

Issues and challenges in sexuality and sex education in Intellectually Disabled

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Abstract

All human beings are sexual from birth to death, and the Intellectually Disabled (ID) are not exempt from this. The issues of sexual needs and sexual behaviour of the ID have been a sensitive and controversial topic. Perhaps because of the taboos associated with Intellectual Disability and sexuality, individually or in combination, very little is known about the sexuality of people with ID, but research studies do indicate that it is much the same as the general population, although opportunities for sexual expression are limited. This article provides an overview of sexuality issues in ID, with regard to sexual rights, sexual development and maturation, menstruation and menstrual hygiene, masturbation, petting, sexual activity, marriage, pregnancy, parenting, sexual abuse, fertility and birth control, menopause, and the progress and issues in sexuality education for ID. Prior research shows that individuals with ID show secondary sexual characteristics and development similar to that of intellectually averaged peers; those in the lower range of functioning develop those characteristics at a slower pace. ID children often neglect menstruation and are non-co-operative in menstrual grooming due to poor understanding, irritability, fatigue and increased seizure. Research reports vaginal hysterectomy as management of this. They

show a lower rate of offspring production than the non retarded. It is estimated that ID children are sexually victimized at 4-10 times the rate of the general population, 39-83% of girls and 16-32% of boys experience sexual abuse before they reach the age of 18. Parents and professionals are pessimistic in the sexual needs of people with IDD and consider them as asexual. There is an urgent need for development of methods to teach them about sexuality and sexual abuse prevention, since research on sex education revealed poor generalization of skills to real life situations. In situ training revealed better generalization, but has the issue of causing emotional distress and dissonance among ID.

Keywords : Sexuality, Intellectually Disabled

Introduction

All human beings are sexual from birth to death, and the Intellectually Disabled (ID) are not exempt from this. In the process of development from childhood to adulthood, every human being should incorporate the values of sexuality to lead a sexually healthy life. Many people tend to link sexuality only with a sexual act or intercourse, but it is not only genital sex. It starts from birth, with identification of gender, how males and females

are both alike and different, sexual role, sexual preferences, eroticism, pleasure, intimacy, how we view our body, how we grow and change, how we socialize and how we reproduce. Human sexuality fulfils procreative, hedonistic and relationship-building functions, as well as constitutes an integral part of a human's personality. Like every human being, the Intellectually Disabled also need to be loved, cared for, valued, protected, and intimate in relationships. But often parents, professionals and other care givers are pessimistic about the sexual needs of people with ID and consider them as asexual or childlike. They are doubtful and concerned about the capacity of the Intellectually Disabled in giving consent for sexual relationships.

The issues of sexual needs and sexual behaviour of the ID have been a sensitive and controversial topic and perhaps because of the taboos associated with Intellectual Disability and sexuality, very little is known about the sexuality of people with ID. But research studies indicate that it is much the same as the general population (Baroff, 1986, Monat-Haller, 1992), although opportunities for sexual expression may be limited by conditions under which individuals with ID live (Abramson, Parker, & Weisberg, 1988).

Method of Literature search and selection

The introduction suggests that sexuality of the ID is an important area which needs urgent attention. Considering the significance of this topic we have written an article after reviewing around 40 articles, dated from 1973 to 2014, which met the criteria in terms of topic- sexuality, sex education and population of interest - individuals with ID. Bibliographic data bases were searched as a first step, and the second step involved discussion with experts regarding important articles in this area. The search string contained mainly three concepts, sexuality, sex education and Intellectually Disabled. Synonyms and related terms were used for these

concepts. Data bases used were Pubmed, Psyc ARTICLES, PsycINFO, and Psychology and Behavioural Sciences Collection.

Sexual health

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

Sexuality

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (WHO, 2006)

Sexual rights

There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights. The working definition of sexual rights given below is a contribution to the continuing dialogue on human rights related to sexual health. “The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human

rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realization of sexual health include:

1. The rights to equality and non-discrimination
2. The rights to be free from torture or to cruel, inhumane or degrading treatment or punishment
3. The right to privacy
4. The rights to the highest attainable standard of health (including sexual health) and social security
5. The right to marry and to found a family and enter into a marriage with a free and full consent of the intending spouses, and to equality in and at the dissolution of marriage.
6. The rights to decide the number and spacing of one's children
7. The rights to information, as well as education
8. The rights to freedom of opinion and expression
9. The right to an effective remedy for violations of fundamental rights
10. The responsible exercise of human rights requires that all persons respect the rights of others.

