



Sexual Behaviors and Sexual Perceptions of Portuguese Adults with Physical Disabilities

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Abstract

The primary goal of this study was to shed light on the sexual behaviors and sexual perceptions of people with physical disabilities living in Portugal. As a result, we adopted a mixed methods study, which utilized a descriptive approach to describe participants' sexual behaviors and a qualitative approach to assess their sexual perceptions. This study surveyed 36 people (mean age = 40.25 years, SD = 10.45), of whom 58.3% ($n = 21$) were male, almost 70% ($n = 25$) were single, and the vast majority self-identified as heterosexual. 58.3% ($n = 21$) of participants did not report partaking in any sexual interactions over the previous 6 months, and 27.8% ($n = 10$) of study participants claimed to have never had sex. Among those who had engaged in sexual activity during the previous six months, kissing, touching, and caressing (38.9%, $n = 6$), receiving erogenous zone stimulation (33.3%, $n = 5$) and performing oral sex (33.3%, $n = 5$) were the most frequently reported activities. Among sexually active participants who reported not having had sex in the previous 6 months (58.3%, $n = 21$), only 2 (9.5%) mentioned that they did not have sex because of personal attributes, such as not feeling attractive. The remaining 19 (90.5%) systematically reported a lack of opportunity or a lack of a partner to justify not engaging in any sexual activity. Results from the content analysis of 36 participants' responses revealed the following 9 recurring themes regarding sexual perceptions: the definitions of human sexuality, the positive and negative impact of sexuality on emotional well-being, sexual problems, obstacles to sexual expression, sexual expectations, positive coping/resilience and interactions with society. Finally, it is important to highlight this study's contributions to the demands of people with physical disabilities in Portugal to be seen as sexual citizens.

Keywords Sexual behaviors · Sexual perceptions · Physical disabilities · Portugal

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Introduction

People with physical disabilities are sexual beings who are entitled to equal rights and opportunities regarding their sexuality and sexual expression. These rights encompass a right to fulfilling relationships, including sex [1], because sexuality and sexual relationships are key aspects of the human experience and are critical to overall quality of life, well-being and physical, emotional and social health [2]. While sexuality is conceived as a private matter, is it highly influenced by societal norms that usually exclude disabled bodies from normative discourse and create a tendency to view the sexual dynamics of people with physical disabilities as non-existent, problematic or threatening, because they may provoke uncertainty, anxiety and fear [3–5].

The exclusion of people with physical disabilities from normative definitions of sexuality has led to the emergence of a cultural script that portrays them as asexual beings [6] and more prone or vulnerable to negative sexual experiences, such as sexual violence, sexually transmitted infections, pornography and prostitution [4]. This perception of vulnerability creates a stigma involving exploitative and disempowering judgments that directly inflict harm on disabled people's psychological health and well-being, in the form of stress, reduced self-esteem, depression and social isolation [5, 7].

By definition, sexuality involves knowledge, values, beliefs, and emotions, thus transcending solely physiological and sexual functioning. Therefore, people with physical disabilities are and should have the autonomy to be sexually active as they choose, despite the fact that they are more likely to experience sexual difficulties in their intimate and sexual activities [8] than people without disabilities. However, previous research has shown that this phenomenon is directly associated with the internalization of not being sexually attractive, having lower sexual self-esteem, possessing higher levels of sexual depression, engaging in sexual activity less frequently [9, 10] and being exposed to the restriction, oppression and suppression of their sexual expressions imposed by health professionals, caregivers and family members [11–13].

Nevertheless, many individuals with physical disabilities often report some level of sexual difficulty, possessing an estimated sexual dysfunction prevalence rate of 65% [14, 15]. Common sexual dysfunctions among people with physical disabilities include erectile dysfunction, impaired vaginal lubrication and ejaculation and reduced sexual pleasure or orgasm. Yet, this assessment implies the application of traditional sexual response models that may not be suitable to people with physical disabilities, since their sexual responses tend to be more variable and adaptable. As a result, people with disabilities' sexual responses often focus on an array of sexual activities (not only intercourse) to achieve sexual pleasure [16], and, despite some limitations caused by their impairments, they can still be satisfied with their sexual activities [17].

