

SEXUAL KNOWLEDGE, SEXUAL EXPERIENCES AND VIEWS ON  
SEXUALITY EDUCATION AMONG ADULTS WITH VISUAL DISABILITIES

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Approval of the Graduate School of Social Sciences

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## **ABSTRACT**

### **SEXUAL KNOWLEDGE, SEXUAL EXPERIENCES AND VIEWS ON SEXUALITY EDUCATION AMONG ADULTS WITH VISUAL DISABILITIES**

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The present study aims to explore sexual knowledge, sexual experiences, and views on sexuality education among adults with visual disabilities. For this purpose, a phenomenological research was conducted with 18 adults with visual disabilities (10 male, 8 female) aged between 20 and 42 through semi-structured interviews. The interview schedule was developed based on the current literature, and reviewed by experts, and thematic analysis method was utilized as data analysis method.

The findings of the study demonstrated that participants evaluated their level of sexual knowledge either sufficient or partially sufficient. Sexual intercourse, sexual intercourse positions, STDs, body characteristics including sexual organs, contraception, fertilization, birth, masturbation, orgasm and oral/anal sex emerged as topics that participants needed further information. Results showed that mass media, experiential learning, and friends were among the main sources of sexual knowledge. Results regarding sexual experiences indicated that participants faced with different kinds of discrimination in terms of sexuality and sexual relationships, including discrimination based on visual disability, desexualization, and receiving disquieting questions regarding visual disability and sexuality. With regard to sexually appealing characteristics, findings suggested that tone of voice, smell, speech/diction, and skin were among the sexually appealing



characteristics for the participants. Considering views on sexuality education, participants evaluated previous sexuality education experiences as mostly insufficient in terms of the content, materials, and accessibility. Results also suggested that participants would like to receive comprehensive sexuality education which addresses issues including human development, sexual health, sexual behavior, sexual relationships, and individual needs.

Keywords: Sexuality, Visual Disability, Sexual Knowledge, Sexual Experience, Sexuality Education

## ÖZ

### GÖRME ENGELLİ YETİŞKİNLERDE CİNSEL BİLGİ, CİNSEL YAŞANTI VE CİNSELLİK EĞİTİMİNE İLİŞKİN GÖRÜŞLER

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Bu çalışma görme engelli yetişkinler arasında cinsel bilgi, cinsel yaşantı ve cinsellik eğitime ilişkin görüşlerin araştırılmasını amaçlamaktadır. Bu amaçla, yaşları 20 ile 42 arasında değişen 18 görme engelli yetişkin ile (10 erkek, 8 kadın) yarı-yapılandırılmış görüşmeler aracılığıyla bir olgubilim araştırması yapılmıştır. Görüşme formu ilgili alanyazına dayalı olarak geliştirilmiş ve uzmanlar tarafından gözden geçirilmiş ve veri analiz yöntemi olarak tematik analiz yöntemi kullanılmıştır.

Çalışmanın bulguları katılımcıların cinsel bilgi düzeylerini yeterli ya da kısmen yeterli olarak değerlendirdiklerini göstermektedir. Cinsel birleşme, cinsel birleşme pozisyonları, cinsel yolla bulaşan hastalıklar, cinsel organları da içeren vücut özellikleri, korunma, üreme, doğum, mastürbasyon, orgazm ve oral/anal seks, katılımcıların daha geniş bilgiye ihtiyaç duydukları konular olarak ortaya çıkmıştır. Sonuçlar kitle iletişim araçları, yaşantısal öğrenme ve arkadaşların başlıca cinsel bilgi kaynakları arasında olduğunu göstermektedir. Cinsel yaşantılara ilişkin bulgular katılımcıların görme engeline dayalı ayrımcılık, cinsiyetsizleştirme, görme engeli ve cinselliğe ilişkin rahatsız edici sorular sorulması gibi cinsellik ve cinsel ilişkiler açısından farklı türde ayrımcılıklara maruz kaldıklarını göstermektedir. Cinsel açıdan çekici gelen özellikler açısından ise bulgular ses tonu, koku, konuşma/diksiyon ve tenin katılımcılar açısından

cinsel açıdan çekici gelen özellikler arasında olduğunu göstermektedir. Cinsellik eğitimine ilişkin görüşler göz önüne alındığında, katılımcılar geçmiş eğitim deneyimlerini içerik, materyaller ve erişilebilirlik açısından çoğunlukla yetersiz olarak değerlendirmişlerdir. Bulgular, ayrıca, katılımcıların insan gelişimi, cinsel sağlık, cinsel davranış, cinsel ilişkiler ve bireysel ihtiyaçlar gibi konuları kapsayan kapsamlı bir cinsellik eğitimi almak istediklerini göstermektedir.

Anahtar Kelimeler: Cinsellik, Görme Engeli, Cinsel Bilgi, Cinsel Yaşantı, Cinsellik Eğitimi

*To my mother, Gülhan & my father, Hüseyin*

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## **LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
CETAD	Sexuality Education, Treatment and Research Association
DİE	State Institute of Statistics
HSEC	Human Subjects Ethics Committee
HIV	Human Immunodeficiency Virus
ICD	International Classifications of Diseases
ICF	International Classification of Functioning, Disability and Health
İŞKUR	Turkish Employment Agency
MEB	Ministry of National Education of Turkey
MS	Multiple Sclerosis
NGO	Nongovernmental Organizations
OZİDA	The Presidency of Administration on Disabled People
SCI	Spinal Cord Injury
SIECUS	Sexuality Information and Education Council of the United States
STDs	Sexually Transmitted Diseases
TurkStat	Turkish Statistical Institute
UN	United Nations
UPIAS	Union of Physically Impaired Against Segregation
WHO	World Health Organization



## CHAPTER I

### INTRODUCTION

“As a man in my thirties, I still felt embarrassed by my sexuality. It seemed to be utterly without purpose in my life, except to mortify me when I became aroused during bed baths. I would not talk to my attendants about the orgasms I had then, or the profound shame I felt. I imagined they, too, hated me for becoming so excited. I wanted to be loved. I wanted to be held, caressed, and valued. But my self-hatred and fear were too intense. I doubted I deserved to be loved. My frustrated sexual feelings seemed to be just another curse inflicted upon me by a cruel God.”

Mark O’Brien, 1990. “On Seeing a Sex Surrogate”, excerpt from *The Sun*

The writer of this passage is Mark O’Brien. He was a poet and a journalist, who had physical disability due to childhood polio and had to spend most of his life in an iron lung. His own brief description of his complicated feelings regarding his experiences depicts the mutual complexity of disability and sexuality. This study aims at uncovering, at least, certain aspects of this issue and shed light on major aspects of the complex relation between visual disability and sexuality, which, to the best of our knowledge, has not been thoroughly addressed in the existing literature. The following part presents the background to the study and explains the purpose and the significance of the study. The brief definition of the terminology used in the study is also introduced.

#### **1.1 Background to the Study**

The understanding of disability has been evolved to a great extent through time. Initially disability was considered as a personal tragedy through a medical approach and defined by words including impairment, handicap or disease (Barnes, 1994; Oliver, 1996). However, later developments have helped emergence of a different understanding of disability that emphasized disadvantages, obstacles, restrictions, exclusion, and discrimination through an

agenda related to social oppression and social change (Oliver, 1996; Shakespeare, 2000; UPIAS, 1976). Health care, education, rehabilitation and employment, which are regarded as public issues, have been discussed extensively through such a different perspective; however, topic of sexuality and disability have not been studied extensively because sexuality is mostly considered as a private issue (Shakespeare, 2000). Likewise, the intersection between sexuality and visual disabilities seems to be neglected in both disability and sexuality studies, although sexuality is usually regarded as an important aspect of human life.

Similar to aforementioned condition of the available literature regarding sexuality and disability, there is lack of attention to the intersection of sexuality and disability in Turkey too. Both disability and sexuality have been contradictory topics in Turkey due to several social and political reasons, mostly related to or emerging from the sociopolitical structure of the society. Until the revision of “Law on People with Disabilities” in 2014 (Engelliler Hakkında Kanun, 2014), the term “handicapped” (özürlü) was usually utilized in various legislations in Turkish language. Moreover, both the state and the society mainly conceptualized disability as it was only made up of an impairment without considering different kinds of environmental or social barriers. Furthermore, findings of a recent study on the subject (OZİDA, 2009) revealed that the majority of the participants had the belief that having a disability is one of the broad test divinely preconditioned by God and it can give rise to a better life after death for the persons with disabilities. What this finding means that people have a tendency to consider disability within a framework based on religion in Turkey. Likewise, sexuality has also been considered within prohibitions and restrictions based on the Islam since there is a conservative nature of people living in Turkey, especially people living in rural areas. Studies also indicate that women sexuality has become an area of oppression and restriction with various types of oppressive acts and mechanisms in Turkey (İlkkaracan, 2001; Parla, 2001; Sarıtaş, 2012). Hence, the intersection of sexuality and disability has become more complicated in Turkey due to existing views, perceptions, and practices regarding sexuality and disability separately. On the other hand, the topic of sexuality and disability maintains its importance, in spite

of these complexities and difficulties, due to the fact that there are an important number of people with disabilities in Turkey.

According to Turkey Disability Survey (DİE, 2002), 12.29% of the population have different kinds of disabilities including mobility, hearing, visual, and intellectual disabilities as well as chronic illnesses and psychiatric conditions. Studies demonstrated that people with disabilities experience various types of obstacles in Turkey including participation in social life (Burcu, 2007), forming family and friendships (Burcu, 2007), economic difficulties especially unemployment (Burcu, 2007; Yakut Çakar, Küçükaslan, & Yılmaz, 2013), educational difficulties (Burcu, 2007; Güneş, Aktaş, Konuk, & Şahsuvaroğlu, 2013; Sart, Ala, Yazlık, & Kantaş Yılmaz, 2004), accessibility problems in terms of services, information and physical environment (Barış & Uslu, 2009; Burcu, 2007; Çağlar, 2012; Sungur Ergenoğlu & Yıldız, 2013; Yelçe, Burat, & Ensari, 2013; TurkStat, 2010), and discrimination at different levels (Şenyurt Akdağ, Tanay, Özgül Birer, & Kara, 2011; TurkStat, 2010). In this context, people with visual disabilities are not free from difficulties that people with any kind of disabilities experienced in Turkey.

The most recent and comprehensive statistics shows that 0.60% of the population have been living with visual disabilities (DİE, 2002). Although sexuality, sexual rights and needs related to sexuality of people with visual disabilities do matter like anyone else, there is no nationwide study, statistics, or sexual health action plan that considers people with visual disabilities regarding sexuality. Existing action plans and related nationwide studies including *Sexual Health and Reproduction Health, National Strategic Action Plan for Health Sector 2005-2015* (Ministry of Health, 2010) and *Survey on Sexual Health and Reproduction Health Among Young Adults* (UN & Demography Association, 2007) do not provide any information or guideline for action related to sexuality of people with visual disabilities. According to TurkStat (2010) Survey on Problems and Expectations of Disabled People, 91.8% of adults with visual disabilities stated that they could not benefit but would like to benefit from health service support, and 85.4% of them would like to benefit from guidance and advice services. Nevertheless, how many of them would like to use these services for their

sexual health related concerns are remain unknown. Despite the fact that the subject of sexuality and visual disability is still a mystery in Turkey, there has been a slightly increased global attention to the topic of sexuality and disability in recent years.

With respect to sexuality and disability studies, a number of researchers particularly argued that barriers rather than impairments have an adverse effect on experiencing sexuality on the part of people with disabilities (Gershick, 2006; Shakespeare, 2000; Shakespeare, Gillespie Sells, & Davies, 1996; Shuttleworth, 2012; Siebers, 2012). The widespread perception of people with disabilities is they are asexual and needy. Furthermore, the lack of opportunity to find partners due to accessibility, social and economic problems, and lack of confidence and assertiveness due to the perception of the society are specified as barriers that people with disabilities face with (Shakespeare, 2000; Shakespeare et al., 1996). Similarly, the perception that people with disabilities are not able to have sex (Siebers, 2012) and have barriers to access sexual experiences and sexual autonomy (Gershick, 2006; Siebers, 2012) are also defined as obstacles for people with disabilities. On the other hand, empirical studies have usually been conducted within impairment based approach in a quantitative manner without considering other social and environmental factors as well as barriers. Studies regarding mobility disabilities indicated that lack of sexual knowledge (East & Orchard, 2014; McCabe, Cummins, & Deeks, 2000), barriers to sexual experiences arised from expectations of the society or other reasons (East & Orchard, 2014; Jemata, Fulg Meyer, & Öberg, 2008; Yoshida, Li, & Odette; 1999), lower levels of sexual self-esteem and sexual satisfaction (McCabe & Taleporos, 2003), pain during intercourse (Altuntuğ, Ege, Akin, Kal, & Sallı, 2014), problems regarding sexual arousal and infertility (Elbozan Cumurcu, Karlıdağ, & Han Almış, 2012) were the issues among people with mobility disabilities. Additionally, spinal cord injury and multiple sclerosis are among the topics that have been studied related to sexuality, and findings generally revealed decreased sexual satisfaction and different kinds of sexual dysfunction problems including orgasm, vaginal lubrication and erection difficulties that people having spinal cord injury and multiple sclerosis faced with (Ghajarzadeh, Jalilian, Mohammadifar, Sahraian, &



Azimi, 2014; Gümüş, Akpınar, & Yılmaz; 2013; Khan, Pallant, Ng, & Whishaw, 2011; Khoei Merghati, Qaderi Mendes, Cardoso, & Savall, 2008; Qaderi & Khoei, 2014).

Intellectual disability has also been studied in relation to topics including sexual knowledge and education, sexual abuse, sex offenders and consent for sexual relationships in various studies (Dukes & McGuire, 2009; Kijak, 2013; Lindsay, Bellshaw, Culross, Staines, & Michie, 1992; McCabe & Cummins, 1996; McGillivray, 1999). Those studies often yielded that different kinds of disabilities bring different considerations to sexual lives of people with disabilities including sexual dysfunction, sexual self-esteem, and issues related to consent for sexual relationships. Yet, whether visual disability brings any considerations in terms of sexuality still remains mostly unknown.

Unlike empirical studies related to sexuality and disability, visual disability has not been studied in terms of sexual functioning, and there are only a limited number of studies regarding visual disability and sexuality in the existing literature. Glass (1984) discusses this fact by indicating that visual disability does not affect sexual functioning directly; hence, researchers do not pay attention to visual disability with a focus of sexual functioning. However, a number of practitioners argued that sexual development and social development, which is also related to sexuality and sexual development, may be affected by the interaction of visual disability and the environment (Davies, 1996; Glass, 1984; Özyürek, 1995). In other words, visual disability or more specifically loss of vision may affect the perception of world, learning, and communication during the childhood so that it may interfere with sexual development unless necessary accommodations have been provided.

The available literature presents a number of empirical studies related to visual disability and sexuality conducted with adolescents in terms of sexual knowledge, sources of sexual knowledge and sexual experiences (Bezerra & Pabliguica, 2010; Duh, 2000; İrdem, 2006; Kef & Bos, 2006; Piquart & Pfeiffer, 2012). Additionally, limited literature exists on empirical studies conducted with young adults and adults with visual disabilities in terms of sexual knowledge,

sexual experience, and sexuality education (Arıkan, 2001; Abramson, Boggs, & Mason, 2013; Kapperman & Kelly, 2013; Kelly & Kapperman, 2012; Krupa & Esmail, 2010; Wild, Kelly, Blackburn, & Ryan, 2014). With regard to sexual knowledge and visual disability, aforementioned studies have presented inconclusive findings. On the one hand, studies of İrdem (2006) and Duh (2000) showed that there is a lack of sexual knowledge among adolescents with visual disabilities, and onset of disability is correlated with the level of sexual knowledge; that is to say, adolescents with acquired visual disability have lower levels of sexual knowledge than adolescents with congenital visual disabilities. On the other hand, other studies indicated that adolescents with visual disabilities thought that they have enough sexual knowledge (Kef & Bos, 2006). Regarding sexual experience, Kelly and Kapperman's (2012) study showed that the onset of sexual intercourse experience is significantly late in young adults with visual disabilities compared to sighted peers. However, Piquart and Pfeiffer's (2012) study did not support this finding as they found that adolescents with visual disabilities do not differ in timing of sexual intercourse in comparison to sighted peers. Furthermore, studies related to sexuality education demonstrated that people with visual disabilities need accessible sexuality education programs through tactile materials, and that they have experienced several obstacles to access sexuality education due to inaccessible environment and materials (Kapperman & Kelly, 2013; Krupa & Esmail, 2010; Wild, Kelly, Blackburn, & Ryan, 2014). To sum up, literature on visual disability and sexuality does not provide a common understanding of sexual knowledge, sources of sexual knowledge and sexual experiences with a focus on voices of people with visual disabilities although existing studies present valuable insights into the subject.

Considering the available literature, the intersection of visual disability and sexuality has not been taken into consideration within a comprehensive framework that focuses on knowledge, experience and education concomitantly. Furthermore, sexuality has not been studied sufficiently to comprehend the perspectives and experiences of people with visual disabilities. Moreover, available literature in Turkey does not provide comprehensive information regarding this topic. Hence, this study aims at exploring self-evaluation of sexual knowledge, sources of sexual

knowledge, different kinds of sexual experiences, and views on sexuality education. A comprehensive understanding of these different dimensions from the perspectives of people with visual disabilities are expected to contribute to the sexuality and disability studies as well as the development of policies including sexual health programs and sexuality education for people with visual disabilities.

## **1.2 Purpose of the Study**

The purpose of the present study is to explore sexual knowledge, sexual experiences, and view on sexuality education among adults with visual disabilities. In accordance with the purpose of the study, major research questions are as follows:

- 1) How do adults with visual disabilities evaluate themselves in terms of sexual knowledge?
- 2) How do adults with visual disabilities access sexuality information?
- 3) How do adults with visual disabilities experience sexuality in general?
- 4) What are the views regarding sexuality education among adults with visual disabilities?

## **1.3 Significance of the Study**

The current study is about sexuality and visual disability overall, and it is important to elaborate the reasons of selecting this topic for the research. First of all, according to World Health Organization (“Visual Impairment and Blindness”, 2014), the estimated number of people with visual disabilities worldwide is 285 million. Considering the number of people having visual disability, it seems worth studying sexuality by portraying the perspectives of people with visual disabilities.

Secondly, there is a lack of knowledge on sexuality related problems and sexuality related health or education plans and programs for people with visual disabilities in Turkey. Aforementioned Survey on Problems and Expectations of Disabled People (TurkStat, 2010), 91.8% of adults with visual disabilities stated that they could not benefit and would like to benefit from health service support, and 85.4% of them would like to benefit from guidance and advice services. These findings seem to be of utmost importance since they revealed that a significant number of adults with visual disabilities do not benefit from such basic public services that can also serve for sexuality related needs and problems of people with

visual disabilities. Moreover, it seems that there has been no specifically planned study to understand the current condition and problems of adults with visual disabilities regarding sexuality and to increase their sexual knowledge considering available Sexual Health and Reproduction Health, and National Strategic Action Plan for Health Sector 2005-2015 (Ministry of Health, 2010). Likewise, any information specific to sexuality and visual disability exists within the Survey on Sexual Health and Reproduction Health among Young Adults (UN & Demography Association, 2007). Hence, it appears important to obtain information about the current condition of people with visual disabilities in order to develop social policies in this context.

In the third place, the lack of empirical studies regarding sexuality and visual disability is another reason to study this subject. Current literature demonstrated that there has been a slowly growing interest on sexuality and disability; yet, they mainly focus on other types of disabilities rather than visual disability. Moreover, the main focus of these studies was on the relationship between sexual dysfunction and disabilities, and the negative effect of disabilities on sexuality. Considering the sample of the empirical studies related to sexuality conducted in Turkey so far, patients with multiple sclerosis (Akkuş & Duru, 2011; Kılıç, Ünver, Bolu, & Demirkaya, 2012), patients with Type II Diabetes (Küçük, Kaya, Küçük, Yoğun, & Buzlu, 2013; Hintistan & Çilingir, 2013), women receiving breast cancer treatment (Cebeci, Balcı Yangın, & Tekeli, 2010), women with physical disabilities (Altuntuğ et al., 2014), patients with hemodialysis (Koç & Sağlam, 2013), adolescents with intellectual disabilities (İşler, Taş, Beytut, & Conk, 2009), women with scleroderma (Oksel & Çıray Gündüzoğlu, 2014), and young adult men with epilepsy (Bağcıoğlu et al., 2013) were examined. Although these studies are of great importance in terms of different kinds of disabilities and sexuality in Turkey, most of them relied on the medical model of disability; therefore, this causes lack of information about environmental challenges and barriers that people with disabilities face with. In addition, there has been no study related to sexual experiences of adults with visual disabilities in Turkey and only a few number of examples available in the rest of the world as well (Bezerra & Pabliguua, 2010; Kelly & Kapperman, 2012; Shakespeare et al., 1996).

Therefore, there is a need to describe and explore sexual knowledge, sexual experiences, and perceptions regarding sexuality education of adults with visual disabilities by focusing personal experiences and perspectives.

Another reason of studying this subject is related to the field of psychological counseling and guidance. Regarding counseling profession, Gordon, Tschopp and Feldman (2014) suggested that counselors should also be aware of common and unique needs of clients with disabilities in terms of issues of sexuality to help them in an effective way. Therefore; an investigation of sexual knowledge, experiences and barriers to sexuality may help counselors to gain an insight related to clients with disabilities. Similarly, the role of school counselors in providing sexuality education is of utmost importance for both students with and without disabilities. Hence, the study is also expected to contribute to planning and implementing counseling services in schools as well.

Furthermore, learning the ways of initiation of sexual relationships, sexual attraction, and sexuality related experiences in the lack of vision may shed light on previously unknown aspects of sexuality. In the literature, sexuality and being sexual are mostly defined based on vision and visual qualities. For instance, according to Sprecher and McKinney (1993), developing a close relationship follows a pathway from first seeing and meeting to going on a first date. In addition, Berger claimed that there are different strategies people use to initiate close relationships (as cited in Sprecher & McKinney, 1993). These are introducing themselves following an observation, mutual gaze or a casual remark; using nonverbal cues to attract the other or getting help from a friend to initiate the contact. Considering such claims, one may assert that people with visual disabilities may not follow these specified steps to initiate relationships due to lack of vision. Interpersonal relationship theories are mainly based on the role of visual cues, visual observation, and nonverbal cues as well; therefore, they cannot be fully employed to explain how people with visual disabilities initiate, develop and sustain intimate and/or sexual relationships. Moreover, there is hegemony of sight and vision with respect to sexual arousal and sexual intercourse in different studies. For example, Özgüven (1997) claimed that the most powerful source of sexual arousal is sight as well as touching. Furthermore, it is also suggested that

touching has an important place in basic visual stimulation. On the other hand, sound and smell are also seen as sources of sexual arousal. Considering all of these claims, learning how people with visual disabilities experience such facets of sexuality may bring us a new and different understanding of sexuality.

Taken collectively, it is expected that the study will contribute to several fields including sexuality education, counseling with people with disabilities, and sexuality and disability studies as a whole. It is also believed that an explorative study can be important in terms of learning the current sexual knowledge levels, possible needs for sexual knowledge and sexuality education experiences as well as sexual experiences of adults with visual disabilities and developing sexuality education programs or revising current programs.

#### **1.4 Definition of Terms**

In the current study, the term visual disability was utilized rather than visual impairment in order to emphasize different aspects of visual disability including impairment, restrictions of participation due to both societal and personal factors. Considering aforementioned slightly different definitions of disability and people with visual disability, the current study utilized following definitions of terms:

**Disability:** “the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors)” (WHO, 2011, p.4)

**People with Visual Disabilities:** It refers to people who have visual function loss at various levels and affected by the interaction of the visual function loss and environmental conditions including different types of barriers.

**Sexual Knowledge:** In the current study, sexual knowledge term refers to knowledge on different aspects of sexuality including human development, sexual behavior, and sexual health.

**Sexual Experience:** In the current study, sexual experience refers to sexual experiences including wet dreams, menstruation, ejaculation, kissing, light petting, heavy petting, oral-genital-anal contact, sexual intercourse, masturbation and the use of contraceptives in childhood, puberty and

adulthood.

**Sexuality Education:** “Sexuality education is a life-long process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy” (SIECUS, 1996, p.6). Sexuality education also refers to “learning about the cognitive, emotional, social, interactive, and physical aspects of sexuality” (WHO Regional Office for Europe/BZgA, 2010, p.20.).

## **CHAPTER II**

### **LITERATURE REVIEW**

In this section, existing literature related to the topics of the current study was presented through subsections on models of disability, disability in Turkey, sexuality in Turkey, visual disability, sexuality and disability, and sexuality and visual disability. By means of a brief summary of models of disability, the researcher provided a brief historical background on changes of definitions and meanings of disability. Moreover, legal and social aspects of disability as well as the condition of people with disabilities in Turkey and sexuality in Turkey were presented in order to provide the reader a general insight about the context in which the study carried out. Subsequent to this framework, existing literature on sexuality and disability as well as sexuality and visual disability were presented.

#### **2.1 Models of Disability**

The definition and meaning of disability as well as the terminology that is used to describe disability situation have been transformed dramatically throughout the historical process. Therefore, models of disability can be regarded as conceptual framework defining disability from different perspectives. A bulk of models of disability including medical model, social model, biopsychosocial model, human rights based approach, minority model, rehabilitation model, expert/professional model, customer/empowering model, economic model, tragedy/charity model and religious/moral model have been presented in the literature. In the following sections, only the medical model, the social model, and the biopsychosocial model of disability will be elaborated. Other models that are not immediately relevant to the study and a through presentation of all the existing models are beyond the scope of this study. Furthermore, the following three main models of disability seem to be sufficient to understand disability and changes in the meaning of disability, and to help to conceptualize the concepts of visual



disability and people with visual disabilities that are relevant to the main subject of the current study.

**2.1.1 Medical model of disability.** Formerly, the medical model of disability had been the dominant model in understanding and conceptualizing disability as well as formation of social policies regarding disability in advance of the development of social model.

Within the scope of the medical model, impairment is seen as a disease and a personal problem of the individual; therefore, the solution to this problem is regarded as the treatment of the individuals by professionals and experts (Oliver, 1996). In other words, medicalization of disability had become the dominant approach in terms of this model. Moreover, this model does not consider environmental and social factors that may explain or affect disability; rather, it focuses on personal factors only and defends the personal adjustment of the people with impairments to the society instead of a social change. To give an example, an advocate of medical model could evaluate a person with visual disability as sick or having disease and needs to be treated, and in case of no treatment, individual adjustment to the society is suggested by prioritizing the visual impairment itself.

**2.1.2 Social model of disability.** The social model of disability was developed as a criticism and reaction to the medical model of disability with the effort of disability rights movement and related organizations. The development of the social model rests upon the ideas specified in the “Fundamental Principles of Disability” text which was written by the Union of the Physically Impaired Against Segregation (UPIAS, 1976). While the medical model evaluates disability through dichotomies such as normal-abnormal and health and disease; the disability was firstly described by considering social and physical barriers that people with disabilities face with in “Fundamental Principles of Disability”. This was the first attempt to develop a more comprehensive understanding of disability, and this approach helped to develop different models such as minority model and rights-based approach model.

UPIAS (1976) firstly made a distinction between impairment and disability by emphasizing environmental barriers including the isolation, exclusion, and

oppression within the society. Hence, they defined impairment and disability as follows:

we define impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body; and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments, and thus excludes them from participation in the mainstream of social activities (UPIAS, 1976, p.20).

The impairment and disability distinction and especially the UPIAS' definition of disability were considered important shifts in the understanding of disability. In this regard, the social model of disability differs from medical model with its emphasis on aspects different than impairment including disadvantages, restrictions, exclusions, and discriminations at various levels of social organizations. To be more precise, the social model prioritized social oppression, social activism, social change and rights, and considered disability as a social problem rather than an individual one in contrast to the medical model (Oliver, 1996; Shakespeare, 2000; UPIAS, 1976). Oliver (1990), one of the social model theorists, argued that the medicalization of disability leaves no individual choices or action for people with disabilities since the control is in the hand of professionals or experts. Moreover, because social model theorists thought that disability is not a medical but social problem, they protested the medicalization process even though they stated that health personnel can use their knowledge for the treatment of impairment but not the disability. To give an example, an advocate of social model could approach a person with visual disability as the one who experience difficulties, exclusion or discrimination due to lack of accessibility, accommodations, and social policies at different levels.

**2.1.3 Biopsychosocial model of disability.** Due to the criticisms to social model of disability which indicate the lack of focus on impairment itself, several models of disability were developed. One of those models, namely the biopsychosocial model was developed by WHO (2001) in the manual called, "International Classification of Functioning, Disability and Health" (ICF). The approach to disability in ICF was described as "biopsychosocial" approach which has its root in the integration of medical model and social model (WHO, 2001).

Within the scope of ICF, disability is considered under two main titles: “Functioning and Disability” and “Contextual Factors” (WHO, 2001, pp.18-19). In this regard, functions of body systems and body structures as well as activities and participation are addressed under the title of “Functioning and Disability”, and environmental factors and personal factors are addressed under the title of “Contextual Factors”. According to ICF (WHO, 2001), impairment is defined as “problems in body function or structure as a significant deviation or loss (p. 12),” and disability is defined as “the outcome or result of a complex relationship between an individual’s health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives” (p.17).

Regarding those definitions, one can easily notice the similarity between definition of impairment made by the UPIAS and WHO. However, the definitions of disability and the given weight to disability in each model seem quite different. In other words, WHO prioritizes the interaction between personal factors and external factors while UPIAS mainly concentrates on external factors including oppression, exclusion, and discrimination at various levels within society. Moreover, WHO does not prioritize disability as the main focus rather the main focus is on the complex relationships among impairment, internal factors, and external factors; whereas UPIAS constitutes their approach by giving priority to disability. Although it is argued that ICF is based on the integration of those two aforementioned models, the underlying model of this approach seems similar to medical model more with its heavy concentration on the individual and lack of focus on societal barriers and change at societal level. On the other hand, it is an undeniable fact that such classifications and categories based on the level of functioning of the individual are necessary in different health settings and for the social policy purposes. Therefore, every approach in those specified models is valuable in terms of perceiving and understanding disability with different dimensions and different focus.

Aforementioned changes in meaning and definitions of disability have also affected how Turkey officially conceptualizes disability and designs social policies regarding disability. Hence, legal and social aspects related to disability as well as

current conditions of people with disabilities in Turkey were mentioned briefly in the next section.

## **2.2 Disability in Turkey**

**2.2.1 Legal and social aspects at a glance.** Considering developments with regard to definition of disability, disability related social policies, legal regulations, and condition of people with disabilities, each country may have unique pathways due to different economic, political and social structures although they may share similarities in this context. For instance, while UPIAS (1976) constituted the social model in England in 70s, a developed country; in Turkey, a developing economy, newly emerging disability organizations, which are not based on philanthropy and protectionism and not included persons with disabilities, were tried to be controlled by the State during and especially after 1980 military takeover (Ertürk, 2003). Such a political atmosphere prevented people with disabilities to form their own rights-based organizations in Turkey. Hence, it was stated that awareness about people with disabilities was developed in a later period (Ertürk, 2003). In this regard, the first legal regulation regarding disability in Turkey was the Law on Disabled People and on Making Amendments in Some Laws and Decree Laws (Özürlüler ve Bazı Kanun ve Kanun Hükmünde Kararnamelerde Değişiklik Yapılması Hakkında Kanun) (Law No. 5378, 2005). The main aim of this law was defined as follows:

...to prevent disability, to enable the disabled people to join the society by taking measures which will provide the solution of their problems regarding health, education, rehabilitation, employment, care and social security and the removal of obstacles they face and to make the necessary arrangements for the coordination of these services (Turkey, Law No. 5378, 2005, p.1).

Although this was the first attempt to develop a legal regulation on disability and people with disabilities, definition of disability within the law was more similar to medical model definition of disability that does not consider different aspects of disability, but the impairment only. However, the law was revised in 2014 including changes in terms, definitions, and the content compared to the law accepted at 2005. Firstly, the name of the law was changed as “Law on People with Disabilities” (Engelliler Hakkında Kanun); secondly, full and equal participation, restrictions of participation and environmental conditions were

emphasized in the definition of disability, and lastly direct and indirect discrimination as well as discrimination based on disability were described within the scope of the law. According to this law (Turkey, Law No. 5378, 2014) a person with disability is defined as “the person who has affected by attitudes and environmental conditions that restrict the full and active participation to the society due to loss of physical, mental, psychological, and sensory capabilities at various levels” (p.1). This change is a very important legal step for not only recognition of people with disabilities, but also recognition of disabling barriers including attitudes, environmental conditions and discrimination. Such an important change can only affect the daily life of people with disabilities affirmatively as long as the implementation of the law is ensured by the State; yet, there are concerns regarding the implementation of the law.

With regard to implementation of the law, eight Nongovernmental Organizations (NGOs) submitted a joint report on evaluation of disability in Turkey, and they criticized the lack of investigation on the implementation and the outcomes of the Disability Law of Turkey (Association of Persons with Visual Impairments et al., 2010). In other words, there are questions in terms of implementation of this law although Turkey adapted its law to international standards. Additionally, there are also a high number of different national legislations regarding care, education, accessibility, employment, economic supplies, health and social security, and social life for people with disabilities (General Directorate of Services for Persons with Disabilities and Elderly People, n. d.). Apart from these national legal regulations and legislations, Turkey also accepted and ratified the implementation of United Nations Convention on the Rights of Persons with Disabilities in 2008 (Law 5825, Turkey). The United Nations Convention mainly aims to secure rights and freedom of all individuals with different kinds of disabilities in a full and equal basis (UN, 2006). Despite the fact that these regulations and laws can secure rights of people with disabilities legally, participating in social life in a full and equal basis seems related to the perception of disability and people with disabilities. To be more precise, how disability perceived in Turkey seems to be as important as legal aspects of disability.

The Presidency of Administration on Disabled People (Özürlüler İdaresi Başkanlığı) (OZİDA, 2009) carried out a study with 4144 participants from various cities of Turkey in order to examine the perceptions regarding people with disabilities. The findings demonstrated that people with mobility disabilities and the helpless ones were perceived as people with disabilities by the participants while they did not perceive chronic illnesses, hyperactivity and attention disorder as disabilities. Moreover, participants' attitudes toward people with intellectual disabilities and psychiatric conditions were more negative in terms of being friend, spouse or colleague. Likewise, they hold more negative attitudes toward people with intellectual disabilities and psychiatric conditions. Additionally, participants indicated that the most challenging disabilities were intellectual disability, visual disability and psychiatric conditions. Lastly, the idea that the disability is a test given by God was highly prevalent among the participants. That is to say, participants held negative attitudes toward particular kinds of disabilities and gave meaning to disability mostly through religiosity.

In sum, the general picture with regard to the legislations related to disability in Turkey seems quite satisfactory with latest changes in spite of the delay in taking such measures. However, the more important thing is that how those legislations affected the lives of people with disabilities, and whether or not the current condition of them in terms of different aspects of life including education, employment, and fulfillment of rights has been improved. On the other hand, different kinds of negative attitudes within society toward people with disabilities still remain. Hence, the next section will briefly discuss the condition of people with disabilities in Turkey in order to present a general framework of the current situation and to provide a basis to comprehend visual disability in this context hereby.

**2.2.2 The condition of people with disabilities.** Turkey Disability Survey (DİE, 2002) presents the most comprehensive statistics on people with disabilities in Turkey. Although the study is relatively outdated, there is no recent and more comprehensive statistics exist regarding people with disabilities. According to the results of this survey, 12.29% of the population has been living with disabilities including chronic diseases and psychiatric conditions (9.70%),

mobility disabilities (1.25%), visual disabilities (0.60%), hearing disabilities (0.37%), speech and language disorders (0.38%), and intellectual disabilities (0.48%). In other words, 8,431,937 people have been living with different kinds of disabilities in Turkey. The same survey also provided information on labor force status and employment, literacy, type and onset of disability, social security, marital status, and expectations from the institutions. According to the results, 15.46% of people having mobility, visual, hearing, and intellectual disabilities, and speech and language disorders (1st group) are unemployed and the percentage of unemployment decreases to 10.77% among people having chronic illnesses (2nd group). Literacy findings showed that the percentage of literate people among first group is 63.67% while the percentage increases to 75.19% among second group. Regarding the status of social security, 47.55% of the first group and 63.67% of the second group have social security. With regard to onset of disability, it was reported that almost 34% of people with disabilities have congenital disabilities and the rest of them have acquired disabilities. Lastly, the most important expectations from public institutions were increasing economic supplies (61.22%), guidance and help for employment (9.55%), care and treatment services at home (4.12%), defending for legal rights (3.5%), and creating opportunities for education (3.31%). The findings of the study concisely pointed out that unemployment, illiteracy, lack of social security, and economic hardships were among the obstacles concerning the condition of people with disabilities in Turkey.

In another comprehensive study, in which 1321 people with mobility and visual disabilities participated in, results indicated that participants experience difficulties with regard to participation in different spheres of social life including family, marriage, friendships, social and cultural activities, and face with economic, architectural, environmental, and educational problems as well as problems raised by the impairment itself (Burcu, 2007). Likewise, the study entitled Survey on Problems and Expectations of Disabled People (TurkStat, 2010), that was consisted of 280.014 participants, illustrated that people with disabilities found physical environmental arrangements including pavements, buildings, markets and public buildings inaccessible; they faced with difficulties regarding the usage of health services in terms of the need for a companion,

communication with health personnel, acquiring knowledge on health concerns, and accessibility within buildings. They also experienced problems regarding employment. Increasing social assistance and support, improving health and care services, increasing job and educational opportunities, and making arrangements regarding accessibility were stated by the participants as expectations from the State. Furthermore, 22.3% of the participants reported that they have thoughts of being exposed to discrimination. In other words, people with disabilities in Turkey face with different kinds of difficulties, namely economic, social or educational difficulties; hence, their expectations from the State are mainly shaped through these problems.

Employment is one of the important issues for people with disabilities as for anyone else since it provides both economic supplies and opportunities for participating in social life. In this regard, Council on People with Disabilities (OZİDA, 2009) was carried out a study on the issue of employment. The Council stated that new approaches to employment of people with disabilities should be developed due to the limited number of employed people with disabilities. Moreover, lack of coordination and collaboration among different institutions of the State in terms of service delivery related to vocational education and rehabilitation, lack of opportunities for e-learning or distance learning, lack of a comprehensive database to develop national policies for employment of people with disabilities, lack of implementation of quota system for employment in institutions, lack of educational experiences, inaccessible environment, negative attitudes of employers, lack of national policies, and deficiencies related to Turkish Employment Agency (İŞKUR) and its recruitment policies were defined as problems in employment of people with disabilities in Turkey. Likewise, in a review study regarding employment of people with disabilities in Turkey showed that exclusionist culture and discrimination, accessibility problems, lack of educated and qualified personnel, lack of supportive technology, problems in implementation of policies for employment of people with disabilities including quota system, recruitment and guidance, lack of support for entrepreneurship among people with disabilities and lack of support following to recruitment phase of employment were the major problems (Yakut et al., 2013). Furthermore, Genç



and Çat (2013) think that Turkey's national policy on employment, namely the sheltered workplaces, may give rise to social exclusion though such policies are considered as helpful for people with disabilities and especially people with intellectual disabilities economically (Çavuş & Tekin, 2015; Genç & Çat, 2013). Hence, employment persists to be an important concern among people with disabilities at individual as well as national levels considering nationwide statistics along with other related empirical and review studies.

On the other hand, education also appears to be another area that people with disabilities face challenges though there are developments in terms of inclusive education practices at different levels nationally. It was emphasized that although the number of children with disabilities increased at the primary level with the practices of special and inclusive education, there remains problems at further levels including secondary and higher education (Güneş et al., 2013). Additionally, accessibility, qualifications of school personnel, negative attitudes of students, families and school administration, lack of educators in the field of special education, and deficiencies in national legislations regarding education of people with disabilities were identified as issues that should be addressed. Likewise, the need for more information regarding inclusive education practices on the part of teachers, who work at schools that practice full inclusion, emerged as another concern regarding education of children with disabilities (Sart et al., 2014). Not only students in primary or secondary levels, but also students with disabilities in higher education face some challenges. For those, forming friendships, relationships with instructors, appropriate places for studying, accessibility, and leisure activities were among the issues that may give rise to problems within higher education system (Burcu, 2002). To be more precise, education can pave the way for healthy social relationships, different social opportunities, and opportunities for employment for people with disabilities; hence, it is one of the most important topics in which necessary measures should be taken in this regard. From a broader perspective, it was reported that the perception of people with disabilities based on mercy and helplessness was highly prevalent and discrimination toward people with disabilities in terms of employment, education, health services, sheltering, access to services, accessibility

and personal life was observed in Turkey (Şenyurt Akdağ et al., 2011). Likewise, physical accessibility (Barış & Uslu, 2009; Çağlar, 2012; Sungur Ergenoğlu & Yıldız, 2013), access to information and services (Yelçe et al., 2013), political participation (Akdeniz, Balamir Coşkun, Demiryol, & Yılmaz, 2013), and access to health and rehabilitation services (Aydın & Aktaş, 2013) were identified as areas that should be evaluated and revised in accordance with the needs of people with disabilities.

In sum, both studies and statistics depicted that the condition of people with disabilities was surrounded by different kinds of obstacles in almost every sphere of life including education, employment, and participation in social life. The lack of consideration of needs of people with disabilities in terms of health, accessibility and political participation has made the existing condition even worse. Despite the fact that experiences of people with disabilities in terms of sexuality cannot be acquired through those studies and statistics, it can be argued that sexuality of individuals cannot be considered completely detached from one's opportunities to participate in social life, labor force and education. Likewise, sexuality of the individuals cannot be considered as totally independent from how sexuality is perceived in a particular context. Hence, sexuality in Turkey is the focus of the next section to provide information about the context in which the present study was carried out.

### **2.3 Sexuality in Turkey**

Sexuality is one of the important aspects of human life and it is a quite broad subject, on which an enormous literature exists. In fact, to analyze and review each aspect of sexuality is beyond the scope of the current study. Hence, how sexuality is perceived in Turkey as well as sexual knowledge, sexual experiences and sexuality education which are the core topics of the current study are briefly presented within the framework of available literature in Turkey.

Similar to the issue of disability, sexuality has also social and political dimensions. Furthermore, how sexuality is perceived in a particular context is important in terms of sexual lives of people living in that context. Particularly, issues of chastity, 'honor' killings, forced arranged marriages, bride price, hymen, marital rape, and virginity examinations were specified as different types of

oppression and restriction on women sexuality in Turkey (İlkkaracan, 2001; Parla, 2001; Sarıtaş, 2012). What this shows is that especially women face with difficulties in discovering, expressing and experiencing their sexuality in Turkey. Moreover, even women do have sexual relationships, they try to hide such experiences or experience them secretly. Regarding this issue, conservative nature of the society, which has become a stable characteristic through time and different governments from the establishment of Turkey and the discipline of Islam, have a strong effect on how people understand and approach to sexuality. Hence, talking about sexuality and experiencing sexuality become difficult in this context.

Considering the effect of religion on sexuality, a number of empirical studies demonstrated the relationship between Islam, religiosity and sexual behaviors as well as sexual attitudes among participants from Turkey. In Hatipoğlu Sümer's (2015) study, conducted with 162 female and 135 male undergraduates, the importance of religion and the frequency of attending religious services were found to be as significant predictors of attitudes toward masturbation, abortion, and homosexuality. Moreover, participants, who were less influenced by the discipline of religion, held more liberal attitudes toward different aspects of sexuality. Likewise, religiosity was found to be a significant predictor of sexual behaviors including masturbation and sexual foreplay/intercourse in a sample of 256 female and 382 male undergraduate students from southeastern part of Turkey (Yaşan, Essizoğlu, & Yıldırım, 2009). Results of the study also demonstrated that male participants had significantly more sexual behaviors (masturbation and sexual intercourse) compared to female participants. Concerning gender differences on sexual behavior, Askun and Ataca's (2007) study suggested that the onset of first sexual intercourse among male participants was significantly early than female participants in a sample of 563 university students. Furthermore, the number of females in terms of being virgin was significantly more than the number of male participants. In addition, religiosity and mother's education significantly predicted attitudes toward women's premarital sexuality in a study that was carried out with 277 female undergraduates (Ergun, 2007). All of these studies, along with aforementioned issues on women's sexuality and the effect of religion depicted

that sexuality in Turkey is embedded into a context that was surrounded by religious, social, and gender related issues.

With regard to sexuality research in Turkey, particularly sexual knowledge and sexuality education rather than sexual experience have been the topics that researchers pay attention in order to both explore these issues across different samples, and to suggest policies. To reach sexual knowledge on an equal basis was specified as one of the core sexual rights by the World Health Organization (WHO, 2006). In other words, each individual has the right to reach necessary and complete knowledge regarding sexuality including reproductive and sexual health, sexual activity as well as sexually transmitted diseases. Although sexual knowledge does not guarantee appropriate sexual behaviors for all individuals, it is an undeniable fact that reliable and accurate information can provide a basis for healthy sexual relationships. According to Turkey Youth Sexual and Reproductive Health Survey (2007), youths aged between 15 and 24, did not have accurate and sufficient knowledge with regard to female and male reproductive organs as well as physiologies. Moreover, results highlighted that participants had knowledge related to changes in female and male puberty based mostly on their own experiences or observations. In terms of contraception, findings revealed that youth had more knowledge on contraception compared to reproductive organs. However, knowledge on emergency contraception seemed to be lower than the whole knowledge on contraception. Regarding sexually transmitted diseases, results pointed out that a high percentage of the youth heard about STDs and especially HIV/AIDS; nonetheless, they did not have sufficient knowledge on the symptoms of main STDs. Apart from these, sources of information about aforementioned topics were usually schools and friends as well as media.

Knowledge on STDs and especially HIV/AIDS is one of the topics that examined widely among different groups including university students and adolescents. A quantitative study, carried out with 530 undergraduates, demonstrated that participants lacked knowledge regarding a number of aspects of HIV/AIDS (Çok, Gray & Ersever, 2001). Likewise, Hatipoğlu Sümer's (2006) study with 165 female and 140 male undergraduates illustrated that there was a need for the usage of methods to prevent the transmission of STDs among sexually

active participants. In another study, conducted with 1314 undergraduate students (619 female; 695 male), results revealed that only 1.3% of the participants responded correctly to all questions on the domain of STD. Although HIV/AIDS was the most well known STDs among the participants, they had insufficient knowledge about other STDs. More importantly, 15% of the students did not have necessary knowledge on signs, symptoms, and ways of transmission of STDs. Interestingly, previous sexual health education was not a significant predictor of knowledge on STDs. On the other hand, the average score of students on sexual knowledge test was about 35 over 100, which seemed as quite low and insufficient score. With regard to these results, findings highlighted that sexual health training was correlated with sexual knowledge overall. Moreover, although they seemed to have appropriate knowledge about contraceptive methods, usage of such methods was not common among participants. Lastly, participants stated that “special physician/hospital” can be a reliable source for sexual knowledge and obtaining advice (Varol Saraçoğlu, Erdem, Doğan, & Tokuç, 2014). Similarly, results of another study revealed that only 16% of the participants had sufficient knowledge about STDs in a sample of 888 freshman students (Ekşi & Kömürcü, 2014). Furthermore, sources of knowledge on STDs were books, newspapers, magazines, radio/television, education in schools, and the health care personnel, in order of significance. In addition, participants were less knowledgeable about symptoms than transmission ways of STDs. In a sample of 330 students, Siyez and Siyez (2009) also demonstrated that the level of knowledge on STDs in a group of university students was average; however, they lacked comprehensive knowledge on the topic.

Other studies have also showed that HIV/AIDS was the most commonly known STD, and there was a need to acquire knowledge on different types of STDs (Özdemir, Ayvaz, & Poyraz; 2003; Yazganoğlu, Özarmağan, Tozeren, & Özgülner, 2011). In addition, Yazganoğlu, Özarmağan, Tozeren and Özgülner’s (2012) recent study, which was conducted with 380 undergraduate students to investigate knowledge on STDs as well as sexual behaviors, showed that the main sources of knowledge on STDs were the Internet and friends respectively. Similar to findings of various studies, it was revealed that HIV/AIDS was the most well-known STD among this sample and gonorrhea, syphilis, hepatitis-B, genital

herpes, genital warts and hepatitis-C were less known STDs. Importantly, participants did not have sufficient knowledge about symptoms and transmission of STDs. In brief, almost all of these studies suggested that young adults need further information on STDs, especially different types of STDs other than HIV/AIDS.

Regarding sexuality education, there is no nation-wide systematic and comprehensive sexuality education program in schools in Turkey; therefore, sexuality education programs are usually provided by school counseling services and school medical personnel. On the other hand, there is also lack of sexuality education programs including reproductive health for the public. However, there are some NGOs (e.g. CETAD) providing sexuality education for individuals. Although there are some possibilities to get a comprehensive sexuality education, one should note that every public school does not have sufficient resources (personnel, time, and instructional materials, etc.), and every individual does not have sufficient financial resource to participate in sexuality education courses given by NGOs.

