ORIGINAL RESEARCH PAPER*

Sexual Education For Individuals With Special Needs: Understanding And Overcoming Current Obstacles

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Abstract

Sexual education has often been a highly debatable, underrated, and undervalued topic. Efforts to address this neglect have yielded significant progress. It is now integrated into numerous countries' educational systems curricula and has been actively promoted. However, progress in this realm has primarily favoured the neurotypical population, leaving the topic of sexuality and individuals with disabilities greatly undervalued and underrepresented. Additionally, existing policy frameworks frequently overlook the unique needs of individuals with disabilities, resulting in uneven delivery and quality of sexual education and programs.

Despite ongoing efforts, numerous obstacles persist, impeding equal access and distribution of sexual education and resources for individuals with special needs. These challenges raise important questions: Do these challenges differ depending on an individual's cultural background, gender identity or age? What sex education programs are currently available for the neurodiverse population? How can the existing barriers be effectively addressed?

This study aims to answer the following research question: "*What are the barriers preventing equal access to sexual education or resources for individuals with special needs? How can these barriers be overcome?*" Utilizing a qualitative approach, the study will involve direct observation of sexual education training for students with special needs, complemented by an online self-paced questionnaire featuring qualitative questions.

In this research study, the term "people with special needs" encompasses individuals with different abilities across a range of conditions and severity levels, including those experiencing movement impairments and other challenges that necessitate special assistance. However, the challenges, barriers, and solutions discussed in the current study predominantly pertain to those with the most severe developmental, cognitive, and physical conditions.

Introduction

Sexuality is an inherent facet of human existence, encompassing both physiological and spiritual dimensions (Hole et al., 2022; Pownall et al., 2012). Nevertheless, it is crucial to acknowledge that discussions surrounding sexuality remain significantly sensitive, often closely linked to existing societal stigmas and taboos (Gokgoz et al., 2021; Hole et al., 2022; Lam et al., 2022; Schaafsma et al., 2014; Young et al., 2012). Individuals with special needs have the same sexual desires as those without disabilities (Lam et al., 2022; Young et al., 2012). However, primary caregivers, guardians, and frontline staff members tend to avoid the presence of this sphere of life for individuals with disability (Gokgoz et al., 2021). Hence, more focus and improvement are necessary in the field of sexual education and existing sexuality destigmatization for individuals with disabilities.

Sex Education

The period of young adulthood is crucial for forming one's identity, establishing meaningful social connections, and exploring one's sexuality (Bahner, 2018). According to Schaafsma et al. (2014), it is crucial to provide sex education before individuals with intellectual disabilities engage in sexual activity. This approach aims to equip them with the knowledge and skills essential for making informed decisions that positively affect their sexual health (Michielsen & Brockschmidt, 2021). Sex education should extend beyond the mere transmission of knowledge related to human physiology, the reproductive system, or preventing sexually transmitted infections (STIs) (Schaafsma et al., 2014). Ideally, the scope of sex education should cover and support individuals' understanding of the basics of emotional involvement, sexuality, partnership and intimate relationship aspects (Frawley & Wilson, 2016; McDaniels & Fleming, 2016).

Stigma Surrounding the Sexuality of Individuals with Special Needs

People have the right to experience their sexuality and gain pleasurable sexual experiences (Pownall et al., 2012; Schaafsma et al., 2014). Individuals with intellectual disabilities (ID) share the exact fundamental sexual needs and desires of those without disabilities (McDaniels & Fleming, 2016; Michielsen & Brockschmidt, 2021). In a research study done in 2018, Hole et al. state that over 80% of the participants with intellectual disabilities had been involved in some form of sexual relationship. It is essential to recognize and affirm these needs, acknowledging that individuals with intellectual disabilities also have the right to experience and develop fulfilling sexual relationships (Young et al., 2012).

The perception of people with intellectual disabilities as either "holy innocent" or "oversexed" contributes to challenges in addressing their sexual desires and needs (Young et al., 2012). The term "holy innocent" usually refers to an existing stereotype that individuals with special needs are entirely devoid of any sexual experiences (Young et al., 2012). While "oversexed" perception means that individuals with special abilities experience and illustrate heightened or uncontrollable sexual desires, often portraying them as hypersexual or deviant (Young et al., 2012). The presence of these assumptions may result in overlooking or downplaying individuals' sexuality.

It is noteworthy to mention that the absence of sexual activity among individuals with disabilities should never be a justification for withholding sex education (Schaafsma et al., 2014). Even if individuals are not currently sexually active, providing sex education remains crucial (Michielsen & Brockschmidt, 2021). It helps navigate their sex-related concerns, as well as protect them from vulnerability and predisposition to being targets of sexual abuse (McCarthy et al., 2022; Schaafsma et al., 2015).