The silence surrounding sexual problems and physical disabilities is reflected in the lack of social role models and reliable and accessible information throughout the world [18], which are key components of being able to make autonomous decisions about sexual behaviors [19]. This is also the case in Portugal, where there is still much progress to be made regarding the deconstruction of myths and spreading a political and social message that people with physical disabilities' right to a sexual life is as important as their rights to accessibility, employment and other basic rights [20]. Furthermore, research on sexuality and physical disabilities in Portugal is still scarce, and more studies are necessary to consolidate this research field in the country. Additional studies could help

contribute to the empowerment and affirmation of people with physical disabilities' sexual rights, especially research that focuses on their perspectives concerning this topic.

Therefore, the primary goal of our study was to articulate such issues and explore the sexual behaviors and perceptions of people with physical disabilities living in Portugal. Correspondingly, we adopted a mixed methods study that utilized a descriptive approach to describe participants' sexual behaviors and a qualitative approach to assess their sexual perceptions. The researchers hope that the study results can be used to draw conclusions and shape the development of more inclusive psychosocial interventions.

Methodology

Study Design and Procedures

This study utilized a mixed research design [21], using purposive sampling techniques [22, 23] to recruit a final sample of 36 Portuguese men and women with different physical disabilities. This study's methodological foundation was based on the participatory research paradigm, which emphasizes researchers' responsibility to advocate for issues that affect study participants [24] and encourages research questions that promote understanding and manifestations of social change among a particular group of people. Additionally, this study followed Simon and Gagnon's [25] sexual script theory, emphasizing how interpersonal and socio-cultural scenarios and interactions can shape a person's sexual meaning and sexual life. In this regard, it is important to highlight that social constructions of physical disabilities and sexuality may become internalized by people with physical disabilities and may cause them to feel sexually excluded and disempowered [13].

Information about the study was disseminated through several Portuguese associations and community centers that work directly with people with physical disabilities (e.g., the Portuguese Association of Disabled People, the Portuguese Association of Spina Bifida and Hydrocephalies and the "Nós Tetrapégicos" Association, etc.), as well as through mailing lists and social networks (e.g., members of nongovernmental agencies and organizations that work with people with physical disabilities, Internet forums and Facebook). Participants responded to the study's online outreach via a website created for this purpose. After being presented with the study description and clarification regarding its research objectives, participants were asked to read and sign an informed consent form, acknowledging their voluntary participation in the study and that they were aware that their data would be kept confidential and anonymous.

A total of 95 contacts with Portuguese organizations were established, specifically requesting them to disseminate the study website and recruit voluntary participants from among their members. Study inclusion criteria encompassed self-identifying as a physically disabled person, living in Portugal, speaking and/or reading Portuguese fluently and being over 18 years of age.

Measurement Instruments

In accordance with the study's principle objectives, all study respondents were invited to complete a structured inquiry consisting of a short section of sociodemographic questions, a section to assess sexual behaviors and a qualitative section consisting of questions designed to assess sexual meanings and expression.

Sociodemographic questions included in the study asked about participants' age, gender, educational attainment, socioeconomic status, professional status, marital status, housing arrangements, and sexual orientation. The sociodemographic section also asked participants about their disabilities and overall health, including questions about their type of physical disability, if their disability was acquired or congenital (and, if acquired, for how long they have had it), pharmacological medication use, non-pharmacological therapy practices and a general health self-assessment item that was scored from 1 to 10. The sociodemographic assessment further questioned participants about their impairment levels, as well as the type and severity of their respective impairments.

