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The relationship of stereotypes, social distance and sexuality knowledge with attitudes towards sexuality of people with mild intellectual disabilities

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Abstract

Background: The present study examines the relationship between stereotypical beliefs about people with intellectual disabilities, desire for social distance, and general knowledge about human sexuality with attitudes towards the sexuality of adults with mild intellectual disabilities.

Method: Two hundred fifty participants from staff, family and community samples completed an online set of questionnaires.

Results: Higher agreement with stereotypical beliefs and lower sexual knowledge were associated with less normalising and more paternalistic attitudes towards the sexuality of adults with mild intellectual disabilities. Higher agreement with stereotypical beliefs was also associated with more negative attitudes. On the other hand, willingness to interact with these adults was associated with more normalising and less paternalistic attitudes.

Conclusions: Interventions that aim to support adults with intellectual disabilities in relation to their sexuality should also address the perceptions of their support network towards them as individuals with disabilities, as well as their knowledge about sexuality.

KEYWORDS
attitudes, intellectual disabilities, sexuality, sexuality knowledge, social distance, stereotypes

1 | INTRODUCTION

Sexuality is a fundamental aspect of an individual's well-being and can be considered like any other human need. Although this seems to be widely accepted, difficulties arise when addressing this aspect among people with intellectual disabilities. Adults with mild intellectual disabilities perceive significant social and cultural barriers to their sexuality (Healy et al., 2009), even though they have the same sexual needs and rights as any other person without disabilities (Borawska-Charko et al., 2017; Brown & McCann, 2018). Indeed, previous studies indicate that up to 75% of adults with mild intellectual disabilities have had sex by age 20 (Baines et al., 2018), and up to 84.2% have had some form of sexual relationship with another person between the ages of 38 and 55 (Gil-Llario et al., 2018).

In contrast to this reality, adults with intellectual disabilities report limited access to sexuality education (Hole et al., 2022). Cautious attitudes are often expressed by staff members (Charitou et al., 2021), and families prefer preventive to educational interventions (Evans et al., 2009). Previous literature has pointed out that adults with intellectual disabilities are more vulnerable to abuse or show altered sexual

behaviour (Medina-Rico et al., 2018). Perhaps a desire for protection is behind this cautious approach to their sexuality. However, this would be part of the problem. Sex education is what would empower people with intellectual disabilities to enjoy sexual fulfilment and protect themselves from abuse and unwanted consequences of sexual intercourse (Gürol et al., 2014). In addition, blocking these adults from displaying age-appropriate sexual and social behaviour is what can lead to inappropriate behaviours (Harris & Tough, 2004). Difficulties should therefore be addressed through appropriate education, information, and support rather than through prohibition or denial.

The support network of the person with an intellectual disability, which often includes family members and staff from disability services (Abigail et al., 2021), has an important role in providing such support for these adults to achieve fulfilment as sexual beings and to express their sexuality (Brown & McCann, 2018). Qualitative research has shown that adults with intellectual disabilities have expressed a need for support from both family and staff regarding various aspects of their affective and sexual lives (de Wit et al., 2022). However, this responsibility also falls indirectly on the community, as community attitudes may influence community opportunities and availability of resources (Oliver et al., 2002). Therefore, addressing the beliefs and attitudes of these three groups—family, staff, and general community—becomes a very important first step when it comes to providing support and opportunities.

These beliefs and attitudes towards the sexuality of adults with intellectual disabilities have positively changed in recent decades (Correa et al., 2022; Lam et al., 2021; Pebdani & Tashjian, 2022). However, they are not as favourable as those towards their peers without disabilities (Cuskelly & Gilmore, 2007; Swango-Wilson, 2008), or with physical disabilities (McConkey & Leavey, 2013; Parchomiuk, 2012). In fact, adults with intellectual disabilities identify a need to change the attitudes and knowledge of all, community members, families, and support staff, when it comes to their sexuality (Coulter et al., 2023). In view of the above, it becomes necessary to pay attention to the factors that may be related to these attitudes, in order to intervene in an adjusted perception and, ultimately, in a better willingness to support these people regarding their sexuality.

Various variables have been associated with perceptions of the sexuality of adults with mild intellectual disabilities. According to review studies, the relationship with sociodemographic characteristics or familiarity with intellectual disabilities, understood as the type of relationship with someone with an intellectual disability, has been widely explored (Correa et al., 2022; Lam et al., 2021; Pebdani & Tashjian, 2022). For example, being older (Chou et al., 2016; Cuskelly & Bryde, 2004; Meaney-Tavares & Gavidia-Payne, 2012; Swango-Wilson, 2008), or having a family relationship compared to staff or community samples (Chou et al., 2016; Cuskelly & Bryde, 2004; Morales et al., 2011; Tamas et al., 2019), are associated with less favourable attitudes. Gender differences seem to remain unclear according to the cited review studies. However, a recent study found that variables measuring cultural orientation, which are more related to belief systems, were significantly more powerful in explaining differences in attitudes towards the sexuality of adults with intellectual disabilities than age and familiarity variables, which revealed a lower predictive power (Ditchman et al., 2017).

