics  
10. [ ] internet or computer games  
11. [ ] public exhibitions  
12. [ ] something else, namely:  

13. [ ] I don’t want more information.

12. When is it easy for a woman to become pregnant?

**PLEASE ONLY MAKE 1 CROSS.**

1. [ ] during the few days after her period  
2. [ ] around halfway between two periods  
3. [ ] during the days just before her period  
4. [ ] during her period  
5. [ ] I don’t know
13. If you forgot to use birth control or something went wrong, there is the 'morning after pill'. That’s emergency contraception. Where did you learn about such a pill?

YOU CAN MAKE MORE THAN ONE CROSS.

1  □ school
2  □ mother
3  □ father
4  □ doctor
5  □ brother or sister
6  □ boyfriend/partner
7  □ friend
8  □ sex education brochure
9  □ television/radio/newspaper
10  □ health fund
11  □ advice centre
12  □ carer
13  □ a different source, namely: ________________________________
14  □ I didn’t know about the ‘morning after pill’.
Now about you and how you see yourself.

14. How do you feel in your own skin?

**PLEASE MAKE A CROSS IN EVERY ROW.**

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>A bit true</th>
<th>Not true</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do lots of sports.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I like using deodorant, creams and hair products.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel too thin.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel happy in my own skin.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I feel too fat.</td>
<td></td>
<td></td>
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<tr>
<td>I think my body is attractive.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I would have cosmetic surgery if I could.</td>
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</tr>
</tbody>
</table>
15. How old were you when you had your first period?

______ years old

☐ I don’t have my period yet.

16. If you already have your period:
   Were you prepared for it?

1 ☐ Yes, I knew about it.
2 ☐ I didn’t know details.
3 ☐ No, I didn’t know about it.
17. Have you ever kissed a boy or cuddled with a boy?

1  □  yes
2  □  no

18. If you have never kissed a boy or cuddled with a boy yet:
   Why not?

*YOU CAN MAKE MORE THAN ONE CROSS.*

1  □  I haven’t met the right boy.
2  □  I don’t want that.
3  □  I’m too shy.
4  □  I’m too young for that.
5  □  I’m scared of doing something wrong.
6  □  I don’t think it’s right.
7  □  The boy didn’t want to.
8  □  My parents could find out.
9  □  I was scared of getting pregnant.
10 □  I like girls.
11 □  A different reason, namely: __________________________
     ___________________________________________________

If you have never kissed a boy or cuddled with a boy:
Please carry on with question 36 on page 21.
19. What have you done or experienced already?

**YOU CAN MAKE SEVERAL CROSSES.**

1  ☐ kissing
2  ☐ a boy stroked my breasts.
3  ☐ a boy touched my privates.
4  ☐ I touched a boy’s privates.
5  ☐ intercourse (sex)

20. If you have not had sex:
   Why haven’t you had sex yet?

**YOU CAN MAKE SEVERAL CROSSES.**

1  ☐ I haven’t met the right boy.
2  ☐ I don’t want that.
3  ☐ I’m too shy.
4  ☐ I’m too you for that.
5  ☐ I’m scared of doing something wrong.
6  ☐ I don’t think it’s right.
7  ☐ The boy didn’t want to.
8  ☐ My parents could find out.
9  ☐ I was scared of getting pregnant.
10 ☐ I like girls.
11 ☐ A different reason, namely: _________________________________

If you have not had sex yet: please continue with question 36 on page 21.
21. How old were you when you had sex for the first time?

______ years old

22. How old was your partner at the time?

______ years old

☐ I don’t know

23. How well did you know the partner with whom you first had sex?

PLEASE ONLY MAKE 1 CROSS. 