Sexual behaviors were assessed using the following questions: "Have you ever had sex?"; "If so, how old were you when you had your first sexual experience?" and "Have you had any type of sexual activity recently (during the past six months)?" Participants who claimed to have engaged in sexual activity in the prior six months were asked to report the frequency of different sexual activities on a scale from 1 to 5 (1 = never; 5 = always), which included solo masturbation, mutual masturbation, oral sex, erogenous zone stimulation, anal penetration, vaginal penetration, kissing/touching/caressing and other activities. Participants who stated that they had not partaken in any sexual activity over the previous six months were asked to provide the reason for their lack of sexual activity during that time period. The study also asked participants questions regarding the use of protection during sex and whether they had ever been subjected to sexual abuse.

A set of 10 open-ended questions were developed to guide the electronic qualitative data collection process. The following questions were asked by the study: "What is human sexuality to you?"; "How does the expression of your sexuality interfere (or not) with your emotional well-being?"; "Do you have any type of sexual problems related to your physical disability that are a source of concern or suffering?"; "How important is sex in your life?"; "What is the overall (positive or negative) impact of your physical disability on the expression of your sexuality?"; "Is there anything that you would like to change in your sexual life?"; "Have you had access to relevant and specific disability-related forms of sexual education?"; "What positive aspects of your sexuality would you like to address?"; "Does your physical disability interfere with your life goals or plans that involve your sexuality?"; and "Is there anything you would like to add to this topic?"

Study participants spent an average of 27 min completing the online questionnaire by typing their responses to the survey. All participants gave their informed consent to take part in this research project. Additionally, this study utilized pseudonyms to refer to participants in order to ensure their anonymity. Furthermore, this study obtained ethical approval from the researchers' academic institution in Portugal.

Data Analysis

The data consisted of direct transcriptions imported from the information provided by participants in online interviews. We used thematic analysis to identify repeated patterns of meaning throughout the data sets [26]. Furthermore, this analysis was conducted from a critical epistemological point of view, recognizing that sexuality is socially constructed and influenced by disability-related experiences and any associated social oppression. In general, thematic analysis is not tied to any specific theoretical framework and can be applied to various theories and methodological approaches [27]. This study used inductive thematic analysis, with data being obtained from the semantic content and latent constructs inherent to participants' written responses [28]. This study utilized NVivo software to aid

in several steps of the data analysis process, namely becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the data report. The study author conducted the initial theme coding and identification, which was subsequently checked, discussed and refined for coding consistency by two independent experts in sexuality, psychology and disability. In cases where the assigned codes did not match, the researcher and the two independent coders engaged in a discussion in order to reach a consensus. English translations of the original Portuguese language interview content were carried out by a health and disability professional who is fluent in both English and Portuguese.

Participants

The study sample was comprised of 36 people with different physical disabilities who completely responded to the three questionnaire sections. Study participants ranged in age from 22 to 60 years old, with a mean age of 40.25 years ($SD = 10.45$). 58.3% ($n = 21$) of participants were male, almost 70% were single ($n = 25$), and the vast majority self-identified as heterosexual. The most represented physical disabilities in the sample were spinal cord injuries (41.7%, $n = 15$), spina bifida (16.7%, $n = 6$) and acquired brain injuries (16.7%, $n = 6$). 58.3% ($n = 21$) of participants did not report partaking in any sexual interactions over the previous 6 months, and 27.8% ($n = 10$) of study participants had never had sex. However, only 27.1% ($n = 10$) of study sample members said that sex did not matter in their lives. The majority of them also reported pharmacological therapy and physical use to control inflammatory process and prevent severe complications and deformities. Table 1 describes participants' sociodemographic information in greater detail.

Results

Regarding the study objective that sought to describe people with physical disabilities' sexual behaviors, just over 75% ($n = 27$) of participants reported not having engaged in any type of sexual activity in the previous 6 months. Among those who reported partaking in some type of sexual activity, kissing, touching and caressing (38.9%, $n = 6$), receiving erogenous zone stimulation (33.3%, $n = 5$) and performing oral sex (33.3%, $n = 5$) were the most frequent activities reported. Table 2 describes the reported sexual behaviors in greater detail. Among participants who reported not being sexually active in the previous 6 months ($n = 21$, 58.3%), only 2 (9.5%) mentioned that they did not engage in any sexual activity due to personal attributes, such as not feeling attractive. The remaining 19 (90.5%) systematically reported a lack of opportunity or lack of a partner to justify not having engaged in any sexual activity.

