MLS PSYCHOLOGY RESEARCH
https://www.mlsjournals.com/Psychology-Research-Journal
ISSN: 2605-5295

How to cite this article:

Polanco Valenzuela, M. (2019). Model of Education in Sexuality and Affectation for Families of Teenagers with Cognitive Disabilities *MLS Psychology Research 2* (1), 65-80. doi: 10.33000/mlspr.v2i1.143

MODEL OF EDUCATION IN SEXUALITY AND AFFECTATION FOR FAMILIES OF TEENAGERS WITH COGNITIVE DISABILITIES

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Abstract. The objective of the study investigates the characteristics of the context surrounding adolescents with cognitive disabilities in relation to sexuality and affectivity, defines the skills and competencies that should be strengthened in families in the subject and designs a pedagogical model to do so. Its framework is the International Convention of the United Nations on the Rights of Persons with Disabilities, which establishes as one of its principles the guarantee and full exercise of the sexual and reproductive rights of persons with disabilities. Hence the question: Is it possible to promote the development of sexuality and the affectivity of adolescents with cognitive disabilities, through a training model in these aspects to parents? The study concludes that despite the advances that have been presented in recent decades, there are still several myths, attitudes and discriminatory practices in sexuality and affectivity, both in society and in the family itself. Nor do fathers and mothers possess the skills and competencies to guide properly. Therefore, the training model contributes significantly to improving the quality of life of adolescents with cognitive disabilities and their families, as well as providing the scientific community and related institutions with a validated technical-pedagogical strategy.

Keywords: cognitive disabilities, model of education, sexuality and affectation, rights, family.

MODELO DE FORMACIÓN EN SEXUALIDAD Y AFECTIVIDAD PARA FAMILIAS DE ADOLESCENTES CON DISCAPACIDAD COGNITIVA

Resumen. El objetivo del estudio indaga por las características del contexto que rodea a los adolescentes con discapacidad cognitiva con relación a la sexualidad y afectividad, define las capacidades y competencias que deben fortalecerse en las familias en el tema y diseña un modelo pedagógico para hacerlo. Tiene como marco la Convención Internacional de Naciones Unidas sobre los Derechos de las Personas con Discapacidad, que establece como uno de sus principios la garantía y el ejercicio pleno de los derechos sexuales y reproductivos de las personas con discapacidad. De allí la pregunta: ¿Es posible promover el desarrollo de la sexualidad y la afectividad de adolescentes con discapacidad cognitiva, a través de un modelo de formación en dichos aspectos a padres y madres de familia? Del estudio se concluye que a pesar de los avances que se han venido presentando en las últimas décadas, aún persisten diversos mitos, actitudes y prácticas discriminatorias en sexualidad y afectividad, tanto en la sociedad como en la familia misma. Tampoco los padres y madres poseen las capacidades y competencias para orientar adecuadamente. Por tanto, el modelo de formación contribuye de manera significativa a mejorar la calidad de vida de adolescentes con discapacidad cognitiva y a sus familias, así como dotar a la comunidad científica y a las instituciones relacionadas con dicha temática, de una estrategia técnico-pedagógica validada.

Palabras clave: discapacidad cognitiva, sexualidad y afectividad, formación, derechos, familia.

Introduction

The latest figures from the National Administrative Department of Statistics - (DANE, *Departamento Administrativo Nacional de Estadística*) - indicate that there are currently 4,185,511 people in the Colombian demography between the ages of 10 and 19 years in 2017 representing 8.49% of the total population for the country (49,291,609), which is high in the general context, and where an important segment is the population with disabilities - PwD. According to the Colombian Family Welfare Institute (ICBF, *Instituto Colombiano de Bienestar Familiar*) (2013), 56,474 children and adolescents were registered with disabilities, 58.3% being males and 47.7% being female; 49% are between 15 and 18 years of age and 32.7% between 11 and 14 years. The percentages highlight the need to work with this population and their families, regardless of their age, barriers, socioeconomic status, or context.

International and National Regulations

Progress has been made in recognizing the concept of human rights for the PwD, reaffirmed at the World Conference on Human Rights and embodied in the Convention on the Rights of Persons with Disabilities -- CRPD, whose purpose is: “promote, protect, and ensure the full enjoyment of human rights by people with disabilities and ensure that they enjoy full equality under the law.” (UN, 2006, p.4). It also recognizes its legal capacity on an equal basis, the obligation to protect them against exploitation, violence and abuse, and establishes guarantee and access to educational programs and Sexual and Reproductive Health –SRH-.

