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ORIGINAL PAPER

Unspoken Needs: Exploring Family Perspectives on the Sexuality of People with Disabilities

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Abstract
This qualitative study explores family members' attitudes, knowledge, and educational needs regarding the sexuality of people with disabilities (PwDs) in Turkey. Drawing on data from 100 adult relatives of disabled individuals aged 13 and above, the study employed content analysis of responses to a structured questionnaire. Most participants recognized the sexual development and needs of their disabled relatives, yet many expressed discomfort and uncertainty in addressing sexuality-related topics. This hesitancy was shaped by cultural taboos, conservative family values, and limited intergenerational dialogue—particularly salient in collectivist societies. Family-based sexuality education was generally confined to hygiene and safety, while complex issues such as masturbation, sexual abuse, and gender and sexual diversity were often overlooked. Attitudes toward romantic relationships and non-normative sexual expressions revealed tensions between traditional norms and evolving social discourses. Importantly, 83% of participants indicated a need for structured, state-supported sexuality education programs for families, with psychologists seen as the most trusted facilitators. The findings underscore the importance of culturally responsive, inclusive, and family-centered sexuality education, contributing to a growing body of international research in underexplored conservative contexts.

Keywords Sexuality education · People with disabilities · Family involvement · Educational needs · Conservative societies · Turkey

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Introduction

People with disabilities (PwDs)—including those with intellectual, developmental, physical, or sensory impairments—often experience barriers in cognitive, emotional, social, and communicative domains due to various prenatal, perinatal, or postnatal factors. As a result, they may require additional support to fully participate in society [1, 2]. According to the Ministry of Family and Social Services Turkey [3], there are 2.5 million registered people with disabilities, representing approximately 3% of the population. However, the World Health Organization (WHO) estimates global disability prevalence at around 15% [4], suggesting that disability may be underreported in some national contexts.

Despite growing awareness of disability rights, sexuality and reproductive health—fundamental aspects of human development—remain largely overlooked for individuals with disabilities. Societal taboos, cultural norms, and persistent misconceptions, such as the belief that "people with disabilities do not have sexual needs," contribute to this neglect [5, 6]. The WHO [7] and UNESCO [8] emphasize that sexuality education is a rights-based, lifelong learning process aimed at enabling individuals to make informed and respectful decisions regarding relationships, intimacy, and wellbeing. These principles are further embedded in the Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being), Goal 4 (Quality Education), and Goal 10 (Reduced Inequalities), which collectively advocate for inclusive access to sexual and reproductive health services, especially for marginalized groups such as PwDs.

Within families, stigma, discomfort, and a lack of accurate information often hinder open dialogue around sexuality. Parents and caregivers—who frequently serve as primary support providers—may struggle to address the sexual development of their disabled children due to anxiety, embarrassment, or insufficient training [9, 10]. In Turkey, this challenge is compounded by conservative cultural values and limited intergenerational communication [11]. Although some families acknowledge the importance of sexuality education, their understanding of appropriate content and delivery methods remains limited [12]. Research also shows that sexuality education, when offered at home, is often restricted to basic issues like hygiene and safety, while more sensitive topics such as masturbation, sexual abuse, and gender diversity are frequently omitted [13, 14].

International studies reveal similar trends. McDaniels and Fleming [1] argue that people with intellectual and developmental disabilities face a greater risk of sexual victimization and misinformation in the absence of inclusive education. Bollinger and Cook [15] emphasize the need to redesign existing curricula to ensure access for all learners, while Al-Shammari and Hornby [16] highlight the additional barriers faced in conservative societies. The home environment plays a particularly critical role in shaping sexual attitudes and behaviors, especially where school-based programs are limited or non-inclusive [17, 18].

Despite increasing scholarly attention, the literature often focuses on parental attitudes and professional perspectives, while the specific educational needs of families—as key actors in sexuality education—remain underexplored. This gap limits the development of culturally responsive and family-centered programs tailored to disability-specific contexts. The societal tendency to perceive PwDs as asexual can lead to overprotective parenting and reduced access to information, thereby increasing the risk of both misinformation and abuse [19, 20].