Regarding the second study objective, the content analysis of participants' responses revealed nine recurring themes encompassing 57 categories. The nine recurring themes are identified and described below, along with illustrative quotes from study participants.

Definitions of Human Sexuality

In discussions concerning their definitions of human sexuality, many participants emphasized the need to define sexuality as a way of expressing feelings, emotions, intimacy and identity, but also as a way to experience sex, sexual desire and sexual satisfaction through

Table 1 Participants' sociodemographic characteristics ($n = 36$)

	n	%	M	SD
Age			40.25	10.45
<i>Gender</i>				
Male	21	58.3		
Female	15	41.7		
<i>Educational attainment</i>				
Up to 12 years of schooling	12	33.3		
University degree	24	66.7		
<i>Socioeconomic status</i>				
Very low	2	5.6		
Low	10	27.8		
Medium	22	61.1		
High	2	5.6		
<i>Professional status</i>				
Unemployed	9	25		
Retired	6	16.7		
Employed	12	33.3		
Other	9	25		
<i>Marital status</i>				
Single	25	69.4		
Married	4	11.1		
De facto civil union	3	8.3		
Divorced	2	5.6		
In a committed relationship	2	5.6		
<i>Housing arrangement</i>				
Rents a house or apartment	6	16.7		
Owns a house or apartment	28	77.8		
Shares a room or part of a house	1	2.8		
Residential care facility	1	2.8		
<i>Sexual orientation</i>				
Heterosexual	30	83.3		
Bisexual	5	13.9		
Gay	1	2.8		
<i>Type of physical disability</i>				
Acquired brain injury	6	16.7		
Spinal cord injury	15	41.7		
Spina bifida	6	16.7		
Cerebral palsy	2	5.6		
Muscular dystrophy	4	11.1		
Hearing and/or visual impairments	2	5.6		
Osteogenesis imperfecta	1	2.8		
<i>Pharmacological therapy use</i>				
Yes	28	77.8		
No	8	22.2		
<i>Non-pharmacological therapy use (i.e., physical therapy)</i>				
Yes	21	58.3		

Table 1 (continued)

	n	%	M	SD
No	15	41.7		
General health self-assessment (1–10)			6.31	1.90
<i>Sexually active</i>				
Yes	26	72.2		
No	10	27.8		
<i>Sexually active in the past 6 months^a</i>				
Yes	15	41.7		
No	21	58.3		
<i>Importance of sex</i>				
Very important	14	39.6		
Somewhat important	12	33.3		
Not important at all	10	27.1		

^aOnly participants who reported being sexually active were asked this question

Table 2 Descriptive characterization of specific sexual behavior frequency over the past 6 months (expressed as a percentage of participants) ($n=36$)

	Never	Rarely	Sometimes	Very often	Always
Kissing, touching, caressing	61.1	5.6	8.3	8.3	16.7
Stimulation of erogenous zones (give)	69.4	5.6	8.3	5.6	11.1
Stimulation of erogenous zones (receive)	66.7	11.1	5.6	5.6	11.1
Solo masturbation	77.8	13.9	5.6	2.8	0
Mutual masturbation	75	13.9	8.3	2.8	0
Oral sex (give)	66.7	11.1	11.1	2.8	8.3
Oral sex (receive)	69.4	8.3	16.7	0	5.6
Vaginal sex (give)	72.2	5.6	2.8	13.9	5.6
Vaginal sex (receive)	83.3	5.6	5.6	0	5.6
Anal sex (give)	83.3	11.1	2.8	2.8	0
Anal sex (receive)	88.9	5.6	2.8	0	2.8
Other activities	88.9	2.8	0	2.8	5.6
Total	75.23	8.35	6.49	3.95	6.03

The “never” column values include the responses of participants who have never had sex (27.8% of all participants)

physical interactions. Characteristics such as gender, genitalia, and attractiveness embedded in these definitions were also mentioned.

