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Institutionalized Queers:
Homosexuality in Residential Facilities for People with Cognitive Disabilities

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Abstract

This article discusses the subject of how homosexual behavior is dealt with in German residential facilities for people with cognitive disabilities. It is based on empirical data from a qualitative pilot study funded by the German Ministry for Family, Senior Citizens, Women and Youths. Although homosexuality was only a marginal topic of this study, it was frequently mentioned in interviews held with various care workers.[1] The passages of the interviews that deal with the residents' homosexual behavior, therefore, serve as the empirical basis for this exploratory research. Dudek, Jeschke and Lehmkuhl argue that there still is a knowledge deficit concerning homosexuality and cognitive disability in Germany, which can be observed both in theory and in practice. This article begins with a short overview of how cognitive disability and homosexuality are discussed in the special education literature. It then applies ideas and concepts from the field of queer theory to the subject. The empirical data is classified and analyzed in four subcategories: a) Homosexuality is treated as a taboo, b) Homosexuality is devalued, c) Homosexual residents are not supported and d) Homosexuality is not discriminated against. The last section of this article discusses the results of the study and provides ideas and recommendations for practice.

Keywords: People with cognitive disabilities, homosexuality and intellectual disability, care worker attitudes toward homosexuality

> A pervasive heterosexual assumption conditions work currently done in disabled sexuality studies. In order to eliminate this bias, researchers and theorists in the field must rethink the conceptual framework within which they conduct their analyses (Tremain, 2000, p. 291).

1. Introduction

This article discusses cognitive disability and homosexuality. It begins by providing a brief overview of the developments in the field of special education in Germany. Secondly, it reviews queer theory/feminist theory in order to present different concepts of homosexuality. Thirdly, the article analyzes qualitative interviews with care workers using three subcategories. The last section discusses the results and provides ideas and recommendations on how the situation for queer people with cognitive disabilities can be improved in practice.

2. Cognitive Disability[2] and Sexuality in Germany

In Germany, the discussion about cognitive disability and sexuality has been growing over the last couple of decades. It is not within the scope of this article to thoroughly discuss the historical developments in Germany even though a comparison between the discourses in different European countries with that in the U.S. would be of interest. It will only be briefly mentioned that deinstitutionalization (Bank-Mikkelsen, 1972) and a wider discussion on sexuality and sexualized violence started earlier in the U.S. than in Germany. This discussion is captured by authors such as Crossmaker (1991), Doe (1990), Furey & Nielsen (1994), Sobsey & Mansell (1997) and Tepper (2000).

In Germany one of the most renowned figures in the discussion of cognitive disability and sexuality is Joachim Walter. He has constantly promoted the liberation of (heterosexual) sexuality for people with cognitive disabilities, e.g. by postulating a catalogue of rights. Walter outlined the situation 25 years ago as characterized by a conglomerate of taboos, such as "sexuality, disability resulting in stigma, living in institutions, no influence on one's living conditions, experience of structural and personal violence, etc." (2002a, p. 588) In his established reader, "Sexualität und geistige Behinderung" (Sexuality and Cognitive Disability), which includes several essays by well-known practitioners in the field, Walter describes the development of the relationship between sexuality and cognitive disability. The beginning of the 1970s, for example, was characterized by separate housing for women and men in institutions and anxiety concerning the "extraordinary sex drive" of people with cognitive disabilities. Special education teachers therefore utilized sex education as a means for preparing their students for life without marriage, and recommended that they suppress all forms of sexual expression. Parents were advised not to kiss their child or adolescent and not to take them on their lap or to stroke them too affectionately. Affection was instead to be expressed with the eyes or by patting their shoulder. Tight clothing was to be avoided because of the fear of physical stimulation.

