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Sexual Education And Special Education

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Sexual Education and Special Education: Why It is Important and Barriers to It

by

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Chapter I: Introduction

People with disabilities are frequent victims of sexual exploitation and sexual abuse. Education and training on sexuality and on relationships have been proposed as a means for reducing the sexual victimization of individuals with disabilities. When provided with appropriate sexuality education, people with disabilities will understand when and if they are being abused, and they will know where and how to report the abuse if it happens.

Historical Background and Context for the Review

Diekema (2003) describes historic patterns of institutionalization and sterilization among the disabled community. As intended outcomes of the eugenics movement in the United States, both institutionalization and involuntary sterilization were intended to protect future generations from the perpetuation of genetic defects. Both the scientific and moral assumptions of the eugenics movement were incorrect. They were sterilized so as not to pass their defect on to the next generation.

Very few schools have a comprehensive sexual education curriculum for Special Education students (Michielsen & Brockschmit, 2021). This absence is one of the many barriers to people with disabilities receiving sex appropriate sex and sexuality education. The absence of this training creates a myriad of problems. First, people with disabilities are sexually assaulted at nearly three times the rate of their peers who do not have disabilities. Almost half of these assaults are never reported. In general, people with disabilities experience domestic and sexual violence at higher rates than people who do not have a disability (Weiss & Glaser, 2021). Data on the sexual exploitation of people who have disabilities show,

> 83% of women with disabilities will be sexually assaulted in their lives, just 3% of sexual abuses involving people with developmental disabilities are ever reported, 50% of girls who are deaf have been sexually abused compared to 25% of girls who are hearing; 54% of boys who are deaf have been sexually abused in comparison to 10% of boys who are hearing, women with a disability are far more likely to have a history of undesired sex with an intimate partner–19.7% vs. 8.2%, and approximately 80% of women and 30% of men with developmental disabilities have been sexually assaulted–half of these women have been assaulted more than 10 times. (Disability Justice, 2022)

Typically, they are taken advantage of by the people that should be taking care of them or by other people with disabilities that may not understand that what they are doing is wrong (Weiss & Glaser, 2021).

Research Question

This review will examine the sexual exploitation of individuals with disabilities and address formal and informal approaches for teaching the population about individual sexuality and sexual behavior. Three foci guide the analysis. First, I will examine the barriers to teaching sex education to students with Cognitive Disabilities. Second, I will address the barriers to teaching sex education to the population with disabilities. Finally, I will discuss why learning sex education is important for people in special education.

Importance of the Topic

The topic has both applied and theoretical importance and consequence. I have worked in four different school districts in the state of Minnesota. The approaches to sex and sexuality education varied across districts in terms of focus, of scope, and of utility.

One district taught sex education by pushing Special Education students into a health class. Students had difficulties following what was being taught. They had many questions and wanted clarification. However, they did not know how to ask them or whom to ask. They left the class with no more knowledge than they had when they entered the class. When asked questions about what was being taught in class, none of them could answer them.

The second district did not do anything to teach the Special Education students about sex or their bodies. Although sexuality is an element of adult life, the district did nothing to facilitate the transition to adult sexuality.

The third district was on the right track. They had an outside organization come in and teach the students about sex education. The person that came in was younger and closer to the age of the students. She understood how to talk to the group and the words to use when working with people close to her own age. The general education high school students responded well to this, but she did not know how to talk to the Special Education students. She shared information that was beyond their level of comprehension, and thus, nothing was learned.

The fourth district only taught sexual abstinence to the students. This does little to teach about how to have safe and healthy sex; it teaches the only way to be safe is to not participate in sexual activities. The approach also shamed people about engaging in sexual behavior.

> In the abstinence-only approach, students learn that abstinence from sexual activity is the only healthy and morally correct option for unmarried people typically falls into three broad categories: 1) exaggerating negative consequences of sexual behavior; 2) demonizing sexually active youth; and 3) cultivating shame and guilt to discourage sexual activity. (Wilson et al., 2015)

This can lead to people being sexually abused being embarrassed that they had sex even if it was not their choice, leading to them being less likely to report a sexual assault.

