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Full Length Research Paper

Attitudes to sexuality in individuals with mental retardation from perspectives of their parents and teachers

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Sexuality is an integral part of adults' life. In the past, ignorance and fear by others have prevented persons with mental retardation (MR) from fully participation as members of society. Attitudes of parents, caregivers and teachers to the sexual expression of individuals with mental retardation are important factors in designing comprehensive programs. The aim of this investigation is to study the attitudes of sexuality in individuals with mental retardation from perspectives of their parents and teachers. This is a descriptive-survey study. A questionnaire was designed with analytical-comparative review of literature and theoretical fundamentals for the study of teachers and parents viewpoints regarding mental retarded sexual problems and their suggestions. After pilot study using convenient sampling method 50 teachers and 48 parents were examined. According to the data analysis, teachers and parents' perspectives and their suggestions were: emphasis on sexual education, energy discharges on adolescent through sport and other physical abilities, emphasis on genetic consultation before marriage, emphasis on life skills education, emphasis on ability of mental retarded perception of sexual needs and love assertion, and perception of relation with confidants and strangers.

Key words: Attitudes to sexuality, mental retardation, teachers and parents perspectives.

INTRODUCTION

Mental retardation (MR) disorder according to the 10th edition of the American Association on Mental Retardation (AAMR) is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18 (Luckasson et al., 2002). This disorder has affect on all developmental aspects. Individuals with mental retardation have difficulties in cognitive abilities, behavioral features, social skills and adaptation.

Various studies have found that children with MR have more behavioral and sexual problems than normal children. Behaviors such as restlessness, hyperactivity, stereotypes, self damaging and various emotional disorders are more common in people with MR (Wolman, 1990).

Adolescent years are important period of human life that is accompanied with prominent changes and developments in individuals. These changes are concerned in various functions of biological, cognitional, psychological, social, and behavioral. Thus, adolescence and puberty is not a physiological and sexual occurrence and it is not limited to physical changes. The occurrence of these changes in individuals with MR is accompanied with greater problems and challenges. While sexuality is an integral part of adult life, however, it has been relatively inaccessible for adults with MR, because of limitations such as lack of privacy in institutional living and family ignorance (Servis, 2006).

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In the past, ignorance and fear by others have prevented individuals with MR from fully participating as members of society (Davis, 1959). Moreover, preventive health concerning sexuality of people with ID was addressed through surgical sterilization as part of nationwide eugenic programs in many countries (Servise, 2006). Because of false beliefs regarding inherent criminality, promiscuity, perversion and sexual behavior, individuals were punished to prevent further perpetuation of "defective gens". This practice was known as selective breeding or eugenics (Davis, 1959). In fact until the 1970s some states still enforced involuntary sterilization laws aimed at individuals with ID (Hergenhah, 1997). In general, earlier studies have revealed two conflicting and stereotypical views of the sexual nature of adults with MR: the first is that they are asexual innocents who should be protected (Blatt, 1987; Deloach, 1994; Morgenstern, 1973), while the second is that these individuals have no control over their sexual appetites and are likely to be promiscuous (Antonak, Fiedler and Mulick, 1989; Cuskelly and Gilmore, 2007). Historically, individuals with MR have not enjoyed the sexual freedom afforded to individuals without disabilities. Although, progress has been made, there is much room for improvement, and while advances have been made in employment, housing and other aspects of community integration, the sexual needs of these individuals have been relatively ignored or strictly controlled by caregivers and service agencies (Bambarea and Brantlinger, 2002; Hinsburger and Tough, 2002). One important barrier that has prevented individuals with MR from fully realizing their sexual rights is the negative perceptions that others have toward these individuals. Researchers have shown that displays of affection and sexual behaviors shown by individuals with MR are seen as less acceptable than the same behaviors shown by persons without disabilities (Scotti et al., 1998). Attitudes of parents and other cares are clearly central to the type of information made available to individuals with MR (Cuskelly and Gilmore, 2007).

Negative views regarding sexuality are particularly detrimental as they serve as primary supports. It is not uncommon for staff or family to deny that sexuality exits, believing instead that an adult with MR is like an innocent child (Kempton and Kahn, 1991; McCabe and Cummins, 1996). An important indicator of the inclusiveness of a community, therefore, is parents and staff attitudes towards the sexual rights of adults with MR.

Heyman and Huckle (1995) found that caregivers of adults with MR feared unwanted pregnancy, inappropriate sexual behaviors, inability to comprehend or cope with sexual relationships, and inability to understand and adhere to social standards of public displays of sexual behaviors. Cuskelly and Bryde (2004) compared the attitudes of parents of an adult with MR, support working adult staff with MR, and a general community sample. Both age and education have been found to be correlated with attitudes to sexual expression of typically developing individuals, with younger and better educated individuals having more liberal attitudes than those who are older and less educated. Similar associations have been found between age and educational level and attitudes to the sexual behavior of individuals with MR (Cuskelly and Bryde, 2004; Murray, 1999; Oliver et al., 2002).

Cuskelly and Gilmore (2007) found that members of general community accept that individuals with MR are sexual beings, and are generally comfortable with these individuals expressing their sexuality. There were few differences in attitudes towards male and female sexuality, and attitudes were only slightly less positive for individuals with MR than for those without a disability. Views about parenting by people with MR were more cautious than for other aspects of sexuality.

