Sex Disabil (2011) 29:165–174
DOI 10.1007/s11195-011-9201-0

ORIGINAL PAPER

# Acceptability of Sexual Relationships Among People with Learning Disabilities: Family and Professional Caregivers' Views in Mexico

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Published online: 15 February 2011


**Abstract** The attitudes towards sexual relationships among persons with learning disabilities (PLD) of parents of children without disabilities were compared with the attitudes of family caregivers (parents of PLD) and with the attitude of professional caregivers. The importance of different situational factors that may alter acceptability judgments (i.e., gender, etiology of the disability, person's present level of autonomy, use of contraceptive devices, and partner's age and possible handicap) with regards to the sexuality of PLD was examined through the use of concrete cases. All the participants lived in Mexico. The only notable difference in attitude that was observed was between parents of PLD suffering from trisomia 21 and parents of PLD suffering from a neuromotor disorder. As a result, it may be erroneous to consider parents of PLD as a homogeneous group regarding attitudes to sexuality. Three different basic philosophies regarding the expression of sexuality among PLD were observed. They were called Mainly Unacceptable (37% of the sample), Mainly Acceptable (36%), and Depending on Circumstances (27%). In this later philosophy, contraception was by far the major determinant of acceptability.

**Keywords** Sexual relationships · Persons with learning disabilities · Family caregivers · Professional caregivers · Mexico

## Introduction

Sexuality is an inherent property of human life: Without sexuality, there is no human life. Sexuality must, therefore, be considered a basic right, and a core aspect of individual identity [1]. However, the sexual rights of people with learning disabilities (PLD) were not an open matter of discussion for a long time [2].

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Since 20 years, however, studies exploring attitudes toward sexuality among PLD have been conducted, using different approaches (qualitative and quantitative), different instruments (e.g., questionnaires, interviews, experimental designs), different samples (e.g., lay people, teachers, administrators, special education teachers, and PLD), over many different countries: USA [3, 4], Australia [5], Sweden [6], Italy [7], Greece [8], Ireland [9], Turkey [10], France [11], and Mexico [12]. The findings are largely convergent. Overall, attitudes towards the sexuality of PLD are moderately positive, more liberal now than they were 20 years ago (also see [13]), and the younger the respondent, the more liberal the attitude. Respondents' main concerns, presently, are more centered on the consequences of the sexual relationships than on the relationships *per se*.

Recent studies have focused on the cognitive processes that lie behind the attitude to sexuality of PLD; that is, on the cognitive process by which acceptability judgments or unacceptability judgments are formed under different circumstances. In a study that was conducted in France, Esterle, Munoz Sastre and Mullet [11] presented their participants with a series of concrete cases where a PLD has regular sexual intercourse with a partner of a different sex. These cases were obtained by orthogonal combination of six (within-subject) factors: PLD's Gender × Etiology of the disability (genetic versus congenital) × Level of autonomy (dependent versus relatively autonomous) × Use of contraceptive techniques × Partner's age (same age versus much older) × Partner's handicap (no handicap versus same handicap). Participants were instructed to judge each case using a continuous acceptability scale. The mean level of acceptability was found to be low. In most cases, the acceptability level was close to the minimum value. Four factors were found to impact on acceptability judgments: Use of contraceptive techniques, level of autonomy, partner's age, and partner's handicap. In addition, the impact of each factor on acceptability judgments was very dependent on the level of the other factors; that is, strong interactions between factors were found.

Morales, Lopez, Esterle and Mullet [12] compared the attitudes of Mexicans and French people, using the material that was created by Esterle et al. [11]. In this study, only three of the four factors that were found to have a significant effect among French participants—use of contraceptive devices, level of personal autonomy, and partner's age—were found to be significant among the Mexican participants. The partner's handicap factor was not significant, but the impact of the contraception factor was stronger among the Mexican participants than among the French participants. Contrary to what was observed among the French participants, among the Mexican participants the three factors were combined in a strictly additive, independent way.

## The Present Study

The present study was aimed at complementing these two previous cognitive studies. First, it was aimed at comparing lay people's attitudes (and cognitive processes) with (a) the attitudes of family caregivers (parents of PLD), and (b) the attitude of professional caregivers (special education teachers, and other personals) in charge of PLD. As shown in previous studies, these attitudes can differ.