Despite the divergent approaches, some themes were present across the four districts. First, when sex education was taught, it was taught from a heteronormative perspective. The variety of other types of relationships and also the appropriateness of being were not addressed.

My applied experiences further demonstrated the need for this review. I worked with a student who had been taught at home that the name for female genitalia was a "Gooch" and that males had "hot dogs." This caused a breakdown in communication when the student said that someone had shown them his "hot dog" and wanted the student to touch it. This child was also watching fetish porn and developing his understanding of how relationships are supposed to work from that. They thought the way to show someone you liked them was to talk dirty to them and say that you want to "hump" them. In these videos, they also learned that the way to show someone you care about them is to urinate on them. The student would stick their hands in their pants and masturbate, or sometimes drop their pants and do the same thing. I believe if this student was taught comprehensive sex education, they would be able to express themself in a more appropriate and acceptable manner.

Focus of the Paper

I identified 11 articles for inclusion in review. My research contains articles from 1999 to 2021. The early article was used to get an understanding of the practice of forced sterilization of the intellectually disabled. The more recent articles feature people with intellectual disabilities as well as the people who take care of them. I used Eric/Ebsco to search for my topic. My search terms included: special education and sex education, intellectual disabilities and sex education,

intellectual disabilities, and forced sterilization. The search was delimited to articles written in the past 5 years except when seeking historical information and data.

Glossary

A number of terms are used uniquely in the context of this paper or have slightly variant connotations or denotations than in common usage. In this section, I define these terms as used within the context of the present research. The terms are arranged in their order of presentation within the review.

1) *Sex Education* is education and learning that increases the knowledge of the functional, structural, and behavioral aspects of human reproduction. (U.S. National Library of Medicine, n.d.).
2) *Sexuality Education* includes:

    > Learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. For children and young people, it aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills, and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people's sexual health and well-being (World Health Organization Europe, 2021)

3) *Intellectual Disability* is a condition characterized by significant limitations in both intellectual functioning and adaptive behavior that originates before the age of 22 (American Association on Intellectual and Developmental Disabilities, 2022).

4) *Heteronormativity* is the assumption that heterosexuality is the standard for defining normal sexual behavior and that male–female differences and gender roles are the natural and immutable essentials in normal human relations. According to some social theorists, this assumption is fundamentally embedded in, and legitimizes, social and legal institutions that devalue, marginalize, and discriminate against people who deviate from its normative principle, e.g., gay men, lesbians, bisexuals, transgendered persons (American Psychological Association, 2022).

Chapter II: Review of Literature

This review examines the use and the consequences of sex and sexuality education in the context of intellectual disabilities. In Chapter I, sex and sexuality education were described, and Intellectual Disabilities (ID) were defined both operationally and theoretically. In addition, the potential benefits of sex and sexuality education for the population with intellectual disabilities were addressed. In Chapter II, research addressing the uses of sex and sexuality as a means for lessening the sexual exploitation of students with ID and as elements of the transition to adulthood that appears in the literature of education and of psychology is reviewed. In Chapter III, the findings from the analysis will be summarized, and the implications of these findings will be described.

Focus of the Review

The sexual exploitation of individuals with cognitive impairments is a chronic social problem in the United States. People who have disabilities are sexually assaulted at nearly three times the rate of their peers who do not have disabilities. Almost half of these assaults are never reported. In general, people with disabilities experience domestic and sexual violence at higher rates than people who do not have a disability (RAINN, 2021).

In addition to the related safety issues, the sex and sexuality education promulgated in most schools does not prepare students who intellectual impairments to allow them to fully understand the variable nature of sexuality, does not allow them to understand sexual behavior to such an extent that they may provide fully informed consent related to sexual acts, and does not prepare them to between social attitudes and misconceptions about sexuality. This review addresses these issues.

Three foci guide the review. First, I review historical trends and patterns about societal and governmental treatment of the sexuality of individuals with intellectual disabilities. Second, I explore the thoughts and feelings of caregivers about the sexuality and sexual education of people with ID. Finally, I examine sexuality and sexual education through the lens of intellectual disability.