Sexuality is a set of behaviors that humans exhibit, in order to satisfy their sexual desires. And, beyond that, it is what represents us as men and women, that is, our identity.—Maria, 22, spina bifida.

It is a physiological and human need. Kisses, hugs, sexual stimulation, touching a woman’s entire body, including her breasts, vagina, butt, lips and entire body.—Francisco, 47, muscular dystrophy.

Despite my great dependence [on others], I feel attractive, active and, with the natural limitations on my movements and posture, I view my sexuality as a way to express my freedom with a very high and healthy level of achievement.—Conceição, 48, muscular dystrophy.

Positive Impacts of Sexuality on Emotional Well-Being

Many participants referenced several positive consequences of their sexual expression, particularly on their emotional well-being. In this regard, many participants claimed that their sexual expression had a direct association with their self-esteem, emotional balance, personal fulfillment, self-confidence and happiness, while also allowing them to meet other people, socialize and feel less isolated. Despite that fact that some participants may feel self-conscious about their bodies, some were able to create a positive sexual narrative for themselves.

The physical fulfilment of my sexual needs favorably contributes to my emotional balance. When I have sex with a woman, I like myself better. I feel really good.—Francisco, 47, muscular dystrophy.

My self-esteem improves because I know that I am wanted, and that I can satisfy my partner on a sexual level.—Bruno, 37, spinal cord injury.

At first it was very complicated. Now, I've learned to relativize [the situation] and live with what I have. In this case, nothing. As I was very sexually active before the accident that caused me to become quadriplegic, I try to live off of the moments that I have already lived. I can visualize them and relive them in detail. I have sex like that and feel happier.—António, 57, spinal cord injury.

Negative Impacts of Sexuality on Emotional Well-Being

Many participants mentioned negative impacts related to sexuality on their emotional well-being. These impacts mainly resulted from confronting the limitations associated with their physical disabilities, often resulting in feelings of frustration, anxiety, depression, discomfort and disgust. These negative emotions may be associated with low self-esteem and lack of open communication regarding sexual expression, thus negatively impacting their mental health.

Yes, given my physical appearance, I was never able to have a partner. Living with my mother has also prevented me from getting one. Some medications make it difficult for me to achieve orgasm. It all makes me feel very frustrated.—Luísa, 57, muscular dystrophy.

Feeling neither sensitivity, nor having control over my erections, made adaptation very difficult and led me to seek satisfaction through feelings in other erogenous areas, such as my mouth, neck, ears, scalp and shoulders. It is essential for me to not feel that my body is only causing work for others (personal assistants, caregivers, medical personnel, etc.) and that I am treated with affection and not just assigned a functional meaning. This can cause me a great deal of discomfort and anxiety.—Bruno, 37, spinal cord injury.

Being paraplegic made me dependent on the help of others, I put on weight drastically, [and] then my self-esteem decreased. I feel very depressed and repulsed with my body.—Ana, 40, spinal cord injury.

Sexual Problems

Most participants mentioned some degree of sexual difficulty, problems or dysfunction. Erectile dysfunction and anorgasmia were the most frequently mentioned problems, but other problems associated with sexual positions, dependency on others and on medications were also commonly referenced. Many of these sexual difficulties may arise from direct trauma to the genital area (due to either accident or disease), damage to the nervous system (such as spinal cord injury), or as an indirect consequence of a non-sexual illness. Limitation involving muscular movements and dependency on others to perform sexually were also mentioned.

One of the effects [of my disability] is erectile dysfunction, so I use medication for sensory stimulation and to have an erection. When this is not possible, I try to use practices that do not involve penetration.—Ricardo, 40, spina bifida.

I feel very limited to very few positions. I depend on others for everything, and the lack of mobility really bothers me, and also the fact that I feel very inhibited because I wear a diaper.—Pedro, 23, spinal cord injury.