According to WHO (2010), sexuality education is not only about learning necessary information and skills, but also having positive values, enjoying sexuality, and having safe relationships. Therefore, sexuality education cannot be seen only as a technical education. However, curriculum in Turkey allows students to learn only reproduction system, STDs, and protection ways and pregnancy in 10<sup>th</sup> grade, and basic female and male anatomy in 8<sup>th</sup> grade (MEB, 2013). Due to the lack of nationwide, standardized and culturally appropriate sexuality education, students can only have opportunity to gain knowledge via biology and science courses throughout their formal education. Nevertheless, this type of sexuality education seems quite far from what WHO proposes. In addition, another concern regarding sexuality education is inadequacy of formal ways of learning and informal sources can provide inaccurate or age-inappropriate sexual knowledge. More importantly, it is also stated that sexuality education should start with the birth of the child, and it should be seen as part of a lifelong learning process. In terms of WHO (2010) schema, important characteristics of sexuality education can be summarized as allowing youth participation, providing an interactive

instruction method, having a continuous aspect, conduct within a multisectorial setting design including schools and different centers, oriented to context, gender sensitive, and cooperation with family and community.

With regard to delivery of sexuality education, schools are not the only responsible institutions. The role of the family in sexuality education is of utmost importance. In this regard, a number of studies (Bulut & Gölbaşı, 2009; Erbil, Orak, & Bektaş, 2010; Tuğrul & Artan, 2001) focused on the relationship between mothers and daughters as well as opinions of mothers in terms of sexuality communication. For instance, Erbil, Orak and Bektaş's (2010) study with 192 mothers, who have daughters, demonstrated that participants did not have a healthy sexuality communication with their own mothers. Participants also reported that menstruation was the mostly communicated topic with their mothers. However, they did not find the information provided by their mothers as sufficient and beneficial. Results also revealed that most of the participants provided sexuality information to their daughters mostly on the topics of menstruation, and biological differences between sexes. Likewise, Bulut and Gölbaşı's (2009) study with 1045 adolescent girls showed that menstruation was the most communicated subject with their mothers. Sexual intercourse, STDs, and contraception were among the topics that mothers did not provide information to their daughters. On the other hand, Tuğrul and Altan (2001) found that in a sample of 665 participants, majority of the mothers reported that they lack knowledge on sexuality education, and in some cases they defined sexuality education merely equal to sexual intercourse. It was also reported that mothers rather than fathers provided sexuality education to both male and female children within families, and they provided such information only in cases that children asked about sexuality mostly with a feeling of shame.

In sum, social, cultural and religious factors have a role in shaping the understanding of sexuality, sexual experiences, sexuality communication and sexuality education in Turkey. What studies implied is that there is urgent need to increase sexual knowledge of young people and to develop comprehensive sexuality education programmes that aim to open healthy sexuality communication channels between parents and their children.

## 2.4 Visual Disability

According to International Classifications of Diseases Manual (revised version of ICD-10, 2015), there are six levels of visual function and these levels are (a) mild or no visual impairment, (b) moderate visual impairment, (c) severe visual impairment, (d) blindness (presenting distance visual acuity between 3/60 and 1/60), (e) blindness (presenting distance visual acuity between 1/60 and light perception), and (f) blindness (no light perception).

ICD-10 was translated into Turkish and using the manual has become an obligation for health institutions from July, 2005 in Turkey (Ministry of Health, 2005). However, it should be noted that the version that is used as an obligation in Turkey does not include the latest revisions regarding visual impairment and blindness. Moreover, in one study conducted by the Ministry of Family and Social Policies and Turkish Statistical Institute (2010), the term people with visual disabilities was defined as “those who have complete or partial visual loss or impairment in both or one eye, those who use artificial eyes or have colour blindness, nyctalopia disorders” (p. XII). Additionally, Mithat Enç, who was an activist with visual disability and worked for the rights of people with visual disabilities, defined visual disability in terms of onset, level of vision, and causes of visual disability in an earlier period. Enç (1972) used the terms “blinds” and “blindness” in his definitions and he divided people with visual disabilities into two categories in terms of the onset of disability namely natural blinds and advantageous blinds. According to Enç, natural blinds have visual disability before the age of 5 and advantageous blinds have visual disability after the age of 5. Furthermore, he also divided people with visual disabilities into three groups in terms of level of vision. These are (a) total blindness in two eyes, (b) blinds who have the perception of light and colour, and follow the shadows of big objects or living creatures, and (c) blinds who have the ability of counting fingers at 1 meter. Although Enç’s definition is one of the early definitions of visual disability in Turkey, one may notice its similarity with ICD 10’s definition that based on visual functioning. Enç (1972) also emphasized the importance of a common definition



of visual disability in order to identify the number of people with visual disabilities as well as development of national policies.

According to State Institute of Statistics (DİE, 2002), in Turkey, the percentage of people with visual disabilities is 0.60%. . Moreover, according to the report of “Problems and Expectancies of Disabled People” (OZİDA, 2010), people with visual disabilities, who are registered in official statistics, have different educational statuses including illiterate (32.21%), literate without a diploma (11.8%), primary school (29.0%), secondary school (12.5%) and highschool or above (14.6%). With regard to employment ratio, only 24.8% of people with visual disabilities are employed. Additionally, only 3.2% of them indicated that they receive advantage of beneficiaries on health and rehabilitation services. Regarding the usage of information and communication tools, mobile phone (52.9%), computer (18.8%) and the Internet (13.3%) are the tools that people with visual disabilities frequently used. However, 45.9% of them indicated that they do not use any information and communication tools. Furthermore, it was indicated that people with visual disabilities are having difficulties in using public transportation and health services due to different reasons including the need for a companion and difficulties in independent movement. In terms of education, 35.8% of people with visual disabilities indicated that they would like to receive education with people having same kind of disability; on the other hand, 27.7% of them indicated that they would like to receive education with people without disabilities. Lastly, their expectations from governmental organizations are increasing social assistance and support services (85.1%), improving health (77.0%) and care services (33.8%), increasing job opportunities (45.5%), increasing educational opportunities (17.4%), and making physical arrangements (23.0%).

To sum up, definitions and levels of visual disability are primarily determined through the function of the eye by considering to what extent the person can utilize the organ effectively. As highlighted by Enç (1972), common definition of visual disability is helpful to identify people with visual disabilities. When it comes to the condition of people with visual disabilities in Turkey, aforementioned statistics suggest that their condition is very similar to people with

different kinds of disabilities in Turkey (as specified in the subsection of “The condition of people with disabilities”) in terms of obstacles related to literacy, education, employment, and access to information.

## 2.5 Sexuality and Disability

**Sexuality** only exists through its social forms and social organization. Moreover, the forces that shape and mould the erotic possibilities of the body vary from society to society... **Sexuality** is not a given, it is a product of negotiation, struggle and human agency (Weeks, 1986, pp.18-19).

**Disability** is the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities (UPIAS, 1976, p.20).

What these descriptions of two different phenomena share in common gives rise to the thought that both sexuality and disability are related with the social and political context. To be more precise, both disability and sexuality have become controversial subjects that give rise to social, political, medical, and ethical debates. Hence, the intersection of sexuality and disability has become even more complex than the separate discussion of its constituent parts. Considering current social and political structure of Turkey, it would not be wrong to say something like playing with two fireballs. Throughout the history, both sexuality and disability have been areas that were medicalized and left to the hands of experts rather than the individuals themselves (Shakespeare, 2000; Weeks, 1986). In other words, these two topics have been evaluated within the perspectives of illness and health for a long time; therefore, experts become responsible to talk about issues related to it rather than individuals who have been directly experiencing them. However, the emergence of sexual rights and disability rights movement has started to change this general picture.

The attention to the topics related to the intersection of sexuality and disability have developed slightly in recent years with a focus on the effect of impairment on sexuality and the interaction of disability and sexuality. However, it still has been a research topic that should be explored further by considering different aspects and perspectives. As Shakespeare (2000) stated, areas including health care, education, rehabilitation and employment have been discussed with

regard to disability; however, the topic of sexuality has not received much attention.

Considering the effect of impairment on sexuality, both Shakespeare (2003) and Gershick (2006), who have studied sexuality and disability both theoretically and empirically, indicated that the impairment itself does not automatically remove sexual expression or sexual pleasure; yet, it may affect sexuality in different ways. In other words, although the impairment itself does not bring a difficulty in experiencing sexuality under all circumstances, different types of disabling barriers may create hardships in sexual lives of people with disabilities. Regarding those barriers, Shakespeare, Gillespie-Sells and Davies (1996) and Shakespeare (2003) stated that barriers mainly stem from the perception that people with disabilities as asexual and they are in need of being protected. Also, lack of opportunities to meet partners due to inaccessible social settings and limited opportunities regarding work and social activities, lack of confidence and assertiveness in initiating and developing relationships and lastly negative past experiences including sexual or physical abuse were specified as other barriers that people with disabilities encountered. Likewise, Shuttleworth (2012) emphasized barriers to access different sexual experiences as well as barriers to feel sexual personally. Additionally, Siebers (2012) argued that people with disabilities face with sexual repression and barriers to sexual autonomy in terms of sexual and romantic relationships and they are perceived as losing their human status because they are also perceived as not able to have sex. Moreover, Gerschick (2006) emphasized stigmatization process, perception of normative bodies, and internalized oppression in terms of intimate and sexual relationships on the part of people with disabilities. It is also indicated that people with disabilities like any other individuals in society are internalizing what the society finds attractive, desirable and sexy; hence, they cannot adapt societal norms due to differences related to disability. What all of these approaches show us is that people with disabilities face with different types of barriers including social, psychological, and attitudinal barriers both in terms of sexuality, and more specifically opportunities to develop healthy sexual relationships.

Regarding empirical studies about sexuality and disability, the current literature is mainly comprised of studies related to mobility disability, intellectual disability, and chronic diseases. Available studies looked at different aspects of sexuality and mobility disability, and in one the studies it was revealed that sexual needs and desires seem to be the same for women with mobility disabilities ( $n = 70$ ) and for women without disabilities ( $n = 64$ ) (Moin, Duvdevany, & Mazor, 2009). In a study with 141 adolescents with mobility disabilities, it was found out that sexual relationships among this group seemed to be lower than the national prevalence, and barriers to sexual activity were widespread (Jemata, Fulg Meyer, & Öberg, 2008). Likewise, sexual experience and sexual knowledge were lower in a sample of 60 adults with congenital physical disabilities. Results also pointed out the participants' need for sexuality information and their negative feelings regarding sexuality. (McCabe et al., 2000). McCabe and Taleporos's (2003) study, which was conducted with 1141 participants, demonstrated that people with physical disabilities had significantly lower levels of sexual self esteem and sexual satisfaction compared to people without disabilities or with mild disabilities. However, the same study also showed that people having physical disabilities for a longer period had more positive attitudes toward sexuality.

In a qualitative study, conducted with 14 women with physical disabilities through focus groups, results illustrated that women faced with barriers to access to sexuality information and lack of opportunities to meet partners. Participants also reported that they have been perceived as not having babies or a sexual life, and they complained about lack of sensitivity among medical personnel regarding their sexual concerns (Yoshida, Li, & Odette, 1999). Moreover, the participants did not only focus on the disability but also culture and gender roles' influence on their sexual lives. Likewise, in an adolescent sample, East and Orchard (2014) found that lack of sexual knowledge, feelings of exclusion in terms of body and identity, feelings of unfulfilling the expectations of society regarding intimate relationships, barriers to access sexual knowledge, being perceived as asexual were main concerns of 12 adolescents with physical disabilities. In another qualitative phenomenological study with 9 women participants with mobility disabilities,

results revealed that participants had concerns about the lack of communication about sexuality with their partners (Kattari, 2014).

Studies related to spinal cord injury (SCI), it was found that there was a decrease in sexual satisfaction of male participants ( $n = 40$ ) after the injury (Mendes, Cardoso & Savall, 2008). In the same vein, Othman and Engkasan (2011) found that there was a significant difference in sexual desire and a decrease in sexual activity following the spinal cord injury; however, no significant difference was observed in terms of sexual function (arousal, lubrication, and reaching orgasm) in a sample of 33 females with SCI and 34 females without SCI. Similarly, achieving orgasm had become a problem for people, following SCI (Sipski, Alexander, & Rosen, 2001; Ferreiro Velasco et al., 2005).

Although most of the research indicated that people after spinal cord injury (SCI) experience sexual dysfunction problems, some studies demonstrated people after SCI satisfied with their sexual lives by experimenting new types of sexual activities in spite of the adverse effects of SCI on sexuality (Charlifue, Gerhart, Menter, Whiteneck, & Scott-Manley, 1992; Kreuter, Sullivan, & Siösteen, 1994; Siösteen, Lundqvist, Blomstrand, Sullivan, & Sullivan, 1990). Similarly, a study showed that the opinions of a group of 85 women with SCI regarding the importance of sex and sexual life did not change after SCI despite that they had sexual dysfunction problems (Harrison, Glass, Owens, & Soni, 1995). On the contrary, in a sample of 62 women with SCI and cervical lesions, participants evaluated the importance of sexual activity lower than the period before SCI. However, it should be kept in the mind that the level of cervical lesion had an effect on sexuality related problems of women (Westgren, Hultling, Levi, Seiger, & Westgren, 1997). Considering, men with spinal cord injury, Courtois, Charvier, Leriche and Raymond's (1993) study revealed that participants with SCI could have erectile function through the use of appropriate stimulation. Moreover, Reitz, Tobe, Knapp and Schurch's (2004) study illustrated that there was no relationship between overall quality of life and perception of sexual activity in a sample of 63 men and women with SCI although they have different kinds of sexual problems.

With regard to multiple sclerosis (MS) and sexuality, a study conducted with 5.979 participants with MS, illustrated that fear of sexual rejection were

widespread among participants. Furthermore, fear of sexual rejection was predicted by gender, bladder symptoms, bowel symptoms, disability and mental health (Quinn, Floof, Mendelowitz, Marrie, & Foley, 2015). Difficulties in sexual life including lack of sexual enjoyment, arousal and orgasm (Khan et al., 2011); sexual dysfunction in terms of desire, arousal, lubrication, orgasm, satisfaction and pain (Ghajarzadeh et al., 2014); delayed orgasm, less intense orgasm, insufficient vaginal lubrication, less libido and decreased genital sensation (Qaderi & Khoei, 2014; Khoei Merghati, et al., 2013); concerns about physical appearance and sexual dysfunction (Gagliardi, 2003) have also been reported in various studies. On the other hand, some studies indicated that depression in MS patients rather than MS predicted sexual dysfunction (Lew Straowics & Rola, 2014), and different stages of MS may have differential effects on sexuality (Sahay, Haynes, Rao, & Pirko, 2012).

Contrary to the studies related to physical disability, spinal cord injury and multiple sclerosis that mainly focused on sexual functioning of participants, studies related to the intellectual disability have mainly focused on issues including consent for sexual relationships, sex offending and, sexual abuse experiences among people with intellectual disabilities. McCabe and Cummins' (1996) study illustrated that people with intellectual disabilities had lower levels of sexual knowledge except topics including menstruation and body part knowledge, lower levels of sexual experiences and higher levels of masturbation experiences, pregnancy and STDs compared to a sample of 50 people without any disabilities. Likewise, Kijak (2013) found that adults with intellectual disabilities experienced sexuality through masturbation and sexual intercourse; however, they lack sexual knowledge about human sexual life. On the other hand, sexual activities such as kissing, petting and sexual intercourse were less common compared to masturbation among participants. Additionally, McGillivray's (1999) study showed that young adults with intellectual disabilities had less knowledge on HIV/AIDS, its transmission, and protection ways. Regarding the consent for sexual relationships, Bernert (2011) argued that women with intellectual disabilities faced with different restrictions regarding sexuality because of policies and programs. Findings also revealed that participants experienced difficulties and faced with

barriers related to sexuality services planning and implementation for this group specifically. In this regard, studies (Dukes & McGuire, 2009; Lindsay, et al., 1992) showed that sexual knowledge in various topics and the consent for sexual relationships and decision making regarding sexuality related issues could be developed through sexuality education programs among people with intellectual disabilities. Furthermore, researchers indicated that people with intellectual disabilities have more risk to face with sexual abuse (Eastgate, 2008; Goldman, 1994) due to lack of sexual knowledge and lack of understanding of social meaning of some behaviors. Regarding sex offenders and intellectual disability, Lambrick and Glaser (2004) asserted that the prevalence of sex offending was similar to the prevalence among people without disabilities; however, people with intellectual disabilities portrayed as more prone to be a sex offender and the authors suggested that this could be handled through implementation of educational programs.

Taken aforementioned studies collectively, it can be concluded that various concerns related to sexuality peculiar to the type of disability were present among people with different kinds of disabilities. While the issues of consent for sexual relationships and sexual abuse have been studied in relation to intellectual disability, the issue of sexual dysfunction has become more dominant among people with SCI and MS as well as people with physical disabilities.

**2.5.1 Studies on sexuality and disability in Turkey.** The topic of sexuality and disability has not been widely investigated in Turkey; hence, literature is very limited. In this regard, the existing literature consisted of a few studies on mobility or physical disability, multiple sclerosis (MS), intellectual disability, psychiatric disability, and chronic diseases including diabetes, rheumatoid arthritis, and stroke. Similar to the trends on researching sexuality and disability, studies in Turkey have also focused on the effect of impairment on sexual functioning.

To begin with, a qualitative study was conducted with 10 women with physical disabilities and results revealed that all of the participants had difficulties regarding sexual life including pain during intercourse and decrease in sexual desire (Altuntuğ *et al.*, 2014). The difficulties that people with physical disabilities

were also elaborated in a review study. In that study, generalizations of the society, barriers to acquiring information, overprotective families and lack of meeting places, physical difficulties in forming and sustaining sexual relationships, difficulties in sexual arousal, emotional problems, and infertility problems were specified as problems related to sexual lives of people with physical disabilities (Elbozan Cumurcu et al., 2012).

Regarding intellectual disability, findings of a study, that was carried out with 60 adolescents with intellectual disabilities, indicated that participants had low levels of reliable and accurate sexuality information, and almost half of them stated that they did not receive any formal sexuality education and information from their parents either (İşler et al., 2009). Additionally, Burcu's (2007) study also provided information on sexuality of people with mobility and visual disabilities. Findings of the study demonstrated that 36.6% of the 1321 participants with either mobility or visual disabilities thought that the disability becomes a difficulty in terms of finding partners and forming marriage. Moreover, rejection from families regarding marriage, economic problems, shyness and not being able to develop relationships with the opposite sex, fulfilling responsibilities within the marriage, and preference of others to marry with someone having similar physical characteristics were indicated as difficulties by the participants regarding marriage and developing relationships. Furthermore, 12% of the married participants revealed that they had been experiencing difficulties with their spouses due to the disability. Participants also specified those problems as "I sometimes need his/her help in some cases and this raises problems", "I feel that she/he feels sorry for me"; "she/he has difficulties to accept me", "I feel that she/he excludes me in making decisions sometimes", "We have problems regarding sexual life", "I cannot fulfill the responsibilities of the marriage", and "I have problems with the family of my spouse's side". Lastly, 40.5% of the participants stated that they did not prefer to marry with a person with disability, and 32.7% of them indicated that the disability was not a matter for them regarding marriage. On the other hand, 19.2% of the participants reported that they preferred to marry with a person with disability since they thought that they could understand and help each other better. Although this study does not directly focus on sexuality, the results appear to have important



conclusions with regard to sexual life concerns of participants. Additionally, it is also important to notice that disability might become a barrier for some participants due to various reasons in establishing close relationships.

Multiple sclerosis (MS) is relatively a more researched topic in Turkish literature. In this regard, one study, which was conducted with 59 participants with MS, showed that patients with Multiple Sclerosis (MS) have also been experiencing sexual problems, and almost half of them indicated that they could not talk with their spouses on sexual problems (Akkuş & Duru, 2011). It was also found that participants with MS faced with difficulties in terms of sexual desire, arousal, lubrication, orgasm, and satisfaction, and weekly sexual activity decreases among participants with MS ( $n = 51$ ) compared to control group ( $n = 57$ ) (Gümüş *et.al.*, 2013). Additionally, gender differences have also been examined in relation to MS and sexuality (Kılıç *et al.*, 2012; Çelik, Coşkuner Poyraz, Bingöl, İdman, Özakbaş, & Kaya, 2012). Findings of these studies showed that women had more sexual dysfunction problems including lubrication, orgasm, arousal, and drive compared to men.

Chronic diseases have also received attention of the Turkish researchers in terms of sexuality. Akkuş, Nakas, and Kalyoncu's (2010) study with 33 patients with rheumatoid arthritis illustrated that participants had problems related to sexual satisfaction due to their illnesses. Moreover, some participants stated that they did not have a healthy communication about sexuality with their partners. Results of a study conducted with 100 Type II diabetes patients demonstrated that participants had sexual problems and there was a relationship between level of depression and sexual satisfaction among the sample (Küçük *et al.*, 2013). In terms of the effect of cancer and cancer treatment on sexuality, Eker and Açıkgöz (2011) found that over 80% of the participants, in a sample of 40 patients, experienced a decrease in sexual desire, sexual satisfaction and in frequency of sexual activity following the diagnosis. It was also stated that the majority of the participants did not acquire information on possible sexual problems regarding diagnosis from any medical personnel. Likewise, sexual desire, arousal, the frequency of sexual activity and orgasm were specified as areas that participants had difficulties due to cancer in a qualitative study with 11 participants (Demirgöz Bal, Dereli Yılmaz, & Kızılkaya

Beji, 2013). A qualitative study, with 8 female participants, it was also demonstrated that receiving breast cancer treatment had experiences of less sexual desire, less sexual activity, and pain, and vaginal dryness during sexual intercourse (Cebeci et al., 2010). Furthermore, stroke and its relationship with sexuality have also been studied. Findings of a study with 103 stroke patients demonstrated that stroke had adverse effects on erection and ejaculation in males and vaginal lubrication and orgasm in females significantly (Tamam, Tamam, Akil, Yasan, & Tamam; 2008). In addition, the frequency of sexual activity in post-stroke period decreased significantly in both sexes. Dereli Yılmaz, Gümüş and Yılmaz' (2015) qualitative study, with 16 poststroke women, demonstrated that women in poststroke period experienced physical and psychological changes including anxiety, fear, and problems related to adjustment to disability, and they also experienced difficulties in terms of responsibilities of marriage, sexual life especially sexual desire and orgasm, and lack of support from medical personnel. Lastly, concerning psychiatric disorders and sexuality, it was found that women with obsessive compulsive disorder had problems in terms of orgasm and sexual sensuality as well as behaved more avoidant compared to women with generalized anxiety disorder in a sample of 23 participants with obsessive compulsive disorder and 26 participants with generalized anxiety disorder (Aksaray, Yelken, Kaptanoğlu, Oflu, & Özaltın, 2001).

Considering the existing literature in Turkey, the focus on sexual functioning and the lack of qualitative studies give rise to the lack of understanding of sexuality and disability in a comprehensive way although almost all of the aforementioned studies provided valuable information in terms of different aspects of various types of disabilities. Moreover, existing literature presents social aspects of sexuality and disability, including prejudices and barriers in a very limited way which might be the result of a focus on medical aspects of the impairment in disability and sexuality studies in Turkey.

## **2.6 Sexuality and Visual Disability**

Why sexuality and visual disability is not an extensively studied topic even though different kinds of disabilities including mobility and intellectual disabilities and chronic illnesses have received attention in terms of sexuality? Glass (1984)

argued that it is not a topic that researchers pay more attention since visual disability does not directly impair sexual functioning or sexual health. In fact, this situation is also valid for hearing disability and sexuality since it is not a widely studied topic among this group either. However, what makes visual disability different from hearing disability is that hearing disability cannot be visible unless one uses visible hearing aids. However, visual disability and especially higher levels of visual disability is visible for the others.

Considering the effect of visual disability on sexuality and sexual development, there has been no empirical study that reports visual disability affects sexual development and sexual functioning adversely. However, there are nonempirical studies which indicated that sexual development and sexuality related social development could be affected by the interaction of visual disability and the environmental conditions (Davies, 1996; Glass, 1984; Özyürek, 1995). Glass (1984) stated that especially children with congenital visual disabilities rather than acquired visual disabilities usually do not have a chance to know bodily characteristics of other people and different sexes, and they also lack the opportunity of making eye contact, understanding facial expressions and body language. Therefore, Glass (1984) argued that children with visual disabilities may have problems regarding self-esteem, body-image and skills related to developing social and sexual relationships. Likewise, Davies (1996) stated that children with visual disabilities showed similar patterns of development as sighted children; however, they have had disadvantages and delays in terms of social and physical aspects of sexuality, which includes sexual anatomy and functions, self-esteem as well as social skills. It was also stated that societal taboos against touching becomes another barrier for those group of children. Similarly, Özyürek (1995) also indicated that a child with visual disability follows the same developmental stages as sighted children; however, there may be barriers in these developmental stages. In this regard, it is stated that babies acquire information about others, behaviors and facial expressions of others, and the world through visual cues mainly; however, a child with visual disability does not have such an opportunity. Therefore, it is revealed that such children need information through other senses more in order to acquire information about the world. Additionally, it is stated that

autoerotic activities including masturbation may be more prevalent among children with visual disabilities since they cannot direct their sexual feelings due to lack of vision (Cutzforth, n.d., as cited in Enç, 1972). In addition, Enç (1972) claimed that stimulus different than visual stimulus may evoke sexual feelings among people with visual disabilities due to lack of vision. What these researchers said can be summarized as children with visual disabilities may experience barriers to learn and comprehend sexuality related information including bodily qualities, facial expressions, and sexual anatomy although they can follow the same physiological development pathway as sighted children. Moreover, the lack of such information may affect self-esteem and social skills of children in which these skills may be required to develop close relationships.

In addition to sexual development, sexual identity development is another important issue in terms of sexuality. Regarding sexual identity development and disability, Grossman suggested that sexual identity development models usually do not take individuals with disabilities into account; therefore, these models become insufficient to address trajectories of sexual development among this group (Grossman, 2003; as cited in Grossman, Shuttleworth, & Prinz, 2003). However, this is usually valid for people with mobility disabilities and the question of whether or not children with visual disabilities follow a different sexual development trajectory still uncovered. Moreover, the spread phenomenon (Sakellariaou, 2006) may be helpful to understand sexual identity development of people with disabilities. According to this approach, all of the personality traits and characteristics of a person with disability become less important than his/her disability, and disability overshadows most of other personal characteristics. In other words, disability itself seems to permeate in all of the characteristics, successes, ambitions and the whole lives of individuals with disabilities. Considering this approach along with the stigmatization of disability (Gerschick, 2006), it can be argued that people with visual disabilities may also have difficulties in terms of sexual identity development and sexual expression. With regard to this issue, results of a study revealed that disability becomes a stigma in people with intellectual disabilities and intellectual disability seems to overshadowed sexual identity (Wilkinson, Theodore, & Raczka, 2014). Although

this study does not directly related to visual disability, the process of stigmatization and its relation to sexual identity development may shed a light on sexual identity development among people with visual disabilities. Moreover, Glass (1984) noted that children with visual disabilities were restricted in schools in terms of sexual exploration which is important to develop a sexual identity, and they also had difficulties in exploring their sexuality through individual activities or friends due to overprotection by the family, lack of opportunities to find a secure and private place, and lack of touching experiences.

Considering empirical studies in the existing literature on sexuality and visual disability, it should be noted that such studies have been very limited in both Western and Turkish literature. Available studies are mainly on topics of sexual knowledge and sexuality education experiences among people with visual disabilities including adolescents and adults. With respect to sexual knowledge and visual disability, İrdem (2006) conducted a study with 100 individuals with visual disabilities aged 15 to 24 from Ankara in order to investigate sexual health knowledge levels and factors related to their knowledge. Results of the study revealed that there was a significant relationship between age, education level, SES and sexual health knowledge level. Gender was not found to be a significant predictor of sexual health knowledge level. Besides, married participants scored significantly higher on sexual health knowledge questionnaire than single participants. Not the place of birth, but the place of one had lived most was also found to be as a significant predictor of sexual knowledge. For instance, participants who mostly lived in urban areas got higher scores from the questionnaire than the ones mostly lived in rural areas. Moreover, congenitally blind participants got significantly higher scores on knowledge test than participants having acquired visual disabilities. Findings related to sources of sexual knowledge depicted that participants gained sexual knowledge from friends (73%), newspapers and magazines (60%), television (57%), films (50%), other printed materials (49%), mother (25%), siblings (19%), relatives (17%), and father (16%) respectively. What is more, 53% of the participants stated that they did not get any specific sexuality education apart from some information provided in health knowledge, science and guidance courses.

The results of a study conducted with 180 sighted adolescents and 104 adolescents with visual disabilities revealed that adolescents with visual disabilities had significantly lower sexual knowledge compared to their sighted peers (Duh, 2000). One of the most interesting findings of this study was that children with visual impairments showed similar knowledge levels in only questions regarding menstruation, reproduction, and conception. The author claimed that a lack of sexual knowledge may be derived from social isolation among peers and overprotection by the family. Furthermore, results of the study also showed that sources of information, level of visual disability, grade, and onset of visual disability were correlated with the level of sexual knowledge among adolescents with visual disabilities. In a similar vein, participants, who were 36 adolescents with visual disabilities, thought that they were sufficiently knowledgeable about sexuality (Kef & Bos, 2006). Results also demonstrated that sources of sexual knowledge were parents and media mostly, and friends rarely. Results related to the perception of the attitude of family members, most of the participants felt that they have been experiencing overprotection from family members as well as opposition regarding dating and sexuality. In terms of gender differences, it was indicated that boys were significantly higher on asking information about sexuality from friends than girls, and they also experienced sexual intercourse at a significantly younger age when compared to girls. Interestingly, it was found that there was no significant difference in sexual knowledge and parental attitudes regarding onset of visual disability and attending regular education. In terms of psychological adjustment, it was found that regular education attendees had significantly higher self-esteem scores than their counterparts in special education schools, and they also had higher scores on acceptance of disability but not at a significant level. In addition, it was also found that perception of overprotection from the family was related to the timing of first sexual intercourse and adolescents with visual disabilities who felt such overprotection had lower scores on self-esteem but not at a significance level. For boys who had more sexual knowledge, findings showed that self-esteem and acceptance of impairment scores were higher; however, this finding was not valid for girls. It is important to note that aforementioned studies are quantitative mainly and they do not provide knowledge about experiences and possible barriers to

access sexual knowledge of the people with visual disabilities.

With regard to sexual experiences and visual disability, Kelly and Kapperman's (2012) study, which was carried out with 9850 young adults, demonstrated that they did not significantly differ from their sighted peers in terms of sexual experiences. Nevertheless, they experienced it later than sighted ones. The study also showed that there is a need for sexuality education. In a qualitative research which shed light on experiences of 5 female adolescents with visual disabilities aged between 12 and 17, it was reported that the participants could clearly make distinction between dating and sexual intercourse, although they did not have such an experience (Bezerra & Pabliguica, 2010). In addition, results suggested that they all seemed to approach positively toward the intersection of love and sex. It was also reported that they could not obtain sufficient information from their families. In another important qualitative study with 25 participants with visual disabilities, the researchers examined whether gender gap continues to be an important issue in men and women with visual disabilities. Results suggested that blind men seemed to be more interested in sex, had more masturbation and more sexual dreams, had more scheme about sexual contact, more likely to be with casual encounters, thought more about sexual fantasies and had more sexual partners throughout life compared to blind women (Abramson et al., 2013). Researchers also stated that there seemed to be no difference exist in terms of sexual pleasure between sighted people and people with visual disabilities. They also suggested that voice, intellectual sharings, common aspirations, personality, and touching to face were important things among people with visual disabilities in partner selection process. Additionally, smell was also found to be an important aspect in dreams among this group. Importantly, it was stated that information about body gained through touching become the content of male masturbatory fantasies.

According to Pinquart and Pfeiffer's (2012) study, conducted with 711 adolescents in which 180 out of them were with visual disabilities and the rest of them were sighted, illustrated that sighted adolescents and adolescents with visual disabilities did not significantly differ in terms of percentages of fallen in love, experiencing first romantic relationship, and sexual intercourse; however, they

differed in having experiences of dating. On the other hand, regarding timing of these kind of relationships, it was found that adolescents with visual disabilities experienced first love, first romantic relationship and dating significantly later than their sighted peers. Interestingly, no significant timing difference was found in terms of first sexual intercourse. Apart from these findings, while female adolescents with visual disabilities were not different from sighted adolescents in timing of first romantic relationship; male adolescents with visual disabilities experienced first romantic relationship significantly later than their sighted counterparts. Also, there was no significant difference between adolescents who have low vision and who are blind regarding first love, date, romantic relationship, and sexual intercourse. Importantly, findings revealed that while sighted adolescents put an emphasis on physical attractiveness and material resourcefulness in mate selection, adolescents with visual disabilities gave more importance to emotional maturity. However, they did not differ in perception of relationship quality. In terms of mate selection, blindness and low vision made a significant difference. In other words, adolescents who had low vision found physical attractiveness more important than those who were blind. Lastly, it was stated that most of the adolescents with visual disabilities in the study experienced a romantic relationship with a partner with visual disability. In this regard, Arıkan (2001) also found that an important number of females with visual disabilities were experiencing problems regarding sexual life either frequently or often in a sample of 154 women with visual disabilities. However, those problems were not specified.

Regarding sexuality education and visual disability, there are criticisms directed toward sexuality education since such programs mainly follow a heteronormative approach. White (2003) argued that sexuality education only provides dominant and mainstream mode of sexuality particularly without the voices of people with visual disabilities. In addition to the absence of sexual experiences of people with visual disabilities in sexuality education programs, previous studies indicated that there seems to be many barriers to mainstream sexuality education programs for people with disabilities (Krupa & Esmail, 2010; Kapperman & Kelly, 2013). In Krupa and Esmail's (2010) empirical study,



participants reported that they experienced different barriers to sexuality education; therefore, they could get such information from their sighted peers and older siblings. Furthermore, results suggested that parent were not usually a source of sexual information. Results also revealed that participants needed tactile learning and models in sexuality education. In other words, mainstream sexuality education programmes are not accessible for this group of individuals. Nonverbals and personal safety in close and sexual relationships were also other concerns for individuals with visual disabilities. In addition, participants stated that they did not want to participate in segregated sexuality education programmes. Hence, authors suggested that students with visual disabilities should receive the same information with other students as well as disability specific sexuality information. They also emphasized the need for specific skills, strategies and tools in terms of personal safety in the programmes. Furthermore, integrated classroom, accessible information packages, inclusive ways such as touching, role-playing and detailed descriptions and tactile models as well as palpable diagrams proposed by the authors in terms of effective delivery and appropriate environment for sexuality education. Likewise, the content of sexuality education was found to be as limited in a study that aimed at learning experiences regarding sexuality education among 30 adults with visual disabilities (Wild, Kelly, Blackburn, & Ryan, 2014). Furthermore, lack of accessible materials in sexuality education programs was also emphasized by participants of this study.

## **2.7 Summary of the Literature Review**

The understanding of disability has been evolved by time across different settings and countries. The former understanding of disability was mainly based on the negative consequences of the impairment that was evaluated as a disease and a personal problem of the individual (Oliver, 1996). However, later developments in both disability movement and human rights movement gave rise to the development of a new understanding of disability. Through the initiative of people with disabilities, the distinction between the impairment and disability was conceptualized so that environmental barriers including isolation, exclusion and oppression within society were taken into account firstly (UPIAS, 1976). By this

way, social problems, that people with disabilities encountered, were included in the agenda.

Despite the aforementioned advancements related to disability, the intersection of sexuality and disability has not received attention up until recently. As Shakespeare (2000) indicates that sexuality is evaluated as a private topic whereas topics including education, rehabilitation, and employment are regarded as public concerns. Hence, sexuality is remained to be unexplored within disability studies until very recently. Likewise, disability related statistics and studies in Turkey majorly focused on subjects consisting of education, employment, health, discrimination, and accessibility rather than sexuality. The statistics demonstrated that there is an important number of people living with different kinds of disabilities (12.29% of the population) in Turkey (DİE, 2002). However, their well-being in terms of literacy, education, employment, social security, participating in social life, access to health, rehabilitation, information and services are of concern (Aydın & Aktaş, 2013; Burcu, 2007; DİE, 2002; Güneş et al., 2013; Sart et al., 2014; TurkStat, 2010; Yakut Çakar et al., 2013; Yelçe et al., 2013). In other words, people with disabilities encounter various problems in Turkey although important legal measures have been implemented by the State including legislations and laws (Law No. 5378, 2014; Law No. 5825, 2008).

In Turkey, the effect of religion and the conservative nature of the society have involved in the perception of sexuality in society. Along with these, particularly women's sexuality has been controlled and oppressed through various ways including the issue of chastity, 'honor' killings, forced arranged marriages, bride price, hymen, marital rape, and virginity examinations (İlkkaracan, 2001; Parla, 2001; Sarıtaş, 2012). Furthermore, empirical studies also pointed out that religiosity has a role in shaping sexual attitudes, sexual behaviors, and premarital sexuality especially among young adults (Ergun, 2007; Hatipoğlu Sümer, 2015; Yaşan et al., 2009). In the light of this general picture, the lack of studies on sexuality and disability is not very surprising since sexuality as a whole has been a controversial subject in Turkey. Despite this general picture, there are studies regarding sexual knowledge and sexuality education in Turkey. However, sexual experiences among people without disabilities also remained untouched to some

extent. Available literature implied that there is a need to increase sexual knowledge on especially STDs as well as transmission and prevention of STDs (Çok et al., 2001; Hatipoğlu Sümer's, 2006; Siyez & Siyez, 2009; Varol Saraçoğlu et al., 2014), develop healthy sexuality communication within family (Bulut & Gölbaşı, 2009; Erbil et al., 2010; Tuğrul & Artan, 2001), and develop sexuality education programs.

Considering sexuality along with disability, the effect of impairment is of concern among many researchers. On the one hand, it was indicated that obstacles and disabling barriers rather than the impairment can create difficulties for sexual lives of people with disabilities (Gershick, 2006; Shakespeare, 2000; Shakespeare et al., 1996; Shuttleworth, 2012; Siebers, 2012). In other words, lack of opportunities in terms of education, employment, finding partners and participating in social life as well as negative attitudes toward sexuality of people with disabilities were evaluated as disabling barriers with regard to sexual expression, sexual autonomy and sexual experiences of people with disabilities. On the other hand, empirical studies illustrated that MS (Multiple Sclerosis) and SCI (Spinal Cord Injury) might put a strain on sexual functioning, sexual satisfaction, and sexual desire (Ghajarzadeh et al., 2014; Gümüş et al., 2013; Khan et al., 2011; Mendes et al., 2008; Othman & Engkasan, 2011; Quinn et al., 2015; Sipski et al., 2001). In addition, studies suggested that people with mobility disabilities experience barriers to sexual activity (Jemata et al., 2008), have lower levels of sexual knowledge and sexual experience (McCabe et al., 2000), lower levels of sexual self-esteem and sexual satisfaction (McCabe & Taleporos, 2003), and sexual dysfunction problems (Altuntuğ et al., 2014; Elbozan et al., 2012 ).

Aforementioned empirical studies on sexuality and disability, especially the ones related to MS and SCI, were mainly conducted within a medical approach in order to examine the effect of impairment on sexuality. Contrary to this, a few studies, conducted with a broader perspective in a qualitative manner, highlighted disabling barriers including access to sexuality information, lack of opportunities to meet partners, feelings of exclusion in terms of body and identity, and being perceived as asexual among people with mobility disabilities (East & Orchard, 2014; Yoshida et al., 1999).

Compared to sexuality studies on mobility disabilities, MS, SCI and other chronic health conditions, visual disability has received less attention in the current literature. The underlying reason of the lack of studies on this subject was argued as the lack of direct effect of visual disability on sexual functioning (Glass, 1984). Nevertheless, a few practitioners indicated that visual disability may have an indirect effect on sexuality related social development consisting of seeing bodily characteristics of other people and different sexes, making eye contact, and understanding facial expressions and body language (Davies, 1996; Glass, 1984; Özyürek, 1995). In light of the current literature on the subject, it is hard to reach conclusive findings due to the lack of studies and different results. However, the literature shed a light on especially sexual knowledge and sexuality education among people with visual disabilities.

Almost all of the empirical studies regarding visual disability and sexuality knowledge were conducted with samples of adolescents. While some studies (e.g. Kef & Bos, 2006) found that adolescents with visual disabilities had sufficient sexual knowledge; other studies (e.g. Duh, 2000) demonstrated that adolescents with visual disabilities had less sexual knowledge compared to their sighted counterparts. Regarding sources of sexual knowledge, friends and mass media were cited as the major sources of sexual knowledge in a sample from Turkey (İrdem, 2006). Whereas, a study conducted in western culture (Kef & Bos, 2006) suggested that main sources of sexual knowledge were parents and mass media. In addition, overprotection from family regarding dating and sexuality was present among different samples (Duh, 2000; Kef & Bos, 2006). Related to sexual experiences, some studies (e.g. Kelly & Kapperman, 2012) indicated that the onset sexual experiences of young adults with visual disabilities were significantly later than their sighted counterparts. On the other hand, other studies (e.g., Pinquart & Pfeiffer, 2012) showed that the onset of first love, first romantic relationship and dating, but not the onset of first sexual intercourse, was later compared to sighted ones.

The aforementioned findings seemed to be differentiate among different samples in terms of sexual knowledge, sources of sexual knowledge, and sexual experiences. Hence, it is not possible to reach an indisputable conclusion regarding

the topic. Only studies regarding sexuality education and visual disability demonstrated conclusive findings. The studies indicated that current sexuality education programs are not accessible and there is a need for the usage of tactile materials to increase accessibility (Krupa & Esmail, 2010; Wild et al., 2014). However, these findings cannot portray the condition of sexuality education in Turkey since a study showed that most of the participants with visual disabilities did not get any specific sexuality education except from health related courses (İrdem, 2006).

Taken collectively, the literature on sexuality and disability was majorly surrounded by quantitative studies with a focus on sexual functioning and the impact of disability. This situation is also valid for the related literature in Turkey. Such a situation gives rise to the lack of comprehensive understanding of various factors possibly related to sexuality among people with disabilities. Likewise, the lack of studies and inconclusive findings in studies on sexuality and visual disability lead to a limited comprehension of sexuality among people with visual disabilities. In addition, sexual knowledge, sexual experiences and sexuality education are usually discussed separately in the available literature. Therefore, there is a need to integrate these three different dimensions to reach an all-embracing knowledge on the topic. By taking all these into consideration, there is a need to conduct a qualitative study to explore sexual knowledge, sexual experiences and views on sexuality education among people with visual disabilities. Such a study can contribute the current literature as well as the comprehension of sexuality and visual disability in the context of Turkey.

## **CHAPTER III**

### **METHOD**

In this chapter, there was an elaboration of the overall research design, data sources, data collection instrument, data collection procedures, data analysis procedures and issues regarding trustworthiness. In addition, limitations of the current study were discussed.

#### **3.1 Overall Research Design**

The main purpose of the study is to explore sexual knowledge, sexual experiences and views on sexuality education among adults with visual disabilities. With regard to this purpose, research questions of the present study are as follows:

- 1) How do adults with visual disabilities evaluate themselves in terms of sexual knowledge?
- 2) How do adults with visual disabilities access sexuality information?
- 3) How do adults with visual disabilities experience sexuality in general?
- 4) What are the views regarding sexuality education among adults with visual disabilities?

In order to answer the research questions, qualitative research method was selected for three reasons. Firstly, the nature of the research questions directly allowed researcher to conduct a qualitative study. As Braun and Clarke (2013) emphasized, researchers do not try to find out a single answer or numbers in qualitative research. Rather, meanings, subjectivity, and context are important considerations in this type of research. Secondly, the study aimed at gaining detailed and meaning based information about experiences of adults with visual disabilities; therefore, qualitative research provided necessary conditions to explore those experiences. Lastly, there is a lack of insiders' perspectives on this

topic; hence, qualitative research allowed participants to elaborate their own views in terms of sexuality overall.

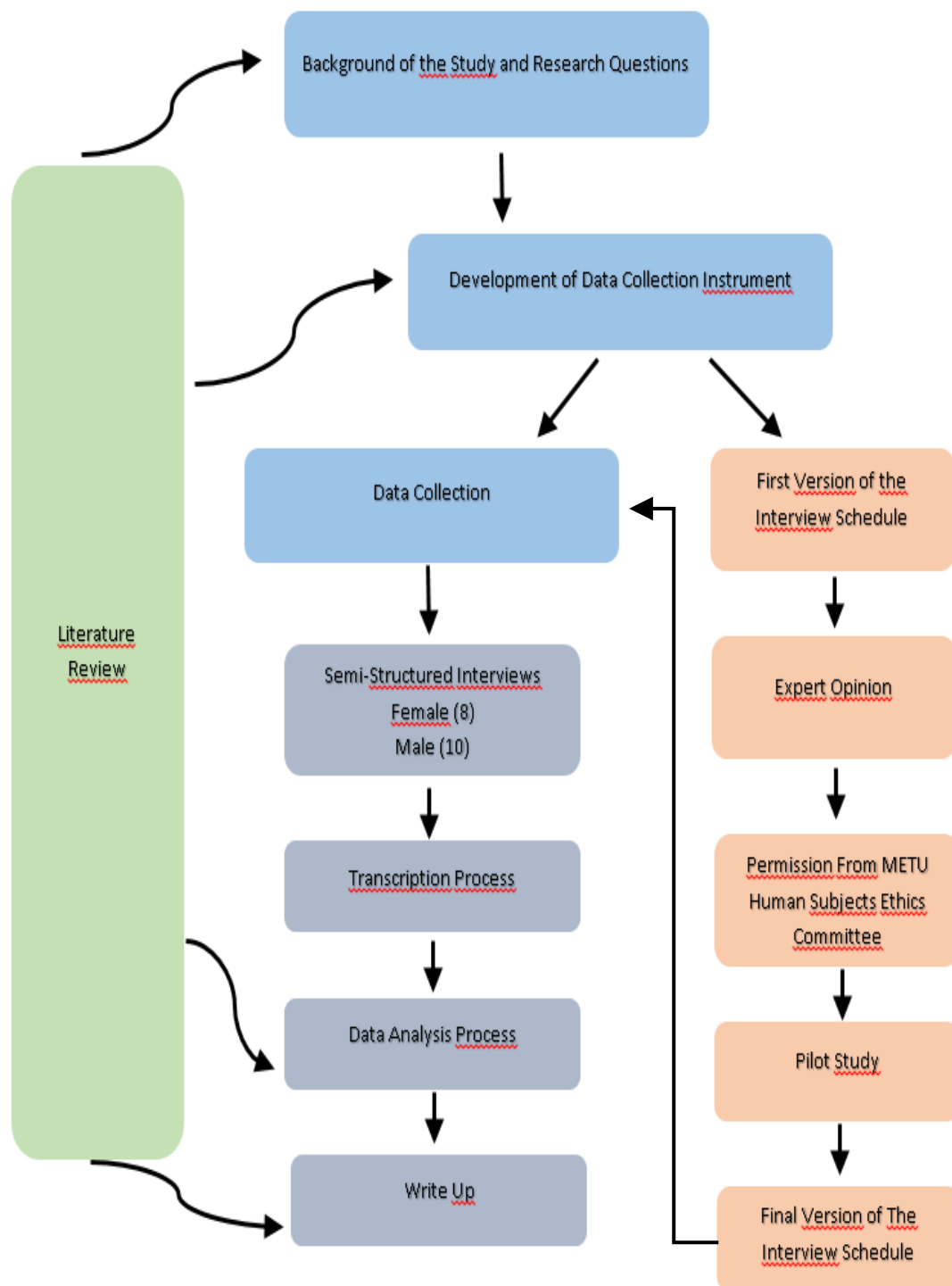


Figure 3.1. Overall Design of the Study

As Creswell (2006, p. 39) pointed out that investigation of “silenced voices”, exploration of unattended topics and a desire to include participants with their own stories in the research process requires qualitative research. Considering these issues within the context of this study, exploration of sexuality in terms of knowledge, experience and education among people with visual disabilities can be best done through qualitative research.

By considering the purpose of the study along with aforementioned reasons for selecting qualitative inquiry, phenomenological approach was chosen as research design of the current study. Phenomenological approach depicts personal meanings, views, and perspectives of individuals by considering their life experiences regarding a phenomenon (Creswell, 2006, p.57). Moreover, this approach is found to be appropriate in cases that different unexamined phenomena will be investigated and elaborated (Yıldırım & Şimşek, 2005, p.72). As Moustakas (1994) states that phenomenology is a strategy to share descriptions of experiences rather than analysis, and it aims to arrive at common experiences, ideas, concepts as well as understandings with the help of exploration of meanings. Therefore, phenomenological approach was utilized in the current study to explore the phenomenon of sexual experiences among adults with visual disabilities in terms of knowledge, experience and sexuality education

### **3.2 Data Collection Instrument**

In this subsection, the development of data collection instrument and processes related to it were elaborated in detail.