In Colombia, this mandate is stipulated in Article 13 of the Constitutional Letter: “the State will protect those people who, especially due their economic, physical or mental status, find themselves in state of visible disability and will punish any abuse or mistreatment committed against them”. In this way it reinvigorates its autonomy, independence, and the freedom to make decisions and the State’s obligation to recognize their capabilities. It means a paradigm shift in understanding and openness toward the realization of human rights.

Lugo and Seijas (2012) state that the international system of rights for PwD has three subsystems: Ibero-American and Inter-American, each with their respective instruments. Legislation has had a periodical transition, initially derived by wars and conflicts, later revolving around labor rights and social security, and lastly based on a development on social and human rights. Table 1 shows these.

Table 1
International Norms on Human Rights for People with Disabilities.

Norms	Concept
Declaration of the Rights of Mentally Retarded Persons (1971) - Declaration on the Rights of Disabled Persons	Ensure the enjoyment of the same political and civil rights of all people.
Directrices de Tallin (1989)	Assume PwD as agents of their own destiny, part of the human talent of society and their own independent subjects.
Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991). Standard Rules on the Equalization of Opportunities for Persons with PwD (1993)	Formulation of policies to organize technical cooperation and guarantee of human rights within and between different States, international organizations and non-governmental agencies.
The Program of Action within the World Conference on Human Rights in Vienna (1993)	Recognizes that "all human rights and fundamental freedoms are universal and thus unreservedly include persons with disabilities". Any type of discrimination is considered a violation of human rights.
The United Nations Convention on the Rights of Persons with Disabilities (2006)	Promotes, protects and safeguards the full and equal enjoyment of human rights and fundamental freedoms of all PwD, promoting respect for their inherent dignity. Urges States to recognize their legal capacity, their required protection against exploitation, violence and abuse, as well as access to education and SRH programs.
Constitution of Colombia (1991), Article 13, Paragraph 3	The State will protect those people who, especially due their economic, physical or mental status, find themselves in state of visible disability and will punish any abuse or mistreatment committed against them.
Decree T-573 (2016)	Adopts the social model and the framework of human rights; PwD have the right to decide under equal conditions; their access to adequate and sufficient information in health must be regulated, while receiving support adjustments and safeguards to make informed decisions, particularly in matters involving the exercise of their SRR.

Note: Source: Author's own creation

In addition to these, we find the Sexual and Reproductive Rights - SRR: for the integrity and ownership of their body, to receive affective and sexual education in the family and at school, to have the sexual and affective life they desire and is possible to achieve, to make decisions about their lives, among others. Notwithstanding the foregoing, in practice this is not true nor is it completely exercised.

Concept of Disability

The concept of disability has evolved over time, with models that establish frameworks for action in the face of PwD themselves. They go on by conceptions arguing that its origin is due to religious, scientific, derived from individual limitations or for reasons, to a large extent, that are social (Palaces, 2008). The latter refers to the social model, which reflects a change in paradigm by focusing not on the person and their shortcomings, but their interaction with the environment and the difficulties it presents for them to fully participate. This means that PwD contribute to society as much as anyone else: "promoting social inclusion and grounded on the basis of certain principles: independent living, non-discrimination, universal accessibility, standardization of the environment, civil dialog, among others" (Palacios, 2008, p.27).

Other models have been developed in this same way: "Diversity Model", "Biopsychosocial", "Political-Activist", "Colonized Minorities" and "Universal Model of Disability", which as stated by Ramirez (2012): "They take on different characteristics and emphasis according to the context where they find themselves or are raised which is why it is important to understand disability as an aspect in constant change and which is dependent on both the population and culture" (p. 31).