Current Educational Programs

Comprehensive Sex Education (CSE)

Comprehensive sexuality education (CSE) is one of the most up-to-date sexual education programs available (Davies et al., 2023). It has demonstrated numerous positive outcomes for individuals due to its integration of psychological, social and physiological facets of relationships (Curtiss & Stoffers, 2023; Hayashi et al., 2011). For example, CSE has been associated with decreases in child sex abuse and violence within dating and intimate partner relationships (Curtiss & Stoffers, 2023). Additionally, it improves healthy relationship development and enhances social and emotional learning among individuals with special needs (Davies et al., 2023). A comprehensive sexuality education approach establishes appropriate intimate partner relationships and connections while contributing to the increased overall well-being of individuals with disabilities (Davies et al., 2023). The multifaceted benefits of CSE support the positive impact of its role as a valuable tool in the education system (Curtiss & Stoffers, 2023).

Reactive Method

Predominantly, available sexual education programs are provided reactively. It means they address an individual's challenging and problematic behaviour after it happens (Curtiss & Stoffers, 2023). The method is a consequence strategy to the existing behaviour and challenges. However, a proactive strategy, implementing prevention-focused methods to educate individuals about appropriate sexual expression beforehand, is a more beneficial option (Curtiss & Stoffers, 2023). There is a need to shift the focus towards proactive education that equips individuals with the knowledge and skills to navigate their sexuality responsibly (Lafferty et al., 2012). According to Lafferty et al. (2012), the proactive approach reduces the likelihood of harmful behaviour, fosters a more informed and empowered approach to sexual expression, and creates a supportive environment that minimizes the occurrence of problematic behaviours.

Gender-Based Education

Sex education for females with intellectual disabilities often tends to be more concentrated on self-protection skills rather than addressing a comprehensive range of topics (Lam et al., 2022). For males, the available education focuses on educating appropriate social distancing and social interactions with opposite-sex or same-sex individuals (Lam et al., 2022). These gender-based divisions neglect the diverse range of needs that individuals may encounter, highlighting and supporting the existing gender-based stereotypes and stigmas (Schaafsma et al., 2015; Young et al., 2012).

Heteronormative Sexual Perspectives

Primarily, existing sexual education programs for individuals with disabilities focus on heteronormative gender identities (McCarthy et al., 2022). Hole et al. (2022) state that primary caregivers for individuals diagnosed with intellectual disability tend to interpret the homosexual behaviours of their offspring as "experimentation" rather than identifying them as expressions of LGBTQI+ identity. This heteronormative approach excludes the presence of the LGBTQI+ community, eliminates sexual diversity, and prevents individuals from gaining knowledge about diverse sexual communities and gender identities (McCarthy et al., 2022).

Hypothesis

The hypothesis asserts that a number of factors may directly affect the equal access and delivery of sex education for people with special needs. They include but are not limited to the stigma surrounding the sexuality of people with disabilities, parental avoidance and fears of sex topics, or inadequate existing training. However, there is still insufficient data, and more research has to be done to get a more in-depth understanding of specific individuals' experiences and unique perspectives that are not covered in the current literature review findings.

Method

Observation

The initial step of this qualitative research method is observation. In this study, the researcher attends a sex education training organized by the Community Integration through Co-operative Education (CICE) program for people with special needs and the Consent Peer Education Program (CPEP) at Humber College. This training, facilitated by the Sexual Violence Prevention and Education Programs Coordinator, is called "Bringing in the Bystander Training Session." It covers topics such as sexual violence, consent, victim-blaming, and effective bystander intervention strategies. The researcher aims to examine how staff have adapted training content to meet the unique needs of students with special needs and evaluate the delivery of the current sex education program at Humber. The focus includes assessing staff interactions with students, addressing questions, and identifying barriers to effective sexual education for students with special needs.

Questionnaire

After the actual observation phase is done, an online questionnaire with open-ended qualitative questions is used to gather data. This questionnaire is sent to consent peer educators (CPEs), primary caregivers, and behaviour instructors with experience in delivering sexual education or resources to individuals with limited abilities. Similar to the approach used by Pownall (2012), the questionnaire starts with general topics on sexual education and gradually introduces more sensitive and personal topics (Appendix B). The thematic analysis of the gathered data examines, arranges, and portrays the common themes across the gathered data while highlighting the primary areas that guide the rest of the research process (Nowell et al., 2017). Additionally, the coding process is implemented in the research study. The coding involves separating the collected information into categories and subcategories to reveal significant patterns between participants' responses (Cascio

et al., 2019). As a result of all participants' responses, consecutive thematic analysis and the implications of the coding process, the researcher aims to gain an in-depth understanding of the chosen research sphere and conclude the exclusive foundational conclusions.