1 ☐ I did not know him at all.
2 ☐ I hardly knew him.
3 ☐ I knew him well.
4 ☐ I was in a steady relationship with him.
5 ☐ I was engaged or married to him.
**24. Where did you meet your partner?**

*PLEASE ONLY MAKE 1 CROSS.*

1. [ ] at school
2. [ ] in a nightclub
3. [ ] during an out-of-school activity
4. [ ] in boarding school or in a home
5. [ ] in my circle of friends
6. [ ] while having treatment or at rehabilitation
7. [ ] online
8. [ ] somewhere else, namely: ________________________________

**25. Was your partner also disabled?**

1. [ ] no
2. [ ] yes, with the same disability as me
3. [ ] yes, but with a different disability, namely: ____________
   ____________________________________________________________________
26. What led to you having sex for the first time?

*PLEASE ONLY MAKE 1 CROSS.*

1. [ ] I wanted it.
2. [ ] My partner wanted it.
3. [ ] We both wanted it.
4. [ ] It just happened.
5. [ ] Something else, namely: ________________________________

27. How was the first time for you?

1. [ ] Nothing special.
2. [ ] It was good.
3. [ ] I had a guilty conscience.
4. [ ] It was unpleasant for me.

28. When you think back on the first time now: what would you say about the timing?

*PLEASE ONLY MAKE 1 CROSS.*

1. [ ] much too early
2. [ ] a bit too early
3. [ ] just right
4. [ ] rather late
29. What contraception did you use the first time?

1. [ ] We didn’t use contraception.
2. [ ] We stopped in time/were careful
3. [ ] Condom
4. [ ] Pill
5. [ ] Hormone injection
6. [ ] Chemical contraceptive (such as Nonoxynol-9)
7. [ ] Something else, namely: _______________________________

30. If you did not use contraception the first time:
   Why didn’t you use contraception?

**YOU CAN MAKE SEVERAL CROSSES.**

1. [ ] It happened so spontaneously.
2. [ ] I was scared of bringing the subject up.
3. [ ] I had taken drugs or alcohol and didn’t have a clear head.
4. [ ] I thought nothing would happen.
5. [ ] We didn’t have any.
6. [ ] I was scared of buying condoms.
7. [ ] We wanted to be careful.
8. [ ] We didn’t really know much about birth control.
9. [ ] I had forgotten to take the Pill.
10. [ ] I don’t know why we didn’t use birth control.
11. [ ] A different reason, namely: _________________________
31. Who did you talk to about your ‘first time’?

YOU CAN MAKE SEVERAL CROSSES.

1  □  father
2  □  mother
3  □  teacher
4  □  doctor
5  □  brother
6  □  sister
7  □  my boyfriend / partner
8  □  my best friend
9  □  other boys
10 □  other girls
11 □  youth group leader
12 □  carer
13 □  someone else, namely: _______________________
14 □  I didn’t talk to anyone about it.

32. How often have you had sex?

1  □  just once
2  □  up to 10 times
3  □  11 to 50 times
4  □  more than 50 times
33. How many partners have you had sex with already?

1  ☐  1 partner  
2  ☐  2 partners  
3  ☐  3 partners  
4  ☐  more than 3 partners  

34. If you have had sex more than once:

What birth control did you use the most recent time you had sex?

1  ☐  We didn’t use birth control.  
2  ☐  We stopped in time/were careful  
3  ☐  Condom  
4  ☐  Pill  
5  ☐  Hormonal injection  
6  ☐  Chemical contraceptives (such as Nonoxinol 9)  
7  ☐  Something else, namely: ________________________________  

35. How much attention do you pay to preventing a pregnancy?

PLEASE ONLY MAKE 1 CROSS. ❌  

1  ☐  I never pay attention to it.  
2  ☐  I rarely pay attention to it.  
3  ☐  I usually pay attention to it.  
4  ☐  I almost always pay attention to it.  
5  ☐  I always pay close attention to it.  
36. How do you feel when people talk about sex?