Wolf and Zarfas (1982) reported that 67% of Canadian parents of children and young adults with MR favored the practice of voluntary sterilization, particularly for those with sever MR. Patterson-Keels et al. (1994) reported that 54% of parents of adolescent or adult women with MR across severity levels insisted that the possibility of pregnancy outweighed reservations about sterilization, while 15% declared that it was difficult managing menstruation.

Research has also shown that persons with MR face a disproportionately high risk for sexual abuse. Estimates of sexual abuse range from 25 to 80% for persons with MR (Stromsness, 1993) compared to 16% of men and 27% of women without disabilities (Finkler, 1994). Craft and Craft (1983) assert that sex education for adults with MR is necessary for preventing unplanned pregnancies and STDs and for fostering adherence to societal standards of behavior. Kempton (1978) found that individuals with MR that participated in a sex education program did not demonstrate adverse effects as some feared. Lumley and Scotti (2001) suggested a comprehensive approach to supporting the sexuality of adults with MR. This approach includes individualized assessment and programs, identifying the important people in life of persons with MR including family and formal care providers, and finally, the support role of agencies providing services to individuals with MR.

Chamberlain et al. (1984) conducted interviews with parents and caregivers and found that one-half of the samples of 11 to 13-year-old U.S women with mild MR attending a multiservice clinic and living in the community had engaged in consensual sexual intercourse; however the incidence was less for those with moderate (32%) and sever (9%) MR. When adjustment was made for age and race, the proportion of sexually active women with mild MR was similar to the general population. Servais et al. (2002) reported that 33, 5 and 0% of women with mild, moderate and severe MR respectively, were considered as having or to have had consensual intercourse. Gust et al. (2003) surveyed a U.S sample of 168 State residential

facility directors. Consensual sexual relations between people with MR was reported as occurring often (15%), sometimes (48%), rarely (33%), or never (4%). Diederich and Graecen (1996) surveyed caregivers and estimated that 41% of French institutionanalized adults with MR had engaged in sexual intercourse at least once.

Finally, in a retrospective study of parental attitudes towards hysterectomies from 1950 to 1973, wheeless (1975) reported that 96% of U.S parents or guardians of women with MR would elect to have the same surgical procedure performed if they had to repeat their decision. The topic of nonconsensual sterilization has been relatively unexplored in males, but a recent study reported that surgical sterilization and drugs are used to prevent reproduction and to decrease sex drive in men with MR, although the practice is not well documented (Carlson et al., 2000). Considering the numerous and contentious discussions regarding sexual rights of people with MR (Greenspan, 2002), there is surprisingly little information on the frequency and nature of sexual experiences in this group. Therefore, considering the fact that no survey study has been conducted about parents and teachers' attitudes in relation with sexual problems of persons with MR in Iran, the present study was designed to find answers to following questions:

1) What are the most important sexual problems in persons with MR from parents' perspectives?
2) What are the most important sexual problems in persons with MR from teachers' perspectives?
3) What differences are there between perspectives of parents and teachers?

METHODS

Participants

A sample of 50 teachers of students with MR and 48 parents of these students took part in the study. The sample has been selected using cluster sampling. All of respondents lived in the Babol City, a northern city of the Iran.

Instruments

To identify the perspectives of parents and teachers of students with MR, we design a questionnaire with an analytical-comparative review of literature and theoretical fundamentals. The questionnaire consisted of 32 items; responses are scored on a 5-point likert scale: "completely agree, agree no comment, disagree, and completely disagree". The instrument includes items such as: individuals with MR have less interest in sex than other individuals; it is a good idea to use drug to suppress sexual desire in individuals with MR; sex education for individuals with MR should be compulsory; individuals with MR have the right to marry.
To determine of the psychometric properties of the questionnaire, it was administered on the parents and teachers in a pilot study. Psychometrics qualities with respect to test-retest reliability, and internal consistency, face and content validity was found to be quite satisfactory (Test-retest coefficients for teachers and parents acquired respectively 0/74 and 0/88; alpha coefficient = 0.80 and /090).

RESULTS

Table 1 presents frequency and percentage of teachers' response to each of items. Furthermore, the Kolmogorov-Smirnov has been used to verify significant difference between teachers response to each item.

According to Table 1, Kolmogorov-Smirnov test results is significant for all items that shows there are significant difference between teachers' responses to each of agree-ment degrees in all items.

According to Table 2, Kolmogorov-Smirnov test results except for items 2, 9 and 20 that are not significant, it is significant for other items that indicate there is difference between responses of parents to each agreement degrees.

To investigate the differences between teachers and parents' responses, t-test was used. These results with Levin test results have been reported in Table 3. In items that Levin test was not significant, t-test results with variances were reported. Based on t test in Table 3, there is significant difference between teachers and parents' responses in items 2, 5, 7, 8, 13, 14, 21, 22, 23, 26, 27, 28, 29 and 30. But there is no significant difference in other items. Also according to Table 3, teachers agreed more with items 7, 8, 14, 21, 22, 28 and 29 than parents, and parents agreed more with items 2, 5, 23, 26, 27 and 30 than teachers. To examine the difference between perspectives of female and male teachers in response to each of the items, t-test was used (Table 4).

