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Parent-Implemented Sexuality and Relationship Training for Individuals with IDD: A Systematic Review

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Abstract

While sexuality and relationship education (SRE) remains limited for many individuals with intellectual and developmental disabilities (IDD), parents and caregivers have significant concerns about how to address sexual health, relationships, consent, and other safety-related topics. SRE is important for all individuals but may be of heightened importance for people with IDD due to increased vulnerability to abuse, limited access to school-based instruction, and social and communication support needs. Parent-implemented training can address knowledge and skill gaps that may leave individuals with IDD both unserved and unprotected. The authors conducted systematic searches of electronic databases and forward and ancestral searches to find available research on trainings that address SRE for parents and caregivers of individuals with IDD. The review summarized twenty-one articles that met the inclusion criteria. The included studies examined researcher-developed interventions and one commercially available program across three delivery formats: in person, via telehealth, and self-paced. Training topics included sexual abuse prevention, anatomy, puberty, hygiene, sexual health, and relationships, with some studies including consent, internet safety, masturbation, LGBTQIA+ identities, and disability rights. Outcomes were generally positive, and many studies reported increases in parent knowledge, awareness, attitudes, comfort, confidence, and self-efficacy. The discussion addresses limitations of the current research and presents recommendations for future research.

Introduction

Historically, social institutions in the United States, particularly the education system, have marginalized people with disabilities (U.S. Department of Education, 2024). Children and adolescents with disabilities were not guaranteed access to education until as recent as 1975, when The Education for All Handicapped Children Act was signed into federal law in the United States (U.S. Department of Education, n.d.). While progress has been made toward guaranteeing students with disabilities access to a free and appropriate public education (FAPE; U.S. Department of Education, Office for Civil Rights [OCR], 2025), these students continue to be excluded from instruction related to sexuality and relationship education (SRE; Andreassen, 2024). The World Health Organization (WHO) postulates that comprehensive sexuality education is critical to the health and survival of young people with and without disabilities (World Health Organization, n.d.). This SRE instruction should include: “families and relationships; respect, consent, bodily autonomy; anatomy, puberty and menstruation; contraception and pregnancy; and sexually transmitted infections, including HIV” (World Health Organization, n.d.).

Individuals with IDD face systemic inequities, including not receiving the same access to SRE as their nondisabled peers (Andreassen, 2024). IDD is an umbrella term that can include genetic syndromes with cooccurring intellectual disability alongside autism with and without intellectual disability. The DSM-5 defines autism as a diagnosis characterized by “persistent deficits in social communication and social interaction across multiple contexts” (American Psychiatric Association [APA], 2022). The DSM-5 defines intellectual disability as “neurodevelopmental disorders that begin in childhood and are characterized by intellectual difficulties as well as difficulties in conceptual, social, and practical areas of living” (APA, 2022). As of 2021, 8.56% of children aged 3–17 had a diagnosed developmental disability, including 1.65% with an intellectual disability and 3.05% with autism (Zablotsky et al., 2023). During the 2020–2021 school year, 464,000 students with disabilities between the ages of 14 and 21 exited the public education system (National Center for Education Statistics, 2024).

As students with disabilities transition into adulthood, the need for ongoing SRE becomes increasingly urgent. After exiting the public-school system, students may lose access to school-based instruction and services. Without explicit SRE, individuals with IDD may experience heightened risk for sexual exploitation, unhealthy relationships, difficulty identifying and reporting abuse, and criminalization for sexual behaviors they were never taught to understand or manage appropriately (Andreassen, 2024; Crowe & Drew, 2021). The overrepresentation of disabled individuals in the prison system further heightens these concerns. In 2016, nearly one quarter of incarcerated individuals (24%) reported having participated in special education classes (Maruschak et al., 2021). Additionally, 38% of state and federal incarcerated individuals reported having at least one disability, which is more than two times higher than that of the general adult population. Cognitive disability was the most commonly reported disability among incarcerated individuals, at 23% (Maruschak et al., 2021). Historical exclusion, ableism, and infantilizing, including the commonly held and incorrect belief that people with IDD are asexual or hypersexual, have contributed and continue to contribute to restricted SRE instruction for individuals with IDD (Weber & Kaufman, 2021).

Education is a human right, and SRE is not an exception (Saxe & Flanagan, 2014). However, there is a substantial gap in access to SRE among people with moderate to profound intellectual disabilities, with one study finding that only 16.18% of US-educated students with ID receive SRE (Barnard-Brak et al., 2015). McAndrews (2023) reported that only Oregon, Washington, and California explicitly require sexuality education to be accessible to students with disabilities. Individuals with disabilities have the right to understand their bodies, relationships, consent, safety, and boundaries (United Nations, 2006). The lack of explicit instruction in these areas increases vulnerability for individuals with IDD as they are not learning to recognize inappropriate behavior or disclose abuse. Individuals with IDD are seven times more likely to experience sexual abuse, yet these crimes often do not result in prosecution (Shapiro, 2018). A study in Norway found that only 30% of reported assaults from women with intellectual and/or physical disabilities led to prosecution (Åker & Johnson, 2020). Access to SRE for people with IDD can lead to increased bodily autonomy, healthy relationships, improved communication surrounding SRE topics, improved health outcomes, safety, and awareness of boundaries (Weber & Kaufman, 2021). SRE is health education, but it also plays a critical role in abuse prevention and safety for individuals with IDD.

Young adults commonly obtain information about sexuality and relationships from family members, peers, schools, healthcare providers, and internet or media sources (Silva et al., 2024). People with intellectual disability face barriers to obtaining information from each of these sources. Informal learning from peers is another limitation because young people with IDD report smaller social networks and fewer formal and informal sources of sexual information than their peers without disabilities (Jahoda & Pownall, 2014). This may reduce opportunities to ask questions and learn about social expectations related to SRE through everyday interactions. Information shared by peers or encountered through media may also be incomplete or inaccurate (Silva et al., 2024). Internet access presents additional concerns because finding information does not ensure that it is reliable. People with IDD may need support to evaluate the credibility of online information and apply it to their own lives, and accessible online resources remain particularly limited for sexual health and mental health topics (Keeley et al., 2026).

Healthcare providers can serve as an important source of SRE; however, they do not always provide this information routinely or comprehensively. Providers report difficulty adapting information to an individual's level of understanding, as well as limited training, accessible resources, and appropriate referral options (Schmidt et al., 2022). Additional barriers include difficulties communicating directly with patients with ID, insufficient institutional support, and discomfort or stigma surrounding sexuality (Kurt et al., 2024). Research on reproductive healthcare has also found that physicians may communicate primarily with caregivers or assume that women with ID are not sexually active, which can limit direct and appropriate sexual-health discussions (Agaronnik et al., 2020).

School-based SRE presents another set of barriers. While school is a common source for students without disabilities, children and adolescents with IDD may have less access to comprehensive and appropriately adapted school-based SRE. Research indicates that students with intellectual disability remain less likely to receive SRE, few curricula accommodate their specific learning needs, and inaccessible resources and the omission of SRE content can create additional barriers to receiving accurate information (Brown et al., 2024; Paulauskaite et al., 2022). When students with IDD receive SRE, teachers' assumptions about their sexuality and capacity to understand the material may limit their access to essential topics (Barnard-Brak et al., 2015; Strnadová et al., 2019). Educators also report inadequate training opportunities, limited knowledge, negative perceptions, and low confidence in teaching SRE to students with disabilities (de Reus et al., 2015; Strnadová et al., 2021).