1. I don’t have a problem talking about sex.
2. I only talk with few people about it.
3. I don’t like talking about sex.

37. What do you think: how many girls and boys your age have already had sex?

1. only a few
2. around a third
3. around half
4. most of them
38. Have your parents or carers given you in-depth advice about birth control?

1 [ ] yes  
2 [ ] no

39. If your parents or carers advised you:
What did they say was the best form of contraception?

1 [ ] Condoms  
2 [ ] Pill  
3 [ ] Stopping in time (being careful)  
4 [ ] Chemical contraceptives (suppositories, Nonoxinol 9)  
5 [ ] Hormone injections  
6 [ ] Something else, namely: ________________________________  
7 [ ] I didn’t get a recommendation.
40. Have you ever sought advice about birth control from a doctor?

1  □ yes
2  □ no

41. If you got advice from a doctor:
What did the doctor say was the best form of birth control?

1  □ Condoms
2  □ Pill
3  □ Stopping in time/Being careful
4  □ Chemical contraceptives (suppositories, Nonoxinol 9)
5  □ Hormone injections
6  □ Something else, namely: ________________________________
7  □ I didn’t get a recommendation.
42. How old were you when you went to see a gynaecologist for the first time?

________ years old

☐ I’ve never been to see a gynaecologist.

43. If you have already been to see a gynaecologist:
   Why did you go?

   YOU CAN MAKE SEVERAL CROSSES.

   1 ☐ My period
   2 ☐ Contraception
   3 ☐ I was worried I was pregnant
   4 ☐ Lower abdominal pain
   5 ☐ HPV vaccination
   6 ☐ A termination (abortion)
   7 ☐ Something else, namely: ________________________________
44. If you have already been to see a gynaecologist:
What was this first appointment like?

1  □  It was the way I expected it would be.

2  □  It was pleasanter than expected, because
____________________
____________________

3  □  It was less pleasant than expected, because
____________________
____________________

45. Are you currently in a steady relationship?

1  □  yes

2  □  no
46. How important is it to you to have the following things in the future?

*PLEASE MAKE A CROSS IN EVERY ROW.*

<table>
<thead>
<tr>
<th></th>
<th>Important 1</th>
<th>Fairly important 2</th>
<th>Not important 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A good sex life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lots of friends</td>
<td></td>
<td></td>
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<tr>
<td>A job</td>
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<tr>
<td>My own flat</td>
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<tr>
<td>Lots of money</td>
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</tbody>
</table>
47. How achievable do you think these things are?

**PLEASE MAKE A CROSS IN EVERY ROW.**

<table>
<thead>
<tr>
<th></th>
<th>Achievable</th>
<th>Fairly achievable</th>
<th>Not achievable</th>
</tr>
</thead>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>A partner</td>
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<td>My own flat</td>
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<tr>
<td>Lots of money</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

48. Do you already have a child?

1  [ ] yes
2  [ ] no

49. Are you pregnant right now?

1  [ ] yes
2  [ ] no
50. What would it be like to become pregnant right now?

If you are pregnant right now:
How did you feel when you found out?

**PLEASE ONLY 1 CROSS.**

1  ☐  a disaster
2  ☐  very unpleasant
3  ☐  not so bad
4  ☐  positive

51. Have you masturbated in the past 12 months?

1  ☐  yes
2  ☐  no
52. Have you ever been physically intimate with another girl or woman?

1 [ ] yes
2 [ ] no

53. If you have already been physically intimate with a girl or woman:
What have you done/experienced already with a girl or woman?

1 [ ] Kissing
2 [ ] Touching genitals
3 [ ] Sex

54. Has a boy or man ever tried to be intimate with you or have sex with you against your will?

1 [ ] no
2 [ ] yes, my boyfriend or ex-boyfriend
3 [ ] yes, a friend or classmate
4 [ ] yes, a new acquaintance
5 [ ] yes, a man I was dependent on, such as a relative, teacher, coach
6 [ ] yes, a stranger
55. If you have been forced into sexual acts against your will: How did this situation end?