According to Table 4, there is significant difference between male and female responses in items 9, 16, 20, 21, 25 and 31. Also results of comparing means show that female teachers have shown more positive attitude than male teachers.

DISCUSSION

In the past, sexual health for individuals with MR largely consisted of preventing reproduction as part of eugenist-based practices designed to eliminate the perceived societal burden of these individuals and to strengthen the gene pool (Oliver and et al., 2002). Attitudes of parents and teachers or other caregivers are clearly central to the amount and type of information made available to individuals with MR. An important indicator of the inclusiveness of a community, therefore, is its attitude towards the sexual rights of adults with MR. While, there is numerous and continuous discussions about sexual rights and individuals with MR (Greenspan, 2002), small amount information about frequency and nature of sexual experiences in this group is surprising. Moreover, efforts should be directed towards best practices that facilitate the ability of self-control and self-determination in these persons.

The present study, therefore, was designed to study attitudes to sexuality in individuals with MR from the

Table 1. Frequency and percent of teachers' response to each of the items, and results of Kolmogorov-Smirnov test.

Rate agreement item	completely agree		Agree	No comment	Disagree	Completely disagree	Total	z	sig
1. Sex education for individuals with MR has a valuable role in safeguarding them from sexual abuse	Frequency	22	24	2	2	0	50	1/84	0/002
	Percent	44	48	4	4	0	100		
2. Individuals with MR have fewer sexual interests than people without MR	Frequency	0	6	1	30	13	50	2/55	0/001
	Percent	0	12	2	60	26	100		
3. Discussion on sexual problems promote promiscuity in individuals with MR	Frequency	3	13	6	26	2	50	2/30	0/001
	Percent	6	26	12	52	4	100		
4. Masturbation in private for individuals with MR is a an acceptable form of sex expression	Frequency	3	20	13	11	3	50	1/72	0/005
	Percent	6	40	26	22	6	100		
5. Masturbation for individuals with MR should be designed as an acceptable form of sex expression in sex education programs	Frequency	1	15	13	16	5	50	1/44	0/03
	Percent	2	30	26	32	10	100		
6. Masturbation should be discouraged for individuals with MR	Frequency	8	21	12	7	2	50	1/81	0/003
	Percent	16	42	24	14	4	100		
7. Individuals with MR more easily stimulated sexually than people without MR	Frequency	16	23	4	6	1	50	2/14	0/001
	Percent	32	46	8	12	2	100		
8. Individuals with MR have stronger sexual feelings than people without MR	Frequency	15	16	7	12	0	50	1/62	0/01
	Percent	30	32	14	24	0	100		
9. Medication should be used as a means of inhibiting sexual desires in individuals with MR	Frequency	7	25	3	10	5	50	2/34	0/001
	Percent	14	50	6	20	10	100		
10. It is best not to discuss issues of sexuality with individuals with MR until they reach puberty	Frequency	8	28	0	14	0	50	2/59	0/001
	Percent	16	56	0	28	0	100		
11. Sex education for individuals with MR should be compulsory	Frequency	15	17	7	10	1	50	1/71	0/006
	Percent	30	34	14	20	2	100		
12. Exercise and physical activities is a good idea to sexual discharge in individuals with MR	Frequency	22	22	3	2	1	50	1/94	0/001
	Percent	44	44	6	4	2	100		
13. Individuals with MR have the right to marry	Frequency	11	23	2	11	3	50	2/26	0/001
	Percent	22	46	4	22	6	100		
14. Individuals with MR should only be permitted to marry if either they or their partners have been sterilized	Frequency	17	17	5	10	1	50	1/79	0/003
	Percent	34	34	10	20	2	100		

Table 1. Contd.

15. Individuals with MR that their disorder is an environmental factor, have the right to marry without sterilization	Frequency	7	29	9	3	2	50	2/39	0/001
	Percent	14	58	18	6	4	100		
16. Whenever possible, individuals with MR should be involved in the decision about their being sterilized	Frequency	7	19	16	7	1	50	1/58	0/1
	Percent	14	38	32	14	2	100		
17. Genetic consulting for individuals with MR should be compulsory	Frequency	31	16	1	2	0	50	2/57	0/001
	Percent	62	32	2	4	0	100		
18. Life skills training for individuals with MR before marriage is very important	Frequency	32	14	4	0	0	50	2/78	0/001
	Percent	64	28	8	0	0	100		
19. Parents of individuals with MR should be trained to prepare their children for marriage	Frequency	28	21	0	1	1	50	2/42	0/001
	Percent	56	42				100		
20. Marriage should not be encouraged as a future option for individuals with MR	Frequency	17	17	3	10	3	50	1/92	0/001
	Percent	34	32	6	20	6	100		
21. Marriage of individuals with MR present society with too many problems	Frequency	7	16	2	20	5	50	1/96	0/001
	Percent	14	32	4	40	10	100		
22. Individuals with MR should marry with mentally retarded persons	Frequency	5	16	5	21	3	50	1/95	0/001
	Percent	10	32	10	42	6	100		
23. Individuals with MR have the right to marry with individuals without MR	Frequency	5	18	7	14	6	50	1/60	0/006
	Percent	10	36	14	28	12	100		
24. Advice on contraception should be fully available to individuals with MR	Frequency	18	27	2	2	1	50	2/23	0/001
	Percent	36	54	4	4	2	100		
25. Individuals with MR are unable to develop and maintain an intimate relationship with a partner	Frequency	2	12	8	25	3	50	2/20	0/001
	Percent	4	24	16	50	6	100		
26. Women with MR should be permitted to have children within marriage	Frequency	0	8	14	20	8	50	1/68	0/007
	Percent	0	16	28	40	16	100		
27. With the right support women with MR can rear well adjusted children	Frequency	5	24	10	9	2	50	2/07	0/001
	Percent	10	48	20	18	4	100		
28. If women with MR marry, they should be forbidden by law to have children	Frequency	9	9	7	20	5	50	1/86	0/002
	Percent	18	18	14	40	10	100		

Table 1. Contd.