Aunos and Feldman [13] reviewed studies conducted in the 80 s and the 90 s examining attitudes toward the expression of sexuality among PLD. They concluded that special education teachers expressed more positive attitudes than parents and service workers. In a study conducted in Sweden, Lofgren-Martenson [6] showed that family and professional caregivers feel strong responsibility for PLD's sexuality. They often act in an authoritative,

disciplinary way. In a study conducted in Australia, Cuskely and Bryde [5] showed that family caregivers expressed less permissive attitudes towards PLD's sexuality than professional caregivers. In a study conducted in Ireland, Drummond [9] found that professional caregivers' attitude toward sexuality among PLD was positive, especially among younger, more educated caregivers. In a study conducted in Italy, Bazzo et al. [7] showed that professional caregivers (social service providers), especially the ones working in outpatient treatment services, expressed moderately liberal, positive attitudes towards the sexuality of PLD. In a study conducted in the USA, Swango-Wilson [4] showed that professional caregivers, especially the older ones, were uncertain about the acceptability of PLD's sexuality. They considered that PLD's sexual expression was less acceptable than their own sexual expression.

The measurement of attitudes towards sexuality among PLD among family and professional caregivers; that is, among the persons who are directly in charge of their education is important because these persons are logically the ones who determine the daily (social, educational, and family) environments in which they grew up [2]. In Mexico, there are about 290,000 PLD [14] but no study to date has ever examined caregivers' attitudes towards PLD's sexuality. Most of the literature on this issue is composed of reflections on the importance of considering sexuality among PLD as an educational priority [15, 16] or general review articles on this topic [17–19]. Our hypothesis was that Mexican professional caregivers' attitudes should be, as in others countries (e.g., [5]), more favorable than Mexican family caregivers' attitudes, and Mexican family caregivers' attitudes should be more favorable than the attitudes of parents of children without disabilities.

Secondly, the present study was aimed at uncovering the possibly diverse philosophies regarding the acceptability of sexual relationships among PLD. Brown and Pirtle [2], in a study about sex education for PLD, have shown the existence of such diverse philosophies among professional caregivers. Using a Q-sort technique, they distinguished four different philosophies: advocates of sex education, supporters of sex education, regulators and humanists. Esterle, Munoz Sastre and Mullet [20] in a study about elderly people's sexuality, showed that three qualitatively different philosophies coexisted among lay people.

In view of these findings, we expected to find at least three different philosophies regarding the acceptability of sexual relationship among PLD: (a) an "always acceptable" philosophy, comparable to the one found in Esterle et al. [20] study, (b) a "never acceptable" philosophy, that should reflect the viewpoint of Mexican people who are older and/or more religiously oriented, and (c) a "depending on circumstances" philosophy that should reflect the viewpoint of the majority of the participants, as in the study by Morales et al. [12].

## Method

### Participants

Overall, the sample consisted of 270 adults living in northern Mexico, and was composed of four groups: 120 parents of children without learning disabilities (67 females and 53 males), aged 22–82 ($M = 41.6$, $SD = 11.51$), 75 family caregivers (68 females and 7 males), aged 17–65 ($M = 38.2$, $SD = 10.52$), and 75 professional caregivers (70 females and 5 males), ages 19–53 ($M = 29.5$, $SD = 9.30$). In the subsample of family caregivers, 25 of them were parents of PLD suffering from Down syndrome and 50 of them were parents of PLD suffering from a neuromotor disorder. Ninety seven per cent of the participants were Catholic, and from these, 60% were regular attendees to the church. All

participants were volunteers, and informed consent was obtained before data gathering. Once the study was completed, two debriefing sessions were organized, one with the family caregivers and one with the professional caregivers.

### Material

The material used was the one created by Esterle et al. [11] for examining the cognitive process by which acceptability judgments are formed. This material had already been successfully used in a previous study conducted in Mexico on lay people [12]. It consisted in 64 vignettes; each one describing a situation of sexual intimacy between a PLD and another person who has or has not the same disability.

