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Attitudes of Turkish Parents Toward Sex Education of Their Intellectual Disability Children

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Abstract

Background: Legal regulations in Turkey state that it is a fundamental right for children with intellectual disability to receive sex education. However, such education is highly limited due to the negative attitudes of these children's parents. Therefore, the main aim of this study is to evaluate the attitudes of Turkish parents toward the sexual education of their intellectually disabled children.
Methods: This quantitative study used the survey method on 311 parents who have children with intellectual disabilities. Data collection was carried out using a Likert-type scale questionnaire developed by the author. Socio-demographic variables were attained, and the data collected were analyzed.
Results: Most of the parents (85%) believe that their children need support for sexual education, but cannot improve themselves to teach such subject without undergoing such education as well. However, the parents appear to have positive attitudes toward sexual education for their intellectually disabled children and believe that it can be provided adequately.
Conclusions: Turkish parents have positive attitudes toward sex education for their children intellectual disability children. Therefore, adequate information about sex education might be needed from the professionals to empower the parents.

Keywords: children, intellectual disability, parents, sex education

INTRODUCTION

Sexuality, which is an important and continuous part of life, is a physiological aspect that starts from birth[1] and has physical, social, cultural, and psychological dimensions. For children with intellectual disabilities, providing sexual education in accordance with their developmental stages is important for them to have a healthy sexual development and thus gain a healthy sexual identity. Sexual education refers to individual learning regarding physical, mental, social, and emotional sexual matters and differentiation by forming positive personality, approaching sexuality, approaching others' behaviors respectfully, and showing positive views.[2] Sexual education includes various concepts such as reproductive organs, social gender roles, physical maturation, body image, and social relations.

Tutar-Guven and Isler[3] reported that sexual education must begin early. However, individuals with intellectual disabilities (IDs) must not differ in terms of receiving such education, which refers to their need and desire to form relationships with others to be able to engage in sexual contact and acquire relevant knowledge.[4] In fact, all people, whether with IDs or not, need appropriate and constant sexual education to develop positive behaviors toward this topic.[5] Sexual education is much more comprehensive than providing information about sexuality. For this reason, each child must be aware of his or her own sexual identity to develop a positive self-image, cultivate a positive relationship with his or her environment and himself or herself, respect human rights, make informed decisions, distinguish false from correct information, differentiate between appropriate and inappropriate sexual behaviors, protect from sexual abuse, and to be able to think about equality and social norms; all of these depend on providing sexual education in accordance with developmental characteristics.[6] Compared with that of ordinary children, the sexual mentality of those with IDs develop at a later time but in the same phases.[7] Their sexual urges, desires, and fantasies are similar and their way of discovering and expressing such feelings is less acceptable because of their dependence on others, restricted living conditions, and limited social opportunities on observing their environment.[8] At the age of puberty, individuals with IDs may demonstrate the same curiosity as ordinary children, but their mental abilities to distinguish between right and wrong, be able to protect themselves against sexual violation, and to be able to control themselves may be much weaker.[9]

Individuals with IDs may be regarded as inhuman, asexual, or childish for years in several countries, such as under-developed ones.[10] Children with IDs may be perceived to have more sexual behaviors than their

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peers or lack control in this area because they do not know where, when, and in what conditions such behaviors are appropriate.[2] The sexual development of children with IDs is mitigated by a lack of adequate learning experiences, segregation, imposed restrictions, lack of privacy, abuse, and overuse of drugs that may be administered to allow them to inhibit their sexual drives. These factors tend to infantilize individuals with IDs or present them as sexually deviant with a lack of true knowledge about their conditions.[11]

Children need to feel healthy and to learn that being a boy or a girl is important. In the context of these needs, children need to obtain detailed information about sexuality from the right sources and at the right time. The foundations of sexual education (attitudes, beliefs, behaviors, and values) are realized with parental participation.[12] For parents, being models for their children in the field of sexuality and to offer suitable educational experiences for their needs is important. Given this aim, parents must have true knowledge about sexual development and positive attitudes toward sexual education. The main goal of sexual education must be to allow an open discussion about sexuality issues when necessary and encourage individuals who reach adolescence to be able to talk comfortably about related topics that may interest them. Lakshmi and Navya[13] discussed that both parents and society thought that children and adolescents with IDs are unsocial toward their genders, indicating that individuals with IDs reflect the need for sexual education. However, the parents are not open to receive such education because of the belief that this kind of training may later lead to sexual abuse. Therefore, these children are thought to not require sexuality education. In addition, if children with IDs receive less formal sexual education, they may misperceive such topics because of their low capacity to understand.[14] Even though receiving sexual education is a universal human right, some parents believe that the relevant expressions of individuals with IDs raise violent negative reactions in society.