29. Individuals with MR should be accessed to persistent support after marriage	Frequency	26	24	0	0	0	50	2/47	0/001
	Percent	52	48	0	0	0	100		
30. Individuals with MR are able to understand sexual needs of their partner	Frequency	3	28	6	13	0	50	2/47	0/001
	Percent	6	56	12	26	0	100		
31. Individuals with MR are able to engage in romantic feelings	Frequency	11	29	5	5	0	50	2/38	0/001
	Percent	22	58	10	10	0	100		

Table 2. Frequency and percent of parents' response to each of the items, and results of Kolmogorov-Smirnov test.

Rate agreement item	Completely agree		Agree	No comment	Disagree	Completely disagree	Total	z	Sign
1. Sex education for individuals with MR has a valuable role in safeguarding them from sexual abuse	Frequency	27	13	4	3	1	48	2/22	0/001
	Percent	56/3	27/1	8/3	6/3	2/1	100		
2. Individuals with MR have fewer sexual interests than people without MR	Frequency	3	4	12	14	5	48	1/30	0/07
	Percent	6/3	29/2	25	29/2	10/4	100		
3. Discussion on sexual problems promote promiscuity in individuals with MR	Frequency	2	12	5	23	6	48	2/14	0/001
	Percent	4/2	25	10/4	47/9	12/5	100		
4. Masturbation in private for individuals with MR is a an acceptable form of sex expression	Frequency	5	7	20	9	7	48	1/45	0/03
	Percent	10/4	14/6	41/7	18/8	14/6	100		
5. Masturbation for individuals with MR should be designed as an acceptable form of sex expression in sex education programs	Frequency	8	17	10	9	4	48	1/59	0/01
	Percent	16/7	35/4	20/8	18/8	8/3	100		
6. Masturbation should be discouraged for individuals with MR	Frequency	9	10	17	9	2	48	1/49	0/01
	Percent	18/8	20/8	37/5	18/8	4/2	100		
7. Individuals with MR more easily stimulated sexually than people without MR	Frequency	0	16	21	7	4	48	1/18	0/003
	Percent	0	33/3	43/8	14/6	8/3	100		
8. individuals with MR have stronger sexual feelings than people without MR	Frequency	2	8	23	14	1	48	1/75	0/004
	Percent	4/2	16/7	47/9	29/2	2/1	100		
9. Medication should be used as a means of inhibiting sexual desires in individuals with MR	Frequency	5	12	13	13	5	48	1/19	0/01
	Percent	10/4	25	27/1	27/1	10/5	100		

Table 2. Contd.

10. It is best not to discuss issues of sexuality with individuals with MR until they reach puberty	Frequency	19	16	5	6	2	48	1/78	0/003
	Percent	39/6	33/3	10/4	12/5	4/2	100		
11. Sex education for individuals with MR should be compulsory	Frequency	17	15	9	2	5	48	1/65	0/009
	Percent	35/4	31/3	18/8	4/2	10/4	100		
12. Exercise and physical activities is a good idea to sexual discharge in individuals with MR	Frequency	19	21	4	1	3	48	2/09	0/001
	Percent	39/6	43/8	8/3	2/1	6/3	100		
13. Individuals with MR have the right to marry	Frequency	28	10	3	3	4	48	2/28	0/001
	Percent	58/3	20/8	6/3	6/3	8/3	100		
14. Individuals with MR should only be permitted to marry if either they or their partners have been sterilized	Frequency	1	6	20	12	9	48	1/65	0/009
	Percent	2/1	12/5	41/7	25	18/8	100		
15. Individuals with MR that their disorder is an environmental factor, have the right to marry without sterilization	Frequency	8	16	15	6	3	48	1/39	0/04
	Percent	16/7	33/3	31/3	12/5	6/3	100		
16. Whenever possible, individuals with MR should be involved in the decision about their being sterilized	Frequency	7	15	19	3	4	48	1/52	0/02
	Percent	14/6	31/3	39/6	6/3	8/3	100		
17. Genetic consulting for individuals with MR should be compulsory	Frequency	29	11	6	0	2	48	2/39	0/001
	Percent	60/4	22/9	12/5	0	4/2	100		
18. Life skills training for individuals with MR before marriage is very important	Frequency	31	14	1	0	2	48	2/47	0/001
	Percent	64/6	29/2	2/1	0	4/2	100		
19. Parents of individuals with MR should be trained to prepare their children for marriage	Frequency	24	21	2	1	0	48	2/11	0/001
	Percent	50	43/8	4/2	2/1	0	100		
20. Marriage should not be encouraged as a future option for individuals with MR	Frequency	12	12	9	11	4	48	1/31	0/07
	Percent	25	25	18/8	29/2	8/3	100		
21. Marriage of individuals with MR present society with too many problems	Frequency	5	4	8	19	12	48	1/87	0/002
	Percent	10/4	8/3	16/7	39/6	25	100		
22. Individuals with MR should marry with mentally retarded persons	Frequency	2	5	13	19	9	48	1/65	0/009
	Percent	4/2	10/4	27/1	39/6	18/8	100		
23. Individuals with MR have the right to marry with individuals without MR	Frequency	15	18	12	3	0	48	1/49	0/02
	Percent	4/2	10/4	27/1	39/6	18/8	100		

Table 2. Contd.