The American Association on Intellectual and Developmental Disabilities has a position statement (Sexuality, 2009) related to human sexuality.

1. People with mental retardation and related developmental disabilities, like all people, have inherent sexual rights and basic needs must be affirmed, defended and respected.
2. Every person has the right to exercise choices regarding sexual expression and social relationships. The presence of mental retardation and related developmental disabilities, regardless of severity, does not in itself, justify loss of rights

related to sexuality

3. Individuals have a right to sexual expression, information to allow informed decisions and sexuality education including information about safe sexual practices, sexual orientation, sexual abuse, and sexually transmitted infections.

4. Individuals have a right to sexual relationships, including marriage, with individuals of their choice

5. Individuals have a responsibility to consider the values, rights and feelings of others.

6. Individuals have a responsibility to seek input from families, friends, religious leaders and others on the personal and societal values associated with sexuality.

7. Individuals have the right to choices related to birth control deciding whether to have and raise children and having control over their bodies.

8. Individuals have the right to choose for themselves whether to be sterilized regardless of the severity of their mental retardation.

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination." (WHO, 2006, updated 2010)

All people have the right within interpersonal relationships to:

1. Develop friendships and emotional and sexual relationships where they can love and be loved, and begin and end a relationship as they choose;
2. Dignity and respect; and
3. Privacy, confidentiality, and freedom of association.

With respect to sexuality, individuals have a right to:

a) Sexual expression and education, reflective of their own cultural, religious and moral values and of social responsibility

b) Individualized education and information to encourage informed decision-making, including education about such issues as reproduction, marriage and family life, abstinence, safe sexual practices, sexual orientation, sexual abuse, and sexually transmitted diseases

c) Protection from sexual harassment and from physical, sexual, and emotional abuse.

d) Individuals have a responsibility to consider the values, rights, and feelings of others.

With respect to the potential for having and raising children, individuals with intellectual or developmental disabilities have the right to:

a) Education and information about having and raising children that is individualized to reflect each person's unique ability to understand;

b) Make their own decisions related to having and raising children with support as necessary;

c) Make their own decisions related to using birth control methods within the context of their personal or religious beliefs;

d) Have control over their own bodies; and

e) Be protected from sterilization solely because of their disability

Sexual development and maturation in ID

Researchers show that individuals with mild and moderate ID show secondary sexual characteristics and development similar to that of intellectually averaged peers. Those in the lower range of functioning develop those characteristics as well but at a slower pace (Deisher, 1973). It is also reported that Intellectually Disabled actively seek for sexual education and opportunities for sexual expression, but varies widely in their attitude in dating, marriage, intercourse, pregnancy, masturbation and homosexuality (Edmonson & Wish, 1975). Fifty percent of adolescent girls with mild ID and 30% with moderate ID are sexually active

(Chamberlain, Rauh, & Passer, 1984). Unfortunately there is still a lack of knowledge on people with a higher degree of intellectual disability. As a consequence, this group may struggle with many problems in building satisfactory relationships with a partner and having a successful sexual life. Due to limited research in this field it is difficult to achieve any general conclusion as to the knowledge and sexual activity of people with low functioning ID. The analysis of studies available in literature gives only a general perspective on this issue

Different research reported that the first wet dream experience among intellectually disabled men appears at the age of 15 (Rowe & Savage, 1987 & Kijak, 2010). The development of secondary sexual characteristics such as pubic hair, development of genitals and breasts are not much different when compared to young people with normal intellectual development (Gawlik, Nowak, & Zalewski, 1995) He also reported that people with moderate disability are not a homogenous group and the first menstruation and wet dreams may be delayed by 3yrs compared with intellectually normal people (Kijak, 2010).