The vignettes were composed according to a six within-subject factor design: Gender × Etiology of the disability (genetic versus congenital) × Level of autonomy (dependent versus relatively autonomous) × Use of contraceptive techniques × Partner's age (same age versus much older) × Partner's handicap (no handicap versus same handicap), 2 × 2 × 2 × 2 × 2 × 2. Under each vignette was a question and a response scale. The question was, "To what extent do you believe that the sexual relationships between _____ and _____ are, in their present form, acceptable?" The response scale was a 11-point scale (0–10) with a left-hand anchor of "Not at all acceptable" and a right-hand anchor of "Completely acceptable." One example is given in the Appendix.

The cards were arranged randomly and in a different order for each participant. The participants answered additional demographic questions about age, gender, educational level, religious belief, and religious background.

### Procedure

Participants were scheduled individually or in small groups. The application session was divided in three phases. First, informed consent was obtained from all participants, and it was specified that the study was voluntary and confidential. In a second phase (familiarization phase), verbal and written instructions as well a series of vignettes taken at random from the complete set were presented to participants. Participants were requested to read the vignettes, and they were reminded that each one described a different situation. They had to assess the level of acceptability of the sexual relationships for each scenario by putting a tic somewhere along the response scale. Once the task was clearly understood by the participants, they were presented with the set of 64 vignettes. The time required to complete the ratings ranged from 25 to 50 min depending on the participant′s pace.

## Results

As one of the objectives of the study was to examine the possibly diverse philosophies that lie behind participants' acceptability/unacceptability judgments, a cluster analysis was performed on the raw data (K-means, Euclidian distances, see [21]). Three clusters were identified. They are shown in Fig. 1. Owing to the high statistical power in the study, the significance threshold was set at $p < 0.001$.

The first Cluster (N = 98, 36%) was termed *Mainly Acceptable*: The acceptability ratings were always relatively high, even when the individuals in the scenarios did not use contraceptive methods. The overall mean value of the ratings was 6.35 (read SD = 1.20). An ANOVA was conducted on the data from this cluster. The results are shown in Table 1

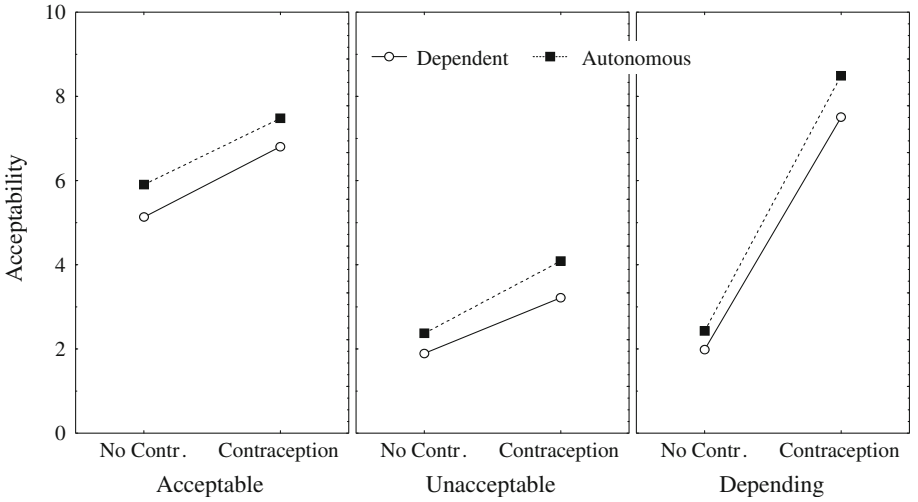


**Fig. 1** Effects of contraception and autonomy in each of the three clusters

(top part). In this cluster, despite the fact that all ratings were relatively high, four factors had a significant effect. Acceptability was higher (a) when the PLD was a male (M = 6.50) than when the PLD was a female (M = 6.16), (b) when the PLD was relatively autonomous (6.69 versus 5.97), (c) when the partners used contraceptive techniques (7.14 versus 5.52), and (d) when they were of similar age (6.67 versus 5.99).