24. Advice on contraception should be fully available to individuals with MR	Frequency	16	16	11	5	0	48	1/44	0/03
	Percent	33/3	33/3	22/9	10/4	0	100		
25. Individuals with MR are unable to develop and maintain an intimate relationship with a partner	Frequency	7	3	15	20	3	48	1/67	0/008
	Percent	14/6	6/3	31/3	41/7	6/3	100		
26. Women with MR should be permitted to have children within marriage	Frequency	9	17	18	2	2	48	1/37	0/05
	Percent	18/8	35/4	37/5	4/2	4/2	100		
27. With the right support women with MR can rear well adjusted children	Frequency	18	20	5	2	1	48	1/93	0/001
	Percent	37/5	41/7	10/4	4/2	2/1	100		
28. If women with MR marry, they should be forbidden by law to have children	Frequency	5	4	7	16	16	48	1/77	0/004
	Percent	10/4	8/3	14/6	33/3	33/3	100		
29. Individuals with MR should be accessed to persistent support after marriage	Frequency	18	20	5	2	3	48	2/02	0/001
	Percent	37/5	41/7	10/4	4/1	6/3	100		
30. Individuals with MR are able to understand sexual needs of their partner	Frequency	9	29	9	3	2	48	2/16	0/001
	Percent	18/8	54/2	18/8	6/3	2/1	100		
31. Individuals with MR are able to engage in romantic feelings	Frequency	18	21	8	1	0	48	1/61	0/01
	Percent	37/5	43/8	16/7	2/1	0	100		

perspectives of their parents and teachers. In this group, with analytical-comparative overview of literature and theoretical fundamentals, we design a questionnaire.

After pilot study and obtaining psychometric qualities, the questionnaire was given to subjects. Finally, the analysis of data revealed following results:

1. 92% of teachers and 83% of parents emphasized on the role of sex education in safeguarding persons with MR from sexual exploitation.
2. More than 60% of parents and teachers disagreed with the idea that discussing about sexual problems will increase promiscuity in individuals with MR.
3. Only about half of parents and teachers disagreed with masturbation in individuals with MR. Moreover, about 50% of partners and teachers agreed that medication should be used as a means of inhibiting sexual desires in individuals with MR.
4. 64% of teachers and more than 66% of parents agreed that sex education for individuals with MR should be compulsory. This finding considers the more delay of education system in providing sex education to persons with MR irrational.
5. More than 80% of parents and teachers believed that exercise and physical activities would be helpful in sexual discharge in individuals with MR. Thus, educational and rehabilitation authorities must allocate more weight to sport hours in curriculum planning for individuals with MR.
6. 68% of teachers and more than 78% of parents believed that individuals with MR have the right to marry. Therefore they cannot be deprived from their natural right. Another interesting point is that most of the parents and teachers believed that when the cause of mental retardation disorder is not genetic, the person with MR passing through the necessary educations (such as life skills) and without sterilization can marry.
7. 94% of teachers and more than 82% of parents believed that genetically consulting before marriage should be compulsory for individuals with MR.
8. More than 90% of parents and teachers emphasized that life skills training for individuals with MR before marriage is very important. Moreover, designing training programs for parent of these individuals is very important.

Table 3. Means, S.D., Levin test and t test for comparing perspectives of parents and teachers.

Item	F Levin test	Sig	Group	N	Mean	S.D	Standard error of mean	t	df	Sig
1	3/51	0/06	Teacher Parents	50 48	3/32 3/29	0/74 1/01	0/11 0/15	0/16	96/00	0/87
2	9/53	0/00	Teacher Parents	50 48	1/00 1/92	0/88 1/13	0/13 0/16	-4/48	88/95	0/00
3	0/07	0/80	Teacher Parents	50 48	1/78 1/60	1/08 1/13	0/15 0/16	0/79	96/00	0/43
4	0/00	1/00	Teacher Parents	50 48	2/18 1/88	1/04 1/16	0/15 0/17	1/37	96/00	0/17
5	1/43	0/24	Teacher Parents	50 48	1/82 2/33	1/04 1/21	0/15 0/17	-2/25	96/00	0/03
6	0/13	0/72	Teacher Parents	50 48	2/52 2/31	1/05 1/11	0/15 0/16	0/95	96/00	0/35
7	0/35	0/56	Teacher Parents	50 48	2/94 2/02	1/04 0/91	0/15 0/13	4/65	96/00	0/00
8	11/17	0/00	Teacher Parents	50 48	2/68 1/92	1/15 0/85	0/16 0/12	3/75	89/99	0/00
9	1/00	0/32	Teacher Parents	50 48	2/38 1/98	1/24 1/18	0/18 0/17	1/64	96/00	0/10
10	0/02	0/90	Teacher Parents	50 48	2/60 2/92	1/07 1/18	0/15 0/17	-1/39	96/00	0/17
11	0/05	0/83	Teacher Parents	50 48	2/70 2/77	1/17 1/28	0/17 0/18	-0/29	96/00	0/77
12	0/17	0/68	Teacher Parents	50 48	3/24 3/08	0/89 1/07	0/13 0/15	0/79	96/00	0/43
13	0/08	0/78	Teacher Parents	50 48	2/56 3/15	1/23 1/29	0/17 0/19	-2/30	96/00	0/02
14	1/17	0/28	Teacher Parents	50 48	2/78 1/54	1/18 1/01	0/17 0/15	5/56	96/00	0/00
15	3/55	0/06	Teacher Parents	50 48	2/72 2/42	0/93 1/11	0/13 0/16	1/47	96/00	0/14
16	0/14	0/71	Teacher Parents	50 48	2/48 2/38	0/97 1/08	0/14 0/16	0/50	96/00	0/61
17	3/04	0/08	Teacher Parents	50 48	3/52 3/35	0/74 1/00	0/10 0/14	0/94	96/00	0/35