I can say that I would like to be able to engage in more sexual positions, with a greater degree of movement. Since I have joint retention, particularly in my mouth, I am less able to perform oral sex. In addition, I wonder if I can relate to other people to keep an activity interesting enough for the person that I am interacting with.—Inês, 48, muscular dystrophy.

Obstacles to Sexual Expression

When asked about possible obstacles to their sexual expression, the majority of participants mentioned discrimination and/or prejudice as major hindrances that arise from presenting themselves to the world in a wheelchair. Feeling less attractive, lacking sexual ability and dealing with physical barriers figured among some of the obstacles that were mentioned. In fact, the attitudes and support of other people are essential in enabling people with physical disabilities to have healthy personal and sexual lives. Addressing ignorance and prejudice, however, some may need additional support to develop relationships, explore and express their sexuality, and access sexual health information and services.

“Prejudice, no doubt about it. When people see me in a wheelchair, they immediately think that I am asexual.”—Marco, 26, spina bifida.

“Being in a wheelchair reduces other people’s desires because of some level of ignorance about people with disabilities’ sexuality.”—Fernando, 38, spinal cord injury.

“Societal standards make me feel like I don’t measure up. I don’t feel sexually attractive. I don’t feel normal.”—Joana, 50, acquired brain injury.

Sexual Expectations

Participants were also asked about their sexual expectations. Their responses encompassed the following three categories of sexual expectations: (1) engaging in more sexual activities (with or without a partner), relationships and interactions; (2) a desire for the disappearance of sexual prejudice regarding people with disabilities; and (3) having access to more information and sexual services adjusted to their needs. These claims often clash with a common view that disabled people’s sexuality is significantly influenced by prejudice (having a broken body), but participants feel empowered to continue claiming access to sexual experiences (whether paid for or not), and the right to be seen as sexual beings.

I wish I could have more sex more often!—Luís, 43, spinal cord injury.

I wish people around me would change the type of beliefs that they have about people with physical disabilities. I want to be seen as a human being and not as an asexual being.—Carlos, 26, spina bifida.

I would love to be able to enjoy the sensitivity and functionality of my sexual organ again. That would be fantastic!—Paulo, 40, spinal cord injury.

If I can’t have a girlfriend (which would be the ideal situation), I should be able to have access to cheaper services provided by sexual workers.—Pedro, 23, spinal cord injury.

“I believe that, overall, this topic should be seen in a more natural and ‘open-minded’ way by people, so that they can demystify certain prejudices or misconceptions that they still have with more information and reliable training.”—Francisco, 47, muscular dystrophy.

Positive Coping/Resilience

Expressing one’s sexuality under certain adverse circumstances can also be an opportunity to grow and develop personal skills and capabilities, thus helping to mitigate adversity. Participants mentioned positive ways of dealing with the impacts of physical disabilities on their sexuality, demonstrating a real capacity to adapt and adjust through positive and more open communication, self-respect, self-acceptance, trust in healthcare professionals and facilitators and through seeking love. In fact, these positive coping strategies and resilience mechanisms are important ways of minimizing negative impacts on well-being and can be seen as important resources to overcome barriers and promote self-acceptance, adaptation and problem-solving.

I was able to open up and accept my differences. Above all, [it is essential to] know how to respect yourself as a person, you and your body.[When] addressing issues related to sexual concerns without fear of expressing them, it is preferable to do so with someone you trust (someone close and/or a healthcare professional). [It is important] to realize that you are not less of a person because you have a physical disability, and that none of this should prevent you from having a sexual life (even if

it must be adapted to your particular situation).—João, 40, hearing and visual impairment.

I used to love sex before the accident, and I still do. Is it different? Yes, it is. But it is still very good.—Tiago, 37, spinal cord injury.

Each case is different. When I had girlfriends without physical disabilities, sex was more pleasurable and comprehensive. Hotel trips were much easier and cheaper. When I had girlfriends with physical disabilities, sex was much more difficult, we had to be helped by a third person, and we had to pay for that help. One helper costs €90 a night, plus round-trip transportation by private car, which costs €40. And the hotel, the cheapest costs around €55 for 3 people, breakfast included!—José, 47, spina bifida.