Differences in state laws and school policies further compound these barriers for students with IDD. Although 41 states and the District of Columbia (DC) require SRE, HIV education, or both, only 26 states require instruction to be medically accurate (Guttmacher Institute, 2025). State requirements also differ significantly regarding curriculum content, inclusivity, parent involvement, and discussions of sexual orientation and gender identity (Guttmacher Institute, 2025). Legislative efforts in 12 states have further restricted comprehensive SRE by specifically prohibiting or limiting instruction related to sexual orientation and gender identity and by narrowing permissible curricular content in K–12 schools (Movement Advancement Project, 2026).

Florida provides a clear example of how these policies can restrict both LGBTQIA+ content and reproductive health instruction. For example, Florida's *Parental Rights in Education Act* (HB 1557) limits classroom instruction on sexual orientation and gender

identity in kindergarten through third grade and other states have since adopted similar curricular restrictions (Florida Legislature, 2022). Additionally, Florida enacted HB 1069 in 2023, which expanded the prohibition on instruction related to sexual orientation and gender identity to prekindergarten through eighth grade and required this instruction in grades 9 through 12 to be age- and developmentally appropriate. HB 1069 also required state approval of materials used for reproductive health instruction and mandated that instruction involving human sexuality characterize reproductive roles as binary, stable, and unchangeable, promote abstinence from sexual activity outside marriage, and teach the benefits of monogamous heterosexual marriage (Florida Legislature, 2023). An earlier version of Florida's HB 1069, referred to by critics as the "Don't Say Period" bill, proposed limiting instruction containing human sexuality to grades 6 through 12; however, lawmakers removed this explicit grade-level restriction before passing the legislation (H.B. 1069, 2023; Heubeck, 2023). Consequently, the need to equip parents with the knowledge and confidence to provide high-quality SRE becomes even more important.

SRE is a continuous process across the lifespan and includes varied social experiences and multiple contexts, which is why parents play a foundational role in providing SRE to their children (Andiana & Slameto, 2024). Parents and other family members play a particularly important role in the lives of individuals with IDD because most continue to live with family well into adulthood. The Arc's Family and Individual Needs for Disability Supports Community Report revealed that 80% of individuals with IDD live with a family member (The Arc of the United States, 2018).

Parents and caregivers also see their children across different social contexts that professionals do not, including friendships, dating experiences, online interactions, and community participation. These contexts and lifelong relationships uniquely position parents and caregivers to provide ongoing real-world SRE guidance beyond intermittent instruction provided by professionals. Parents can respond "in the moment" to provide contextually specific answers to questions, coaching, reinforcement for appropriate behavior, and redirection and instruction for inappropriate behavior.

Despite the importance of this role, many parents do not feel equipped to provide SRE. Parents report often ignoring and avoiding discussion of SRE topics with their children due to a lack of confidence in providing quality SRE (Yurdakul & Kublay, 2025). These needs may also persist as individuals with IDD move into adulthood. Smith Hill et al. (2025) found that parents of emerging adults with intellectual disability continued to report gaps in their knowledge and comfort related to SRE, particularly for topics they perceived as more sensitive or complex. Many parents also expressed interest in additional SRE training. In addition to having limited guidance on SRE content and instruction, parents often report feelings of discomfort or anxiety surrounding what and how to teach SRE topics to their children (Strnadová et al., 2021). This disconnect between the important role parents play as SRE educators and their reported lack of support, confidence, and comfort highlights the need for parent-focused SRE training.

The screening process conducted by the first and second authors identified six previous literature reviews. Each review differed from the present review in at least one key aspect, including methodology (n = 2), population (n = 6), or measured outcomes (n = 5). The reviews focused on distinct characteristics of SRE including identifying educational interventions for individuals with ID (André et al., 2024; Hui, 2024; Schaafsma 2015), communication on sexuality between parents and adolescents with autism (André et al., 2020), views and experiences of families and direct care staff on the sexuality of adults with ID (Brown & McCann, 2019), and SRE outcomes for students with ID (Paulauskaite et al., 2022). These past reviews have strictly focused on either autism (André et al., 2020) or ID (Andre et al., 2024; Brown & McCann, 2019; Hui, 2024; Paulauskaite et al., 2022; Schaafsma et al., 2015) and have not considered both. Futhermore, only one review included parent-focused SRE interventions (André et al., 2024), but the remaining reviews did not examine research-led parent training interventions. Andre et al. (2024) conducted an integrative literature review, Brown and McCann (2019) conducted a narrative literature review, and the remaining studies conducted systematic literature reviews (André et al., 2020; Hui, 2024; Paulauskaite et al., 2022; Schaafsma et al., 2015). However, none of the systematic reviews specifically examined researcher-led parent SRE training interventions. Andre et al. (2024) reviewed SRE intervention for parents of individuals with ID but limited the search to studies conducted within the last ten years (Andre et al., 2024). This narrower search window excluded earlier parent training studies identified in the present review. Across these reviews, no studies aimed to identify researcher-led parent SRE trainings for parents of individuals with IDD across the lifespan.

The purpose of the present study was to systematically review previous studies that implemented researcher-led parent SRE trainings designed for parents of individuals with IDD. By reviewing the trainings available, this study identified what trainings already exist and their effectiveness. We described key characteristics of the trainings across studies, including participant demographics, dosage and duration of trainings, topics covered, training delivery method, outcomes, and how researchers measured outcomes. This review addressed a critical gap in literature by examining how to prepare parents and caregivers to deliver SRE when education systems provide limited or no instruction to individuals with IDD.

Method

The first author conducted systematic searches using three databases in Spring 2024: Education Resources Information Center (ERIC), Medline, and PsychINFO with no limit placed on year of publication. The authors limited the search to articles published in English. Our searches included only peer reviewed literature. The database searches combined the following terms: (train* OR skills OR teach OR instruction OR intervention OR BST OR behavior skills training OR parent training OR modules) AND (sexuality OR sex education OR sex and relationship education OR sexual health OR masturbation OR self-stimulation OR solo sex) AND (intellectual dis* OR developmental dis* OR autism OR ASD OR autism spectrum disorder OR Asperger's OR Down syndrome). To maximize identification of eligible studies, the first author also conducted backward citation searching (n = 698), forward citation searching (n = 839), and a hand search of *Sexuality and Disability* (n = 1,616). The hand search and backward citation search did not identify any eligible studies. See Fig. 1 for a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flowchart of search results.

Study Selection and Data Extraction

The database search yielded 3,864 records. The first author then imported the records into Covidence, an online systematic review software platform (Covidence, 2024). Covidence identified and removed 2,776 duplicate records, leaving 1,085 titles and abstracts for screening. The first and second authors independently screened titles and abstracts using the predetermined inclusion and exclusion criteria. When the abstract alone did not provide enough information to determine eligibility, first and second authors examined the full-text article. After title and abstract screening, 21 full-text articles met inclusion criteria. The first and second authors excluded three articles during full-text review because they did not report data, published in a language other than English, or did not measure parent outcomes. This resulted in 18 studies from the database search. The first author used a forward citation search for three additional studies, bringing the total number of studies included in the final review to 21. The first and second authors resolved one disagreement during the screening process through discussion and reached consensus that the article did not meet the inclusion criteria. The first and second authors extracted data from each included study, including participant characteristics, intervention details, delivery format, topics covered, study design, assessments, outcomes, and researcher-reported findings. The PRISMA flow diagram (Fig. 1) presents the full identification, screening, eligibility, and inclusion process for the review.