In the field of German special education the first debate on homosexuality took place in the mid-70s. Escher (1975, p. 23-24 quoted by Walter, 2002a, p. 590) wrote, "[…] the step from masturbation to homosexuality […] was a social progress." Here, homosexuality was seen as overcoming egocentric isolation and based upon an improved social bonding capability. Walter (2002a, p. 590) points out that the inhuman non-coeducational structures in the facilities hindered the development of heterosexual behavior. In the late '70s, the first symposia and conferences on cognitive disability and sexuality took place, and a discussion about sexuality as a basic human right followed in the '80s. Still, activists advocating for the right to sexuality were blamed for romanticizing disability. The AIDS crisis in the 1980s was followed by a debate about contraception, during which many facilities for people with disabilities retreated from their prior liberal mission statements. A federal campaign nevertheless succeeded in implementing sex education as a potential means of AIDS prevention. Finally, in 1992 a new legislation made sterilization against one's will illegal. Walter ends his short history by stating that at his time of writing [2002], people with disabilities were formally given the same personal rights to freely develop their sexuality as the so-called "non-impaired normal population." Since the end of the 1990s, there has been a wide variety of publications and few smaller research studies that address practical issues. In addition, seminars, workshops, and on- and off-the-job training on different questions of sex education are available. Additionally, people with cognitive disabilities are entitled to take part in courses teaching self-determination principles, free of charge. Finally, there is an ongoing discussion about the question of sexual assistance to be offered by specialized sex workers or by staff (Walter, 2002a).

3. Cognitive Disability and Homosexuality

The above-mentioned development has, in principle, been positive. Nevertheless, the consideration concerning the topic of disability and sexuality is mainly limited to heterosexual behavior. Tremain's (2002) statement that a heterosexual assumption conditions work done in Disability Studies cannot yet be determined for this rather young discipline in Germany. This aspect, however, must be emphasized when considering standard work in the field of special education. In most textbooks homosexuality is not mentioned at all or is done so in a rather negative context. We can, for example, see in the sex education model proposed by Schröder (in Walter, 2002b, p. 137), how homosexuality is only mentioned in the context of abstinence, masturbation, castration, pornography, celibacy and sexual offenses. In her thesis, Zima (1998), points out that homosexual contacts occur more often in non-coeducation facilities for the cognitive disabled than in those for non-disabled people. This statement is however not further commented upon. She refers to a possible interpretation of this statement by Engler (1975; cited in Zima, 1998, p. 40), who compares the deprivation of disabled people in residential facilities as being similar to imprisonment. Engler comes to the conclusion that the implementation of co-educational approaches in institutions would result in the increasing disappearance of homosexual tendencies. He states, however, that queer-bashing and defamation ought to be avoided in the pedagogical everyday life.

With these passages we merely want to point to a trend, without making an exhaustive claim. The obvious ignorance towards research on homosexuality in the standard work is remarkable especially given that the current state of theory on sexuality has moved beyond these old-fashioned views of homosexuality. Some research on this topic can be found within the field of Disability Studies. Disability Studies favors a social model, which does not focus on disability as an individual problem, but as a social construct (see e.g. Priestley, 2003, pp. 23; Waldschmidt, 2003, pp. 11). This, in turn, implies the questioning of the very category of disability and the utilization of it as a tool for analyzing the construction of normality and ability. This change of perspective opens up an opportunity to see intersections with feminist theories and queer theory. McRuer (2003, p. 79), for example, states, "homosexuality and disability clearly share a pathologized past." It is not exclusively the similar starting point, however, which makes it attractive to apply some of the research done in queer theory to Disability Studies as exemplified by attempts to connect queer studies with Disability Studies in the German context. Raab (2003), for example, emphasizes that there is a lack of theory dealing with lesbians with disabilities in general and tries to apply some aspects of queer theory to Disability Studies and vice versa. The following aspects of queer theory might be especially worthwhile to consider in the context of sexuality and cognitive disability:

Queer theory criticizes binary constructs such as heterosexuality and homosexuality, and the division of sex and gender as well as identity politics based on stable identity constructions. For example, Greenberg (1988) provides a historical analysis of the construction of homosexuality, Hark (1996) examines marginalized lesbian identities, Feinberg (1996) and Bornstein (1994), both transgender activists, criticize the binary construction of men and women. Queer theorists often refer to Foucault (1977), who challenged the idea that homo- and heterosexuality are stable identities, stating that homosexuality as a sexual identity is a comparatively modern construction. He argues that until the end of the 18th century the moral and societal focus of interest concerning sex was centered on marriage. Marital sex was discussed and monitored and other forms of sexual encounters were often punished, although there was not much knowledge about them (ibid., p. 51). This focus shifted away from marriage — as Foucault points out — at the end of the 18th and beginning of the 19th century. Now sexual preferences outside of marriage were discussed, and different forms of sexual interests were classified and pathologized. Following Foucault, the important difference to earlier understandings of sexuality was its construction as much more than just sexual practice. Sexual practices were often linked to a certain identity, a past and sometimes even to a special phenotype (McRuer, 2003, p. 81). Foucault (1977, p. 58) writes, "Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy into a kind of interior androgyny, a hermaphrodism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species."

Butler (1990) challenges the long used division between sex and gender as she argues that there is no "prediscursive" nature (sex) upon which culture (gender) is inscribed. She points out that the sex-gender division itself is socially constructed (ibid., p. 24). Until the 1990s, the sex-gender system was, for the most part, seen as progressive since it enabled the argument that differences between the sexes are not simply determined by biology, but are a result of socialization. Although there is no need to assume the existence of only two genders, Butler points out that sex and gender are constructed as one entity with the implicit presumption that a certain sex coincides with a certain gender. Butler questions the nature of this binary system and explains it as the result of a "heterosexual matrix" (ibid., p. 21), which reproduces itself in the everyday performance of being male or female. Furthermore, it is not only sex and gender which are conceptualized in a rather deterministic manner, but also desire, which plays an important part in the system of "compulsory heterosexuality" (ibid., p. 199). The norm shows itself as either a male or a female body, provided with the appropriate gender expression and a corresponding desire for the opposite sex.

Strathern (1980) points out that the binary construction of reality is not universal, but situated in a certain western socio-political context. She states, "we use 'male' and 'female' in a dichotomous sense. They represent an entity (the human species) divided into two halves, so that each is what the other is not" (ibid., p. 182). The logical result of this complementary model is that the devaluation of sexual expressions apart from heterosexuality is already inherent to this normative concept. There is only one right way in which the two halves fit together, all other forms are, at best, second-class.

The displayed construction of sex, gender and desire establishes heterosexuality as the norm. Rubin (1984) stresses this argument in criticizing how sexuality is structured in binary oppositions, e.g. in "good sex" and "bad sex." She analyzes a "sex hierarchy" in which "good sex" is heterosexual, matrimonial, monogamous, reproductive, and at home. "Bad sex," on the other hand, is exemplified by practices such as masturbation, sex outside of marriage, homosexual encounters, etc. (ibid., p. 13 ff.).

These are some basic ideas, which might be useful as an alternative theoretical approach to work in the field of special education as mentioned above. In the next section, we will explore how the ideas from queer theory can be applied to everyday practice in residential facilities.

4. Method

The presented work is based on data from a pilot study on "The handling of sexual self-determination and sexualized violence in residential facilities for people with cognitive disabilities," which was funded by the German Ministry for Family, Senior Citizens, Women and Youths from 1999 to 2003. The data collection consisted of 10 expert interviews in the USA and Germany and of interviews and focus groups in two medium-sized residential institutions situated in two different German cities, one in a metropolitan and one in a more rural setting. Prof. Jörg Fegert, M.D. and Prof. Ursula Lehmkuhl, M.D. were the program managers. (To protect the confidentiality of the institutions and individuals involved in this study, no further identifying details will be given.)

The goals of the project were twofold: first, to analyze a wide array of qualitative data, which were collected from both staff and residents with cognitive disabilities in two cooperating residential facilities where people with minor, moderate and (less frequently) severe cognitive disabilities lived. Second, to develop a curriculum for practitioners based on the research results.