As shown in Table 2, more than half the parents of children with Down's syndrome, and about half the professional caregivers formed part of this cluster. Also, about one third of parents of children with a neuromotor disorder, and about one quarter of the parents of children without any disability formed part of this cluster.

The second cluster (N = 100, 37%) was termed *Mainly Unacceptable*. The acceptability ratings were always relatively low, even when the individuals in the scenarios did use contraceptive methods. The overall mean value of the ratings was 2.80 (SD = 1.01). An ANOVA was also conducted on data from this cluster (see Table 1, center part). In this cluster, despite all the ratings were relatively low, three factors had a significant effect.

**Table 1** Composition of the three clusters

| Subsample of participants | Clusters | | | |
|---|---|---|---|---|
| | Mainly Acceptable | Mainly Unacceptable | Depending on Circumstances | Total |
| Parents of PLD suffering from Down's syndrome | 13 (52%) | 5 (20%) | 7 (28%) | 25 |
| Parents of PLD suffering from a neuromotor disorder | 17 (34%) | 23 (46%) | 10 (20%) | 50 |
| Professional caregivers | 35 (47%) | 24 (32%) | 16 (21%) | 75 |
| Parents of children without disabilities | 33 (27%) | 48 (40%) | 39 (33%) | 120 |
| Total | 98 (36%) | 100 (37%) | 72 (27%) | 270 |

**Table 2** Results of the three ANOVAs conducted on the three clusters

| Factors | Effect | | Error | | *F* | *p* | $\eta^2$ |
|---|---|---|---|---|---|---|---|
| | *df* | *MS* | *df* | *MS* | | | |
| Cluster "Mainly Acceptable" | | | | | | | |
| Gender (G) | 1 | 175.44 | 97 | 13.43 | 13.05 | 0.001 | 0.11 |
| Etiology (E) | 1 | 8.9 | 97 | 8.72 | 1.02 | *ns* | 0.01 |
| Autonomy (A) | 1 | 780.83 | 97 | 19.76 | 39.49 | 0.001 | 0.28 |
| Contraception (C) | 1 | 4,129.13 | 97 | 23.24 | 177.65 | 0.001 | 0.64 |
| Partner's age (Ag) | 1 | 750.08 | 97 | 20.15 | 37.20 | 0.001 | 0.27 |
| Partner's disability (D) | 1 | 17.04 | 97 | 48.27 | 0.35 | *ns* | 0.00 |
| G × E | 1 | 24.62 | 97 | 4.87 | 5.05 | *ns* | 0.05 |
| G × A | 1 | 1.37 | 97 | 5.37 | 0.25 | *ns* | 0.00 |
| E × A | 1 | 20.32 | 97 | 5.62 | 3.61 | *ns* | 0.03 |
| G × C | 1 | 16.42 | 97 | 4.74 | 3.46 | *ns* | 0.03 |
| E × C | 1 | 13.50 | 97 | 8.82 | 1.52 | *ns* | 0.01 |
| A × C | 1 | 17.25 | 97 | 6.40 | 2.69 | *ns* | 0.02 |
| G × Ag | 1 | 3.08 | 97 | 7.72 | 0.39 | *ns* | 0.00 |
| E × Ag | 1 | 11.88 | 97 | 5.42 | 2.19 | *ns* | 0.02 |
| A × Ag | 1 | 152.81 | 97 | 6.39 | 23.89 | 0.001 | 0.19 |
| C × Ag | 1 | 6.31 | 97 | 4.82 | 1.30 | *ns* | 0.01 |
| G × D | 1 | 77.90 | 97 | 7.12 | 10.92 | 0.001 | 0.10 |
| E × D | 1 | 12.58 | 97 | 6.46 | 1.94 | *ns* | 0.01 |
| A × D | 1 | 8.07 | 97 | 5.12 | 1.57 | *ns* | 0.02 |
| C × D | 1 | 110.63 | 97 | 10.58 | 10.44 | 0.001 | 0.10 |
| Ag × D | 1 | 29.07 | 97 | 6.43 | 4.51 | *ns* | 0.04 |
| Cluster "Mainly Unacceptable" | | | | | | | |
| Gender (G) | 1 | 6.95 | 99 | 5.097 | 1.36 | *ns* | 0.01 |
| Etiology (E) | 1 | 0.70 | 99 | 3.95 | 0.17 | *ns* | 0.00 |
| Autonomy (A) | 1 | 729.67 | 99 | 12.10 | 60.25 | 0.001 | 0.37 |
| Contraception (C) | 1 | 3,689.04 | 99 | 26.39 | 139.77 | 0.001 | 0.58 |
| Partner's age (Ag) | 1 | 696.30 | 99 | 12.64 | 55.06 | 0.001 | 0.35 |
| Partner's disability (D) | 1 | 15.70 | 99 | 30.02 | 0.52 | *ns* | 0.01 |
| G × E | 1 | 1.72 | 99 | 2.92 | 0.58 | *ns* | 0.01 |
| G × A | 1 | 2.36 | 99 | 1.94 | 1.21 | *ns* | 0.01 |
| E × A | 1 | 0.28 | 99 | 1.92 | 0.15 | *ns* | 0.00 |
| G × C | 1 | 1.35 | 99 | 3.41 | 0.39 | *ns* | 0.00 |
| E × C | 1 | 3.56 | 99 | 2.60 | 1.36 | *ns* | 0.01 |
| A × C | 1 | 61.03 | 99 | 7.03 | 8.67 | *ns* | 0.08 |
| G × Ag | 1 | 2.14 | 99 | 5.46 | 2.55 | *ns* | 0.02 |
| E × Ag | 1 | 1.89 | 99 | 1.85 | 0.98 | *ns* | 0.01 |
| A × Ag | 1 | 32.63 | 99 | 2.62 | 12.42 | 0.001 | 0.11 |
| C × Ag | 1 | 120.72 | 99 | 6.53 | 18.47 | 0.001 | 0.15 |
| G × D | 1 | 16.70 | 99 | 3.67 | 4.54 | *ns* | 0.04 |
| E × D | 1 | 0.50 | 99 | 2.29 | 0.22 | *ns* | 0.00 |
| A × D | 1 | 0.92 | 99 | 2.79 | 0.33 | *ns* | 0.00 |