Myths and Beliefs

One of the aspects that creates the highest affectation in PwD is the way in which society and their families reinforce mistaken beliefs and myths, which violates in many cases their SRR. From which: "These types of mistaken beliefs and myths belittle sexuality as being understood in a different way to established norms and converts people, who could otherwise enjoy satisfactory sexuality, into asexual beings…" (Bustamante, quoted by Mineducación, 2007, p. 10). It negatively impacts the identity, esteem, autonomy and exercise of sexuality, which translates into poor sexual socialization and restricted access to the universe of the intimate (Cobo, 2012). Other consequences are loneliness, low self-esteem, limitation of affective relations, lack of relations between couples and unsatisfactory or inadequate sexuality (Cáceres, 2014).

Depending on the type and extent of the deficit, PwD have their specificity in the possibilities and ways of living their sexuality. However, they do not fundamentally differ in anything to what people without disabilities experience, but society imposes barriers with wrong and discriminatory attitudes.

International and national evidence (Carrillo, 2012; Cobos, 2015; DNP, 2013; López, 2002; Parra, 2013) reflects the issue that we are before a problem. Society and institutions, in particular the family unit, are determining factors in the formation of sexuality and affectivity. In them, roles are defined, and beliefs, ideas and thoughts on sexuality and the body are determined. It plays a vital role by modeling and prioritizing values, creating stereotypes and imagined ideas that favor or deprive their proper development. For example: that PwD are sexless beings, always behaving as if they were children, emotionally and physically dependent on others, should only marry or pair with similar people or have sex with another person with their same condition due to their inability to attract normal people (Torices, 1997). This significantly impacts their affective, social and sexual development (see Table 2).

Table 2
Myths and Realities of Sexuality for People with Disabilities.

Myths and False Beliefs	Reality
There is an absence of sexual desires and needs in cognitive PwD since they are "asexual beings."	This perception generally motivates the violation of RSS for cognitive PwD, treating them as permanent children, without recognizing their interests, hopes, desires, affective-sexual manifestations, needs for body contact and sexual intimacy as any other human being.
Cognitive PwD have hyper sexual, uncontrolled or aggressive behaviors.	This feeds uncertainties and fears in families and leads to social neglect, silencing and preventing the proper development of sexuality in adolescents with CPwD due to it being considered unnecessary or dangerous, unaware that this is normal at such a life stage.
Cognitive PwD are perceived as unattractive people, they do not arouse sexual desire in others.	This is directly related to social stereotypes and cultural patterns that underlie the idea of beauty and the positive or negative that the culture establishes over the physical attributes of men and women, all of which usually do not fit with cognitive PwD.
Cognitive PwD are not suitable to marry or live as a couple, have children and take care of them and are unable to cope with loving relationships.	This idea when accepted creates serious and complex implications for the development of autonomy, undermining confidence in themselves and others, loss or confusion of identity as a sexual being, and causing low self-esteem. Though cognitive PwD require special care or greater family support, they have similar conditions or the same capabilities that people without any type of disability have.
It is thought that Cognitive PwD transmit their disability genetically.	It presupposes that the origin of the CPwD is always genetic. Scientific evidence ascertains that its origin is due to multiple causes, one of which is genetics but certainly not the only one. In addition, it involves relating the concepts of sexuality and reproduction without considering the integrality of sexuality.
Affective-sexual education is not relevant for Cognitive PwD as this "encourages", stimulates and increases their sexual behavior.	By denying the possibility and the right for cognitive PwD to receive adequate and timely affective-sexual education, the opportunity for them to create emotional relations is retracted, increasing the risk of unwanted pregnancies, sexually transmitted infections, conflicts and making them vulnerable to abuse and sexual assault. Good sexual education favors the development of personality and social relations.
Cognitive PwD are passive and lack the capabilities to make autonomous decisions.	It is mistakenly believed that cognitive PwD do not have the sufficient intellectual level to understand those abuses of which they may be subject to or to decide on adequate demands. Although they are particularly vulnerable to sexual abuse or physical abuse, this is mainly due to factors related to emotional dependency, submission to third party individuals, loss of privacy or lack of training.
The families of cognitive PwD are overprotective, especially with women, perceiving them as passive.	This is partially true as parents are usually overprotective due to gender stereotypes, reinforced by media or at home through sexist parenting patterns. There is greater social acceptance of male adolescent sexuality, while females are socially suppressed or punished.

Note: Source: Author's own creation.