In this research project, we did not see any need to work with diagnoses but instead favored a social model of disability. The empirical part of the study consists of verbal data. This required a certain ability of expression as well as at least a minimal capacity for self-reflection from the interviewees.[3] Ulrike Lehmkuhl and Karin Jeschke collected and analyzed the data using "semi-focused interviews" (based on Witzel, 1985). In order to create precise and comprehensive interview questions, previous results were reviewed (e.g. Klein & Wawrok, 1997). The interviews with the staff started out with an open, narrative-generating question on sexuality or incidents of sexualized violence in the residential institution. The following parts of the interviews were focused on self-determination and sexualized violence. Each interview began with an open-ended question and followed with a detailed catalogue of more structured questions. These interviews were conducted in a slightly modified version with the program managers/coordinators as opposed to that of the care workers. The care workers at the residential facilities in the study are trained in the field of special education in training facilities that offer 1-, 2-, or 3-year programs with some additional hours of on-the-job training. They are responsible for all matters and needs of the daily life of their "cases." These needs range from assistance with personal hygiene to managing finances with the underlying goal of fostering greater independence.

The empirical analysis in this article is exclusively based on passages of the interviews with staff concerning sexual orientation. Homosexuality was only officially addressed in one interview question. It was, however, mentioned by 10 of the 25 interviewed care workers and program managers. Five of them talked about this topic more extensively. The interviews were analyzed according to Grounded Theory (method: open coding) by Strauss and Corbin (1996). Open Coding makes it possible to discover underlying concepts in verbal data and differentiate them in their dimensions.

5. Empirical Results

As mentioned above, some of the employees explicitly brought up the topic of homosexuality in the interviews. In most of these passages it is noticeable that homosexuality is often not accepted as an equal form of sexual expression but as a less valuable or inferior form of sexuality. In contrast, there are also some passages where homosexuality is brought up in a non-pejorative manner. In the following section we want to analyze the interview partners' statements concerning the topic of homosexuality. (Names have been changed to protect the identity of the residents and care workers.)

It is striking that although homosexuality was only a marginal topic in the interviews, addressed by one or two questions, a variety of attitudes can be seen. The statements of the employees can be divided into four central categories:

a) Homosexuality is treated as a taboo
b) Homosexuality is devalued
c) Homosexual residents are not supported
d) Homosexuality is not discriminated against

a) Homosexuality is treated as a Taboo

Some passages give the impression that the care workers and program managers in the facilities try not to talk about homosexuality. The distant or reserved attitude that some of the employees display reflects their obvious difficulty in even using the word "homosexuality." The problem of using the term can be seen in statements, which can only be understood in context. This is clearly visible in some statements, like that of one male care worker: "I think, IT is tolerated."[4] Another male care worker states, "So that I can then say along those lines that, well, there is a tendency or they have a tendency towards it."

b) Homosexuality is devalued

To demonstrate the presence of an apparent devaluation of homosexual expressions, we first want to use a passage from an interview with a female care worker who sees a positive side effect of homosexuality: She says, with a laugh, "at least perhaps also, I mean, at least no girls get pregnant from that." On the one hand, she hints at the problem of unwanted pregnancies. On the other hand, the use of the phrase "at least" indicates that the only good thing about homosexual sex is that pregnancies are impossible.

Two more examples of devaluation are the following passages by a female care worker who is employed at the school for special education in one of the residential institutions:

> This was awkward. Well, she was once fixated on some girl. And then she always was almost like, yes, erotic. She urgently wanted to say hello to her first. And then there always was this immense love and she constantly mentioned her name. From time to time she did not want to start the lesson, before she had taken the time to say hello to that girl.

In reference to another pupil the care worker said:

> I particularly had this one boy […] who obviously had more of a fixation on boys and that (partially also) became apparent in the school where he cuddled, hugged and, well, chatted. Even to the point of kissing.

The words used in both quotations to describe homosexual behavior are striking. The special education teacher uses the phrase "he/she has a fixation" to describe one female student's strong emotional-erotic orientation towards another female student. In the second case she uses this phrase to stress one of her male student's same-sex attraction. The word "awkward" and especially the phrase, "he/she has a fixation," presents the behavior as abnormal. It even reminds one of a clinical-diagnostic context in which these words are often used. This is quite a good example to stress that heterosexuality is constructed as the norm by the persons interviewed.