Table 3. Contd.

18	0/72	0/40	Teacher Parents	50 48	3/56 3/50	0/64 0/90	0/09 0/13	0/38	96/00	0/70
19	0/53	0/47	Teacher Parents	50 48	3/52 3/42	0/61 0/68	0/09 0/10	0/79	96/00	0/43
20	0/19	0/66	Teacher Parents	50 48	2/70 2/35	1/30 1/31	0/18 0/19	1/31	96/00	0/19
21	2/30	0/13	Teacher Parents	50 48	2/00 1/40	1/31 1/25	0/19 0/18	2/33	96/00	0/02
22	3/26	0/07	Teacher Parents	50 48	1/98 1/42	1/19 1/05	0/17 0/15	2/49	95/36	0/01
23	10/24	0/00	Teacher Parents	50 48	2/04 2/94	1/25 0/91	0/18 0/13	-4/09	89/69	0/00
24	3/27	0/07	Teacher Parents	50 48	3/18 2/90	0/85 0/99	0/12 0/14	1/52	92/42	0/13
25	0/00	1/00	Teacher Parents	50 48	1/70 1/81	1/04 1/14	0/15 0/17	-0/51	96/00	0/61
26	0/01	0/93	Teacher Parents	50 48	1/44 2/60	0/95 0/98	0/13 0/14	-5/96	96/00	0/00
27	3/37	0/07	Teacher Parents	50 48	2/42 3/13	1/03 0/91	0/15 0/13	-3/58	95/39	0/00
28	0/36	0/55	Teacher Parents	50 48	1/94 1/29	1/32 1/30	0/19 0/19	2/45	96/00	0/02
29	4/77	0/03	Teacher Parents	50 48	3/52 3/00	0/51 1/11	0/07 0/16	2/96	65/02	0/00
30	3/28	0/07	Teacher Parents	50 48	2/42 2/81	0/95 0/89	0/13 0/13	-2/11	95/95	0/04
31	0/26	0/61	Teacher Parents	50 48	2/92 3/17	0/85 0/78	0/12 0/11	-1/49	96/00	0/14

It is noteworthy that life skills education can be entered in formal curriculum for individuals with MR. Moreover, educating parents should be considered in various workshops.

8. The need for individuals with MR to be supported after marriage, with emphasis on the ability of these persons to understand the sexual needs and lovely feelings of marriage, and so on, were other points that parents and teachers agreed and emphasized on.

Examining the difference between parents and teachers perspectives in response to each of the questionnaire items are reported in the study's results. The results have shown that two groups emphasized on the aforementioned strategies. Also, comparison between women and men teachers' responses has shown that female teachers have shown more positive attitudes than male teachers generally.

Some of the most important results of this study such

Table 4. t-test results for examining the difference between perspectives of females and male teachers.