Historical Trends and Patterns in Governmental and Societal Response to Sex and Sexuality among the Population with Intellectual Disabilities in the United States

Before people with disabilities were included in society, they were mostly institutionalized. This practice continued well into the 1970s (Diekema, 2003). Practices based on the false assumptions of eugenics and on discrimination arising from ableism provided the theoretical rationale for the mistreatment of individuals who had disabilities.

In the United States, involuntary sterilization was a recurrent practice for over 100 years. In the late 19th and early 20th centuries, the incorrectly held Darwinian belief that all traits are passed down from generation to generation provided the rationale for the practice. A variety of methods were employed to limit the reproduction of groups perceived as other. Women with ID were institutionalized during their fertile years. Laws forbade the marriage of people with ID. Many males were castrated (Diekema, 2003).

In 1907, states began passing laws that allowed or even sometimes mandated the sterilization of people with ID and DD. The justification was that society would be better off if certain individuals were not able to reproduce. Buck vs Bell (1927) was a court case addressing whether the state of Virginia could sterilize individuals identified as mentally ill or cognitively impaired. In 1927, the Supreme Court ruled that states could legally perform sterilization

procedures. Skinner vs. Oklahoma (1942) extended states' rights to perform involuntary sterilization procedures on habitual criminals. Within the context of this legislation, a habitual criminal was defined as any person who was convicted two or more times in Oklahoma or in any other State of "felonies involving moral turpitude," is thereafter convicted and sentenced to imprisonment in Oklahoma for such a crime. Later court rulings held that reproductive decisions without the interference of others are a human right for prisoners, and thus, states could no longer require the sterilization of prisoners. These cases led to people with disabilities having the right to not be forced sterilized in the 1960s. However, by 1960 over 60,000 men and women had been sterilized in accordance with state laws (Diekema, 2003).

Court rulings changed the locus of debates about sterilization. When it became harder to get their daughters with ID sterilized, parents filed lawsuits requesting that their daughters get sterilized to protect their daughters from things like unwanted pregnancies or the burden of the family dealing with menstruation. When the Supreme Court upheld the decision that birth control was legal and acceptable, people started calling sterilization "birth control" (Diekema, 2003).

New Forms of Barriers to Discussing and Practicing Sexuality

Michielsen and Brockschmidt (2021) describe relationship education as a sensitive subject for both the abled and disabled population, but they note that the addition of a disability adds another layer of complexity to an already challenging topic. The authors examined 14 peer-reviewed studies that addressed barriers to teaching sexual education to people with disabilities. Michielsen and Brockschmidt identified six recurrent barriers across the set of studies.

Although the barriers appeared across studies, many of the perceived obstacles were based on radically different assumptions. The first two barriers are based on presumed societal

attitudes. The first barrier is that many people think of children and young people with disabilities as asexual and believe they will never have any sexual desires or thoughts. Believing a disabled person is not going to want to have sex makes teaching them about sex seem irrelevant. The second barrier is the belief sex education for disabled people should be about protecting themselves from sexual behavior rather than looking at it as being pleasurable. The second class of barriers emerges from assumptions and attitudes of teachers. The third barrier is educators reporting a lack of support when teaching sexuality to students with special needs. Fourth barrier is educators being embarrassed to talk about the subject due to the lack of training and support. This leads to a non-comprehensive sexual education. Fifth barrier is that none of the educators and professionals that work with students with special needs knows whose responsibility it should be to teach them about sex education. Sixth barrier is that, with such a diversity of students with disabilities, a standard sexuality curriculum cannot be used. Sexuality is a sensitive subject and cannot be taught the same way to each student. Not only does the disability affect how special education students learn, but culture, religion, and home values also need to be considered, as well (Michielsen & Brockschmidt, 2021).

If these barriers are to be overcome, it is important to design a program that aims to empower the students. Most of the barriers described in this study were caused by the education providers. The best way to overcome this is to empower people with disabilities to ask questions and demand information. If empowered, people with disabilities will not only be able to obtain the information, but they will also be able to use it to have healthy relationships (Michielsen & Brockschmidt, 2021).