Sexual Education

It is not until the 80s-90s when the problems and needs around the sexual education of PwD are finally explained. The first programs appear for the prevention of risks associated with sexual behavior and to become aware of problems such as sexual abuse. Prevention programs were based on knowledge but offered few practical applications (Lopez, 2002). Recognizing the differences and particularities of PwD, as well as recognizing their RSS, comes late. Another difficulty is the low production of studies on sex education and intervention, despite the fact that the issue has taken relevance in recent years and undertaken various initiatives. The need to educate sexually and worry about their caregivers should be given equal conditions for non-disabled people (Navarro, Torrico and López, 2010).

For Caricote (2012), it is essential to identify the real need hiding PwD manifestations, as well as the possible risks that make training necessary in aspects related to sexuality, reproduction and preparation for life. For that reason, we must make a great effort with institutions, professionals and the general population, where discriminatory and exclusionary attitudes are present.

Although the Convention establishes that: “People with disabilities, including children, must maintain their productivity on an equal basis with others” and “respect for the rights of persons with disabilities to decide freely and responsibly on the number of children they want and the time that must elapse between births…,”. Discussions in reproductive rights, maternity and paternity, upbringing or the conformation of couples is still ongoing in studies, with the prevailing opinion being that they should not or are not able to enjoy each of their rights (University of Rosario, 2015). Hence the importance of creating strategies, models and innovative training methodologies that create greater awareness about the role of the family unit, its importance for affective and sexual development and its impact on quality of life.

The Family

The family is the main socialization unit for every human being where values, principles and beliefs regarding all aspects of life are transmitted and established, with its influence being fundamental as of the early years. Varas (2011) says that: “Dependency on others for care can restrict their opportunities in expressing their sexuality, due to a loss of privacy and overprotective parents or caregivers" (p. 1). The role of the family on these aspects significantly marks their sexuality and their way of experiencing life.

For Hernández, Lopez and Avila (2006) to be a father or mother is no easy task, especially when handling situations from which there is little or no information, made more complex if they are children with disabilities. The unit may be affected in their roles, dynamics and relationships. “The person with some disability and their family, live in a series of feelings and reactions to the new situation which will influence the relationships to be established within the same” (Hernández et al., 2006, p. 176).

Caricote (2012) asserts that when a member in a family is born with or acquires a disability, intrafamily communication becomes painful and unexpected, experiencing anxiety, depression, guilt and social isolation. They interact rigidly, ever revolving around the member with disability, with emotional relationships mediated by this, living in the midst of incapacitating, immature or inflexible feelings.

Family guidance considers that sex education requires information and learning on the subject, understanding how to socialize, reflecting on the importance of educating and not to ignore or remain silent, while understanding their role in sexual and affective development (Godoy, 2007). For Lopez (2011) families that act as well constitute adequate attachment figures, are acceptable models, as they protect against risks, answer questions, anticipate important evolutionary events, talk openly, offer and seek help, stimulate autonomy, prevent abuse and promote self-care.

Education in sexuality and affectation transcends the person with some disability and encompasses their close circle and other support networks. Cáceres (2014) provides some criteria: be consistent with the current perspective, take a positive approach, be multifocal, work jointly, carry out a structured and systematic planning, formulate clear objectives and contents, use active and participative methodologies, take advantage of open spaces, promote discussion, communicate and promote interpersonal skills.

Educational Strategies and Models

There are few findings with respect to this subject. There are experiences that introduce the topic into their areas of work, many having been developed informally, to sensitize or because they are part of a wider program. For a proper response it is necessary to differentiate from the type, nature, intensity, degree and temporariness of each disability, adapting and using adapting methodologies while bearing in mind that affective and sexual socialization must be taken up by the family, contemplating individual characteristics, possessing a comprehensive and overall vision, on the basis of respect for collective rights, understanding that there is no single model, addressing and preventing discrimination, establishing sexual-affective interactions and developing autonomy, responsibility and respect, among others (Lopez, 2003). These programs, in addition to those addressing pedagogy and the development of competencies, are the foundation of the validated program.

In this regard, Fantova (2000) proposes the creation of strategies that provide elements for families to build their own speeches and special ways of living with a disability. They should also resort to the experiences of other countries, such as positive parenting: “based on the best interests of the child, who cares, develops their capacities, is not violent and offers recognition and orientation that includes the establishment of limits that enable the child’s full development” (FEMP, 2010, p.11), based on three suppositions: basic family social institution, dynamic system of interpersonal relationships and supports, and based on warm and protective emotional ties, structured environment, stimulation and supportive learning, recognition of children’s value, parental training and education without violence.