Results

Part 1: Observation Phase

During the observation, the first notable difference was the lower number of students in the classroom, totalling 33 students, 24 male and 9 female. This number is approximately 30% less than during training for students without special needs. Additionally, the number of facilitators during the training was three times higher than usual, with six staff members, including two workshop instructors and four supporting staff members. The training duration was almost 0.50 hours shorter (1.25 hours) than the usual workshop (1.90 hours). However, it is notable that the training was not oversimplified, and all the essential terms and concepts were thoroughly described. Interestingly, the training facilitators switched from a lecture-style workshop to a discussion-based and high student-participation training option. From the primary researcher's perspective, an increased number of facilitators and supporting staff members, coupled with fewer students in the classroom, enabled the professional to approach students seeking clarifications on the material. The heightened direct interaction between professionals and students resulted in more person-centred information delivery.

Accessibility Integration

The training setup was designed for maximum accessibility. The room featured six tables, each seating five or six students, equipped with TV screens and whiteboards. Facilitators primarily used a large TV screen, with all TV screens displaying the same content, accommodating students with visual challenges. Attendees also received hard copies of the training material, allowing individuals with hearing impairments to follow along and participate. Students used the whiteboards for small group activities, ensuring that all answers were written and orally presented, promoting inclusive participation.

Part 2: Questionnaire Phase

During the questionnaire, all of the participants collectively advocated and reinforced the importance of sexual education for individuals with special needs, seeing the empowering nature of this knowledge, enabling self-advocacy and informed decision-making. The diverse viewpoints highlight the necessity for a comprehensive and customized approach to sexual education that considers the distinct needs and obstacles encountered by individuals with disabilities.

Area of Struggle and Existing Barriers

Accessible Information

Caregivers, sexual prevention professionals, and educational therapists face challenges in creating engaging, relevant, and accessible sexual education for people with special needs. They lack resources for workshops and meaningful conversations in this area, leading to a sense of inadequate support and societal stigma. Tailoring information to diverse needs is crucial, but the scarcity of resources makes designing workshops difficult. Enhanced resources and support are urgently needed to address the complex challenges of providing comprehensive sexual education to individuals with special needs.

Cultural Considerations and Reluctance

Cultural and religious awareness presents an added layer of complexity in sexual education for individuals with special needs. Families may feel uncomfortable or resistant, complicating the educational process. For instance, discouraging certain behaviours like public self-touching can be challenging for caregivers (Appendix B, Figure 4). Some cultures view sex as taboo, making discussions on consent difficult, as highlighted by Consent Peer Educator 1 (Appendix B, Figure 5). The perspective on masturbation varies across cultures and religions, posing barriers for professionals. Managing these situations requires a delicate balance and respect for diverse beliefs and values, adding complexity for educators and therapists in this field.

Comprehension Level

Participants also highlight individual comprehension levels as a significant barrier in sexual education for individuals with special needs. The caregiver expresses concerns about presenting information that matches her daughter's level of comprehension, balancing accuracy with understandability (Appendix B, Figure 5). Similarly, the clinical instructor emphasizes the importance of using clear and simple language to enable individuals to engage with the material and participate in discussions effectively (Appendix B, Figure 4).

Individual's Age

Age emerges as a notable barrier in sexual education for individuals with special needs, as highlighted by frontline professionals (Appendix B, Figure 5). The behaviour analyst recounts challenges in explaining certain behaviours in young children, such as pelvic pressing, which can be misunderstood by parents due to the child's age (Appendix B, Figure 5). Additionally, the educational therapist emphasizes the importance of considering age in cognitive development and attention span, requiring tailored teaching methods for younger learners (Appendix B, Figure 5). Consent Peer Educator 1 notes that some individuals struggle to engage with services due to discomfort discussing sex and intimacy related to their age (Appendix B, Figure 5). Tailoring instructional approaches to accommodate age-specific needs is crucial for effective learning outcomes and overcoming comprehension barriers.

Individual's Gender Identity

Gaining trust, establishing relatability, and addressing existing gender-oriented issues proved challenging, especially considering the educator identified with a different gender (Appendix B, Figure 4). Negotiating these challenges became complex, emphasizing the need for sensitivity and effective strategies when dealing with gender dynamics, especially in a field as sensitive as sexual education. Within the questionnaire, the behavioural therapist shared their experience working directly with a 14-year-old non-verbal boy with a disability, specifically focusing on creating a teaching program on masturbation (Appendix B, Figure 4). The therapist encounters challenges in determining the optimal teaching model, struggling to balance providing guidance and fostering the boy's independence. This struggle highlights the nature of teaching sensitive topics, requiring careful consideration of individual needs, communication abilities, and the final goal of promoting autonomy. These experiences underscore the intricate challenges faced by professionals in the realm of sexual education, particularly when navigating gender diversity and individualized teaching strategies. The need for tailored approaches, empathy, and ongoing reflection is evident in addressing the unique needs of individuals with special abilities in sexual education practices.