**Table 2** continued

| Factors | Effect | | Error | | *F* | *p* | $\eta^2$ |
|---|---|---|---|---|---|---|---|
| | *df* | *MS* | *df* | *MS* | | | |
| C × D | 1 | 146.71 | 99 | 7.41 | 19.78 | 0.001 | 0.16 |
| Ag × D | 1 | 1.41 | 99 | 5.22 | 0.26 | *ns* | 0.00 |
| Cluster "Depending on Circumstances" | | | | | | | |
| Gender (G) | 1 | 27.19 | 71 | 5.26 | 5.16 | *ns* | 0.07 |
| Etiology (E) | 1 | 9.03 | 71 | 7.01 | 1.28 | *ns* | 0.02 |
| Autonomy (A) | 1 | 593.68 | 71 | 15.49 | 38.30 | 0.001 | 0.35 |
| Contraception (C) | 1 | 38,630.41 | 71 | 45.19 | 854.83 | 0.001 | 0.92 |
| Partner's age (Ag) | 1 | 403.75 | 71 | 14.07 | 28.69 | 0.001 | 0.28 |
| Partner's disability (D) | 1 | 57.33 | 71 | 21.07 | 2.72 | *ns* | 0.03 |
| G × E | 1 | 20.85 | 71 | 3.26 | 6.39 | *ns* | 0.08 |
| G × A | 1 | 6.12 | 71 | 3.32 | 1.84 | *ns* | 0.02 |
| E × A | 1 | 0.07 | 71 | 4.13 | 0.01 | *ns* | 0.00 |
| G × C | 1 | 4.01 | 71 | 6.93 | 0.57 | *ns* | 0.01 |
| E × C | 1 | 4.62 | 71 | 3.73 | 1.23 | *ns* | 0.02 |
| A × C | 1 | 83.42 | 71 | 7.42 | 11.23 | 0.001 | 0.13 |
| G × Ag | 1 | 3.23 | 71 | 7.74 | 0.41 | *ns* | 0.01 |
| E × Ag | 1 | 4.25 | 71 | 3.15 | 1.35 | *ns* | 0.01 |
| A × Ag | 1 | 3.44 | 71 | 3.49 | 0.98 | *ns* | 0.01 |
| C × Ag | 1 | 13.13 | 71 | 4.26 | 3.07 | *ns* | 0.04 |
| G × D | 1 | 42.01 | 71 | 4.77 | 8.79 | *ns* | 0.11 |
| E × D | 1 | 0.94 | 71 | 4.75 | 0.19 | *ns* | 0.00 |
| A × D | 1 | 7.03 | 71 | 5.067 | 1.38 | *ns* | 0.01 |
| C × D | 1 | 280.05 | 71 | 10.96 | 25.53 | 0.001 | 0.26 |
| Ag × D | 1 | 31.66 | 71 | 3.57 | 8.85 | *ns* | 0.11 |