**3.2.1 Interview schedule.** Interviewing is a method to explore individual experiences, ideas, and feelings on different topics mainly by using open-ended questions in qualitative research studies (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). The main advantage of the interview method is that it is helpful to reach at detailed answers which reflect subjectivity of the each participant.

Within the context of this study, an interview schedule was prepared by the researcher for data collection through semi-structured interviews. Following a careful literature review, questions were formed in terms of obtaining information from the participants regarding sexual knowledge, sexual experience, and sexuality



education. The interview schedule was comprised of 4 different sections and these sections are demographic information, sexual knowledge, sexual experience, and sexuality education respectively. In demographic information section, there are questions regarding age, marital status, birth of place, education, work, level of income, perception of level of income related to disability, the condition of having any other disability, the official level and perceived level of disability, onset of disability, evaluation of independent movement, special education experience and educational level of the family. Secondly, sexual knowledge section consists of questions with regard to self-evaluation of sexual knowledge, sources of sexual knowledge and evaluation of the sufficiency of sexual knowledge. Sexual experience section includes questions on first recollection regarding sexuality, puberty, first sexual intercourse experience, evaluation of current sexual life, sexual partners, current birth control methods and experiences of sexual abuse, humiliation or sexual violence. Lastly, there are questions regarding previous sexuality education experiences and its evaluation, ideal sexuality education for people with visual disabilities and suggestions for sexuality education for families and young people with visual disabilities in sexuality education section.

Subsequently, the first version of the interview schedule was designed (Appendix A) to obtain expert opinion from people including faculties and activists in the field of disability and sexuality. In the current study, one expert is a doctorate student with a visual disability in psychological counseling and guidance core area, one is a faculty who specialized in measurement and evaluation field, one is specialized in sexuality education in the counseling field, and the other one is specialized in qualitative study and working with minority population in medical faculty. Expert team evaluated questions in three dimensions (sexual knowledge, sexual experience and sexuality education) in terms of content, scope and the clarity of questions. In this regard, expert team provided feedback for the interview schedule by suggesting revisions for some questions to increase clarity, and suggesting new questions and content for different dimensions to extend the study's scope. After the expert opinions obtained, the first version of the interview schedule was revised by considering their suggestions. Based on those suggestions, several questions involving current birth control method, partners with or without

disability, sexual fantasies, sexual abuse or any other negative experiences, prejudices toward different sexual activities, additional materials used in different sexual activities were included in the sexual experience part of the interview schedule. In addition, one question which aims to get participants' suggestions regarding sexuality education, families and youth was included in the sexuality education part. Lastly, the wording of some questions was also revised to increase clarity.

In addition to interview schedule, an interview journal which helps the researcher to take notes after each interview was prepared (Appendix B). Field notes regarding researcher's observations about the participant and the overall interview are suggested for qualitative researchers (Mack et. al., 2005). Hence, the interview journal is seen as an important part of the study itself. In the current study, interview journal includes sections regarding how the researcher reached the participant, observation about interview environment, researcher's personal experiences including feelings, thoughts and behaviors during the interview, unanticipated circumstances and events, and researcher's observation of the participant's interviewing experience.

**3.2.2 Pilot study.** Following the revision of the interview schedule, approval from the Human Subjects Ethics Committee (HSEC) at Middle East Technical University was obtained by the researcher. A pilot study was utilized with a male with visual disability in order to evaluate the structure of the questions, effectiveness of the questions in terms of obtaining the information specified in the research questions, and to observe the environment and interview process in reality. The participant, who has a college degree, has been actively working in an organization for people with visual disabilities. Pilot interview revealed that the questions in the revised form were effective to obtain the knowledge and experience from participants in general. Following the pilot interview, an evaluation session was conducted with the respondent to get his own views and suggestions regarding comprehensibility, scope of the questions, the style and the attitude of the interviewer. The pilot interview experience showed that there was a need to restate some of the questions in order to make them easily understandable on the part of the participants. Additionally, based on the

suggestions of the respondent, a question with regard to evaluation of physical appearance was added to sexuality information to acquire more information about how participants with visual disabilities can get knowledge about their physical appearance. Hence, the final version of the interview schedule was prepared by taking expert opinions and the outcome of the pilot interview into consideration.

### **3.3 Participants**

In this subsection, participant selection process and characteristics of the participants were elaborated.

**3.3.1 Participant selection process.** In the present study, semi-structured interviews were conducted with 18 adults with visual disabilities through snowball sampling. Inclusion criteria for the study were as follows:

- 1) Having visual disability (congenital or acquired in the early years of life),
- 2) Being older than 18,
- 3) Having no other disability except visual disability,

Subsequent to HSEC approval (05.01.2015), an invitation letter, which describes briefly the inclusion criteria, the researcher, and the study, was prepared. This letter was shared in various e-mail groups in order to reach the participants. In this process, the researcher contacted with different disability related associations including Association of Blinds of Turkey (Türkiye Görme Engelliler Derneği- TÜRGED), Association of Visually Impaired in Education (Eğitimde Görme Engelliler Derneği), Association of Women with Disabilities (Engelli Kadın Derneği- EN-KAD), 6 Nokta Körler Derneği (Six Dots Foundation For The Blind), and Anatolian Association of People with Disabilities (Anadolu Engelliler Birliği Derneği), as well. The invitation announcement was shared within those associations via e-mails or in general meetings. In this invitation announcement, a brief explanation about the study and the interviews as well as e-mail address of the researcher were provided. In addition, former participants provided contact information of other people with visual disability in order to take part in the study.

Following the first announcements, volunteers for the study communicated with the researcher via e-mail. Then, the researcher obtained phone numbers of volunteers in order to carry out a brief telephone interview. In this brief telephone interviews, the researcher provided information about the study and the interviews

and an appropriate time for the interview was specified together with the volunteers if they satisfied the inclusion criteria. During this announcement process, various people from different cities, including İstanbul, Ankara, Gaziantep, İzmir, Tokat, and Tekirdağ were volunteer to participate in this study; however, only İstanbul and Ankara were selected to conduct interviews due to several reasons. In the first place, the number of volunteers in Ankara and İstanbul were more than the participants in other cities. In addition, time, energy, and financial constraints were considered and the selection of the cities were done accordingly. One possible way to include participants in other cities could be Skype or telephone interviews; however, these options were considered as not appropriate since face-to-face observation of the researcher and face-to-face relationship between interviewer and interviewee were also sources of valuable information during the study. Besides, confidentiality cannot be guaranteed in Skype or telephone interviews. To sum up, selection of the places where the data gathered was determined by considering ethical and financial issues as well as the research process itself.

During the data collection process, 26 interviews were conducted between 10.01.2015 and 15.03.2015 in İstanbul and Ankara. However, 8 of the participants were not included in the sample due to several reasons. Two female participants were excluded from the study because of reproductive disorders which was observed as an important factor on sexuality development of them. One female participant was excluded from the study due to epilepsy, one male participant was excluded due to olfactory impairment, two female participants were excluded due to later onset of visual disability, one male participant was excluded due to cardiovascular disease which affect his daily life, and lastly, one male participant was excluded due to not allowing tape recording. Although having any other disability than visual disability as an exclusion criteria took part in the announcements and in the beginning of each interview, the respondents were asked whether they have any other disability or not; none of the participants evaluated reproductive disorder, olfactory impairment, epilepsy, and cardiovascular diseases as disabilities. However, studies showed that such disabilities might have an effect on sexual life and when this information was combined with observations during

interviews, it was decided to exclude those participants from the study.

Furthermore, in the beginning of the study, there was no inclusion or exclusion criteria based on the onset of the disability; however, throughout the data gathering process, it was understood that data related to sexual knowledge especially sources of sexual knowledge, sexual experiences such as first sexual intercourse and early experiences with regard to sexuality certainly differentiates in participants who have acquired disability after the age of 25 when compared to participants who are congenitally blind or having acquired visual disability in relatively early years of their lives. Hence, later onset of disability became an exclusion criteria during the data gathering process.

In advance of data collection process, targeted number of the participants was 20 (10 females, 10 males); however, this aim could not be achieved due to several reasons. In the first place, some possible participants, whom contacted via telephone following the first announcement, explained their concerns about face-to-face interview in such a very sensitive and private topic. Since they wanted to interview via telephone or Skype due to shame and shyness, they could not be included in the study. In addition, personal information of 28.000 people with disabilities including name, surname, the level of disability, identity number, and addresses were shared on the Internet by the Ministry of Family and Social Policies by mistake during data collection process (February, 2015). In this circumstance, a number of possible participants shared their concerns about confidentiality of the private information and distrust by giving reference to this negative event. Unfortunately, this event also affected the number of the participants adversely. Therefore, the number of participants at the end of the data collection process became 18 (10 male, 8 female).

**3.3.2 Characteristics of the participants.** The study was carried out with 18 individuals with visual disabilities (10 males, 8 females) aged between 20 and 42. The mean age of the participants was 29, and only five of the participants were older than 30. Hence, the participants were mainly comprised of young adults in the current study. In terms of sexual orientation, participants reported that they were mainly heterosexual. Out of 18 participants, 3 of them described themselves homosexual, queer (having homosexual relationships currently) and having

bisexual tendencies. In terms of marital status, 5 of the participants were married and only one of them was married with a non-disabled person. The rest of the participants, except one male participant were single and they stated that they had no current intimate relationship.

In terms of working conditions, 15 participants were currently working in public sector, one participant had a part-time job and scholarship from the State, and the other two participants maintained their lives through family support and scholarships. With regard to educational status half of the participants were university graduates (3 continue at graduate level), 5 high school graduates (2 of them continue to attend Open University), one middle school graduate, and 3 of them were university students. Table 3.1 presents the demographic characteristics of the present study participants.

Table 3.1 *Main demographic characteristics of the participants*

<b>Variable</b>	<b>Information</b>
<i>Gender</i>	- Male (n = 10) - Female (n = 8)
<i>Age</i>	- x < 30 (n = 13) - x > 30 (n = 5)
<i>Sexual Orientation</i>	- Straight (n = 15) - Other (n = 3) (Homosexual, queer etc.)
<i>Marital Status</i>	- Married (n = 5) - Single (n = 13)
<i>Working Status</i>	- Employed (full-time) (n = 15) - Other (n = 3) (part-time, scholarship, family support etc.)
<i>Educational Background</i>	- University graduates (n = 9) - Highschool graduate or lower (n = 9)
<i>Onset of Disability</i>	- Congenital (n = 14) - Acquired (n = 4)
<i>Official Level of Disability</i>	- 85% (minimum) - 100% (maximum)

Table 3.1 *Main demographic characteristics of the participants (cont'd)*

<b>Variable</b>	<b>Information</b>
<i>Perceived Level of Income</i>	<ul style="list-style-type: none"> <li>- Sufficient (n = 6)</li> <li>- Partially sufficient (n = 5)</li> <li>-Not sufficient (n = 7)</li> </ul>
<i>Perceived Level of Income (Regarding disability related needs)</i>	<ul style="list-style-type: none"> <li>- Sufficient (n = 4)</li> <li>- Partially sufficient (n = 2)</li> <li>-Not sufficient (n = 12)</li> </ul>
<i>Self-evaluation of Independent Movement</i>	<ul style="list-style-type: none"> <li>- Very sufficient (n =7)</li> <li>- Sufficient (n = 8)</li> <li>- Not sufficient (n = 3)</li> </ul>
<i>Educational Level of Parents</i>	<ul style="list-style-type: none"> <li>- University (n = 2)</li> <li>- High school (n = 5)</li> <li>- Middle school (n = 2)</li> <li>- Primary school (n = 16)</li> <li>- Literate (n = 11)</li> </ul>

Considering special education experience at schools for students with visual disabilities, 14 participants attended 8 years special education, 3 participants had partial special education attendance due to acquired visual disability (3 years, 5 years, 6 years), and only one participant indicated that he dropped out school at fourth grade due to visual disability and attended to open school.

The official level of disability among participants ranged between 85% and 100%; however, there were changes in health reports due to changes in legislation throughout time. For instance; participants who had 90% level of disability in their health reports usually indicated that they were experiencing total blindness almost with only a perception of light and darkness. In terms of acquired and congenital visual disability, 4 participants pointed out that they had acquired visual disability and one at 8 months-old, one at age 1, and two participants at age 7. On the other hand, the rest of the participants (n = 14) indicated that they had congenital visual disability. However, 7 of the participants in congenital group indicated that they had low vision during early childhood period and their vision had become worse over time. Among those 14 participants, 3 indicated that they have total blindness currently and the rest of them (n = 11) pointed out that they only have perception of light and darkness currently.

Considering the perceived level of income of the participants, 6 of them indicated that their income was sufficient, 7 said that their income was not sufficient, and lastly, 5 of them evaluated that their income was partially sufficient for personal and marital expenditures. On the other hand, when they were asked about whether the income was sufficient enough to meet their disability related needs, 12 participants pointed out that the income was insufficient in terms of obtaining softwares or other tools for accessibility. Furthermore, 4 indicated that the income was sufficient for disability related needs, and lastly, 2 said that the income was not sufficient in certain situations.

Regarding evaluation of independent movement ability, 8 of the participants indicated that their level of independent movement was sufficient for daily life activities and 7 of them evaluated their level of independent movement as above average and very sufficient. On the other hand, 3 participants evaluated their level of independent movement as not sufficient.

With regard to educational level of parents reported by the participants, the majority of the parents were mainly literate without any formal education (  $n = 11$ ) or graduates of primary school only ( $n = 16$ ). Moreover, there were also middle school ( $n = 2$ ) and high school graduates ( $n = 5$ ) as well as 2 university graduates.

In terms of the place that participants had lived longer, the majority of them, except 4 participants, have lived longest in Istanbul or Ankara. Moreover, 7 of the participants were born either in Istanbul or Ankara, and the rest of them were born in other cities. Therefore, it can be said that the majority of the participants was born in big cities and had lived in metropolises usually.

### **3.4 Data Collection Procedures**

**3.4.1 The interview process.** In the interview process, researcher communicated with the participants in advance of the interview to determine the appropriate date and time. In this context, the priority was given to the schedule of the participants. Half of the interviews were carried out in İstanbul and the rest of them were carried out in Ankara. In Ankara, interviews were mainly conducted in an office of a private counseling center as well as an office of an association in Kızılay. Interviews conducted in İstanbul were carried out in an office of an



association in Kadıköy. On the other hand, a few of the interviews were conducted in places where the participant selected such as workplace or house due to independent movement or familial concerns (having an infant etc.). Due to inaccessibility problems, in both cities, researcher met with the participants at the specified time and place, and accompanied participants to the interview place. In all interviews, participants were provided with water, tea etc. in order to create a comfortable atmosphere.

Prior to each interview, researcher informed participants by reading informed consent form (Appendix C) to get their consent for participation in the study as well as consent for the tape-recording of the interview. In the beginning of each recording, participants were asked one more time about voluntary participation and permission regarding tape-recording in order to record the consents.

As Seidman (2006) elucidated, interview process may lead to emotional stress or discomfort in some participants because of the developed intimacy between interviewer and the interviewee. In addition, certain information which should take place in the consent form are specified in different sources (Seidman, 2006). Therefore, clarification of the aim of study, basic information about the researcher, confidentiality, dissemination of the findings, possible risks and benefits, the rights of the participants including leaving the study in case of discomfort, having a break, not answering question that make them feel distress as well as approximate duration of the interview is of utmost importance while getting informed consent. Hence, the informed consent in the current study was formed by considering all these factors. Lastly, the duration of the interviews ranged from 1 hour to 2 hours, and the average duration of the interviews was calculated as 85 minutes.

### **3.5 Data Analysis Procedures**

In this subsection, data storage, transcription process and data analysis procedures were elaborated.

**3.5.1 Data storage method.** In the course of the interviews, Zoom H1 professional tape recorder was used to record the interviews, and each interview record was saved in personal computer as in the form of “P1\_10.01.2015” in

which P signifies participant, the number signifies the sequence of the interview, and the date shows the date of realization of the interview.

**3.5.2 Transcription process.** In advance of the data analysis, all of the interviews were transcribed by the researcher verbatim including laughters and moments of silence. In terms of transcriptions of the qualitative data, Ezzy (2002) suggested to transcribe initial interviews prior to the rest of the interviews in order for an evaluation of the interviewer herself/himself especially. Hence, the first two interviews were transcribed right after the interviews. This process allowed the researcher to evaluate herself in terms of the manner of questioning, prompting and following the pace of the interviewee, and listening for what the participant had told.

The rest of the interviews were transcribed subsequent to the end of the data collection process. In the course of transcriptions, Express Scribe transcription software which does not recognize speech in Turkish language, but enabling the process with its key control system for playback, was utilized.

**3.5.3 Data analysis.** In the current study, thematic analysis was utilized as data analysis method. The purpose of thematic analysis is to specify the themes and patterns in the data through an inductive way without using any predetermined categories in advance of coding process (Ezzy, 2002). In other words, it aims to constitute a meaningful whole from what was said in the interviews by looking at patterns, themes, similarities, and differences among participants.

As Braun and Clarke (2006) pointed out, thematic analysis steps comprise of transcription, coding, and emerging of the themes. In this context, the coding is the initial step of the data analysis. In the current study, hard copies of each transcript with a space on the right margin were used for manual coding in the initial coding process. In the meantime, researcher read each transcript and wrote codes on the space provided by following open coding process which means an exploratory coding process. Since the researcher became very familiar with the data by means of interviews, transcription process, and the period of revision of transcripts; there was a pre-understanding of possible categories and themes. During open coding process, it was understood that there is a pattern at the macro

level which shaped through research questions of the study regarding demographic information, sexual knowledge, sexual experience, and sexuality education. For this reason, coding process mainly shaped through major research questions of the study. Eventually, in order to facilitate coding process, it was decided to assign different colors to different kind of information. Hence, paragraphs related to demographic information, sexual knowledge, sexual experience, and perceptions about sexuality education were marked with assigned colors and coded. In addition, issues that did not fit any of those topics were marked with different colored pen. Overlapping issues and concepts in each category were also marked in order to evaluate them.

As Ezzy (2002) highlighted, open coding process is similar to experimentation in which the researcher tries to code a large amount of data inductively in order to reach codes that can be applied to the data. Due to the fact that codes were mainly shaped by major research questions, the researcher directly carried out a selective coding process. In addition to manual data analysis, all of the codes and categories were written in a Word document with related quotations from each participant and then categories, themes, and codes were arranged in an Excel document in order to understand whether there is a need for revision regarding categories or codes. Furthermore, the Excel document enabled the researcher to measure frequencies regarding each theme and category in a comprehensive manner. By this way, the researcher organized the final version of themes and categories that formed these themes. Sexual knowledge theme consisted of two categories namely general self-evaluation of sexual knowledge and sources of sexual knowledge. Sexual experience theme consisted of three categories namely sexual experiences in childhood and puberty, sexual life in adulthood, and sexuality and visual disability: different forms of discrimination participants faced with. Lastly, views on sexuality education included four categories namely previous sexuality education experience, content of sexuality education, instructional strategies, and responsibility of the parents and individuals with disabilities. Table 3.2 presents the categories, codes and subcodes which formed three themes of the current study.

Table 3.2 *Categories, Codes and Subcodes*

Category	Codes	Subcodes
General Self-Evaluation of Sexual Knowledge	<ul style="list-style-type: none"> <li>- Sufficient</li> <li>- Partially sufficient</li> </ul>	
Sources of Sexual Knowledge	<ul style="list-style-type: none"> <li>- Mass media</li> <li>- Experiential learning</li> <li>- Friends</li> <li>- Family and Relatives</li> <li>- School based sexuality education and courses</li> <li>- Sighted period</li> <li>- Health personnel</li> </ul>	Internet, reading materials, TV, porns, tactile experience, sexual experience, mother, father, relatives (e.g. aunt), sexuality education sessions, health course, religion course, Qur'an course
Sexual Experiences in Childhood and Puberty	<ul style="list-style-type: none"> <li>- First recollections regarding sexuality</li> <li>- Puberty</li> </ul>	Content, feelings, perceptions, menstruation, wet dreams, masturbation, feelings
Sexual Life in Adulthood	<ul style="list-style-type: none"> <li>- First sexual intercourse</li> <li>- Sexually appealing characteristics</li> <li>- Current sexual life</li> <li>- Finding partners</li> <li>- Partners with or without disabilities</li> <li>- Sexual abuse</li> </ul>	Age, evaluation, voice, speech/diction, smell, skin, body characteristics, satisfied, not satisfied, educational places, social places, via friends, associations and rehabilitation center, while walking
Sexuality and Visual Disability: Different Forms of Discrimination Participants Faced With	<ul style="list-style-type: none"> <li>- Difficulties in finding partners</li> <li>- Desexualization</li> <li>- Disquieting questions regarding sexuality and the ability to have sexual intercourse</li> </ul>	
Previous Sexuality Education Experience	<ul style="list-style-type: none"> <li>- Status of having sexuality education</li> </ul>	Yes, no
Content of Sexuality Education	<ul style="list-style-type: none"> <li>- Human development</li> <li>- Sexual health</li> <li>- Sexual behavior</li> <li>- Sexual relationships</li> <li>- Individual needs</li> <li>- Sexuality of people with disabilities</li> <li>-Goals of sexuality education</li> </ul>	There should not be a separate topic, there should be a separate topic

Table 3.2 *Categories, Codes and Subcodes* (cont'd)

Category	Codes	Subcodes
Instructional Strategies	<ul style="list-style-type: none"> <li>- Accessibility</li> <li>- Type of instruction</li> <li>- Delivery of sexuality education</li> </ul>	Tactile materials, auditory information, verbal description of visuals, videos with audio description, reading materials, inclusive, segregated, educators, location of sexuality education, onset of sexuality education
Responsibility of the Parents and Individuals with Disabilities	<ul style="list-style-type: none"> <li>- Sexuality communication</li> <li>- Oppression</li> <li>- Parent education</li> <li>- Family support</li> </ul>	

### 3.6 Trustworthiness

Regarding trustworthiness, qualitative researchers described a number of different strategies for validation of the study (Creswell & Miller, 2000; Ezzy, 2002; Lincoln & Cuba, 1985). For instance, Lincoln and Cuba (1985) described four important topics that should be considered to satisfy the criteria for trustworthiness namely credibility, transferability, dependability, and confirmability.

Peer debriefing and member checks which are proposed by Lincoln and Cuba (1985) are the strategies that were utilized in order to increase the credibility of the current study. In addition, discussions were held with a faculty member from another university who is qualified in qualitative research with regard to interviews, data analysis, and interpretation as an external check for the study. During these discussions, the expert posed questions regarding the study and especially its methodology, and provided information in terms of the process of the study. As Creswell and Miller (2000) highlighted, this peer review process with an independent person enabled the researcher to discuss the findings and interpretations with a professional who was not involved but interested in the study. Furthermore, member checks were conducted in relation to transcriptions. In this context, three participants were selected randomly and transcriptions of the

interviews were sent to them in order to obtain transcription approval from the participants. As Lincoln and Cuba (1985) indicated, member checks provided an opportunity for the participants to confirm transcriptions that increased the credibility of the study.

Additionally, the researcher described different aspects of the study including data instruments, participants, data collection, and data analysis procedures in detail in order to satisfy the criteria of transferability which is defined as making transferability judgments possible based on research findings through detailed descriptions of different stages of the study (Lincoln & Cuba, 1985).

Audit trail was another strategy used to establish dependability and confirmability of the study. From the beginning of the study, the researcher discussed different aspects or stages of the study with her supervisor. The researcher consulted to the supervisor in every step of the study including development of the interview schedule, selection and inclusion of the participants, conducting interviews, data analysis, and interpretation. The supervisor of the researcher acted as the auditor in the current study and she examined all parts of the study consisting interview schedule, transcriptions, data analysis and interpretation, and discussed her evaluations with the researcher in periodical meetings.

Several steps were also followed to ensure the overall trustworthiness of the study prior to data collection and data analysis. First, the researcher consulted four experts to receive feedback regarding the interview schedule, and piloted the interview schedule prior to the actual interview process, which were elaborated in detail in the interview schedule section. Expert opinion and pilot study enabled the researcher to review and revise the questions within the interview schedule which is of utmost importance in data collection process. Both expert opinions and pilot study increased the reliability and the validity of the data collection instrument. Second, researcher obtained informed consents from the participants in terms of both tape recording and voluntary participation in the study. Moreover, this tape recording allows the storage of valid data on the part of the participant. Third, the

transcription process was conducted by the researcher herself and this provided the necessary familiarity with the data to the researcher. Fourth, the coding process was carefully conducted and different revisions and checks were done during coding and thematic analysis procedures in order to make reliable codings across different participants and reach valid themes.

### **3.7 The Role of the Researcher**

In qualitative research, the researcher has an important role in the process of data collection since the researcher is the one who collects data through using himself/herself as an instrument; hence, it is essential to elaborate the research related background of the researcher including values, biases and personal issues which may have an effect on research process (Creswell, 2006; Denzin & Lincoln, 2003; Malterud, 2001).

In this regard, my perception of and attitudes toward people with disabilities and especially people with visual disabilities had been shaped through my personal experiences. Until I began undergraduate study on guidance and psychological counseling, I was one of the people who had feelings of pity and mercy for the people with disabilities. However, I came across with several persons with visual disabilities at undergraduate level, and fortunately one of them has become a best friend of mine during undergraduate years. Moreover, this friendship has changed my perception to disability dramatically through time. I had understood that people with disabilities did not only made up of their disabilities and they were not different human beings that deserve mercy from ‘able-bodied’ people. I observed that visual disability did not withhold someone to play backgammon, to study counseling, and to have romantic relationships, sexual feelings and sexual experiences; however, negative perception of people did withhold actually. Moreover, courses related to special education, developmental disorders and counseling as well as a number of faculty had an impact on me in terms of conceptualizing and approaching disability. To sum up, undergraduate years have become a time period for me to gain insight of the disability, people with disabilities and obstacles that they faced with not only in undergraduate education, but also in romantic and/or sexual relationships. Furthermore, my work experience at ODTÜ Disability Support Office had also an impact on me in terms

of further understanding on disability, students with disabilities, obstacles related to higher education that students face with and reasonable accommodation process which aims to remove obstacles related to examinations and courses. During this period, I had understood that my previous perception of disability was mainly based on social and environmental barriers. However, the work experience showed me that the impairment itself has also negative consequences for a person with disability similar to social and environmental barriers, and the effect of impairment should be also considered in order for different accommodations. In summary, both educational and work experiences of mine had a strong impact on me and how I conceptualize disability as a whole while I began to study on sexuality and visual disability.

Keeping my background and perspective related to disability in mind, I tried to ensure an objective stance within interviews by listening what participants shared in a careful manner, not interrupting and not directing participants in a way that personal views can be justified. Additionally, I both observed and noted my own feelings, thoughts and behaviors as well as participants' feelings and behaviors within interviews through using interview journals. In this regard, this tracking of interviews provided me an opportunity to talk about my feelings and thoughts related to interviews with peers that helped me throughout the study. By taking all these steps as well as aforementioned ethical procedures, I was able to develop and sustain an objective stance during data collection process.

### **3.8 Personal Observations of the Researcher**

Throughout the data collection process, I had opportunities to observe participants during interviews and to meet, observe and talk nonparticipant people with visual disabilities in organizations for people with visual disabilities where I conducted some of the interviews. As previously stated, I actually made interviews with 26 participants; however, 8 of them were excluded from the study due to having other kinds of disabilities. Hence, my observations were shaped through all of these interviews because it was difficult to separate the ones who were not included in the study from observations. Moreover, I believe that presenting my observations in a holistic way by considering all interviews may be better to



understand the context of the interviews as well as experiences of mine and the participants.

The interviews were the most interesting part of the data collection process compared to reaching participants and specifying an interview date. The distinct features of the interviews were that each interview was full of pauses, the moments of shame and laughs. Talking about sexuality was not easy for all participants especially for a few women participants; hence, moments of pauses, shame and laughs experienced oftenly. What I observed in this context was that men felt more confident while talking about their sexual experiences; whereas, women felt shyness in this sense. Even in evaluating sexual knowledge, women participants which I observed as having very good sexual knowledge behaved cautiously; while men participants especially men who had sexual intercourse experience evaluated their sexual knowledge in a more confident manner even though some of them were having current misconceptions or current misspellings of words related to sexuality. Moreover, talking about someone's sexuality was not an easy task for me either. When I looked at interview journals, I can see that I had challenging moments while I was listening sexual experiences of participants especially in the very first interviews since I had constructed sexuality as a "private" issue based on my experiences within family and in different social environments. As I noticed that participants honestly talked about their experiences and as I began to get used to conducting interviews, the process had become easier and better. Although the hardness of talking about sexuality, I conducted interviews at houses of a number of participants and even in a prayer room of an association. Hence, it can be said that participants were willing to talk about this topic because most of them were having difficulties related to lack of experience, lack of opportunities for romantic and sexual relationships, and faced with different kinds of discrimination.

During the interviews, questions related to views on sexuality education were the part that almost all participants felt comfortable to explain their experiences and suggestions regarding sexuality education. On the other hand, sexual knowledge and especially sexual experiences were the parts that most of the participants felt uncomfortable.

### **3.9 Limitations**

Although the findings of the study shed a light on how people with visual disabilities experience sexuality, their needs regarding sexuality education, and their perceived level of sexual knowledge, the number of participants in the current study was less than the desired number of participants. This was one of the limitations since findings might be more detailed if the sample size could be increased. Furthermore, the characteristics of the participants varied to some extent in terms of congenital vs. acquired blindness, age, marital status, and educational levels. Hence, detailed comparisons among participants based on such characteristics could not be made due to small sample size. On the other hand, the aim of the study was not to generalize findings to the whole population with visual disability; therefore, the generalizability was not a concern in the current study. Nevertheless, it should be noted that the study elaborated different kinds of experiences among people with visual disabilities from different perspectives and provided relatively a detailed picture regarding research questions.

Secondly, data sources were based on only interviews conducted with the participants and interview journals written by the researcher. It could have been better to include other kinds of sources to increase trustworthiness of the study; however, the nature of the sexuality topic itself did not allow researcher to use different data sources such as observation or using third parties as sources.

Lastly, sexual experiences of the participants were not elaborated in detail although one of the aims of the study was to explore sexual experiences of people with visual disabilities. This was partly due to the fact that participants mostly felt uncomfortable while talking about their sexual experiences so that they responded to experience related questions briefly.

## **CHAPTER IV**

### **RESULTS**

In this section, the results of the study were presented under three main headings, namely sexual knowledge, sexual experience, and views on sexuality education.

#### **4.1 Sexual Knowledge**

In the course of interviews, participants were asked about their perceived level of sexual knowledge as well as sources of sexual knowledge related to various subtopics including sexual anatomy, sexual intercourse, sexually transmitted diseases (STDs), contraception and birth control, oral/anal sex, masturbation, fertilization, orgasm, and sexual intercourse positions. Data analysis on sexual knowledge revealed two main themes namely general self-evaluation of sexual knowledge, and sources of sexual knowledge. Regarding the first theme, it should be noted that obtaining self-evaluation in terms of sexual knowledge became one of the challenging parts of the interviews due to a number of reasons. Firstly, a number of participants, especially female participants, found self-evaluation difficult due to feelings of embarrassment and shyness. Secondly, the lack of an objective measurement made the process harder. Therefore, in some cases the researcher preferred to obtain knowledge levels in different ways such as probing with different subtopics and trying to learn what participants know about them.

**4.1.1 General self-evaluation of sexual knowledge.** Participants were asked about how they overall evaluate themselves in terms of sexual knowledge, and how they evaluate their knowledge on various sexuality topics. What participants said about their level of sexual knowledge was coded as insufficient, partially sufficient, or sufficient. In the following section, results were presented firstly according to the gender of the participants.

**Male participants.** Firstly, 6 out of 10 male participants stated that they had sufficient sexual knowledge which means that their level of knowledge was sufficient on various sexuality related situations they faced with in general. One participant said that “I am knowledgeable. I have much knowledge except extreme points. Those are things such as sex toys or very high fantasies that include violence or some materials. I don't have any information about them, I don't want to know more anyway; but except these I consider myself at good level.” (P10-Male, 27). Similarly, another participant emphasized that he had sufficient theoretical knowledge despite a lack of actual experience as “There are other things too that I know in many ways, theoretically; even though I do not put into practice; but sometimes, as I said, I don't find the need to practice them.” (P23-Male, 28). Here, it should be remarked that male participants in this category felt that they have knowledge which they need in different contexts. In this group, 4 participants pointed out that they did not need further knowledge regarding sexuality; however, one participant stated that he would like to learn more about STDs as “Well in fact diseases that are sexually transmitted are a little more problematic. There are some diseases that I don't know about. Except those, I feel sufficient.” (P1- Male, 29) and another one indicated that he needed to learn different sexual intercourse positions by saying “Well as I said, different positions, I don't know how it can be seen, but I think that if I had more information about them, maybe it could be more different.” (P21- Male, 36). Apart from these, two participants stated that they would like to learn knowledge on female body, and own body in a relatively earlier period. In this context, one said that “It could be good if I could learn maybe a little earlier about the things that I learnt about myself, of course, about my body and my development.” (P23- Male, 27)

On the other hand 4 male participants stated that they had partially sufficient knowledge in terms of sexuality which means that they felt that they lack knowledge on a number of topics regarding sexuality. Related to this, one said that “well let me put it this way, you learn in time. Of course I can't say that we know everything excellently, but basically, more or less, we know normal things.” (P6-Male, 39). Likewise, another participant evaluated himself in terms of knowledge as “Well I think I am kind of well (knowledgeable), yes not very very well but I

am kind of well.” (P25- Male, 29). In this group, only one of the participants indicated that he did not need further knowledge on sexuality although he indicated that he had partially sufficient knowledge. However, the rest of them (n = 3) stated that they needed to acquire knowledge regarding different topics of sexuality. Related to specified needs, two of them, who did not have sexual intercourse experience, strongly emphasized the lack of knowledge regarding female body especially female sexual organ and sexual intercourse. One illustrated this important need for knowledge as:

You know, I don't know vagina at all. I don't know it (smiles)... Anatomically, the definition of its anatomy and so on, I read about them but in appearance and shape I don't know what it's like.. I don't know I swear. No, I can't define it because only based on those definitions, I mean written definitions that it is lubricious, its borders are twisted into inside and so on, there are definitions like these. But because in my head, for example, I can't visualize your face that I haven't seen; even if you tell it to me. I mean there is a thing that I cannot visualize visual elements when you tell me about them. I don't know why but there is a problem that I cannot visualize. (P3- Male, 27)

Similar to this, the other participant talked about this need as:

About vagina, of course normally in our primary school there wasn't any education on it; but as far as the education provided, even though I don't know its shape, I know that it is made up of two parts but I cannot describe its shape because I haven't seen or touched one, you know what I mean? (laughs) (P9- Male, 30).

Hence, female body, especially female sexual organ, was found to be an important area that there was a lack of knowledge among participants who did not experience sexual intercourse, and felt like they had partially sufficient knowledge. Here, it seems important to note that one of the participants mentioned the difficulty of forming mental pictures by only audio information due to visual disability, and the other one evaluated this lack of knowledge as related to being unmarried and not having sexual intercourse experience as:

If you are asking physically, not sufficient because I am not married after all. This is one of the conditions of being married, you know, and it doesn't exist, I mean, for the present time (laughs). I mean now, as you can guess, because we are single, we don't have a regular sexual life. (P9- Male, 30).

In addition to female sexual organ, the lack of sexual intercourse knowledge was illustrated by one participant as “I haven't had an experience, I haven't had an experience about how sexual intercourse is. Because I didn't have a

sexual intercourse, I don't know what it is, how it is.” (P3- Male, 27). In addition, STDs (n = 1) and birth control pills (n = 1) were among topics that a few participants would like to learn earlier than the time of actual learning. Related to this, one indicated that “... AIDS, Hepatitis B and stuff like that. I learnt about them there; but one would wish that we learnt these things at the age of 12 or 13, or age 9. I mean not after a certain age.” (P6- Male, 39). Lastly, other two male participants in this group mentioned the need to learn sexual desire among women by emphasizing their lack of knowledge on this topic and one stated that:

About women...like women desire, how women want men? Well there are also urban legends that say women are more willing (to have sex), women are not easily satisfied; yet I don't think that it is true... to tell the truth, I am curious about how this is in women. (P6- Male, 39).

Additionally, strategies to prevent early ejaculation (n = 1) and sexual intercourse positions (n = 1) were mentioned as topics that participants would like to learn more information. In this context, one stated that “I'd like to know more about methods of sexual intercourse. I wish I knew which positions give more pleasure. It could be good, I mean, to know which method is more pleasurable, more satisfying.” (P3- Male, 27).

***Female participants.*** In terms of overall self-evaluation with regard to sexual knowledge, 6 female participants indicated that they had sufficient knowledge. However, responses of women seem partly different from male participants' descriptions of sufficient knowledge in this context. To make it clear, contrary to male participants, the majority of women who described their level of sexual knowledge as sufficient, did not seem to feel confident, and several female participants evaluated themselves based on their perception of sexual knowledge of people around them. A number of participants (n = 2) evaluated their knowledge by comparing themselves to others' level of knowledge, one example of this is that:

that is to say, when I look around I think that I am more knowledgeable than others, you know, against some suppressed emotions. You know, I come across those who suppress this emotion, for example, they don't have any information. That is to say, there is a thing, neither there is nor there isn't (laughs). But I don't know, I think I have information but I couldn't test the level of this information because to tell the truth, I don't know. (P18- Female, 20).

Likewise, another participant who found her knowledge sufficient stated that:

Let me put it this way, I got this information, I mean, I know more as compared to a newly-wed person. I mean, for example, I also had a boyfriend, I haven't experienced such things but I have more information as compared to those who have experienced. For example when we sit and talk, there are many people who ask me how I know all these stuff. (P12-Female, 25).

Another participant approached this question in a careful manner by stating “I am sure that there are many things that I don't know of, but when I evaluate myself as compared to other people, I can say that I know above average. I am not at an advanced level, but I know a lot.” (P16- Female, 24). There was also a participant who mentioned her desire to learn more by stating “I mean, I can't say none. Of course I have sexual activities and sexual knowledge. But I don't think that even I am at the place that I'd like to be.” (P 4, Female, 31). To be more precise, all of the women except one stated that there were topics that they would like to learn more although they evaluated their knowledge as sufficient. Besides, it should be noted that the majority of the female participants in “sufficient group” provided much more information on various topics of sexuality than male participants although they had reservations with regard to their level of knowledge. On the other hand, two of the participants stated that they had partially sufficient knowledge. In this regard, one said “Well about these, not any kind of information... I know some stuff thanks to my own knowledge but I haven't been informed about this topic by anyone“ (P22- Female, 25). Another participant also stated there might be topics that she had no knowledge.

In this section, it should be noted that a few number of participants ( $n = 3$ ) hardly evaluate themselves in terms of sexual knowledge. In addition, 2 participants did not answer some of the questions related to several topics including masturbation, orgasm, and oral/anal sex due to different reasons. Based on observations of the researcher, possible reasons might be shame, shyness, and negative attitude toward some topics within sexuality. Similar to answers of male participants, AIDS was the most well known STDs among female participants. Overall, female participants stated that they would like to improve their knowledge on birth control and birth control methods ( $n = 1$ ), fertilization ( $n = 1$ ), birth ( $n =$

1), STDs (n = 1), masturbation (n = 1), orgasm (n = 1), oral/anal sex (n = 2), and sexual intercourse (n = 1). In this context, one participant emphasized the lack of knowledge on birth control as:

I have rough knowledge about birth control methods. To be true, I don't have clear knowledge, for example birth control pills, which pills are to use, how and when they are used. I don't have any information about these topics. At the same time I only have information about condoms. (P18-Female, 20).

Likewise, another participant focused on insufficient knowledge on STDs and transmission ways by saying:

Well, I wish we knew about which diseases are the sexually transmitted diseases. Because I haven't read, I feel alone in some of these things. Which diseases are transmitted in which ways and by which things. For example there are some diseases that can be transmitted via touching a person's skin. (P20- Female, 42).

Unlike male participants, female participants who did not have sexual intercourse experience (except one) could describe male sexual organ and stated that they had sufficient knowledge on this topic. Another interesting finding was that female participants did not point out the need to learn or practice sexual intercourse although 4 females did not have sexual intercourse experience. Moreover, it was noted that more female participants had negative attitudes toward sexual intercourse before marriage and oral/anal sex.

**4.1.2 Sources of sexual knowledge.** Sources of sexual knowledge varied to a great extent among participants based on personal life experiences (see Figure 4.1). Moreover, sources also varied in diverse topics related to sexuality. It is important to indicate that all of the participants acquired sexual knowledge through utilizing not one but many different sources. Results were presented through types of sources. In this section, the frequencies with regard to sources were also



provided in order to demonstrate the utilization of them in numbers.

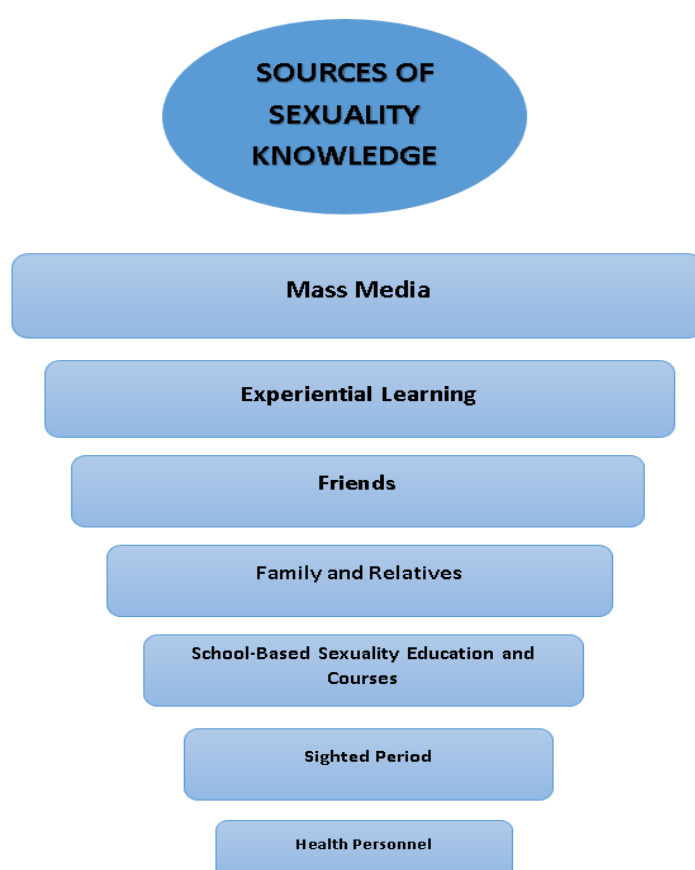


Figure 4.1 *Visual Representation of Sources of Sexual Knowledge*

**Mass Media.** Participants utilized mass media extensively in order to acquire sexuality related information, and it became the mostly used source among the sample ( $f = 60$ ,  $n = 11$ ). In this section, it should be bear in mind that people with visual disability can use mass media with the help of different tools for accessibility such as screen reader programs (e.g. Jaws) or materials written in Braille alphabet. However, such screen reader programs cannot describe the visuals on mass media unless there is an audio description or there is a version of embossed print material.

First, participants benefitted from the Internet ( $f = 18$ ,  $n = 11$ ) in terms of learning general sexual knowledge, female body and sexual organs, STDs, menstruation, woman orgasm, masturbation, oral/anal sex, fertilization, pregnancy, and hymen. One participant stated that he took advantage of the Internet by emphasizing the emergent technology as “Actually like this, of course we keep up

with changing technologies, in addition to this internet documents, what life brings us, things we have to do. When all these things come together we also try to learn something” (P9- Male, 30). The easy-to-use aspect of the Internet and search engines in terms of reaching sexuality related information was emphasized as “You know, when you reach the internet connection you can do this easily, you can reach lots of information, there are many sources to read but before you reach the internet connection you cannot have much information.” (P5- Female, 23). Similarly, another one also put emphasis on access to sexual knowledge through the Internet by saying “Thanks to internet, it is a system which demonstrate everything explicitly in these times when you write” (P1- Male, 29).

Although the Internet was found as an important source, a few participants mentioned the concerns related to the content and reliability of the information on the Internet. One participant indicated that there was a need to find reliable websites and sources on the Internet because there were lots of unreliable information as:

What I trust as a source is internet as everyone, is internet a good source? It is also full of silly information. But we should know to pick out such as we should know to pick out while researching for each topic. (P24- Male, 27).

On the other hand, Uzman TV which is a channel that provides scientific information regarding various topics on the Internet was emerged as one of the reliable sources on the Internet as two participants strongly emphasized it. In addition, two participants found the Internet useful to verify the information that they hear from people around them. Regarding learning sexual intercourse, one said:

...what I heard during teenager years were not so credible for me. It passed like a movie in a manner as it happened like that, but when you search on the internet and realize that what you heard is written on the internet and they are similar incidents, something is shaped in your mind, that is to say (P 23, Male, 28).

Second, different types of reading materials were also indicated as another important source regarding mass media ( $f = 21$ ) including books ( $f = 10$ ), novels ( $f = 1$ ) and other unspecified reading materials ( $f = 10$ ). General sexual knowledge, male and female sexual organs, fertilization, sexual intercourse, and oral/anal sex

were topics that participants obtained knowledge through reading. In this context, one said:

One of my friend give me a recommendation about a book. A recommendation a book related to anatomy, I did not remember the title of the book but when I read, I discovered my body on that way, namely. Especially, such as clitoris and vagina, I discovered on that way. That is to say I have information on this way. (P 18- Female, 20).

Moreover, one participant found novels accessible and informative for people with visual disability since they contain detailed descriptions. Another participant stated “There is a book in Braille about contraceptive methods. I did not remember the complete title it was like sexual technical information, its author was a foreigner. I read it. Ee there were basic information, I know from there.” (P2- Female, 36). It was observed that the reliability of reading materials was not a concern of participants, and a few found such materials especially books that provide scientific information as reliable.

Apart from these, participants also benefitted from audiovisual materials including TV ( $f = 9$ ), movies ( $f = 1$ ), and porns ( $f = 3$ ); however, the frequency of using audiovisual materials was less than the use of Internet and reading materials. It seems important to note that participants usually utilized audio aspect of such materials; however, a few participants ( $n = 2$ ) who had low vision in their early childhood years (before age 7) indicated that they could gather knowledge about female-male body and different body types on TV through the help of low vision in early childhood period. One said:

My vision was like that, for example you passed near me I recognized you from your walk, height, weight rather than your face. I had a vision to recognize on that way. It was television which had a great influence on my recognition of women’s anatomy because television is bright my possibility to recognize on television is higher. It was on that way. (P3- Male, 27).

Although porns were one of the underused sources compared to others, one participant emphasized the misinformation conveyed by porns as “For example if you learn something through porn movies, ee for example, you perceive like yes, a woman screams to demonstrate how much pleasure she get ee yes you are on the right way” (P13- Male, 27). Lastly, cyber sex ( $f = 1$ ) through detailed descriptions and guidance in terms of sexual intercourse, phone applications ( $f = 1$ ) in terms of learning sexual intercourse positions, and telephone service ( $f = 1$ ) of a

condom brand in terms of learning different types and functions of condoms were mentioned as other sources of sexual knowledge in mass media category.

***Experiential learning.*** Experiential learning emerged as second mostly used source for sexual knowledge ( $f = 41$ ) following mass media. In this context, experiential learning means learning sexual knowledge through touching or experiencing, and results indicated that experiential learning was irreplaceable for an important number of participants due to visual disability and not being able to utilize visual sources directly.

Participants obtained information through touching or experiencing on topics including female and male body, female and male sexual organ, sexual intercourse, the usage of condoms and panty liners, ejaculation, birth, wet dreams, and sexual intercourse positions. What one participant said regarding this category was a pretty good example that illustrates the importance and power of experiential learning in case of visual disability as:

until you come across first, in a word, real experience; some types of myths would be created on your mind. Like powerful man, especially of course in the learning process you learn as man's dominance, then see what man's doing, woman's being passive rather than being active. Later, you experience that and change it. (P13- Male, 27).

As in the example stated above, experiential learning provides conditions to verify a previously learnt knowledge or change a misconception. In this context, an important number of male participants indicated that the content of wet dreams or more specifically how they visualize female sexual organ changed subsequent to sexual intercourse or touching experience. One participant mentioned how he misconceptualized the female sexual organ in his wet dreams before having actual experience as:

Well, when I was fifth grade of primary school there was a girl I loved. I saw her but it was not a dream as in real world. In this case it was something that I imagined. In a word, How can I say? For example, I realized that it was different what I dreamed about the location of vagina and where it was in reality. (P21- Male, 36).