When talking about their clients' heterosexual desires, however, care workers tend to talk in a more accepting, sometimes even benevolent manner. Only homosexual behavior is described as strange, not normal and has to be explained. For an example one female care workers says when talking about the encounter of Paul and Rosa:

> Of course, they can dance with one another and hug — it doesn't go beyond that anyhow. He visits her in her bedroom and listens to music with her. Or she makes sure that he doesn't dance with another girl. Like a middle age couple. They are very cute.

A further form of devaluation is evidenced in the perception of homosexuality as just a phase the residents are going through:

i) Homosexuality as "just a phase"

In some comments it is implied that homosexual behavior is an "exploration phase." Even though this could be the case, it is an explanation, which — once again — is never brought up to explain heterosexual desire. A female employee working in the occupational unit (mainly a laundry) expresses this view in the following sequence:

> And I can just say, that I got the impression, that they were really curious about each other and if the topic here is really, if you can already call it, well, homosexuality, well, I don't think so […]. No, in retrospect, how I perceive it, he is to a similar extent interested in women. And I think that was simply pure curiosity.

Her male colleague in the occupational unit reflects:

> And what I hear is that same-sex friendships do exist. Maybe just because the group only consisted of men or so. Well, that does exist of course. Yes, I would say that it is probably more to, to experiment.

ii) Deprivation as a "reason" for homosexuality

Some of the staff explain same sex contacts by referring to them as "compulsory homosexuality", a phenomenon they mainly locate in same-sex residential facilities. It is remarkable that this rather strong term, which is not very common in everyday language, is used in this context. A female employee states that:

> […] apart from pure 'purpose-relationships,' which result from groups with only men. For very severely impaired persons with a cognitive disability it is so, that you can — in quotation marks — say, that those people had compulsory homosexual sex with each other.

A male employee states:

> On the one hand, it naturally is the case that people end up in compulsory homosexuality because they are forced to. I think that, that is also a form of abuse because it is an abnormal situation that they are crowded together in the institution, exclusively relying on each other.

A third male worker says:

> All the relationships between those men. […] They can't imagine a sexual relationship between a man and a woman. They have lived in separate institutions for men or women for years. Yes, and god — what else could they do? Build up homosexual relationships. I think that most of them, well actually all can't imagine what normal sexuality is like. They can't. How could they?

The emotional distance this employee suddenly introduces, in using the words "those men," is striking. The employee probably wants to make clear that homosexuality, but maybe also cognitive disability, has nothing to do with him. Consequently, homosexuality and heterosexuality are constructed as stable identities, which, as discussed above, Foucault (1977) challenged, stating that homosexuality as a sexual identity is a rather modern construction.

Moreover the term "compulsory homosexuality" is used as a means to criticize the long lasting separation of men and women in institutions for people with cognitive disabilities. This term suggests that the residents in these institutions are forced to have same-sex contacts since there are no people of the opposite sex around. In one interview this "compulsory homosexuality" is even labeled as a form of abuse. This is interesting since it is — even in institutions with a strict gender separation — usually a decision that the residents make themselves, if they have sex with same-sex partners or not. In fact, it is remarkable that same-sex residential facilities are mentioned at all, since co-education has been common in most of the institutions for more than 10 years now, including the two institutions surveyed in the study. Even in the remaining "men only" or "women only" living situations, co-education characterizes daily life in terms of work or school. Therefore it is problematic to explain homosexual behavior as a result of an absence of other sexual opportunities. The last two sentences in the quote of the third male care worker finally explicitly reveal the pejorative attitude of the employee towards homosexuality since he claims that a homosexual lifestyle is not part of a "normal" sexuality. The ambiguous character of such an argumentation becomes obvious in the following paragraph.

c) Homosexual Residents are not supported

In addition to interview passages, in which homosexuality is treated as a taboo or is devalued, we found some passages in the interviews, in which staff described their ways of handling homosexuality, which do not fit into the above two categories.

i) Homosexuality is not accepted in the community of people with a cognitive disability

The interviewed care workers stress the difficulties residents are confronted with if they want to live in an open homosexual relationship. Regarding open homosexual relationships, a male care worker, who works for a community-based group home for men and women with minor cognitive disabilities and no demand for 24 hours assistance by staff, says:

> Yes, because the acceptance […] in the community — especially in (this) group — […] is not too strong.