Furthermore, sexuality education for PwDs is a critical yet under-addressed issue worldwide, particularly in conservative societies where cultural and religious norms influence family attitudes and educational policies. In Turkey, families often face significant challenges in addressing sexuality education for PwDs, reflecting broader patterns seen in conservative contexts globally [21, 22]. Across regions such as the Middle East and North Africa (MENA), South Asia, Latin America, and East Asia, common themes emerge, including protective family attitudes, cultural and religious taboos, and limited access to comprehensive sexuality education [22, 23].

This study seeks to address this critical gap by exploring the attitudes, knowledge levels, and learning needs of families regarding the sexuality of individuals with disabilities. By focusing on caregivers as recipients—not just facilitators—of sexuality education, the research aims to inform the design of inclusive, accessible, and evidence-based programs that empower both PwDs and their families.

Research Questions

The general aim of this study is to describe the views, behaviors, attitudes, and educational needs of family members aged 18 and above who have a person with disabilities aged 13 or older regarding the sexuality of PwDs. Within this framework, the study seeks to answer the following questions:

1. What are the views, behaviors, and learning needs of family members who have a person with special needs aged 13 or older regarding the sexuality of PwDs?
2. According to family members, how should sexuality education provided to families be designed in terms of content, timing, location, facilitators, duration, and participant gender composition?

Method

Research Design

This study was conducted using qualitative research and a case study approach was preferred, as it allows for an in-depth examination of a limited phenomenon. This method enables the researcher to contextualize and holistically analyze a specific social unit.

Study Group

The study group was formed using purposive sampling, a non-probability sampling technique commonly employed in qualitative research. As Patton [24] explains, purposive sampling involves selecting cases that are particularly informative and relevant to the research objectives. The criteria established for this research were as follows:

- Having a person with special needs in the family,
- The person with special needs being aged 13 or older,
- The participant being 18 years of age or older,

- Residing in Turkey.

The age criterion of 13 years was selected because children typically enter puberty by this age at the latest [25]. The case study sampling model does not aim for generalizability by nature. Accordingly, the study group was defined as "individuals aged 18 and above residing in Turkey who have a family member with special needs aged 13 or older." To ensure diversity in age, gender, and type of special need, efforts were made to maintain a broad sample size, resulting in the participation of 100 volunteers.

Demographic characteristics of the participants and the individuals with special needs in their families are presented in Table 1. The sample was predominantly female and middle-aged, with most participants having completed high school education. The majority reported being the child's parent or sibling, reflecting close caregiving relationships. Regarding the individuals with special needs, physical and intellectual/cognitive disabilities were the most commonly reported types. As some participants had more than one family member with special needs, the total number of individuals with disabilities ($n=116$) exceeded the number of participants ($n=100$), and the total number of disability-type responses ($n=170$) similarly reflects multiple responses per participant.

Data Collection

Questionnaire Development

The data collection process was structured around a four-stage framework, developed by synthesizing key methodological elements from [26] and [27], as outlined below:

1. *Problem Identification* It was determined that adult family members of PwDs lacked sufficient or accurate knowledge regarding the sexuality of persons with disabilities. Additionally, due to the scarcity of international-level research on the sexuality of PwDs in Turkey, a study on this topic was deemed necessary.
2. *Item Writing* Questionnaire items were developed under the supervision of academic advisors. During the literature review conducted to address the research problem, findings and recommendations from prior studies [10, 18, 22, 28, 29, 30, 31, 32, 33, 34, 35, 36], as well as the first author's professional experience as a physiotherapist working with persons with disabilities (PwDs), were utilized.
3. *Expert Review and Pilot Questionnaire Development* To ensure content validity and reliability, an evaluation form was developed. Experts in the field, family members of PwDs, a clinical psychologist with sexual therapy experience, and the director of a special education and rehabilitation center were consulted. Content validity ratios were calculated following Lawshe's method [37]. At this stage, a preliminary explanatory section introducing the questionnaire, and its objectives was prepared. In a subsequent section, experts were asked to evaluate each item's relevance and to provide suggestions or additional comments if necessary. For example, the sexual therapy expert recommended replacing the term "healthy child" with "non-disabled child" and advised using "individuals with special needs" instead of "disabled" throughout the questionnaire to avoid alienating some family members who might otherwise decline participation. A consent form was also prepared, including a presentation detailing the questionnaire's