Discussion

The participants' responses underscored the critical importance of providing sexual education and resources for individuals with special needs, highlighting the significance of this often underrated and neglected area. The emphasis on teaching how to identify and avoid dangerous circumstances resonates as a means to lessen the vulnerability of this population to abuse or exploitation. The literature review and data support this concern since it is noted by Schaafsma et al. (2015) that this population is almost three times more likely to be the target of sexual abuse. The participants underline the role of sexual education in fostering healthy relationships that address physical, mental, and emotional needs.

The participants suggested some of the possible improvements that can be made to enhance the existing educational courses and models. This includes developing online self-paced programs and small group settings to meet diverse needs. Integrating visual aids and interactive elements to enhance engagement and comprehension. Models or body replicas can be particularly useful for visual learners and those who may struggle with verbal explanations, providing a tangible way to understand their bodies and navigate various situations. Additionally, integrating disability-specific content into sexual education holds immense value, as highlighted by Davies et al. (2023) and echoed by a clinical instructor who emphasizes the importance of educating individuals with disabilities from a young age. This approach aims to provide accurate, relatable, and relevant sexual information, promoting acceptance and respect for diverse abilities. Moreover, involving experts in sexual education, as suggested by a behavioural analyst, can greatly benefit workshops and educational sessions (Appendix B, Figure 6). These experts bring specialized knowledge and ensure that frontline specialists, educators, and healthcare professionals are equipped to support individuals with disabilities regarding sexual health and education.

Establishing a supportive and inclusive learning environment has emerged as another crucial strategy in facilitating effective sex education for individuals with special needs (Appendix B, Figure 6). Individuals with disabilities should have access to ongoing support and acceptance by the neurotypical population. Finally, parent-oriented workshops and education, coupled with collaboration and support from parents, are seen as indispensable components in providing comprehensive sexual education for neurodiverse individuals. By facilitating open and transparent communication

channels, educators can gain valuable insights into parents' preferences and concerns and create programs following appropriate limits.

Impact

As a researcher, reflecting on the study's potential impact on the obstacles of sexual education and resources for people with diverse needs is an opportunity to envision tangible changes in society. My hope is to reach a wide audience, from educators in various settings and healthcare professionals to caregivers and individuals with disabilities themselves. By illuminating the challenges faced in sexual education and the scarcity of resources for this population, the goal is to spark meaningful conversations and drive advocacy efforts for improved access to inclusive sexual education. Ultimately, the current research is driven by a desire to create positive change by promoting equitable access to sexual education and resources for individuals with diverse needs.

Conclusion

The findings from this research study underscore the significant challenges encountered by individuals with disabilities in accessing sufficient sexual education and resources. The data was collected from individuals who provide frontline care and behavioural treatment or are primary caregivers to individuals with special needs. Identifying specific factors influencing the availability and quality of such resources is crucial for understanding and addressing barriers in this area. However, the study suggests that further research is needed to fully grasp these issues and recognize additional concerns that may have been overlooked.

The obstacles identified through the primary research phases likely encompass a range of factors, including cultural considerations and implications, an individual's gender identity, comprehension level, age, and the scarcity of resources to gain, create, and distribute accessible and engaging information for this population. By recognizing these barriers, healthcare providers, sexual educators, and primary caregivers can work towards developing strategies to improve access to sexual education and resources for people with disabilities.

Finally, ongoing research and promotion of this integral sphere can help to uncover new insights and identify emerging challenges that may impact the sexual health and well-being of individuals with disabilities. Tackling the existing taboos and neglect surrounding sexuality and disability can lead society to foster a more supportive, inclusive, and unbiased environment. In such an environment, every individual feels empowered to seek out the information and resources integral to making educated decisions concerning their sexual well-being and sexual activities.

Limitations

Due to the established timeline for the primary research, the objective was to recruit six participants representing caregivers, sexual education professionals, and frontline staff members, such as behavioural therapists. This multi-perspective approach was selected to ensure diverse data collection and capture various viewpoints, given the different levels of engagement with individuals with special needs. Although the minimum number of participants was met, there was no equal distribution of representatives. As a result, there was one caregiver, three frontline staff members, and three sexual education professionals. Moreover, the nature of the questionnaire, which was self-paced, meant that there was no direct control or guidance from the primary researcher. This aspect added complexity to the data collection process, making it more challenging and less straightforward. Another significant limitation of the study is the vague population scope. It could be more accurate to target a specific population, such as individuals with Down Syndrome, Autism Spectrum Disorder (ASD) or a particular movement impairment. The current research employs broad terms like "people with special needs" or "individuals with disabilities." This research aimed to understand the challenges and barriers faced by the overall neurodiverse population. However, for future research, selecting a more precise population cohort would yield more accurate data regarding the specific obstacles associated with each diagnosis.