Karjach (2021) examined what comprehensive sexual education is and why it is important. He specifically emphasizes what should be taught and the effects. Karjach notes that people with any disability regardless of the severity of the conditions are more likely to experience an unhealthy sexual experience. The proposed remedy is Comprehensive Sexuality Education (CSE).

According to the International Technical Guide (UNESCO, 2018), CSE is:

> … a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to: realize their health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their well-being and that of others; and understand and ensure the protection of their rights throughout their lives. (UNESCO, 2018)

Karjach expanded CSE to Comprehensive Sexuality Education High School and Elementary (CHRSE). It is a more inclusive curriculum with inclusive language and discussions about gender expression, gender identity, sexual orientation, and respect for individual differences. The results of the analysis suggest that only about 5% of school-aged children reported learning about gender identity and expression, or sexual orientation through their current sexual education classes (Karjach, 2021).

Students that have Intellectual Disabilities learn differently and need different types of instruction to learn. Explicit instruction works best for teaching students about the potential risks of abuse and exploration. The education model must provide explicit instruction about what abuse is and how to report it. It should also talk about safe places, consequences of potentially

life-altering choices (unprotected sex) and knowledge of what a healthy relationship is, and their right to have one (Karjach, 2021).

Karjach (2021) argues for multiple sources of information and guidance related to sexuality and sexual behavior. Often no one knows who is teaching CHRSE to students with disabilities. They assume it is someone else's job. Parents think it is the school's job and vice versa. Everyone should be talking about it. Repetition never hurts when it comes to learning. Parents should be talking with their children about it; teachers should be talking about it and trying to give the same message. This is also true for other advocates and medical professionals that are in contact with a child. A clear and consistent message from all the adults responsible for their care and well-being benefits the learner. If everyone can create a flow of information that is consistent, generalized, supported by research, and across different social areas, the health and well-being of all the relationships would improve.

Non-Western Perspectives on Sex and Sexuality Education

Hayashi et al. (2011) studied the history of sexual education in Japan and addressed how it affected people with disabilities. Sexual education in Japan started after WWII and was called Education in Sexual Morality. In the 1970s, it was changed to Sex Education, and in the 1980s after AIDS was discovered, Comprehensive Sex Education was started. This introduced physiological, psychological, and social aspects of relationships into sex education. However, people with ID were not included in sex education until well after this. This omission led to people with ID not having the correct skills for healthy relationships. Sex-related problems were reported because of this. Some of these issues were seemingly minor like approaching people too closely or inappropriately embracing people. Some of these issues were much more alarming,

such as exposing genitals or public masturbation. These things were perceived to be caused by a lack of social skills and understanding in the person with ID. The authors believe that the lack of social skills affected interpersonal relationships, making it hard for people with ID to start a relationship and when initiated, the lack of proper social skills reduced the length and sustainability of the relationship.

Hayashi et al. (2011) propose teaching social skills to people with ID in an attempt to improve their relationships. The authors field tested the approach on 17 participants that living in a group home in Japan. Social skills were assessed using the Kikuchi's Scale of Social Skills (KiSS-18).

The social skills classes were split into eight sessions, one session a week for 8 weeks. The first week focused on personal hygiene/self-care. The second week focused on first impressions. The third week focused on communication training. The fourth week focused on self-assertiveness like being able to tell people what they wanted in situations like getting a haircut or shopping. The fifth week focused on personal space, keeping appropriate space between themselves and other people. The sixth week focused on sexual harassment and male-female relationships. The seventh week focused on the differences between male and female bodies. The eighth week was a review of week seven, with a trip to the exhibit "Mysteries of The Human Body".

The KISS scores rose significantly in the group that took the courses, and it stayed relatively the same in the control group, showing that the program did help the individuals with ID gain interpersonal skills that can lead to better relationships. This helped improve their skills from an initial meeting to developing a deeper relationship.

The Importance of Sex and Sexuality Education

Brown (1997) examined why it is important to teach people with intellectual disabilities sexual education. The author notes that "Since it is evident that the individual with intellectual disabilities will experience, at the least sexual desires and more likely some type of sexual activity, it is imperative that we address this issue with openness and nonjudgment" (Brown, 1997, p. 6). He notes that the problem is not that sexuality is missing from people with ID, it is that adequate education is missing.