The study’s contribution and the training model in sexuality and affectation is evident. The work tool to consolidate said input is based on the existing regulations, the human rights approach, RSS, basic concepts, competency-based pedagogical orientations, dynamic strategies and participatory and articulate social support networks for teens with CPwD.

Method

The study is qualitative although it combines techniques and quantitative and qualitative instruments, a cross-sectional, descriptive and observational study that identifies the knowledge, attitudes and practices in sexuality and affectation in families with teens exhibiting CPwD. A CAP survey was initially applied, built by the researcher, subsequently validated by families and experts on the subject (Polanco and Martin, 2017).

For the final model, apart from the results obtained in the survey, semi-structured interviews, questionnaires to key actors, observations and specialized scientific literature search were all employed. From this, a training model was designed and validated: theoretical, pedagogical and methodological aspects.

Participants

The study at all times had a representative number of families with adolescents presenting CPwD who were members of specialized Cognitive PwD organizations and educational institutions within the city of Bogotá. It had to with participants who largely represent families in this population by their socio-demographic characteristics and those of their children. In total, 60 families participated and were distributed in each of the stages: KAP validation, KAP implementation, and the design and validation of the model. Ethical criteria were considered for research and informed consent.

Procedure

The KAP survey was used, with semi-structured interviews being carried out as developed by the researcher from the document review and previous experiences based on the identification of variables and categories of interest. The survey gathers information about what people know, and how they feel and behave with respect to the subject. The KAP is a consolidated methodology that is widely used due to its potential to generate meaningful conclusions (Save the Children, 2012). In addition to the selected variables, it enabled gathering information on the families of adolescents with CPwD and facilitate the training model's design.

Once the variables and categories were defined, questions and statements were established that responded to them, following the survey methodology as reviewed and validated by expert peers (professionals in social and human sciences, specialized in SRH and working with PwD) at two points in time. A pilot test was subsequently applied in order to adjust its comprehension, sufficiency and length. The semi- structured interview was then conducted to professionals and family members, equally validated, in order to deepen qualitative aspects not evidenced by the survey.

Once the model was designed so as to validate its content, it was resorted to the focus group with the families of adolescents with CPwD so that, under the premise of the attention and thematic interest "approach", they would assess the clarity and relevance of the objectives, the model's contribution, development, strengthening of the competences, adequacy, relevance, sequence, organization of content, chances of comprehension, the established lessons and the minimum time expected. The model was adjusted through discourse and comparison.

Results

The problem's analysis and the triangulation of data, techniques, and correspondence of the findings with those reported in the literature, led to the construction of the model, developing a validated conceptual and didactic tool to be implemented in contexts of health, education and protection that affects the quality of life of the cognitive PwD and their families.

The model (see Figure 1), is designed considering gaps in knowledge, myths, beliefs, prejudices, stigmas and practices. It gathers conceptual and pedagogical references that integrate the training plan as a response to the minimum that families need for the accompaniment in sexuality and affectation. It is understood as the practical way to understand the processes related to pedagogical aspects that traverse it: how one learns and teaches, skills, appropriate methodologies for personal and collective appropriation of knowledge, attitudes/values and skills/practices, conceptual references, guiding principles, didactic or resources, activities, learning assessment, modalities (face-to-face, virtual, course, workshop, conference, or other).