Voice breaking or lowering of pitch is a discernible symptom of boys' sexual development and is found to be the same with intellectually normal young men which shows correct production of male sex hormones in this group. Sex hormones also lead to an increase in the growth of external sex organs, especially stimulating testicles to produce reproductive cells. The size and external appearance of these organs don't exhibit any difference with their normal peers.

Even though the ID develops normal secondary sexual characteristics, they need more help in understanding these changes. It is now recognized that the sexual interests and desires of the mild and moderately disabled vary in intensity just like those in the non-disabled population.

Knowledge of Intellectually Disabled about sexual development

Research by Kijack (2010) confirms that people with ID recognize their changes but rarely understand those changes. They need education and training to understand these changes to prevent getting knowledge from undesirable sources. Lack of knowledge results in fear and uncertainty. Studies reported that 99% of the study subjects were able to describe their physical changes but only 37% described the changes in the opposite sex. They found difficulty (78%) explaining the reasons for menstruation and wet dreams. The majority found it difficult to explain the development of pubic hair and involuntary erection as a part of adolescence. They exhibited very poor knowledge regarding contraception (90%) and STDs (98%).

Menstruation and menstrual hygiene

Among women with Intellectual Disability, the average age at onset of menarche is almost similar to that of any women in the general population. The average age of having the first menstruation for disabled women is 14. Most appear to have regular menstrual cycles. Research conducted by Goldstein (1988); McCabe, Cummins, & Deeks (2000). reported that young women with Intellectual Disability menstruate on average for 5.5 days, average length of menstruation cycle amounting to 28.3 days. McCabe reported that 87.9% teenagers with Intellectual Disability had regular menstrual periods. Recent studies of gonadal function in women with Down Syndrome have found distributions of age at menarche and frequencies of women with regular menses that are much closer to those in the general population than had been presumed from earlier studies. Between 65% to 80% of women with Down Syndrome have regular periods, while 15-20% have never menstruated. Nonetheless, international studies have generally supported that most

cycles show evidence of ovulation and formation of corpus luteum, suggesting that gonadal endocrine function is within normal ranges in the majority of women with Intellectual Disability. Many women with ID are treated with psychotropic medication or anti epileptic drugs. Psychotropic drugs can interfere with a number of hormonal and metabolic functions. A common finding is hyperprolactinemia in association with neuroleptic drug use. Prolonged elevations in prolactin can lead to a decline in the Follicular and Luteinizing hormone, leading to a decline in ovarian function.

Several problems are reported when ID do not possess the skills of menstrual care. Due to neglect of personal care and resulting odour, community movement is restricted (Kreutner, 1981). They often reject menstruation, and are non-cooperative in menstrual grooming due to lack of understanding, irritability, aggression, self-injury, tantrums, fatigue, and increased seizure in girls who are epileptic

Therapeutic Amenorrhea

Therapeutic amenorrhea may be used in women with Intellectual Disability who are unable to manage menstrual hygiene effectively or in women who show self-injurious behaviour related to menstruation. The most common form of therapeutic amenorrhea is suppression of menstrual cycles with Lynestrenol. In one report, a Finnish Gynaecologist noted that 66% of his patients with intellectual disabilities had been prescribed Lynestrenol at some time in their life. Alternatively, endometrial ablation, abrasion of the inner layer of the uterus, may be used to suppress menstruation and establish therapeutic amenorrhea. Researchers reported vaginal hysterectomies are also performed as management of this.

Masturbation

Research by Kijack (2010) reported that

most youth with moderate disability engage in masturbation. This phenomenon reaches its peak at 17-20 years of age. A majority of them 76% masturbate. They rarely use social sexual behaviors like necking, petting, sexual contact. 100% masturbate when alone at home. It was observed that masturbation practices are also done outside home, in schools, parks, green squares, public toilets, shops, trams, buses, forests and even infirmaries. It is assumed that for 15% of ID, other than releasing sexual tension, masturbation is a way to fulfill functions of emotional contact with an element of exhibitionism in the form of attracting somebody's attention and satisfying the need to have contact with another person.

Petting

Petting involves two people and requires mutual interrelation of both partners, and hence it is a higher level of sexual development. Kijak (2010) documents that 24% of the sample have participated in sexual caressing. Only 11% admitted regular petting activity with a stable partner and in most cases, petting activity occurred at home when parents and their family members were absent.