Tasci reported that many parents want to provide their children with IDs with sexual education in accordance with their family structures and cultures.[15] Although receiving sexual education from parents appears to be stable, the rates are still low and such information cannot adequately compensate for the gaps as compared with formal instruction.[16] In addition, despite having the best opportunities and intentions, most parents in Turkey are still inadequate, infrequent, and often inappropriate educators of their own children with IDs on sexual education.[17] While raising children, the attitudes of parents on sexual matters are considered secret. Parents are hesitant to answer their children's questions about sexuality and engage in behaviors such as changing the subject, shaming the child regarding this issue, or providing false answers.

Sexual education must be provided before individuals with ID is sexually active, to provide them with enough knowledge, cognition, and adequate skills that are needed to make decisions and have a positive effect on their sexual health.[18] Thus, sensible action must be taken to prepare children with IDs to be able to act responsibly about their own healthy sexual development. They should be educated appropriately in schools and at home by their parents, who must also have positive attitudes toward sexual education, sufficient information about sexual development, and positive behaviors that are appropriate to their children's development and needs.[19] Children with IDs need more sexual information in accordance with their mental development level, because unlike other individuals, they do not have the chance to learn and develop by sharing their sexual knowledge and experiences with the help of their parents, peers, or in society. The reason for related problems on sexual education is that appropriate and adequate information and answers cannot be given at the right time by the right people. For this reason, parents' attitudes toward sexual education of their children with IDs are vital because these affect the latter's sexuality perceptions.[20] Determining the attitudes of parents toward sexual education is also important to provide this issue with the necessary attention and to ensure that these parents develop positive attitudes. Therefore, the aims of the present study were 1) to explore parents' attitudes toward sexual education of children with IDs and 2) to begin new studies to be planned by researchers.

METHODS

In the present study, data collection was used via the quantitative survey method. Here the survey method was preferred because of the aim to learn about parents' perceptions and their attitudes toward the sexual education of their children with IDs. The intent was also to reach a large number of parents through the scale used, as explained in previous literature. In addition, the researchers believed that they could gain access to a massive level of information from a large demographic in a relatively short time. Moreover, the survey allows for data to be derived from multiple sources at once.

The developed scale was sent to 349 parents that were selected by using a random sampling system, which takes a subset of a statistical population wherein each member has an equal probability of being chosen. In this study, the selected random sample chosen was meant to be an unbiased representation of the total population. A total of 311 parents of children with IDs voluntarily participated in a study in Konya, a province in middle Anatolia, one of the eighty in Turkey. Their children with IDs are educated in special schools or in special classes in inclusive schools and in private special education and rehabilitation centers affiliated with the Ministry of

National Education in Turkey. Konya province has 19 special schools, 38 special classes, and 57 private special education and rehabilitation centers. Among these, five special schools, six special classes, and two private special education and rehabilitation centers where children with IDs are educated were selected for random sampling of parents. Out of 349 parents who participated in this study, 311 scales were filled and considered acceptable whereas 38 were not included due to incomplete answers or unsent answers during the required time.

As previously stated, data collection was carried out using the scale developed by the author, a Likert-type scale named 'Scale of Attitudes of Parents Toward Their Intellectually Disabled Children's Sexual Education' (SAPATID-SE), (please see Appendix 1 for detailed information). This psychometric scale was used to understand the people's views and perspectives, as explained in Heimann.[21] The Likert-type scale directly measured the parents' perspectives about teaching sexuality to their children with IDs.

It is important to note that before the main study, the researchers applied to the Ethics Committee in the University of Necmettin Erbakan and received the acceptance letter that allows the data collection. This scale was then used in the main research and the reliability was 0.93. The scale was sent to 349 parents of children with IDs and were collected via post. A total of 311 scales were received, and the rest (38) were excluded for several reasons: parents (11) did not want to participate in this research; the scales were not sent back in time (21); and some surveys were incomplete (6).