Figure 1

Identification

Identification

Interrater Reliability

The first author independently coded all included articles. The first author trained the second and third authors in the coding procedures by reviewing the coding procedures by reviewing the coding table and the data to extract. Before independently coding articles, all authors coded two articles together and discussed disagreements until they reached 100% agreement. After training, a random number generator selected 38% of the included articles (*n* = 8) for interrater reliability coding. The third author independently coded five of these articles, and the second author independently coded three. Initial agreement between

the first and second authors was 100%. Initial agreement between the first and third authors was 94%. The authors discussed all disagreements until they reached 100% agreement.

Results

The authors found 21 studies that met the inclusion criteria with a total of 1,027 participants. We extracted the following information from each study when available: (a) location (country), (b) participant demographics (role, number, disabilities, gender, race, education level, and age), (c) intervention details (dosage, duration, commercial availability, how training was delivered), (d) interventionist information (training, qualifications), (e) topics covered within the intervention, (f) research questions, (g) study design (pre-test/post-test, RCT, etc.), (h) assessments, and (i) researcher-reported results.

Study Location

The included studies took place in 10 countries (Table 1), with more studies conducted in the United States than any other country (n = 9; Bowman et al., 2010; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Frank & Sandman, 2021; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976) and Turkey (n = 4; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Yıldız & Cavkaytar, 2017). Additional locations included: United Arab Emirates (n = 1; Alhassan & Gharaibeh, 2024), Malaysia (n = 1; Chin & Ramachandram, 2024), Taiwan (n = 2; Chou et al., 2019; Chou et al., 2020), Australia (n = 1; Donnelly et al., 2023), Spain (n = 1; Gil-Llario et al., 2025), Iran (n = 1; Goli et al., 2021), and India (n = 1; Gupta, 2024).

Participant Characteristics

Seventeen studies (n = 17, 81%) recruited parents and caregivers as participants (n = 893). However, four studies expanded their intervention training to direct care staff and service workers (Bowman et al., 2010; Chou et al., 2019; Chou et al., 2020; Wilson & Baldwin, 1976).

The primary disabilities across studies were autism (n = 389; 38.9%) and/or intellectual disability (n = 475; 46.3%). Other diagnoses (n = 50) included attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), speech-language impairment (SLI), vision impairment (VI), hearing impairment (HI), and physical disabilities. Bowman and colleagues (2010) and Wilson & Baldwin (1976) did not report participant disability demographics.

Table 1

Participant Demographics

Reference	Country	Sample size (n)	Role	Gender (% Female)	Age	Race / Ethnicity (%)	Education Level (%)
Alhassan & Gharaibeh, 2024	United Arab Emirates	91	Parents	100%	Range = 25–45		29.7% secondary school or less, 46.2% diploma/bachelor's degree, 24.2% postgraduate studies
Bowman et al., 2010	United States	85	Developmental disability service providers	73.2%	M = 30.1		33.8% high school, 23.9% some college, 35.2% bachelor's degree, 7.0% master's degree
Chin & Ramachandram, 2024	Malaysia	30	Parents	83.3%	NR		26.7% secondary education, 26.7% diploma equivalent, 43.3% bachelor's degree, 3.3% master's degree
Chou et al., 2019	Taiwan	78	Parents and service workers	69.2%	M = 57.9		NR
Chou et al., 2020	Taiwan		Parents and service workers				
Clatos & Asare, 2016	United States	15	Parents	66.7%	Range = 25–57	73% white, 13.3% African American, 6.7% Hispanic, 6.7% more than two racial groups	3.5% less than high school, 26.3% high school, 14% some college, 33.3% undergraduate degree, 22.8% graduate degree or higher
Corona et al., 2016	United States	8	Parents	75%			
DeVries et al., 2024	United States	6	Parents	66.7%	M = 41.5	16.6% American Indian or Alaska native, 83.3% white	
Donnelly et al., 2023	Australia	145	Parents and caregivers	86%			1.7% primary school, 16.5% high school, 44.6% TAFE/Diploma/Certificate, 24.8% university/bachelor's degree, 11.6% postgraduate, 0.8% not reported
Frank & Sandman, 2021	United States	26	Parents and caregivers	92.3%	Range = 41–64		88.5% college degree or higher

NR = not reportable (data format could not be summarized using mean or range); CG and EG were included; ____ = not reported; Rule: Only include parent-implemented sex ed interventions; TAFE = Technical and Further Education

Reference	Country	Sample size (n)	Role	Gender (% Female)	Age	Race / Ethnicity (%)	Education Level (%)
Gil-Llario et al., 2025	Spain	38	Parents and guardians	83.7%			
Goli et al., 2021	Iran	81	Parents	100%	Range = 25–55+		1.2% elementary, 37% intermediate, 44.4% high school diploma, 17.3% academic
Gupta, 2024	India	11	Parents	100%			
Gündoğdu et al., 2024	Turkey	24	Parents	87.2%	M = 45.71		66.7% primary, 29.2% secondary, 4.2% high school
Kok & Akyuz, 2015	Turkey	84	Parents	50%	Range = 31–50+		28.6% primary school, 39.3% secondary school, 25% high school graduate, 7.1% university graduate
Kurt & Kürtüncü, 2024	Turkey	48	Parents	100%	38.12		47.9% primary school, 43.8% high school, 8.3% university/postgraduate
Nichols & Blakeley-Smith, 2009	United States	10	Parents and caregivers				
Pugliese et al., 2020	United States	56	Parents	86.9%	M = 48.4		10.9% high school, 29.1% some college, 32.7% bachelor's degree, 27.3% graduate degree
Rooks-Ellis et al., 2020	United States	26	Parents and caregivers	92.3%			7.7% high school, 26.9% some college, 34.6% bachelor's degree, 26.9% graduate degree
Wilson & Baldwin, 1976	United States	32	Direct care staff				
Yıldız & Cavkaytar, 2017	Turkey	22	Parents	100%			45% primary school, 32% middle school, 9% high school, 13% college

NR = not reportable (data format could not be summarized using mean or range); CG and EG were included; ____ = not reported; Rule: Only include parent-implemented sex ed interventions; TAFE = Technical and Further Education

Nineteen studies (n = 19, 90.5%) provided information on the gender of parents and caregivers. Female participants comprised most of the sample (n = 827, 79.8%), and five studies included exclusively mothers (Alhassan & Gharaibeh, 2024; Goli et al., 2021; Gupta, 2024; Kurt & Kürtüncü, 2024; Yıldız & Cavkaytar, 2017). Chou and colleagues (2020) and Wilson & Baldwin (1976) did not report on the gender of parents and caregivers.

Thirteen studies provided information on the gender of participating children or children of participating parents (Chin & Ramachandram, 2024; Chou et al., 2020; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Frank & Sandman, 2021; Gil-Llario et al., 2025; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Rooks-Ellis et al., 2020). Across these studies, many of the children were male (n = 311, 63.7%).

Three studies (14.3%) provided information on parent race (Clatos & Asare, 2016; DeVries et al., 2024; Rooks-Ellis et al., 2020), one study provided information on Jordanian and Syrian nationalities (Alhassan & Gharaibeh, 2024), and one study provided information on youth race (Pugliese et al., 2020). Most of the parent participants were white based on the three studies that reported race (n = 47, 87.2%)

Sixteen studies provided information on the ages of participating children or children of participating parents (Chin & Ramachandram, 2024; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Frank & Sandman, 2021; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Yıldız & Cavkaytar, 2017). Many of the participants were children and adolescents ages 6–18; however, four studies included adults over the age of 18 (Chou et al., 2020; Goli et al., 2021; Gupta, 2024; Frank & Sandman, 2021). Six studies measured child outcomes (Chou et al., 2020; Corona et al., 2016; Gil-Llario et al., 2025; Gupta, 2024; Kurt & Kürtüncü, 2024; Pugliese et al., 2020).