YOU CAN MAKE SEVERAL CROSSES.

1 [ ] I fought him off.
2 [ ] There was kissing and genital touching.
3 [ ] We had sex.
4 [ ] Other sexual acts.

56. If you have been forced into sexual acts against your will: Have you ever told anyone about it?

1 [ ] yes, my mother/father/carer
2 [ ] yes, a different adult
3 [ ] yes, a friend
4 [ ] no, nobody
57. Is there anything about this subject that is very important to you and has not been mentioned in this survey? Please write about it here.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for your time and trouble.
The University of Leipzig has been commissioned by the Bundeszentrale für gesundheitliche Aufklärung (BZgA) to conduct a study about young people’s sexuality. We would like to study about 500 male and female students with disabilities, living in Leipzig. Your child has been chosen for this study to get the most representative result possible. It is very important that all the chosen students participate in it.

The subject of this study is free education sexuality-sensitizing behavior amongst young people living in Leipzig. The results will be published in BZgA’s “Sexualität und Gesundheit” series and can be used for developing educational material about sexuality education. Young people, parents, and teachers do not always feel it easy to talk about relationships, love, sexuality, and reproduction. We also want to support sexologists, pedagogues, and doctors when they are often confronted with the subjectivity by providing them with the newest and this survey.
Questionnaire

Sent out similar questionnaires already been conducted in the past (1989-1991, 1993-1994, 1995-2004, 2003 and most recently 2006). It has been found that national changes in young people's attitudes are relevant. The study is designed to contribute to developing appropriate materials for education - families and schools.

We would kindly request your permission to let your daughter participate in the study.

All of the information will be treated absolutely confidentially and evaluated purely from a scientific perspective. The respondents are anonymous. They will obtain a processing number. This is necessary in order to contribute the responses to the different schools with the questionnaire material for the centers for adolescent health care.

In order to ensure that the young people answer truly and also feel on secure points to answer the questions in the questionnaire.

We would like to emphasize once more that all of the data will remain anonymous, strictly confidential. We will serve purely scientific purposes.

Thank you for your co-operation.

Dr. Elisabeth Hiltz
Director.
Bundeszentrale für gesundheitliche Aufklärung

Should you have any questions or suggestions, please get in touch with me.

Responsible for the project at the Institute of Language, Society, Workforce and Adolescence.

Telephone: 0111/107830
Fax: 1061/9724561
Email: ensa@anna.uni-mainz.de
Consent form

I hereby give my consent for my son/my daughter (please give the full name)
________________________________________ to participate in the written survey
carried out by the BZgA and the University of Leipzig on the subject of Youth
Sexuality. I consent to the information provided by my child being used in line with
the data protection regulations §5 BDSG (Federal Data Protection Act) anonymously
and exclusively for scientific purposes.

________________________________________
Date       Signature

Please give the signed consent form to your child so he/she can give it to the school.
It is the authorization for your child to participate in the survey.
Online information about the study

www.forschung.sexualaufklaerung.de
www.english.forschung.sexualaufklaerung.de

There is additional information online about the Youth Sexuality and Disability project as well as about the scientific symposium in Leipzig, where the survey results were presented and discussed. The BZgA's bilingual website contains studies, evaluations, pilot projects and expert papers about the subjects of sexuality education, contraception and family planning in both German and English.

The website www.forschung.sexualaufklaerung.de gives users a fast way to access the BZgA’s ongoing and completed research projects. Every project is accompanied by a project profile and an abstract. This basic information is supplemented by selected results, literature lists and links, information about experts and background information.

www.english.forschung.sexualaufklaerung.de
The BZgA’s publications and online services

FORUM Sexualaufklärung Publication 1-2010 – Sexuality and Disability
As far back as 2001 the FORUM Sexualaufklärung und Familienplanung (Sexuality Education and Family Planning) addressed the subject of sexuality and disability. It was the first step towards taking a debate to the public and creating greater awareness of the many diverse questions. In the 1/2010 edition the FORUM once again addresses this issue and can look back over what has changed in the past nine years.