Similar to abovementioned experience, as it was stated in sexual knowledge part, two of the male participants who did not have sexual intercourse or touching experience specified that they had difficulties in understanding female sexual organ. Moreover, they indicated the need of experiential learning to fully

comprehend female sexual organ which shows the importance of experiential learning in such cases. Regarding experiential learning, one female participant indicated that she learnt male sexual organ via a kind of sexual play as:

Sometimes some of my friends came with me to home. We went to my room for studying purposes. At the time rather than experiencing a sexual relationship, I heard about sexual organ, man's sexual organ, testicles, penetration and ejaculation. I had a chance like that. (P4- Female, 31)

Learning properties of female and male body also seemed to be actualized through experiential learning more specifically with the help of touching in a number of participants. One participant illustrated how a person with visual disability need touching in order to know physical characteristics and how touching may serve as seeing as:

Of course there have to be touching because you cannot see the person in front of you, not only her vagina. For example if she is your beloved or girlfriend, wife or partner , you feel need to touch her, you need to touch her face and ears, let me say while you are touching her nose, arms all over her body, you also see her. While touching her back, belly, legs, feet you somehow portrayed her, actually, you understand how her body is with observing. (P23- Male, 28).

Moreover, experiential learning seems to be helpful in terms of understanding the usage of condoms and panty liners from the perspective of the participants. In this context, one participant told how he comprehended condoms fully as:

...I am a person who have no vision so I cannot know without handling what it is, how it is used etc. otherwise I should take this and try myself. Actually, what is ..I do not know anything about till my elderly years. I do not know what kind of object this is....there was a festival. We opened a stand there, there were many other stands for example one of them was about sexual health which was opened by youth organization. They gave us, and it was my first time to come across with it, I took and opened it, I looked to understand what it is. In a word, I learned it in such a place (P24- Male, 27).

Likewise, a few number of female participants mentioned that they acquired knowledge of the usage of panty liners via experiential learning. Similar to the use of touching, understanding how to masturbate were based on experiential learning following hearing about it from others on the part of male participants. In this context, what one participant said clarifies this issue in detail as:

Masturbation.. I learned it during high school years. Of course, I heard about it from my friends and both while listening and while trying aa how this happened, well, without exactly knowing how it is happened, when you touch your penis or trying to masturbate you feel that something is happening and you feel like moving, you understand that what you do and what have told is the same. (P23- Male, 28).

In general, it can also be inferred that experiential learning is sometimes utilized to verify other types of knowledge. More importantly, none of the participants found experiential learning unreliable, and in some cases, experiential learning becomes the only way of gathering reliable information due to visual disability.

***Friends.*** Following mass media and experiential learning, friends as a category became the third mostly utilized source among the participants ( $f = 37$ ). Female-male body, personal hygiene, birth control, masturbation, menstruation, general sexual knowledge, wet dreams, puberty, ejaculation, orgasm, oral/anal sex, oral/anal sex, the usage of condoms were the topics that participants acquired information via friends. As it can be seen, friends appear to be an extensively used source in almost every topics regarding sexuality. Furthermore, male participants made use of friends as a source of sexuality information more than female participants. On the other hand, friends seem to be the most unreliable source from the perspective of the participants. Mostly male participants stated this unreliability issue as exemplified in the following statement “Unfortunately, our knowledge depends on older men narratives in which some kinds of myth added on their own adventures and their experiences.” (P13- Male, 27). Another male participant also mentioned how their same-sex peers mentioned their sexual experiences by exaggerating as:

Namely, they told with aggregating... such as one said that on that age he went to brothel, the other one read something on magazines and did this job, some of them said using soap...in a word, for me of course I do not have a chance to use magazines. (P21- Male, 36).

Additionally, another male participant indicated that how friends cannot provide fully reliable information by saying:

Well, under favor of my friend who was older than me. We told everything to each other without hesitation anyway. I was asking him, how it did, how was it happening, he told me. He was like..He would not mention foreplay because he was not educated. He did not mention that people give

importance today, only he told, you kiss and sleep with, that is all. (P25-Male, 29).

As it can be inferred from the aforementioned experiences, friends perceived as the most unreliable source mostly cited by males. On the other hand, none of the female participants who obtained information from friends evaluated it as an unreliable source. One female participant mentioned lack of sexuality related conversations among females except menstruation as:

...there were some chat between men like that. Aa somebody jerked of and it grew 5 cm etc. (laughing). It is superficial but people specially youths start like this. For women for girls it was not verbalized. They only talked about menstruation, actually if they were experience something, they probably would keep it secret. (P4- Female, 31).

Similarly, another female participant indicated how male friends provided sexuality information to female friends. Regarding friends category, another important finding is that especially male participants, who stayed at boarding school for students with visual disability indicated that older friends in that setting as a source for sexual knowledge. One example was provided by a male participant in terms of masturbation as "I have studied at a boarding school especially on secondary school. You will guess, conversation of men at the men's dormitory. Then, there are people who are experienced or not. People talk about you do it like that." (P1- Male, 29).

It should be noted that most of the participants had experience of staying at boarding school since schools for students with visual disability provides such an environment due to the lack of such schools in every city. Hence, friendships became a source for sexual knowledge in such an environment. It was also stated that some of students in these schools were older due to late onset of schooling, and those older friends which may have possibly more sexual knowledge, whether reliable or not, share what they know about the topic with their younger friends.

***Family and relatives.*** Fourth mostly used source for sexual knowledge emerged as family and relatives among the participants ( $f = 22$ ). Here, the important thing is that family and relatives were used as source for sexual knowledge more among female participants compared to male participants.

Male participants (n = 3) utilized this source for personal hygiene, menstruation, and fertilization. However, except one male participant, none of them acquired information directly. In one of the cases, a male participant learnt menstruation through observing and hearing from female family members which explained as:

When you live with two women at home you have some kind of idea but these are not told explicitly. Let me say. It called as Rıfkı. Mother, Rıfkı has come, who is Rıfkı? (laughing). Hee, then you understand it is menstruation period. (P1- Male, 29).

Another one stated that he informed by mother about birth but not accurately. Only one male participant stated that he felt lucky due to the support of his family in terms of sexual knowledge by providing him information on personal hygiene regarding hairing as:

how should I say my father talked to me about this topic for example, about hygiene of genitals etc.. Because I do not have vision, we talked about I could shave or not, and about some methods such as depilatory, my father took care of me about these topics. First, my mother and father talked to me in general issues, after that my father took care of me in details. (P24- Male, 27).

On the other hand, 7 out of 8 female participants indicated that they received sexuality related knowledge from either parents (especially mothers) or relatives. Mostly, menstruation, hymen, and the usage of panty liners were the topics that participants acquired knowledge through the help of mothers or same-sex relatives. One participant stated how she learnt menstruation from her mother as:

My mother told me when you grow up to 13-14 years old, you would experience something like that. Namely, she said us not to afraid. Even, she would do something to us with joy because we grow up to young women. She cooked something us to eat, she would take us somewhere with thinking my girl grow up to a young woman. We were 5 girl and a boy. That is to say, she did something joyfully for each of us. She told our first steps. (P20- Female, 42).

Similar to male participants' experiences, only one female participant illustrated that there was an open sexuality communication between her and her mother on topics other than menstruation, hymen, or the usage of panty-liners as:

My mother is a person who give information when you ask, rather than saying shut up, she gives information. Only she said, do not ask these things in front of everyone. Even contraception methods would be talked.



Everything is comfortable between cousins, we also can talk with my mother at the same comfort. (P16- Female, 24).

As it is stated above, same-sex relatives also provide some kind of sexuality information to female participants. One said how she acquired information related to birth from her aunt as:

And because my aunt got treatment of tube baby and me also stayed with her, I know from there...I have an aunt between my friends who I get along with well. This aunt gave me lots of information on these issues. She informed me and said you should also know. She gave lots of information about these issues by saying “recognize me as a elder sister and a friend (P12- Female, 25).

Aforementioned, only two of the participants indicated that there was open sexuality communication within the family; however, the rest of the participants did not report such an atmosphere, and emphasized the lack of sexuality communication as well as the lack of sexual knowledge among their parents. In this regard, one participant emphasized the conservative environment within family as a barrier to sexuality communication as:

No, I do not talk to my family because my family is so different than me they are a conservative family. I am the opposite of them because I did not say to grow up with them, I stayed generally in boarding schools, just I have said they are conservative family, namely, but we have an intimate relationship with my mother. However, even my mother was not informed about these topics appropriately, actually, she was born in a village and grew up there, so she grew up in a conservative area and under pressure. Naturally, I cannot expect that she would inform me. So there is nothing about these issues related to my family. (P5- Female, 23)

Lastly, families or relatives provided misinformation regarding sexuality including topics such as birth and hymen in order to keep their children (especially female children) away from sexual experiences. One participant expressed how she was deceived regarding birth as:

We asked my mother why she should be with us during delivery, well, to understand how it happened. My grandmother told me, look, a hole opens at your kneepan, the baby comes from there and the hole closed again by the God. Well, telling this story opening and closing up from there was because of protecting us doing something to us with curiosity. (P20- Female, 42).

To sum up, while family members and relatives may be a reliable source in terms of menstruation and personal hygiene, sexuality communication within family was not common among participants. Furthermore, families and relatives

may become unreliable with regard to topics such as hymen and birth to especially their female children.

***School-based sexuality education and courses.*** In addition to other sources, school-based sexuality education (in one or two sessions only) and courses including health course, religion course and Qur'an course were indicated as less frequently used sources for sexual knowledge ( $f = 18$ ). Only three of the participants stated that they could obtain sexuality related information in terms of puberty through one or two- session sexuality education in school. In this context, it is a surprising fact that although 10 out of 18 participants stated they had some kind of sexuality education, only three of them mentioned those education experiences as sources for knowledge. In this regard, one participant indicated how she acquired knowledge on female sexual organ through informative booklets provided by the school as "Well, in the first place there were booklets on these issues distributed at school. First, I decided to investigate my body in order to recognize myself and one day I looked the area called as clitoris." (P4- Female, 31).

In addition to this, two participants indicated that they gathered information about masturbation and ejaculation in relation to religious practices within Qur'an course. Lastly, two of the participants gathered information on STDs and sexual organs via health course within school curriculum, and only one participant obtained information regarding menstruation through religion course within school curriculum.

***Sighted period.*** Another source for sexual knowledge emerged as sight for a few number of participants ( $n = 4$ ) who had low vision in their early childhood years. In this context, those participants stated that they have tentative images of female and male body and when they learn a new piece of sexuality related information, they can associate this new information based on images that they formed during their low sighted period. What one participant told in this regard was a pretty good illustration of making use of sighted period to converge old and new information and form a mental picture about it:

I would say about this topic, after I started to have no vision, for me information that I gathered consisted of what I heard around and what I

read, it is necessary for everything not only for sexual organ. Any information that I heard, for example they described me a woman or it would be any other thing such as a car or something else. When they describe each part, I recall my information of past when I had vision, then think about this was similar to that and reunite these parts to form an image. That is why, for the sexual organ, I reunited what I heard and read, and then a form of it was appeared in my mind. ..Well, an image was appeared, I did not see them but it was a simplicity comes from having vision before. (P24- Male, 27).

Although low vision period could ease forming mental pictures about new information for some of the participants; not all of the participants indicated such an advantage. Yet, all of them stated that sighted period as a source of knowledge including learning about physical characteristics of female and male body, except sexual organs of the opposite sex.

**Health personnel.** Lastly, only two participants indicated that they acquired knowledge through applying health services and doctors. One of the participants also stated that she found doctors as a reliable source for getting sexual knowledge as “Honestly, I rely on my husband and my doctor most and I cannot get information from anyone, I mean, I cannot ask such things among friends” (P20- Female, 42). The other one also indicated that he obtained knowledge from health center personnels.

Although it was not mentioned often, one lesbian participant indicated that she had reservations regarding acquiring knowledge from health personnel due to their negative attitudes and heterosexist views toward people with disabilities. She mentioned one negative experience of her which made her not to go any gynecologists then as “Directly he/she said relationship with your boyfriend, well, between you, you should know whether he had a kind of disease or not, and I said not boyfriend but my friend” (P5- Female, 23).

**4.1.3 Summary of the results regarding sexual knowledge.** To sum up, results regarding self-evaluation of sexual knowledge demonstrated that more than half of the participants (n = 12) felt that they had sufficient knowledge and the rest of the participants (n = 6) felt that they had partially sufficient sexual knowledge. In this regard, participants specified a number of topic that their current level of knowledge was insufficient and they would like to learn more information. These topics included sexual intercourse, sexual intercourse positions, STDs, body

characteristics including sexual organs, contraception, fertilization, birth, masturbation, orgasm and oral/anal sex. Especially, male participants, who did not have sexual intercourse or touching experience, had no knowledge about female sexual organ and sexual intercourse; whereas, female participants did not need further knowledge in terms of male sexual organ. On the other hand, orgasm and masturbation were among the topics that especially female participants had no knowledge whereas male participants did not need further information usually. In terms of sources of sexual knowledge, results indicated that mass media ( $f = 60$ ,  $n = 18$ ), experiential learning ( $f = 41$ ,  $n = 18$ ) and friends ( $f = 37$ ,  $n = 15$ ) were main sources of sexual knowledge among participants. Moreover, family and relatives ( $f = 22$ ,  $n = 9$ ), school-based sexuality education and courses ( $f = 18$ ,  $n = 5$ ), sighted period ( $n = 4$ ) and health personnel ( $n = 2$ ) were less utilized sources of sexual knowledge among participants. While friends and the Internet under the mass media category raised doubts in terms of reliability, experiential learning was emerged as the most reliable source of sexual knowledge among participants. In this regard, results revealed that experiential learning provided most concrete sexual knowledge for most of the participants.

## **4.2 Sexual Experience**

Participants were asked about their sexual experiences and data analysis regarding this part revealed 3 main themes namely sexual experiences in childhood and puberty, sexual life in adulthood, and different forms of discriminations based on sexuality and visual disability.

### **4.2.1 Sexual experiences in childhood and puberty.**

*First recollections regarding sexuality.* Participants were asked about their first recollections regarding sexuality before age 8. Firstly, it should be noted that one female participant stated that she did not remember such an early recollection due to her age (42) and again one female participant stated that she did not remember anything regarding sexuality without indicating any reason (age:20). Fourteen out of 18 participants provided recollections before the age of 10 and the rest 2 participants could only go back to the age of 13-14 and provided recollections from that age period. One of those participants explained the difficulty to remember earlier periods through authoritarian family practices as “I

don't remember much because we grew up in a strict family... the authority of the father... such issues were not talked about, these were taboo and so on." (P6-Male, 39). It was observed that a number of participants had difficulties in providing first recollections regarding sexuality.

With regard to first recollections, the content mainly encompassed tactile experiences including touching sexual organs or body ( $f = 8$ ), kissing ( $f = 3$ ), and touching only body ( $f = 1$ ); auditory experiences related to sexuality on TV or from relatives ( $f = 2$ ), sight related experience of magazines ( $f = 1$ ), and lastly, olfactory (smell) experiences of the person that the individual like ( $f = 1$ ). Participants gained those experiences through sexual plays that include experiences including touching, kissing, light petting ( $n = 8$ ), observations ( $n = 3$ ), and dreams ( $n = 2$ ). In terms of tactile experiences, participants mainly mentioned their experiences of touching sexual organs of the same-sex peers, and only two participants indicated that they did not touch same-sex persons. In this context, what one female participant said can properly represent first recollections included tactile experiences as:

Our neighbor's daughter... We used to play house together. I don't remember if she was the mother and I was the father or I was the father and she was the mother. Well we took off our underwear. Umm, probably she had seen her parents before. Because my parents were very careful about that. She climbed on me. Well, you know doing things to my vagina. I don't remember what happened, it was a long time ago. She tried to grind and my mother caught us. We were doing it in the apartment building's hall (laughs). She gave me a good thrashing with a broom. That's the first thing I remember. (P2- Female, 36).

In sum, tactile experiences in recollections of the participants consisted of touching different parts of body through sexual plays, kissing, being kissed by an older person, handhold, pretending sexual intercourse, and being hugged by an older person. In addition to tactile experiences, a few participants mentioned auditory experiences in which they heard something related to sexuality on TV or from relatives. It is important to note that in both cases participants talked to their parents immediately after that experience, and those are the participants who made strong inferences regarding sexuality in relation to the recollections. One mentioned his experience as:

there was a film on TV. I watched it, one man rapes a woman and she gets his child. In another scene a woman passes out and falls and another man helps her and so on and I said oh he will rape her. After that my mother tongue-lashed me... I mean being silenced and reprimanded is difficult in itself for a child. And you worry about if you did or said something wrong. That's how I remember how I felt at the time. Like that. After that incident I got the idea that I should not talk about such issues at home. And I didn't talk about them at home for a long while. This is a wrong idea and a different thing you know but I remember this from that period. (P21- Male, 36).

On the other hand, one participant indicated that he had dreamed his teacher that he liked in his dreams, and the recollection mainly includes smell. Lastly, one participant who had low vision in childhood period stated that he found sexuality related magazine; however, did not remember what he saw. When it comes to which feelings that participants experienced during those moments specified in the first recollections, except one male and one female participants, all participants, who provided first recollections indicated that they had been felt positive feelings during those moments. Although most of them had difficulties in specifying their feelings exactly, they defined those moments as nice and beautiful. Mostly specified feelings were joy ( $f = 3$ ), curiosity ( $f = 3$ ), enjoyment ( $f = 3$ ), love ( $f = 2$ ) excitement ( $f = 1$ ), happiness ( $f = 1$ ), ambition ( $f = 1$ ), and feeling protected ( $f = 1$ ). Only one participant could not state any feeling related to first recollection. On the other hand, two participants mentioned partially negative feelings which are anxiety (as well as curiosity) and blame or feeling like doing something wrong; however, only one of them completely mentioned negative feelings. Those participants were the ones whose first recollections included observations of someone's sexual activity or sexuality related content on TV and talking to mother about it.

In addition, participants were also asked about whether any perception that they formed regarding sexuality based on specified first recollection. Seven out of 16 participants stated that no perception was formed regarding sexuality since they did not feel that this was something related to sexuality rather they found the content of recollections as childish and pure. One participant indicated that he did not remember such a perception. Four of the participants stated that they formed a tentative perception regarding female body, sexual orientation, sexual intercourse,

and desire for opposite sex based on those experiences. In this context, one participant who provided a recollection includes imitation of sexual intercourse indicated that he could tentatively infer what sexual intercourse is like by saying:

this might have given me this idea. You know, how to put it, yes there are two human beings, they cuddle each other and perhaps the organs touch each other and so on. I think that's it, I came to imagine its shape but I still didn't know the anatomy of woman. (P24- Male, 27).

On the other hand, 4 of the participants indicated a change in the perspective or a strong perception regarding sexuality based on these recollections. It seems important to note that 3 of those participants had either positive or negative conversation/interaction with their family members (mothers) in these recollections. In this context, one participant, whose negative experience mentioned above, talked about his inference by telling:

After that incident I got the idea that I should not talk about such issues at home. And I didn't talk about them at home for a long while. This is a wrong idea and a different thing you know but I remember this from that period. (P21- Male, 36).

Furthermore, one participant who talked with her mother after an observation related to sexuality stated a change in her perception of sexuality as "one should take a bath after sexual intercourse... intercourse is not only for having a child." (P16- Female, 24). Lastly, one participant who had a recollection about sexual plays with peers including touching indicated that her negative attitude toward sexuality had changed subsequent to this experience. She described this change as:

I thought it was a nice thing because it was something that makes people happy and thrilled and you know something that happens as a result of a connection; I've decided not to be so cool to sexuality anymore and you know, not to think what a shame when someone's had a sexual relationship because it was, well, a nice thing something that makes people happy and thrill them. And after all we exist thanks to sexuality.(P4- Female, 31).

**Puberty.** Participants also expressed how they experienced physical changes during puberty. In this context, bodily changes (e.g. breast, hairing etc.), masturbation, wet dreams, and menstruation were among the topics that participants mentioned. Participants' feelings regarding changes in puberty had emerged as excitement and confusion mainly. One female participant expressed her excitement as:

My breasts grew, pubic hair was coming up, I got really excited when my breasts first began to grow. In addition, growing up was great, so was the shaping a woman's body. For example my hips had become larger, they were becoming larger, before that I was a petite slim skinny person. (P16-Female, 24).

Similar to this, joy related to maturation in puberty another common topic among participants a male participant said "I was even happy to grow up." (P9-Male, 30). However, this does not mean that there were not any difficulties that participants faced with during this period. Participants also experienced some difficulties including not knowing how to satisfy sexual desire, anxiety due to hairing, and changes in face and body including acnes. Perceived restriction regarding masturbation and relationships with girls among male participants, and perceived restriction from family due to puberty among female participants were other difficulties they reported. One male participant expressed his feeling regarding changes in body and face as "Of course my face my body made me really sad." (P10- Male, 27). Furthermore, participants emphasized that they experienced changes in puberty in a similar way with their peers without visual disability. One participant summarized this situation by saying "You know the slow growth of the sexual organ, pubic hair, you know the voice change, more interest in the opposite sex. I mean, I think I went through it like everyone else does." (P25- Male, 29).

A few female participants perceived oppression regarding social norms related to transition to womanhood during puberty and one of them summarized this situation as:

When you're a child you're, I don't know how to put it, a bit more, I don't know how to say it, more relaxed, you know. Because there's nothing there about womanhood, you're just a child but after my body has developed I thought I should be more careful, you know, I can't show cleavage, you can't show your breasts, I should be careful in that sense. (P16- Female, 24).

Another participant was mentioned parental supervision and control by saying:

When we reached puberty they told us that we should wear bras. You know, they said that the clothes during adolescence can't be the one you wear for primary school. We weren't let out much. Girls in the 5<sup>th</sup> grade can't go out, play in the parks... we used to ask why, we are also children like them. No, you're adolescents, moving towards being big girls, young



girls. They would say no to such things but wouldn't tell us why. (...) you know, some grownups some impertinent people, you know, might try to do things to you but they wouldn't tell us what those things are. So that we won't hear and learn such things. Perhaps they wouldn't tell thinking that some of us who learn about these things could try them with other children. (P20- Female, 42)

Wet dreams mostly created feelings of confusion among female and male participants. All of the male participants had wet dreams during puberty; however, some of them stated that the onset of wet dreams were relatively late compared to other friends' experiences. For instance, one male participant emphasized the late onset of wet dreams and the content of his dreams as:

I haven't masturbated in the junior high, no wet dream either. What's interesting is that the wet dreams began quite late. You know, after 18 more or less. And, you know, what I think it that perhaps one can't dream what he hasn't fully experienced. Or you can't visualize in your dream something you don't know how it looks like. You see things similar to what you imagine before. (P21- Male, 36).

On the other hand, only a few female participants indicated that they had wet dream experiences. The ones who had such experiences did not remember the content of wet dreams contrary to male participants. Four female participants stated that they had wet dreams experiences and one female mentioned about her experience as "I mean yes it was like that, how I shall say (silence) when I wake up in the morning I see a wet spot in my underwear. You know I really can't figure out." (P22- Female, 25).

Male participants indicated that they did not have often wet dreams experiences although they had at least one experience contrary to female participants. As it is stated before, the content of wet dreams among male participants had significantly changed after they had actually experienced sexual intercourse or touched the female sexual organ. What one male participant indicated was a representative example of the experience of wet dreams among male participants by saying:

In fact intercourse in my dreams was similar to how I imagine intercourse during the day... an indistinct female sexual organ and I'm doing you know I'm having an intercourse with it I mean it was whatever I have in my mind vaguely. (P25- Male, 29).

Considering masturbation experiences in puberty, only three female participants indicated that they had such experiences in that period, and they

learned masturbation through self-discovery. There were also female participants who indicated that they did not learn how to masturbate during puberty, rather they learned in a later period. Although they have current masturbation experiences, they did not have such experiences in puberty. On the other hand, one female participant did not want to answer the question related to masturbation. Lastly, one participant indicated that she did not know anything about masturbation. In this context, a few participants revealed their negative attitudes toward masturbation.

Contrary to what female participants experienced, masturbation emerged as a topic that male participants frequently talked with their peers or older friends from school and experienced during puberty. Male participants usually tried to masturbate after they heard about it or they discovered masturbation on their own. Only one male participant stated that he did not ejaculate through masturbation neither in adolescence nor in the adulthood period. He stated his condition as:

I can say that at least I know one or two people besides me. Self ejaculation is problematic for the visually impaired including me. Let me tell you this, before I got married I have even worried about whether I was a man... As I told before I couldn't manage to do it with voice or stuff. (P21- Male, 36).

The rest of the male participants indicated that they experienced masturbation during puberty. A few male participants ( $n = 3$ ) indicated that they were sexually aroused by different female voices and formed fantasies during their masturbation experiences in puberty. One of them summarized the condition as:

At the beginning we, I masturbated based completely on voice but whenever we mingled into society we reached school age of course we had short-term affairs we began to flirt then we began to get most pleasure. Interestingly human beings can get aroused by even the voices they hear if they can't find anything else. There were no computers or internet around at the time. So we can't reach many sources. But there were female DJs in radios at the time, I used to listen to them a lot (laughs) I used to get excited by that. (P9- Male, 30).

Although male participants had masturbation experiences, a few of them ( $n = 3$ ) expressed that they felt guilty due to masturbation, or they limited its frequency because of thinking that it is not an ethical behavior. Two of them were thinking about whether or not masturbation is appropriate according to religious practices and one male participant said "I'll tell two things about masturbation. First, I was eager (laughs). But when I was in high school I was very religious,

how shall I say, puritan. But I was also ambivalent. (...) I also had self-imposed limits.” (P24- Male, 27).

Male participants also indicated they experienced restriction regarding both masturbation (n = 1), and close relationships among boys and girls at boarding school (n = 5). One of them talked about perceived restriction regarding relationships among girls and boys at school by saying “Teachers did not want to see a girl and boy while flirting. If they saw such things, even they might apply criminal action against this” (P9- Male, 30). In terms of perceived restriction in school, male participants pointed out that school administrators tried to control such close relationships among them although none of the participants were punished because of such relationships. In addition, only one male participant reported that school teachers tried to control masturbation through talking to students. That participant explained the situation and feeling evoked by this situation as:

He/She has said don't play with the toys downstairs. (laughs) I remember that. ... You know, we were told not to masturbate. ... You think maybe it's harmful, you know, it's adolescence and many things pop up in your mind. I've even thought to myself perhaps we're doing it for no reason. Later we've even thought about being... I recall even discussing among us are we becoming perverts, are we perverts. (P3- Male, 27).

One of the mostly elaborated topics among female participants was menstruation. As it is stated in sexual knowledge part, the majority of participants acquired knowledge about menstruation from their mothers. With regard to first menstruation experiences, some participants indicated that they did not understand they were experiencing menstruation exactly. One participant explained this by saying:

But for example I didn't get it when I had my first period. How did it happen? I began menstruating at 12, I looked at it and thought what it is I'm not wetting myself and stuff. That day I was staying at my auntie's and she said you're menstruating. I didn't know about it so I said what is that. She said from now on you have to use pads. (P22- Female, 25).

Although a number of participants had feelings of confusion in the course of first menstrual experience, they utilized different strategies in order to understand their period and adapted to the new situation with the help of those strategies. What one participant said was a good example of the very first feelings of confusion and the adaptation process as:

When I had my first period (laughs) of course it was a shock, what will happen now and so on. Of course the biggest problem is the pad, putting the pad in place, to understand whether it is full or not or recognizing your first menstruation. You learn slowly by experience, you explore or in putting the pad on my family has helped me a lot. You know you learn slowly in time. (P18- Female, 20).

In this learning process, due to their visual disability, participants employed a number of strategies that are not based on vision. Those strategies included observing physical and emotional changes before menstruation period including acnes, pain, sensitiveness in breasts and tenseness; counting the days and touching the liquid in order to understand whether it is blood or any other liquid by considering its structure and form. One participant emphasized physical and emotional changes before menstruation as signs to start using panty liners by saying:

Well, either I use the calendar or there are signs before it comes. A little soreness in the vagina, even it's rare sometimes a strong craving for sweets one day before or high irritability, like leave me alone. I understand with such things. I can put on the pad beforehand. (P4- Female, 31).

As mentioned in sexual knowledge part, female participants learned how to use panty liners in menstruation periods either by experiential learning, or from their mothers, older friends. One indicated how she learnt the usage of panty liners from older friends at boarding school by also mentioning some misinformation provided by them as:

Well, when I was in the boarding school the big girls there used to tell horrifying things. You know, you get slapped in the first menstruation. You shouldn't take a bath when you're on your period or else you'll be possessed by evil spirits (laughs) because there were all kinds of people there, from the villages as well as cities. Of course what we first came to know was what we've heard from the big girls. But of course we've also heard nice scientific things like how to put on a pad, how you protect yourself when you're on your period, but we've also heard superstitious stuff. You don't make love on your period, it's sinful and you'll be possessed; don't take a bath and you'll be possessed; don't touch the Quran when you're on period and what have you, we've heard such things, too (laughs) (P4- Female, 31).

In terms of hairing during puberty, the majority of the participants pointed out that they were knowledgeable about the changes regarding hairing with the help of their peers, older friends, or family. Therefore, they mainly did not experience confusion. However, one male participant stated that he did not know

hairing and thought that it was something like rope when he first touched hairs on his genital area by saying “Of course, I think to myself how this thread has stuck on to me and is hurting me, I mean it was so weird.” (P21- Male, 36). In terms of hygiene regarding hairing, all of the participants found a personally appropriate way to handle this process based on what they knew about hairing and hygiene through peers, older friends or family. In some cases, same-sex parent helped the participants for shaving. However, most of the participants did not prefer such a help and the ones who received such a help for shaving felt feelings of shame. One female participant expressed the situation by saying:

When the pubic hair began to grow during puberty, first my mom wanted to shave it with a razor blade. I let her once. Afterwards I’ve shaved myself. It was embarrassing for me that mom was doing it. Opening my crotch wide to my mom and her cleaning it was shameful so afterwards I always did it myself. Anyway, I now go to places that does such things (laughs) (P2- Female, 36).

#### **4.2.2 Sexual life in adulthood.**

**First sexual intercourse.** In terms of sexual intercourse experience, 4 women out of 8 stated that they did not have such an experience but the rest of them did. It should be noted that only two of the women participant who did not have sexual intercourse experience were unmarried. On the other hand, only 2 men out of 10 stated that they did not have sexual intercourse experience.

The first sexual intercourse experiences of those 4 female participants were with people with visual disability whom were their romantic partners. Moreover, the age range of the first sexual intercourse among females changed between 15 and 28. While two of them evaluated that experience as pleasurable, the others evaluated them as unpleasurable experiences. In total, female participants mentioned lack of knowledge and experience ( $f = 3$ ), lack of pleasure ( $f = 1$ ), shame ( $f = 1$ ), and excitement ( $f = 1$ ) regarding those experiences. One female participant, whom experienced first sexual intercourse at the age of 18 with an intention of rebelling to her family, mentioned the lack of knowledge and experience by focusing the issue of chastity as:

We started talking, you know, dating. You know, we’re young, there are certain things that the body wants. We kiss, neck, well, share the bed but no progress after a certain point. I first told him, what is called chastity is not about this for me. Let’s say we break up tomorrow. When you’re with

someone else, when you say you haven't touched any woman or when I say I haven't touched any man; that is a lie also, if it is about being honest. I suggested let's experience this. And so we had the intercourse. Of course it was interesting, we didn't know how to do it. (laughs) After all, there was no experience from watching porn movies or other sources. It hurt a lot of course, I don't know it normally hurts that much but it was pleasant. (P2- Female, 36).

Another female participant also talked about the issue of chastity and her first sexual intercourse experience as:

It was a bit stressful because I'm not a person who cares about virginity and such but I think there were still certain taboos in the subconscious that the society has imposed on us. I was thinking oh I'll be a different person now. Even I was quite knowledgeable. But I was also young. He also told me that he was excited and it was his first time. But it wasn't something that went all the way. (P4- Female, 31).

On the other hand, another female participant who experienced sexual intercourse at the age of 28 (within marriage) with an experienced partner indicated the lack of knowledge, courage, and fear regarding sexual intercourse by mentioning her feelings of shame and shyness as:

I mean I was very frightened. I was very... I don't know. It was like now, more developed times we would experience it more consciously but we were not. It was too bad... I can't say that it was wholly negative but considering my shyness it was a very difficult experience. Not being knowledgeable, being shy, or not knowing what that thing is, that organ is, all of these are... You know, I was so perplexed, I didn't know what to do. Of course, it's only you and that person in that room, there's nowhere to go. But if you go what then? He expects consummation, you're under his matrimony. If you run away today it'll happen again tomorrow, it'll definitely happen. (P20- Female, 42).

The last female participant who had first sexual intercourse experience with same-sex person also mentioned forbidden nature of such relationships as:

You know, let's sleep together and stuff, we usually slept together. This was also not permitted, in fact I then understood why it was not allowed (laughs) why they don't let us. They both say no harm girl to girl and stuff but they also ban it. It was ridiculous but it is how our country is. Violence is not prohibited but everything related to love is. We thought to ourselves this is also part of why it was not allowed. I mean when lying together you begin to feel something instinctively when you cuddle, she also feel the same, it's all begun with mutual touching. (P5- Female, 23).

In summary, female participants mentioned the lack of knowledge and experience, the issue of chastity and their attitudes toward it, the obligation of

sexual intercourse within marriage, and feelings including pleasure, excitement, shyness, fear, and shame with regard to their first sexual intercourse experience.

Among male participants, on the other hand, the onset of first sexual intercourse experience ranged between the ages of 17 to 26. Half of the male participants stated that their first sexual intercourse experiences were with their romantic partners and four of them had such an experience with persons with visual disability. Two of male participants stated they firstly tried this experience in a brothel; however, they did not evaluate those experiences as first sexual intercourse experiences due to not exactly actualizing penile vaginal intercourse or lack of romantic feelings. One, who did not have any ejaculation experience through masturbation or sexual intercourse until he married, talked about his experience as:

We went to a brothel with friends but I couldn't...ejaculate there either. That day probably was one of the worst for me; I thought perhaps there's something wrong with me. As I told before, after the marriage when I saw that it could happen that made me really happy; I hadn't shared it with my wife before the intercourse took place... I think that the books I've read, family pressure, a subconscious guilt about going to such places and anxiety; we went there as three friends and I was the last to go in, I was worried before I went in, after I got out although nothing happened I bragged about it. (P21- Male, 36).

The rest of four participants experienced sexual intercourse firstly with people whom they were not in a romantic relationship. Unlike female participants, only one out of 8 participants indicated that there was a lack of knowledge during their first sexual intercourse relationship as:

Man has to go back and forth during intercourse, right? I stayed put. I didn't get it. People say that I didn't get excited. They're lying you know, it's the first time. I sweated a lot. Then I asked what happened. Then Metin told me how it should be but the girl had made much fun of me... you don't know about it at the time (P6- Male, 39).

Males who had that experience with experienced partners or partners whom they were having good communication ( $n = 3$ ) evaluated those experiences as satisfying. In this context, one participant explained:

Because she knew she was more experienced, well of course I theoretically knew many things; what did I know, umm, for example intercourse shouldn't happen before foreplay, that isn't right, I had information like that but I had never experienced it practically. Where she helped me was for example came when I ejaculated prematurely in my first experience.

She wasn't critical of me about that; I also, based on what I've learned, said, damn, I'm sorry, it wasn't an intercourse that would make you happy. On the contrary, she said this is normal, are you crazy. It was very nice and another nice thing was that for example she was telling me what she likes. You know, for example, I don't want it today or today I want it this way. (P13- Male, 27).

Moreover, male participants who firstly try brothels to experience such a sexual relationship evaluated their first sexual intercourse with their romantic partners as magnificent, and very good by focusing on positive feelings such as happiness and romance. One compares those two experiences as:

Well, there's this in fact. Before 2011 I've had an experience with someone I didn't love, to be honest, in somewhere like a brothel. It was really below my expectations. I was also very tired. A friend and I looked for the place for 5 hours or so in the dry cold. I thought to myself, is that it, made so much of by people, supposed to be so joyful. But later on, when I experienced it in 2011 with my lover I said to myself that's it, when there's something emotional and if you're not that tired (laughs) something similar to what people talk about happens. (P1- Male, 29).

On the other hand, one male participant assessed his first sexual intercourse experience as unfavourable including acts related to humiliation from partner by saying:

but in high school I got close with someone who was couple of years older than me based on mutual attraction. We went a bit farther with him sexually but it was a form of communication like this: the other party begins to humiliate me after communicating. Or he forces me to intercourse in the most inappropriate occasions. Especially when we're with someone else, chatting, and so on, he seriously criticizes me, plainly says that he does not like me from certain respects. But when we are alone or if his needs are at stake, he tries to have sex. That's why I don't consider my first real sexual experience as a healthy and right one. (P10- Male, 27).

***Sexually appealing characteristics.*** Participants were asked about which characteristics they may sexually find attractive or appealing as well as their definitions of sexy man and woman. At this point, it is important to emphasize that a few participants ( $n = 3$ ) indicated that sexuality and romance were so converged, thus they cannot evaluate personal characteristics as merely sexual or romantic. Participants mentioned a high number of qualities that they found sexually attractive. Despite the fact that they talked about physical qualities including having a well-shaped body ( $f = 4$ ), being tall ( $f = 3$ ) and being curvy ( $f = 1$ ) or muscular ( $f = 1$ ), results also showed that qualities including tone of voice, smell



and speech/diction, and skin ( $f = 17$ ) were regarded as the most sexually appealing qualities. Several participants reported that tone of voice ( $f = 7$ ) became very important in case of visual disability and one said that:

But I like that very much for instance, that I did not mentioned among others, that of voice, tone of voice; it has a significant influence on me. That is very important... Well, you know that there are those who have a tone like poetry, well I don't know how to state this but... It can not be explained, so to speak, however the tone of voice is very much.. for me fancy someone, in any case, rather than fancying, you know such a thing is the primary criterion for me, because since we do not see you take first the voice. I guess that is one of the things I place significance. (P16- Female, 24).

In terms of smell as an attractive quality, one stated that "... I would prefer his/her scent to be natural, normal. Not masked, not too much perfumed" (P10- Male, 27). Another participant also emphasized how tone of voice and speech were of utmost importance for her in the course of partner selection as "That person's energy, so to say, way he/she speaks, tone of voice, you know all those are factors for me" (P5- Female, 23). Personality characteristics seem to be important sexually appealing qualities among the participants. In this context, personality or emotional characteristics namely having a good and compatible character, strongness, intelligence, self-confidence, behaviors, intimacy, romantic behaviors and feelings including love and passion were reported as other important sexually appealing qualities by the participants ( $n = 10$ ). One participant indicated how personal qualities were important for him as:

Hygiene, manner of dressing, intelligence, comprehension. Intelligence is important, you know, cause intelligence brings about comprehension, understanding. Discovering the right path, understanding the other, talking to the other; all those things already are contained in intelligence. Saying intelligence, I do not mean some genius, inventing something, you know, that we should understand each other and also talking sincerely to each other. I like sincerity, you know, because I want him/her to realize, what we are doing is, not like a secret thing, a disgusting thing, not an hanky panky, not in such weird definitions, but natural. So to say, I think we should answer each other's needs. (P24- Male, 27).

Furthermore, physical properties including having a well-shaped body, having a good physical appearance, being tall or having a muscular body were also mentioned as other sexually appealing qualities ( $f = 6$ ). Since participants have visual disability, it seems important to elaborate how they understand such visible

qualities including physical appearance or well-shaped body. As it was mentioned in the sources of sexual knowledge section, one modality that participants used to reach such information was touching. Another way was to ask sighted people to describe the person, as in the case of one participant who had low vision earlier:

When you find a lady, you ask someone who can see to tell how she is, and also since you had eye vision before you need to envision the person in your mind. For instance, just now when you tell me what blue is, I know what this blue is, I can envision, cause I had seen it before. But you cannot explain someone who never had eye vision, what color is. Since I had seen a lady before, I can envision the person in my mind when they describe her. (P6- Male, 39).

Contrary to this, another male participant elaborate how his thoughts on beauty were based on other types of knowledge rather than visual knowledge or visual description from sighted friends by saying:

Other than these, whether beautiful or ugly, it doesn't matter. Because beauty, ugliness are relative concepts, you know. For example, you do not see but you fancy a person's voice; you cannot tell that she is ugly, but if a friend tells you that the girl with you is very ugly, this does not make any sense to you. He/she can speak of visual ugliness as much as he/she wants. All in all, since I do not care about how this girl looks, beautiful or ugly, by way of asking others about her visage, her bodily and facial features, think as if her visual aspects are closed to me, neutral for me. But, her voice, I don't know, things like her stance against me, her approach to me are more important for me. (P23- Male, 28).

For definitions of sexy man and woman, participants gave weight to physical qualities more, compared to qualities that they indicated in terms of sexual attraction. Although voice, speech, personal characteristics were mentioned with regard to personal definitions of man and woman, most of the participants prioritized physical qualities including body size and shape, being tall or short, size of breasts, physical appearance, sexy clothing and being hairy or not.

***Current sexual life.*** In terms of current sexual life, 6 out of 18 participants indicated that they currently have sexual partners. It appears important to state that 5 of those participants were married (2 female, 3 male). Among single participants (n = 13), only one male participant indicated that he had a sexual partner. On the other hand, the rest of the participants did not have any sexual partner and they all indicated that they were currently not in a romantic relationship either.

Among participants who had a sexual partner, two stated that they were currently satisfied with their sexual life; however, the rest of them (n = 3) expressed that they did not feel satisfied with regard to current sexual life due to several reasons. Underlying reasons of the unsatisfaction included limited opportunities for satisfying sexual life due to childcare, and relatives who are currently staying with participants to help the childcare (n = 2), and lack of good communication with the partner regarding sexual needs and desires. One indicated how sexual life after childbirth seems to change negatively as:

After the baby was born, we did not have a sexual life for almost one, one and a half, two months. Because we were caring for the baby, you know the postpartum psychosis, and well we both are visually impaired. There are people in the house who would help take care of the baby. We hardly could get together. Another one should also attend to the baby other than the care taker. Because of all these, we had to have a long break to this period. But something happened, I mean, time to time as a biological need. I felt it but other than this I ended up in a situation thinking it is no big deal if it does not happen. But still I naturally had considerable difficulty, biologically. (P25- Male, 29).

Besides, another participant emphasized the lack of passion and good communication with her husband as:

I can say, well you know, I do not have intensive desire but it is not only about my husband, you know, in general my body does not long for making love that much... It is that my partner comes early and I feel uneasy about the seminal fluid. For example, my biggest problem is this, but of course I can't tell him because it would hurt his feelings... It is that the ones I had relations before, my partners, were my lovers. Naturally there was that intense feeling of love, that intensive desire to experience the sharing. The exaltation was already there. Naturally, there was no need for anything extra. You know, for example, I used lingerie, with lacework and everything, you know, alluring underwear, for only one person. Actually I cannot do this with my husband for instance. I did not do it even when we were lovers. I guess that that thing called passion is important for me. (P2-Female, 36).

On the other hand, a male participant who was satisfied with his current sexual life put an emphasis on communication between partners in terms of needs, and desires as:

Actually we could talk to each other openly, my husband and I. For example, I know this: I hear that women keep hidden, even from their husbands, their premenstrual periods, experiencing it as if it is a secret, and that they do not utter their problems, or they keep secret whether they have orgasm or not. I don't know if these are exactly true; I get these only from

what I read and what I hear. But, now we are open to each other in every matter. We talk to each other. We motivate each other. We encourage each other. Up to now, we can talk about his needs, my needs. In that sense it is very good for me. I do not feel any problems. (P24- Male, 27).

Half of the participants who did not have a current sexual partner evaluated their sexual life as below average or not very satisfying. There were participants who also found their current sexual life average ( $n = 3$ ) and ones who had concerns related to sexual intercourse before marriage due to their values ( $n = 3$ ). Those participants did not provide a detailed evaluation regarding their sexual life. Especially female participants in this category, mostly stated that they were not searching for a sexual partner; rather, they would like to develop romantic and meaningful relationships.

When it comes to individual sexual activity, once more, a number of females ( $n = 3$ ) stated that they did not masturbate; on the other hand, males usually indicated that they did continue individual sexual activity. The ones who currently had individual sexual activity did not usually use any additional material while they were masturbating. Rather, they did it with the help of the different fantasies including strong man-submissive woman, sexual acts based on foot fetishism or simply sexual intercourse. On the other hand, only a few participants indicated that they took advantage of erotic videos and porn videos in the course of masturbation.

***Finding partners: How participants meet partners without eye contact?***

Regarding how participants meet with their partners whom they were/are having sexual activity to a some extent, results revealed that participants met with their partners in places including school ( $f = 10$ ), via friends ( $f = 5$ ), cafes and social places ( $f = 6$ ) internet ( $f = 2$ ), association for blinds ( $f = 3$ ), while walking ( $f = 2$ ), and in rehabilitation center ( $f = 1$ ). Considering those places, participants usually found partners in places where they could form direct or face-to-face relationships with their possible partners such as schools and cafes. One participant stated this as “Ehm... you know, always, I mean, it happened, you see, it happened always in school. Cause our social environment is the school, you know, university or the high school.” (P24- Male, 27).

Regarding school as a place to meet possible partners, it should be noted that most of the participants found their first partners at schools for students with visual disabilities. Moreover, university and highschools which offers inclusive education also became places for meeting. Furthermore, friends became another mean to meet partners as in the case of one female participant “I had a darling women friend, with whom my wife has also been also friends. They had met earlier on. My friend called me and wanted to meet and I went there. So we met.” (P2- Female, 36).

Another place for meeting was emerged as places related to visual disability including associations for visual disability and rehabilitation centers. An interesting result was that a few participants (males) met with their partners while they were walking or while they were in cafes. In such cases, a female usually approaches to the person with visual disability in order to help for walking or to start a conversation in café. Moreover, they initiated a sexual relationship due to the fact that they were curious about having a sexual intercourse experience with a person with visual disability. In this regard, one participant mentioned as:

I was sitting at a coffee shop. A lady came near me and asked to join me. I said, sure, take a seat. We talked and talked. She said let’s stroll around. Well, I did, we strolled around. We had some intimacy and we slept, she and I. I did a very stupid thing, I told about it in a friendly gathering. Later on, two or three blinds had gone to that coffee shop and sat waiting (laughter). (P6- Male, 39).

Another male participant shared a similar experience by saying:

I had met one in a café. Another one when I was crossing the street. She wanted to help. I said to her that I knew that place but that she could help if she wanted, just not to be rude. She had found me very interesting. After we crossed she asked me what I would do. I said I would go to the café. She asked to join me. I said she might, that in the end, I have good communication with people, and I definitely do not have anything to be shy about or refrain from.... In the café while having a chat, while we were talking, you know, one subject follows another, about many different things you talk, and after some time, you cannot help but, come to the issue of sexuality. You know, as she asks about extent of my sexual relations and my sexual life, and similarly I ask about her; I asked her when she asked me that question, as I was saying, like, “how are YOU, what are YOU doing, what is YOUR condition? (P23- Male, 28).

Lastly, participants who defined their sexual orientation lesbian and gay stated that they found some of their partners through using different websites via the Internet.

***Partners with or without disabilities.*** In terms of having partner with or without disabilities, 12 of the participants stated that they had partners from both group, and 3 of them had partners with disabilities. The remaining 3 participants were exempted from this part due to lack of sexual activity (including kissing, touching etc.). When participants were asked to briefly describe their experience with partners with/without disabilities, the majority of them revealed that there was no difference in their experiences with partners with/without disabilities. In this context, one participant said “I think it doesn’t make any difference when one can see and the other does not. But my blind friend was a sexually experienced girl and she did not have taboos regarding sexuality.” (P13- Male, 27). Furthermore, participants in this category mentioned some differences in sexual experiences with people with/without disabilities; however, they strongly emphasized that the difference was not due to disability but lack of knowledge or experience in terms of sexuality.

On the other hand, a few participants (n = 2) expressed that sighted partners seemed to them better in terms of leading during sexual activities. One participant stated that:

Well the others who can see are naturally better, you know, since they do not know visual disability you have something totally as you lead them but the others lead you... You know because they know, also, you know it is more attractive, you know, cause he/she looks at your body (P6- Male, 39).

Contrary to this, three participants indicated that they prefer to be with partners with visual disability since they feel more comfortable and equal with those persons in sexual relationship. One participant described her feelings as:

For me, it is better to be someone who is blind... You are at the same page... He/she gets to know you also with hands and body touching. You know him/her too. But one that can see, more or less, or let’s say completely, that is the thing, sees every inch of your body. I mean, not only by touching, but also visually, you see, turns on and off the lights whenever he/she wants. He/she does this or that; can observe us from the mirror. At that point you feel, I mean I feel. Incomplete is not the right word but there were times I find this troubling. That’s why it is more appropriate, better to be with a blind (Laughs)... I mean, when he/she brings the visual data to

the forefront, when he/she tries to do so, sometimes, he/she changes with the mood. Then, I can find him/her bothersome. (P2- Female, 36).