Table 1 Demographic characteristics of participants and people with disabilities

Variable	Category	f	%
Participant gender	Female	63	63.0
	Male	37	37.0
Age	18–25	8	8.0
	26–35	13	13.0
	36–45	34	34.0
	46–55	28	28.0
	56–64	12	12.0
	65 and older	5	5.0
Education level	Illiterate	2	2.0
	Literate (no formal education)	1	1.0
	Primary school	24	24.0
	Middle school	8	8.0
	High school	38	38.0
	University	19	19.0
	Master's degree	6	6.0
	Doctoral degree or higher	2	2.0
Relationship with PwD	Child	60	60.0
	Sibling	22	22.4
	Parent	4	4.3
	Grandchild	4	3.5
	Grandparent / In-law	2	1.7
	Nephew, uncle, or similar	1	0.9
	Other	5	5.2
PwD gender ($n=116$)	Male	69	59.5
	Female	47	40.5
Disability Type[a]	Physical / orthopaedic / motor	45	26.5
	Intellectual / cognitive	32	18.8
	Autism spectrum disorder	25	14.7
	Chronic illness	15	8.8
	Speech and language difficulties	14	8.2
	Emotional / behavioural / social	11	6.5
	Visual impairment	8	4.7
	Hearing impairment	8	4.7
	Specific learning disability	7	4.1
	ADHD	5	2.9

$N=100$ unless otherwise indicated. [a] Multiple responses were allowed; $n=170$ responses from 116 individuals. Percentages based on $n=170$

content and assurance that responses would be treated anonymously, and that personal data would be kept confidential.

4. *Pilot Testing, Analysis, and Finalization* Pilot testing involved observational validation of the questionnaire's validity and reliability. Prior to the pilot, approval was obtained from Ankara University Social Sciences Sub-Ethics Committee (decision no. 55, dated 06.02.2023). The questionnaire was then administered to six individuals for pilot purposes. Items that were misunderstood or incorrectly answered were revised accordingly. For instance, response options such as "I permit/I do not permit" were changed to "I find

appropriate/I do not find appropriate" based on participant feedback. Following pilot testing, the questionnaire was finalized.

Questionnaire Sections

a. *Demographic and Personal Information Section* This section comprises 16 items designed to capture factors that may influence family members' perspectives on the sexuality of PwDs and their educational needs.
b. *Section on Knowledge and Beliefs about Sexuality* Containing 26 items, this section addresses both family members' own views and behaviors as well as their knowledge and understanding of sexuality-related matters concerning PwDs.
c. *Educational Needs Assessment Section* Consisting of 7 items, this section aims to inform future educators by identifying the qualitative and quantitative aspects that sexuality education should encompass.

The necessary data for the study were collected via a questionnaire prepared for family members of PwDs, administered both online and in printed form. Completing the questionnaire took approximately 30 min. The questionnaire was administered between 03/04/2023 and 31/12/2023. Reaching 101 participants during the data collection process took approximately nine months. In the middle of the process, one response was excluded after it was determined that the participant did not meet the established criteria. Upon confirming that 100 eligible participants had completed the questionnaire, data collection was concluded.

Data Analysis

Frequency and descriptive analyses were conducted to examine the demographic characteristics of family members, as well as their knowledge, attitudes, behaviors related to sexuality, and the qualitative and quantitative features of the proposed educational interventions. Frequency analysis is useful for quantitatively assessing the proportional distribution of responses and understanding the significance of the data [38].

A five-point Likert scale was used, with participants indicating their level of agreement on each item from 1 (never) to 5 (always). The mean score for each item was calculated by dividing the total score by the number of respondents. The following ranges were applied to interpret the mean scores: 1.00–1.79 = "never," 1.80–2.59 = "rarely," 2.60–3.39 = "sometimes," 3.40–4.19 = "mostly," and 4.20–5.00 = "always." These categories guided the interpretation of participant responses in the findings section.

Findings

Sexuality-Related Questions Asked by PwDs and Family Members' Self-Assessed Competence

More than half of the PwDs in this study did not pose any questions about sexuality to their family members, with a significant portion unable to communicate such questions due to

speech limitations. Among those who did inquire, the topics most commonly related to fundamental bodily changes and personal hygiene (see Table 2). Discussions about physiological sexual functions, such as menstruation and nocturnal emissions, were less frequent, while more sensitive issues—including sexual abuse, masturbation, and difficulties with sexual activity—were rarely addressed. Overall, these findings suggest that while basic sexual health topics may occasionally be raised within families, more complex or intimate subjects remain largely unexplored in the familial context.