Order number: 13327004

Youth Sexuality 2010. Representative repeat survey of 14 – 17-year-olds and their parents – focus on migration
This report presents the main results of the representative survey Youth Sexuality 2010. The goal of the survey was to acquire empirical data that, thanks the representative nature of the samples, could generate reliable statements about the attitudes and behaviours of young people and their parents regarding sex education, sexuality and contraception. The study follows on surveys from previous years with the express goal of finding trend developments.

Bestellnummer: 13316270

www.loveline.de
A website for young people about love, relationships, sexuality and contraception. With chats, an encyclopaedia, knowledge games, FAQs, surveys, news and monthly hot topics young people can expand their knowledge in an interactive, up-to-date way.

www.schwanger-unter-20.de
This website has lots of information and guidance for pregnant women under the age of 20 and their partners. In addition to information about financial support and important facilities, those affected will find answers to frequently asked questions. They are encouraged to take advantage of help. As young pregnant women and fathers-to-be they can have their own say in the experience reports.
The website http://www.sexualaufklaerung.de focuses on presenting media from the area of sexuality education, contraception and family planning. The web pages provide an overview of publications on current and completed studies, expert papers, examinations, campaigns and pilot projects addressing various target groups.

The volumes of the series Research and Practice in Sexuality Education and Family Planning are presented with a short summary of their contents. Every volume can be ordered directly via the BZgA's order system, as well as downloaded as a PDF file.

The BZgA's regular information service, FORUM Sexuality Education And Family Planning is also introduced in detail and offered for download. The abridged versions of studies and repeat surveys are also available online. The series Research and Practice in Sexuality Education and Family Planning has published more than 20 items to date and is being continually expanded. Several volumes are no longer available in print, but they are available in electronic format.

The BZgA's expert databases can also be accessed via the website www.sexualaufklaerung.de. The service currently includes six expert databases and is continually being expanded. The following databases are available on the subject area of sexuality education and family planning:

- Women's health and promoting health: literature, data, organizations
- Prenatal diagnostics and an unfulfilled desire for children: information materials, educational brochures, media, measures

The ‘list of materials’ provides information about all of the BZgA’s publications, while the information letter FORUM Sexuality Education and Family Planning presents relevant developments in the series of volumes, and with the expert study series Research and Practice in Sexuality Education and Family Planning the BZgA offers a forum for discussion and a link between the academic and practical fields.

The Expert Study series publishes the opinions of experts as well as studies and pilot projects which reflect the current state of work in sexuality education and family planning. Special volumes also document the results of conferences and congresses.

The present volume examines the attitudes and knowledge of young people with physical disabilities, or visual/hearing impairments at special-needs schools in Saxony regarding matters of sexuality. The main subject matters of the quantitative survey are sexuality education in school and at home, first sexual experiences and contraception, as well as physical development, desire for children and experiences with violence.

Some of the results of selected studies and representative repeat surveys have been published in abridged versions. Special publications contain the results from conferences and congresses.
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- sexuality education and family planning in special-needs education

Youth Sexuality and Disability

Youth Sexuality and Disability – Results from a survey carried out at special-needs schools in Saxony

Results from a survey carried out at special-needs schools in Saxony

Publisher: Bundeszentrale für gesundheitliche Aufklärung

Research and Practice in Sexuality Education and Family Planning

The study series Research and Practice in Sexuality Education and Family Planning documents surveys and expert papers as well as results from pilot projects. The individual volumes reflect the current state of research as well as presenting developments and trends. The spectrum of subjects ranges from addressing fundamental questions to discussing selected topics and supporting practical work. Multipliers are offered material for their work as well as for initial, advanced and in-service training purposes.

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