After collecting the fully filled scales, Statistical Package for the Social Scientists (SPSS 21) was used to analyze the data. Descriptive statistics techniques such as frequencies and percentages were applied to provide a detailed description about the perspectives of parents. In other words, the data analysis was made on the basis of the scores obtained from the participants. The scores were defined as follows: "definitely agree" (67–80 points), "agree" (42–67), "disagree" (29–41), and "definitely disagree" (16–29). On the scale, participants' answered "definitely agree" (5 points), "agree" (4 points), "disagree" (2 points), and "definitely disagree" (1 point). After the data collection and analysis, the highest score for answers to the scale was 78 and the lowest score was 22. Interestingly, among the parents, six responded "definitely agree" and six answered "definitely disagree" to all the questions in the scale. The scores received from the scale was calculated as explained in Karaca.[22] As previously explained, the scale included 16 items with no reverse. Thus, the lowest score that could be obtained was 16 while the highest possible score was 80. Those who scored between 16 and 28.8 were considered to "strongly disagree," between 28.8 and 41.6 were "disagree," between 41.6 and 54.4 were "no view," between 54.4 and 67.2 were "agree", and those between 67 and 80 were "strongly agree." Following Karaca,[22] P = n − 1/n formula was used for this scoring.

RESULTS

As a quantitative method, as explained before, the scale was used to explore the parents' perspectives and attitudes toward the sexual education of their children with IDs. Prior to the main study, a pilot test was carried out; the scale was sent to 148 parents and 146 were filled and returned. The parents who participated in the pilot test were excluded from the main study. The Spearman's Rank Order Correlation Coefficient Statistical Technique was used to correlate the individual scores with the total scores to account for the item analysis that determines the internal consistency. Subsequently, all correlating items with negative and low positive attitude scores were discarded and those with +0.80 scores were selected. In the end, 16 items were raised from the scale and formed five points of the Likert-type scale with which the data about parents' attitudes and opinions on sexual education of their children with IDs were collected.

Demographic information of parents

Table 1 shows that more than half of the parents (56%) were mothers, and the rest (44%) were fathers. Most of the parents were 20–50 years old (77%) and the rest of the 72 (23%) were 51 years old and above. More than two-thirds of the parents (73%) were primary school graduates, 56 (18%) were secondary school graduates, and the rest (9%) were high school graduates. In addition, more than half of the parents had 1–2 children.

Table 2 shows that approximately 85% of the participants agree that children with IDs need support for sexual education. However, half of the parents do not agree that sexual issues cannot be controlled with education. An interesting finding here is that approximately 40 parents have "no view" on this topic, but over 200 parents state that they want to have positive attitudes toward sexual education for children with IDs.

More than half of the parents provide positive responses on using visual materials during sexual education for children with IDs. The majority agree that similar to other students, children with IDs should be informed about sexual health issues. The participants are asked whether children with IDs must have sexual education at an early age, to which more than half of the respondents agree in accordance with Item VI. However, 65 parents have "no views" about this issue and is another interesting finding.

Most of the parents do not agree that children with IDs

TABLE 1. Demographic information of the participants (N = 311)

Variables	Frequency	Percentage
Gender		
Mother	175	56.3
Father	136	43.7
Age		
20–30	29	9.3
31–40	91	29.2
41–50	119	38.2
51–60	49	15.8
61–over	23	7.4
Educational level		
Primary school	227	73
Secondary school	56	18
High School and Higher education	28	9
Number of Children in family		
1	87	28
2	77	24.8
3	49	15.7
4	28	9
5	56	18
6 and over	14	4.5

can improve themselves without having sexual education. This finding is important because many parents believe that children with IDs do need sexual education for self-improvement. However, the parents also believe that their children can improve themselves through their own experiences. In other words, more than half of the parents of children with IDs do not accept sexuality education, which they believe must be provided at home. In addition, more than 75% of the parents agree that information about sexuality education must be provided to these children.

Half of the parents believe that children with IDs are aware of their needs in terms of sexual education. An interesting finding here is that a third of the respondents have "no view" on this issue. According to almost half of the parents, the media can provide benefits for sexuality education for children with IDs. Moreover, most of the parents disagree that children with IDs do not need sexuality education.