Conflict of Interest

No conflict of interest or financial interest exists in the current study.

Acknowledgement

I want to thank my research participants for sharing your experiences, answering my questions, and dedicating your valuable time to my research. Without your input, the research would not have been possible.

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Note on Contributor

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Appendices

Appendix A: Letter of Invitation and Informed Consent Form

Invitation

My name is Anastasiia Melnikova. I am a fourth-year student in the Bachelor of Behaviour Science Program at Humber College. I am currently conducting research for my undergraduate thesis, where I am the primary researcher.

This study aims to answer the question: *What are the barriers preventing equal access to sexual education or resources for individuals with special needs? How can these barriers be overcome?* I am answering this research question through the chosen research method of a questionnaire. Your participation and contribution are crucial in highlighting this topic, providing valuable insights into the ongoing dialogue on inclusive sexual education and its promotion. As part of your participation, you will be asked a series of questions about your experiences, perspectives, and insights regarding the existing obstacles in accessing or delivering sexual health education or resources. The procedure of this study will include an approximately 20–30-minute questionnaire. The link for the questionnaire will be sent to a participant via email. The questionnaires are to be completed by 11:59 pm on March 1st, 2024.

Research Approval

My thesis topic has been approved by the Research Ethics Board at Humber College for Student Research. It is my own research, not the research of Humber College. The thesis study is supervised by Humber College Professor Deborah Vincent.

Confidentiality and Informed Consent

The research findings are shared amongst 4th year Bachelor of Behavioural Science students and faculty at Humber College. The completed thesis may be uploaded to a research library for the Bachelor of Behavioural Science Program. Additionally, any participant is free to withdraw at any point from the study prior to the data analysis. No identifying information is included in data analysis unless stated otherwise. All of the information you share in this study will be kept confidential. It is stored on the researcher's personal computer and is password-protected. All identifying information is deleted at the end of the study. I believe there are no risks in participating in this study than the risks you may experience in everyday life. The findings from this research may be used for future research with the approval of the research participant.

Contact Information

If you have any questions or want more information, you can email the primary student researcher, Anastasiia Melnikova, at the following email: anastasiia.melnikova@humber.ca. If you wish to take your questions beyond the primary researcher, you may contact the faculty supervisor of this study, Deborah Vincent, at deborah.vincent@humber.ca.

Participation Certification

I agree to participate in this study. I have made this decision after reviewing the invitation, confidentiality and informed consent. I acknowledge that I can ask for further information about the study and my participation in it. I understand that I can withdraw my participation at any time if I change my mind prior to the completion of the data analysis, which is approximately two weeks after the questionnaire completion deadline.

Date: _____

Participant Name: _____

Participant Signature: _____

Appendix B: Quantitative Questionnaire & Participants Answers

1. What is your relation to an individual with special needs? Can you tell me your experience providing sexual resources or education to an individual with special needs?

Table 1 Participants' Answers to Question 1

Participant ID	Participant Response
Participant 1 (Caregiver)	Mom, It is hard to explain and uncomfortable because I don't know if I am explaining it as I should.
Participant 2 (Sexual Violence Prevention and Education Coordinator)	My experience is related to providing education through my work at Humber. I work to provide sexual health and consent resources for everyone on campus. This has allowed me to work with students and persons of varying needs and experience. Some of these students would either self-identify or be identified as people with special needs.
Participant 3 (Consent Peer Educator 1)	In the past, I have worked as a Consent Peer Educator at Humber College. In this position, I provided educational resources to individuals with various needs and abilities. I have also worked with children and adults with special needs in the city of Brampton in a recreational capacity.
Participant 4 (Consent Peer Educator 2)	Consent youth leader
Participant 5 (Behavioural Analyst, BA)	Been working with individuals with special needs for about four years through applied behavioural analysis services. I have had many experiences teaching sexual education and resources to clients who were as young as 8 and as old as 26. I have used visuals and social stories to support their understanding of safe places to experience masturbation and to teach them how their bodies are changing through puberty. I have also worked closely with families to support their children within the home setting for self-touch and appropriate nudity. It has not been easy, the resources out there are very slim, and most of the time, I end up working with families on their specific goals for sex ed and applying my knowledge and experience to that specific goal. Most research is focused on "problem behaviour that relates to sexual behaviour" but never healthy sexual behaviours or replacement behaviours.
Participant 6 (Educational Therapist, ET)	I was an educational therapist for students with intellectual and developmental disabilities. Through this position, I facilitated learning in life skills and elementary/high-school curriculums. I provided sexual education and resources to students and families when there were conflicts or gaps noticed in their behaviour. For instance, if a student were exposing themselves at school or not respecting other students' boundaries, we would have a conversation about consent and sexual health and provide their families with resources regarding the topics discussed.
Participant 7 (Clinical Instructor, CICE)	I am a Clinical Instructor who has been in the CICE classroom at Humber as a clinical placement.