The latter would make sense, as understanding attitudes towards the sexuality of adults with intellectual disabilities requires disability to be approached from a broader perspective (Parchomiuk, 2013). Qualitative studies agree that fear of abuse or inappropriate approximations often underlie more restrictive attitudes (Charitou et al., 2023; Dupras & Dionne, 2014). Stereotypical views of people with intellectual disabilities as childlike (Jahoda et al., 2010; Scior & Werner, 2015), dependent or in need of protection are common (Scior & Werner, 2015), and would be consistent with a view of them being uninterested in sex or unfit for relationships, feeding the aforementioned fears. Indeed, a negative perception of intellectual disabilities, based on a medical model, has been associated with less favourable attitudes towards their sexuality (Parchomiuk, 2013). Typically, this negative perception is associated with negative and deficit-focused views, in line with the stereotypical views mentioned above. All of these stereotypical beliefs or views of people with intellectual disabilities may be associated with a biased view of their sexuality. However, to our knowledge, no quantitative study has examined the relationship between these beliefs and attitudes towards the sexuality of these adults.

If the way in which adults with intellectual disabilities are perceived can be related to attitudes towards their sexuality, general attitudes towards these people should not be overlooked. Beliefs and attitudes towards people with intellectual disabilities have been linked to different life domains (Ditchman et al., 2016, 2017) such as sexuality, although this last domain has received less attention (Ditchman et al., 2017). According to a recent systematic review by Scior (2011), attitudes towards people with intellectual disabilities seem to have changed very little in terms of stigma. Furthermore, laypeople tend to express a greater desire for social distance from those with a disability. The concept of social distance is used in research on intellectual disabilities, adapted from the field of mental-illness (Scior & Furnham, 2011), as a measure of dispositional attitudes towards individuals with intellectual disabilities (Ouellette-Kuntz et al., 2010) and discriminatory intentions or stigma (Pelleboer-Gunnink et al., 2021), with the advantage of being easy and quick to assess compared to other attitudinal or dispositional measures or scales. A greater disposition or better attitude towards this group may lead to more favourable dispositions towards a sensitive issue, such as their sexuality.

When measuring attitudes towards the sexuality of adults with mild intellectual disabilities, beliefs or knowledge about human sexuality may play an important role in the convergence of sexuality and disability. People with intellectual disabilities are often framed as lacking cognitive capacity for sexuality, as a result from sexual ableism (Gill, 2015; Hole et al., 2022), and sexuality knowledge may have an important role. For example, rehabilitation counsellors' knowledge of sexuality and disability was associated with greater willingness to provide counselling or educational support to people with spinal cord injury (Kazukauskas & Lam, 2010), and training on sexuality and disability among staff from disability services with more favourable attitudes towards the sexuality of people with intellectual disabilities (Deffew et al., 2022; Grieve et al., 2009; Meaney-Tavares & Gavidia-

Payne, 2012). However, so has general sexuality training among staff (Pebdani, 2016), and enrolment in a sexuality course among psychology students (Franco et al., 2012). The perception of the adult with an intellectual disability as asexual has been linked to a predominant heteronormative idea of sex (Esmail et al., 2010). It would not be surprising, therefore, if common misconceptions about sexuality underlie inaccurate and reductionist beliefs about sexuality in these adults.

There is a lack of research that attempts to examine these associations between stereotypical views of adults with intellectual disabilities, attitudes towards this collective, or general knowledge about sexuality with attitudes towards the sexuality of people with mild intellectual disabilities. Therefore, the present study aims to take a first step towards filling this gap in the literature by using quantitative strategies to examine how attitudes towards the sexuality of adults with intellectual disabilities are related, not only to previously studied variables, but also to these new ones, related to belief systems. More specifically, this study aims to examine the role of age, gender, familiarity, stereotypical perceptions of disability, attitudes towards people with intellectual disabilities through the concept of social distance, and general knowledge about sexuality. Also, the predictive power of each set of variables will be assessed. This should enable professionals to determine which aspects other than 'sexuality and disability' to focus on when supporting adults with disabilities, their families, staff or even when raising awareness in the community.

2 | METHOD

2.1 | Participants

This study was part of a larger project that aims to explore current attitudes towards the sexuality of adults with intellectual disabilities in Spain, and to identify factors that may be associated with resistance to change in these attitudes.