What I was and what I have become—it's nice to think that inviting love into my life has improved my identity, almost as if I were speaking to a divine being.—André, 39, acquired brain injury.

Societal Interactions

Several study participants referenced negative societal views regarding physical disabilities and the sexuality of people with disabilities, in particular. Taboos, prejudice and discrimination are singled out as sources of oppression by society at large. Participants stated that social isolation should be reduced through positive community interactions, in addition to demanding formal policies, formal sex education and greater freedom. Some participants also mentioned the intersections of more than one type discrimination, such as being physically disabled and bisexual, gay or lesbian. Also, they made several recommendations that would address their needs, such as better care in reproductive support, fighting homophobia or promoting sex education.

I would like society to understand that, although not all people with disabilities have sexual abilities, this does not apply to everyone, and we are human beings who feel desire, and we can be desired by others too.—Paula, 34, spinal cord injury.

The possibility to adopt children should be taken into account in a special (less 'restrictive') way for people with physical and reproductive disabilities. On the other hand, reproductive disabilities should be considered when seeking to provide redress for disabilities and their social impacts (positive discrimination).—Hugo, 39, spina bifida.

I am doubly discriminated against for being gay and quadriplegic. Architectural barriers are difficult to overcome, but mental ones are even more so. I know the world I live in. What am I going to do? [I am] trying to live in the best way possible, without jeopardizing my emotional balance and what I have achieved.—Daniel, 57, spinal cord injury.

This is a very important topic. We must take into account that sex is also psychologically based. A person shouldn't feel any taboos or shame in order to feel natural pleasure and happiness with his/her body. Teaching pleasure is fundamental for the person to know himself/herself properly. We are all different and we have differ-

ent tastes and desires, which are subject to different perspectives.—Marta, 28, spina bifida.

Society overlooks the social integration of people with disabilities. If they are not socially integrated, they will obviously be affected sexually. The two cannot be separated. Once a person is socially integrated and their differences are accepted, sexuality comes naturally. Human beings have a great capacity for adaptation, and physical disabilities are no exception. But, societal integration and the acceptance of differences is fundamental. This rule applies to everyone – 'disabled' or 'normal'.—Mariana, 43, spinal cord injury.

Discussion

This study sought to explore sexual behaviors and dynamics (including perceptions, beliefs, opinions and attitudes) among 36 Portuguese people living with physical disabilities. Despite the fact that 58.3% ($n=21$) of sexually active participants claimed that they had not engaged in any sexual activity over the previous 6 months and that 27.8% ($n=10$) of participants indicated that they were not sexually active, sex was still considered as being very important or somewhat important to 73% ($n=26$) of respondents, emphasizing their nature as sexual beings.

Regarding sexual behaviors, kissing, touching, and caressing, receiving stimulation of erogenous zones and performing oral sex were the most frequently reported sexual activities by participants. This finding is supported by the results of earlier studies [29–31], which indicated that people with physical disabilities have significantly lower odds of partaking in sexual activities that involve penetration and greater chances of not engaging in sex, at all. Nevertheless, the vast majority of those who reported not having sex stated that this was because of a lack of opportunity or lack of a partner. This further reinforces the notion that people with physical disabilities view themselves as sexual beings who must confront a normative construction of sexuality that focuses on the “ability” to have sex, is shaped by an emphasis on sexual intercourse and which questions their “ability” to have sex or assumes that having sex is no longer possible for them (“can you still have sex?”) [13].

Regarding sexual dynamics, this study examined participants’ perspectives of their sexual expression, perceptions and opinions. Overall, participants’ narratives reflect a positive view of sexuality, characterized by resilience and an optimistic attitude, despite the fact that they still have to deal with great amounts of prejudice, invisibility and social depreciation, which perpetuate the idea of people with physical disabilities as being undesirable, unattractive and asexual [12, 16]. These restrictions may also be reinforced by the internalization of the conservative and heteronormative norms embedded in Portuguese society. In turn, this leaves less room to develop specific and adapted responses to people with physical disabilities’ particular needs, such as having access to sex workers [32] or the implementation of policies that would allow for less restrictive adoption guidelines, thus interfering with their overall sexual well-being [33].