2. Could you give your perspective on the importance of providing sexual education and resources for individuals with special needs?

Table 2 Participants' Answers to Question 2

Participant ID	Participant Response
Participant 1 (Caregiver)	Individuals with special needs must get sexual education in order to make educated choices about their bodies and relationships as they age. By teaching people with disabilities how to identify and avoid dangerous circumstances, sexual education may lessen the likelihood that they will be victims of abuse or exploitation. Sexual education helps children establish healthy relationships by addressing their physical, mental, and emotional needs.
Participant 2 (Sexual Violence Prevention and Education Coordinator)	It is extremely important that we provide sexual health education and resources to folks with special needs. Our society often infantilizes people with disabilities or special needs because their functioning may look different from what is seen as "normal." But we know that sexual health, consent awareness, and sexual violence awareness are important areas of education for all individuals. People with disabilities experience higher rates of sexual violence due to people taking advantage of them, but I also think our system of education has failed to teach people, including people with special needs, what is right and wrong or what is consensual or not consensual.
Participant 3 (Consent Peer Educator 1)	It is important to provide sexual education to individuals with special needs to reduce stigma. Often, we do not consider the sexual health and education of individuals with physical disabilities, but we must educate individuals in ways that accommodate their physical and mental capacity.
Participant 4 (Consent Peer Educator 2)	I feel the area of sexual education for individuals with special needs is neglected. Due to this neglect, many individuals feel unsure or intimidated about how to proceed and open those lines of communication. I think additional training and resources would benefit those individuals with special needs as well as those who work with the individuals.
Participant 5 (Behavioural Analyst, BA)	I believe this is one of the most important skills to teach this group of individuals, mainly for safety purposes. Working with an already vulnerable population, these are the things you worry about for them. I worry about them being taken advantage of or not understanding when the space is safe to do sexual activities. I think that just as other typical functioning humans, they deserve to experience healthy sexual activities as well as understand their own bodies as they change and grow throughout their lives. It is just as important as other life-functioning skills and will not only keep them safe but also those they have relationships with. We want to ensure they build healthy relationships with others, and healthy sexual behaviours play into those types of relationships as they grow.
Participant 6 (Educational Therapist, ET)	Sexual education is important for individuals with special needs because it is empowering to learn about your own body, relationships, and health. This knowledge allows people with special needs to advocate for themselves and know when to seek support. Additionally, it is important to provide sexual education that is representative and specific to people with special needs.
Participant 7 (Clinical Instructor, CICE)	I also believe that it is so important for them to learn about providing consent when they might be involved in sexual activities.

3. Did you get a chance to complete a sexual health education program or any form of training prior to delivering sex-related information to an individual with special abilities? If yes, could you specify? If not, do you believe it could potentially benefit you by providing sexual education or resources and in what way?

Table 3 Participants' Answers to Question 3

Participant ID	Participant Response
Participant 1 (Caregiver)	I did not get a chance to complete a program, but I would love to get the opportunity to try. I think completing a program would give me better information to connect with and understand how to explain to my child with special needs. Raising a child with special needs is a lot more challenging and also different than raising an average child. I would like to hope and believe I can find tools and guidance on how to break down information so that she will understand sexual education and safety.
Participant 2 (Sexual Violence Prevention and Education Coordinator)	My work is more related to sexual violence prevention, which sexual health is part of, so I have taken courses on sexual violence prevention and support. I also pursued knowledge through books like "Come As You Are" by Emily Nagoski and other readings. I have also completed and facilitated the "It Takes All of Us" asynchronous module and "Bringing In the Bystander" sexual violence prevention training. Other than these, research, reading, and attending workshops by sex educators have been important and helpful things that have supported my ability to teach about sexual health. More training would be very useful, especially training about providing sexual health and sex education to people with special needs.
Participant 3 (Consent Peer Educator 1)	Yes, prior to working as a consent peer educator, I completed training on the Accessibility for Ontarians with Disabilities Act (AODA) and general training on consent and sexual assault. This training allowed me to deliver education about consent to individuals of all abilities.
Participant 4 (Consent Peer Educator 2)	The training I received was very broad and was not catered to individuals with special abilities. Having additional training that is more specific would be beneficial, even just for interacting with others and finding out how they would handle various situations.
Participant 5 (Behavioural Analyst, BA)	I have not. I did get direct support from Supervisors who have gone to sexual education workshops for those on the spectrum but was unable to attend one myself. This is something I have been looking into and hope to get more educated on and even specialize in. I think 100% it would benefit me to get proper training in sexual health education to ensure I am always learning and growing to be able to provide effective treatment and support to those I work with. This is something that should be mandatory for those in the field to ensure we are thinking about these skills for our clients and to ensure our families are supported during the process.
Participant 6 (Educational Therapist, ET)	Unfortunately, I did not, and I had to find my own resources to learn about sex-related information for those with special needs. I believe that it could have benefited me in that I would have been able to answer more questions from students. I also wish that I had more knowledge on specialized sexual health as an educational therapist, for example, what barriers individuals with Autism Spectrum Disorder might face in sexual relationships.
Participant 7 (Clinical Instructor, CICE)	No, because I do not deliver the education directly (we are guests in the CICE classroom at Humber College, and we do a presentation of a community health promotion project to the CICE students), but I do believe that this is very important.