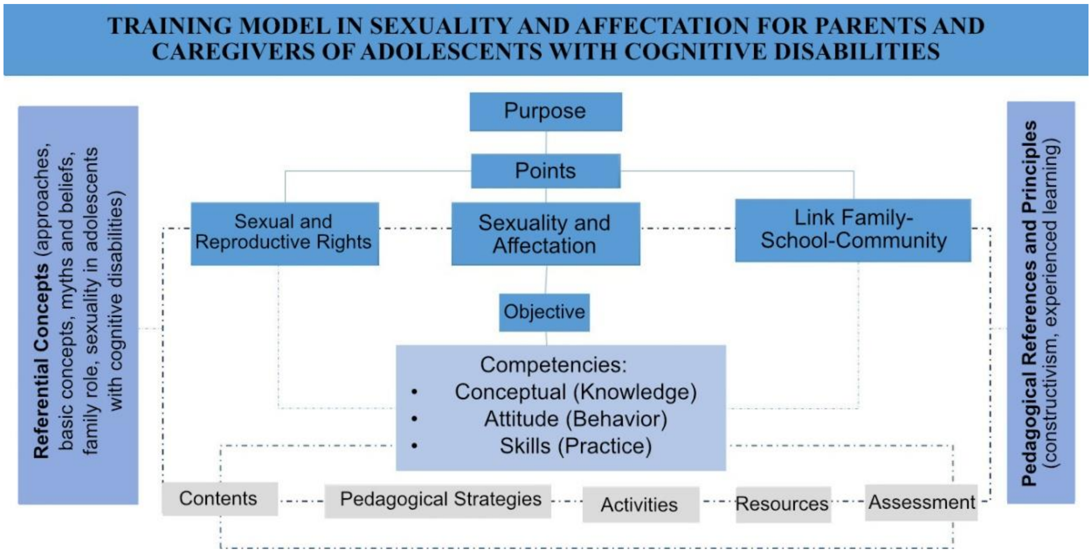

Figure 1. Training Model Sexuality and Affectation.

The purpose of the model is to promote the development of competencies, attitudinal and conceptual practices in sexuality and affectation through the implementation of pedagogical tools that facilitate dialog of knowledge, recognition of capacities and potential, the improvement of ties of trust and confidence in themselves as well as strengthening their autonomy and self-determination in the framework of human rights. This requires a facilitator with professional skills and personal qualities because of the importance and complexity of the topic, the expectations of those involved and the degree of commitment that the work involves. These are professionals in the the areas of health, education, protection, social and human sciences working on a daily basis in projects, plans, programs and/or policies related to human rights, SRH, PwD, the family, group management, ethics, socially sensitivity, with high ability to listen, have an active and dynamic attitude, understand and respect differences, among others (Office of the Ombudsman and Profamilia, 2007; Garcia, 2007).

The model is flexible, dynamic, participative and adaptable to the different educational modalities, in accordance with the institutional needs and resource availability (human, technological and financial). It is likely to be adjusted considering any particular situations, cases and requirements as well as the capacity to respond to new questions. The time for each activity are sufficiently broad, with the possibility of being extend according to demand from families, scheduled sessions, the adolescent's needs, evolutionary cycle, type and degree of disability. The modalities are: face-to-face, virtual and semi-face-to-face.

The model is part of the conceptions and approaches that address the condition of their potentialities, comprehensiveness, capabilities and strengths to develop tools to improve their quality of life. These references are especially important within the training plan for families to recognize and adapt themselves in such a way that their work as trainers values adolescents as subjects with rights.

It is supported in a rights-based approach and those of differential, life cycle, SHR, inclusive education, basic concepts in sexuality and affection, emotional ties, social support networks, positive parenting, caring for him/herself, myths and beliefs, family and strengthening of the family, adolescent sexuality with CPwD, pedagogical references, constructivist perspective, reflection and self-reflection, construction and interaction of subjectivities, analysis of reality and context, dialog of knowledge, experiential learning, active participation, teamwork, evaluation, conceptual skills, attitudes and practices, as well as a properly structured plan. One such training points is illustrated in Table 3.

Table 3
Training Plan for each of the Transversal Points

Training Point	**Sexuality and Affectation**	
Objective:	Contribute to the valid knowledge on the reality of adolescents with CPwD so that fathers, mothers and caregivers transcend mistaken beliefs and myths around their sexuality and affection, developing capacities and skills that guarantee the SRH and promote their autonomy.	
	Competencies	
Conceptual	**Behavior**	**Internship**
Clarifies basic concepts about sexuality, roles and gender-related issues.	Protect and provide guidance to adolescents with CPwD by providing truthful and appropriate information to their needs.	Geared toward their family system in issues related to sexuality and affectation.
Recognizes myths, misconceptions and prejudices surrounding	Confronts people and identifies situations that create stigma and	Creates inclusive environments guiding in the different areas on

sexuality and affectation of persons with CPwD.	discrimination by expressions of affection and experience of SRH in adolescents with CPwD.	the need to dismantle myths, beliefs and prejudices.
Identifies situations of vulnerability and/or risk where the adolescent with CPwD may be immersed in.	Clearly serves the concerns raised by adolescents with CPwD, guaranteeing the effective exercise of their SHR.	Creates secure environments free of risk for adolescents with CPwD.
Identifies and understands the emotions and their importance in health and psychological well-being.	Validates the emotions and affective expressions of adolescents with CPwD.	Promotes the recognition of the affectation of the teen with CPwD.