Sexual Activity

Chamberlain et al (1984) reported that 34% of Intellectually Disabled had sexual intercourse at least once, and 43% of active people became pregnant. Women who are sexually active are found to experience predominantly penetrative sex but express lack of sexual pleasure. Many women are victims of sexual violence from spouses, dates, or casual sexual partners (Jenkins & Davies, 2006). McCabe (1999) reported around 58% of his study participants had a previous experience of sexual intercourse and 31% were currently active.

Capacity to give consent for sexual activity

This is a topic that deserves more attention.

There is no consensus covering definition of sexual consent capacity and its standards of determination, and there are no universally accepted criteria for the same. Different countries have different standards for sexual consent. As per the recommendation of many states, sexual consent capacity requires understanding and knowledge of nature, its possible consequences, and moral qualities of sexual behavior.

Murphy and O'Collaghan (2004) delineated six criteria for sexual consent capacity

1. Knowledge of body parts, sexual relations, sexual act
2. Knowledge of the consequence of sexual relations, STD, pregnancy
3. Understanding appropriate sexual behavior and its context
4. Understanding that sexual contact must be voluntary
5. Ability to recognize potentially abusive situations
6. Ability to show assertiveness in social and personal situations and to reject unwanted advances

Marriage, pregnancy and parenting

The Intellectually Disabled show a lower rate of offspring production when compared with their intellectually normal peers, yet the majority are potentially fertile with margins of individual variation. The American Journal of Mental Retardation documented that the risk of producing ID offspring was as follows: 40% when both the parents are ID, 15% when one parent is ID, 1% when both the parents are not disabled. Although having children is a social and economic complication, forced sterilization of individuals with ID was deemed inhumane in the 1940s when the dangers of an overzealous eugenics movement were revealed by World War II atrocities. Parents of ID are not convinced about their children marrying and rearing children, they viewed that

their children lacked the capacity to parent on their own. (Alcorn, 1974, Whitcraft and Jones, 1974, Dupras and Tremblay, 1981, Wolf and Zarfes, 1982). But the majority (60-80%) of mild ID expressed their interest in marrying and raising children (David, Smith, & Friedman, 1976; Brantlinger, 1988).

Sexual abuse

Sexual Abuse of children with Intellectual Disabilities is increasing in alarming proportions. In the general population, between 5 and 10% of boys and at least 20% of girls have been sexually abused (Sobsey & Doe, 1991). As high as these numbers are, individuals with Intellectual Disabilities are at a greater risk of being sexually victimized. The rate of sexual abuse among the Intellectually Disabled is ranging from 2-4 times the rate of the general population. 39% - 83% of girls and 16% - 32% of boys with Intellectual Disability typically experience sexual abuse by the time they reach the age of 18. Sexual abuse is recurrent and lasts for a longer period of time when the victim is a person with a disability (Strickler, 2001; Sullivan & Knutson, 2000). The Intellectually Disabled are more vulnerable to sexual abuse due to limited communication ability, dependence on others for care, social isolation, poor social judgment and an emphasis on compliance (Nettelbeck & Wilson, 2002). People with Intellectual Disability are rarely educated about sexuality issues or given self-assertiveness training which is necessary in learning the difference between "safe" versus "unsafe" people and situations, and in knowing how to say "no" to unwanted sexual propositions. They often think they do not have the right to refuse sexually abusive treatment, especially if the abuser is an authority figure, such as a parent, step-parent, relative, teacher, caseworker, pastor or some other individual who is well-respected by other family members, neighbours and co-workers.