Item	F Levin test	Sig	Group	N	Mean	S.D.	Standard error of mean	t	df	Sig
1	1/02	0/32	Male teachers Female teachers	23 27	3/30 3/33	0/88 0/62	0/18 0/12	-0/14	48	0/89
2	0/27	0/60	Male teachers Female teachers	23 27	0/87 1/11	0/81 0/93	0/17 0/18	-0/97	48	0/34
3	3/42	0/07	Male teachers Female teachers	23 27	1/65 1/89	0/93 1/19	0/19 0/23	-0/77	48	0/44
4	3/16	0/08	Male teachers Female teachers	23 27	2/04 2/30	1/22 0/87	0/26 0/17	-0/85	48	0/40
5	0/06	0/80	Male teachers Female teachers	23 27	1/78 1/85	1/04 1/06	0/22 0/20	-0/23	48	0/82
6	3/06	0/09	Male teachers Female teachers	23 27	2/70 2/37	0/88 1/18	0/18 0/23	1/09	48	0/28
7	2/94	0/09	Male teachers Female teachers	23 27	3/22 2/70	0/85 1/14	0/18 0/22	1/78	48	0/08
8	3/97	0/05	Male teachers Female teachers	23 27	2/52 2/81	1/27 1/04	0/20	-0/88	42	0/38
9	29/66	0/00	Male teachers Female teachers	23 27	1/91 2/78	1/50 0/80	0/15	-2/47	32	0/02
10	0/86	0/36	Male teachers Female teachers	23 27	2/57 2/63	0/99 1/15	0/21	-0/21	48	0/83
11	0/00	0/97	Male teachers Female teachers	23 27	2/78 2/63	1/17 1/18	0/24	0/46	48	0/65
12	3/94	0/05	Male teachers Female teachers	23 27	3/04 3/41	1/15 0/57	0/24 0/11	-1/38	31	0/18
13	7/79	0/01	Male teachers Female teachers	23 27	2/78 2/37	1/00 1/39	0/21 0/27	1/22	47	0/23
14	0/92	0/34	Male teachers Female teachers	23 27	2/52 3/00	1/20 1/14	0/25 0/22	-1/44	48	0/16
15	6/46	0/01	Male teachers Female teachers	23 27	2/87 2/59	0/63 1/12	0/13 0/22	1/10	42	0/28
16	0/12	0/73	Male teachers Female teachers	23 27	2/17 2/74	0/89 0/98	0/18 0/19	-2/12	48	0/04
17	3/09	0/09	Male teachers Female teachers	23 27	3/35 3/67	0/88 0/55	0/18 0/11	-1/55	48	0/13

Table 4. Contd.

18	1/08	0/30	Male teachers Female teachers	23 27	3/43 3/67	0/66 0/62	0/14 0/12	-1/28	48	0/21
19	1/44	0/24	Male teachers Female teachers	23 27	3/48 3/56	0/73 0/51	0/15 0/10	-0/44	48	0/66
20	16/15	0/00	Male teachers Female teachers	23 27	2/26 3/07	1/48 1/00	0/31 0/19	-2/23	37	0/03
21	0/30	0/59	Male teachers Female teachers	23 27	1/26 2/63	1/14 1/11	0/24 0/21	-4/29	48	0/00
22	0/51	0/48	Male teachers Female teachers	23 27	1/83 2/11	1/27 1/12	0/26 0/22	-0/84	48	0/40
23	0/88	0/35	Male teachers Female teachers	23 27	2/13 1/96	1/14 1/34	0/24 0/26	0/47	48	0/64
24	0/25	0/62	Male teachers Female teachers	23 27	3/09 3/26	1/00 0/71	0/21 0/14	-0/71	48	0/48
25	0/10	0/75	Male teachers Female teachers	23 27	1/30 2/04	0/97 0/98	0/20 0/19	-2/64	48	0/01
26	0/24	0/63	Male teachers Female teachers	23 27	1/48 1/41	0/99 0/93	0/21 0/18	0/26	48	0/80
27	0/56	0/46	Male teachers Female teachers	23 27	2/57 2/30	0/95 1/10	0/20 0/21	0/92	48	0/36
28	0/01	0/92	Male teachers Female teachers	23 27	1/57 2/26	1/31 1/26	0/27 0/24	-1/91	48	0/06
29	0/00	0/96	Male teachers Female teachers	23 27	3/52 3/52	0/51 0/51	0/11 0/10	0/02	48	0/98
30	0/12	0/73	Male teachers Female teachers	23 27	2/43 2/41	0/99 0/93	0/21 0/18	0/10	48	0/92
31	0/16	0/70	Male teachers Female teachers	23 27	3/22 2/67	0/74 0/88	0/15 0/17	2/38	48	0/02

as emphasis on sex education, sexual discharge through sport and other physical activities in adolescence, emphasis on genetic consulting before marriage, emphasis on life skills training, emphasis on ability of persons with MR in understand sexual needs and lovely feelings, and understanding of relations with confidants and strangers are consistent with research results (Cuskely and Bryde, 2004; Oliver et al., 2002; Chamberlain et al., 1984; Cuskely and Gilmore, 2007; Servise et al., 2002; Craft and Craft, 1983; Kempton, 1978; Lumley and Scotti, 2001). With respect to the negative stereotypes and prejudices about sexual issues and problems in individuals with MR and suppression of the sexual desires in them by their parents and teachers, therefore, the following suggestions are offered, based on the obtained findings in this study:

1. Sex education should be entered in formal and

informal curriculum of individuals with MR.
2. Life skills education should be entered in educational programs as one of the mean topics of lessons for individuals with MR.
3. With free genetically consulting, genetic information identity is prepared for individuals with MR.
4. Parents of individuals with MR are trained about sexual needs of individuals with MR.
5. Continues, long term person-centered planning and support is designed.
6. It is possible that the attitudes of parents and teachers may differ depending upon the level of disability, however further investigation is needed to verify this subject.
7. There is a need to move beyond descriptive research and use experimental designs to exchanges of parents and teachers attitudes.
8. As a result, a great deal of research is needed to (i) provide a more comprehensive picture of parents and other caregivers attitudes about sexual needs in individuals with MR, (ii) develop effective evidence-based practices designed to facilitate individual self-control over sexual intercourse.

REFERENCES

Antonak RF, Fiedler CR, Mulick JA (1989). Misconceptions relating to mental retardation, Ment. Retard., 27: 91-97.

Bambarea LM, Brantlinger E (2002). Toward a healthy sexual life: An introduction to the special series on issues of sexuality for people with developmental disabilities, Sever. Disabil., 27: 5-7.