On the other hand, only one participant mentioned that he would feel confident due to being selected by a person without disability by saying:

Of course being admired by someone who does not have impairment may boost my self-confidence more. Just to sleep with. Until now, I have never thought I should only be with someone without impairment, but if I want to marry, I would like to marry with someone without impairment. (P9- Male, 30).

**Sexual abuse.** In terms of sexual abuse and harassment, two female participant had experiences of attempts to sexual abuse and one female participant had an experience of sexual abuse. Regarding sexual abuse attempts, one female participant expressed that the attempt was actualized by outsiders in the name of helping a person with visual disability to walk easily as:

When I was 20-21 years old I experienced something like that... I entered the street the way I did not know, two young men said that they would help me. I fell into one of them's arm, we walked a while together it was 4 or 5 in the afternoon when it become darker. We walked a while, I guessed we should reach the ring that I get on but they said we hadn't reached yet. then I realized that cars passed towards to us instead of passing the other way and we get away from the metro station..I realized that and jumped to the road and passed pavement across, they came after me, a couple who knew me from the bus came an help me to the bus...I probably had trouble with those two men if I did not realize.. (P2- Female, 36).

Although there is a widespread thought that women with visual disabilities may be at risk more than women without disabilities, participants had different views with regard to this argument. One female participant who was exposed to sexual abuse emphasized that females with visual disabilities may be at risk less than others since people may pity them regarding their disabilities. Apart from this, another female participant viewed the risk of sexual abuse as same between women with and without visual disabilities. However, there were also a few women who were not sexually abused; still, they had concerns and feelings of insecurity regarding such an attempt due to lack of vision. One participant explained this insecurity as:

I was not exposed to sexual abuse, but I am really scared in this country. Sometimes, there might be concerts and at those times I was usually concerned about how to get back from that place alone... If I go back in taxi alone, I usually ask the driver about where we are because I am

panicked. I was isolated from the environment and not know where the taxi is going exactly. (P5- Female, 23).

Apart from sexual abuse and harassment, almost all of the participants regardless of gender stated that they felt uncomfortable due to uninvited touch from others especially others who touched to help them without asking. In this context, some indicated that those touchings might have corrupt intent. Moreover, such behaviors from others, regardless of good or bad intention, bothered participants since such people did not obtain a permission to help the participants.

**4.2.3 Sexuality and visual disability: Different forms of discrimination participants faced with.** Considering sexuality and visual disability, results demonstrated that participants faced with different forms of discrimination including prejudices, humiliation, and desexualization. As it can be understood from the quotations stated below that, it is difficult to make clear-cut distinctions among these different types of discriminations in specified experiences since they seem to be intertwined. In other words, almost all of the examples seem to have an underlying premise that people with visual disability may not have same sexual desires or sexual experiences as people without disabilities do have. This main underlying premise shows that different types of discriminations mainly based on sexual myths including “people with disabilities are asexual”, “people with disabilities do not have sexual desire”, and “people with disabilities do not have a sexual life or “their sexual life is not same with people without disabilities”.

***Difficulties in finding partners.*** Results showed that 13 out of 18 participants had or currently having difficulties in finding partners. Most of them ( $n = 8$ ) thought that they face with barriers in finding partners with regard to their visual disability and especially negative perception of possible partners about disability. As well as visual disability, a number of participants mentioned other underlying reasons which may explain such difficulties. These reasons include lack of courage, and concerns regarding chastity, marriage, and STDs.

*Visual disability as a perceived obstacle:* “After they learned our disability, their perspectives have been changing”. An important number of participants had experiences of being rejected by the possible partners due to their visual disabilities or even if they did not have such a negative experience, they had



concerns about being rejected especially when they would like to declare their love with a sighted person without any other disabilities. One participant emphasized how perception of possible partners about visual disability became a barrier for him as:

Yes, there is one now, I mean, since I have a girlfriend I have one (means sexual life). But when I don't have one, of course, it is not easy. Still it is not an easy thing, specially, you know, at this stage still your disability has an impact. I mean, say, she sees you somewhere; on internet, ok, you are tall, you are handsome, and whatnot; but later: "oh, you don't see, huh?" Yep. That's why, you know, the cane, figuring out you don't see, or even if there is the love dimension, results in a prejudice and actually withdrawal, withdrawal on the side of both the girl and the man... It is like that, you know, still if there is not love in the country, there is too little room for having sexual relations. You date, you spend a certain time with, a week or two, a day or two, whatever, then you know these things either happen or not. Therefore, you know, since she does not ever take the chance of love or being lovers, the sexuality dimension never takes place. (P1- Male, 29).

As one can infer from the quotation above, another important concern among participants is to develop romantic relationships because they mostly stated that having sexual relationship cannot be possible without a romantic relationship. Moreover, it is stated that visual disability becomes a problem on the part of the partner in most cases if they especially fall in love with a sighted person. One participant mentioned his concerns regarding declaring his love to a sighted person as:

On top of it, of course, if we are interested in someone healthy, you know someone without any disability, after all we never mention it because we have disabilities. Unfortunately, I had many loves for I would open myself if I had not have disability. Unfortunately our disability can arrest us in these matters of course... If I had no disability, as a matter of fact I would go and directly talk... Well it is the fear of being rejected; instead of her rejecting and walking away from me, I want her to be with me. Cause, I think if I open up, she would completely withdraw. In the end, I think there is no possibility for her to accept me. You can think that she has a lot of healthy people around and it is not a person such as me she would choose. Other than that, I don't know, I refrain from opening up thinking that what if she reacts strongly and if I so, that I am not ready for this. (P9- Male, 30).

Likewise, some emphasized concerns about having visual disability and prejudices of others as:

To begin with, visual disability is a major disadvantage in this matter. You shall first persuade those (means sighted partners) to date with you, and

then you shall persuade them to make love with you. It requires great effort. I mean, first you make her accept you, she will know you, espouse you, then she will be with you... The first thing in their mind, well, is “with a person with visual disability, why?” Like that, probably, you know, such feelings emerge, they do, well, they do not want to get close, they close all communications. There is hardship coming from these situations. For instance, they have also peer pressure. Say you have a boyfriend and he is visually disabled. Like “hey are you dating with a visually disabled? Why sister, aren’t there anybody else left?” Cause I experienced these things; one of my girlfriends left me because I was visually disabled. (P25- Male, 29).

Another participant shared her experience in which she tried to develop a relationship via the Internet and how she was rejected after she disclosed her disability as:

For example, someone with whom you correspond on the internet very well at the beginning, say, after you say you don’t have sight, suddenly changes his/her attitudes, things turn to be “ok we can still write as friends”, that is a very common situation. You know, well, you know, I quit writing on such sites, because it hurts you, you know, I mean, it is also annoying to see that only for that reason you are rejected, parted away, put a distance with. (P5- Female, 23).

Participants, who thought that perception of others on visual disability can become a barrier for them, also indicated how people perceive them as only being made up of visual disability. In other words, they felt like possible partners firstly focused on the disability and cannot see any other personal qualities of the person. One participant who did not have a partner and associated this with prejudices of others regarding his/her disability as:

I have the opinion that, even if someone is interested in me, he/she stays away because of my disability... You know, from some point of view, it is being perceived as a deficiency. You know, in this world even if you are a distinguished professor of rocket science, at some level, always there is a prejudice, especially in our society. Whatever you may have achieved, eventually, your intelligence, your whatnot or your beauty is always at the background, cause at the foreground, there is a very marked thing: disability. (P16- Female, 24).

Likewise, another participant emphasized how possible partners may see a person with visual disability as a burden and do not want to develop a relationship as:

That’s a reality. I mean, you don’t have sight. Say, you will go the movie theater. Your partner thinks like that: “oops! We are going to a picture; I will tell him all the movie.” Walking on the street, either she or I have to take the other’s arm. (She thinks) even if we come close, I make sound, he

will not be able to see me. Or, women have that feeling which requires being often complimented about their beauty. You are so beautiful my dear... First of all, one way or another, you have to prove yourself, either through an intellectual parlance or by way of being comfortable with the girls. Yeah, OK, you are beautiful darling, but I am not interested in this side of you, it does not have any significance for me. What is important for me is your feelings and your physical features when I touch you, I mean, your facial beauty is not important. (P25- Male, 29).

Apart from visual disability, lack of courage was also specified another obstacle in finding partners. Regarding this concern, one participant said:

Lack of courage but not about sexuality, lack of courage for expression. For expressing yourself. For example, when you sit with someone, of course you don't say immediately but. Later on, in saying "I like this, would you please let me...", fear of losing that person or how she will react or the fear that she could tell someone, if she would tell about this to someone, becomes an issue. (P3- Male, 27).

Lastly, concern about chastity was shown another difficulty in this context and one female participant stated:

Regarding the relationship, now for example, when you date with someone, in the end I am a virgin lady, I am afraid of this. I mean, because I am afraid to lose my virginity, I do not come too close with. In the end, if I lose it, on top of all, you know, when the one you will marry faces you, you can explain if necessary but, you know, you have hard time, maybe, maybe you fear that he won't accept. Since I am living with this fear I want to give myself completely to a certain person. That's why I don't want to have that much of a relation with anyone. I don't support having relations anyway. (P22- Female, 25).

***Desexualization: "They do not consider that we can also have sexual desires"***. Regarding sexual experiences, another common topic from the perspective of participants was related to sexual myths. The majority of the participants mentioned how others perceive their sexuality in a discriminatory way. Firstly, six participants (1 female, 5 male) indicated that they had experiences of desexualization which they tentatively describe as not being perceived as sexual beings by others ( $f = 8, n = 7$ ). Especially male participants stated that their female friends usually do not perceive them as having sexual needs and desires. One participant simply summarized this condition as:

With us, for instance with me, I have always felt that girls are more relaxed. I mean, she would have acted in certain ways with taking hardly into consideration that I might have sexual desires for her, or she would easily get into buddy talk with me, for instance, maybe she is not a person who could do the same with some other men. Then, why, you know, am I

different from the others? I am also a man, you should avoid me too (laughs) (P24- Male, 27).

Similar to this, other participants who mentioned experiences of desexualization mainly thought that they were not perceived as equal as males without disabilities. In other words, as one participant mentioned some females who do not touch males as a rule can easily touch a male with visual disability. Again, one male shared his opinions about how people see sexuality of people with visual disability based on his experiences of desexualization as:

A man without a sight is a man the society does not see as a sexual threat. They do not pick up any sexual threat from a man without a sight. Again, they also do not see a man without sight as something that could be sexually inclined towards. That's why they look at that man as if he does not have any sexual inclination, or could be sexually affected, as if he does not have anything, like an angel... For them sexuality is evil but you are away from all these, different from all these, you are out of this. (P13- Male, 27).

Additionally, one female participant emphasized how society perceives them as nonsexual beings who cannot have menstruation or give birth to child based on her experiences as:

It is like that, you know, they look at me as if I cannot give birth for instance, or as if, well, I cannot be with someone, you know, also would not be with someone. They do sometimes, you know... It is something like that, for example, let me tell you the smallest incident. We are at the school, the high school, we are sitting with friends, so and so. A girl said that she had a bellyache, that she will be sick and she added that it had been always the same, that it had been aching a lot, so and so... And I said that mine had not been so painful. She said to me: "Oh! Do you menstruate too? (laughs)" (P18- Female, 20).

Likewise, one participant indicated how he was behaved different than his peers during school activities by saying:

It's like that, for example, when I was at the junior high, the girls and boys used to change outfits for the physical education class, separately. I could be there when the girls were changing, for example, because I was disabled. This is not a right thing, for example. But, because I do not see, they acted comfortably. Other than this, that, also that girl's behavior, I thought, maybe she pitied me, maybe, cause I don't have sight. Other than this, you know she might have been thinking that she should show something, like that, I don't know, I can't think of any other reasons... Then, I was 13-14 years old, that's 21-22 years ago. (P21- Male, 36).

In another case, the participant had experience of desexualization while he

was with his girlfriend and he explained the situation as:

We were eating there, at the garden table (with his girlfriend). She said, “look, the ezme is not hot”, she put some into my mouth with a spoon; it was hot, it burnt my mouth. Also a lady there said to my friend, “you love your brother, don’t you?” My girlfriend said that I was her boyfriend, not her brother. The lady said “Oh! Your boyfriend.” My girlfriend said, “Why? Couldn’t it be?” She replied “No, I am looking at you and looking at him, that” Well, you know we are used to such things but my girlfriend was not. I was trying to cool her down, in vain. Later, we had to deal with the catfight (laughs). We often experience similar situations. (P6-Male, 39).

Additionally, one participant expressed how people around him approached negatively when he said that he fell in love with a sighted girl by saying “There were people even said to me that how can you be interested in she/he; I mean, how can you be interested in her/him because you cannot see.” (P9-Male, 30).

***Disquieting questions regarding sexuality and the ability to have sexual intercourse.*** Not only during interviews, but also before and after the interviews, participants strongly emphasized that people asked disquieting questions regarding their personal abilities to do something including eating and studying. Similarly, results showed that the majority of the participants had been asked by others regarding their ability to have sexual intercourse, and other questions related to their sexuality and visual disability (n = 9). The most prominent question in this category that participants feel uncomfortable was about how they experience sexual intercourse. In this context, one participant said:

Some said that. “When you have sex, how will you hit the target?” I would say, “how do you do it when drinking soup?”, “Do you look when you have intercourse; do you look from below?”, I would say things like that. You know there were those stupid questions like how we would find the spot... How will you find the hole? Such a stupid question, as if life is only about that hole. (P3- Male, 27).

On the other hand, there were examples regarding the thoughts of people with disabilities do not have a sexual life as:

Yes, I mean, “what are you going to do with it?” For example, I, ehm, had sexual relation. They say “are you also having sexual relations? I say “Why not? Am I not a man, too?” “How do you experience it”, they ask. Because people do a lot of things using their eye sight, they believe that those without sight cannot do certain things. (P6- Male, 39).

Such questions seemed to be mainly asked to male participants; however, female participants were also object of such questions. In this context, a female

participant received such question from a person whom she did not know and described the situation as “He/she paused and unexpectedly said “well then, can you have sexual relations?” I froze. I said “what are you saying? What a stupid thing to say!” Then he/she said “yeah, you can’t, right?” (P5- Female, 23). Taken collectively, it is important to consider that people who asked such questions seem to not respecting to individual boundaries of people with visual disabilities from the perspective of the participants. Therefore, they felt embarrassed when such questions directed to them as in the case of one female participant:

When I was staying at a hospital, one woman asked me a question. “You” she said, “how do you be together with your husband?” I am asked this question... Well, I, I had to, well do like this (covers her face, shy) ... I had to cover my face. Actually, these things are very embarrassing.... (P20- Female, 42).

Besides, a few participants ( $n = 3$ ) indicated that people around them usually make jokes about visual disability and sexuality through discriminatory idioms and anectodes (fikralar). One male participant explained such a situation as:

They say, for example, the blind does,..., whatever he could hold... Hence, blinds are mentioned in jokes, say Namık Kemal Jokes and others, malevolently in this sense. Generally the ones who are actually wronged are the blinds...Actually, I did not like such jokes about blindness and sexuality ever. Still today there are colleagues making such jokes about me. (P21- Male, 36).

**4.2.4 Summary of the results regarding sexual experiences.** Results regarding sexual experiences revealed important information for a wide range of comprehensive topics. In terms of first recollections, findings suggested that the content mainly composed of tactual experiences ( $n = 8$ ) and observations ( $n = 3$ ) as well as dreams ( $n = 2$ ) that came after tactual experiences. Feelings related to first recollections mainly consisted of positive feelings including joy ( $f = 3$ ), curiosity ( $f = 3$ ), enjoyment ( $f = 3$ ), love ( $f = 2$ ), excitement ( $f = 1$ ), happiness ( $f = 1$ ), ambition ( $f = 1$ ) and feeling protected ( $f = 1$ ). Moreover, results suggested that particularly participants who communicated with family members in the course of these specified first recollections had changed their perception or formed a perception regarding sexuality compared to participants who did not have such communication. Results regarding puberty indicated that changes in this period brought both positive and negative feelings to the participants. The frequency of wet dreams and masturbation were more in male participants than female

participants, whereas concerns related to menstruation were more dominant in female participants. Moreover, results also indicated that receiving support in terms of hairing, personal hygiene, the usage of panty liners and menstruation was common especially in female participants. With regard to sexual life in adulthood, results revealed that a number of participants ( $n = 6$ ) did not have sexual intercourse experience and knowledge, lack of pleasure, shame, excitement, shyness and fear were specified as thoughts or feelings related to first sexual intercourse. Participants described tone of voice, smell, speech/diction and skin as most sexually appealing characteristics for them; moreover, being tall, having a well-shaped body, being curvy and muscular were also specified among sexually appealing characteristics. In terms of current sexual life, results suggested that only 6 participants (5 married, 1 single) had sexual partners currently and all of the sexual partners, except one, had also visual disability. Participants who had different kind of sexual experiences with both partners with or without disabilities indicated that there was no difference between a person with disability and a person without disability in terms of sexuality. Moreover, there were participants who did not satisfy with their current sexual life due to childcare, presence of relatives for childcare and lack of good communication with sexual partner. Considering finding and meeting partners, results suggested that participants met possible partner in school, via friends, cafes and social places, the Internet, association for blinds, while walking and in rehabilitation center. Additionally, results showed that participants mostly faced with different kinds of discrimination in terms of sexual relationships and finding partners including discrimination based on visual disability, desexualization and receiving disquieting questions regarding visual disability and sexuality.

### **4.3 Views on Sexuality Education**

In order to learn views on sexuality education, participants were asked about their previous experiences of sexuality education, views on ideal sexuality education for people with visual disability, and suggestions regarding sexuality education. The analysis of the findings revealed five main categories namely previous sexuality education experience, content of sexuality education,

instructional strategies for sexuality education, delivery of sexuality education, and suggestions regarding sexuality education.

#### **4.3.1 Previous sexuality education experience.**

*Status of having sexuality education.* In terms of previous sexuality education experience, 10 (6 male, 4 female) participants out of 18 expressed that they had some kind of sexuality education experience within school curriculum including health courses and separate sexuality education sessions or within community based seminars related to sexuality. The rest of the participants stated that they had no sexuality education experience in any settings. It is important to note that none of the participants attended to comprehensive sexuality education programs; rather, their experiences were mainly based on gaining knowledge regarding sexuality through courses within school curriculum (health course) or through one or two times sexuality education sessions provided by school counselors or school nurses.

#### *Evaluation of previous sexuality education (school-based sexuality education).*

*Insufficient.* The majority of the participants who had sexuality education experience in schools evaluated the education as insufficient in nearly all cases. First of all, participants frequently emphasized the inadequacy of the content in sexuality education sessions or health education courses. In this context, it was noted that the content was very limited in mentioned experiences since participants did not have the opportunity to take comprehensive and systematic education within school curriculum or any other settings. In all cases, one or two sexuality education sessions were conducted and the content mainly based on changes in puberty including menstruation, hairing and other bodily changes. In this context, one participant stated “In that education, they covered topics such as menstruation and woman reproductive systems. Sexuality education groups came by a few times as far as I remember” (P16- Female, 24). Especially, the ones who obtained knowledge through health education courses highlighted insufficiency of the content in which only adolescence period and related changes were described. Related to this, one participant said “In high school, it was covered in health classes, but it was not an important issue. A teacher, once, covered some topics in



a small, simple health class. However, it was neither adequate nor efficient” (P23-Male, 28). One of the participants who obtained one session sexuality education with guidance counselor stressed the content and inadequacy of it as “Mostly they covered issues like masturbation, ejaculation, and girls’ menstruation periods. And they did not teach anything else. Things like hair growth, how ejaculation works, wet dreams, and alterations in body... They did not cover such topics.” (P3- Male, 27). Regarding the content of the education, it was observed that sexual health, sexual behavior and sexual relationships were not included in the content although human development in terms of physiology and puberty was included in the sessions to some extent. Furthermore, one participant focused on the lack of accurate knowledge in education sessions and its possible effect on false inferences regarding sexuality as:

Less than inadequate because it did not give any information. You are in your adolescence time, its not giving any information leads to misinformation. Since you interpret somethings in your mind, thus a chance of misinformation arises. And perhaps experiencing wrong things. (P3-Male, 27).

Another participant also pointed out the inadequacy and superficiality of the education by emphasizing the timing of the education and developmental needs by saying:

In middle school, there was something like a seminar. I mean, it may be adequate for that age, since topics such as woman menstruation was covered, honestly I don’t remember. Because, at that time kids 5-6 years older than us told us lots of things, so we found what they teach in seminar of little importance and superficial. (P 13- Male, 27).

When the delivery of the previous sexuality education experiences is considered, it was observed that sessions mainly provided by school counselors, experts (doctors or related health personnel) and school nurses. Moreover, girls and boys took education separately in most of the cases. For example, one participant emphasized this segregated education and the shallow content provided in the seminar as a concern:

They separated girls and boys in the seminar, in our time; however, they should have put boys and girls all together. I mean, what are they afraid! Maybe later in primary school, once they took boys and girls together but it was really superficial. They did it since it was on the curriculum, nothing else. (P4- Female, 31).

Although it was not mentioned in all cases, one participant talked about an experience of being teased by boys subsequent to separate sexuality education session as “They gave us hygienic pads at the end of the seminar, plastic bags made noise. Boys made fun of us ‘haha they gave you pads, ain’t they’ the boys in the class.” (P16-Female, 24).

Accessibility and the lack of materials were other concerns reported by the participants. Majority of the participants stated that supplementary educational materials were not used during sexuality education sessions in order to make the education more concrete. Therefore, information provided throughout these sessions were evaluated as abstract and superficial as one participant stated:

everything is so theoretical, nothing practical in particular... Erm.. just abstract knowledge, I mean... I was in a 24 student class, 13 girls and 14 boys. The woman, teacher, proceeds “girls have their breasts grow in puberty, hair grows in pubics. It is all abstract. Oh yeah, girls have their tits grow, very nice (smiles). That is what I learnt. (P1- Male, 29).

In this sense, making reasonable accommodations according to the needs of participants with visual disability in sexuality education sessions is another matter in terms of the accessibility of the education. Furthermore, sexuality education sessions in alleged inclusive educational settings were not accommodated to the needs of persons with disabilities. In some cases, the content of the education was inaccessible for students with visual disability. For example, one participant said “...erm..they showed pictures over the computer, but we were visually impaired so we were not able to see them, just listened to what our friends told us.” (P12- Female, 25). In terms of materials used in education, embossed print materials were provided to some participants during education; however, there were problems in terms of accessibility of the materials in other cases such as providing inaccessible booklets instead of Braille printed booklets. One stated that booklets and the instructional method were not accessible as:

My mother or a friend read something like that. In middle school mom read it to me, in university my friends did. You may find those metarials online, I did not do the research. But no way, accessibility... The guy drew in on the blackboard, you don’t know what is gong on. (P4- Female, 31).

Likewise, another participant stressed that additional materials were not utilized during sessions; rather, instruction was mainly based on lecturing as:

I did not care if they used visual material or powerpoint slides at that time, but they were recounting. It was in words however no materials. I would prefer use of mannequins representing male and female body, maybe an illustration of coitus with those mannequins, even an handicapped student, they did not have those back then, should see what an hygienic pad is like, you will use this when you have your period. I will not deem the knowledge of 46 chromosomes, the knowledge passed on quickly, as accessible. They were not quite accessible as a matter of fact. (P16-Female, 24).

Contrary to the aforementioned evaluations, one participant said that though it was not completely sufficient, the education was effective in listening to the unspoken aspect of development as:

At first, I was like why teachers are telling us such things. How come they can talk in these issues, I was objecting. But at times, when you think of, there are families, they don't give any information on those issues. My grandmother never told my mother about the menstruation. She never knew and was scared when it happened. But my mother talked to me on those issues because of what she experienced. In that perspective, I think it is good to have sexuality education seminars. (P12-Female, 25).

In this context, it appears that she is the only participant whose attitude toward sexuality education had changed following the session. Nevertheless, the rest of the participants, who took sexuality education and evaluated it as insufficient, did not state such a change neither in knowledge nor in attitude.

*Sufficient.* Only one participant, who had school based sexuality education provided by the school nurses twice, indicated that the education was, to a great extent, sufficient in terms of the content and accessibility. Following is the detailed description and evaluation of the participant:

In school for blinds,, they gave us sexuality education seminar. Nurses were there. They recounted there. They gathered boys and girls separately. They told boys about their situation, what happens with puberty. Of course, we knew since we were experiencing. Apart from that, sexual problems, diseases, for example... Boys may have problems related to male genital organ, they were talking about. What should we wear, as far as I can remember, they talked about it, too. Testicles, how much they produce what, and then in order to kepp them healthy one should wear loose staff instead of tight clothes. When it came to the girls, they talked about the alterations girls experience, the bleeding. Things like that, physical changes. They did it in words, therefore it was accessible. Content was good, they introduces us our bodies. For instance, what happens in male body biologically, these lead to those health problems. These will happen to you. You should wear those, in need apply to those places. I think it was great. What happens in woman, they told us in words. They gave girls

hygienic pads, and to us booklets. In order to give to our parents. (P24-Male, 27).

It was noted that only a few participants elaborated their educational experiences deeper since most of them felt that they did not obtain accurate and reliable information through these experiences. Moreover, it seems important to emphasize that participants who evaluated educational experiences in detail were the ones who received one or two-times sexuality education sessions. The ones who received sexuality information through only health courses did not provide detailed evaluations.

*Evaluation of previous sexuality education (community-based sexuality education).* In addition to school-based sexuality education, there was one participant who gained sexual knowledge within a community based meeting although meeting was not entirely organized in order to provide sexual knowledge. In this context, the participant described how s/he obtained knowledge on sexually transmitted diseases (STDs) within a multicultural meeting designed to eliminate prejudices toward minority groups as:

...in 2012, there was an activity called living library. The aim was that learning the sources of prejudices and eliminating prejudices with different questions by meeting people whom subjected to prejudices and marginalized by the society. You met in a café, for instance, there was an person with headscarf and visual disability. There was a Kurdish friend. Erm, there was a homosexual friend. Erm, there was a person with AIDS. I mean, people asked questions related to your daily life that they wonder in order to eliminate prejudices. It was that kind of activity. Of course, you were working on your prejudices too, you were asking questions. In this regard, a significant information exchange was actualized with friends with AIDS ( P1- Male, 29).

It should be noted that the participant expressed positive feelings and the impact of the meeting on challenging attitudes toward people with STDs based on this experience.

**4.3.2 Content of sexuality education.** Participants were asked about which topics should be included in the content of sexuality education, and main categories emerged namely; human development, sexual health, sexual behavior, sexual relationships, and individual needs. Furthermore, they also reflected different opinions with regard to whether sexuality of the disabled should be a separate topic within sexuality education or not.

**Human development.** In terms of human development, the majority of the participants (n = 14) stated that sexual anatomy and physiology including different sexes, body types, and individual differences in sexual organs should be included in sexuality education. Related to this, participants shared their concerns about the lack of inaccessible material depicting sexual anatomy and the hegemony of visual information on these topics. Hence, they stated the need of learning those topics through sexuality education within an accessible environment for people with visual disability. Moreover, it is indicated that people with visual disabilities may face with barriers in learning body types due to cultural views on touching and the lack of accessible materials; therefore, body types such as thin and fat body types should be introduced in the content. Another concern is to learn the variation across sexual organs among different individuals such as the size of the penis or personal differences in vagina.

In addition to sexual anatomy, puberty and adolescence were other topics that participants pointed out as important in terms of understanding human development. Physical changes in puberty including hairing, personal hygiene in this period and emotional reactions toward physical changes were evaluated as essential in the education.

Lastly, a few participants (n = 3) emphasized the topic of sexual orientation in order to eliminate homophobic views and increase awareness regarding different sexual orientations in the education. One participant stated such a need as “everybody thinks that it is a taboo but I would like that children should know sexual orientation and gender in their early years... What is man, what is woman, what is homosexual?...” (P10- Male, 27).

**Sexual health.** Considering sexual health, contraception, pregnancy, personal hygiene, STDs and ways of prevention, usage of condoms and pantyliners, sexual abuse, assault, violence and harassment were introduced as important topics in the education. Especially, the usage of condoms and panty liners was seen as essential in case of visual disability since the usage of these objects has not been explained in an accessible manner. One stated that “If there is a need, it can be done through hands on training. For example, especially I think

that the usage of hygienic pads should be taught to girls through hands one training” (P24- Male, 27).

Self-protection in the sense of protecting oneself from sexual assault or harassment was also mentioned as an important aspect of the education. One participant expressed such a need as:

I think that, in sexuality education, firstly there should be information on protection, I mean, how an individual can protect himself/herself in case of sexual abuse or rape. There will be such an education for women absolutely. In the end, you cannot know what to do in the moment of sexual abuse, you can be scared and anxious and cannot think about the healthy approach in different situations. I think that information on this topic should be provided primarily” (P18- Female, 20).

**Sexual behavior.** Sexual intercourse and masturbation were widely mentioned topics that should be included in the content of sexuality education. Some participants stated that there is a need of learning various aspects of masturbation since there is a commonly held false belief among people that masturbation could be dangerous for health. Furthermore, it is indicated that sexual intercourse is something that should be introduced by using an accessible instructional strategy to overcome fears related to first sexual intercourse, and eliminate misconceptions about it. Moreover, sexual satisfaction, sexual dysfunction, sexual intercourse positions, and types of sexual toys were specified as other important topics that should be explained in the education sessions.

**Sexual relationships.** A number of participants (n = 3) also focused on the romantic aspects of sexual relationships and they stated different suggestions in this sense. Firstly, many indicated that respect, love and equality as well as reciprocity in sexual relationships are of utmost importance for both partners; therefore, these topics should be included in the content of sexuality education. In this regard, one stated that reciprocity of sexual relationships and pleasure should be mentioned in the content as

the fact that anything can be satisfactory when there is a reciprocal desire, I mean, either man or woman should get satisfaction so that they give you satisfaction too because it is not something that one sided, you can only satisfy yourself psychologically in this way” (P6- Male, 39).

Likewise, a few number of participants stated that positive aspects such as pleasure regarding sexuality should be introduced in the education. Equality and respect within sexual relationships was emphasized as:

... and the need that partners should be equal in the course of sexuality. Of course, one may be dominant in different intercourse positions, but, everything should be done with the consent of the partner. I mean no one could say that I am gonna impose you something and one should be respectful to the other. Such things may be included. (P5- Female, 23).

Last but not least, some stated that people may have anxiety regarding developing and maintaining such relationships and they need knowledge in order to decrease their anxiety levels.

***Individual needs.*** A few number of participants (n = 2) mentioned personal skills as important in developing and maintaining romantic and sexual relationships; hence, they suggested that personal skills based on individual needs should be introduced in the content. One participant indicated that dating and initial phase of relationships may be included in the content by saying “Well, before the communication process with another person, I mean, acquaintance and dating processes should be included” (P9- Male, 30).

***Sexuality of people with disabilities as a separate topic.***

*There should not be a separate topic.* Participants were asked whether there should be a separate topic about sexuality of people with disabilities within sexuality education and 13 participants stated that there should not be a separate part regarding sexuality of people with disabilities in such an education. Moreover, participants expressed why there is no need in this context with several reasons. Firstly, the majority of them remarked that there is no difference between people with or without disabilities in terms of sexuality. In this regard, majority of the participants clarified that the disability itself is not related to how one person express or experience sexuality. For example, one participant said

...I think there is no need (indicating separate topic). I do not know, I mean, we are living the same thing all in all and it is nothing to do with disability. It is not something you experienced through seeing, or if we talk about people with hearing disability, you cannot experience sexuality through hearing. The important thing is to know the topic, apparently, I do not hink that there is a need for make it separate (P5- Female, 23).

Likewise, another participant stated that there is no direct relationship between disability and sexuality as "...I think there should not be such topic, I mean, disability is not directly related to sexuality. " (P23- Male, 28).

Additionally, participants mentioned that physiology, feelings, needs, pleasure, and experiences are similar in both people with and without disabilities. In this context, one participant emphasized these topics as:

...I think there is no such need. All in all, your body, desires and emotions... I mean, a blind lady for instance is not different from you. Or I, for instance, my sexual needs is not different from any other person. I mean, there is no difference as an incident, there may be differences in terms of mentality, but the incident is the same. For instance, if there is a difference in sexual organs in blinds and sighted people, there may be such need for this topic; but, the system is the same and there is no need I think. I am not sure it is right or wrong, but it should not be segregated according to my mentality (P23- Male, 28).

Similarly, one participant said "The disabled have the same vagina or penis, and non-disabled have same vagina or penis. It is all the same." (P3-Male, 27) by focusing on the sameness of the sexual organs or anatomy in general.

Apart from these, a few participants (n = 4) also emphasized how such a separate topic may lead to prejudices and discrimination toward people with disabilities in terms of sexuality since a separate topic may lead people to think that sexuality of people with disabilities is different than others. In this regard, one participant stated:

... All in all, I feel discomfort when people categorize disabled people... I mean that I don't like it when people do that, it is differentiating. Of course, there should be information about disabled people to the individuals; but, it should not be delivered in a discriminatory manner. I mean, there is no difference between the sexuality of disabled people and sighted people, I would rather not prefer the topic of disabled sexuality to illustrate the differences. It is discriminating, it gives out the message of the disabled have a different sexuality and we should not touch it, this is the subtext. (P18- Female, 20)

Similarly, one participant expressed the concern about discrimination in this topic as

...even positive discrimination should not be executed. I do not think that the topic of sexuality of people with disabilities is necessary... I don't see any difference, only difference should be in how you deliver the education, and it should not become a separate topic. (P16- Female, 24).



*There should be a separate topic.* On the other hand, five out of 18 participants stated that there may be a separate topic regarding sexuality of people with disabilities. However, none of the participants said that sexuality of people with visual disability and sexuality of people without disabilities are different. In contrary to this, a few participants emphasized that sexuality of people with mobility impairment differs because of the disability condition. In this regard, one participant stated that:

... Yeah, it could be, because at times I wonder how the sexual life of a person with physical disability is. But, now, sexual life for a person with hearing disability and a person with visual disability looks similar. Like people without disabilities, there are not much difference. Because, most of the moves most of the operations are the same, only they prefer touching more. Thus, normal couples may also prefer touching more, it is more like a preference. But, I think that sexual life of a person with orthopedical disability would be harder. And if both people are orthopedically disabled it is though. May god help them. (P25- Male, 29).

Moreover, two participants stated that there should be such a topic in order to express or show the fact that people with disabilities have also sexual lives and they can make decisions regarding sexuality autonomously. Within this context, on participant said:

It should be here and it must be taught, I mean it should be taught that disabled people have sexual life too. Erm, a disabled person if she/he is the one having strong character, having sexual experiences with that individual does not mean to abuse her/him or a sighted lady should also consider what can be understood as a sexual intent while approaching a sightless man because it should be taught that this person also has sexual emotions and desires. (P13- Male, 27).

Similarly, another participant suggested that such a topic may serve to increase awareness and to block discriminatory questions which are asked to people with disabilities about their sexual lives as:

Of course, there should be. Now we are talking about blindness but there are people with paraplegia. Let me put it this way, men or women whose waist below is not working, how is their sexual life. Neither society knows, nor they, if it is not from birth and happened later in life. If it is from birth, I don't know how anything happens. what kind of a sexual life they should have? What kind of sexual life they sustain? What the deaf and the mute do? There should be a comprehensive education program with all the sub topics. A system should emerge. How sex works with a blind-blind couple or "how is men and women to a blind person" is not the only thing that should be taught, I think normal people should learn, too. It is bad to encounter such questions. How do you do it? It is really offensive and heart

breaking in reality. There is a couple, blind wife and blind husband. How do you do it. Ok, the system, the educational system should be comprehensive to raise self awareness and change the society. (P10- Male, 27).

Lastly, one participant focused on awareness regarding people with disabilities including their sexuality via a course within school curriculum as:

That is to say, I have been advocating to adding the courses such as disability and let's learn about people with disabilities in the curriculum, namely, it has some benefits. One of the benefits is that it provides people to learn about how to support people with disabilities, it is the most important one. The second one even we do not want to accept, each people is a candidate of being a disabled person and when becomes disabled, at least if the person come across something like that they experience something they heard about instead of knowing anything about it. The third one, today's children will become adults tomorrow so when they become managers in the future they will solve problems about people with disabilities easily. That's why if there is such a course, whatever name the people those concerned gives.. in this course disability and sexuality will be held as a topic. It is better to study this topic in that course (P21- Male, 36).

*Goals of sexuality education.* The goals of sexuality education is another topic arised during the interviews although a specific question was not asked to the participants. Participants highlighted that providing necessary, accurate and reliable sexuality information should be the main goal of sexuality education. Similar to this, another aim was specified as awareness raising in terms of various aspects of sexuality including sexism, misconceptions, pornography, and societal prejudices toward sexuality. In this context, many indicated that there are a lot of misconceptions regarding sexuality and these should be eliminated through a qualified education. Apart from misconceptions, decreasing sexist views and the negative effects of pornography were shown as one of the goals and one participant said that:

For example, an awareness education about porn would be given to children. That is to say, what is seen there is a mounting and it should be told that sexual experience has two sides; it should be told so seriously not only to people with vision loss but to everybody. It should be told that it has two sides and it is not like one side is active and the other one is passive or nobody hold a match to score a goal (P13- Male, 27).

**4.3.3 Instructional strategies.** During interviews, participants were also asked about how sexuality education should be delivered to people with visual disability as well as how ideal sexuality education can be organized for people

with visual disability. In this regard, three sub-category has emerged from what participants talked about this topic namely accessibility, type of instruction, and delivery of sexuality education.

***Accessibility.*** All of the participants emphasized accessibility of sexuality education and especially the accessibility of instructional materials used within education program. It was noted that the issue of accessibility was of great importance for all participants and almost all of them shared their views on how sexuality education can be accommodated to the needs of persons with visual disability. In this sub-category, views of participants will be provided thorough separate sub-headings.

***Tactile materials.*** Regarding tactile materials, almost all of the participants emphasized the sense of touching as an important instructional strategy for people with visual disability in terms of teaching sexuality especially sexual anatomy. Furthermore, sculptures, 3D materials and other tactile materials were suggested for sexuality education program developers. In this context, one participant stated the importance of touching and using sculptures as:

We thought like there should be sculptures woman and man. Their sexual organs are examined and recognized from it. For example, I will tell you something like that. We made one of our friends to examine a model of a house. We asked him what is that, namely, what that is. He examined again and again and said I do not know what it is I wonder. That is to say, he permanently lives in it, he knows it, he will tell you if you ask him to tell about it however when you gave it to his hands, he did not know about it. Now, we will move on this direction, he will have theoretical knowledge etc. but it is actually, actually a great problem. It should be told and showed to people with visual disability. (P25- Male, 29).

Another participant stated that 3D materials are of utmost importance in order to comprehend not only anatomical knowledge (sexual organs etc.) but also body types and sexual intercourse positions:

I have thought about a project on this issue in time; demonstrating some positions for people with visual disability with sculptures. In these sculptures vagina and penis would be explicit and clear. The position of legs and bodies should be very clear, and all the positions should be demonstrated on sculptures. Because if it is not three dimensional. That is to say if it is relief figure, it is just a graphic, I guess in this magazine it is like that. Let say, they bloat up aluminum folio or silicon; whatever you do not it would not give the vision of three dimensional one that is to say a person who have no vision from the birth, she cannot understand from

those relief figures as in the case of three dimensional ones. But I believe in that, that is to say for example it should demonstrate those developmental stages such as how we show pictures to a person who have vision we should demonstrate the other one sculptures, to children. Step by step, it comes here and it happens like that, after that it shapes like this etc. we should show like that...you cannot explain it with a picture, namely, relief figure. Ok tell him with a relief figure but after showing the sculpture for example I make you to examine a full-figured woman. Then give the picture by saying you touched it and examined it and it is the picture version of the sculpture. But you asked after giving only the picture, you cannot get any answers and feedback from this person. But if you first make him to examine the sculpture and then show the picture, for example you will even get a drawing from him also by saying draw the full-figured woman. (P13- Male, 27).

In addition to this, one participant also mentioned the role of tactile materials by emphasizing the inadequacy of providing only auditory information by saying:

A woman's or man's talking about himself or herself does not fill any gap. There should certainly be models which demonstrate explicitly how a woman and man or man and man make it together; it is a condition for tactual sensing. (P10- Male, 27).

Similarly, another participant pointed out the role of sculptures and tactile materials on comprehending the real characteristics of sexual organs including shape and size by saying:

There is a school for blinds namely Mithat Enç. It was a building of a physical education institute. Before it became a school for blinds there were sculptures of a naked woman and a naked man in the entrance of the building. For example it is a great. People graduated at those years said that they were comfortable and a man never harasses a woman because he wonders about her, they did not have silly dreams, actually they saw the reality there. (P10- Male, 27).

*Verbal description of visuals.* Apart from tactile materials, two participants pointed out the need for auditory information regarding visuals used in sexuality education sessions. Although tactile materials were mostly preferred by the majority of the participants, verbal description of visuals was also suggested in case of not being able to use tactile materials "If a visual theme is given intensely with a film screening or a slide show; it should be provided a different method for blinds in order them to perceive it. At least description should be made." (P2- Female, 36).

*Videos with audio description.* Similar to verbal description of visuals, in a few participants' view, videos including erotic movies and other educational

videos should be presented with audio description in order to accommodate the content and visuals for people with visual disability. In this context, one participant said:

As a crazy idea, is it possible a porn video with audio description or not. It would be maybe. But maybe it would not give pleasure enough but disabled person or example can turn of the audio description and apply this only with voice and breaths. But he/she will watch the video with audio description (P4- Female, 31).

*Reading materials (Braille, embossed print materials, e-books, reference list).* Apart from tactile materials, participants also indicated the use of accessible reading materials in sexuality education. In this regard, it was stated that these materials might be efficient both during and after the education sessions especially in individual study times. Firstly, majority of the participants asserted that Braille format of the educational materials should be utilized in sessions in order to include people with visual disability. One participant emphasized Braille format materials by saying:

Two types of books with Braille and audio should be prepared and published. Eventually, some of the people who have visual disability do not know Braille alphabet, for those who do not know it should be given as audio, well, maybe he/she hears about from someone, he/she will want to know, in those books it should be told.. For those which are in Braille, for example there are drawings, figures will be drew to carton or books published in braille (P21- Male, 36).

Similar to Braille format, embossed print materials (materials that are made by creating a raised area of a specific image on a special paper for people with visual disability) and accessible e-books were suggested as instructional materials. One participant indicated the need for embossed print materials, audio books and e-books within sexuality education by saying “it would be giving the booklets published about sexuality as audio or written or embossed print format as well as giving e-book” (P4- Female, 31).

Lastly, two participants pointed out the need for an accessible reference list in order to acquire further sexuality information through different accessible sources. One said “information may be given about accessible sources that they gain information on the topic in detail” (P16- Female, 24).

***Type of instruction.*** In addition to accessible instructional strategies, participants suggested different types and aspects of instruction and how the format of the instruction should be for a better learning environment. One of the mostly suggested types of instruction was hands on training since participants thought that sexual knowledge might remain abstract unless a hands on training with different instructional materials is done. One participant mentioned hands on training as: “firstly, description of the objects and concrete perception is needed. Later, how can I say. Something like that. For example putting a preservative on a model. It can be shown with hands on training” (P 18- Female, 20). Likewise, another participant emphasized the usage of tactile materials in hands on training as: “Human anatomy is needed to be presented to people with visual disability with models but well drawn models” (P21- Male, 36). Through hands on training, the need for concrete learning in topics related to sexuality can be met from the perspective of participants. Furthermore, other types of instructions suggested by the participants include verbal teaching (e.g. seminars), one-to-one meetings, and working groups. In this regard, one participant said:

For example a meeting would be organized with the presence of a pedagogue, later, you know after one to one meeting with children and raising awareness, work shop groups, some specific groups would be formed and these topics are started to be talked periodically. (P5- Female, 23).

It seems important to note that all of the suggestions were made in order to increase effectiveness of the sexuality education from the viewpoint of individuals with visual disability. Hence, seminars on different topics were seen as an important type of instruction, and question and answer technique was suggested in order to encourage the benefit of the sexuality education. On the other hand, the need for a special, one-to-one session with an expert in order to ask private questions and talk about his/her own private concerns in an comfortable and trustworthy environment was emphasized. Likewise, a possible need for private sessions in order to learn his/her own body with the support of an expert was also mentioned.

### ***Delivery of sexuality education.***

*Inclusive or segregated sexuality education.* Considering delivery of the education, majority of the participants were in favor of inclusive education if the education is accessible for the people with visual disability. However, they also stated that people with visual disability may need some special/segregated sessions in some cases such as sessions related to individual needs or tactile learning.

On the one hand, half of the participants prefer inclusive sexuality education which means that people with or without visual disability should take sexuality education sessions together and in an accessible manner. Participants had concerns with regard to discrimination in case of segregated sexuality education. In this context, one participant stated that sexuality of people with or without visual disabilities are the same and segregated education may lead other people to think that people with visual disability may not have sexual relationships with sighted people as:

There is no difference between a hetero who can see and a hetero who cannot. It is also true for the homosexuals. That's why they should be kept together so that there is no tendency for discrimination. When you separate them, when I accompany my class mates, there could be questions like, "why didn't he/she come? Will he/she find only the ones like him/herself, sleep only with them, have sexual relations only with them? (P10- Male, 27).

Likewise, one participant also mentioned the advantage of inclusive education in developing an acquaintance among people with visual disability and people without any disabilities as:

I mean, keeping them together is always more advantageous. At the end, person without disability understands fully the others with disabilities. In this, such things are experienced. On the other hand, a person with disability also understands fully a person without disability, I am saying this completely regarding the sexuality. (P9- Male, 30).

Similarly, another participant indicated that inclusive education may serve to increase awareness with regard to sexuality of the people with disability and stated that:

When you conduct education for persons with disability in front of those without disabilities, awareness is raised. People say "hmm, there are those who perceive life like this." That's why I am saying that they should be kept together. But, well the problems regarding the specific disability could be solved, but you should not separate them in education. (P4- Female, 31).

Apart from the advantages of inclusive education in terms of awareness and developing a positive attitude toward people with visual disability, participants also pointed out the importance of accommodations for people with visual disability in sexuality sessions by focusing on accessibility:

If there would be a slide projection, the blind could hear only when small texts are read. If, say, you know, there would be a film screening the blind will again be excluded. Here, firstly we have to consider such things. You know, how will that thing we call sexuality education be conducted in general? If it will be using, as I mentioned, such methods like a film or, what else, a slide projection, you know using mostly visual methods, then another method should be provided for the blinds, for them to be able to perceive. That's why I am saying, not one by one, but that the education should be given separately. But if it will be given superficially, already there is such sexuality education. In there, there is no problem keeping them together. (P2- Female, 36).

On the other hand, learning through touching and tactile materials may rise to humiliation from other sighted peers and therefore the education should be segregated. In this context one participant stated that:

I think there should be specific education for people with visual disability, I do not think that it should be given in the same place with people who have vision. It is something like that, you present the pictures of objects, for example with a projector you project and show body shapes for people with vision. For them for those who have vision it is important to see but for us it is important to touch. But for people with vision, touching comes after seeing, touching is a later stage and for us it is in the first stage so I think it is not welcomed by them I think. (P 18- Female, 20).

Similarly, another participant had concerns about humiliation and pity from others due to inaccessible visual materials within sexuality education:

If there is visuality in the incident, people with vision can perceive just looking. But for a person who is blind, how a vagina of a girl, he would ask and his friend is going to tell, the other friends also hear about it. I say it for those periods, teenager years. There will be a chaos in the classroom. A blind one tries to learn something; teacher demonstrates a picture of a woman, for example tells something on the picture with pointing some places. And children see these points but the blind one does not see and he needs to ask friends and teachers. When he asks, he is made fun of by the others. (P23- Male, 28).

One participant was in favor of segregated education due to visual content by stating that “for a person without vision should certainly touch it, at least she/he should feel by touching the model. Hence there should be differentiation as people with vision and people without vision” (P21- Male, 36).



Furthermore, inclusive education subsequent to tactile learning sessions was suggested in order to make both groups equal in terms of prior knowledge, along with increasing awareness, and maintaining equality between both groups. For instance, one of the participants stated that:

After tactile materials are introduced, I believe, I mean after they learn about the body and similar things, it is not inconvenient for them to be together. As a matter of fact, it would be even better since, then, they would not be separated. In my opinion, only that thing, while the students without disability are being given visual education on this is this and that's that, if the students with visual disability are given tactile education and after that it would be better they both are given education in the same place. Because, on the one hand this would provide the person with disability to think that he/she is not different, even if he/she has disability, that he/she feels or will feel the same sexual impulses. When the persons with disability are separated, you know, we know the school atmosphere, others would approach to the one with the disability with questions like, "what did they tell you? They told us this and that, did they tell you too? (P3- Male, 27).