Twelve studies provided information on parent and caregiver ages (Alhassan & Gharaibeh, 2024; Bowman et al., 2010; Chin & Ramachandram, 2024; Chou et al., 2019; Clatos & Asare, 2016; DeVries et al., 2024; Frank & Sandman, 2021; Goli et al., 2021; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Pugliese et al., 2020). Parent and caregiver ages varied significantly across studies. Parent ages ranged between 25 and 60 + years; however, many parents were between the ages of 35–49 years. For full reporting, please refer to Table 1.

Fourteen studies included information on parent education levels (Alhassan & Gharaibeh, 2024; Bowman et al., 2010; Chin & Ramachandram, 2024; Chou et al., 2019; Clatos & Asare, 2016; Donnelly et al., 2023; Frank & Sandman, 2021; Goli et al., 2021; Gündoğdu et al., 2024; Kok & Akyuz, 2015); Kurt & Kürtüncü, 2024; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Yıldız & Cavkaytar, 2017). Many participants completed secondary education or an undergraduate degree (Table 1).

Intervention

One study included a commercially available intervention: The Birds and Bees Program © (DeVries et al., 2024). Twenty studies included interventions that were researcher-created (Alhassan & Gharaibeh, 2024; Bowman et al., 2010; Chin & Ramachandram, 2024; Chou et al., 2019; Chou et al., 2020; Clatos & Asare, 2016; Corona et al., 2016; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976; Yıldız & Cavkaytar, 2017).

Intervention dosage varied across studies in both total training time and number of sessions. For this review, interventions were described as brief trainings lasting less than five hours (Bowman et al., 2010; Chin & Ramachandram, 2024; Clatos & Asare, 2016; Goli et al., 2021; Kok & Akyuz, 2015; Rooks-Ellis et al., 2020; Yıldız & Cavkaytar, 2017), moderate trainings lasting 5–12 hours (Corona et al., 2016; DeVries et al., 2024; Frank & Sandman, 2021; Gündoğdu et al., 2024; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009), and extended trainings lasting 18–36 hours (Chou et al., 2020; Gil-Llario et al., 2025; Gupta, 2024; Wilson & Baldwin, 1976). One intervention used a self-paced format (Alhassan & Gharaibeh, 2024). The study by Pugliese et al. (2020) appears separately because dosage varied by condition, with the attentional control group receiving less than five hours, the self-guided group receiving approximately 12 hours, and the facilitator-led group receiving approximately 31 hours. Three studies did not clearly report total intervention duration (Chou et al., 2019; Donnelly et al., 2023; Wilson & Baldwin, 1976). The review also recorded the number of sessions when studies reported this information because total hours alone did not capture the structure of intervention delivery. Trainings ranged from one-time workshops to multi-session programs delivered across several weeks or months. Most studies took place in person, while Alhassan and Gharaibeh (2024), Chin and Ramachandram (2024), and DeVries et al. (2024) delivered interventions online or via telehealth.

Interventionist Qualifications

Fifteen studies provided information on interventionist qualifications. Interventionists included clinical psychologists (Corona et al., 2016; DeVries et al., 2024; Gil-Llario et al., 2025; Gupta, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020), researchers who developed the program (Clatos & Asare, 2016; Goli et al., 2021; Kurt & Kürtüncü, 2024; Rooks-Ellis et al., 2020; Yıldız & Cavkaytar, 2017), adults with intellectual disability working alongside professionals (Chou et al., 2019; Chou et al., 2020), and individuals that work in a related field such as occupational therapy, health education, counseling, special education, social work, and behavior specialty (Chou et al., 2019; Chou et al., 2020; Clatos & Asare, 2016; Corona et al., 2016; Donnelly et al., 2023; Frank & Sandman, 2021; Wilson & Baldwin, 1976). One study asked parents to help facilitate the

intervention after receiving training (Chou et al., 2019). Except for Yıldız & Cavkaytar (2017), studies that reported interventionist details involved multiple interventionists.

Topics Covered in Intervention

Interventions included training topics that consistently addressed sexual health, characteristics of healthy relationships, sexuality, and sexual abuse prevention. Fifteen interventions (n = 15; 71.4%) included sexual abuse awareness and prevention as one of the training topics (Alhassan & Gharaibeh, 2024; Bowman et al., 2010; Chin & Ramachandram, 2024; Chou et al., 2020; Corona et al., 2016; DeVries et al., 2024; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Yıldız & Cavkaytar, 2017). Two studies exclusively focused on sexual abuse awareness and protections (Alhassan & Gharaibeh, 2024; Bowman et al., 2010). Their training topics concentrated on indicators of sexual abuse, reporting strategies, and creating safer environments. In addition, Bowman et al. (2010) addressed risks of sexual abuse such as contracting sexually transmitted infections, workplace conditions that could increase the risk of sexual abuse along with strategies to mitigates those risks and shifting harmful attitudes that enable abuse.

In addition to sexual abuse and prevention, the majority of interventions incorporated topics of anatomy and physiology such as naming body parts, private body parts, reproductive anatomy, and physiological changes during puberty (Chin & Ramachandram, 2024; Chou et al., 2020; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020); Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976; Yıldız & Cavkaytar, 2017). Nine of these interventions expanded upon these topics by covering hygiene and self-care practices (Chin & Ramachandram, 2024; Corona et al., 2016; DeVries et al., 2024; Donnelly et al., 2023; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Yıldız & Cavkaytar, 2017). Nine studies included menstruation hygiene as its own topic (Chin & Ramachandram, 2024; Corona et al., 2016; Donnelly et al., 2023; Frank & Sandman, 2021; Goli et al., 2021; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Pugliese et al., 2020; Yıldız & Cavkaytar, 2017).

Seven interventions included sexually transmitted infections as a training topic (Bowman et al., 2010; Chou et al., 2020; Corona et al., 2016; DeVries et al., 2024; Goli et al., 2021; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Yıldız & Cavkaytar, 2017). Eleven interventions incorporated relationships into training topics, which included training on healthy versus unhealthy relationships, dating etiquette, communication, and types of relationships (Chin & Ramachandram, 2024; Chou et al., 2020; Corona et al., 2016; DeVries et al., 2024; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-Llario et al., 2025; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Yıldız & Cavkaytar, 2017). Five interventions provided training on masturbation but did not state what the training entailed (DeVries et al., 2024; Goli et al., 2021; Pugliese et al., 2020; Wilson & Baldwin, 1976; Yıldız & Cavkaytar, 2017). One training included masturbation to identify it as an inappropriate sexual behavior (Goli et al., 2021). Four interventions included training on consent (DeVries et al., 2024; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-Llario et al., 2025). One intervention offered training on safety practices for LGBTQIA+ youth (DeVries et al., 2024). One intervention trained parents on common myths about sexuality and disability (Clatos & Asare, 2016). Two interventions included training on internet safety (Corona et al., 2016; Goli et al., 2021). Two interventions incorporated legal issues into their training topics (Corona et al., 2016; Gupta, 2024). Corona and colleagues included training on legal issues that may result from adolescent sexual behavior, while Gupta and colleagues focused on educating participants on the POSH Act (Sexual Harassment of Women at Workplace Act, 2013), which protects women against workplace sexual harassment (Corona et al., 2016; Gupta, 2024). One intervention prioritized a rights-based framework within their training topics (Chou et al., 2020). This study aimed to empower the disabled community by advocating that sexual health as a right. Chou et al. (2020) was the only intervention that focused on disability rights and culture.