Following the distribution of topics raised by PwDs, participants were asked how they responded to such questions. Approximately 15.7% reported that they answered based on what they already knew, while 14.8% indicated that their responses varied depending on the nature of the question. When asked to evaluate the adequacy of their answers, participants' self-assessment yielded an average score of 3.6 on a 5-point Likert scale, corresponding to a "mostly sufficient" level. This finding suggests that many family members feel reasonably confident in their ability to respond to sexuality-related questions and may not perceive a clear or urgent need for additional training in this area.

Participants' Views on What PwDs Should and Should Not Know About Sexuality

In addition to examining the topics that PwDs themselves inquire about, participants were asked to indicate which sexuality-related subjects they consider appropriate for PwDs to know (see Table 3). These responses provide valuable insight into the boundaries of sexual knowledge that families deem suitable, highlighting both areas of concern and topics considered less essential.

The majority of participants expressed that PwDs should be informed about personal hygiene and bodily changes, indicating a general acceptance of basic sexual health knowl-

Table 2 Distribution of sexuality-related questions asked by PwDs to their family members

	Response options	f	%
What questions does your family member(s) with special needs ask you regarding their sexual development, needs, health, or your attitudes toward these topics?	Does not ask anything	63	54.8
	Cannot ask due to inability to speak	29	25.2
	Bodily changes	17	14.8
	Personal hygiene	15	13.0
	Menstruation (periods)	7	6.1
	Use of sanitary pads	7	6.1
	Reasons for your protective attitude	6	5.2
	Behaviors to be mindful of in public	5	4.4
	Nocturnal emission	5	4.4
	Penile erection	5	4.4
	Abuse / Harassment / Rape and ways to protect against them	4	3.5
	Pregnancy	3	2.6
	Masturbation (self-stimulation by touching sexual organs)	2	1.7
	Non-communicable diseases such as ovarian, uterine, prostate, or breast cancer	2	1.7
	Pornography	2	1.7
	Other: …	1	0.9
	Physical difficulties in initiating or maintaining sexual relations	1	0.9
	Note. Multiple responses were allowed (n = 174)	∑ PwDs: 115	

Table 3 Distribution of topics participants consider appropriate for PwDs to know about regarding sexuality

	Response options	f	%
In your opinion, what should your family member(s) with special needs know about sexuality?	Personal hygiene	73	63.5
	Bodily changes	65	56.5
	Abuse / Harassment / Rape and how to protect themselves	48	41.7
	Reason for your protective attitude	43	37.4
	Menstruation (periods)	34	29.6
	Masturbation (self-stimulation of genital areas)	32	27.8
	Nocturnal emission	31	27.0
	Use of sanitary pads	31	27.0
	Erection of sexual organs	29	25.2
	How to overcome difficulties related to sexual intercourse	20	17.4
	Sexually transmitted infections (STIs)	20	17.4
	Already knew what was necessary due to being an adult before developing special needs	19	16.5
	Non-contagious diseases or cancers of ovaries, uterus, prostate, or breasts	17	14.8
	Physical challenges in initiating or maintaining sexual intercourse	16	13.9
	Pregnancy	16	13.9
	Methods of contraception	15	13.0
	Does not need to know anything	13	10.4
	Pornography	6	5.2
	Brothels	5	4.3
	Other: (Should know everything)	1	0.9
	Note. Multiple responses were allowed ($n = 534$).	∑ PwDs: 115	

edge. However, a substantial proportion of participants believed that topics such as pornography, brothels, and the physical challenges related to sexual intercourse should not be shared with PwDs. These findings suggest that families tend to set boundaries when it comes to transmitting sexual knowledge, especially regarding topics considered explicit or morally sensitive.

Participants were asked to identify which sexuality-related topics they believed PwDs should not be informed about (see Table 4). The responses reveal a tension between protectionist attitudes and the principle of access to comprehensive sexuality education.