Acceptability was higher (a) when the PLD was relatively autonomous (3.23 versus 2.55), (c) when the partners used contraceptive techniques (3.65 versus 2.13), and (d) when they were of similar age (3.22 versus 2.56). Several interactions were also significant but their effect sizes was small.

As shown in Table 2, only one fifth of the parents of children with Down's syndrome, and about one third of the professional caregivers formed part of this cluster. In contrast, half of the parents of children with a neuromotor disorder, and about two fifth of the parents of children without any disability formed part of this cluster.

The third cluster (N = 72, 27%) was termed *Depending on Circumstances.* The overall mean value of the ratings was 5.10 (SD = 0.64). In this cluster, the same three factors as in the second cluster had a significant effect. Acceptability was higher (a) when the PLD was relatively autonomous (5.46 versus 4.74), (c) when the partners used contraceptive techniques (8.00 versus 2.21), and (d) when they were of similar age (5.40 versus 4.81). Several interactions were also significant but their effect sizes were small, except for Contraception × Partner's Disability. When there was no contraception, the partner's level of disability had a small effect, whereas, in the other case, it had no effect.

One fourth of the parents of children with Down's syndrome, and about one fifth of the professional caregivers, and of the parents of children with a neuromotor disorder formed part of this cluster. In contrast, about one third of the parents of children without any disability formed part of this cluster. The composition of the three clusters was not significantly affected by the participants' age, gender, educational level, and belief in God. Sixty-one percent of the members of the Mainly Acceptable cluster, 66% of the members of the Mainly Unacceptable cluster, and 51% of the members of the Depending on Circumstances cluster were regular attendee to the church, *ns*.

Finally, an overall ANCOVA was conducted with a Group (parents of children without disability, parents of PLD suffering from Down's syndrome, parents of PLD suffering from a neuromotor disorder and professional caregivers) × Gender × Etiology × Autonomy × Contraception × Partner's age × Partner's handicap design, $4 \times 2 \times 2 \times 2 \times 2 \times 2 \times 2$, was conducted. The covariables were the participants' age, gender, and religious beliefs. The group effect was significant, $F(3,262) = 4.36$, $p < .005$.

Subsequent post-hoc comparisons (Least Significant Differences tests) showed that the acceptability mean scores were not different from one group to the other except between parents of children suffering from Down's syndrome ($M = 5.51$) and parents of children suffering from a neuromotor disorder ($M = 4.24$). For professional caregivers, and parents of children without disabilities, the mean score were 5.06 and 4.55.

## Discussion

The present study was conducted in Mexico. It compared the attitudes towards sexual relationships among PLD of parents of children without disabilities with (a) the attitudes of family caregivers (parents of PLD), and (b) the attitude of professional caregivers (special education teachers, and other personals in charge of PLD). The hypothesis was that professional caregivers' attitudes should be more favorable than family caregivers' attitudes, and family caregivers' attitudes should be more favorable than the attitudes of parents of children without disabilities [13].