Women subject to sexual abuse often do not recognize abuse and they never report it. They

are being abused by people whom they relate to more, and are left with unpleasant feelings which they bear in silence. Men become aggressive in their future relationships and often become abusers themselves (Swango-Wilson, 2009)

Fertility and birth control

In a number of countries, women with intellectual and developmental disabilities are as likely to marry and bear children as their peers. While little research has addressed fertility in women with intellectual disability, it is reasonable to assume that most adults are fertile unless they have a disorder that affects genital organs or brain regions responsible for hormones that regulate ovarian function. For example, only a few births to men and women with Down Syndrome have been documented. In addition, in some countries a majority of women with Intellectual Disabilities use some form of contraception. Oral contraception is preferred, with low dose combinations of progestins and estrogens. Depot progesterones are also widely used as contraceptives. Their advantage stems from the fact that they need to be administered only four times a year. However, irregular vaginal bleeding ("spotting") and effects on cholesterol metabolism, which might increase the risk of coronary heart disease, need to be considered. More radical procedures, such as a hysterectomy, may also be used to prevent pregnancy. In the past, sterilization was widely used to prevent pregnancy, often without the consent of the person with ID. In more developed countries, guidelines for sterilization now require extensive documentation of the medical rationale for the treatment, including documentation of informed consent procedures. Endometrial ablation, hysterectomy and sterilization, while effective, are irreversible, raising legal and ethical concerns about these procedures. Determination of the perceived problems surrounding management of menstruation and/or fertility should be medically

documented and should be undertaken as much for the information of the women herself as for the convenience of the caretaker.

A research by McCarthy (2011) explored the prescribing practices and attitudes of general practitioners when women with ID approach them for contraception. Most of them (57.9%) had encountered 10 or fewer cases. Most common methods were the pill (39.7%) and depot Medroxy Progesterone Acetate (34.2%), and the third most cited adopted method is using intrauterine devices (IUD). Almost all (92.1%) reported that women have less understanding about their contraceptive choices, and 55.8% reported that their main concern was ease of use. Practical skills may also be a problem in implementing birth control practices. Many persons with intellectual disabilities have motor problems which limit their ability to use condoms effectively, as well as poor understanding of their proper use. Sexual education needs to include practice in condom diaphragm/pill use with instructions adapted to the capacity of this population. It is crucial to recognize profound cultural differences in sensitivity to the content of such education for women and in recruiting and preparing care staff and instructors.

Menopause

Very little is known about menopause in women with ID. Limited studies have reported on the median age at menopause and no study has systematically tracked changes in hormones and ovarian function with age in a large group of women with ID. Thus, there is very little information on how decreases in hormones after menopause may affect health and cognitive ability. Studies of menopause have found that the median age at menopause was 3 to 5 years earlier in women with ID compared with women in the general population. Women with Down Syndrome and women with Fragile X appear to have an especially early onset of menopause.

Gynaecological services and The Intellectually Disabled

Kijack (2010) reported that women with ID don't receive any services from Gynaecologists. Men could not check their testicles on their own, and women didn't test their breasts. Schools don't provide such medical examination and many parents neglect the problem. Kempton, Bass, & Gordon (1985) reported that within the first two years of menstruation, ovulation periods are generally connected with abnormal uterine bleeding, however thyroid disease, anti-convulsion therapy and neuroleptic drugs may also contribute to these symptoms.

Sexuality Education programme: progress and issues

Formal sex education for the Intellectually Disabled is an area of deep concern; it raises various unanswered questions. In 1970 there was a trend to deinstitutionalization. But they were protected and denied a sexual life. Sex education programs have been developed in order to improve the sexual health of people with Intellectual Disability. Sexual health, as defined by the World Health Organization (WHO, 2006) is not merely the absence of disease or negative experiences regarding sexuality, but includes positive aspects as well, such as "the possibility of having pleasurable and safe sexual experiences" (p.5). Furthermore, WHO's definition states that "the sexual rights of all persons must be respected, protected and fulfilled" (p.5). In short, all people have the right to experience sexuality in a positive and pleasurable way. Walcott (1997) developed a Family Life Education Trainers manual to address the sexuality needs of moderately and severely disabled people between 11-35 years to teach basic facts about sexuality, to respond appropriately to questions, and to help parents to talk to their children with disabilities. This manual accommodated the cognitive limitations of the disabled and included