The initial sample included records from 467 participants. The following inclusion criteria were applied for this study: (1) Completion of the full set of questionnaires. Partial responses (i.e., responding only to the first two scales) were not taken into account (157 excluded); (2) correctly answering a control question included in the social distance questionnaire (4 participants excluded); (3) not being enrolled in a related undergraduate or postgraduate course (55 participants excluded); and (4) being over 18 years old (1 participant excluded).

Therefore, the final sample consisted of 250 participants between 18 and 74 years of age ($M_{age} = 37.16$; $SD = 12.57$). Of these, 98 were staff of organisations for people with intellectual disabilities, 44 were first- or second-degree relatives of people with intellectual disabilities, and 108 were categorised as general population with no connection to people with intellectual disabilities.

2.2 | Procedure

Data were collected through an online survey using the Qualtrics™ platform (www.qualtrics.com) between June 2022 and December 2022. Staff and family samples were recruited through the collaboration of four service networks for adults with intellectual disabilities (providing residential, occupational and day-care services), in two autonomous communities in Spain, between June 2022 and July 2022. An email explaining the aim of the project and the need for collaboration was sent to each network coordinator. Further explanations were provided if necessary. Once accepted, additional information and the link to the informed consent and online survey were sent for each network coordinator to distribute. The general population sample was recruited through social media outreach between June 2022 and December 2022. Participation was requested through an announcement that included a brief explanation of the study purpose and a link to the consent form and the survey. The study complied with the ethical principles of the Declaration of Helsinki. This study procedure and protocol were submitted for approval by both the data treatment unit of the principal investigator's university and the Clinical Research Ethics Committee of their autonomous community. Both bodies gave their approval.

2.3 | Instruments

2.3.1 | Sociodemographic questionnaire

Participants were asked about their gender (female, male, other), age, whether they currently worked in a resource for people with intellectual disabilities, whether they had a family member with an intellectual disability and whether they knew someone with an intellectual disability.

2.3.2 | Assessment of attitudes towards sexuality of people with intellectual disability (ASEXID)

Developed and validated by Gil-Llario, Fernández-García, et al. (2021), this scale is composed of 18 items that assess attitudes towards different aspects related to the sexuality of adults with intellectual disabilities through three factors: 'Normalising attitude' (seven items, where higher scores are related to the belief that the sexuality of people with intellectual disabilities has the same characteristics as the sexuality of adults without intellectual disabilities, α for this study = .73), 'Negative attitude' (five items, where higher factor scores are related to the belief that people with intellectual disabilities have less interest in sexuality than those without a disability, and that it is unnecessary or dangerous to talk about it, α for this study = .67), and 'Paternalistic attitude' (six items, where higher factor scores are related to the belief that people with intellectual disabilities are unable to control their sexuality or associated risks, α for this study = .68). These items are scored on a five-point Likert-type scale ranging from 1 'strongly disagree' to 5 'strongly agree'. Respondents were asked to think about adults with mild intellectual disabilities when answering the entire questionnaire.

2.3.3 | Stereotypes-trait-rating scale

An adaptation of the stereotype-trait-rating scale proposed by Pelleboer-Gunnink et al. (2021) was used. This scale consists of 18 statements including stereotypical beliefs about people with intellectual disabilities. Respondents have to rate their agreement with these statements, from 1 'completely disagree' to 5 'completely agree'. Although the original version of the scale proposes four factors (stereotypes related to being 'friendly', 'in need of help', 'give nuisance' or 'unintelligent'), only those factors with acceptable reliability in this Spanish sample were included for analysis. According to previous literature, the minimum value for Cronbach's alpha should be .65 (Vaske et al., 2017). Therefore, only the factors 'Friendly' (5 items, i.e., people with intellectual disabilities are 'friendly', 'affectionate', 'happy', α for this study = .89) and 'Nuisance' (5 items, i.e., people with intellectual disabilities 'give nuisance', 'neglect themselves', 'are criminal', α for this study = .67) were considered for regression analysis. Higher scores on each factor are associated with higher agreement with the corresponding set of stereotypes.

2.3.4 | Social distance

Adaptation of the unifactorial indicator of social distance used by Pelleboer-Gunnink et al. (2021). It consists of five statements, in which participants are asked about how willing they would be to interact with someone with an intellectual disability in a variety of situations (i.e., spend an evening socialising). These statements are rated in a Five-point Likert scale, from 1 'definitely not' to 5 'definitely'. Higher scores are associated with a greater willingness to interact with people with intellectual disabilities, and therefore to less desire of social distance. Cronbach's alpha for this study = .81.

2.3.5 | Control question

Embedded as the sixth item of the social distance scale, to test whether the participants paid enough attention to the wording of the items. This item asked participants to answer 'maybe yes, or maybe not'. Participants who responded with a different option were excluded.