In a different part of the interview, the same male employee stresses:

> Limited […] because it is relatively difficult […] to live homosexually in the normal society. And for people with cognitive disabilities it is even more difficult […] there is still the ideal; the man has to be big and strong […] I have to say […] men have an ideal so, and the woman, well, has to have long legs, this Barbie-copy, let me put it like that.

This quotation is quite interesting evidence for the connection between sex, gender and desire, which we raised in our reference to Butler (1990). Concerning the way residents react to non-heterosexual desire, a male care worker from an occupational unit explains: "Well, the ones who are able to talk, it is a taboo for them. They try to hide that."

In these statements the discrimination against homosexual behavior in some residential facilities becomes obvious. The residents seem to know that their homosexual desire is something that remains better hidden and not displayed in public.

ii) No staff responsibility to support their clients in living homosexuality is accepted

Even though the above-mentioned care worker knows about the discrimination against homosexual behavior/relationships and expresses that residents do not show their homosexuality publicly because they are afraid of such discrimination, he still does not address this topic mentioning the following reason:

> […] they have to […] accept themselves, that they are homosexuals […] if they find the acceptance for themselves, maybe they can make it visible to the outside.

It is difficult to follow this argument because it is not clear how the residents can reach a state of acceptance, if there is no one in their immediate environment who are themselves accepting such behavior.

In a different part of the interview the same member of staff says:

> […] so far, I have not addressed this topic in the group, since there is no (emotional) acceptance.

The explanation for his silence fails to persuade. It is surprising that he knows about the discrimination of homosexual desire and yet decides not to act against such discrimination. There are a lot of plausible explanations why he does not do anything from his rather privileged position as employee. Quite an amount of theory deals with the subject why people do not act up against discrimination. It would, however, go beyond the topic of this article to elaborate on this.

d) Homosexuality is not discriminated against

In contrast to these rather negative perspectives from staff members and their views on homosexuality some passages can be found that indicate a neutral or supportive attitude on the part of the staff towards residents' homosexual behavior. These attitudes are presented in the following four interview passages.

The first statement is made by a male care worker:

> We talk relatively gender neutral: partner [German female version] or partner [German male version]. For most people with a cognitive disability living in our institution it is more or less taboo to date a same sex partner.

This male employee acknowledges the fact that homosexuality is a taboo among the residents he works with. He advocates not assuming the residents' sexual orientation by using gender-neutral speech. So presumably, a staff member might ask a resident whether he or she has a girl- or boyfriend. This way of dealing with sexual orientation is rather uncommon in organizations and expresses openness towards other forms of desire than heterosexuality.

The next passage is taken from an interview with another male employee. He states:

> Well, I think that there are no limits in our residential facility. As long as two people both act according to their free will and someone has a homophile tendency it is OK and is tolerated by staff.

According to this statement, as long as nobody is forced against his/her will, all sexualities are to be treated equally. Even though this sounds like a role model for diversity, some suspicion remains. He uses the word "tolerated," which raises the notion that it takes some effort to define this as something that is equal.

The same care worker further elaborates:

> We have a female staff member who is 'married to' another woman and that is accepted. I presume that it wasn't always this way. I mean we attended her marriage celebration with some residents. It is very important that I also 'live' with them and that they meet such people and talk to them […] so that the topic becomes more tangible and less abstract for the adolescents.

This passage is remarkable since it gives some concrete ideas of how to improve acceptance of other sexual orientations in facilities for people with cognitive disabilities. By inviting residents to her marriage, the lesbian employee functions as a role model for both staff and residents. This is presented as important for providing a tangible learning experience.

In his last interview passage on this topic, the employee concludes:

> Yes, it is supportive to make it public […] not to make such a mystery out of it. I mean to talk about it openly, not to advertise it on banners, but that you as an employee make it a topic on a regular basis. Or to raise the topic at social meetings in the group.