This data underscores a protective stance held by many caregivers regarding sexual knowledge for PwDs. Topics such as reproductive autonomy, sexual expression, and body-related information remain areas of discomfort for a significant number of participants. The reluctance to provide knowledge on topics like masturbation, STI prevention, or even personal hygiene may limit PwDs' ability to make informed decisions and protect themselves from harm. While 40% of participants supported unrestricted access to information, the remaining their selective withholding of content points to the need for family-centered interventions that educate caregivers on the rights-based, developmental, and health-focused aspects of sexuality education.

Participants' Views on the Possibility of PwDs Having Diverse Sexual Orientations

This section explores participants' perceptions regarding whether PwDs can possess diverse sexual orientations, including homosexual, bisexual, and transgender identities (see

Table 4 Distribution of topics participants believe should not be known by PwDs

	Response options	f	%
What do you think the person(s) with special needs in your family *should not* know about?	There is no harm in them learning what they want.	46	40.0
	Pornography	48	41.7
	Brothels	52	45.2
	Physical difficulties in initiating or maintaining sexual intercourse	24	20.9
	How to overcome difficulties in sexual intercourse	24	20.9
	Contraceptive methods	12	10.4
	Masturbation (self-stimulation of sexual organs)	20	17.4
	Pregnancy	7	6.1
	Abuse / Harassment / Rape and prevention methods	10	8.7
	Sexually transmitted infections	16	13.9
	Cancers or other non-infectious diseases of the reproductive organs	7	6.1
	Menstruation (periods)	4	3.5
	Use of sanitary pads	4	3.5
	Nocturnal emission	17	14.8
	Erection of sexual organs	16	13.9
	Bodily changes	11	9.6
	Personal hygiene	10	8.7
	Appropriate public behavior	13	11.3
	Reason for protective attitudes	4	3.5
	Other: "Should not know for now."	1	0.9
	Note. Multiple answers were allowed ($n=346$).	∑ PwDs: 115	

Table 5 Distribution of participants' views on whether PwDs can have diverse sexual orientations by type of disability

	Type of disability	No, cannot	Undecided/No opinion	Yes, can
Can individuals with special needs have diverse sexual orientations such as homosexual, bisexual, or transgender?		%	%	%
	Physical / Orthopedic	20.0	43.0	34.0
	Intellectual / Cognitive	35.0	36.0	26.0
	Visual	19.0	30.0	48.0
	Hearing	14.0	29.0	54.0
	Speech and Language Difficulties	14.0	26.0	56.0
	Emotional, Behavioral and Social Adjustment Difficulties	16.0	36.0	45.0
	Attention Deficit and Hyperactivity Disorder	16.0	33.0	48.0
	Specific Learning Disability	16.0	34.0	48.0
	Autism	29.0	36.0	34.0
	Chronic (Long-Term) Illnesses	16.0	32.0	49.0

Percentages may not add up to 100% due to missing data

Table 5). The analysis considers variations across different types of disabilities, highlighting how attitudes may shift depending on the nature of the special need.

The findings reveal a general openness among participants to the notion that PwDs can have diverse sexual orientations, particularly for those with sensory impairments such as hearing or speech difficulties, where agreement rates are notably higher. Conversely, a con-

siderable proportion of participants express skepticism or denial of such possibilities within groups characterized by autism and intellectual disabilities, reflecting persistent societal prejudices associated with these conditions. Indecision or lack of opinion remains relatively low across all groups.

Families' Educational Needs and Attitudes Toward Sexuality Education

A significant majority of participants (79.1%) expressed the need for sexuality education programs specifically designed for families of PwDs. This perceived necessity was particularly pronounced among families of individuals with intellectual disabilities, autism spectrum disorders, and emotional adjustment difficulties. Regarding the timing of such education, 65.3% of respondents favored delivering it before the adolescent developmental stage of the individual with special needs, while 22.4% considered adolescence itself to be a more appropriate period.

Regarding the topics participants wished to learn in order to support PwDs, the findings reveal a pronounced focus on protective and rights-based issues (see Table 6). Many sought information on preventing abuse and navigating online safety, indicating concerns about vulnerability. Interest was also expressed in puberty, sexual rights, and reproductive health, whereas fewer participants prioritized issues related to sexual functioning or medical treatments. Importantly, over one-third reported no desire for further information, reflecting possible stigma or lack of perceived need.