The hypothesis was not supported by the data. The professional caregivers' attitudes were more favorable than the attitudes of parents of PLD suffering from a neuromotor disorder, and they were also more favorable than the attitudes of parents of children without disabilities. These differences were, however, not significant. In contrast, the attitudes of parents of PLD suffering from trisomia 21were more favorable than the attitudes of professional caregivers and the attitudes of parents of children without disabilities. This second set of differences was no more significant than the first. The only significant difference was, surprisingly, between the two groups of parents of PLD. The mean score of the parents of PLD suffering from trisomia 21 was the highest observed in this study and the mean score of the parents of PLD suffering from a neuromotor disorder was the lowest observed.

In other words, it may be erroneous and risky to consider the parents of PLD as a homogeneous group regarding attitudes to sexuality. The daily experience of a family caregiver of a PDL suffering from a neuromotor disorder is probably very different from the daily experience of a family caregiver of a PDL suffering from trisomia 21, to the point that considerable differences regarding sexual attitudes can emerge between these family caregivers. Interestingly, these attitudes, which are associated with the specific experience of each caregiver, generalize to all kinds of learning disabilities.

Another objective of the study was to pinpoint the possible different philosophies that lie behind the participants' acceptability/unacceptability considerations. The hypothesis was that at least three different philosophies should be observed: (a) an "always acceptable" philosophy, (b) a "never acceptable" philosophy, and (c) a "depending on circumstances" philosophy. This hypothesis was well supported by the data.

The more common philosophy that was identified was labeled *Mainly Unacceptable*. The unacceptability judgments were, however, not categorical judgments (that is, the ratings were not systematically very close to the minimum value on the acceptability scale), hence the label given to the cluster. This philosophy was above all the philosophy of the parents of PLD suffering from a neuromotor disorder.

Another, common philosophy was labeled *Mainly Acceptable*. In this second case, the acceptability judgments were not categorical judgments (that is, the ratings were not systematically very close to the maximum value on the acceptability scale), hence the label given to this second cluster. The "mainly acceptable" philosophy was above all the philosophy of the parents of PLD suffering from trisomia 21 and the philosophy of the professional caregivers. Finally, a *Depending on Circumstances* philosophy was, as expected, identified. The main circumstance that impact on acceptability in this cluster was, logically, the use of contraceptive devices.

The Mexican society's attitude towards sexual relationships among PLD appeared to be rather polarized. In our sample, two large groups of equal size were observed, one mainly favorable and the other mainly unfavorable. In addition, this relative polarization can be observed among the three subgroups in this society that were examined in the present study: parents of children without disabilities, family caregivers, and professional caregivers. These three groups only differ in the relative proportions of favorable or unfavorable persons in each group. A minority of participants in the present study, notably parents of children without disabilities, expressed, however, attitudes that varied as a function of the context in which the sexual relationships took place.

This polarization of the Mexican society regarding sexuality in PLD (and probably sexuality in general), is certainly a non negligible factor that can explain the lasting difficulties encountered by the successive Mexican governments for implementing sexual education programs directed at PLD as well as at persons without disabilities. For instance, as early as in 1930, the Public Education Secretary (SEP), which is the main government institution ruling education in Mexico, made a first valuable attempt to include sexual education in school programs. However, due to demonstrations against this initiative from mothers of families, the implementation of the program had to be discarded [17]. Much more recently, in 2009, an event that was similar in kind happened in a Mexican city: People burned textbooks published by the SEP, complaining about the way sexual contents were presented.

The present study provides, however, encouraging data: It indicates that although there are groups of people that express a low level of acceptability towards the sexual rights of PLD, the majority of the professionals with closer proximity to these persons (68%), as well as a notable part of the lay people (60%), expressed openness toward the sexual expression of the PLD. Future research might be directed at creating and testing educative programs that can sensitize the public to the needs and human rights of PLD.

## Appendix

Carlos Jimenez, 19 years-old, has regular sexual intercourse with Claudia Ramirez, 42 years-old. Carlos has a learning disability. He suffers from an intellectual retardation that

is due to a trauma during delivery. Carlos is, unfortunately, completely dependent. Claudia suffers from the same kind of learning disability than Carlos. Carlos and Claudia do not use any contraceptive device.

*To what extent do you consider that the sexual relationships between Carlos and Claudia are, in their present form, acceptable?*

Not at all o-----o-----o-----o-----o-----o-----o-----o-----o-----o-----o Completely

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