Half of the parents believe that children with IDs can have genuine behaviors after sexuality education. Further, nearly all of the parents believe in the necessity of such education, and that children with IDs must learn which behaviors are appropriate in terms of sexuality. A third of the parents do not have a view but half of the parents agree that children with IDs can have withdrawn behaviors if they were not well educated about sexual life.

The parents were asked about whether the think children with IDs who receive sexual education can respect private life. More than half of the parents considered that these children can respect private life after their sexual education. By contrast, 22% of the parents disagree, indicating that the children may not be respectful of others' privacy on sexuality.

More than half of the parents accept that they must have positive attitudes toward teaching sexuality education for their children with IDs. However, a third of the parents disagree. An interesting finding is that several parents have no idea about teaching sexuality to children with IDs while reflecting their negative attitudes. Overall, most of the participants believe that children with IDs must receive sexuality education, mainly from parents.

DISCUSSION

The results above indicate a positive attitude of parents toward sexuality education of children with IDs. Notably, the general responses of parents are related to positive attitudes toward sexual education, similar to those of a previous study in Çerçi[23] that parents of children with IDs have positive perspectives on sexuality and relevant education for their children. Jin[24] also revealed that parents' attitudes toward sexual education are generally good. These two studies support the present results, indicating that most of the parents' attitudes are positive and they intend to provide their children with sexual education, whether in school or at home. However, the question here is how these children can receive acceptable sexual education if their parents have insufficient knowledge on this matter and therefore cannot educate their children at home.

The parents who agree that their children must receive sexual education (78%) cannot progress without having such knowledge (56%) and yet, like children with normal development, those with IDs must receive such education (83.6%). Consistent with this finding, Boyacıoğlu *et al*.[25] found that most of the parents want to receive sexual education. Ariadni[26] stated that all parents agree that such knowledge is important for children with IDs because in their experience, the physical changes in their children during puberty are the same as those of children with normal development. Pownall, Jahoda, and Hastings[27] compared attitudes and behaviors of mothers of young children with and without IDs, and found that both groups attached similar importance to dealing with their children's sexuality development and were confident in similar ways of

TABLE 2. Parents' attitudes in providing sexual education

Parents' attitudes	Definitely Agree		Agree		No View		Disagree		Definitely Disagree	
	n	%	n	%	n	%	n	%	n	%
1. Children with IDs need social support for sexuality education	162	52.0	105	33.8	37	1.9	7	2.3	0	0.0
2. Sexual matters observed with children with IDs cannot be controlled with education	17	5.5	84	27.0	42	3.5	126	40.5	42	13.5
3. Parents' negative attitudes towards sexuality education results negatively for their children with IDs	98	1.5	106	4.1	58	18.6	42	13.5	7	2.3
4. There is benefit from visual materials during the sexuality education provided for children with IDs	42	3.5	91	9.3	84	27.0	71	22.8	23	7.4
5. Children with IDs should be informed as other children about sexuality health issues	168	54.0	92	29.6	28	9.0	9	2.9	14	4.5
6. Children with IDs should have sexuality education in early ages	84	27.0	78	25.1	65	20.9	70	22.5	14	4.5
7. Children with IDs can improve themselves without having sexuality education	21	6.7	49	15.8	66	21.2	140	45.0	35	11.3
8. Sexuality education courses should be provided by the parents only	56	18.0	84	27.0	58	18.6	99	31.8	14	4.5
9. Information about sexuality life must not be provided any time for children with IDs	0	0.0	52	16.7	28	9.0	154	49.5	77	24.8
10. Children with IDs students are aware of needs about sexuality education	56	18.0	85	27.3	91	29.3	65	20.9	14	4.5
11. The media (TV, newspaper, other publications) can be beneficial for sexuality education of children with IDs	7	2.2	143	46.0	35	11.3	84	27.0	42	13.5
12. Children with IDs do not need sexuality education	7	2.2	30	9.6	29	9.3	161	51.8	84	27.0
13. Children with IDs can demonstrate their genuine behaviors after having sexuality education	70	22.5	92	29.5	63	20.3	72	23.2	14	4.5
14. Education help for sexuality education should be offered for appropriate sexual behaviors	126	40.5	141	45.3	14	4.5	9	2.9	21	6.8
15. Children with IDs can demonstrate withdrawn behaviors if they are not educated about sexual matters	44	14.1	98	31.5	85	27.3	63	20.3	21	6.8
16. Children with IDs can respect private life if they are educated	84	27.0	78	25.1	79	25.4	56	18.0	14	4.5