Research Questions and Purpose

Across the included studies, there were two consistent categories of research questions: changes in parent knowledge and attitudes and effectiveness and feasibility of training. Nineteen interventions (90.5%) investigated parent and/or service provider knowledge and attitudes surrounding SRE (Bowman et al., 2010; Chin & Ramachandram, 2024; Chou et al., 2019; Chou

et al., 2020; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976; Yıldız & Cavkaytar, 2017). Twelve interventions (60%) investigated the effectiveness and feasibility of SRE training for parents and caregivers (Bowman et al., 2010; Chin & Ramachandram, 2024; Corona et al., 2016; DeVries et al., 2024; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Pugliese et al., 2020; Yıldız & Cavkaytar, 2017).

These studies targeted both parent and child outcomes. Parent outcomes included: attitudes toward sexuality (Chou et al., 2019; Chou et al., 2020; Clatos & Asare, 2016; Frank & Sandman, 2021; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976; Yıldız & Cavkaytar, 2017), knowledge (Alhassan & Gharaibeh, 2024; Bowman et al., 2010; Chou et al., 2020; Clatos & Asare, 2016; DeVries et al., 2024; Donnelly et al., 2023; Gil-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Pugliese et al., 2020; Wilson & Baldwin, 1976), comfort discussing SRE (Clatos & Asare, 2016; Corona et al., 2016; Nichols & Blakeley-Smith, 2009), confidence (Bowman et al., 2010; Donnelly et al., 2023), self-efficacy (Clatos & Asare, 2016; DeVries et al., 2024; Frank & Sandman, 2021 Goli et al., 2021; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Pugliese et al., 2020), number of topics discussed post intervention (Chin & Ramachandram, 2024), satisfaction (Kok & Akyuz, 2015), and competence (Nichols & Blakeley-Smith, 2009; Rooks-Ellis et al., 2020). Please refer to Table 2 for full reporting.

Table 2
Curriculum and Training Topics

Reference	Name of Curriculum	Commercially Available (Y/N)	Training Duration	Delivery Method
Alhassan & Gharaibeh, 2024	Not specified	N	Self-paced	I, T
Bowman et al., 2010	Sexual Abuse Prevention Training Program	N	4 hours	G, IP
Chin & Ramachandram, 2024	Sexual Health Training Program	N	2 hours	G, T
Chou et al., 2019	Rights to Sexual Health Programme	N	Not specified	G, IP
Chou et al., 2020	Sexual Health Intervention	N	18 hours	G, IP
Clatos & Asare, 2016	Sexuality Education Intervention	N	1 hour	IP
Corona et al., 2016	Not specified	N	12 hours	G, IP
DeVries et al., 2024	The Birds and Bees Program ™	Y	12 hours	G, T
Donnelly et al., 2023	Comprehensive Sexuality Education and Support	N	Not specified	G, IP
Frank & Sandman, 2021	Home B.A.S.E for Intellectual Disabilities	N	9 hours	G, IP
Gil-Llario et al., 2025	Saludiversex-A	N	31.5 hours	G, IP
Goli et al., 2021	Sexual Health Training	N	3.3 hours	G, IP
Gündoğdu et al., 2024	Sexual Health Education	N	6 hours	G, IP
Gupta, 2024	Sex Education Training	N	36 hours	G, IP
Kok & Akyuz, 2015	Parent Health Education	N	4 hours	G, IP
Kurt & Kürtüncü, 2024	Sexual Health and Development Education Program	N	5.3 hours	G, IP
Nichols & Blakeley-Smith, 2009	Parent Sexuality-Education Curriculum	N	8 hours	G, IP
Pugliese et al., 2020	Supporting Teens with Autism on Relationships	N	22.5 hours	G, IP, T
Rooks-Ellis et al., 2020	Sexuality Education for Parents of Children with Intellectual and Developmental Disabilities	N	Not specified	G, IP
Wilson & Baldwin, 1976	Pilot Sexuality Training Workshop	N	Not specified	G, IP
Yıldız & Cavkaytar, 2017	Sexuality Education Program for Mothers of Young Adults with Intellectual Disabilities	N	4 hours	G, IP

G = group, I = individual, T = telehealth, IP = in-person

Study Design

Many studies (66.7%) used a pre-post intervention design. Study designs varied and were described by authors as: descriptive-analytical design (Alhassan & Gharaibeh, 2024), pre-post intervention design (Bowman et al., 2010; Chin & Ramachandram, 2024; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Donnelly et al., 2023; Gupta, 2024; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976; Yıldız

& Cavkaytar, 2017), quasi-experimental design (Chin & Ramachandram, 2024; Chou et al., 2019), non-equivalent multiple-groups with replications design (Chou et al., 2020), parallel mixed methods design (Frank & Sandman, 2021), randomized control trial (Gil-Llario et al., 2025; Goli et al., 2021; Gündoğdu et al., 2024; Kurt & Kürtüncü, 2024; Yıldız & Cavkaytar, 2017), within subjects design (Clatos & Asare, 2016), and a two-part exploratory study design (Nichols & Blakeley-Smith, 2009).

Eleven studies (52.4%) were quantitative (Alhassan & Gharaibeh, 2024; Bowman et al., 2010; Chin & Ramachandram, 2024; Clatos & Asare, 2016; Donnelly et al., 2023; Goli et al., 2021; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Kurt & Kürtüncü, 2024; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976), two studies (9.5%) were qualitative (Corona et al., 2016; Gupta, 2024), and eight studies (38.1%) were mixed-method (Chou et al., 2019; Chou et al., 2020; DeVries et al., 2024; Frank & Sandman, 2021; Gil-Llario et al., 2025; Nichols & Blakeley-Smith, 2009; Pugliese et al., 2020; Yıldız & Cavkaytar, 2017).

Assessments

Twenty studies (95.2%) included parent outcome measures, and six studies (28.6%) included child outcome measures. Assessments ranged from commercially available and previously published instruments to researcher-developed questionnaires, surveys, interviews, and feedback forms (Table 3). Parent outcome measures most commonly assessed knowledge, attitudes, awareness, comfort, confidence, self-efficacy, communication, satisfaction, competence, and perceived social support. Child outcome measures assessed sexual knowledge, sexual development knowledge, abuse-risk detection, social self-efficacy, skills application, quality of life, and adaptive or daily living behavior.

Researcher-Reported Results

Parent Outcomes

Across the included studies, parent outcomes were generally positive, with many interventions demonstrating statistically significant improvements in parent knowledge and awareness (Bowman et al., 2010; Chou et al., 2019; Chou et al., 2020; Clatos & Asare, 2016; Corona et al., 2016; DeVries et al., 2024; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-