4. Were there any areas you struggled with while delivering sex-related information to an individual with special abilities? If so, please elaborate.

Table 4 Participants' Answers to Question 4

Participant ID	Participant Response
Participant 1 (Caregiver)	As children get older, they tend to explore their bodies and touch or look at themselves in public areas where others will make weird looks and harsh remarks. I had to explain to my child not to touch herself in public areas and to do things in private. At times, she does it in public, so I have to run and tell her again. I don't think she understands why she cannot do these things.
Participant 2 (Sexual Violence Prevention and Education Coordinator)	Making sure the information is what folks are looking for. People with special needs, just like anyone, are at different points in their learning journey about sexual health and their own bodies. Making sure to understand what information is relevant and helpful during an educational session is important.
Participant 3 (Consent Peer Educator 1)	None that I can recall at the moment.
Participant 4 (Consent Peer Educator 2)	In my experience, I struggled when male-specific issues came up. It was difficult for me to speak with the individual and gain their trust when they were dealing with specific male issues. However, I found this was also dependent on the specific individuals involved. My experience comes from working with youth from diverse backgrounds. Therefore, there were
Participant 5 (Behavioural Analyst, BA)	Yes, I think the biggest struggle for me was teaching a young boy (14) how to masturbate. This was something he was unable to do, and he would experience erections without a way to relieve himself. He was also non-verbal, and it was challenging to select the best way to teach him. Do we use visuals? Do we do a social story? It was challenging to also select modelling or allow him to figure it out himself. It was great working with the family as they were very open and willing to teach these skills to their child, but it was challenging as we didn't want him to accidentally harm himself while trying to masturbate. This was something that came with many layers, teaching him how to do the action, where it was appropriate to do the action and what elements of his environment had to be present in order for him to be able to complete the action. Another side challenge would be cultural and religious awareness. Many families are not comfortable or accepting of these challenges their child goes through, which makes it more challenging. For example, of course, we do not want the client touching himself in public, but if we suppress the behaviour in one place, we have to teach a replacement behaviour, and that is always hard to navigate.
Participant 6 (Educational Therapist, ET)	I struggled to make the information accessible and engaging. I did not know how to present the concept of consent to younger students, and I wish that I had created better learning activities in class.
Participant 7 (Clinical Instructor, CICE)	Sometimes, related to the individual comprehending the information being provided. It is important to use simple, clear language and to observe the individuals and engage them in discussion to make sure that they understand the presentation materials and invite them to ask questions.

5. Can you identify any barriers that challenge your delivery of sex information? (Tip: some of the examples can include but are not limited to the age or gender of an individual, your level of knowledge in the sex sphere, personal perspectives, or your/individual's cultural background).

Table 5 Participants' Answers to Question 5

Participant ID	Participant Response
Participant 1 (Caregiver)	As a parent, I accept the possibility of knowledge gaps and the fear that the information I present may not completely match my daughter's current level of comprehension. Given her developing understanding, I am aware of the need to find a middle ground between providing correct information and making sure it is understandable for her age and level of development.
Participant 2 (Sexual Violence Prevention and Education Coordinator)	Cultural background and home experience are often barriers if parents or guardians have not opened up the conversation with their child. Often, parents will also infantilize their child, so they may not begin the conversation about sexual health, which means you may have to break down barriers of stigmas, confusion, perspectives and more before getting to the simplest of ideas. This is the case with anyone, but it can be exacerbated with people with special needs because people may think they won't understand or should not be having sex.
Participant 3 (Consent Peer Educator 1)	Some individuals were not receptive to sex education, as they were not mature enough to learn. Some individuals lacked comfort when discussing sex and intimacy and had trouble engaging with our services due to their age. Another barrier may be culture, as some individuals did not discuss sex in their culture and found it very challenging to discuss consent. Sex was viewed as "taboo" in their culture/religion, which sometimes made it difficult to convey information as an educator.
Participant 4 (Consent Peer Educator 2)	I think the environment and relationship you have with the individual, as well as the relationships the individual has with others, plays a big part in the delivery. I think unclear responsibilities also play a role and can become a barrier when it comes to the delivery of sex information.
Participant 5 (Behavioural Analyst, BA)	The barriers I have experienced would be the age of the child as well as the cultural or religious values that the family has for their child. For example, one child I worked with was only about five years old, but she was engaging in pelvic pressing. The family had a hard time understanding why she was doing this, as she was so young. So age can sometimes throw parents off, and they may not understand the sensory implications of a child or that children can experience self-gratification at a young age. Another family had cultural implications where the mom actually was upset we provided her son (8) private time in the washroom as she just wanted us to stop him only. I had mentioned to her that replacement behaviour is always thought of as we do not want the behaviour to worsen in other places or create a negative experience for the child who is trying to express themselves. I also felt that those with very strict religious beliefs have a hard time accepting the fact that masturbation is natural to the human experience. This was something that parents often did not want their children to do, which made it hard to teach appropriate sexual behaviours.