teaching. Similarly, Apteslis[28] reported that the parents agree on the necessity of sexual education for all young people with and without IDs. Gurol *et al*.[29] explained that all mothers, particularly those with sons, concurred that sexuality education is important. Although literature mainly supports the present finding that, similar to their peers, children with IDs must receive sexual education, the problem lies in who can teach and provide professional sexual education to these children. Training given by experts can prove beneficial for both children with IDs and their parents.

In this study, the Turkish parents believe that the sexual education of their children must start at an early age. Although no specific age range was defined to start sexual education, children can ask their parents various questions on sexuality from an early age. For the parents, their answers to these questions may be included in the sexual education because they have not

received enough information on how to teach their children in a convincing way regarding sexual education. Notably, children receiving adequate information about sexuality is also important for their positive sexual development in later ages, indicating that sexual education during childhood can become the basis of sexuality in adulthood. This context may lead to the satisfaction of children's emotional condition, which positively affects the wellness and true understanding of these children.

The parents in this study agree that children with IDs who are properly educated can respect theirs and others' private lives (52%). Similarly, Corona *et al*.[30] previously indicated that 36% of parents wanted their children with IDs to learn privacy skills. Sexual education enables children with IDs to comprehend their physical, emotional, intellectual, and sexual development, and thus lead to their cultivation of a positive personality. In addition, these children can be respectful of the rights, views, and behaviors of other people and develop positive behavior patterns and value judgments.[31]

Parents do not accept training on sexuality because of the belief that only they must provide this kind of training. These parents also reflect such perspectives by saying that sexuality education starts at home. The parents have an important role in the child's health in all areas of development and in displaying positive attitudes with themselves and their environment. For this reason, parents are expected to be knowledgeable and conscious when providing information to their children. A previous study reported that 76% parents agree that they must be their children's first educators. Ganji *et al*.[32] also stated that 78% of parents agree that they were the first source and educators providing sexuality information to their children. Öncü *et al*.[33] concluded that parents have the highest responsibilities to teach sexuality education at home. This training must be provided for children with IDs during the early ages.

In the present study, the parents believe that children with IDs are aware of their needs about sexuality (45%) and the media can be beneficial for sexual education (48%). By contrast, Bilgic[34] concluded that the mothers in Turkey appear to be unwilling to allow children to watch sexual images with the belief in the possibility of imitating such scenes, or behave toward others as similar to those watched on the TV. The lack of well-devised sexual education both on the part of their families and schools resulted in obtaining their knowledge either from mass media or other undesirable sources. In addition, the lack of adequate knowledge, especially concerning the symptoms of sexual development, causes much surprise, fear, and uncertainty, which can be overcome by using standardized program developed for parents of children with IDs.

In the present study, the parents also believe that children with IDs can have genuine behaviors on sexuality after receiving well-designed and culture-based sexuality education. In addition, the parents consider that children with IDs can respect the privacy of others after their education. Parents of children with IDs agreed that having normal sex life may lead these children to protect themselves from molestation. The treatment of those with abnormal sexualities or sexual problems may remain highly important issues in rapidly developing countries, such as Turkey, unless these people receive adequate and appropriate systematic sexuality education programs.

Regular seminars and conferences using assistive digital technologies and materials related to sexuality should be organized to encourage parents to gain adequate knowledge received about sexual education. Parents should be able to participate in discussion activities in which they could share their experiences and motivate each other to challenge and improve their children's sexual development. Furthermore, a structured training program on sexuality education for parents with children with IDs should be developed in accordance with their social culture and suitable to their values and ethical principles; and this developed curriculum must be regularly adapted to the parents.

CONCLUSIONS

Parents have positive attitudes toward sexual education for their children with IDs and consider that sexuality education is highly important for children with IDs and must provide such information professionally starting from an early age. Parents need well-designed and culture-based training from professionals, with defined goals and objectives of the developed curriculum according to their needs and thereby meet their requirements.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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