Table 3

Assessments

Reference	Parent Assessment(s)	Child Assessment(s)	Outcome(s) Measured
Alhassan & Gharaibeh, 2024	Mothers' Awareness/Knowledge Scale (RD)	—	Awareness/knowledge
Bowman et al., 2010	Sexual Abuse Attitudes and Knowledge Questionnaire (RD); Global Perceptions Scale (PP)	—	Knowledge; attitudes
Chin & Ramachandram, 2024	Structured Interview (RD)	Vineland Adaptive Behavior Scales, Third Edition (CA)	Number of topics discussed; adaptive behavior
Chou et al., 2019	Attitudes to Sexuality Questionnaire–Individuals with an Intellectual Disability (PP)	—	Attitudes
Chou et al., 2020	—	Assessment of Sexual Knowledge Tool (PP); Personal Outcomes Scale (CA)	Sexual knowledge; attitudes; quality of life
Clatos & Asare, 2016	30-item Questionnaire (RD)	—	Knowledge; attitudes; communication; self-efficacy
Corona et al., 2016	Parent Questionnaire (RD); Parent Satisfaction Questionnaire (RD)	Adolescent Knowledge Questionnaire (RD)	Comfort; number of topics discussed; adolescent knowledge
DeVries et al., 2024	Parent Knowledge Questionnaire (RD); Parent Self-Efficacy Scale (PP); Parenting Outcome Expectancy Scale (PP); Parent Feedback Questionnaire (RD)	Vineland Adaptive Behavior Scales, Third Edition, Personal Daily Living Skills Domain (CA)	Knowledge; self-efficacy; outcome expectations; daily living skills
Donnelly et al., 2023	Pre/Post Workshop Surveys (RD); Follow-Up Surveys (RD)	—	Knowledge; confidence
Frank & Sandman, 2021	Author-Created Surveys (RD); Modified Attitudes to Sexuality Questionnaire–Individuals with an Intellectual Disability (PP)	—	Attitudes; self-efficacy
Gil-Llario et al., 2025	Parent Ad Hoc Questionnaire (RD)	Inventory of Sexual Knowledge of People with Intellectual Disability (PP); Detection of Sexual Abuse Risk Screening Tool (PP)	Sexual knowledge; abuse-risk detection; parent communication
Goli et al., 2021	Awareness Questionnaire (RD); Attitude Questionnaire (RD); General Self-Efficacy Questionnaire (PP)	—	Awareness; attitudes; self-efficacy
Gündoğdu et al., 2024	Parental Self-Efficacy Scale; Knowledge Assessment Questionnaire	—	Knowledge; self-efficacy
Gupta, 2024	Awareness on Sexual Health Education	Family Life and Sexual Health Assessment (CA)	Awareness; knowledge; communication/decision-making
Kok & Akyuz, 2015	Information Questionnaire (RD); Self-Efficacy Questionnaire (RD); Satisfaction Items (RD)	—	Knowledge; self-efficacy

RD = researcher-developed or study-specific assessment, PP = previously published assessment, CA = commercially available or standardized assessment

Reference	Parent Assessment(s)	Child Assessment(s)	Outcome(s) Measured
Kurt & Kürtüncü, 2024	Sexual Development Characteristics of Children with Adolescent Intellectual Disability Scale (PP)	Sexual Development Knowledge Assessment Scale for Children with Intellectual Disabilities (PP)	Parent awareness; sexual development knowledge
Nichols & Blakeley-Smith, 2009	Comfort Ratings Questionnaire, Parent Version (RD; PP); End of Group Evaluation (RD)	—	Comfort
Pugliese et al., 2020	Parent Knowledge Questionnaire (RD); Parent Feedback Questionnaire (RD); Parenting Self-Efficacy Scale (PP); Parenting Outcome Expectancy Scale (PP)	Youth Knowledge Questionnaire (RD); Video Vignette Skills Application Test (RD); Youth Feedback Questionnaire (RD); Social Self-Efficacy Scale (PP)	Parent/youth knowledge; self-efficacy; outcome expectations; social self-efficacy; skills application
Rooks-Ellis et al., 2020	31-item Questionnaire (RD)	—	Attitudes; communication; competence
Wilson & Baldwin, 1976	Knowledge and Attitude Questionnaire	—	Knowledge; attitudes
Yıldız & Cavkaytar, 2017	Family Needs Survey (PP); Sexuality Education of Individuals with Intellectual Disabilities Attitude Scale (PP); Revised Parental Social Support Scale (PP); Social Validity Survey (RD)	—	Attitudes; perceived social support

RD = researcher-developed or study-specific assessment, PP = previously published assessment, CA = commercially available or standardized assessment

-Llario et al., 2025; Goli et al., 2021; Gupta, 2024; Kurt & Kürtüncü, 2024; Nichols & Blakeley-Smith, 2009), attitudes toward sexual abuse (Bowman et al., 2010; Pugliese et al., 2020), attitudes toward sexuality (Bowman et al., 2010; Clatos & Asare, 2016; Frank & Sandman, 2021; Goli et al., 2021; Gupta, 2024; Rooks-Ellis et al., 2020; Wilson & Baldwin, 1976; Yıldız & Cavkaytar, 2017), and self-efficacy (Clatos & Asare, 2016; Donnelly et al., 2023; Frank & Sandman, 2021; Goli et al., 2021; Gündoğdu et al., 2024; Kok & Akyuz, 2015; Rooks-Ellis et al., 2020). However, results were not consistently significant across all outcome measures. For example, Bowman et al. (2010) found no significant change on the Global Perceptions Scale but did report gains in knowledge and attitudes. Corona et al. (2016) reported no significant changes in parent comfort levels, although parents reported discussing more SRE topics with their children. Chou et al. (2020) found that there were no significant changes in sexual attitudes or quality of life. While DeVries et al. (2024) reported increases in parent knowledge, only 54% of participants completed the intervention. Additionally, two studies examined intervention feasibility, and both studies found that parent-implemented SRE interventions are feasible and acceptable (DeVries et al., 2024; Donnelly et al., 2023).

Child Outcomes

Six studies included child outcome measures. Overall, findings for child outcomes were more mixed than parent outcomes. Some studies reported improvements in child sexual knowledge, sexual development knowledge, abuse-risk detection, social self-efficacy, or skills application (Chou et al., 2020; Gil-Llario et al., 2025; Gupta, 2024; Kurt & Kürtüncü, 2024; Pugliese et al., 2020). However, child outcomes were not consistently significant across studies. Chin and Ramachandram (2024) reported overall significant improvements across outcomes but did not observe change on the Vineland Adaptive Behavior Composite. Corona et al. (2016) found no significant differences in adolescent knowledge scores from pretest to posttest. DeVries et al. (2024) found no significant differences in the Vineland-3 Personal Daily Living Skills domain. Chou et al. (2020) also found no significant change in quality of life.

Qualitative Results

Two studies included limited qualitative or open-ended findings. Gupta (2024) described the study as qualitative, although most findings were based on pretest and posttest scores and percentages. Mothers reported feeling less fearful about sexuality education and more prepared to teach their children about privacy, safety, and sexual development. Corona et al. (2016) was primarily quantitative but included open-ended parent feedback. Parents valued hearing from other families and sharing ideas. Neither study reported a formal theoretical framework. Gupta briefly referenced biopsychosocial development, while Corona et al. drew on autism-specific teaching practices such as direct instruction and visual supports.

Discussion

This systematic review examined researcher-led SRE trainings designed for parents and caregivers of individuals with IDD. Across the included studies, most interventions led to positive outcomes, including an increase in parent knowledge, confidence, and comfort discussing SRE topics with their children. This review identified important gaps in the literature surrounding parent-implemented SRE interventions and several areas where existing trainings may not fully meet the needs of parents and individuals with IDD.

Commercial Availability of Parent SRE Interventions

Parents play a foundational role in their children's access to sexuality and relationship education; however, only one parent-implemented SRE intervention included in the present review was commercially available (DeVries et al., 2024). Researchers developed most interventions for use in a single study rather than based on an established SRE curriculum or parent-training model. As a result, interventions varied in content taught to parents, the type of training they received, and the methods used to evaluate implementation. This variability limits replicability and makes it difficult to identify which intervention components are most effective. It also raises concerns about accessibility, as researcher-developed interventions may not be available to families outside of research settings. In some cases, families may have no way to access the materials once the study has ended.