*Educators.* Participants also expressed their ideas on who should be the provider of sexuality education by focusing on the academic qualifications as well as the personal characteristics of the educator.

Main concern of the participants was the qualification of the educators in terms of sexual knowledge and instructional strategies. Hence, they suggested some professionals who may provide such an education in a qualified manner. School counselors, pedagogues, experts, mental health workers, and specialists from medical faculty were mostly referred as professionals. Additionally, a few participants stated that same-sex educators can be more beneficial in creating a comfortable educational environment for students. Moreover, educating classroom teachers in topics related to sexuality was also suggested because they are in close contact with students and spend a considerable time with them. Furthermore, education for the educators was also emphasized due to the importance of the proficiency of the educators in terms of sexuality because educators around students are also seen as sources of sexual knowledge for the students. One stated the importance of qualification on the part of the educators:

It should be conducted within a planned and programmed framework and also be conducted by informed people. Say, maybe a science or health teacher could well may do it but, it would be better if it is conducted by people who are educated in this area. I mean, child psychologists, psychiatrists, people who have professionalized on children and on

sexuality education, it would be a lot better if the education is given by such people, because the approach of the educator is very important. (P3-Male, 27).

*Characteristics of educators.* In terms of personal characteristics of the educators, many described the importance of positive qualities as an important aspect of the educator including positive attitudes toward students, trustworthiness, and respect to privacy. In this regard, positive attitude and trustworthiness of the educator was emphasized since it may serve the purpose of creating a comfortable environment in which students may feel themselves safe and ask questions freely. On the other hand, some emphasized the need of respecting for privacy as a quality of the educator since receivers of the education may share their feelings, thoughts and behaviors trustfully in such a condition. One participant stressed that educators should gain trust of the students in initial sessions as:

Another thing is that, since this education causes shyness, at the beginning the educator may try to gain the trust of the students, you know. If not, say I am a 6th year student, say he/she comes and asks "x, did you ever have a wet dream?", I would not be able to answer, I would freeze. Most probably I wouldn't say anything. But if there, he/she is someone you trust, like a friend, I don't know what could be a different technique but, after he/she introduces him/herself as a trustworthy person, by asking to the students..... maybe it is very important to gain this trust first in correcting the disinformation or disorientation of the children in this issues. (P3- Male, 27)

*Location of the education.* Participants also stated opinions on where the sexuality education should take place. They suggested schools, health centers, special clinics, and Qur'an courses as the main places. Majority of the participants evaluated schools as the best place for sexuality education. Participants stated that open and accurate information should be provided to students within schools whether in school curriculum or in sexuality education sessions. Moreover, a few participants pointed out that the environment of a high number of schools as well as their curriculum and educational practices are transphobic and homophobic; hence, this should be eliminated effectively for the benefit of students in terms of sexuality. One explained her views by saying:

...and at school the specialists show it visually on the board but I think it should be shown to the students with visual disability by a model (skeleton). I mean, say my vagina is here, my uterus is there, my ovary is here and there passes the sperms. Here is the male sexual organ. Even if not with embossed figures or skeletons you can feel by touching, I think it

should be shown on the human body and these educations are not satisfactory for the persons with visual diasbility. Cause it felt like an imaginary thing until a friend sat with me and explained to me. (P4-Female, 31).

In addition to schools, many highlighted the need of acquiring knowledge when an individual needs such information through special clinics and centers. On the other hand, one participant indicated that people can gain knowledge through Qur'an courses in which a limited content of sexuality and religious practices are mentioned.

*Onset of sexuality education.* The onset of education was another topic emerged during the interviews and participants expressed their views on when the sexuality education should begin for better and healthy sexual life. In this regard, most of the participants stated that the education should begin in early years since a child is ready to get such knowledge. They also stated that it was important to learn those things in early years for a better sexual life in adulthood. In addition, age- appropriate continuing education was also emphasized due to the need of lifelong learning in this topic. Moreover, it was indicated that the sexuality education should begin in schools in order to provide accessible and accurate knowledge for children with visual disability during school years. One participant stressed that early childhood sexuality education may not harm children; rather, it may help them to understand sexuality better with its different aspects:

I mean, first of all I think this education should be given beginning by the childhood. Since we assume it nonexistent, since we see children and sexuality as a taboo, we think that if they know they would be affected. However, maybe if he/she knows about it, he/she would be better in analyzing it. That's why I think such a study should be conducted starting with the primary school and also not only the heterosexual side, but, you know, describing all the differences. (P5- Female, 23).

#### **4.3.4 The Responsibility of Parents and Individuals with Disabilities Regarding Sexuality Education.**

*The responsibility of parents in sexuality education.* It should be noted that majority of participants stressed the role of parents in providing sexual knowledge and facilitating the healthy sexual development of children.

*Sexuality communication.* In this regard, participants pointed out the issue of providing open and accurate information as well as age-appropriate information within family. One stated:

Ah, we are living in such a society that people lives it but cannot tell it. I mean your child have kept the troubles to him/herself. Ah, you had already experienced them, they should not live them as well. You have to talk and tell. (P6- Male, 39).

Regarding age-appropriate information, one participant stated that "... you have to tell the children only as much as they could perceive. At the point where he/she cannot perceive you should openly state that you postpone for later." (P2- Female, 36). Satisfying the curiosity of the children in an appropriate manner was also evaluated as important by one of the participants as:

The most important subject is that between the family and the individual, anyway, you have to do this with each and every children. As response to the questions asked, or the issues of interest, rather than saying that "this is nasty, let's not talk about this", you should be informative in dealing with children, for this period of childhood. (P16- Female, 24).

*Oppression.* The issue of oppression was another concern reported by the participants. Negative family reactions toward the sexual orientation of the children, restricting sexual plays, blaming the child due to sexual acts, and oppressing the sexuality of the children were stated as mistakes of families. Participants indicated that oppression may have harmful consequences on child sexuality. In this regard, one participant said:

Children from an oppressive family could also make fun of it, mock the subject. For example, someone, someone coming from an environment where sexuality is contained and designated only for men could say "such things are not for talking freely" and ignore women's free existence. (P 16- Female, 24).

One of the participants emphasized that families should allow the child to know his/her own body without restrictions "Firstly, the child should be provided with the chance of recognizing her body, mind and herself. For instance, when she touches her vagina or clitoris, she should not be hindered." (P4- Female, 31).

Another participant also emphasized the role of parents in teaching children sexuality as a natural part of life by saying:

Rather than conveying sexuality as a taboo, they need to tell the child that sexuality is a natural thing and that the child approach it accordingly. They should tell the child what is wrong and right in a natural way, not through

frightening, but through informing them in a natural way. This needs to be told to both the children and their families not by frightening them but in a humane way. (P5- Female, 23).

Likewise another participant said “This is my opinion on this issue: The children can play sexual plays so long as they do not give harm to one another. The important thing is to do this in accompany with information.” (P10- Male, 27). Imposing gender roles and negative reactions toward sexual orientation within family was also emphasized as:

We have a social pressure; boys are given toy cars, and girls are given dolls. One takes motherhood as a model, and the other fatherhood. As a matter of fact, neither of them constitutes sufficient preconditions to experience womanhood and manhood. In fact, a woman absolutely has sex, and a man who drives a car and brings home the bread is seen as father, and this is inherited when the child is grown up. (P10- Male, 27).

*Parent education.* Participants indicated that their parents did not have accurate sexuality information; that’s why they couldnot equip their children with reliable information. Hence, developing sexuality education programmes for parents was another topic introduced by the participants. One participant indicated the need for parent education by saying:

In fact, families and people in our society should receive sexual education, these should at least be something that can be talked with family. Otherwise, many people grow up with quite poor knowledge and believe in it. Otherwise there are people who come to us and ask I have hugged with my friend, and will I get pregnant. There are some scientific research on the people who are rebuked by their families due to jerking of and thus feeling guilty. (P1- Male, 29).

Furthermore, another participant indicated that particularly families of children with disabilities should be educated in terms of sexuality as “First of all, of course families are to be educated, those families having children with disabilities are to be provided awareness. This is a general trouble. Yet, for the families with disabled children, this is doubled, tripled trouble.” (P2- Female, 36). Additionally, one participant emphasized the lack of knowledge among families and said:

Families are not well-informed about the process of children’s entering into adolescence. There is such a problem in the country. Therefore, I think that all the families have the need for information about what they should do in the period when their children enter into adolescence. (P5- Female, 23).

*Family support.* Lastly, it was stated that families should support their children in terms of not only providing accurate sexuality information but also supporting their whole sexual development. In this regard, two participants emphasized the significance of being good role models for children in terms of romantic relationships which is seen as the basis of sexual relationships. Related to this, one participant said:

They should be right models for the children. That is, they should behave loosely. They can hug and touch each other. Of course, on the condition of not preceeding too much. That is, we as parents and adults, need to show children that love contains sexualiaty as well, that they are integrated to one another. (P10- Male, 27).

Family support was also highlighted to increase self-confidence and autonomy of children. Furthermore, participants pointed out the importance of respecting individual boundaries which signifies recognizing the rights and individuality of the children. Similarly, it was also indicated that respecting the privacy of the children with regard to sexuality is of utmost importance. Lastly, support and guidance provided by the family were evaluated as beneficial for children. Regarding self-confidence and independence one participant indicated that:

And in order to have an independent attitude of mind and self-confidence, this is not related to sexuality of course. The child should be given the opportunity to tell what she is thinking. Even if she thinks in a wrong way, she should not be excluded because of her wrong ideas, but be told that she can think in a different way (P4- Female, 31).

In addition, accepting and respecting the sexuality of children with visual disability by the parents was also emphasized by one of the participants as:

Tell this your children, show this them. They are visually impaired, but they have sexual orientations as everybody does. They do jerk off too. They have essential needs, the family needs to provide help on this issue. Yet I know that one of my friends' father were depilating his son during shower. Instead of this, he would have told this to him. He would have definitely learnt after a couple of accidents. I do not know what he is doing at the moment. (P 25- Male, 29).

In terms of respecting the privacy and individual boundaries one stated that:

That is I think no support should be provided on this issue, the only thing that needs to be done is to tell because if you provide support on this you then breach the privacy. Then, this would stay as problem in the future life of the individual. It will absolutely stay at the subconscious. For instance,

even when he is having sexual intercourse with someone else, he would feel lack of self confidence because even his hair was depilated by his father. This is what I think on this issue”(P25- Male, 29).

It was also suggested that families should not impose their own fear about sexuality on their children; rather, they should provide a safe base for them. One stated that:

There should be right role models. Besides, no matter of what kind of model you are, sexual orientation is not related to having right model or questioning. He should not be afraid of anything, he should feel relaxed. The more we normalize the issue, the safer it becomes. However, the more we keep it secret, make it odd, the more we have problems with different aspects. (P 10- Male, 27).

***Individual responsibility in sexuality education.*** A few participants underlined the responsibility of the individuals in terms of learning and increasing sexual knowledge. In this regard, participants emphasized responsibility of the individual with visual disability in terms of sexual knowledge, sexual experience and sexuality education by considering various topics. The first topic in this context was the responsibility of the individual in terms of making inferences from former sexual knowledge. Additionally, reaching sexuality information and elimination of misconceptions regarding sexuality by using individual resources and skills were also emphasized. Last but not least, a few number of participants widely emphasized the role of individual in developing himself/herself in terms of knowledge, personality, and experience. In this context, one participant emphasized the importance of knowing one’s own sexuality, body, and mind as:

What my suggestions to the adolescence with visual handicap are to improve themselves, fix their personalities, and to know their bodies. I am revolving around the same issue. But this is something like knowing and revealing themselves both in terms of body and mind. However, without a guiding light, they experience disappointing things and thus they get discouraged. That is why they should fix their personality firstly. This is my suggestion to children with disabilities. For instance they ask me whether to go out with a 12-13 year-old boy. I reply that you know the best, but do not go out with them. Maybe you can hold hands of the boy you like. Still do not go out before knowing yourself. I have not gone out with other people until 15-16 years old. When you fix your personality, you can easily introduce yourself to others. (P4- Female, 31).

Similar to this, another participant explained that:

This is totally related to knowing yourself and having peace of mind. As I have said, when I fall in love with someone who does not have visual

handicap, I tell myself that I am disabled, but I am an individual, I have fallen in love, and I want him to love in love with me too. I am sometimes get rejected, but sometimes be accepted. However, in order to have results, one needs to take initiative. The self-confidence and knowing oneself are very important in this respect. (P4- Female, 31).

Likewise, one pointed out the responsibility of the individual with disability as:

Besides this issue, the rest is up to the disabled individual. She cannot touch everyone one by one (laughing). She needs to know the needs of woman's body. After having such information, she should learn by reading and researching with her own experiences. That is, is she wants, she should experience. (P24- Male, 27).

Apart from this, advancing independent movement was another issue that linked to development of oneself in terms of sexuality and access to different sources as:

Therefore, if the person cannot go outside, her family can provide support to her to get the sources on this issue. If the person can stand on her own feet, independent living,, if she can go outside by her own, she can learn on her own. (P9- Male, 30).

The responsibility of the individual with visual disability in making inferences based on previous knowledge was also emphasized as: "I think of something like that you have a definition based on your mother and other people around you from birth. I think that you can easily predict. ... Still it there is such a need, it should be done." (P24- Male, 27).

#### **4.3.6 Summary of results regarding views on sexuality education.**

Results demonstrated that participants did not have any experience of comprehensive sexuality education; rather, more than half of the participants (n = 10) indicated that they had some kind of sexuality education within school curriculum including health courses or separate sexuality education sessions. In this regard, participants majorly evaluated previous sexuality education experiences as insufficient in terms of the content, materials and accessibility issues. Results suggested that participants would like to receive comprehensive sexuality education which address issues including human development, sexual health, sexual behavior, sexual relationships, individual needs. Moreover, participants (n = 13) mostly stated that there should not be a separate topic about sexuality of people with disabilities since there is no difference between people with or without disabilities in terms of sexuality and a separate topic may evoke



prejudices and discrimination. On the other hand, the rest of the participants stated that there should be a separate topic in order to raise awareness of the sexuality of people with disabilities and to learn about sexuality of people with different kinds of disabilities including mobility disabilities. Furthermore, accessibility of the sexuality education was one of the important concerns of the participants, and tactile materials, videos with audio description and accessible reading materials in the format of Braille, embossed print materials, e-books and reference list were prioritized as instructional materials that increase accessibility by the participants. With regard to inclusive or segregated sexuality education, half of the participants indicated that they preferred inclusive education because segregated education might lead to prejudices and discrimination; however, inclusive education might increase awareness. On the other hand, the other half of the participants had concerns regarding humiliation and pity from others while using tactile materials, and they preferred to take segregated sexuality education or inclusive education subsequent to tactile material session special for people with visual disabilities. Moreover, academic qualifications and personal characteristics of the educators were evaluated as important factors in terms of delivery of sexuality education, and location of the sexuality education was majorly defined as schools. Lastly, the responsibility of parents in terms of issues related to oppression, receiving sexuality education and support for children and responsibility of the individuals with visual disabilities learning and increasing sexual knowledge were mentioned as important factors in sexuality education by the participants.

## **CHAPTER V**

### **DISCUSSION AND IMPLICATIONS**

In this chapter, firstly summary of the major findings was presented. Subsequent to the summary of major findings, results of the study were discussed in accordance with research questions of the study and related literature. Regarding the discussion part, it should be kept in mind that interpretations were only made for the participants in the sample not for people with visual disabilities in general since generalization of the findings was not an aim of the current study. Additionally, there was an implications part that includes implications for practitioners, implications for researchers and implications for policy makers.

#### **5.1 Summary of the Major Findings**

The main aim of the present study was to explore sexual knowledge, sexual experiences and views on sexuality education among adults with visual disabilities. In this regard, the study revealed results in terms of sexual knowledge, sexual experience and views on sexuality education among 18 adult participants with visual disabilities. Concerning sexual knowledge, results suggested that more than half of the participants ( $n = 12$ ) evaluated their sexual knowledge as sufficient and the rest of the participants ( $n = 6$ ) evaluated their sexual knowledge as partially sufficient. Sexual intercourse, sexual intercourse positions, STDs, body characteristics including sexual organs, contraception, fertilization, birth, masturbation, orgasm and oral/anal sex were found as topics related to sexuality that participants needed and would like to learn further information. Sources of sexual knowledge emerged as mass media including the Internet, books, novels, other types of reading materials and audiovisual materials including TV, movies and porns, experiential learning, friends, family and relatives, school-based sexuality education, sighted period and health personnel respectively.

With regard to sexual experience, results revealed that first recollections regarding sexuality mainly comprised tactile experiences as well as auditory, sight-based and olfactory experiences and feelings related to those first recollections were mostly positive feelings including joy, curiosity, enjoyment, love, excitement and happiness. In this regard, only a few participants had experiences of forming a perception or changing perspective regarding sexuality based on the specified recollections. Regarding changes in puberty, results showed that participants experienced both positive and negative feelings in the face of these changes and findings also highlighted that male participants experienced wet dreams and masturbation more than female participants. During puberty, perception of restriction regarding masturbation and close relationships between girls and boys was another topic specified by participants. Moreover, findings also showed that receiving support from parents in terms of hairing, shaving and especially menstruation during puberty was another characteristic of sexual experiences during puberty from the viewpoint of the participants. With regard to sexual life in adulthood, results revealed that a number of participants ( $n = 6$ ) did not have sexual intercourse experience and lack of knowledge, lack of pleasure, shame, excitement, shyness and fear were specified as thoughts or feelings related to first sexual intercourse. Participants described tone of voice, smell, speech/diction and skin as most sexually appealing characteristics for them; moreover, being tall, having a well-shaped body, being curvy and muscular were also specified among sexually appealing characteristics. In terms of current sexual life, results suggested that only 6 participants (5 married, 1 single) have sexual partners currently and all of the sexual partners except one have visual disability also. Participants who had different kind of sexual experiences with both partners with or without disabilities indicated that there was no difference between a person with disability and a person without disability in terms of sexuality. Moreover, there were participants who did not satisfy with their current sexual life due to childcare, presence of relatives for childcare and lack of good communication with sexual partner. Considering finding and meeting partners, results suggested that participants met possible partner in school, via friends, cafes and social places, the Internet, association for blinds, while walking and in rehabilitation center. Additionally, results showed that participants mostly faced with different kinds of discrimination

in terms of sexual relationships and finding partners including discrimination based on visual disability, desexualization and receiving disquieting questions regarding visual disability and sexuality. Lastly, results with regard to sexuality education demonstrated that participants did not have any experience of comprehensive sexuality education; rather, more than half of the participants (n = 10) indicated they had some kind of sexuality education within school curriculum including health courses or separate sexuality education sessions. In this regard, participants majorly evaluated previous sexuality education experiences as insufficient in terms of the content, materials and accessibility issues. Results suggested that participants would like to receive comprehensive sexuality education which addresses issues including human development, sexual health, sexual behavior, sexual relationships, individual needs. Moreover, participants (n = 13) mostly stated that there should not be a separate topic about sexuality of people with disabilities since there is no difference between people with or without disabilities in terms of sexuality and a separate topic may evoke prejudices and discrimination. On the other hand, the rest of the participants stated that there should be a separate topic in order to raise awareness of the sexuality of people with disabilities and to learn about sexuality of people with different kinds of disabilities including mobility disabilities. Furthermore, accessibility of the sexuality education was among one of the important concerns of the participants, and tactile materials, videos with audio description and accessible reading materials in the format of Braille, embossed print materials, e-books and reference list were prioritized as instructional materials that increase accessibility by the participants. With regard to inclusive or segregated sexuality education, half of the participants indicated that they preferred inclusive education because segregated education may lead to prejudices and discrimination; however, inclusive education may increase awareness. On the other hand, the other half of the participants had concerns regarding humiliation and pity from others while using tactile materials and they preferred to take segregated sexuality education or inclusive education subsequent to tactile material session special for people with visual disabilities. Moreover, academic qualifications and personal characteristics of the educators were evaluated as important factors in terms of delivery of sexuality education and location of the sexuality education was majorly defined as schools. Lastly, the

responsibility of parents in terms of issues related to oppression, receiving sexuality education and support for children and responsibility of the individuals with visual disabilities learning and increasing sexual knowledge were mentioned as important factors in sexuality education by the participants.

## **5.2 Discussion Based on Research Questions**

In this section, there was a discussion for each of the research questions of the study in connection with the related literature.

**5.2.1 Research question one (RQ1): How adults with visual disabilities evaluate themselves in terms of sexual knowledge?.** In the current study, participants evaluated their level of sexual knowledge as either sufficient or partially sufficient as consistent with the findings of Kef and Bos's (2006) study. As it was mentioned in the results chapter, male participants evaluated themselves in a more confident manner and most of them did not specify a topic related to sexuality that they would like to learn further information. On the other hand, female participants evaluated their level of sexual knowledge in a more careful manner in which even the ones, who indicated that their level of sexual knowledge was sufficient, specified topics related to sexuality that they would like to learn further information. Similar to Abramson, Boggs and Mason's study (2013), which showed that there is a gender gap in terms of sexual behaviors especially, the current study also demonstrated that there is a gender gap in self-evaluation of sexual knowledge among participants. When the results were examined through the level of education of the participants, one important finding was that participants, whose level of education were higher, evaluated themselves in a detailed way and they identified areas that they did not have in depth information easily than other participants whose level of education were lower in general.

Furthermore, results demonstrated that there was a need of further sexuality information among participants in topics including STDs, sexual intercourse, female sexual organ, sexual intercourse positions, birth control methods, masturbation, orgasm, oral/anal sex and strategies to prevent early ejaculation. In this regard, male participants who did not have tactual experience strongly emphasized the need for knowledge in terms of female sexual organ whereas female participants did not indicate such need although some of them did not have

related tactual experiences. This finding demonstrated the importance of tactual experiences for male participants especially. The main concern among them was not exactly or concretely knowing female sexual organ due to lack of tactual experience. Moreover, STDs were also another topic that participants needed further information. Although not all of them specified need for knowledge on STDs, mainly HIV/AIDs was the most well-known STD among all participants. Consistent with related studies, findings demonstrated that participants usually lack knowledge on other STDs and symptoms of STDs especially (Ekşi & Kömürcü, 2014; Siyez & Siyez, 2009; Varol Saraçoğlu, et al., 2014). On the other hand, there were female participants who did not have information on orgasm and masturbation; however, male participants did not reveal any need for further information on these topics.

**5.2.2 Research question two (RQ2): How adults with visual disabilities access sexuality information?.** Based on what participants expressed regarding access to sexual knowledge, this research identified seven different sources that had become tools for acquiring sexual knowledge namely mass media (the Internet, books, novels, other unspecified reading materials, TV, movies and porns), experiential learning, friends, family and relatives, school-based sexuality education and courses, sighted period, and health personnel. Existing studies on visual disability and sexual knowledge demonstrated that people with visual disabilities had different kind of sources for sexual knowledge including friends, newspapers and magazines, television, films, mother, siblings, relatives and father (İrdem, 2006; Kef & Bos, 2006). Those studies also demonstrated that people with visual disabilities have utilized not only one source but multiple sources to learn different topics regarding sexuality. Likewise, the current research also showed that participants took advantage of multiple sources to gain sexual knowledge, and mass media consisting of the Internet, books, novels and other reading materials became one of the main source of sexual knowledge for the participants. In this context, participants could not utilize the visual aspects of these sources currently due to visual disability; however, they utilized these sources to gain auditory information with the help of screen reader programs or Braille alphabet which can make the Internet and other reading materials accessible in case of visual

disability. Although the Internet was emerged as the mostly utilized source under mass media category, participants expressed concerns regarding reliability of the knowledge on the Internet. Similarly, porns were not evaluated as sources for reliable sexual knowledge. However, there were no concerns about reliability of books, other types of reading materials, TV, and movies.

The current study in terms of sources of sexual knowledge showed that experiential learning emerged as the most powerful source of sexual knowledge among participants. Due to visual disability, only auditory information was not sufficient to learn all topics related to sexuality concretely and comprehensively. Moreover, experiential learning has a special place in comprehending bodily characteristics, sexual organs, usage of condoms and panty liners and sexual intercourse. In other words, experiential learning through touching and experiencing was one of the most reliable source for participants in terms of comprehensive and concrete learning as well as elimination of early misconceptions regarding sexuality. In this regard, the current study showed that touching can serve as sight in many cases for the participants and touching may help in making previous sexual knowledge more concrete. However, learning through touching cannot be possible and more importantly cannot be appropriate in every situation and in this regard what Glass (1984) and Davies (1996) argued regarding touching and societal taboos have great importance. To give an example, touching a glass or a laptop in order to learn the structure of these objects may be easier and appropriate in almost any time; however, touching sexual organs or different body parts of a person is something totally different than touching a laptop. In this case, the consent of the other person, societal taboos regarding touching and barriers toward romantic and sexual relationships for people with visual disabilities become a part of the learning through touching.

Although the study of Kef and Bos (2006) revealed that families emerged as one of the major sources of sexual knowledge, the current study showed that sexuality communication within family was not common among participants. This finding was in line with findings of İrdem's (2006) study which showed that family, relatives and siblings were less utilized sources of sexual knowledge among adolescents with visual disabilities in Turkey. Similar to Erbil, Orak and

Bektaş's (2010) and Bulut and Gölbaşı's (2009) study, menstruation was a topic that female participants in the current study gained information from their mothers mostly. When information provided by parents is taken into consideration, it can be seen that parents provided information on menstruation, hairing and the usage of panty liners but not sexual behaviors and sexual health, except personal hygiene. Moreover, there were examples that families as well as relatives provided misinformation regarding birth and hymen which may evoke fear and shame especially in the case of female participants. This finding can be related to controlling female sexuality through issues of hymen and premarital sex in Turkey (Parla, 2001; Sarıtaş; 2012, İlkcaracan, 2001). In this regard, the conservative structure of the society and families as well as views regarding premarital sexual activity can be helpful to explain insufficient sexuality communication within families as specified in various studies (Bulut & Gölbaşı, 2009; Erbil et al., 2010; Tuğrul & Artan, 2001).

On the other hand, although friends were emerged as a mostly utilized source especially among male participants, it was one of the most unreliable sources of sexual knowledge from the viewpoint of the participants. In this regard, masculinity is constructed through having a lot of sexual experiences and knowing sexuality more than others as well. As Glass (1984) stated that people having congenital visual disability have less chance to know different body parts due to lack of vision. In this regard, previous sighted period served as a baseline for some of the participants in order to synthesize new auditory information with previous visual schemas. On the other hand, school based sexuality education sessions and health personnel were among the least utilized sources of sexual knowledge among participants although schools and medical institutions can be places that people acquire sexual knowledge and ask their questions related to sexuality. OZİDA's (2010) study showed that people with visual disabilities had difficulties in using public transportation and health services due to the need for a companion, difficulties in independent movement and accessibility issues; in this regard, using medical institutions as sources of sexual knowledge may not be easy for the participants due to such reasons including accessibility and need for a companion issues.



Another related issue is that more than half of the participants indicated that their level of income was not sufficient to meet disability related needs including assistive technology and different types of devices to increase accessibility. In this regard, owning a personal embossed print or Braille print devices is very difficult since most of assistive technology devices are very expensive and the level of income of the participants was not sufficient to afford such technologies. Hence, lack of income and expensiveness of assistive technology devices may become barriers to access to accurate and concrete sexuality information.

**5.2.3 Research question three (RQ3): How adults with visual disabilities experience sexuality in general?.** In order to experience sexual activities with a partner, one firstly needs to find a partner except individual sexual activities like masturbation. In this regard, consistent with other related studies (Brodwin & Frederick, 2010; Shakespeare, 2000; Shakespeare et al., 1996; Shuttleworth, 2012; Siebers, 2012), results demonstrated that participants faced with different forms of discrimination regarding sexuality including prejudices, humiliation, and desexualization based on visual disability, and all of these became barriers to initiate and sustain sexual relationships for participants. Based on results, it can be inferred that even in the beginning of the romantic relationships, which can possibly include different aspects of sexual activities, participants experienced such barriers due to attitudes of people toward visual disability, sexuality and romantic relationships. Hence, developing sexual relationships became more difficult in this case since as most participants indicated sexuality goes hand in hand with romance especially in Turkey. In this regard, being rejected by a possible partner due to visual disability or having concerns about the possibility of being rejected were very widespread among the participants. Similar to stigmatization process (Gershick, 2006), participants were mainly marked by their visual disabilities as visual disability was the only characteristic of the person without considering other personal characteristics. Therefore, developing a sexual relationship with or declaring love to a sighted person evaluated as difficult due to fears of being rejected, and negative attitudes of people toward people with visual disabilities. In such cases, participants with visual disabilities usually tried to

compensate visual disability by proving possible partners that they are intelligent or they have other abilities or characteristics as well.

Another barrier to developing sexual relationship was desexualization experiences of participants. Due to visual disability, participants were being treated as they do not have sexual desires or a sexual life and especially male participants were subjected to desexualization. In this regard, Siebers (2012) argued that people with disabilities are treated as losing their human status and they face with problems in terms of sexual autonomy. Likewise, the results of current study regarding desexualization showed that male participants were treated as they lost their masculinity. Although there is a continuous control over female sexuality in Turkey, male sexuality have evaluated differently and masculinity is mostly identified with having sexual experiences and “being a man” through first wet dream and sexual intercourse experience is widespread. Hence, not being perceived as sexual beings brings male participants in the study to the result that losing “manhood” status. For female participants, desexualization turns into a thought that women with visual disabilities cannot have menstruation cycles or cannot give birth to a child. Since womanhood is mainly identified with giving birth to child, doing the cleaning or the housework in Turkey, visual disability does not directly rise to not being perceived as sexual beings but being perceived as a woman who cannot fulfill responsibilities of being a woman. Therefore, results illustrated that especially man with visual disabilities in the study were being treated as losing their “manhood” or “masculine” status compared to female participants. Similar to desexualization experiences, results demonstrated that participants received disquieting questions regarding sexuality and their ability to have sexual intercourse and they also faced with discriminatory jokes regarding sexuality and visual disability. The underlying thoughts of these different kinds of discrimination is that people with visual disabilities may not be able to experience sexual intercourse and to have sexual desires and feelings due to lack of vision.

Being sexual or having sexual attractiveness and sexuality as a whole mostly defined with a focus of visual factors including having a pretty face, sexy clothing, appealing color of skin and eyes as well as with idioms like “love at first sight”. However, the current study showed that there could be nonvisual factors

related to sexual attractiveness in the case of visual disability. With regard to sexual attractiveness, another important result suggested that participants mostly found tone of voice, smell, speech/diction and skin as sexually appealing characteristics. It can be inferred from this finding that auditory and tactual characteristics gain importance in terms of sexual attractiveness in case of visual disability. This finding is in line with the findings of Abramson, Boggs and Mason's (2013) that also showed how voice, touching a face and smell are important in partner selection process for people with visual disabilities. Unlike Pinquart and Pfeiffer's (2012) study, the current research does not support the result that people with visual disabilities consider emotional maturity as an important factor in partner selection process. Rather than emotional maturity and visible physical characteristics, auditory and tactual characteristics including voice, smell, skin and body type were considered as important sexually appealing characteristics in the current study. However, when participants were asked about their definitions of sexy man and woman, the answers were mainly based on physical and visual characteristics rather than auditory or tactual characteristics. Gershick (2006) indicated that people with disabilities also internalize what society accepts as attractive, desirable and sexy. In this regard, the answers of participants in terms of sexy man and woman can be explained by such an internalization of normative standards of beauty and being sexy. Moreover, sight is regarded as an important tool to find and meet partners (Sprecher & McKinney, 1993) and the results of the study revealed that participants find and meet partner in different places including educational institutions, cafes and other social places, associations for people with visual disabilities and rehabilitation centers. Additionally, there were also partners who participants met through friends and while walking. This finding showed that participants need to get in touch with possible partners in different ways including through having conversation rather than through sight.

Similar to sexually appealing characteristics, tactual experiences were also formed the main content of first recollections regarding sexuality among participants. Moreover, results indicated that feelings related to first recollections were mainly positive. Another important finding was that participants who communicated with their family members within specified first recollections

regarding sexuality were the ones who formed a general perception or change in a previous perception in terms of sexuality. This demonstrated the power and the effect of sexuality communication in terms of forming perceptions regarding sexuality. With regard to puberty, results showed that both positive and negative feelings were present regarding bodily changes among female and male participants. However, parental supervision and control, transition to womanhood and feelings of oppression due to social norms related to this transition were more widespread among female participants. On the other hand, while wet dreams and masturbation were main topics regarding puberty from the perspective of male participants; menstruation was the main concern in puberty from the perspective of female participants. Similar to current sexual life, wet dreams and masturbation practices were less widespread among female participants compared to male participants. Those findings regarding puberty indicated that females were more prone to oppression regarding changes in puberty than male participants. Moreover, it can be inferred that controlling female sexuality even becomes a topic in puberty. On the other hand, male participants had concerns regarding whether masturbation is appropriate in terms of religion or not so that they tried to restrict themselves usually. This finding also demonstrated the effect of religion on masturbation practices among male participants and in line with the findings of a number of studies (Hatipoğlu Sümer, 2015; Yaşan et al., 2009). Additionally, the findings demonstrated that male participants experienced restrictions regarding intimate relationships from school administration at boarding school. Moreover, regarding both menstruation and hairing, findings suggested that participants usually found appropriate personal solutions to the problems that may arise due to lack of vision in terms of being aware of menstrual cycles, the usage of panty liners, and personal hygiene. The support of family in terms of menstruation and personal hygiene gained importance until participants get used to the new situation and find personal solutions. Furthermore, results also revealed that the content of wet dreams had changed subsequent to sexual experience on the part of male participants. In this regard, this finding also illustrated the importance of tactual experience in case of visual disability.

Results related to sexual life in adulthood demonstrated that female participants had more concerns regarding chastity and premarital sex, and it was one of the major reasons that half of the female participants did not have sexual intercourse experience. However, majority of the male participants did not have such a concern regarding sexual intercourse experience, except two male participants (age: 27 and 30) who did not have sexual intercourse experience due to lack of courage and lack of opportunities. Moreover, the lack of courage mainly stems from the thought that visual disability can be a disadvantage to initiate romantic relationships.

Regarding first sexual experiences, results demonstrated that the difficulties that participants experienced did not rise from the visual disability but other reasons including lack of knowledge and experience as well as lack of pleasure. Moreover, the participants who were satisfied from the first sexual experience were the ones who have good communication with the partner or having an experienced partner. In terms of current sexual life, majority of the participants did not have a sexual partner and females in this group had less experience of individual sexual activities (e.g. masturbation) compared to males. Consistent with Abramson, Boggs and Mason's (2013) study, gender gap in terms of masturbation experiences, sexual dreams and interest in sex were more widespread among male participants who did not have sexual partners compared to females. On the other hand, evaluation of current sexual life among participants who have sexual partners depended on opportunities for sexual contact and good communication with the partner. Participants who have children lacked opportunities for sexual contact with their partners due to the presence of people who helped them for child care at home. In this context, it should be reminded that sexual partners of the participants were also majorly having visual disability.

**5.2.4 Research question four (RQ4): What are the views regarding sexuality education among adults with visual disabilities?.** Receiving accurate and reliable information regarding sexuality and sexual health and participating in sexuality education programs without any discrimination are defined as human rights related to sexuality for all people including people with disabilities (IPPF, 2008; UN, 2006). In the current study, results showed that participants could not

benefit from such comprehensive sexuality education programs in order to access accurate and reliable information. Although there were experiences of acquiring sexual knowledge on some topics via school based sexuality education sessions, health or religion courses or community-based sexuality education programs, results demonstrated that those experiences were mostly evaluated as insufficient by the participants in terms of content and accessibility. Additionally, previous sexuality education experiences of the participants were limited in a way that merely topics related to puberty and sexes rather than sexual health, sexual behavior, STDs or contraception were taught to participants. Considering this finding in conjunction with the views of the participants on how the content of sexuality education programs should be in ideal state, participants mostly claimed that school-based comprehensive sexuality education programs that cover a wide range of topics on sexuality in depth and begin at an early age should be developed. In this context, what participants demand regarding sexuality education is consistent with *Guidelines for Comprehensive Sexuality Education: Kindergarten-12<sup>th</sup> Grade* that was developed by *Sexuality Information and Education Council of the United States* (SIECUS, 1996), and indicated that comprehensive school-based sexuality education programs should be included in educational institutions at different grades by considering age, developmental level and culture. Hence, views of participants regarding content, location and onset of sexuality education were very similar to the universal guidelines and suggestions on sexuality education. On the other hand, results indicated that mainstream school-based comprehensive sexuality education programs may not be fully helpful and sufficient for participants with visual disabilities unless reasonable accommodations applied in settings that people with disabilities receive sexuality education.

Regarding reasonable accommodations in sexuality education, one of the most prominent finding was that using accessible instructional strategies including tactile materials, Braille print materials and embossed print materials were of utmost importance for the participants. Similar to other related studies (Kapperman & Kelly, 2013; Krupa & Esmail, 2010; Wild, Kelly, Blackburn, & Ryan, 2014), results of the current study also demonstrated that there was a strong need for

tactile materials which could contribute to learning process for people with visual disabilities in sexuality education sessions. Almost all of the participants strongly emphasized the role of tactile materials and the power of touching in especially understanding sexual anatomy. Different from auditory information, tactile materials including sculptures or other 3D materials can provide people with visual disabilities a space to learn not only sexual anatomy but also body types and sexual intercourse positions in a concrete way. Thus, findings showed that hands on training with these tactile materials can ease learning process in case of visual disability. In addition to tactile materials, results suggested that videos with audio description and accessible reading materials including Braille, embossed print materials, e-books and reference list may also support people with visual disabilities in terms of acquiring sexual knowledge in an accessible way. Findings regarding accessibility especially tactile materials were in line with suggested accommodations for students with visual disabilities in terms of teaching science subjects (Bülbül & Eryılmaz, 2012; Kumar & Stefanich, 2001; Supalo, 2005). Moreover, accessible reading materials were also suggested accommodations for students with visual disabilities in different educational settings (Kennedy, Treanor, & O'Grady, 2008). Such accommodations can be helpful to construct a mental image of different body parts, body types in terms of size and shape and sexual anatomy as a whole especially for people having congenital visual disabilities.

Results related to whether or not sexuality of people with disabilities should be a separate topic and sexuality education should be inclusive or segregated demonstrated that participants primarily would like to be treated in a nondiscriminatory and equal manner. A separate topic regarding sexuality of people with disabilities was not preferred by most of the participants since such a separate topic may form or rise discrimination and prejudices toward sexuality of people with disabilities. Although there were participants who preferred that such a separate topic should be in the content of sexuality education, their concern was mainly to increase the awareness of sexuality of people with disabilities in the eyes of people without disabilities. In this context, either approach highlighted the need that participants would not like to be seen as different from people without

disabilities in terms of sexuality. Likewise, views on inclusive or segregated sexuality education also showed that participants would like to be treated equally in a nondiscriminatory manner. Inclusive sexuality education was the one mostly preferred by participants especially if educational materials and education as a whole were accessible for people with visual disabilities. However, there were also concerns about being humiliated or being approached through feelings of pity during the usage of tactile materials in front of sighted people. Concerns of participants regarding discrimination, humiliation and approaches based on mercy and pity seem to be understandable since studies show that people with disabilities face with various kinds of discrimination in different circumstances (Şenyurt Akdağ et al., 2011; TurkStat, 2010). Hence, choices of participants with regard to inclusive or segregated sexuality education and sexuality of people with disabilities as a separate topic were also shaped through such concerns.

Besides, responsibility of parents and individuals with visual disabilities were also emphasized by the participants. Similar to findings of Tuğrul and Altan's (2001) study, participants in the current study also thought that their parents need sexuality education in order to establish a healthy sexuality communication with their children. Consistent with related studies' findings (Bulut & Gölbaşı, 2009; Erbil et al., 2010; Tuğrul & Artan, 2001), participants indicated that there was a lack of sexuality communication within family or there was sexuality communication only in topics related to menstruation or puberty. Additionally, oppression regarding sexuality related activities, including negative reactions toward sexual orientation of the children and restriction or blaming sexual acts or plays of the children was another important concern of the participants. However, it should be noted that there is a distinction between parental control and supervision and oppression by the family; therefore, parental control with an appropriate manner regarding sexuality is important and necessary for sexual development of the children. Apart from the responsibility of families, the responsibility of the individuals with visual disabilities was also highlighted by the participants. In this regard, Brisenden (1986) indicated that control over one's life, making decisions, taking risks and responsibilities and independent living as a whole were important issues in a life of a person with disability. Hence, to acquire



and develop sexual knowledge and to find opportunities in order to fill the gap in current sexual knowledge were also responsibilities of the people with visual disabilities.

Lastly, it should also be noted that university students or graduates that constituted the majority of the sample elaborated their views on sexuality education in a detailed manner and made comprehensive suggestions for sexuality education for people with visual disabilities compared to middle school or high school graduates in the sample.

### **5.3 Implications for Practitioners**

The findings of the current study have a number of implications for practitioners working in schools and mental health institutions. The results of the current study showed that there is a need for further sexuality information and comprehensive sexuality education. In this context, schools are the places that students can acquire and advance their sexual knowledge and the role of school counselors is of utmost importance to provide sexual knowledge. Although there is a lack of school-based comprehensive sexuality education programs in Turkey, school counselors can provide age appropriate sexuality information to students through group guidance sessions, seminars or individual counseling sessions. It is important to note that school counselors themselves should be qualified in order to organize such programs; hence, sexual knowledge and education of them also gain importance. In this regard, obtaining support from health personnel such as school nurses or doctors seems both necessary and important since sexuality is a comprehensive topic having both physiological and psychological aspects. Specifically, school counselors who work at schools for students with visual disabilities have a special place to convey knowledge about sexuality to students. Therefore, development of such programs or sessions becomes more important in such settings. Additionally, working with parents of students with visual disabilities and guiding them in a way that they can constitute a healthy sexuality communication with their children by providing them knowledge about developmental needs and conditions of their children, family training programs can be developed.

Furthermore, the findings of the current study implied that people with visual disabilities encountered negative attitudes and discrimination based on visual disability. At this point, the advocacy role of psychological counselors have an importance in terms of raising awareness about sexuality of people with visual disabilities in society. Psychological counselors can work toward social change. Moreover, they can work on systemic factors and possible barriers that people with visual disabilities faced with regarding sexuality. In addition, with the help of psychoeducational programs, psychological counselors may have a role on eliminating negative attitudes and discriminatory approaches with regard to the current topic.

The current study implied that participants needed further information on sexuality and would like to have more opportunities to meet with partners and develop relationships. Not only school counselors, but also psychological counselors and psychologists, who provide services for people with visual disabilities in rehabilitation centers, can also work on improving sexual knowledge of people with visual disabilities, and help them teaching social skills to initiate and maintain intimate relations with others. Moreover, people who work in health institutions and mental health field should also keep in their mind that people with visual disabilities have also sexual lives, sexual desires, and feelings. Hence, it seems better to gain awareness about attitudes toward sexuality of people with visual disabilities. The results of this study showed that difficulties that participants face with regarding sexuality do not mainly related to visual disability. For this reason, when a topic related to sexuality become a focus of a particular session, mental health professionals should not only consider the effect of lack of vision but also environmental factors that can affect the sexuality of the individual with visual disability. In other words, it is important to be aware that not every sexual problem of a client is related to his or her disability, and a wider perspective is needed to evaluate client's condition.

#### **5.4 Implications for Parents of Children with Visual Disabilities**

Although the present study was conducted with adults with visual disabilities, there are a number of implications for parents of children with visual disabilities based on what participants expressed about their childhood and puberty

retrospectively, and their suggestions for sexuality education. Parents have an important role in terms of child development and in case of having a child with visual disability, satisfying the child's curiosity regarding sexuality, creating opportunities to recognize body parts of different sexes via tactile materials or verbal descriptions, respecting individual boundaries of the child and supporting in terms of increasing sexual knowledge and development of independent living skills are of utmost importance for sexual development and increased sexual self-esteem of people with visual disabilities. The current study showed that there is a lack of sexuality communication within families of the participants; hence, developing appropriate sexuality communication with children with visual disabilities in a natural way without blaming, forbidding or scaring can provide necessary sexuality information for the children. By this way, families can also create a safe environment in which the children can ask about their sexuality related questions when there is a need. Additionally, the current study illustrated that parents of participants lack sexual knowledge; hence, developing themselves in terms of sexual knowledge is also another important step in terms of sexuality education of the children with visual disabilities. In this way, parents can convey accurate and reliable knowledge to their children. Moreover, findings also showed that family support in terms of enhancing and encouraging independence and self-confidence was also important for sexuality. Therefore, families of children with visual disabilities can support their children in different ways to increase independent living skills and self-confidence.

### **5.5 Implications for Policy Makers**

The current study has several implications for policy makers based on the results of the study. Firstly, the current study showed that participants with visual disabilities put emphasis on school-based comprehensive sexuality education programs. Although school counselors, to some extent, can provide sexual knowledge to students through various seminars or programs, the development of comprehensive sexuality education programs at national level by considering local cultural backgrounds and differences is a more lasting and effective solution to fulfill the needs of students with visual disabilities in terms of sexual knowledge. Such comprehensive programs are not only helpful for students with visual

disabilities but also to all students with or without visual disabilities. However, policy makers should also consider reasonable accommodations and special needs of students with visual disabilities while developing comprehensive sexuality education programs. In this regard, the findings of the study showed that tactile materials were of utmost importance in sexuality education sessions for students with visual disabilities in order to make the information related to sexual anatomy and sexuality more concrete. Hence, age appropriate tactile materials should be prepared through the collaboration of practitioners in the field of sexuality education, developmental psychology and school counseling. In this context, hands on training has a special place in case of visual disability and comprehensive programs should include such hands on training sessions for those students. Additionally, the booklets or any other materials that will be handed out to the students should be accessible (either in Braille or e-book format). To sum up, the needs of students with visual disabilities should be considered in developing comprehensive sexuality education programs, and programs should be accommodated according to the needs of students with visual disabilities. In addition, the current study showed that adults with visual disabilities may also need further sexuality information in various topics since sexuality education is a lifelong process. Hence, sexuality education programs for not only school-age children, but also adults with visual disabilities gain importance. In this regard, sexuality education programs can be developed through the collaboration of medical institutions in various community settings. Again, the needs of people with visual disabilities should be considered in these community based sexuality education programs.

With regard to educators of sexuality education, the current study demonstrated that academic qualifications and personal characteristics of educators were concerns of participants. For this reason, educators who will provide sexuality education for people with visual disabilities should also be educated in order to increase their subject knowledge and develop necessary personal skills. Hence, this concern should be also considered by policy makers in developing sexuality education programs.

Furthermore, negative attitudes and discriminatory approaches toward sexuality of people with visual disabilities were also concerns of participants in the current study. In this regard, the current study showed that participants were not comfortable with such approaches naturally. Hence, nationwide programs can be developed and implemented in order to eliminate such negative and discriminatory approaches toward sexuality of people with visual disabilities. In those programs, the content may include mainly the idea that people with visual disabilities also have sexual lives and sexual autonomy in order to eliminate sexual myths regarding visual disability and sexuality.

## **5.6 Directions for Future Research**

Based on the findings of the current study and personal observations of the researcher there are a number of recommendations of areas that future research can be undertaken. Firstly, the current study did not include a comparison between people with and without visual disabilities. Hence, it is recommended that a qualitative study similar to the current research can be conducted with two groups namely adults with visual disabilities and adults without visual disabilities in order to comprehend similarities and differences between adults with or without visual disabilities in terms of sexual knowledge, sexual experience and views on sexuality education. In this regard, it appears important to keep characteristics of the participants such as age, educational level and gender alike. Secondly, development of a sexuality education program which includes accommodations for people with visual disabilities can be another track for future research.

Thirdly, the participant recruitment process of the current study showed that there were people with visual disabilities who had other types of disabilities such as olfactory and chronic disabilities. Hence, a similar qualitative study can be conducted with those groups in order to understand sexuality of people with multiple disabilities. Moreover, people with different sexual orientations may have different concerns regarding sexuality. Hence, a qualitative study can be conducted to explore the concerns of LGBTIQ individuals having visual disabilities.

Furthermore, the pilot study and interviews showed that there were men with visual disabilities who could not ejaculate through masturbation but only through sexual intercourse. Therefore, a study that tries to explore such

physiological aspect and its relation to visual disability can be conducted to understand whether such condition is a common experience among men with visual disabilities. Moreover, attitudes toward sexuality of people with visual disabilities can be studied among groups including sighted people in order to comprehend related variables and sources of negative and positive attitudes toward sexuality of people with visual disabilities.