This passage advocates an active role for the employees in normalizing homosexuality by addressing it openly, on a regular basis and in everyday contact with the residents.

6. Discussion

The analysis of special education literature and the data from our pilot study has shown an apparent similarity in terms of dealing with homosexuality. The subject is often omitted or consists of repetitions of everyday knowledge and old-fashioned prejudices.

The following different forms of dealing with homosexuality have been found both in the literature review and in the interview data. In a nutshell, homosexuality is conceptualized as:

— a compromise, if no heterosexual contacts are available,
— a transitory situation that will disappear with the implementation of coeducation,
— a form of sexuality not worth mentioning at all.

We argue that the reproduction of prejudices are neither in the interest of researchers nor in the interest of people with cognitive disabilities, especially for those who are living outside the heterosexual norm.

Tremain (2000, p. 298) states: "Indeed, I have aimed to show the supposedly incoherent genders and sexualities of disabled queers shall remain under-researched and under-theorized until, and unless, the conception of sex, gender, and desire that currently circulates within disabled sexuality studies is changed." Because we agree with this statement, we have tried to take a first step in outlining theory which might be helpful for rethinking and re-conceptualizing ideas on sexuality, normality and identity in the field of disabled sexuality studies. Moreover, we would like to acknowledge here that, in practice, first steps have been made. Even though several of the analyzed interview passages show partly subtle, partly open forms of discrimination, some interviewees nevertheless display openness to the existence of diverse sexualities.

In addition to the necessity to apply new theory on sexuality to the field we would like to provide some ideas for practice: If the personal right to free sexuality is taken seriously, there is a need for staff training to deal with homosexual and heterosexual interests and the desires of their clients to a similar extent. Teaching models, which enable one to respond to possible discrimination and to encourage the development of sexuality, should be developed. Moreover, as shown in our data analysis, the personal stance employees take towards sexuality is crucial to their handling of sexual diversity. Therefore, explorations of personal attitudes towards the issue should be supported in staff training.

David Hingsburger, a renowned author and sex educator in the field of sexuality and disability, stressed in an expert interview we conducted with him for our pilot study prior to interviewing care workers, in answering the question how to judge the quality of his counseling work: "How many people do you support who are married? How many are engaged or dating? What percentage of them are homosexual? That's, to me, that's the barometer, you know." Thus, Hingsburger explicitly connects the quality of his work to the openly lived diversity of sexualities in the facilities. Moreover, all forms of sexual expression that are not of harm to self or others, as Hingsburger points out in the expert interview, should be promoted. Furthermore, he recommends if, for example, an employee has problems with a resident's homosexuality, the consequence should not be to restrict the opportunity for the resident to live according to his or her desires but to have the members of staff educated or, if necessary, transferred to another part of the residential institution.

We would like to conclude with the following ideas for change based on results from our analysis:

— More research from diverse disciplinary backgrounds on the topic "sexuality and cognitive disability" is needed.

— The application of theoretical frameworks from gender studies and queer studies to this field is recommended.

— Training with the goal to promote awareness amongst staff for diverse sexual orientations should be developed and offered.

— Topical supervision by a professionally trained supervisor should be made available to staff.

— Homosexual role models could be helpful. These could be other homosexual residents or a member of staff who could offer information and facilitate the potential coming-out of residents.

— Residential institutions should provide resources for homosexual residents. They should know where and how they can obtain help and information, for example, for their coming-out or in case of verbal or physical attacks.

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Endnotes

[1] This term is used to refer to all employees, regardless of profession, who offer direct service for people with cognitive and physical disabilities.
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[2] The authors prefer to use the term cognitive disability as an alternative to the pejorative and stigmatizing terms "mental disability" and "developmental disability." The term "learning disability" is not used, because in German it has an underlying connotation of self-determination not suitable for the description of life in institutions.
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[3] For results of the pilot study, see Thomas et al. (2002) and further publications in print. Passages on homosexuality found in the course of the analysis were extracted and re-analyzed for this article.
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[4] All quoted interview passages are translated by the authors.
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