This is an important concern because an intervention cannot make a significant impact if it never reaches the families who need it. Future research should consider not only whether intervention is effective, but also how parents will access and use it in their everyday lives. Programs could provide materials through online modules, short videos, downloadable lessons, visual supports, or step-by-step guides that parents can return to when questions arise. These materials should also be easy to understand and adaptable for individuals with different communication and support needs including those who use augmentative and alternative communication (AAC) and those with significant support needs.

Researchers may also need to work more closely with schools, healthcare providers, disability organizations, and family-support agencies that parents already know and trust. These organizations could help connect families with SRE resources and provide support as parents begin using them. Training professionals to deliver established programs may also help reach more families without requiring the original researchers to lead every session.

Finally, families are unlikely to need this support only once. Their questions may change as their children experience puberty, friendships, dating, online interactions, healthcare decisions, and adulthood. Therefore, parent SRE interventions may be more useful when they provide ongoing support that families can revisit over time. Interventions may remain within research studies instead of becoming practical resources for families if researchers do not prioritize accessibility and long-term use.

Training Content

Many interventions addressed sexual abuse awareness and prevention, which reflects the heightened risk of abuse for individuals with IDD. However, only four interventions included consent (DeVries et al., 2024; Donnelly et al., 2023; Frank & Sandman, 2021; Gil-Llario et al., 2025), which is concerning due to the major role that consent plays in abuse prevention. "Consent" is not a supplemental topic. Rather, these interventions should prioritize teaching bodily autonomy, saying "no," and unhealthy relationships. When interventions omit these topics, individuals with IDD may face greater vulnerability to abuse (Andreassen, 2024; Weber & Kaufman, 2021). Similarly, only two interventions addressed internet safety (Corona et al., 2016;

Goli et al., 2021). This was one of the more shocking findings of this review, especially considering that online spaces have been identified as a common setting for exploitation (Álvarez-Guerrero et al., 2024).

Studies also varied in their coverage of other topics. Less than half of the included studies addressed menstruation hygiene (45%). This finding is particularly concerning given that women and girls with IDD receive less menstrual and reproductive health education than their neurotypical peers and often face persistent stigma surrounding menstruation and sexuality (Randall et al., 2024). Menstruating people with IDD may face unique challenges related to menstruation, especially when they lack consistent access to running water, private bathrooms, menstrual hygiene products, or clear instruction about menstrual health (Moss et al., 2026). When SRE interventions exclude menstruation and menstrual hygiene, individuals may lack the knowledge and support needed to manage their bodies safely and with dignity, further reinforcing inequities, stigma, and discrimination (Moss et al., 2026; United Nations Educational, Scientific and Cultural Organization et al., 2018).

Only five studies (25%) included training on masturbation. One study specifically mentioned masturbation to classify it as an inappropriate behavior alongside exhibitionism and to teach parents how to “control” these behaviors (Goli et al., 2021). However, the intervention did not describe what these strategies entailed. Not addressing masturbation can cause parent and caregiver responses to default to punishment and/or prohibition instead of intentionally teaching appropriate time and place which may be more sustainable and functional across the lifespan (American Academy of Pediatrics, 2020). Previous research surrounding this topic has determined that parents often feel discomfort in discussing masturbation with their child, which only highlights the importance of interventions that equip caregivers to do so (Hill et al., 2025). Masturbation is a typical part of sexual development; however, caregivers need training to recognize unusual masturbation behaviors, as these behaviors may be indicative of stress, possible abuse, or the need for more explicit SRE (American Academy of Pediatrics, 2020).

Participation Representation

It is important to note here that cultural values and stigma surrounding sexuality may influence these gaps, especially for multiply marginalized individuals whose identities and bodies are already heavily regulated (Drew et al., 2024). Omitting these SRE topics perpetuates the same ableist beliefs that have long contributed to restricted access to quality SRE instruction for individuals with IDD (Schaafsma et al., 2015). Parents may lack the knowledge needed to support healthy sexual development, respond appropriately to common developmental behaviors, or recognize indicators of abuse. Overall, these omissions are important because their inclusion supports bodily autonomy, quality of life, privacy, independence, and self-determination.

Only one intervention included supportive practices and considerations for LGBTQIA+ youth (DeVries et al., 2024). Individuals with IDD are more likely than their nondisabled peers to identify as a member of this community (Warrier et al., 2020), which makes this finding especially concerning. LGTBQIA+ individuals with IDD experience multiple forms of marginalization related to both disability and sexual and gender diversity, resulting in fewer opportunities to receive identity-affirming SRE (Drew et al., 2024). When SRE fails to include diverse sexual orientations and gender identities, it may ultimately reinforce the invisibility of LGBTQIA+ individuals with IDD and leave parents and caregivers without the knowledge needed to support individuals who identify as LGBTQIA + or who are exploring their identities. These exclusions are not neutral. Instead, they reflect the broader social marginalization that lives at the intersection of sexuality and disability (Drew et al., 2024).

Finally, reporting on participant demographics raised additional concerns about representation and whose input shaped this literature. May studies (75%) did not report race and ethnicity. As stated above, cultural and religious values deeply shape sexuality. Cultural beliefs influence how families discuss sexuality, topics discussed, parental comfort with SRE, and willingness to participate in interventions (UNESCO et al., 2018). Without this demographic information and acknowledgement by researchers and educators, readers cannot assess how race and ethnicity may influence parent comfort levels, attitudes, implementation of interventions, and overall outcomes. The omission of these demographic characteristics also limits the ability to evaluate whether interventions are culturally responsive or whether findings are generalizable across diverse populations. The intersectionality of disability, sexuality, and culture further shapes families’ experiences with SRE and access to culturally relevant supports (Drew et al., 2024). Additionally, mothers and women comprised nearly all parent and caregiver participants across studies. However, studies that reported child demographics primarily included boys. This discrepancy

suggests that families often expect mothers to serve as the primary sexuality educators regardless of the child's sex, and despite evidence that fathers and other caregivers also influence children's sexual development and relationships (Schaafsma, 2023). This mismatch may create barriers that current parent-implemented SRE interventions have not yet identified or addressed.

The exclusion of these topics indicates that parent trainings reflect narrow assumptions about SRE for individuals with IDD. Rather than preparing parents for the broad range of experiences relevant to SRE, many interventions primarily focused on biological knowledge while giving comparatively little attention to topics such as LGBTQIA+ identities, legal issues, rights, internet safety, and self-determination. It also suggests that parent SRE interventions have not fully considered real-world scenarios that individuals with IDD may face. As individuals with IDD increasingly participate in inclusive schools, employment, postsecondary education, online environments, dating relationships, and community life, parents require training that prepares them to support decision-making, safety, autonomy, and healthy relationships across these contexts rather than responding only after concerns arise. Unlike professionals, parents remain involved across developmental stages and can provide ongoing sexuality and relationship education that evolves alongside their child's changing needs.

Limitations

The search included only English-language, peer-reviewed articles, which may have excluded relevant studies published in other languages. During the screening process, the first and second authors excluded 1,064 studies that did not meet inclusion criteria. Studies were most commonly excluded because they did not include a parent training intervention or did not include individuals with IDD. The review used multiple search strategies to increase the likelihood of identifying all relevant studies. Despite these efforts, the search may not have identified every relevant study.

Future Research

Future research should focus on the development and assessment of more standardized and commercially available parent-implemented SRE interventions. The development of future parent SRE interventions should be based on known parent training preferences. Previous studies have found that most parents prefer flexible delivery methods, such as group-based learning with monthly in-person sessions, self-paced programs, or online training sessions (Hill et al., 2025). Future research should consider these preferences in the development of new programs so that it is easier for parents and caregivers to participate and use the intervention outside of a research study.