According to Brown (1997), people with ID will mature sexually and at about the same time as their peers. Because of increased integration into society, people with ID need to be able to have access to more information. This responsibility for teaching people with ID about sexuality now falls on teachers, and to a greater degree caregivers (Brown, 1997). The author uses the U.S. The Sex Information Council of the U.S has defined of sexuality to delimit the scope of his examination. According to the council, "Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response systems; with roles, identity, and personality; with individual thoughts, feelings, behaviors, and relationships. It addresses ethical, spiritual, and moral concerns, and group and cultural variation" (as cited in Brown, 1997).

Public and Private Attitudes about Sex and Sexuality Education

Using these dimensions, Brown examined the beliefs of individuals about the sexuality and sexual behavior of individuals who have intellectual disabilities. Four patterns emerged. Some respondents were strong supporters of human rights for people with ID. They believed it is very important to provide sexual education, including the moral implications of participating in

sexual activities. They also believed that people with ID should be allowed to get married and have children if they have had the correct education. This group was absolutely against the sterilization of people with ID to control sexual behavior and outcomes. The second pattern of responses showed the belief that abstinence education was the best and that it would protect people from possible abuse. Participants in this cluster did not believe in sex before marriage for anyone. They did not believe that sterilization should be used to control sexual behavior. A third response pattern favored education for people with ID combined with extensive birth control measures. These birth control measures included sterilization so that people with ID could not have children. Respondents with the most liberal attitudes believed people with ID should have the right to education not only about sexuality, but also about birth control methods, and that they should be allowed to participate in sex and procreation if they wanted to do so.

Zarrilli (2021) reviewed the sexual education of people with disabilities. She stated people with Intellectual and Developmental Disabilities (IDD) often do not receive Comprehensive Healthy Relationship and Sexuality Education (CHRSE). This group is more vulnerable to sexual abuse and exploitation. This leaves parents responsible for this education for their children.

She examined the beliefs, comfort level, program type, preferred communication strategies, content, and training needed to build collaboration between home and school in order to help strengthen parent-child communication and understanding of healthy relationships and sexuality (Zarrilli, 2021). She argues that increasing the knowledge of people with IDD will help promote autonomy and competence.

Fifty percent of the parents felt that teaching CHRSE to their children should be shared between themselves, health professionals, and trained school staff. Forty-seven percent believed that they had the primary responsibility to teach CHRSE, and only one parent believed that the school should have primary responsibility for teaching it. Sixty-three percent of parents believed Comprehensive Sexual Education (CSE) should be taught across grade levels. One parent preferred an abstinence-only approach, and 16% preferred an abstinence-plus approach. Seventy-five percent of parents said they believed their children were more at risk for sexual exploitation or abuse without CSE. Fourteen percent said they thought their children may be more at risk but that they were not sure. Nine percent said they did not believe their children were more at risk for sexual exploitation or abuse without CSE. Fifty-four percent of respondents thought CHRSE should start in middle school (ages 11-13), 21% thought it should start in high school, and 19% thought it should start in elementary school. Two parents thought it should not be taught in school at all. Seven percent of parents stated they did not believe their child had any interest, and never would, in a romantic relationship (Zarrilli, 2021).

The parents did not only answer the questions above but were able to write in answers about what is important when it comes to their children and CHRSE. The areas parents thought were important to CHRSE training were written as follows: hygiene, mutual respect, boundaries, inappropriate touching, gender identity, sexual diseases, and pregnancy. They felt that schools needed to teach a basic curriculum and leave the work politics out of the schools. Some write-in concerns included, “Stop trying to indoctrinate our children”; “What if the adolescent has no desire for intimacy, relationships, or physical companionship?”; “Explain the differences in the definition of love. I love my son but I also love my husband and what this means”; “Respect

people, no means no, no hitting, no sex until mature enough to handle it, do not follow the crowd, talk to someone if you have questions about sexual diseases"; "Self-advocacy"; "Protection"; and "Consent is a big one, as a mother of a boy, it is important that he respects women and their ability to say no at any time and that he respects that". The results suggest that CHRSE is important and the human rights of every person. CHRSE builds skills that can help people live full and productive lives. The problem is considering who should be in charge of training, and what should be taught.