The research findings indicate that the sexual dynamics of study participants operate at two main levels—an intrapersonal level and an interpersonal level. At the intrapersonal level, participants’ discourses were influenced by individual factors associated with their physical disabilities (e.g., beliefs, impacts on their well-being, sexual problems, sexual expectations, coping, etc.). In contrast, at the interpersonal level, their discourses were

influenced by external or social factors (e.g., obstacles to their sexual expression and their interactions with society). As found in earlier studies [20, 34], this dual reality reflects the need to constantly adjust and adapt to the idiosyncratic aspects of each physical disability and the external demands that tend to reinforce stereotypes. This process is characterized by psychoemotional disablism and affects what people think about themselves, which, in turn, has a negative impact on their sexuality, often leading to sexual inhibition and isolation [35].

Since role models with physical disabilities are scarce, social stigma is persistently and inherently present in the study participants' narratives. The construction of people with physical disabilities' asexuality in Portugal is shaped by the influence of an external script [25] that contrasts with the responses voiced by most study participants. In fact, when many participants spoke about their sexual inabilities or difficulties, they were actually speaking about their need to renegotiate what it means for them to be sexual beings in a context where nondisabled others observe them based upon their own social expectations, highlighting the importance of considering disability as a social construction [13].

Based upon the need to improve their sexual lives, participants made several suggestions helpful to guiding future research in this field and to implementing social and political policies that are more inclusive and open in regard to the sexual rights of people with physical disabilities. Their recommendations encompassed suggestions, such as greater access to assistants and sexual providers, more effective and formal sexual education, addressing people with disabilities' sexuality without prejudice or taboos, improving communication and minimizing the negative impacts of sexuality on their overall well-being. Therefore, future research should focus on other stakeholders who have a direct impact on people with physical disabilities' lives, such as family members, healthcare professionals and educators, among others. This focus should seek to combine various efforts to implement strategies that are aligned with the common goal of helping people with disabilities to develop a more pleasurable and satisfying sexual life.

Limitations

This study was not without limitations. Given the nature of this study, we chose not to conduct a separate analysis for each specific physical disability. This decision was made based upon the relatively small number of participants in each category and because possible individual and social effects are transversal to all people with physical disabilities who are consistently exposed to some level of sexual stigma. Despite the fact that our objective was to assess the perceptions of Portuguese people living with physical disabilities, future research should include larger samples that compare the specificities inherent to distinct physical disabilities.

Furthermore, several limitations restrict the generalizability of the study findings, such as the fact that sample members were well educated, possessed Internet and technological access and were recruited through social organizations and social networks. The extent to which the study participants are representative of other people living with physical disabilities in Portugal remains to be seen. However, the intention of this study was not to provide generalized findings, but, rather, to enhance the understanding of people with physical disabilities' sexual lives in Portugal.

Moreover, concerns regarding the sample's representativeness in terms of gender and sexual orientation also call into question the generalizability of the study results. Future studies should include more physically disabled men and women who self-identify as gay or lesbian. Additionally, the use of complementary methodologies, such as in-depth face-to-face interviews, focus groups or research action plans would be beneficial additions to the literature regarding people with physical disabilities' sexual lives.

Conclusions

This study made important contributions to the demands of people with physical disabilities in Portugal to be seen as sexual citizens. Through this study, participants were given a voice to express their sexual experiences and dynamics, exposing personal and intimate realities, with the goal of reaching and educating social, political and public audiences to overcome multiple existing barriers. This process allows for the creation of more inclusive and facilitative conditions that acknowledge and accept that people with physical disabilities are sexual beings, who have the right to control, access and choose when it comes to negotiating their bodies, their identities, their relationships and their sexual expression.

Compliance with Ethical Standards

Conflict of interest There are no conflicts of interest to be declared.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the respective institutional and/or national research committees and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

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