Future research should also ask parents and caregivers directly what they need through structured pre-assessment. Researchers should examine when parents think SRE should be introduced, which conversations they have already had, what those conversations looked like, and what makes these topics difficult to address. This should include topics such as consent, boundaries, privacy, menstruation, masturbation, healthy relationships, sexual identity, gender identity, internet safety, abuse prevention, and sexual health. Parent input could help researchers develop practical tools that show caregivers what to teach, when to teach it, and how to approach these topics in ways that are accessible, culturally responsive, and aligned to family needs.

Researchers should also conduct qualitative studies grounded in relevant theoretical frameworks to better understand how parents make decisions about SRE in everyday life. This work may help explain why some interventions are helpful and where parents continue to feel unprepared. Future research should also prioritize including more specific information about participant demographics because this information can and should inform practice. Demographic information should include age, race, ethnicity, gender, disability category, communication needs, and caregiver relationships for both the parent and child. This information would give researchers a better understanding of parent-implemented SRE research is representing and whether these interventions meet the needs of diverse families. Future studies should also describe family and student characteristics that may shape intervention needs, such as whether the child is already sexually active, has experienced safety concerns, or displays behaviors that caregivers identify as inappropriate.

Future research should also examine the postsecondary outcomes of students with IDD who receive SRE compared to those who do not. This could include outcomes related to adult relationships, consent knowledge, abuse prevention, self-advocacy,

independent living, community participation, and/or involvement with the criminal justice system. Considering these outcomes would help researchers better understand whether SRE has a lasting impact and how it affects postsecondary transition outcomes.

Additionally, future research should more clearly identify how to teach consent, determining the ability to consent, individualize consent, and what guidelines to use when discussing consent with individuals with IDD. This is important because others often assume or deny consent on behalf of people with IDD rather than teach consent as a skill.

Finally, future studies should also include post-intervention follow-ups to determine whether parents maintain knowledge and confidence over time and apply what they learned after the intervention ends. Researchers could explore whether parents started SRE conversations at home, felt more comfortable answering their child's questions, and/or practiced topics like consent, boundaries, privacy, menstruation, and safety in everyday situations. This would help determine whether parent-implemented SRE interventions lead to meaningful changes in parent behavior, not just short-term gains in knowledge and comfort.

Conclusion

Overall, this systematic review identified 21 researcher-led parent-implemented SRE interventions for individuals with IDD. Although existing interventions generally improved parent's knowledge, confidence, and self-efficacy, important gaps remain in content, accessibility, and representation. Many interventions omitted topics such as consent, LGBTQIA+ identities, internet safety, menstruation, masturbation, and disability rights despite their importance to SRE. Most interventions were also researcher-developed and unavailable outside of research settings, limiting access for families. If current systems rely on parents and caregivers to serve as primary SRE educators for individuals with IDD, future research must go directly to parents to understand what they need, what they are already doing, and what supports would help them provide accurate and developmentally appropriate SRE at home. Expanding parent-informed, evidence-based SRE interventions may increase access to SRE, reduce vulnerability to abuse and exploitation, and support the autonomy, safety, relationships, and quality of life of individuals with IDD.

Declarations

Author Contribution

C.M. conceptualized the study, conducted the literature searches, led study screening and data extraction, coded all included studies, analyzed and synthesized the findings, and wrote the original manuscript. C.D. contributed to study screening and data extraction, independently coded a subset of studies for interrater reliability, supervised the project, and provided critical feedback and manuscript revisions. H.S. independently coded a subset of studies for interrater reliability and contributed to resolving coding discrepancies.

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Figures

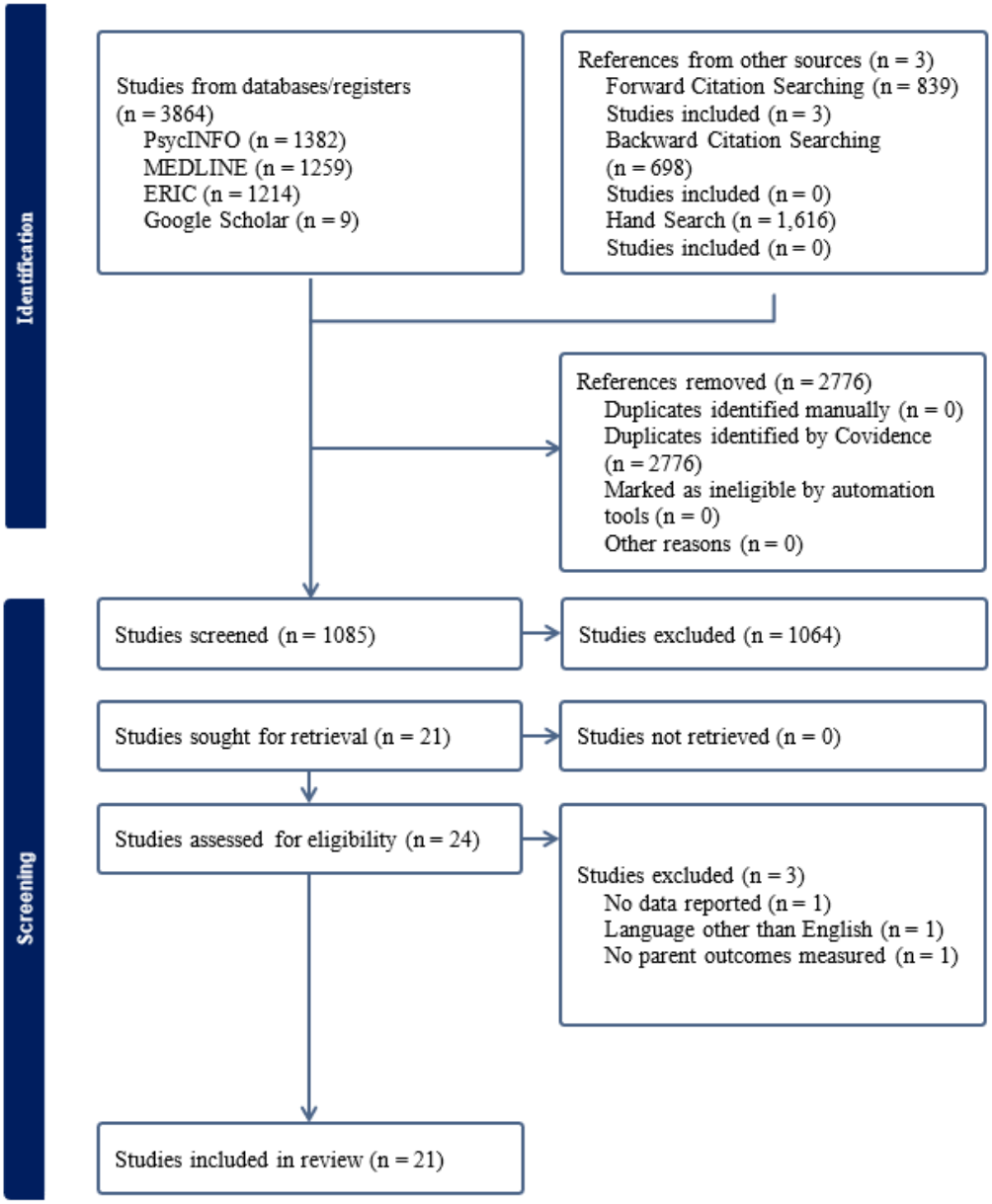


Figure 1

Legend not included with this version.