Table 6 Distribution of topics participants wish to learn to support PwDs regarding sexuality

	Response options	%
In which specific topics concerning sexual rights, health, development, and reproductive issues would you prefer to acquire knowledge in order to effectively support the individual(s) with special needs within your family?	Types of abuse / harassment / assault and ways to prevent them	46.0
	Ways to stay safe while using the internet and social media	43.0
	I do not want to acquire information / I do not need information	36.0
	Sexual maturation process during puberty	26.0
	Sexual rights of individuals with special needs	26.0
	Urinary tract infections	22.0
	Non-communicable diseases such as ovarian/uterine/prostate/breast cancer or other diseases	19.0
	How to overcome difficulties related to sexual intercourse	18.0
	Menopause / andropause	14.0
	Is masturbation harmful or sinful?	13.0
	Sexually transmitted infections	11.0
	In vitro fertilization treatments for individuals with special needs	10.0
	Menstrual cycle	10.0
	Use of libido-reducing medication	10.0
	Contraceptive methods	8.0
	Menopause-delaying treatments	8.0
	Erectile dysfunction	6.0
	Premature ejaculation	6.0
	Pornography and addiction	5.0
	Sterilization	5.0
	Other:	0.0

Table 7 Distribution of participants' preferences regarding the professionals who should deliver sexuality education to families of PwDs

	Profession	%
By whom would you prefer sexuality education for families of individuals with special needs to be delivered in a group setting?	Psychologist	79.0
	Medical doctor	63.0
	Psychological counsellor / Guidance teacher (graduates of Guidance and Psychological Counselling)	61.0
	Special education teacher	52.0
	Physiotherapist	27.0
	Nurse	15.0
	Religious official	12.0
	Other: Sociologists	2.0

Multiple responses were allowed ($n = 311$)

Participants' Views on the Location, Timing, and Providers of Sexuality Education

Participants expressed a range of opinions regarding the appropriate setting for delivering sexuality education to families of PwDs. While some favored university departments (34.7%), others preferred special education centers (26.5%) or guidance and research centers (21.4%). Despite this variation in setting, a common theme emerged in participants' emphasis on the involvement of professionals with psychosocial expertise and academic qualifications (see Table 7). This preference reflects families' desire for sexuality education to be provided in environments that are not only institutionally appropriate but also staffed by experts capable of offering reliable, evidence-based, and inclusive guidance. Health and education professionals—particularly those with backgrounds in psychology—were most frequently identified as suitable educators, whereas religious or culturally affiliated figures were only marginally favored.

Although there was no complete consensus on the duration of the education program, 45.7% of participants considered a program consisting of 5 to 8 sessions to be sufficient. Regarding gender-based participation, 56.5% supported mixed-gender education sessions, whereas 29.3% believed that males and females should be educated separately. These findings indicate a general recognition among families of the need for sexuality education, while also highlighting the diversity in expectations about its implementation.

Discussion and Conclusion

This study underscores the critical role of family-centered sexuality education by examining the attitudes, knowledge levels, and educational needs of families of PwDs. The findings align with a consistent body of literature that highlights knowledge gaps and cultural taboos surrounding the sexuality of individuals with disabilities, particularly in conservative societies [39, 40]. Most families in this study acknowledged the necessity of sexuality education, primarily motivated by the need to protect PwDs from sexual abuse—a concern similarly noted by [10] and [11]. However, their educational priorities were limited to narrowly defined "safe" topics such as personal hygiene and social norms, neglecting core areas of sexual development including menstruation, nocturnal emissions, and sexual orientation.

This selective approach to sexuality education reflects a broader pattern of avoidance and discomfort, also identified in other Turkish studies [12]. Importantly, nearly 80% of families reported that PwDs do not ask, or are unable to ask, questions related to sexuality. This finding may reflect not only communication challenges associated with intellectual or developmental disabilities but also the internalization of cultural taboos that suppress sexual expression [30, 32]. Literature indicates that when sexuality is framed as "non-existent" or irrelevant in the lives of individuals with disabilities, their sexual agency is denied and their vulnerability to abuse may increase [28, 41].