Topp (2021) examined the attitudes of mothers on the sexual development of children with ID. All parents influence their children. They teach them social skills and how to be responsible. As they transition into adolescence, children change, and parents should be there to help them grow and develop their sexuality. Sexuality is an expression of what we are as human beings, as well as one of the most basic human instincts. It encompasses things like loving, gaining approval, giving and receiving affection, and feeling valuable. With non-disabled adolescents, parents do this without thinking. However sexual development and education about it is ignored when it comes to adolescents with ID (Topp, 2021). Children with ID express themselves in ways that non-disabled peers typically do not. They may display aggression like kicking, hitting, and a bad temper. These may not be tolerated by the community or in social environments. These behaviors may lead to not getting the education needed to develop a healthy sexual identity.

Topp (2021) examined maternal attitudes in Turkey. Forty-six percent of the mothers said they felt incapable of providing sexual education to their child with ID, while 97% said they had not received any information on the matter of teaching their child sexual education. Parents did

not think that their children were developing sexually but did think they had some traits in the sub-areas of sexual arousal, sexual harassment, sexual satisfaction, and sharing sexual issues. The results suggest the parents are not thinking of their child with ID as having a sexual identity, but they do notice sexual changes in their children and often see these changes as unhealthy. Because the child with ID is likely to live with their parent for longer, their sexual behavior is scrutinized by their parent more than with their non-disabled peers.

Topp (2021) reports that although adolescents depend on their parents to teach them sexual education, the parent often does not have sufficient knowledge of sexual development. The parents were not able to recognize changes in behavior as sexual development, and therefore, they were not able to teach their children sexual education to detriment of their developing a healthy sexual identity.

The Perceptions of Sex and Sexuality Education of Members of the ID Population

Schmidt et al. (2021) examined sexuality from the perspective of a person with Intellectual or Developmental Disabilities (IDD). The author wanted to understand the sexual experiences and perspectives of adolescents, and young adults (AYA) with IDD, how they are getting sexual education, and how it can be changed to help them understand it better. Comprehensive sexual and reproductive health (SRH) education has been shown to help support sexual development in adolescence and has reduced the number of sexually transmitted infections (STI), unplanned pregnancies, number of partners, and improved the use of condoms (Schmidt et al., 2021). However, there is a limited understanding of how adolescents with IDD learn about SRH and the factors that may help improve their understanding of the information.

Quint et al. (2016) report that students with IDD reach physical maturity at about the same age as their peers without disabilities. Because of the biological change in their bodies and the hormones flowing through them, adolescents with IDD will have a curiosity surrounding one's bodies and will form their own sexual identity. However, if they are not allowed the same opportunities as their non-disabled peers, they may not be able to form a healthy sexual identity. One of the biggest barriers for children with IDD to forming a healthy sexual identity is that people see them as either hypersexual or asexual. Therefore, people do not think they need to learn SRH.

Quint et al. (2016) wanted to compare and contrast the emergence of sexuality identity among the population with IDD. Specifically, they wanted to understand the sexual experiences and perspectives of adolescents and young adults with intellectual or developmental disabilities. They were also interested in the sources of information that produced the understandings of sexual behavior within the group. The goal was to use this information to develop a more complete and functional sex and sexuality curriculum for learners with IDD.

This study used eight participants between 15 and 24 years old with either self or parent-reported IDD. The participants were largely white, male, and heterosexual. One quarter of the participants either reported that they were bisexual or did not report their sexual orientation. The participants varied in their level of sexual activity: a) 25% of the participants reported being sexually active; b) 75% that said they were not currently sexually active, all but one said they plan on being sexually active in the future. The participants also received information about sexuality and sexual health from different sources caregivers (100%), school (87%), and health care providers (50%). The participants received information from all of these sources, but they

felt more comfortable talking with caregivers. The participants reported that they did not remember the information learned in formal education. Other sources of information were peers, siblings, self-exploration, and pop culture (Schmidt et al., 2021).