Content	**Activities/Time**	**Appeals**	**Assessment**
Clarifying concepts: sexuality, sex, gender, gender identity, sexual orientation.	Conversational-Comprehensive Exposition-Plenary: 2:30 Hours	Power Point, video beam, sound, board.	Pre-post questionnaire
Recalling the basics: functions of sexuality, cycle/stage of life, adolescent sexuality, sexuality in the CPwD	Discussion groups-Conversational-Plenary: 2:30 Hours	Guides for group work, board, markers, power point, video beam	Discussion synthesis
Stigma and discrimination-myths and beliefs	Round table-Cases and situations-Conversation: 2:30 Hours	Guide questions, board, markers	Rapporteur Summary
Risks: STD, non-planned pregnancies, gender violence, sexual abuse-violence, abortion, VTP	Conversation–Case study: 2:00 Hours	Sheets, case study–orientation questions, markers	Billboards, conversation rapporteur
Self-care: corporeality, habits and healthy life styles, condom and dual protection, fertility regulation, prevention of violence, sexual abuse	Group and individual activities: body narrative, Autobiography–Comprehensive Exposition–Participation of expert professionals: 2:00 Hours	Music, guide sheets–power point–sound- video beam	Autobiography
Basic human emotions and how they manifest; affective links	Affective list-Plenary-Family Children-Integration-Comprehensive Exposition: 2:30 AM Hours	Paper with silhouetted people, markers, power point - video beam	Pre-post assessment
Importance of human communication: dialog with parents and caregivers with their children; active listening; confidence	Role playing-Situational analysis-Domestic games-Work alongside parents and children: 2:00 AM Hours	Sheets, situational guidelines, links, sound	Answered guides, rapporteur

Note: Source: Author's own creation.

Discussion

The training model has been designed and validated collectively, on the basis of rights, skills and competences, while it strengthens and fills gaps in the subject's knowledge, develops skills for the to act in an appropriate manner toward the requirements of adolescents with CPwD and trains in skills to cope with the continuous demands in the fundamental aspects for a human being, such as sexuality and affectation.

Despite the increase in models of disability approach in which respect for "the person" is of importance, and of the progress in methodologies, techniques and tools of intervention, studies show that the approach to issues of sexuality and affectation in cognitive PwD and their environment continues to be a taboo subject, either due to ignorance, lack of knowledge, negative attitudes or discrimination, and wrongful beliefs that infringe on human rights and their SHR, many times stemming from inside their home (Louis, 2014).

Families recognize their agreement with the information and proposed topics, but taking into account such aspects as: differences in age, type of disability, sex, concerns, life cycle and level of training. Likewise, they conclude that spaces for exchange between parents and children are required to nurture learning and to promote mutual support. The training is also carried out frequently and addresses the issues of concern, that training should be mandatory in the educational institution, promoting the entire community's commitment while sharing responsibility.

The model makes the cognitive PwD learn about each other and to accept themselves, expressing themselves bodily-wise so that they feel happy and recognize that sexuality is not the source of problems but one of satisfactions (Cobo, 2012; Garcia, 2007). In this same sense, Sánchez (2013) asserts that it is about learning how they are and work, ways to express themselves and feel affection, the pleasure and enjoyment of sexuality, appreciating and respecting the body itself and that of the other, learning to make autonomous decisions, reflecting about themselves, their relationship with others, and lastly, to respond to concerns and questions about sexuality.

In line with the studies on the subject, it is important to highlight that these training programs toward families must be based on the biography of each PwD and must also offer possibilities to solve their interpersonal relationship and intimacy needs. It is also necessary to consolidate a triad in the process that includes the person with a disability, their family and professionals by unifying criteria, values and attitudes toward sexuality and integrating such principles as dignity and respect. It also provides facets for identifying and communicating feelings, learning and reinforcing social skills, effective use of play time and employing a variety of teaching resources that have a positive impact on self-esteem and communication (Couwenhoven, 2001; López, 2002, cited by Campo, 2003).