Last but not the least, the exploration of sexual experiences among participants remained somewhat limited in the current study. Hence, a qualitative study that only focuses on sexual experiences of people with visual disabilities can be conducted in order to reach more detailed exploration. In addition, a further research subject may be sexual socialization among people with visual disabilities in order to explore how people with visual disabilities form gender identity, gender roles, values regarding sexuality and sexual attitudes through the impact of families, religion, and mainstream views of society.

## REFERENCES

- Abramson, P. R., Boggs, R., & Mason, E. J. (2013). Sex is blind: Some preliminary theoretical formulations. *Sexuality and Disability*, 31(4), 393–402. doi: 10.1007/s11195-013-9313-9.
- Akdeniz, E., Balamir-Coşkun, G., Demiryol, T., & Yılmaz, V. (2013). Siyasal Katılım. In Menda, E., Balkan N., & Berktaş, N. (Ed.) *Engelsiz Türkiye için: Yolun neresindeyiz? Mevcut durum ve öneriler* (pp. 259-273). İstanbul: Sabancı Üniversitesi Yayınları.
- Akkuş, Y. & Duru, G. (2011). Problems and factors affecting the sexual lives of patients with multiple sclerosis living in Turkey. *Sexuality and Disability*, 29(1), 55-63. doi: 10.1007/s11195-010-9191-3
- Akkuş, Y., Nakas, D., & Kalyoncu, U. (2010). Factors affecting the sexual satisfaction of patients with rheumatoid arthritis and ankylosing spondylitis. *Sexuality and Disability*, 28(4), 223–232.
- Aksaray, G., Yelken, B., Kaptanoğlu, C., Oflu, S. & Özaltın, M. (2001). Sexuality in women with obsessive compulsive disorder. *Journal of Sex and Marital Therapy*, 27(3), 273-277.
- Altuntuğ, K., Ege, E., Akin, B., Kal, H. E., & Sallı, A. (2014). An investigation of sexual/reproductive health issues in women with a physical disability. *Sexuality and Disability*, 32(2), 221–229. doi: 10.1007/s11195-014-9342-z
- Arıkan, Ç. (2001). *Türkiye’de görme özürlü kadınlar: Sorunlar, beklentiler, çözüm önerileri*. Ankara: Ankara Üniversitesi Basımevi.
- Askun, D. & Ataca, B. (2007). Sexuality related attitudes and behaviors of Turkish university students. *Archives of Sexual Behavior*, 36(5), 741-752.
- Aydın, R. & Aktaş, İ. (2013). Sağlık ve rehabilitasyon hizmetlerine erişim. In Menda, E., Balkan N., & Berktaş, N. (Ed.) *Engelsiz Türkiye İçin: Yolun Neresindeyiz? Mevcut durum ve öneriler* (pp. 273-287). İstanbul: Sabancı Üniversitesi Yayınları

- Bağcıoğlu, E., Acar, A., Coşkun, K. Ş., Akpınar, A., Yürekli, V.A., Oruç, S., Mayda, H., & Bahçeci, B. (2013). Sexuality in young adult men aged 18–24 with epilepsy. *Sexuality and Disability*, 31(3), 229-237.
- Barış, M. E. & Uslu, A. (2009). Accessibility for the disabled people to the built environment in Ankara, Turkey. *African Journal of Agricultural Research*, 4(9), 801-814.
- Barnes, C. (1994). *Disabled people in Britain and discrimination: A case for anti-discrimination Legislation*. London: Hurst & Co.
- Bazzo, G., Nota, L., Soresi, S., Ferrari, L., & Minnes, P. (2007). Attitudes of social service providers towards the sexuality of individuals with intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 20(2), doi: 110–115. 10.1111/j.1468-3148.2006.00308.x
- Bernert, D. J. (2011). Sexuality and disability in the lives of women with intellectual disabilities. *Sexuality and Disability*, 29(2), 129–141. doi: 10.1007/s11195-010-9190-4
- Bezerra, C. M. & Pabliguica, L. M. F.(2010). The experience of sexuality by visually impaired adolescents. *Revista da Escola de Enfermagem da USP*, 44(3), 577-582. doi: ttp://dx.doi.org/10.1590/S0080-62342010000300005
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginner*. London: Sage. Retrieved from <http://core.ac.uk/download/pdf/16706435.pdf> on November 2014.
- Brisenden, S. (1986). Independent living and the medical model of disability. *Disability, Handicap & Society*, 1(2), 173-178, doi: 10.1080/02674648666780171
- Brodwin, M. G. & Frederick, P. C. (2010). Sexuality and societal beliefs regarding persons living with disabilities. *Journal of Rehabilitation*, 76(4), 37-41.



- Bulut, F. & Gölbaşı, Z. (2009). Adolesan kızların cinsellikle ilgili konularda anneleri ile olan iletişimlerinin değerlendirilmesi. *TAF Preventive Medicine Bulletin*, 8(1), 27-36.
- Burcu, E. (2007). *Türkiye’de özürlü birey olma: Temel sosyolojik özellikleri ve sorunları üzerine bir araştırma*. Ankara: Hacettepe Üniversitesi Yayınları.
- Bülbül, M. Ş. & Eryılmaz, A. (2012). *Görme engelli öğrenciler için fizik ders araçları*. Ankara: Murat Kitabevi
- Cebeci, F., Balcı-Yangın, H., & Tekeli, A.(2010). Determination of changes in the sexual lives of young women receiving breast cancer treatment: A qualitative study. *Sexuality and Disability*, 28(4), 255-264.
- Charlifue, S. W., Gerhart, K. A., Menter, R. R., Whiteneck, G., & Scott-Manley, M. (1992). Sexual issues of women with spinal cord injuries. *Paraplegia*, 30, 192-199. doi:10.1038/sc.1992.54
- Cole, S. C. & Cole, T.M. (1993). Sexuality, disability, and reproductive issues through the lifespan. *Sexuality and Disability*, 11(3), 189-205.
- Courtois, F. J., Charvier, K. F., Leriche, A., & Raymond, P. (1993). Sexual function in spinal cord injury men. I. Assessing sexual capacity. *Paraplegia*, 31, 881-784. doi:10.1038/sc.1993.120
- Creswell, J. W. (2006). *Qualitative inquiry and research design: Choosing among five approaches*. USA: Sage Publications.
- Creswell, J. W. & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-131.
- Cuskelly, M. & Bryde, R. (2004). Attitudes towards the sexuality of adults with an intellectual disability: parents, support staff, and a community sample. *Journal of Intellectual & Developmental Disability*, 29(3), 255–264. doi: 10.1080/13668250412331285136
- Çağlar, S. (2012). Engellilerin erişilebilirlik hakkı ve Türkiye’de erişilebilirlikleri. *Ankara Üniversitesi Hukuk Fakültesi Dergisi*, 61(2), 541-598.

- Çavuş, Ö. H. & Tekin, A. (2015). Türkiye’de engellilerin istihdam yöntemi olarak korumalı işyeri. *Dokuz Eylül Üniversitesi İktisadi ve İdari Bilimler Fakültesi Dergisi*, 30(1), 145-165.
- Çelik, D. B., Poyraz-Coşkun, E., Bingöl, A., İdman, E., Özakbaş, S., & Kaya, D. (2013). Sexual dysfunction in multiple sclerosis: Gender differences. *Journal of the Neurological Sciences*, 324, 17–20.
- Çok, F., Gray, L. A., & Ersever, H. (2001). Turkish university students’ sexual behavior, knowledge, attitudes and perceptions of risk related to HIV/AIDS. *Culture, Health & Sexuality*, 3(1), 81-99.
- Davies, J. (1996). *Sexuality education for children with visual impairments*. Retrieved from <http://www.tsbvi.edu/component/content/article/129-materials/3254-sexuality-education-for-children-with-visual-impairments> on June 13, 2014.
- Denzin, N. K. & Lincoln, Y. S. (2003). *The sage handbook of qualitative research*. California: Sage Publications.
- Demirgöz-Bal, M., Dereli-Yılmaz, S., & Kızılkaya-Beji, N. (2013). Sexual health in patients with gynecological cancer: A qualitative study. *Sexuality and Disability*, 31(1), 83-92.
- Dereli Yılmaz, S., Gümüş, H., & Yılmaz, H. (2015). Sexual life of poststroke women with mild or no disability: A qualitative study. *Journal of Sex and Marital Therapy*, 41(2), 145-154.
- DİE (2002). *Turkey disability survey*. Devlet İstatistik Enstitüsü Matbaası, Ankara.
- Duh, J. (2000). Sexual knowledge of Taiwanese adolescents with and without visual impairments. *Journal of Visual Impairment and Blindness*, 94(6), 385-395.
- Dukes, E. & McGuire, B. E. (2009). Enhancing capacity to make sexuality-related decisions in people with an intellectual disability. *Journal of Intellectual Disability Research*, 53(8), 727–734. doi: 10.1111/j.1365-2788.2009.01186

- Dune Moira, T. (2012). Sexuality and physical disability: Exploring the barriers and solutions in healthcare. *Sexuality and Disability*, 30(2), 247–255. doi: 10.1007/s11195-012-9262-8
- East, L. J. & Orchard, T. R. (2014). ‘Why can’t I?’: An exploration of sexuality and identity among Canadian youth living with physical disabilities. *Journal of Youth Studies*, 17(5), 559-576.  
<http://dx.doi.org/10.1080/13676261.2013.834316>
- East, L. J. & Orchard, T. R. (2014). Somebody else’s job: experiences of sex education among health professionals, parents and adolescents with physical disabilities in Southwestern Ontario. *Sexuality and Disability*, 32(3), 335-350. doi: 10.1007/s11195-013-9289-5
- Eastgate, G. (2008). Sexual health for people with intellectual disability. *Salud Pública de México*, 50(2), 255-259.
- Eker, F. & Açıkgöz, F. (2011). The impact of cancer and its treatment on sexual , desire, satisfaction and functioning: findings from an exploratory study in rural Turkey. *European Journal of Cancer Care*, 20(6), 769-75. doi: 10.1111/j.1365-2354.2011.01262.x.
- Ekşi, Z. & Kömürcü, N. (2014). Knowledge level of university students about sexually transmitted diseases. *Procedia- Social and Behavioral Sciences*, 122, 465-472.
- Elbozan Cumurcu, B., Karlıdağ, R., & Han-Almış, B. (2012). Fiziksel engellilerde cinsellik. *Psikiyatride Güncel Yaklaşımlar*, 4(1), 84-98.  
doi:10.5455/cap.20120406
- Enç, M. (1972). *Görme özürlüler: Gelişim, uyum ve eğitimleri*. Ankara: Ankara Üniversitesi Eğitim Fakültesi Yayınları.
- Erbil, N., Orak, E., & Bektaş, A. E. (2010). Anneler cinsel eğitim konusunda ne biliyor, kızlarına ne kadar cinsel eğitim veriyor? *Uluslararası İnsan Bilimleri Dergisi*, 7(1), 366-383.
- Ergun, M. A. (2007). Social determinants of attitudes towards women’s premarital sexuality among female Turkish university students. *Sexuality & Culture*, (2007) 11, 1–10 doi: 10.1007/s12119-007-9005-7

- Ertürk, E. (2003). *Disability in Turkey* (Unpublished masters thesis), İstanbul: Boğaziçi Üniversitesi Atatürk İlkeleri ve İnkılâp Tarihi Enstitüsü.
- Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. Crows Nest, NSW: Allen & Unwin.
- Ferreiro-Velasco, M. E., Barca-Buyo, A., Salvador de la Barrera, S., Montoto-Marques, A., Miguens- Vazquez, X. & Rodrigues-Sotillo, A. (2005). Sexual issues in a sample of women with spinal cord injury. *Spinal Cord*, 43, 51–55. doi:10.1038/sj.sc.3101657
- Franco, D. G., Cardoso, J., & Neto, I. (2012). Attitudes towards affectivity and sexuality of people with intellectual disability. *Sexuality and Disability*, 30(3), 261–287. doi: 10.1007/s11195-012-9260-x
- Gagliardi, B. A. (2003). The experience of sexuality for individuals living with multiple sclerosis. *Journal of Clinical Nursing*, 12(4), 571–578.
- General Directorate of Services for Persons with Disabilities and Elderly People (n.d.). *Konularına Göre Ulusal Mevzuat*. Retrieved from <http://eyh.aile.gov.tr/mevzuat/konularina-gore-ulusal-mevzuat> on May, 2015.
- Genç, Y. & Çat, G. (2013). Engellilerin istihdamı ve sosyal içerme ilişkisi. *Akademik İncelemeler Dergisi*, 8(1), 363-393.
- Gershick, T. J. (2006). Toward a theory of disability and gender. *Signs*, 25(4), 1263–1268.
- Ghajarzadeh, M., Jalilian, R., Mohammadifar, M., Sahraian, M. A., & Azimi, A. (2014). Sexual function in women with multiple sclerosis. *Acta Medica Iranica*, 52(4), 315-318.
- Glass, D. D. (1984). Sexuality and visual impairment. *SIECUS Report*, 12(5). Retrieved from <http://www.iiav.nl/eazines/email/SiecusReport/1984/May.pdf> on May, 2015.

- Gordon, P.A., Tschopp, M. K., & Feldman, D. (2004). Addressing issues of sexuality with adolescents with disabilities. *Child and Adolescent Social Work Journal*, 21(5), 513-527.
- Grieve, A. & McLaren, S. (2008). Staff attitudes towards the sexuality of people with learning disabilities: a comparison of different professional groups and residential facilities. *British Journal of Learning Disabilities*, 37, 76–84. doi:10.1111/j.1468-3156.2008.00528.x
- Grossman, B. R., Shuttleworth, R. P., & Prinz, P. M. (2003). Locating sexuality in disability experience, a report from disability studies: theory, policy, and practice, The Inaugural Conference of the disability studies. *Sexuality Research and Social Policy*, 1(2), 91-96.
- Gümüő, H., Akpınar, Z., & Yılmaz, H. (2014). Effects of multiple sclerosis on female sexuality: A controlled study. *Journal of Sexual Medicine*, 11, 481–486. doi: 10.1111/jsm.12397
- Güneő, H., Aktaő, İ., Konuk, Ö. & Őahsuvaroęlu, T. (2013). Eęitim . In Menda, E.,Balkan N., & Berktaı, N. (Ed..) *Engelsiz Tırkiye iin: Yolun neresindeyiz? Mevcut durum ve neriler* (pp. 173-229). İstanbul: Sabancı Üniversitesi Yayınları
- Harrison, J., Glass, C. A., Owens, R. G., & Soni, B. M. (1995). Factors associated with sexual functioning in women following spinal cord injury. *Paraplegia*, 33, 687–692. doi:10.1038/sc.1995.144
- Hatipoęlu Smer, Z. (2006) Sexual knowledge and behaviors of Turkish university students: Are students at risk?. *Paper presented at the European Conference on Educational Research, University of Geneva*. Retrieved from <http://www.leeds.ac.uk/educol/documents/158425.htm> on May 2015.
- Hatipoęlu Smer, Z. (2015). Gender, religiosity, sexual activity, sexual knowledge, and attitudes toward controversial aspects of sexuality. *Journal of Religion & Health*, 54(6), 2033-2044. doi: 10.1007/s10943-014-9831-5
- Hintistan, S. & ilingir, D. (2013). Sexual dysfunction in Turkish men and women with type 2 diabetes mellitus. *Sexuality and Disability*, 31(1), 31-41.
- IPPF (2008). *Sexual rights: An IPPF declaration*. Retrieved from

<http://www.ippf.org/resource/Sexual-Rights-IPPF-declaration> on February, 2015.

İlkkaracan, P. (2001). *Islam and women's sexuality: A research report from Turkey*. Retrieved from [http://www.kadinininsanhaklari.org/static/yayin/wwhr/islam\\_womens.pdf](http://www.kadinininsanhaklari.org/static/yayin/wwhr/islam_womens.pdf) on March, 2015.

İrdem, F. P. (2006). *Görme engelli gençlerin cinsel sağlık bilgi düzeyleri üzerine bir araştırma* (Unpublished masters thesis), Ankara: Hacettepe Üniversitesi Sosyal Bilimler Enstitüsü.

İşler, A., Taş, F., Beytut, D., & Conk, Z. (2009). Sexuality in adolescents with intellectual disabilities. *Sexuality and Disability*, 27(1), 27-34.

Jemata°, L., Fugl-Meyer, K. S., & Öberg, K. (2008). On intimacy, sexual activities and exposure to sexual abuse among children and adolescents with mobility impairment. *Acta Paediatrica/Acta Paediatrica*, 97, 641–646. doi: 10.1111/j.1651-2227.2008.00757.x

Kapperman, G. & Kelly, S. M. (2013). Sex education instruction for students who are visually impaired: Recommendations to guide practitioners. *Journal of Visual Impairment*, 107(3), 227-230.

Kattari, S. K. (2014). Sexual experiences of adults with physical disabilities: Negotiating with sexual partners. *Sexuality and Disability*, 32, 499-513. doi: 10.1007/s11195-014-9379-z

Kef, S. & Bos, H. (2006). Is love blind? sexual behavior and psychological adjustment of adolescents with blindness. *Sexuality and Disability*, 24, 89–100. doi:10.1007/s11195-006-9007-7

Kelly, S. M. & Kapperman, G. (2012). Sexual activity of young adults who are visually impaired and the need for effective sex education. *Journal of Visual Impairment & Blindness*, 106(9), 519-526.

Kennedy, S., Treanor, D., & O'Grady, M. (2008). DAWN (Disability Advisors Working Network), *Handbook of teaching students with disabilities: Guidelines for academic staff*. Cork: NAIRTL.

- Khan, F., Pallant, J. F., Ng, L., & Whishaw, M. (2011). Sexual dysfunction in multiple sclerosis. *Sexuality and Disability*, 29, 101–111. doi: 10.1007/s11195-011-9198-4
- Kılıç, B., Ünver, V., Bolu, A., & Demirkaya, Ş. (2012). Sexual dysfunction and coping strategies in multiple sclerosis patients. *Sexuality and Disability*, 30(1), 3-13.
- Kijak, R. (2013). The sexuality of adults with intellectual disability in Poland. *Journal of Sexuality and Disability*, 31, 109–123. doi: 10.1007/s11195-013-9294-8
- Khoei-Merghati, E., Qaderi, K., Amini, L., & Korte, J. E. (2013). Sexual problems among women with multiple sclerosis. *Journal of the Neurological Sciences*, 331, 81–85.
- Koç, Z. & Sağlam, Z. (2013). Determining the correlation between sexual satisfaction and loneliness levels in patients with hemodialysis in a Muslim community. *Sexuality and Disability*, 31(1), 13-29.
- Kreuter, M., Sullivan, M., & Siösteen, A. (1994). Sexual adjustment after spinal cord injury-comparison of partner experiences in pre- and postinjury relationships. *Paraplegia*, 32(11), 759-770.
- Krupa, C. & Esmail, S. (2010). Sexual health education for children with visual impairments: talking about sex is not enough. *Journal of Visual Impairment and Blindness*, 104(6), 327-337.
- Kumar, D. D. & Stefanich, G.P. (2001) *Science instruction for students with visual impairments*. ERIC Digest. Retrieved from <http://www.gpo.gov/fdsys/pkg/ERIC-ED464805/pdf/ERIC-ED464805.pdf> on March, 2015.
- Küçük, L., Kaya, H., Küçük, M., Yoğun, Ö., & Buzlu, S. (2013). The relationship between depression and perception of sexuality in patients with type II diabetes in Turkey. *Sexuality and Disability*, 31(1), 43-52.
- Lambrick, F. & Glaser, W. (2004). Sex offenders with an intellectual disability. *Sexual abuse: A journal of research and treatment*, 16(4),

Law No 5378 (2005). *Engelliler Hakkında Kanun*, retrieved from <http://www.mevzuat.gov.tr/MevzuatMetin/1.5.5378.pdf> on February, 2015.

Law No. 5825 (2008). *Engellilerin Haklarına İlişkin Sözleşmenin Onaylanmasının Uygun Bulunduğuna Dair Kanun*, Retrieved from <https://www.tbmm.gov.tr/kanunlar/k5825.html> on February, 2015.

Lew-Starowicz, M. & Rola, R. (2014). Correlates of sexual function in male and female patients with multiple sclerosis. *Journal of Sexual Medicine*, 11, 2172–2180. doi: 10.1111/jsm.12622

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Lindsay, W. R., Bellshaw, E., Culross, G. Staines, C., & Michie, A. (1992). Increases in knowledge following a course of sex education for people with intellectual disabilities. *Journal of Intellectual Disability Research*, 36(6), 531-539

Mack, N., Woodsong, C., MacQueen, K. M., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's field guide*. Family Health International, USA.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *Qualitative Research Series*, 358(9280), 483-488.

McCabe, M. P., & Cummins, R. A. (1996). The sexual knowledge, experience, feelings and needs of people with mild intellectual disability. *Education and Training in Mental Retardation and Developmental Disabilities*, 31(1), 13–22.

McCabe M. P. & Taleporos, G. (2003). Sexual esteem, sexual satisfaction, and sexual behavior among people with physical disability. *Archives of Sexual Behavior: An Interdisciplinary Research Journal*, 32(4), 359-369.

McCabe, M. P., Cummins, R. A., & Deeks, A. A. (1999). Construction and psychometric properties of sexuality scales: Sex knowledge, experience, and needs scales for people with intellectual disabilities (SexKen-ID),



people with physical disabilities (SexKen-PD), and the general population (SexKen- GP). *Research in Developmental Disabilities*, 20(4), 241-254.

McCabe, M. P. (1999). Sexual knowledge, experience, and feelings among people with disability. *Sexuality and Disability*, 17(2), 157-170.

McGillivray, J. A. (1999). Level of knowledge and risk of contractingHiv/Aids amongst young adults with mild/moderate intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 12(2), 113-126.

MEB (2013). *Sağlık bilgisi ders kitabı*. Retrieved from <http://www.meb.gov.tr/2013-2014-egitim-ogretim-yili-elektronik-ortamda-hizmete-sunulan-ilk-ve-orta-ogretim-ders-kitaplari/duyuru/6319> on May, 2015.

Mendes, A. K., Cardoso, F. L., & Savall, A. C. R. (2008). Sexual satisfaction in people with spinal cord injury. *Sexuality and Disability*, 26(3), 137-147. doi:10.1007/s11195-008-9083-y

Ministry of Health (2010). *Sexual health and reproduction health, national strategic action plan for health sector 2005-2015*. Retrieved from <http://sbu.saglik.gov.tr/Ekutuphane/kitaplar/a%C3%A7sap9.pdf> on June 13, 2014.

Moin, V., Duvdevany, I., & Mazor, D. (2009). Sexual identity, body image and life satisfaction among women with and without physical disability. *Journal of Sexuality and Disability*, 27, 83–95. doi:10.1007/s11195-009-9112-5.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

O'Brien, M. (1990). *On seeing a sex surrogate*. The Sun Magazine. Retrieved from [http://thesunmagazine.org/issues/174/on\\_seeing\\_a\\_sex\\_surrogate](http://thesunmagazine.org/issues/174/on_seeing_a_sex_surrogate) on May 2015.

Oliver, M. (1990, July). The individual and social models of disability. In *joint workshop of the living options Group and the Research Unit of the Royal College of Physicians* (Vol. 23). Retrieved from <http://disability-studies.leeds.ac.uk/files/library/Oliver-in-soc-dis.pdf> on May, 2015.

Oliver, M. (1996). *Understanding Disability: From theory to Practice*. New York, Palgrave.

Oksel, E. & Çıray-Gündüzoğlu, N. (2014). Investigation of life experiences of women with scleroderma. *Sexuality and Disability*, 32(1), 15-21.

Othman, A. S. & Engkasan, J. P. (2011). Sexual dysfunction following spinal cord injury: The experiences of malaysian women. *Sexuality and Disability*, 29, 329–337. doi: 10.1007/s11195-011-9207-7

Önem, R., Çelik, S., Öncü, J., Tankaya, O., Kolat, U., Sungu- Danışmant, B., Sevindik, C. S., & Özer, Ö. A. (2014). Assessment of marital adjustment and sexuality in women with rheumatoid arthritis. *Archives of Rheumatology*, 29(4), 280-288. doi: 10.5606/ArchRheumatol.2014.4293

Özdemir, L., Ayvaz, A., & Poyraz, Ö. (2003) Cumhuriyet üniversitesi öğrencilerinin cinsel yolla bulaşan hastalıklar konusundaki bilgi düzeyleri. *C. Ü. Tıp Fakültesi Dergisi*, 25(1), 10-14.

Özgüven, İ.E. (1997). *Cinsellik ve cinsel yaşam*. Ankara: PDREM Yayınları.

Özyürek. M. (1995). *Görme yetersizliği olan çocuğu bağımsızlığa hazırlamak için ana baba rehberi*. T.C. Başbakanlık Aile Araştırma Kurumu Yayınlan. Ankara: Bizim Büro Basımevi.

Özürlüler İdaresi Başkanlığı (OZİDA) (2009). *Toplum özürlülüğü nasıl anlıyor?*. Retrieved from [http://www.ozida.gov.tr/arastirma/toplum\\_ozurlulugu\\_nasil\\_anliyor.pdf](http://www.ozida.gov.tr/arastirma/toplum_ozurlulugu_nasil_anliyor.pdf) adresinden on January, 2015.

Özürlüler İdaresi Başkanlığı (OZİDA) (2009). *4. Özürlüler şûrası istihdam yöntemleri ve yeni yaklaşımlar komisyonu*, Başbakanlık Özürlüler İdaresi Başkanlığı, Ankara

Özürlüler İdaresi Başkanlığı (OZİDA) (2010). *Problems and expectancies of disabled people*. Retrieved from [http://www.turkstat.gov.tr/Kitap.do?metod=KitapDetay&KT\\_ID=1&KITA\\_P\\_ID=244](http://www.turkstat.gov.tr/Kitap.do?metod=KitapDetay&KT_ID=1&KITA_P_ID=244) on Jan, 2015.

- Parla, A. (2001). The 'honor' of the state: Virginity examinations in Turkey. *Feminist Studies*, 27, 65-88. <http://dx.doi.org/10.2307/3178449>
- Pinquart, M. & Pfeiffer, J. P. (2012). What is essential is invisible to the eye: Intimate relationships of adolescents with visual impairment. *Journal of Sexuality and Disability*, 30(2), 139-147. doi:10.1007/s11195-011-9248-y
- Qaderi, K. & Khoei, E. M. (2014). Sexual problems and quality of life in women with multiple sclerosis. *Sexuality and Disability*, 32(1), 35-43. doi:10.1007/s11195-013-9318-4
- Quinn, H., Flood, S., Mendelowitz, E., Marie, R. A., & Foley, F. (2015). Predictors of fear of sexual rejection in individuals with multiple sclerosis. *Sexuality and Disability*, 33(1), 53-61. doi: 10.1007/s11195-014-9374-4
- Reitz, A., Tobe, V., Knapp, P.A., & Schurch, B. (2004). Impact of spinal cord injury on sexual health and quality of life. *International Journal of Impotence Research*, 16(2), 167-74.
- Sahay, R. D., Haynes, E. N., Rao, M. B., & Pirko, I. (2012). Assessment of sexual satisfaction in relation to potential sexual problems in women with multiple sclerosis: a pilot study. *Sexuality and Disability*, 30(2), 227-236. doi: 10.1007/s11195-011-9242-4
- Sakelleriaou, D. (2006). Sexuality and disability: A discussion on care of the self. *Sexuality and Disability*, 30, 187-197. doi:10.1007/s11195-011-9219-3
- Sarıtaş, E. (2012). Seksoloji: 1945-1955 arası Türkiye'de cinsel terbiye. *Fe Dergi: Feminist Eleştiri*, 4(1). Retrieved from [http://cins.ankara.edu.tr/8\\_6.pdf](http://cins.ankara.edu.tr/8_6.pdf) on May, 2015.
- Sart, Z. H., Ala, H., Yazlık, Ö., & Kantaş Yılmaz, F. (2004). Sınıf öğretmenlerinin kaynaştırma eğitimindeki yeterlilikleri. *Kastamonu Eğitim Dergisi*, 18(2) 345-354.
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and social sciences*. New York. Teachers College Press.

- Shakespeare, T. (2000). Disabled sexuality: toward rights and recognition. *Sexuality and Disability*, 18(3), 159-166.
- Shakespeare, T. & Gillespie-Sells, K. (1996). *The sexual politics of disability: Untold desires*. London: Cassell.
- Shuttleworth, R. (2012). Bridging theory and experience: A critical-interpretive ethnography of sexuality and disability. In McRuer, R. & Mollow, A. (Ed.), *Sex and Disability*. Duke University Press.
- SIECUS (1996). *Guidelines for comprehensive sexuality education. Guidelines for comprehensive sexuality education: Kindergarten–12th grade*. New York. Retrieved from <http://sexedu.org.tw/guideline.pdf> on January, 2015.
- Siebers, T. (2012). A sexual culture for disabled people. In McRuer, R. & Mollow, A. (Ed.), *Sex and Disability*. Duke University Press.
- Siösteen, A., Lundqvist, C., Blomstrand, C., Sullivan, L., & Sullivan, M. (1990). Sexual ability, activity, attitudes and satisfaction as part of adjustment in spinal cord-injured subjects. *Paraplegia*, 28(5), 285-95.
- Sipski, M.L., Alexander, C. J., & Rosen, R. (2001). Sexual arousal and orgasm in women: effects of spinal cord injury. *Annals of Neurology*, 49(1), 35-44.
- Siyez, D. & Siyez, E. (2009). Üniversite öğrencilerinin cinsel yolla bulaşan hastalıklara ilişkin bilgi düzeylerinin incelenmesi. *Türk Üroloji Dergisi*, 35(1), 49-55.
- Sprecher, S. & McKinney, K. (1993). *SAGE Series on Close Relationships: Sexuality*. Thousand Oaks, CA: SAGE Publications, Inc. doi: <http://dx.doi.org/10.4135/9781483326252>
- Sungur Ergenoğlu, A. & Yıldız, S. E. (2013). Fiziksel erişilebilirlik. In Menda, E., Balkan N., & Berktaş, N. (Ed.) *Engelsiz Türkiye için: Yolun neresindeyiz? Mevcut durum ve öneriler* (pp. 123-173). İstanbul: Sabancı Üniversitesi Yayınları.
- Supalo, C. (2005). Techniques to enhance instructors' teaching effectiveness with

chemistry students who are blind or visually impaired. *Journal of Chemistry Education*. 82(10), 1513-1518.doi: 10.1021/ed082p1513

Şenyurt-Akdağ, A., Tanay, G., Özgül, H., Kelleci-Birer, L., & Kara, Ö. (2011). *Türkiye’de engellilik temelinde ayrımcılığın izlenmesi raporu*. Retrieved from İstanbul Bilgi Üniversitesi İnsan Hakları uygulama ve Araştırma Merkezi. [http://insanhaklarimerkezi.bilgi.edu.tr/docs/Engellilik\\_Izleme\\_Raporu.doc](http://insanhaklarimerkezi.bilgi.edu.tr/docs/Engellilik_Izleme_Raporu.doc) on March, 2015.

Tamam, Y., Tamam, L., Akil, E., Yasan, A., & Tamam, B. (2008). Post-stroke sexual functioning in first stroke patients. *European Journal Of Neurology*, 15(7), 660-666.

Tuğrul, B. & Artan, İ. (2001). Çocukların cinsel eğitimi ile ilgili anne görüşlerinin incelenmesi. *Hacettepe Üniversitesi Eğitim Fakültesi Dergisi*, 20(20), 141- 149.

TurkStat (2002). Turkey disability survey report. TurkStat’s report in 2002 retrieved from [http://www.tuik.gov.tr/PreTablo.do?alt\\_id=1017](http://www.tuik.gov.tr/PreTablo.do?alt_id=1017) on January, 2014.

TurkStat (2010). *Survey on problems and expectations of disabled people*. Retrieved from [http://www.eyh.gov.tr/upload/Node/8703/files/survey\\_on\\_problems\\_and\\_expectations\\_of\\_disabled\\_people\\_2010.pdf](http://www.eyh.gov.tr/upload/Node/8703/files/survey_on_problems_and_expectations_of_disabled_people_2010.pdf) on June 13, 2014.

UN & Demography Association (2007). *Turkey youth sexual and reproductive health survey*. Retrieved from [http://www.nd.org.tr/custom/odesismc/Ingilizce\\_rapor.pdf](http://www.nd.org.tr/custom/odesismc/Ingilizce_rapor.pdf) on January, 2015

UN (2006). *United Nations convention on the rights of persons with disabilities*. Retrieved from [http://www.un.org/disabilities/documents/convention/convention\\_accessible\\_pdf.pdf](http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf) on January 2015.

UPIAS (1976). *Fundamental principles of disability*. Retrieved from <http://disability-studies.leeds.ac.uk/files/library/UPIAS-fundamental-principles.pdf> on January, 2015.

Weeks, J. (1986). *Sexuality*. Psychology Press. London: Routledge.

Westgren, N., Hultling, C., Levi, R., Seiger, A., & Westgren, M. (1997). Sexuality in women with traumatic spinal cord injury. *Acta Obstetrica et Gynecologica Scandinavica*, 76(10), 977-83.

WHO (2001). *International Classification of Functioning, Disability and Health*. Retrieved from [http://psychiatr.ru/download/1313?view=1&name=ICF\\_18.pdf](http://psychiatr.ru/download/1313?view=1&name=ICF_18.pdf) on May, 2015.

WHO (2006). *World health report: Working together for health*. Retrieved from [http://apps.who.int/iris/bitstream/10665/43432/1/9241563176\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43432/1/9241563176_eng.pdf) on March, 2015.

WHO (2011). *World report on disability*. Retrieved from [http://www.who.int/disabilities/world\\_report/2011/report.pdf](http://www.who.int/disabilities/world_report/2011/report.pdf) on March, 2015.

WHO Regional Office for Europe/BZgA (2010). *Standards for sexuality education in Europe*. Cologne.

WHO (2014). "Visual Impairment and Blindness", Retrieved from <http://www.who.int/mediacentre/factsheets/fs282/en/> on May, 2015.

WHO (2015). *The revised version of ICD 10* (International Classifications of Diseases). Retrieved from <http://apps.who.int/classifications/icd10/browse/2015/en> on January, 2015.

Varol Saraçoğlu, G., Erdem, İ., Doğan, S., & Tokuç, B. (2014). Gençlik cinsel sağlığı: Türkiye'deki bir üniversitede öğrenciler arasında cinsel bilgi, tutumlar ve davranışlar. *Nöropsikiyatri Arşivi*, 51, 222-228. doi: 10.4274/npa.y6768.

Yakut Çakar, B., Küçükaslan, B., & Yılmaz, V. (2013). İstihdam. In Menda, E., Balkan N., & Berktaş, N. (Ed.) *Engelsiz Türkiye için: Yolun neresindeyiz? Mevcut durum ve öneriler* (pp. 229-259). İstanbul: Sabancı Üniversitesi Yayınları.

- Yaşan, A., Eşsizoglu, A., & Yıldırım, E. A. (2009). Predictor factors associated with premarital sexual behaviors among university students in an Islamic culture. *International Journal Of Sexual Health*, 21, 145–152. doi: 10.1080/19317610903113813
- Yazganoğlu, K., Özarmağan, G., Tozeren, A., & Özgülnar, N. (2012). Üniversite öğrencilerinin cinsel yolla bulaşan enfeksiyonlar hakkında bilgi, tutum ve davranışları. *Deri Hastalıkları ve Frengi Arşivi Dergisi*, 46, 20-25.
- Yelçe, N. Z., Burat, M. B., & Ensari, P. D. (2013). Bilgi ve hizmete erişim. In Menda, E., Balkan N., & Berktaş, N. (Ed.) *Engelsiz Türkiye için: Yolun neresindeyiz? Mevcut durum ve öneriler* (pp. 19-123). İstanbul: Sabancı Üniversitesi Yayınları.
- Yıldırım, A. & Şimşek, H. (2005). *Sosyal Bilimlerde Nitel Araştırma Yöntemleri*. Seçkin Yayıncılık.
- Yoshida, L. & Odette, F. (1999) Cross-cultural views of disability and sexuality: experiences of a group of ethno-racial women with physical disabilities. *Sexuality and Disability*, 17(4), 321-337.
- Young, R., Gore, N., & McCarthy, M. (2012). Staff attitudes towards sexuality in relation to gender of people with intellectual disability: A qualitative study. *Journal of Intellectual & Developmental Disability*, 37(4), 343–347. doi: 10.3109/13668250.2012.70498
- Wild, T., Kelly, S., Blackburn, M., & Ryan, C. (2014). Adults with visual impairments report on their sex education experiences. *Journal of Blindness Innovation and Research*, 4(2). Retrieved from <https://nfb.org/images/nfb/publications/jbir/jbir14/jbir040202.html>. doi: <http://dx.doi.org/10.5241/4-42>
- Wilkinson, V. J., Theodore, K., & Raczka, R. (2014). ‘As normal as possible’: Sexual identity development in people with intellectual disabilities transitioning to adulthood. *Sexuality and Disability*, 33(1), 93-105. doi: 10.1007/s11195-014-9356-6

## APPENDICES

### Appendix A: First Version of Interview Schedule

**Tarih ve saat (başlangıç ve**

**bitiş):** \_\_\_\_\_

**Görüşmenin yapıldığı yer:**

\_\_\_\_\_

**Katılımcı ile iletişimi sağlayan**

**kişi/kurum:** \_\_\_\_\_

#### **Giriş**

Merhaba, ben ODTÜ Rehberlik ve Psikolojik Danışmanlık yüksek lisans programı öğrencisi Hilal Döner. Görme engelli yetişkinlerde cinsel bilgi, cinsel deneyim ve cinsel eğitime yönelik görüşler üzerine bir araştırma yapıyorum ve sizinle bu konuda konuşmak istiyorum. Görme engelli bireylerle bu konuda görüşme yapmak istememin sebebi cinselliğe ilişkin bilgi, deneyim ve algıları sizin bakış açınızdan yansıtmak isteyişimdir. Araştırmadan çıkacak sonuçların görme engelli yetişkinlerin cinselliğinin anlaşılmasına, konu ile ilgili eğitim programlarının düzenlenmesine ve ilgili politika yapıcılara öneriler sunulmasına yardımcı olacağını düşünüyorum. Bu sebeple konu ile ilgili duygu ve düşüncelerinizi samimiyetle yanıtlamanız elde edilecek sonuçlar ve sunulacak öneriler açısından oldukça önemlidir.

Görüşme yaklaşık bir saat sürmektedir. Bu görüşme sürecinde söyleyeceklerinizin tümü gizli tutulacaktır. Araştırma bulguları yazılırken, kişisel bilgileriniz ve sizi çağırabileceğiniz türde bilgiler kesinlikle rapora yansıtılmayacaktır. Ancak katılım



sırasında kendinizi rahatsız hissederseniz, istediğiniz zaman görüşmeyi sonlandırmak istediğinizi belirtebilirsiniz.

Görüşmeyi izin verirsiniz kaydetmek istiyorum. Bunun sizin için bir sakıncası var mı?

Başlamadan önce, söylediklerimle ilgili sormak istediğiniz bir soru var mı?

## **Görüşme Soruları**

### **A.Kişisel Bilgiler**

- Yaş:
- Medeni Durum:
- Doğum yeri:
- En uzun süre yaşanılan yer:
- Öğrenim durumu:
- Çalışma durumu:
- Gelir düzeyi (Kişinin gelire ilişkin yeterlik algısı):
- Görme engeli dışında başka bir engel var mı?:
- Engel düzeyi (resmi oran-kişinin deneyimi):
- Engelin başlangıcı (doğuştan-sonradan):
- Bağımsız hareket (kişinin algısı):
- Engele yönelik eğitim alma durumu:
- Anne-Baba (Sağ/Ölü – Eğitim durumu):

### **B.Cinsel Bilgi**

- Cinsel bilgi açısından kendinizi nasıl değerlendiriyorsunuz?
  - Erkek/Kadın anatomisi, üreme, mastürbasyon, regl, cinsel birleşme, cinsel yolla bulaşan hastalıklar, doğum kontrol yöntemleri, vb. konularda.
- Şu anda var olan cinsel bilginizi nasıl elde ettiniz?
  - Cinsel bilgi kaynakları: aile, akranlar, sağlık personeli, okul,

öğretmen, kardeşler, medya (internet, radyo, gazete), vb.

- Cinsel bilgi düzeyinizden memnun musunuz?
  - Memnun değilseniz, ne tür bilgileri öğrenmiş olsaydınız size yardımcı olurdu?
  - Memnunsanız, ne tür cinsel bilgiler size en çok yardımcı oldu?
  - Cinsel deneyiminizde var olan bilgilerinizin yeterli olduğunu düşünüyor musunuz?

### **C. Cinsel Deneyim**

Şimdi, çocukluktan yetişkinliğe kadar sizin cinsel deneyiminiz ile ilgili bazı sorular soracağım.

- Çocukluk döneminden bugüne kadar çevrenizdeki insanlardan sizin cinselliğe ilişkin duyduklarınız nelerdir?
  - yetiştiği ortamda söylenenler, algıda bir değişiklik olup olmadığı, aileden hissedilen bir baskı olup olmadığı vb.
- Cinselliğe ilişkin hatırladığınız ilk anınızı anlatabilir misiniz?
  - Kaç yaşındaydınız?
  - Bu anının olduğu duruma geri dönerseniz ne gibi bir duygunun baskın olduğunu söylersiniz?
  - Bu olay/durum sonrasında cinselliğe nasıl bir algınız (kanınız) oluştu?
- Ergenlik dönemindeki bedensel/fizyolojik değişiklikleri nasıl deneyimlediniz?
  - Kadın ve erkek bedenindeki değişiklikler, cinsel etkinlikler vb.
- İlk cinsel deneyiminizden bahsedebilir misiniz?
  - Kaç yaşındaydınız?
  - Nasıl bir deneyimdi?
  - Bu deneyim nasıl bir ilişki içerisinde gelişti?
- Şimdiki cinsel yaşamınızı nasıl değerlendiriyorsunuz?
  - Hangi ortamlarda cinsel partner buluyorsunuz?
  - Beraberlik yaşadığınız kişi/kişilerde size çekici gelen özellikler nelerdir? (ses, koku, dokunma, duygusal olgunluk, kişisel

özellikler, vb.)

- Seksi kadın/erkek/partneri nasıl tanımlarsınız?
- Cinsel etkinlikler

#### **D.Cinsel Eğitim**

Bu bölümde birbiri ile bağlantılı üç soru soracağım.

İlk olarak;

- Cinsel eğitimin erişilebilirliğini nasıl değerlendiriyorsunuz?
  - Öğretim teknik ve materyallerinin erişilebilirliği vb.
- Cinsel eğitimin içeriğini nasıl değerlendiriyorsunuz?
  - Cinsel eğitim içeriğinde engelli bireylerin cinselliğine ilişkin ayrı bir bölüm olmalı mı? Bu konuda düşünceleriniz nelerdir?
- Sizce görme engelli bir birey için ideal cinsel eğitim nasıl olmalıdır?
  - İçerik, materyal, öğretim yöntemi, eğitim ortamı, vb.

#### **Kapanış**

- Konu ile ilgili size sorulmayan ancak önemli olduğunu düşündüğünüz ve paylaşmak istediğiniz bir şey var mı?

**Zaman ayırdığınız ve katılımınız için teşekkür ederim.**

## Appendix B: Final Version of Interview Schedule

**Tarih ve saat (başlangıç ve bitiş):** \_\_\_\_\_

**Görüşmenin yapıldığı yer:** \_\_\_\_\_

**Katılımcı ile iletişimi sağlayan kişi/kurum:** \_\_\_\_\_

### Giriş

Merhaba, ben ODTÜ Rehberlik ve Psikolojik Danışmanlık yüksek lisans programı öğrencisi Hilal Döner. Görme engelli yetişkinlerde cinsel bilgi, cinsel yaşantı ve cinsel eğitime yönelik görüşler üzerine bir araştırma yapıyorum ve sizinle bu konuda konuşmak istiyorum. Görme engelli bireylerle bu konuda görüşme yapmak istememin sebebi cinselliğe ilişkin bilgi, deneyim ve algıları sizin bakış açınızdan yansıtmak isteyişimdir. Araştırmadan çıkacak sonuçların görme engelli yetişkinlerin cinselliğinin daha iyi anlaşılmasına, konu ile ilgili eğitim programlarının düzenlenmesine ve ilgili politika belirleyicilere öneriler sunulmasına yardımcı olacağını düşünüyorum. Bu sebeple konu ile ilgili duygu ve düşüncelerinizi samimiyetle yanıtlamanız elde edilecek sonuçlar ve sunulacak öneriler açısından oldukça önemlidir.

Görüşme yaklaşık iki saat sürmektedir. Görüşme esnasında ihtiyaç duyduğunuz takdirde ara verilebilecektir. Bu görüşme sürecinde söyleyeceklerinizin tümü gizli tutulacaktır. Araştırma bulguları yazılırken, kişisel bilgileriniz ve sizi çağrıştıracak türde bilgiler kesinlikle rapora yansıtılmayacaktır. Ancak katılım sırasında kendinizi rahatsız hissederseniz, istemediğiniz soruları yanıtlamayabilir ve dilediğiniz zaman görüşmeyi sonlandırmak istediğinizi belirtebilirsiniz.

Görüşmeyi izin verirseniz kaydetmek istiyorum. Bunun sizin için bir sakıncası var mı?

Başlamadan önce, söylediklerimle ilgili sormak istediğiniz bir soru var mı?

## Görüşme Soruları

### A. Kişisel Bilgiler

Bu bölümde sizinle ilgili bilgi alabileceğim çeşitli sorular soracağım.

- Yaş:
- Medeni Durum:
- Doğum yeri:
- En uzun süre yaşanılan yer:
- Öğrenim durumu:
- Çalışma durumu:
- Gelir düzeyi:
- Görme engeli dışında başka bir engel var mı?:
- Engel düzeyi:
- Engelin başlangıcı:
- Bağımsız hareket:
- Engele yönelik eğitim alma durumu:

Şimdi anne babanız ile ilgili bilgi almak istiyorum.

- Anne-Baba (Sağ/Ölü – Eğitim durumu):

### B. Cinsel Bilgi

Bu bölümde size cinselliğe ilişkin bildiklerinizle ilgili çeşitli sorular soracağım.

Cinsel bilgi bu çalışma kapsamında erkek-kadın anatomisi, üreme, mastürbasyon, cinsel birleşme, menstürasyon, cinsel yolla bulaşan hastalıklar, korunma yöntemleri dahil olmak üzere cinselliğe ilişkin bildikleriniz anlamına gelmektedir.

- Cinselliğe ilişkin bildiklerinizi düşününce kendinizi nasıl değerlendiriyorsunuz? Erkek/Kadın anatomisi, üreme, mastürbasyon, regl, cinsel birleşme, cinsel yolla bulaşan hastalıklar doğum kontrol yöntemleri, oral/anal seks, orgazm vb. hangi konularda bilginiz var? En fazla? En az?
- Cinselliğe ilişkin bildiklerinizi nasıl öğrendiniz? Cinsel bilgi kaynakları: aile, akranlar, sağlık personeli, okul, öğretmen, kardeşler,

medya (internet, radyo, gazete), vb.

- Cinselliğe ilişkin bildikleriniz karşılaştığınız durumlarda yeterli oluyor mu? Yeterli ise, hangi açılardan yeterli? Ne tür cinsel bilgiler size en çok yardımcı oldu?
- Yetersiz ise, hangi açılardan yetersiz? Daha öncesinde neleri biliyor olsaydınız size daha yararlı olurdu?

### **C. Cinsel Yaşantı**

Şimdi, çocukluktan yetişkinliğe kadar cinsel yaşantınız ile ilgili bazı sorular soracağım.

- Cinselliğe ilişkin hatırladığınız ilk anınızı anlatabilir misiniz?
  - Kaç yaşındaydınız?
  - Bu anının olduğu duruma geri dönerseniz ne gibi bir duygunun baskın olduğunu söylersiniz?
  - Bu olay/durum sonrasında cinselliğe ilişkin nasıl bir algınız (kanınız) oluştu?

Şimdi bireysel cinselliğiniz ve ergenlik dönemi ile ilgili sorular soracağım.

- Ergenlik dönemindeki bedensel/fizyolojik değişiklikleri nasıl deneyimlediniz?
  - Kadın ve erkek bedenindeki değişiklikler, cinsel etkinlikler, mastürbasyon, ıslak rüya vb.
- Varsa, ilk cinsel deneyiminizden bahsedebilir misiniz?
  - Kaç yaşındaydınız?
  - Nasıl bir deneyimdi?
  - Bu deneyim nasıl bir ilişki içerisinde gelişti?
- Şimdiki cinsel yaşamınızı nasıl değerlendiriyorsunuz?
  - Cinsel partner bulma konusunda zorluk çekiyor musunuz? Çekiyorsanız, bu zorluklar nelerdir? Çekmiyorsanız, bugüne kadar hangi ortamlarda cinsel partner buldunuz/buluyorsunuz? Cinsel partnerinizde size çekici gelen özellikler nelerdir? (ses, koku, dokunma, duygusal olgunluk, kişisel özellikler, vb.)
  - Seksi kadın/erkek/partneri nasıl tanımlarsınız?