Schmidt and their colleagues (2021) report that adolescents with IDD have the same biological and chemical changes in their bodies as their peers. They have the same interest in relationships, intimacy, and sexual activities as their peers. If they do not have access to SRH that they understand, it will lead to unhealthy relationships and them getting abused or being an abuser. SRH education needs to be adjusted so people with IDD can learn how to have safe and healthy relationships.

Shaping the Curriculum

Schaafsma et al. (2106) believes sex education programs improve sexual health. Sexual health is not only the absence of disease or negative experiences, but it also includes the possibility of having pleasurable and safe sexual experiences.

The authors report that little information is available regarding what methods are effective for teaching sexual education to people with ID. They found that the studies were mostly focused on whether sexual education had an impact on attitude, skills, or knowledge. People with ID experience several problems when it comes to sexual health (Schaafsma et al., 2016). The problems are no different from their non-disabled peers, but the percentage of people experiencing them is higher. Examples of this are that people with ID are three times more likely to report being sexually abused than nondisabled peers and that people with ID experience more difficulties finding, forming, and maintaining relationships, even though they desire them.

Relationship problems may be caused not only by a general lack of behavior, but also by social and decision-making skills, and deficits in sexual knowledge.

The environment is another area that can cause it to be hard for people with ID to develop good sexual health. Because parents and caregivers are with children (and adults) with ID all the time, they influence sexual health even when they do not realize it. There is much less privacy for people with ID. This does not allow them to explore sexual opportunities with themselves or others. When privacy is allotted, there are strict rules about what or how they can do things. People with ID are not allowed to be alone with other people and if they are in a relationship, it is seen as cute, and not a real relationship (Schaafsma et al., 2016).

To develop a complete vision of the sexuality and sexual behavior of individuals with ID, Schaafsma et al. interviewed 20 individuals with ID–10 were male, and 10 were female. The average age was 28.9 years. Eight participants lived alone, and the other 12 lived in group homes. Most of the participants received help from organizations, even when they lived on their own.

A semi-structured interview was used to obtain the information. Topics talked about were sex education, relationships, sex, social media, parenthood, and support. Nineteen of the 20 participants reported that they received sex education. All the participants that said they received sex education said it was fun, nice, and interesting. They also said that some class members were ashamed or giggly in class. Some of participants said they took sex education formally, but when asked any questions about what they had learned, they would not be able to answer. The topics mentioned in these sex education classes were condom use (20), contraception (10), sexually

transmitted infections (13), and AIDS/ HIV (11). Some less talked about topics included fetus development, pregnancy, the female body, boundaries, and friendships (Schaafsma et al.,2016)

Half of the participants were in relationships. Two of the older females were married. One of the participants was looking for a long-distance relationship because it was less troublesome. The environment often had a negative impact on some of the past relationships. Three participants reported their parents interfered. One reported that peers spread rumors about them cheating. Reports of restrictions from staff members occurred.

Fourteen of the 20 participants reported having sex. Half of them reported using safe sex practices (condoms and other contraceptives). Some of the positive things that were reported about sex were “sex is pleasure for two” and “sex makes you feel good,” but they also reported “it’s ok if it doesn’t happen” and “sex belongs within a serious relationship.” Fifteen people reported that they would like to have children. The younger participants wanted to experience life before having children. When asked what they would need to raise children, the participants responded mostly with material things. Eighteen participants reported using social media to keep in touch with people. One participant reported having over 200 friends on his social media account. Some participants talked about their experiences with online dating sites. Five of them received negative messages or no response messages on these sites.

Some participants reported negative experiences with sexual experiences. Four reported being sexually abused. All of them were placed out of their homes and under the age of 23. One older man reported having a bad experience with another man while on vacation. Two of the participants kicked someone when they did not listen to their “no”. One participant used a razor to pleasure himself. A male said that women had told him he was not good in bed and had a

small penis. Two females reported having experiences with being harassed on the telephone. One man reported being used by his girlfriends, spending all of his money on them to have his girlfriend cheat on him in his own apartment (Schaafsma et al., 2016).