The findings are congruent with those proposed by Torres and Beltran (2002) in relation to the experiences of sexuality programs directed to PwD cognitive impairment. The authors summarized the main works of sexual orientation and education taking into account the theme, purpose and methodology of each program, concluding that, unfortunately, there are few programs of this nature aimed at parents of cognitive PwD. They also state that the training area should include the role of professionals to orient their processes toward the acquisition and improvement of attitudes, skills and knowledge, useful for families when dealing with various situations.

Applied to the context of the nation, we return to what Lugo and Seijas (2012) pose on the advances that have taken the training topics and research related to disability from a global look, especially within university and postgraduate programs, which compensates for shortcomings in these areas.

The above evidences that it has to do with experiences and valuable research but mostly isolated, of an institutional character, sporadic, with few professionals in charge, incomplete or partial in spite of the importance that may view the subject as being.

Lastly, the objectives of the model are consistent in providing innovative and creative teaching tools. The contents are sufficient and clear, the themes are inclusive and incorporates pedagogical approaches and methodologies that integrate parents, caregivers, sectors, institutions and social actors. This therefore confirms the obvious need to train families, teachers, health professionals and those responsible for public policy, more appropriately on these issues.

Conclusions

The research work that resulted in the design and validation of the training model constitutes an opportunity to be replicated in various social contexts and social sectors in the country - health, education, justice and protection-, who have some degree of influence in public policies, as well as in the plans, programs, projects and strategies that address PwD, necessitating greater articulation, coordination and integration between them. That means overcoming professional and institutional jealousy arising from the joint group work in order to multiply efforts, physical and human resources.

Since the claim is to have a theoretical-practical tool, it is possible to adjust and adapt to the needs and requirements of the population with disabilities. This is part of the human rights approach that involves respect for diversity and differences in needs, desires and expectations of the PwD, in line with the Convention.

This leads to the relevance that possesses the training model for the scientific community and the social impact it possesses for the city, country, and the region of Latin America, especially in those communities with greater needs in care, education, protection and health. It is a contribution to historically vulnerable demographies in the midst of the economic difficulties and constraints, cultural and social rights of the region. It is a response to the permanent cultural, social, technological and economic changes facing the country’s reality forcing professionals to innovate and update themselves in other ways of understanding the world and its problems.

Within its achievements and successes new and emerging challenges were also identified, including the construction and consolidation of common elements for the work of the social officials and the possibility of creating new lines of interinstitutional and intersectoral work with PwD and their families which are more inclusive and equitable based on the rights approach, supporting the project.

With the model completed comes a training tool in sexuality and affectation geared toward families and caregivers of adolescents with CPwD, significantly contributing to the development and improvement in their quality of life, within all dimensions, strengthening knowledge and attitudes in these topics, as well as strengthening the responsiveness toward concerns and needs that arise in aspects related to the experience of sexuality and affectation. Future researchers and those officials with influence over public policies at the national, regional and local levels may, on the basis of the programming provided throughout the research work, stimulate new fields of academic knowledge and locally impact comprehensive care as continually or sporadically offered to the population with disabilities.

Despite advances in knowledge and the opportunity provided by the study for strengthening families and their children with CPwD, much remains to be done. The conceptual and validated methodological tool are available, however, it needs to be put into practice which translates into the possibility of other research or projects from different disciplines and sectors involved. It is not an easy task due to the resistance created against it, the limited resources for training, disinterest from governments and with disability not being a priority.

Principles such as human rights, SHR, differential approach, inclusive education and gender perspective, among others, must be part of the plans, programs, projects, strategies and training activities of the educational agents, accompanied by didactic material and specialized human resources, which in turn enable us to share knowledge and successfully exchange experiences.

However, the study contributes significantly in having more theoretical and practical elements for its approach, compared to the limitations with regard to the gaps that exist in literature. It is therefore required to implement political action and advocacy with decision makers, educational and health institutions, international agencies, non-governmental organizations and associations that grouped or defend the rights of PwD.

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Date Received: 12/12/2018
Date Reviewed: 11/06/2019
Date Accepted: 13/06/2019