Participant ID	Participant Response
Participant 6 (Educational Therapist, ET)	The age of individuals was a barrier in my position, as students ranged in age from 8 to 16 years old. I found it difficult to educate very young students about consent and found myself continuously repeating lessons about setting and respecting other people's boundaries. This was also my first patient-facing role, so I had a huge learning curve to overcome in how I communicate with younger children. I had limited experience with individuals with special needs prior to this role and had to seek mentorship from staff members and learn from external resources.
Participant 7 (Clinical Instructor, CICE)	I believe that some challenges include the individual's comfort level on the topic. The individual may not be ready or want to take part in sexual health discussions. Culture may impact the individual as sexual health discussions are not done in some cultures, or sexual activities may not be allowed until after the person is married.

6. From your perspective, what are some strategies that can be used to overcome barriers to providing sex education for individuals with special needs? (Tip: some of the examples can include but are not limited to developing disability-specific sexual content, extending the accessibility of teaching programs, or completing ongoing sexual training programs).

Table 6 Participants' Answers to Question 6

Participant ID	Participant Response
Participant 1 (Caregiver)	It is crucial to have a nurturing and unbiased atmosphere where individuals of all abilities may receive inclusive and pertinent sex education that fosters comprehension, independence, and overall welfare.
Participant 2 (Sexual Violence Prevention and Education Coordinator)	Asking questions, having safe environments to provide education, working in small groups to be able to answer more questions, starting from the ground up and not being afraid to get complex, providing different methods of delivery and other accessibility, patience, and content that progresses at the pace of the individual or group.
Participant 3 (Consent Peer Educator 1)	Creating online and self-paced programs can be used to overcome barriers to providing sexual education. By creating online courses, individuals are able to complete their education at their own pace and in a format that works for them. For instance, individuals who are hard of hearing could read the subtitles on a video rather than attend an in-person seminar that doesn't have an interpreter.
Participant 4 (Consent Peer Educator 2)	Communication overall between the individual as well as those around them. The more information that is known, the better. I would want to know from their parents' perspective what they have told them and what topics they would be comfortable allowing others to talk about. I would want to make sure that I understood the boundaries of what we are allowed to talk about and what we are not allowed to talk about. Additionally, I think more programs should be available and made more accessible not only for those who would facilitate the teachings but also for families.

Participant ID	Participant Response
Participant 5 (Behavioural Analyst, BA)	Some strategies that I think would overcome these barriers would be sexual education that caters to those on the spectrum. To have experts teach and host workshops to educate those in the field. I also think models or body replicas could support those who are visual learners and those who may not have the cognitive ability to follow visuals or verbal explanations. Something to demonstrate to the client how their body works and what to do in certain situations. I also think parent-specific workshops would be extremely beneficial. I think that parents are a huge part of the teaching process, and in order to teach clients effectively, we need their families to also understand the importance and to ease their anxious minds regarding the whole topic. Sexual education is still taboo among typical functioning people, so I think educating families would support and ease their minds to then be able to better support their children. Those on the spectrum or with disabilities in general deserve access to sexual education just as the rest of the population, and this should be a priority in the field.
Participant 6 (Educational Therapist, ET)	I believe that an effective strategy should include developing a training program that is specific to individuals with disabilities. This training program should be mandated for all staff who work in primary, secondary, and post-secondary educational facilities. I also believe that a program like this should be mandatory for all healthcare providers, mental health counsellors, and social workers. This top-down approach will hopefully result in more accessible sexual health education that addresses people with special needs.
Participant 7 (Clinical Instructor, CICE)	I believe that it is important to develop disability-specific content and that this information is provided to these individuals at a younger age (i.e. as part of the sexual health curriculum in schools) or ensure that healthcare providers engage in discussions with these individuals as they mature to ensure that they are educated on their bodies, sexual health etc. I think that the CICE program at Humber is providing great information on sexual health to those students who attend the program, and similar programs that provide this much-needed information would be of great benefit to individuals with disabilities.