Although many participants in this study stated that they could respond to sexuality-related questions from PwDs, the content of their responses was often superficial, indicating a lack of depth and scope. This finding supports arguments of Dewinter, De Graaf and Begeer [42] that without a broader social acceptance of diverse sexual identities among people with disabilities, especially autistic individuals, educational efforts are likely to remain exclusionary. Indeed, the belief that PwDs—especially those with intellectual disabilities or autism—either cannot or should not have diverse sexual orientations was commonly expressed by participants. This contradicts international findings, which indicate that autistic individuals may in fact demonstrate greater variability in sexual orientation compared to their neurotypical peers [42, 43, 44].

The tendency to frame sexuality in purely biological terms, with limited recognition of its emotional and social dimensions, is consistent with findings from other conservative contexts [15, 21]. Sexuality is not merely a bodily function; it is a core aspect of identity, intimacy, and social inclusion [39]. Therefore, family-centered sexuality education programs should aim not only to inform but also to transform—helping families move from a framework of protection and control to one of understanding, respect, and support.

Furthermore, the finding that 83% of families expressed a need for state-supported educational initiatives underlines the systemic nature of this gap. This echoes previous intervention-based findings [45], which showed that targeted education for families improved their awareness and attitudes toward sexuality and abuse prevention. To be effective, such programs should be developed in response to the specific concerns and values of the target audience, incorporating both scientific and psychosocial perspectives. In line with UNESCO [46], education content must be inclusive, age-appropriate, and rights-based.

The families' preferences regarding the delivery of sexuality education also revealed important socio-cultural dynamics. Although religious authorities were generally not preferred, their inclusion by some participants suggests that religious perspectives continue to hold significance for certain families in navigating sensitive topics. This aligns with previous research emphasizing the complex role of religious values in shaping parental attitudes, particularly in conservative societies [47]. Likewise, the suggestion that educators be gender-matched with participants reflects enduring modesty norms and gender roles [48]. These findings indicate that culturally sensitive programming—while upholding professional standards—must also recognize and respect the diverse worldviews of its audience.

When compared with studies conducted in countries exhibiting conservative characteristics similar to those of Turkey, the challenges observed among Turkish families in this study resonate with broader patterns documented across conservative societies worldwide. For instance, in the Middle East and North Africa (MENA) region—characterized by similar cultural and religious conservatism—families of PwDs also tend to avoid open sexuality discussions due to prevailing taboos, despite increasing recognition of sexual rights in more

urban and educated populations [21]. South Asian countries like India and Pakistan face comparable difficulties; protective family attitudes emphasize safety and hygiene over comprehensive sexual health education, reflecting concerns similar to those identified here [22].

In East Asian societies such as China and Japan, family honor and social face deeply influence restrictive approaches to sexuality education for PwDs, mirroring overprotective tendencies found in Turkish families [23]. Conversely, Latin American contexts, influenced by Catholic cultural norms, demonstrate mixed patterns where disability rights movements have promoted more inclusive family education programs tailored to cultural sensitivities.

In conclusion, this study reveals a complex interplay between knowledge, attitudes, and socio-cultural beliefs that shape how families engage with the sexuality of PwDs. Families often exhibit a form of passive ambivalence: they do not fully reject sexuality education but tend to delay or restrict it. Nevertheless, their openness to support, when it is culturally appropriate and professionally delivered, suggests a readiness for change. Accordingly, there is a compelling need to develop holistic, inclusive, and context-sensitive sexuality education interventions that empower families, protect PwDs, and promote their full participation in society.

Limitations and Implications for Future

This study has a few limitations that should be acknowledged. The purposive sampling and case study design restrict the generalizability of the findings beyond the participating families of PwDs in Turkey. Importantly, the perspectives of PwDs themselves were not included. However, conducting direct research with this population requires specialized expertise, and the current research team comprises physiotherapists and adult educators, whose skills guided the study design and ethical considerations. Future research involving multidisciplinary teams and longitudinal designs could address these limitations, thereby providing a more comprehensive understanding of the evolving needs and perspectives surrounding sexuality education for PwDs.

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Data Availability No datasets were generated or analysed during the current study.

Declarations

Conflict of interest The researchers declare that they have not experienced any conflicts of interest at any stage of the study.

Ethical Approval This study is based on a master's thesis and received ethical clearance from Ankara University Social Sciences Sub-Ethics Committee (approval number 55) on February 6, 2023, prior to data collection. Portions of the original Turkish text were translated into English using tools such as Google Translate, thesaurus.com, and ChatGPT.

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