visual and tactile cues. The teaching procedures include verbal instructions, modeling, rehearsal and social reinforcement. It was a comprehensive manual which includes modules on puberty, reproductive organs, male/female differences, menstruation, masturbation, sexual intercourse, interpersonal relationships, self-esteem, identification and prevention of sexual exploitation, personal hygiene, physical exercise and nutrition. An optional module addresses sexual orientation, STD prevention, marriage, parenting and contraception practices. There is a concern of applicability to the profoundly disabled, therefore, even though teachers supported the manual well, there was concern about not accurately addressing sterilization and abortion. Most of the sex education programmes are focused mainly on biological development, but there is a need for assessment studies to be done among ID people (Chivers and Mathieson, 2000). A number of people were interested in knowing how to meet people and how to talk to people who they were interested in. The framing of sexuality as an illogical discourse leads to separation of sex from intimacy, desire and pleasure and reinforce isolation of the ID. Liou (2013) found that most of the students with ID had relatively high levels of knowledge of puberty physiology, body boundaries, and identification of improper sexual relationships, but less knowledge of coping methods when facing abusive situations and identification of abusive situations. However, Murphy in 2004 found that adults with ID were less knowledgeable in the areas of pregnancy, contraception and STDs, and legal aspects of sex and sexual health, compared to young people without ID. McCabe et al., (2000) emphasized the importance of involving people with ID in the planning phase of sex education programmes so that their needs can be addressed better. He has done a study to discover the expectations of ID, parents and professionals. Parents denied the need for a sexual relationship

and also demonstrated fear of abuse. Professionals emphasized safety, legal issues, protection from STDs and prevention of pregnancy. ID identified a theme of relationship knowledge, how to make relationships, friendships, prevention of AIDS and STDs, differences between men and women, what to do during pregnancy and marriage, and development of skills for responsible sexual activity.

Behaviourally focused programmes directly model and reinforce appropriate responses to abusive or potentially abusive situations, but they require several weeks of training and evaluation. In a Chinese study, the BST group demonstrated greater knowledge regarding sexual abuse and self-protection skills at post test, which was maintained at 2 months follow up, though the scores on the recognition of appropriate touch requests showed a decreasing trend (Lee & Tang, 1998). Researchers recommended that booster sessions and longer duration programmes should result in better retention. There is research evidence that in situ practice of skills may promote generalization of skills (Miltenberger et al, 1998, Raymond et al, 1999) but there is an issue of causing emotional distress (dissonance) among ID. Emily Lund 2014 developed a single session curriculum SAFE (Stopping Abuse For Everyone) for ID. Anecdotal experiences are useful, but formal data on efficiency is yet to be collected.

Attitude towards sex education programmes

Guroi, Polat, and Oran (2014) investigated the attitude of 9 mothers of children with Intellectual Disability aged 7-18 years. They found that the mothers totally ignored the sexuality education of their children, but all except one accepted the need of such education. Parents are often concerned about, and responsible for, their children's physical and emotional safety, but they are confused and uncertain of talking about sexuality issues with their intellectually disabled children. There are various contributing reasons,

one is being uncomfortable talking about reproductive organs and functions. They fear that knowledge about sexuality and reproduction will encourage their children to experiment. But the fact is that people with developmental disabilities, whose parents discuss the aspects of sexuality with them, are better prepared to protect themselves from abuse and able to express sexuality.

The study concluded that sexual education should be provided to teach boys how to behave when stimulated, to wear clothes that don't emphasize sexual urges, and that family planning need not be involved in sex education. The majority thought that ID children could not have a sex life, emphasized the need to keep a close watch on them to avoid sexual abuse, and to keep them away from healthy siblings. A qualitative study conducted by Amy Swango Wilson (2008) on perception of sex education for individuals with ID in the USA reported that parents were denied this need. Analysis of 12 interviews reported that participants identified current education materials

as being too broad and overwhelming. Safety issues were a concern of parents, professionals and health care professionals. These groups acknowledged the sexuality of individuals but did not consider it to be a major concern for sex education. Individuals with ID were concerned about relationship development, skills for sexual activity and use of protective measures.

Conclusion

Even though the Intellectually Disabled are sexual beings, parents and professionals are pessimistic towards their sexual needs and consider them as asexual. Intellectually Disabled all over the world, face challenges in receiving proper sex education programmes, which in turn hinder their proper sexual development. There is an urgent need for the development of methods to teach them about sexuality and sexual abuse prevention, since research on sex education revealed poor generalization of skills to real life situations.

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