When asked what is important to be taught in sex education, the participants responded with safe sex, with “safe sex” being always using a condom, or women using a contraceptive. Fewer mentioned emotional things like “be sweet to each other” or “don’t do anything you don’t want to do” (Schaafsma et al., 2016) The reason that the participants could be focusing on safe sex as the primary goal of sexual education is because that is what they have been taught in the past. But most importantly people with ID do express interest in relationships and physical interactions including sex. Most of the participants say they have been through sex education but cannot tell you anything they learned about in it. They will also say that they get push back from parents and staff when they ask questions about sex. They then turn to social media to learn about sex (Schaafsma et al., 2016).

Chapter III: Conclusion and Recommendations

The purpose of this paper was to look at sexual education and how it related to special education. It looked at the barriers to people in special education receiving a full and comprehensive sexual education. Chapter I provided a background on the topic and why it was important to me. Chapter II provided article reviews that looked at past and present views on sexual education for people with ID. It also looked at views from caregivers and people with a disability. In this chapter, I will discuss the findings and talk about what I think they mean. The main barriers to teaching Sexual Education I found were: -

1. What is the best way to teach sexual education to special education students?
2. What should be taught?
    - Dangers
    - Social Skills
    - Pleasurable
    - Relationships.
3. Who teaches sexual education to Special Education students? When this has been decided, you also need to look at what kind of training do the people teaching have.
4. When should it start being taught?

This is just some of the information that is needed before even starting sexual education. This will also be information that is different for each person, based on family, learning style, and religion.

Summary

Most of the studies reviewed for this paper agreed on the same things. They talked about how sex education is not enough, a comprehensive sexual education curriculum must be made. This education cannot just focus on the act of sex and the consequences of it. It needs to focus on the person and relationships. Each person and relationship are different. Many schools have moved towards a comprehensive sexual education program for their general education students. The group that is being left behind in this is the students with special needs, the children in special education. To reach the people in this group there cannot be one single way of teaching this subject. These students have special needs and need individualized ways to be taught. This is one of many barriers to students in special education receiving a comprehensives sexual education.

Another barrier is a lack of training. There are three main areas where special education students get sexual education: formal education, parents and caregivers, and medical personnel. None of these three groups get specialized education on how to teach children with special needs Sexual Education. If they do not know how to teach it, they may think “I am not going to teach it because I do not want to do it wrong,” or they may be embarrassed to talk about the subject, so they do not. This leads to a lack of knowledge about sexual health in a population that sometimes cannot learn independently. They do not have the skills to learn things passively, they need direct instruction to have concepts sink in.

People also believe that people with disabilities do not want to have sex or relationships, that they are asexual, therefore do not need to be taught about sex or sexuality. Or they believe all they need to know is the dangers of sex and all the bad things that can happen. They do not

talk about how there can be relationships without sex or how sex can be pleasurable. This can lead to some socially unacceptable behavior. The problem with this point of view is that it is false. Having relationships is a basic human need, having sex is enjoyable, and people with disabilities have the same sexual desires as their non-disabled peers. They just need to be taught how to have a healthy sexual identity in a different way than their peers.

If people in special education are not receiving comprehensive sexual education, they will find information on sex somewhere else. The majority of these places may be TV, movies, songs, and the internet. These are not the best places for anyone to be getting a sexual education. There are more examples of unhealthy relationships in these areas than there are of healthy ones. If they do not know what is healthy, then they are more likely to be taken advantage of. If they are taken advantage of, they will not know what to do. This leads to the staggering fact that 7 out of 10 people with disabilities will be taken advantage of at least once in their lifetime.

Parents and caregivers agree that people with disabilities need a sexual education, they just do not know how to give it or where their children can get it. This is what needs to be changed. There needs to be a base comprehensive sexual education curriculum, one that can be changed and modified to work for every student in special education. It needs to be a sexual education that focuses on not only the physical side of sex but on interpersonal relationships and about how other people's relationships may look different from theirs. What is acceptable in a relationship, what is not. What do you do if you are involved in a relationship, and it does not seem right?

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