Şimdi cinsel etkinliklerinize ilişkin sorular soracağım.

- Engelli cinsel partneriniz oldu mu? Engelli olan ve olmayan partnerlerinizle cinsel yaşantılarınızı nasıl karşılaştırırsınız?
- Aktif cinsel hayatınız varsa cinsel hastalıklardan korunma ve doğum kontrol yöntemi kullanıyor musunuz?
- Yetişkinlerin cinsel etkinlikleri sırasında kullanabilecekleri dergi, video, film, fotoğraf gibi materyaller mevcut. Siz bu tarz materyaller kullanıyor musunuz? Kullanıyorsanız neler?
- Engelinizden dolayı cinsel yaşamınıza ilişkin ailenizden/akrabalarınızdan/arkadaşlarınızdan/çevrenizden gelen herhangi bir baskı, kısıtlama yaşadınız mı? Yaşadıysanız sizin cinselliğe bakışınızı nasıl etkiledi?
  - Engellilerin cinselliğine yönelik varsa çevrenizden duyduklarınız sizin cinselliğe bakışınızı nasıl etkiledi?
- Engelinizden dolayı alay edilme, hor görülme ya da aşağılanmaya maruz kaldınız mı?
- Engelinizden dolayı taciz, cinsel istismar, şiddet, tecavüz/tecavüz girişimine uğradınız mı?
- Engeliniz dolayısıyla dokunma gereksinimi duyduğunuz bir durumda yanlış anlaşıldığınız, bu durumun taciz olarak algılandığı bir yaşantınız oldu mu? Olduysa anlatır mısınız?

#### **D. Cinsel Eğitim**

Bu bölümde birbiri ile bağlantılı üç soru soracağım.

İlk olarak;

- Cinsel eğitim aldınız mı?
- Aldıysanız, ne zaman ve nereden (okul, özel kuruluş ve derneklerin eğitimi vb.)?
- Aldıysanız, cinsel eğitimin erişilebilirliğini nasıl değerlendiriyorsunuz?
  - Öğretim teknik ve materyallerinin erişilebilirliği vb.
- Aldıysanız, cinsel eğitimin içeriğini nasıl değerlendiriyorsunuz?
  - Sizce hangi konuları kapsamalı?
  - Genel cinsel eğitim uygulamalarında engelli bireylerin cinselliğine

ilişkin ayrı bir bölüm olmalı mı? Bu konuda düşünceleriniz nelerdir?

- Sizce görme engelli bir birey için ideal bir cinsel eğitim nasıl olmalıdır?
- Yetişkin biri olarak çocuk ve ergen görme engelli bireyleri düşündüğünüzde bu kişilere cinsellik eğitimi ile ilgili önerileriniz neler olurdu?

**Kapanış**

- Konu ile ilgili size sorulmayan ancak önemli olduğunu düşündüğünüz ve paylaşmak istediğiniz bir şey var mı?

**Zaman ayırdığınız ve katılımınız için teşekkür ederim.**



## Appendix C: Informed Consent

Sayın Katılımcı;

Bu çalışma Doç. Dr. Zeynep Hatipoğlu Sümer'in danışmanlığında, ODTÜ Eğitim Bilimleri Bölümü, Rehberlik ve Psikolojik Danışmanlık Yüksek Lisans Programı öğrencisi Hilal Döner tarafından yürütülmektedir. Çalışma kapsamında görme engelli bireylerin cinsel bilgi, cinsel yaşantı ve cinsel eğitime yönelik görüşlerinin incelenmesi amaçlanmaktadır.

Çalışmanın amacı doğrultusunda, yaklaşık iki saat süren bir görüşme yapılacaktır. Görüşmede cinsel bilgi, cinsel yaşantı ve cinsel eğitim ile ilgili soruların yer aldığı yarı yapılandırılmış bir görüşme formu kullanılacaktır. Çalışmaya katılım tamamıyla gönüllülük temelindedir. Bu görüşme sürecinde söyleyeceklerinizin tümü gizli tutulacaktır. Araştırma bulguları yazılırken, kişisel bilgileriniz ve sizi çağırabilecek türde bilgiler kesinlikle rapora yansıtılmayacaktır. Ancak katılım sırasında kendinizi rahatsız hissederseniz, istemediğiniz soruları yanıtlamayabilir ve dilediğiniz zaman görüşmeyi sonlandırmak istediğinizi belirtebilirsiniz.

Çalışmanın objektif olması ve elde edilecek sonuçların güvenilirliği bakımından anket uygulamalarında *samimiyetle duygu ve düşüncelerinizi yansıtacak* şekilde yanıtlar vermeniz önemlidir. Görüşme verilerinin analiz sürecinde kullanılabilmesi için sizin açınızdan da uygunsa görüşmeyi kaydetmek istiyorum. Uygulama sonunda bu çalışma ile ilgili sorularınız cevaplanacaktır. Katılımınız için şimdiden teşekkür ederim.

Çalışma hakkında daha fazla bilgi almak için Arş. Gör. Hilal Döner (Tel: 0312 210 71 96; E-posta: [hilal@metu.edu.tr](mailto:hilal@metu.edu.tr)) ile iletişim kurabilirsiniz.

***Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesip çıkabileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayımlarda kullanılmasını kabul ediyorum.*** (Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

Tarih

İmza

## Appendix D: Turkish Summary

### 1.GİRİŞ

Engellilik tanımı ve anlamı zaman içerisinde farklılaşmıştır. Geçmiş dönemlerde engellilik bir hastalık ve bireysel bir sorun olarak anlamlandırılmış ve bu kavrayış doğrultusunda engellilik yalnızca yeti yitiminin olumsuz sonuçları temelinde değerlendirilmiştir (Oliver, 1996). Engelliliğe yaklaşım açısından medikal modelin egemen olduğu bu dönemde sosyal değişim yerine engelli kişilerin topluma kendi çabaları ve uzmanların tedavisi aracılığıyla uyum sağlaması beklenmiştir (Oliver, 1996). İngiltere’de engelli bireyler tarafından kurulmuş olan Ayrımcılığa Karşı Fiziksel Engelliler Sendikası tarafından yayınlanan “Engelliliğin Temel İlkeleri” (UPIAS, 1976) adlı metin ile birlikte ilk kez yeti yitimi ve engellilik ayrı iki kavram olarak tanımlanmış ve engelliğe yaklaşımı kökten değiştirecek olan sosyal model ortaya çıkmıştır.

Sosyal model savunucuları engelliliğin yeti yitiminin ötesinde bir toplumsal sorun olduğunu belirterek; toplumsal alandan dışlanma, ayrımcılık ve çevresel engellere vurgu yapmışlardır. Dolayısıyla, engelli kişilerin tedavi edilmesi yerine toplumsal bir değişimin engelleri ortadan kaldıracağını öngörmüşlerdir (Oliver, 1996; Shakespeare, 2000; UPIAS, 1976). Bu anlayış değişikliği ile birlikte engellilik çalışmaları alanında engelli bireylerin farklı alanlarda karşılaştıkları güçlükler, ayrımcılık ve engelli hakları sıklıkla araştırmalara konu olmuştur. Ancak, Shakespeare’in (2000) de belirttiği üzere kamusal olarak kabul gören eğitim, sağlık ve istihdam gibi alanlar engellilik çalışmalarına sıklıkla konu olurken; özel ve kişisel bir alan olarak tanımlanan cinsellik konusu engellilik çalışmalarında yakın bir zamana kadar önemli bir yer edinmemiştir.

Engellilik ve cinsellik konuları ayrı ayrı düşünüldüğünde her iki konunun da toplumsal bağlamda anlam kazandığı görülmektedir. Yukarıda özetlenen tabloya benzer bir şekilde Türkiye’de de engellilik çalışmaları alanında eğitim, istihdam ve ayrımcılık gibi konular sıklıkla ele alınmış; ancak, cinsellik ve engellilik konusunda benzer bir yol izlenmemiştir. Engelli bireylere ilişkin

istatistikler Türkiye nüfusunun %12.29'unun, kronik hastalık ve psikiyatrik durumlar (%9.70), hareket engeli (%1.25), görme engeli (%0.60), işitme engeli (%0.37), dil ve konuşma bozuklukları (%0.38) ve zihinsel engel (%0.48) gibi engel gruplarında yer aldığını göstermektedir (DİE, 2002). Aynı istatistikler engelli bireylerin istihdam, okuryazarlık ve ekonomik durum ile ilgili sorunlar yaşadığına ve en önemli beklentilerinin engelli bireyler için ekonomik desteğin artırılması olduğuna işaret etmektedir. Görgül çalışmalar ve derleme çalışmaları da engelli bireylerin sosyal hayata tam ve eşit katılım anlamında engellerle karşılaştığını; ekonomik, çevresel, mimari ve eğitimle ilgili engellerin de mevcut olduğunu ortaya koymaktadır (Burcu, 2007; Güneş, Aktaş, Konuk & Şahsuvaroğlu, 2013; TurkStat, 2010; Yakut Çakar, Küçükaslan & Yılmaz, 2013). Buna ek olarak, fiziksel erişilebilirlik (Barış ve Uslu, 2009; Çağlar, 2012; Sungur Ergenoğlu ve Yıldız, 2013; TurkStat, 2010), bilgi ve hizmetlere erişim (Yelçe, Burat ve Ensari, 2013), politik katılım (Akdeniz, Balamir Coşkun, Demiryol ve Yılmaz, 2013), sağlık ve rehabilitasyon hizmetlerine erişim (Aydın ve Aktaş, 2013; TurkStat, 2010) açısından da engelli kişilerin güçlüklerle karşılaştığı belirtilmiştir. Ayrıca engelli bireylere yönelik acıma gibi duyguların Türkiye toplumunda yaygın olduğu, engelliliğin önemli bir çoğunluk tarafından Allah'ın insana verdiği bir sınav olarak görüldüğü ve engelli bireylerin ayrımcılığa maruz kaldığı da rapor edilmiştir (Şenyurt-Akdağ, Tanay, Özgül Birer ve Kara, 2011; OZİDA, 2010).

Türkiye'de önemli oranda engelli nüfus bulunması ve bu grubun farklı sorunlarla karşılaşılıyor olmasına rağmen cinsellik açısından olası sorun ve taleplerinin bilinmeyip; bu konuda kapsamlı bir çalışma yapılmaması şaşırtıcı bir durum olarak görülmemelidir. Nitekim, cinsellik Türkiye'de halen tartışmalı bir konudur. Kadın cinselliği üzerindeki baskı ve kısıtlamalar, bekaret, 'namus' cinayetleri, başlık parası, evlilik içi tecavüz ve bekaret kontrolleri gibi farklı biçimlerde devam etmektedir (İlkkaracan, 2001; Parla, 2001; Sarıtaş, 2012). Toplumun genel muhafazakar yapısı ve İslam dininin etkisi cinsellik algısını şekillendirmektedir. Çeşitli araştırmalarda, dinsel (religiosity) mastürbasyon, kürtaj, eşcinsellik ve evlilik öncesi cinsellik gibi konulara yönelik cinsel tutumları şekillendirdiği (Ergun, 2007; Hatipoğlu Sümer, 2015); mastürbasyon ve cinsel

birleşme gibi cinsel davranışlarla ilişkili olduğu (Yaşan, Essizoğlu ve Yıldırım, 2009) bulunmuştur. Ayrıca, cinsel davranış sıklığı, ilk cinsel birleşme zamanı ve bekaretin cinsiyet ile ilişkili olduğu da belirtilmiştir (Askun ve Ataca, 2007; Yaşan, Essizoğlu ve Yıldırım, 2009). Bu anlamda görgül çalışmalar da Türkiye’de cinselliğin deneyimlenmesi ve cinselliğe ilişkin tutumlar ile dinselliğin ve toplumsal cinsiyetin ilişkisini desteklemektedir. Buna ek olarak, ilgili alanyazın cinsel yolla bulaşan hastalıklar konusundaki bilginin artırılması ihtiyacını (Çok v.d., 2001; Hatipoğlu Sümer’s, 2006; Siyez ve Siyez, 2009; Varol Saraçoğlu v.d., 2014) ve aile içerisinde sağlıklı cinsellik iletişimin kurulması gerektiğini ortaya koymaktadır (Bulut ve Gölbaşı, 2009; Erbil v.d., 2010; Tuğrul ve Artan, 2001).

Engellilik ve cinsellik konulu çalışmalara ilginin son yıllarda arttığı gözlemlenmektedir. Bu çalışmalar belli engel grupları bağlamında cinselliğe dair net ve kesin sonuçlar ortaya koymasa da konuyla ilgili önemli bir bilgi kaynağı olmaktadır. İlgili alanyazın özellikle engelli bireyler arasında yeti yitiminden kaynaklı cinsel işlev bozukluklarına ve yeti yitiminin olumsuz sonuçlarına odaklanmaktadır. Multiple Skleroz (MS) ve spinal kord yaralanması durumlarında cinsel işlev bozuklukları, cinsel doyum ve arzuda azalma ile yeti yitiminin ilişkisi gibi farklı çalışmalar tarafından ortaya konulmuştur (Ghajarzadeh v.d., 2014; Gümüş v.d., 2013; Khan v.d., 2011; Mendes v.d., 2008; Othman & Engkasan, 2011; Quinn v.d., 2015; Sipski v.d., 2001). Hareket engelli bireyler arasında da düşük cinsel bilgi seviyesi, cinsel özsaygı ve cinsel doyumda azalma, engeller dolayısıyla cinsel yaşamının etkilenmesi ve cinsel işlev bozukluklarının varlığı çeşitli çalışmalar aracılığıyla gösterilmiştir (Altuntuğ, Ege, Akın, Kal ve Sallı, 2014; Elbozan Cumurcu, Karlıdağ ve Han Almış; 2012; Jemata, Fulg Meyer ve Öberg, 2008; McCabe v.d., 2000; McCabe ve Taleporos, 2003).

Bir grup araştırmacı da engelli bireylerin cinsel yaşamının yeti yitiminin etkisinden de öte çeşitli engelleyici durumlar ve çevresel engeller dolayısıyla olumsuz etkilenebileceğini savunmaktadır (Gershick, 2006; Shakespeare, 2000; Shakespeare, Gillespie Sells ve Davies, 1996; Shuttleworth, 2012; Siebers, 2012). Bu bağlamda engelli bireylerin istihdam, eğitim ve fiziksel erişilebilirlik açısından yaşadıkları sorunlar, partner bulma ve sosyal yaşama katılma olanaklarındaki kısıtlılıkların cinsel ilişkileri başlatma, geliştirme ve sürdürme açısından güçlük

yaratabileceği de vurgulanmaktadır. Engelli bireylerin toplum tarafından aseksüel ve korunması gereken kişiler olarak algılanmasının da cinsellik açısından engelleyici olduğu belirtilmektedir (Shakespeare v.d., 1996; Shakespeare, 2000). Siebers'in (2012) da belirttiği gibi engelli bireyler cinsel ilişki yaşama yetisine sahip değilmiş gibi algılanmakta ve cinsel açıdan özerklikleri yok sayılmaktadır. Bahsi geçen alanyazın engelli bireylerin cinsel deneyimlerinin yeti yitiminin getirebileceği olası güçlükler dışında da birçok faktörden etkilenebileceğine işaret etmektedir.

Görme engellilerde cinsellik konusu ise cinsellik ve engellilik ile ilgili alanyazında çok daha bakir bir alan olarak karşımıza çıkmaktadır. Görme engelinin cinsel işlevler ve cinselliğin deneyimlenmesi üzerine doğrudan etkisinin olduğunu gösteren bir çalışmanın olmaması bu durumu açıklayan bir sebep olarak gösterilmektedir (Glass, 1984). Ancak cinsellik fiziksel, sosyal ve psikolojik birçok boyutu içermektedir ve yalnızca cinsel işlevler konusundan ibaret değildir. Görme engelinin cinselliği doğrudan etkilediğine yönelik bir çalışma olmasa da, alanda çalışan kişiler, görmeme durumunun çevresel faktörlerle de birleşerek farklı cinsiyet özelliklerini görerek anlama ve tanıma, göz kontağı kurma, yüz ifadelerini anlama ve beden dilini okuma gibi cinsellikle ilişkili sosyal gelişimi etkileyebileceğini belirtmektedirler (Davies, 1996; Glass, 1984; Özyürek, 1995). Buna ek olarak, görme engelli çocukların, gören çocuklarla benzer gelişim evrelerinden geçtiği, ancak cinselliğin sosyal ve fiziksel boyutlarıyla ilgili olan cinsel anatomi bilgisi, öz saygı ve sosyal beceri gibi kişisel bileşenlerin yeti yitiminden etkilenebileceği düşünülmektedir (Davies, 1996). Bir diğer değişle, görme engelinin fizyolojik açıdan değil de cinselliğe ilişkin bilgi edinme (anatomik özellikler vb.) ve cinsellikle ilgili olan sosyal gelişim (sosyal beceri, özsaygı, yüz ifadeleri ve beden dilini anlama vb.) üzerinde etkili olabileceği öne sürülmektedir.

Görme engeli ve cinselliğe ilişkin mevcut alanyazın genellikle cinsel bilgi ve cinsellik eğitimi konularına ilişkin az sayıda çalışmadan oluşmaktadır. Bu çalışmalar içerisinde yalnızca cinsellik eğitimine ilişkin olanların daha net ve kesin görünen sonuçları bulunmaktadır. Cinsellik eğitimine ilişkin çalışmalar, mevcut cinsellik eğitimi programlarının görme engelli bireylerin ihtiyaçları göz önüne

alınarak hazırlanmadığını göstermektedir (Krupa ve Esmail, 2010; Wild, Kelly, Blackburn ve Ryan, 2014). Görme engeline özgü uyarlamaların yapılmaması, erişilebilirlikle ilgili sıkıntılar, eğitim içeriğinin yetersizliği ve dokunsal materyallerin eksikliği, görme engelli bireylerin cinsellik eğitiminden yeterince faydalanamamasına neden olmaktadır. Cinsel bilgiye ilişkin kısıtlı sayıda araştırmalardan birinde görme engelli bireylerin yeterli cinsel bilgiye sahip oldukları belirtilirken (Kef ve Bos, 2006); bir diğerinde gören kişilere kıyasla daha az cinsel bilgiye sahip oldukları belirtilmektedir (Duh, 2000). Sınırlı örneklemelerle gerçekleştirilen ve farklı bulguları olan bu çalışmalardan cinsel bilgi düzeyine ilişkin kesin bir sonuca ulaşmak mümkün görünmemektedir. Türkiye’de gerçekleştirilen bir çalışmada başlıca cinsel bilgi kaynakları arkadaşlar ve kitle iletişim araçları olarak ortaya çıkarken (İrdem, 2006); bir başka çalışmada, aileler ve kitle iletişim araçları başlıca bilgi kaynakları olarak bulunmuştur (Kef ve Bos, 2000). Cinsel yaşantı ile ilgili olarak, Kelly ve Kapperman’ın (2012) çalışmasında görme engellilerin cinsel yaşantılarının gören akranlarından farklı olmadığı, ancak akranlarına kıyasla daha geç bir dönemde cinselliği yaşıladıkları bulunmuştur. Öte yandan, Pinquart ve Pfeiffer’in (2012) çalışması da görme engelliler ve görenler arasında ilk cinsel birleşme zamanının farklı olmadığını, ancak görme engellilerin romantik ilişki deneyimlerinin daha geç bir dönemde başladığını göstermektedir. İlgili bir diğer çalışma da görme engelli erkeklerin görme engelli kadınlara kıyasla cinsellik ile daha fazla ilgili olduğunu, mastürbasyon ve cinsel birleşme gibi cinsel davranışları daha sık deneyimlediklerini, daha çok cinsel partnerleri olduğunu ve cinsel fantezilere ilişkin daha fazla düşündüklerini ortaya koymuştur (Abramson, Boggs ve Mason, 2013).

### **1.1. Çalışmanın Önemi ve Amacı**

İlgili alanyazın bütünlüklü olarak göz önüne alındığında görme engeli ve cinselliğe ilişkin çalışmalar kısıtlı sayıda olması, sonuçların farklılaşması, bilgi, yaşantı ve eğitim boyutunun bütünlüklü bir şekilde ele alınmaması dolayısıyla kapsamlı bir bilgi sunma noktasında yetersiz kalmaktadır. Cinselliğin ve engelliliğin farklı bağlamlarda farklı anlamlar taşıyabileceği de düşünüldüğünde, Türkiye’de görme engelli bireylerin cinsellik deneyimlerinin bilgi, yaşantı ve cinsellik eğitimine ilişkin olarak detaylı bir şekilde ele alınması önem

kazanmaktadır. Dolayısıyla, bu çalışmada görme engelli yetişkinlerde cinsel bilgi, cinsel yaşantı ve cinsellik eğitimine ilişkin görüşlerin incelenmesi amaçlanmaktadır. Çalışmaya yön veren araştırma soruları şu şekildedir:

- 1) Görme engelli yetişkinler cinsel bilgi açısından kendilerini nasıl değerlendiriyorlar?
- 2) Görme engelli yetişkinler cinsel bilgiye nasıl erişim sağlıyorlar?
- 3) Görme engelli yetişkinler cinselliği nasıl deneyimliyorlar?
- 4) Görme engelli yetişkinler arasında cinsellik eğitimine ilişkin görüşler nelerdir?

## **2. YÖNTEM**

### **2.1 Araştırma Deseni**

Araştırma soruları, çalışmanın herhangi bir genelleme amacı taşıması, sayısal verilere ulaşma ve tek bir cevap arama eğiliminde olunmaması (Braun ve Clarke, 2013) göz önüne alınarak; görme engelli yetişkinlerin kendi deneyimlerini dillendirebilmelerine olanak sağlaması açısından çalışmada nitel araştırma deseni kullanılmıştır. Nitel araştırma yöntemi yaklaşımlarından biri olan olgubilim, bir olguya ilişkin yaşam deneyimlerinin göz önüne alınarak; kişisel anlam, görüş ve perspektiflerin yansıtılabileceği bir yaklaşımdır (Creswell, 2006, s.57). Ayrıca bu yaklaşım sıklıkla araştırılmamış olan olguların derinlikli bir şekilde incelenmesi için de uygun bulunmaktadır (Yıldırım ve Şimşek, 2005, s.72). Bu sebeplerle görme engelli yetişkinlerde cinsellik deneyimleri olgusunun bilgi, yaşantı ve cinsellik eğitimi bağlamında incelenmesini amaçlayan bu çalışmada da olgubilim yaklaşımı kullanılmıştır.

### **2.2. Veri Toplama Aracı**

Veri toplama süreci yarı yapılandırılmış görüşmeler aracılığıyla gerçekleştirilmiştir. Görüşmede kullanılan soru formu, ilgili alanyazın ve araştırma soruları doğrultusunda geliştirilmiştir. İlk görüşme formu uzman görüşü ve etik kurul onayı alındıktan sonra bir pilot görüşme ile test edilmiş ve görüşme sorularına son hali verilmiştir.

### 2.3. Veri Toplama Süreci

Görüşme formunun hazırlanmasının ardından araştırmacı bilgileri (e-posta, öğrenim bilgisi vb.), katılım ölçütleri ve çalışmaya ilişkin genel bilgileri içeren bir davet mektubu hazırlanmış ve katılımcılara ulaşmak amacıyla görme engelli bireylerin üye olduğu farklı e-posta gruplarında bu yazı paylaşılmıştır. E-posta aracılığıyla yapılan duyurular dışında birçok görme engelli derneği ile iletişim kurulmuştur. Bu yöntemle ek olarak çalışmaya katılan kişilerin yönlendirmesi ile de farklı katılımcılara ulaşılmıştır. Çalışmaya katılım ölçütleri aşağıdaki şekildedir:

- 1) Görme engelli olmak (doğuştan ya da yaşamın erken dönemlerinde oluşan görme engeli),
- 2) 18 yaşından büyük olmak,
- 3) Görme engeli dışında herhangi bir engeli bulunmamak.

Görüşmeler 10.01.2015 ve 15.03.2015 tarihleri arasında Ankara ve İstanbul illerinde gerçekleştirilmiştir. Görüşme öncesinde katılımcının onayı alınarak görüşmeler ses kayıt cihazı ile kaydedilmiştir. Bu süre zarfında toplam 26 kişi ile görüşme yapılmıştır. Ancak görme engeli dışında farklı engeli olduğu belirlenen kişiler örneklemden çıkarılmıştır. Veri toplama süreci sonunda toplamda 8 kadın, 10 erkek olmak üzere 18 katılımcı çalışmaya dahil edilmiştir.

### 2.4. Katılımcılar

Katılımcıların özellikleri göz önüne alındığında yaşlarının 20 ile 42 arasında görülmektedir. Cinsel yönelim açısından 3 katılımcı kendini eşcinsel, queer ve biseksüel eğilimleri olan kişiler olarak tanımlarken; katılımcıların büyük çoğunluğu kendilerini heteroseksüel olarak tanımlamıştır. Evlilik durumu açısından 5 katılımcı evli, 13 katılımcı bekardır ve bekar olanlar arasından yalnızca bir kişi halihazırda romantik ilişki içerisinde olduğunu belirtmiştir. Katılımcıların büyük çoğunluğu (n = 15) kamu sektöründe tam zamanlı olarak çalışmaktadır. Eğitim durumu açısından ise katılımcıların yarısı üniversite mezunu ve diğer yarısı ise lise ya da daha alt eğitim düzeyi mezunudur. Katılımcıların önemli bir kısmı 8 yıl görme engelliler okulunda eğitim görmüşlerdir (n = 14). Görme engelinin oluşum zamanı göz önüne alındığında yine büyük çoğunluğun doğuştan belli



düzeylerde görme engelli olduğu görülmektedir (n = 14). Katılımcıların sağlık raporlarındaki engel oranı %85 ile %100 arasında değişmekte olup; yalnızca 3 katılımcı kendini tamamen kör olarak tanımlamıştır. Geri kalan 15 katılımcı belli düzeylerde ışık ve gölge algısı olduğunu belirtmişlerdir. Gelir düzeyi algısı ile ilgili olarak 12 katılımcı gelirlerini yetersiz ya da kısmen yeterli olarak algıladıklarını belirtmişlerdir. Buna ek olarak, görme engeline ilişkin olarak ortaya çıkan ihtiyaçlar söz konusu olduğunda (erişilebilirlikle ilgili materyal ve teknolojik cihazlar vb.) 12 katılımcı gelirlerinin bu gibi durumlarda yetersiz olduğunu belirtmiştir. Katılımcılardan 8'i bağımsız hareketini gündelik yaşam için yeterli olarak değerlendirirken, 7'si ortalamanın üzerinde ve çok yeterli olduğunu belirtmiştir. Katılımcılardan 3'ü de bağımsız hareketlerini yetersiz bulmuştur. Aile eğitim düzeyi göz önüne alındığında katılımcıların ebeveynlerinin büyük bir çoğunluğunun ilköğretim mezunu ya da okuryazar olduğu görülmektedir. Son olarak katılımcıların büyük çoğunluğu yaşamlarının uzun bir bölümü İstanbul ve Ankara gibi büyük şehirlerde geçirmişlerdir.

## **2.5. Veri Analizi**

Veri toplama sürecini takiben görüşmelerin deşifreleri araştırmacı tarafından yapılmış ve veriler tematik analiz yöntemi kullanılarak analiz edilmiştir. Braun ve Clarke'ın (2006) belirttiği gibi tematik analiz yöntemi deşifre, kodlama ve temaların belirlenmesi aşamaları doğrultusunda yapılmıştır. Açık kodlama aşamasında araştırma soruları bağlamında belli örüntülerin olduğu fark edilmiş ve kodlama genel olarak bu sorular bağlamında seçici kodlama yöntemiyle yapılmıştır. Kodlar ve alt kodların son hali belirlendikten sonra veriler tekrar bu kodlar bağlamında gözden geçirilmiştir. Kodlama sonucunda cinsel bilgi, cinsel yaşantı ve cinsellik eğitime ilişkin farklı kategoriler ortaya çıkmıştır. Araştırmanın güvenilirliğini artırmak amacıyla ilgili alanyazında belirtilen yöntemlerden akran değerlendirmesi (peer review), süpervizör tarafından süreç denetimi (audit trail), üye kontrolü (member check) ve uzman görüşü kullanılmıştır (Creswell ve Miller, 2000; Ezzy, 2002; Lincoln ve Guba, 1985).

Araştırmadan elde edilen sonuçlar görme engelli yetişkinler arasında cinsel bilgi, cinsel bilgi kaynakları, farklı boyutlarıyla cinsel yaşantılar, geçmiş cinsellik eğitimi deneyimleri ve cinsellik eğitime ilişkin görüşlere ışık tutmaktadır. Cinsel

bilgi düzeyi ve yeterliliği açısından kendilerini değerlendiren katılımcıların büyük bir çoğunluğu (n = 12) cinselliğe ilişkin bilgilerinin yeterli olduğunu belirtmişlerdir. Katılımcıların bir kısmı da (n = 6) bilgi düzeylerini kısmen yeterli olarak değerlendirmiştir. Sonuçlar katılımcıların cinselliğe ilişkin belli konularda daha kapsamlı bilgi ihtiyacı duyduklarını ortaya koymaktadır. Cinsel birleşme deneyimi olmayan erkek katılımcıların kadın cinsel organını kavramada güçlük çektikleri ve hem kadın cinsel organı, hem de cinsel birleşme konusunda bilgiye ihtiyaç duydukları görülmüştür. Erkek katılımcıların aksine, cinsel birleşme ya da erkek cinsel organına dokunma deneyimi olmayan kadınların, erkek cinsel organına dair bilgi ihtiyaçlarının olmadığı ve kavrama konusunda güçlük çekmedikleri görülmüştür. Buna ek olarak, cinsel yolla bulaşan hastalıklar, cinsel birleşme pozisyonları ve doğum kontrol yöntemleri, erkek katılımcıların daha fazla bilgi edinmek istediği konular olarak ortaya çıkmıştır. Kadın katılımcılar arasında da doğum kontrol yöntemleri, üreme, doğum, cinsel yolla bulaşan hastalıklar, mastürbasyon, orgazm, oral/anal seks ve cinsel birleşmeye ilişkin bilgi ihtiyacı olduğu gözlemlenmiştir. İlgili alanyazına uygun olarak, her iki grupta da HIV/AIDS en çok bilinen cinsel yolla bulaşan hastalık olmuştur, ancak farklı türde cinsel yolla bulaşan hastalıklar konusunda da bilgi ihtiyacı bulunmaktadır (Ekşi ve Kömürcü, 2014; Siyez ve Siyez, 2009; Varol Saraçoğlu, Erdem, Doğan ve Tokuç, 2014).

### **3. BULGULAR VE TARTIŞMA**

#### **3.1. Cinsel Bilgi**

Cinsel bilgi kaynakları ile ilgili olarak bulgular kitle iletişim araçları (internet, tv, okuma materyalleri vb.) (n = 18), yaşantısal öğrenme (n = 18) ve arkadaşların (n = 15) başlıca bilgi edinme kaynakları olduğunu göstermektedir. Bulgular, yaşantısal öğrenmenin, yani deneyimleyerek ya da dokunarak öğrenmenin katılımcılar açısından en somut cinsel bilgiyi sağladığını ortaya koymuştur. Yaşantısal öğrenme bu yönüyle birçok katılımcı tarafından güvenilir bir bilgi edinme kaynağı olarak görülmektedir. Bu bulgu, görme engelliler açısından dokunma ve deneyimlemenin önemine, bilgi ve yaşantının bir anlamda iç içe geçmiş olduğuna işaret etmektedir. Öte yandan, internet ve özellikle erkek katılımcılar açısından arkadaşlar güvenilirliği düşük olan kaynaklar olarak

değerlendirilmektedir. İrdem'in (2006) Türkiye'de gerçekleştirdiği çalışmaya benzer bir şekilde, aile ve cinsellik eğitimi, katılımcıların cinsel bilgi edinme konusunda daha az faydalandığı kaynaklar olarak ortaya çıkmıştır. Bu noktada, Türkiye'de cinsellik eğitimi programlarının eksikliği ve aile içi cinsellik iletişiminin kısıtlı olmasının (Bulut ve Gölbaşı, 2009; Erbil, Orak ve Bektaş, 2010; Tuğrul & Artan, 2001) katılımcıların bu gibi kaynaklardan faydalanamamasına sebep olduğu söylenebilir. Katılımcıların erişilebilirliği sağlayan çeşitli teknolojilerle (örneğin Jaws) işitsel olarak önemli oranda cinsel bilgi edindiği görülsede bulgular, yaşantısal öğrenmenin görme engelliler açısından bilginin somutlanmasında üstün bir kaynak olduğunu ortaya koymaktadır. Ancak görsel materyallerin cinselliğin öğrenilmesinde baskın olarak kullanılması, dokunsal materyallerin eksikliği ve Glass'ın (1984) da belirttiği gibi dokunmanın önündeki toplumsal engeller, cinsel anatominin öğrenilmesi açısından katılımcılara engel oluşturmaktadır.

### **3.2. Cinsel Yaşantı**

Cinsel yaşantı ile ilgili bulgular katılımcıların ergenlik dönemindeki değişiklikleri genel olarak şaşkınlık, heyecan ve mutluluk gibi duygularla karşıladıklarını göstermektedir. Buna ek olarak, kıllanma, cinsel arzuyu nasıl tatmin edeceği konusunda bilgi sahibi olmama, yüz ve bedendeki değişiklikler (sivilce vb.), bazı katılımcılar tarafından kaygı veren ergenlik dönemi değişiklikleri olarak tanımlanmıştır. Kadın katılımcılar açısından ergenlik döneminde öne çıkan konular regl ve bedensel değişiklikler (kıllanma, göğüslerin belirginleşmesi vb.) olurken; erkek katılımcılar açısından öne çıkan konular ıslak rüyalar, mastürbasyon ve bedensel değişiklikler olmuştur. Bulgular, kadın katılımcıların ergenlik döneminde kadınlığa geçiş sürecine ilişkin sosyal normlar, aile gözetimi ve aile kontrolü sebebiyle baskı algıladıklarını göstermektedir. Abramson, Boggs ve Mason'ın (2013) çalışmasına paralel olarak mastürbasyon ve ıslak rüya erkek katılımcılar arasında kadın katılımcılara göre daha yaygındır. Önemli bir diğer bulgu da, erkek katılımcılar arasında erken dönem ıslak rüya içeriklerinin cinsel yaşantı sonrasında değişmesidir. Kadın cinsel organına dokunma ya da cinsel birleşme deneyimi sonrasında erkek katılımcılar ıslak rüya içeriklerinin gerçeğe daha yakın olacak şekilde değiştiğini vurgulamışlardır. Cinsel

bilgi kaynaklarında da belirtildiği gibi yaşantısal öğrenmenin önemi ıslak rüya içeriklerinin değişmesiyle kendini yeniden göstermektedir. Kadın katılımcıların aksine erkekler açısından mastürbasyon konusu ergenlik döneminde özellikle arkadaşlar arasında sıkça konuşulan konulardan biridir. Erkek katılımcılar arasında, farklı kadın seslerinden etkilenecek ya da çeşitli cinsel fantaziler oluşturarak mastürbasyon yapıldığı görülmektedir. Ancak erkekler arasında mastürbasyon sonrası suçluluk, mastürbasyonun dini anlamda uygun olup olmadığı üzerine düşünceler ve bu endişelerle birlikte gelen kendini kısıtlamaların mevcudiyeti de araştırmada ortaya çıkmıştır. Bu bulgu, mastürbasyona yönelik cinsel tutumun dini öğretilerden etkilenme ile ilişkili olduğunu gösteren çalışmaları destekler niteliktedir (Hatipoğlu Sümer, 2015; Yaşan v.d., 2009). Buna ek olarak, ergenlik döneminde özellikle erkek katılımcıların önemli bir kısmı yatılı okulda kız-erkek ilişkilerinin yönetim tarafından baskılandığını belirtmişlerdir. Görme engelli kadınların regl dönemlerine ilişkin sıklıkla merak edilen konulara da katılımcıların deneyimleri ışık tutmaktadır. Kadın katılımcılar regl olmaya başladıklarında yakınlarından ve kendilerinden büyük arkadaşlarından regl ve ped kullanımı konusunda bilgi alsalar da, bu dönem sonrasında kendilerine özgü görmeye dayalı olmayan yöntemler kullanmışlardır. Sivilceler, ağrı, göğüslerde hassasiyet ve gerginlik gibi belirtiler üzerinden ya da gün sayma ve sıvının yapısına dokunma gibi yöntemler ile regl dönemini anlama kadın katılımcılar tarafından sıklıkla ifade edilmiştir. Benzer bir şekilde, kıllanma ve kişisel temizlik gibi konularda da hem kadın, hem erkek katılımcılar akranlar, aile ve kendilerinden büyük arkadaşlardan da bilgi edinerek; kendilerine has görmeye dayalı olmayan yöntemler geliştirmişlerdir.

Yetişkinlik dönemi cinsel yaşantılarına ilişkin bulgular kadın katılımcıların yarısının ( $n = 4$ ) ve iki erkek katılımcının cinsel birleşme deneyimi olmadığını göstermektedir. Bulgular, ilk cinsel birleşme deneyimi esnasında kadın katılımcıların bilgi, deneyim ve haz eksikliği gibi durumlarla karşılaştıklarını, utanç ve heyecan gibi duygular yaşadıklarını göstermektedir. Erkek katılımcılar arasında ilk cinsel birleşmeye ilişkin bulgular bilgi eksikliğinin kadınlara kıyasla daha az deneyimlendiğini ve partner ile iyi iletişimin ilk cinsel birleşmeyi güzel kıldığını ortaya koymaktadır. Genelevde ilk cinsel birleşme deneyimini yaşayan az

sayıda erkek katılımcı bu deneyimlerini olumsuz ve romantik duygulardan yoksun olarak değerlendirmiş ve bunları ilk cinsel birleşme deneyimi olarak değerlendirmek istememişlerdir. Ayrıca yalnızca 6 katılımcının halihazırda bir cinsel partneri olduğu ve bunlardan 5'inin evli olduğunu görülmüştür. Cinsel partneri olan katılımcıların yarısı güncel cinsel yaşamlarından memnun olmadıklarını belirtmiştir. Evli ve küçük çocuğu olan katılımcılar eşlerinin de görme engelli olması nedeniyle evde çocuk bakımı için bir kişinin olmasının ve hamilelik sonrası dönemin cinsel yaşamlarını kısıtladığını belirtmişlerdir. Cinsel partneri olmayan katılımcıların yarısı, güncel cinsel yaşamlarının ortalamanın altında olduğunu belirtmiştir. Partneri olmayan kadınların bir kısmı da evlilik öncesi cinsel ilişkiye karşı olduklarını ve cinsel partner arayışında olmadıklarını belirtmiştir. Bulgular, partneri olmayan kadın katılımcılar arasında mastürbasyon gibi bireysel cinsel etkinliklerin erkeklere oranla daha az olduğunu göstermektedir.

Katılımcıların önemli bir bölümünün herhangi bir romantik ilişki içerisinde olmaması ve cinsel partnerlerinin bulunmaması, katılımcıların romantik ve cinsel ilişki kurma açısından karşılaştıkları engellerle açıklanabilir. Bulgular, katılımcıların görme engeline bağlı önyargılar ve ayrımcılık ile karşılaştıklarını ve bu sebeple ilişki kurmada güçlük yaşadıklarını göstermektedir. Katılımcıların önemli bir çoğunluğu partner bulmada güçlük yaşadıklarını belirtmişlerdir (n = 13). Bu güçlüğün temel sebeplerinden birinin de görme engeli ve insanların engelli biriyle birlikte olma konusundaki olumsuz yaklaşımları olduğu belirtilmiştir. Cesaretsizlik ve bekaret, evlilik öncesi cinsellik ve cinsel yolla bulaşan hastalıklara ilişkin kaygılar da bu güçlükler arasındadır. Katılımcıların görme engeli dolayısıyla olası partnerler tarafından reddedildikleri ya da reddedilme korkusu taşıdıkları için özellikle gören kişilerle romantik ilişki kurma konusunda sıkıntı yaşadıkları da bulunmuştur.

Sakelleraou (2006) tarafından da belirtildiği gibi, katılımcılar olası partnerler tarafından kişisel özelliklerinin görmezden gelindiğini ve yalnızca görme engeline odaklanıldığını vurgulamışlardır. Bu durumun da ilişki kurmanın önünde bir engel olduğu ortaya çıkmıştır. İnternet üzerinden tanışma gibi durumlarda da görme engelli olduklarını belirttikten sonra karşı tarafın yaklaşımının değiştiği ve ilişki kurulamadığı belirtilmiştir. Buna ek olarak,

özellikle erkekler katılımcılar arasında yaşantılanan cinsiyetsizleştirme süreci katılımcıların ilişki geliştirmesinin önündeki bir diğer engeldir. Katılımcılardan bir kısmı cinsel arzuları, ihtiyaçları ve bir cinsel yaşamı olduğu gerçeğinin diğer insanlar tarafından görülmediğini ve özellikle erkek katılımcılar kadınların kendilerine engelli olmayan erkeklere davrandıklarından farklı davrandıklarını belirtmektedir. Siebers (2012) tarafından vurgulanan engelli kişilerin diğer kişiler gözünde insan konumunu yitirmesi durumu, bu durumda engelli kişilerin “kadın” ve “erkek” olma konumunu yitirmesi olarak ortaya çıkmaktadır. Bulgular, katılımcıların önemli bir kısmının a (n = 9) tanıdığı ya da tanımadığı insanlardan cinselliklerine ilişkin rahatsız edici sorular aldığını göstermektedir. “Siz nasıl seviyorsunuz?” ve “deliği nasıl buluyorsun?” gibi sorulara ek olarak görme engellilerin cinselliğine ilişkin yapılan ayrımcı şaka ve fıkraların katılımcıları rahatsız ettiği görülmüştür. Cinsiyetsizleştirme örneğine benzer bir şekilde bahsi geçen bu sorular da insanların görme engellilerin cinsellik açısından yeterliliklerine ilişkin önyargıları olduğuna işaret etmektedir.

Abramson, Bogs ve Mason’ın (2013) bulguları ile uyumlu olarak, katılımcılar açısından cinsel açıdan çekici gelen özellikler ses tonu, koku, konuşma tarzı/diksiyon ve ten olarak ortaya çıkmıştır. Bu bulgu görme engeli durumunda işitsel ve dokunsal diğer özelliklerin, cinsel açıdan çekici özellikler olarak ön plana çıktığına işaret etmektedir. Görmenin romantik ve cinsel ilişki kurma ve özellikle partnerlerle tanışma açısından önemli olduğu belirtilmekte (Sprecher ve Mckinney, 1993) ve “ilk görüşte aşk” gibi sözlerle görmenin rolü vurgulanmaktadır. Bulgular katılımcıların eğitim kurumları (okul, üniversite vb.), kafe vb. sosyal mekanlar, görme engelli dernekleri, internet ve rehabilitasyon merkezleri aracılığıyla partner bulunduğunu göstermektedir. Katılımcılar açısından bu bulgu sadece görme ile değil farklı ortamlarda iletişim kurarak romantik ya da cinsel ilişki başlatılabileceğini göstermektedir.

### **3.3. Cinsellik Eğitimi**

Cinsellik eğitimine ilişkin bulgular katılımcıların kapsamlı cinsellik eğitimi alma deneyimlerinin olmadığını göstermektedir. Ancak İrdem’in (2006) bulgularına benzer bir şekilde önemli sayıda katılımcı (n = 10) sağlık bilgisi dersleri ve sınırlı sayıda cinsellik eğitimi oturumu kapsamında sınırlı bilgi

edindiklerini belirtmişlerdir. Ancak bu ders ve oturumlar kapsamında verilen bilgiler, katılımcıların önemli bir çoğunluğu tarafından içerik ve erişilebilirlik açısından yetersiz olarak değerlendirilmiştir. Görme engelliler açısından ideal cinsellik eğitime ilişkin görüşler, katılımcıların cinsel sağlık, cinsel davranış, insan gelişimi, cinsel ilişkiler ve bireysel ihtiyaçlar gibi konulara da yer veren geniş kapsamlı cinsellik eğitiminden faydalanmak istediklerini göstermektedir. Eğitimin içeriğinde “engellilerde cinsellik” gibi ayrı bir başlığın olmasının gerekli olmadığı, engeli olan ve olmayan bireylerin cinsellik açısından farklı olmadıkları belirtilerek vurgulanmıştır. Böyle bir başlığın, engellilerin cinselliğine yönelik önyargı ve ayrımcılıkları artırabileceği belirtilmiştir. Öte yandan, bir grup katılımcı, böyle bir başlığın engellilerin cinselliğine dair farkındalığı arttırabileceğini ya da hareket engelli kişilerin cinselliği nasıl yaşantıladıklarına ışık tutacağını vurgulamıştır.

Cinsellik eğitime ilişkin ortaya çıkan önemli bir diğer bulgu da katılımcıların erişilebilir cinsellik eğitimi talebidir. Katılımcılar açısından dokunsal materyallerin eğitimdeki rolünün önemi büyüktür. İlgili alanyazın ile uyumlu olarak, cinsel anatomi, beden tipleri ve cinselliğe ilişkin diğer bilgilerin heykeller, 3 boyutlu dokunsal materyaller ve kabartma şekiller aracılığıyla görme engelliler açısından somutlanabileceği belirtilmiştir (Kapperman ve Kelly, 2013; Krupa ve Esmail, 2010; Wild, Kelly, Blackburn ve Ryan, 2014). Buna ek olarak, eğitimde kullanılan okuma materyallerinin erişilebilir olması (Braille, e-kitap formatı vb.) ve eğitimin uygun olduğu durumlarda uygulamayı da içermesinin önemi araştırmada ortaya konmuştur. Katılımcıların yarısı, engelli olmayan kişilerle ve görme engellilerin ihtiyaçlarına da uygun şekilde hazırlanmış kapsayıcı cinsellik eğitimi programlarının olmasını uygun görmektedir. Kapsayıcı olmayan eğitim programlarının ayrımcılık ve önyargılara yol açabileceği düşünülmektedir. Diğer yarısı ise, dokunsal materyallerin gören kişilerin önünde kullanılmasının aşağılanma ve acıma gibi durumlara sebep olabileceğinden ve bu nedenle görme engellilerin ayrı eğitim almasından ya da dokunsal materyallerle yapılacak uygulamanın ayrı bir oturumda yapılmasından yanadır. Ailelerin cinsellik eğitimi alması, çocuklarına cinselliğe ilişkin baskı uygulamaması ve çocuklarını kişisel gelişim ve cinsel bilgi açısından desteklemesi ve cinsellik konusunda çocukları ile

sağlıklı iletişim kurmalarının önemi birçok katılımcı tarafından vurgulanmıştır. Son olarak, cinsel bilgi edinme sürecinde görme engelli kişilerin kaynaklara ulaşma ve kendilerini geliştirme sorumluluklarının olduğu da katılımcılar tarafından belirtilmiştir.

### **3.4. Çalışmanın Çıkarımları**

Araştırma sonuçlarının uygulamacılar, görme engelli çocuğu olan aileler ve politika oluşturucular açısından belli çıkarımları bulunmaktadır. Araştırma hem görme engelli yetişkinlerin belli konularda detaylı cinsel bilgiye ihtiyaç duyduğunu, hem de erişilebilir, kapsamlı cinsellik eğitimi programı talepleri olduğunu göstermiştir. Bu anlamda okul psikolojik danışmanlarının rolü ve cinsellik eğitimi programları oluşturulması açısından savunuculuk temelinde hareketi önem kazanmaktadır. Buna ek olarak, erişilebilir cinsellik eğitimi programlarının hazırlanması konusundaki sosyal politikaların gözden geçirilmesi ve görme engelli bireylerin ihtiyaçlarının göz önüne alınması gerekmektedir. Son olarak, görme engelli çocuğu olan ailelerin çocukları ile cinsellik açısından iyi bir iletişim kurmaları ve bilgi vermeleri cinsel bilgi, yaşantı ve eğitim açısından önem kazanmaktadır.



## Appendix E: Thesis Copy Permission Form

### ENSTİTÜ

Fen Bilimleri Enstitüsü

☐

Sosyal Bilimler Enstitüsü

☒

Uygulamalı Matematik Enstitüsü

☐

Enformatik Enstitüsü

☐

Deniz Bilimleri Enstitüsü

☐

### YAZARIN

Soyadı : Döner

Adı : Hilal

Bölümü : Eğitim Bilimleri Bölümü

**TEZİN ADI** (İngilizce) : Sexual Knowledge, Sexual Experiences and Views on Sexuality Education among Adults with Visual Disabilities

**TEZİN TÜRÜ** : Yüksek Lisans

☒

Doktora

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