Blatt B (1987). The conquest of mental retardation. Austin TX Pro-Ed.

Carlson G, Taylor M, Wilson J (2000). Sterilization, drugs which suppress sexual drive, and young men who have intellectual disability, J. Intellect. Disabil. Res., 25: 91-104.

Chamberlain A, Rauh J, Passer A, McGrath M, Burket R (1984). Issues in fertility for mentally retarded female adolescents: Sexual activity, sexual abuse, and contraception, Pediatrics, 73: 445-450.

Craft A, Craft M (1983). Sex education and counseling for mentally handicapped people, Tunbridge Wells. UK: Costello. p. 68.

Cuskelly M, Bryde R (2004). Attitudes towards the sexuality of adults with an intellectual disability: Parents, support staff, and a community sample, J. Intellect. Dev. Disabil., 29: 255-264.

Cuskelly M, Gilmore l (2007). Attitudes to sexuality questionnaire (individuals with an intellectual disability): scale development and community norms, J. Intellect. Dev. Disabil., 32(3): 214-221.

Davis SP (1959). The Mentally retarded in society. New York: Columbia University Press. p. 43.

DeLoach CXP (1994). Attitudes toward disability: Impact on sexual development and forging of intimate relationships, J. Appl. Rehabil. Consult., 25: 18-25.

Finkler D (1994). The international epidemiology of child sexual abuse, Child Abuse Negl., 18: 409-417.

Greenspan S (2002). A sex police for adults with mental retardation? Comment on Spiecker and Steute, J. Moral Educ., 3: 171-179.

Gust DA, Wang SA, Grot J, Ransom R, Levine WC, Scotti J (2003). National survey of sexual behavior and sexual behavior policies in facilities for individuals with mental retardation/developmental disabilities. Ment. Retard., 5: 365-373.

Hergenhah BR (1997). An introduction to the history of psychology (3rd Ed.). Pacific Grove, CA: Brooks/Cole. p. 65.

Heyman B, Huckle S (1995). Sexuality as a perceived hazard in the lives of adults with learning difficulties, Disabil. Soc., 10: 139-155.

Hinsburger D, Tough S (2002). Healthy sexuality: Attitudes, systems, and policies, Res. Pract. Persons Sev. Disabil., 27: 8-17.

Kempton W (1978). Sex education for the mentally handicapped, Sex. Disabil., 1: 137-145.

Kempton W, Kahn E (1991). Sexuality and people with intellectual disabilities: A historical perspective, Sex. Disabil., 9: 93-111.

Luckasson R, Borthwick-Duffy S, Buntinx WHE, Coulter DL, Craig EM, Reeve A, Schalock RL, Snell ME, Spitalnick D, Spreat S, Tasse M (2002). Mental retardation: Definition, classification, and systems of supports (10th Ed.).Washington DC: American Association on Mental Retardation. pp. 5-19.

Lumley VA, Scotti, JR (2001). Supporting the sexuality of adults with mental retardation: current status and future directions. J. Posit. Behav. Interv., 3(2): 109-119.

McCabe MP, Cummins RA (1996). The sexual knowledge, experience, feelings, and needs of people with mold intellectual disability, Educ. Training Ment. Retard. Dev. Disabil., 31: 13-22.

Morgenstern (1973). The psychosexual development of the retarded. In .F. de Ia Cruz, & G.D.LVeck (Eds.). Human sexuality and the mentally retarded Oxford: Brunner/Mazel. pp.15-28.

Murray JL, MacDonald RA, Levenson VL (1999). Staff attitudes towards the sexuality of individuals with learning disabilities: A service- related study of organizational policies. Br. J. Learn. Disabil., 27: 141-145.

Oliver MN, Anthony A, Leimkuhl TT, Skillman D (2002). Attitudes toward acceptable socio-sexual behaviors for persons with mental retardation: Implications for normalization and community integration. Educ. Training Ment. Retard. Dev. Disabil., 37: 193-201.

Patterson-Keels L, Quint E, Brown D, Larson D, Elkins TE (1994). Family views on sterilization for their mentally retarded children. J. Reprod. Med., 39: 701-706.

Scotti JR, Slack BS, Bowman RA, Morris TL (1996). College student attitudes concerning the sexuality of persons with mental retardation: Development of the perceptions of sexuality scale, Sex. Disabil., 14: 249-263.

Servise L (2006). Sexual health care in persons with intellectual disabilities. Ment. Retard. Dev. Disabil., 12: 48-56.

Servise L, Jacques D, Leach R (2002). Contraception of women with intellectual disabilities: Prevalence and determinants, J. Intellect. Disabil., 108-119.

Stromsness MM (1993). Sexuality abused women with mental retardation: hidden victims, absent resources, Women Ther., 14: 139-152.

Wheeless CR (1975). Abdominal hysterectomy for surgical sterilization in the mentally retarded: A review of parental opinion. Am. J. Obstet. Gynecol., 122: 872-876.

Wolf L, Zarfas DE (1982). Parents attitudes toward sterilization of their mentally retarded children, Am. J. Ment. Defic., 87: 122-129.

Wolman, B (1990). Handbook of treatment of Mental Disorders in Childhood and Adolescence. N.j, Prentice Hall Inc, New York.