2.3.6 | Sexuality knowledge

Based on a previous study (Claramunt, 2011), 11 questions were adapted to assess respondents' degree of general knowledge about sexuality. This questionnaire included 11 statements to be answered with true or false, about sexuality and genitality (i.e., 'when we talk about sexuality, we only mean sexual intercourse), sexuality throughout life (i.e., 'old people can still have a sexual life full of pleasure'), masturbation (i.e., 'masturbation is ok to experience sexual pleasure'), STIs (i.e., there are effective medical treatments for most STIs) and pregnancy (i.e., during menstruation pregnancy cannot occur). The percentages of correct answers (three categories: 100%, 91%, 82%, or less) were used as indicators of sexual knowledge for this study. The full set of questions can be consulted in Appendix A.

2.4 | Data analysis

Hierarchical regression analysis was performed for each attitudinal factor to examine the relationship between the study variables and the three attitudinal factors, as well as the increase in variance accounted for by each regression model (R^2_{adj}). The additional contribution of each set of variables was examined by changes in R^2 (ΔR^2).

Five blocks were defined to address the study aims. Step 1 included sociodemographic data on gender (0-female, 1-male) and age. Step 2 added sample group in nested dummy variables (1-staff vs. 0-family sample, 1-general population vs 0-family sample). Step 3 included the 'friendly' and 'nuisance' stereotypes. Step 4 included social distance. Finally, step 5 included the sexuality knowledge indicator in two nested dummy variables, comparing those who got 100% of the answers correct with those who got 91% (1–0, respectively), and those who got 82% or less to those who got 91% (1–0, respectively). This order of variable inclusion was chosen to facilitate results interpretation, first controlling for sociodemographic and familiarity variables.

To assess potential multicollinearity, Variance Inflation Factors (VIF) were checked (Belsley et al., 1980). The VIF values in this study did not exceed 1.349, so multicollinearity was not a concern. Data were examined using the SPSS statistics 25 package.

3 | RESULTS

3.1 | Missing data and outliers

Only participants who responded fully to the entire set of questionnaires were considered for data analysis. Among their responses to these scales, no missing values were detected. The three subscales of the ASEXID were examined for outliers, and assessed by inspecting a box plot for values greater than 1.5. Seventeen outliers were identified, nine of which corresponded to the normalising attitude subscale and eight to the negative attitude subscale. Upon visual examination of the identified cases, it was determined that these scores originated from 10 general population participants, 2 staff participants, and 5 family participants, with varying age ranges. No data entry errors were identified. Given the size of the study sample, these outliers were assumed to be true outliers that were part of the study's distribution, without being removed or specially treated. Among the independent variables, two age outliers were identified without differences in results significance after the removal of cases, so these were

maintained for the present study. The same was observed for two cases among the social distance scale scores.

3.2 | Descriptives

Sociodemographic data on age and gender for each reference group are described in Table 1.

3.3 | Means, SD, and correlations between scales

Means, standard deviations and correlations were calculated for the ASEXID and Stereotypes-trait-rating subscales, and the social distance measure (see Table 2). Overall, attitudes towards the sexuality of adults with intellectual disabilities tended to be favourable (normalising attitude, M = 30.75, SD = 3.71; negative attitude, M = 6.77, SD = 2.25), while scores for paternalistic attitudes were intermediate (M = 14.44, SD = 4.16). Agreement with stereotypical beliefs that adults with intellectual disabilities are 'friendly' was somewhat high (M = 19.41, SD = 3.90), while agreement with stereotypical beliefs that adults with intellectual disabilities are a 'nuisance' was close to intermediate scores (M = 10.57, SD = 3.40). Willingness to interact with someone with an intellectual disability, measured by social distance, was high (M = 22.61, SD = 2.81). Correlations appeared between scores for various of the measures included as predictors, ranging from small to medium when significant (see Table 2).

For the sexuality knowledge indicator, 73 participants (29.2%) answered less than an 82% of the questions correctly, 101 participants (40.4%) answered 91% of the questions correctly and 76 participants (30.4%) answered 100% of the questions correctly.

TABLE 1 Age and gender sociodemographic data by mean of familiarity.

	Mean age (SD)	Gender (% women)
Staff ($n = 98$)	37.93 (10.55)	81.6%
Family ($n = 44$)	41.95 (14.49)	77.3%
General population ($n = 108$)	34.62 (12.96)	73.1%

3.4 | Regression models

Results on the series of hierarchical regression analysis are summarised in Table 3, presented by attitudinal subscale.

3.4.1 | Normalising attitude

Older age was associated with a less normalising attitude (model 1, $\beta = -.351$, $p < .001$; model 5, $\beta = -.274$, $p < .001$), while staff showed a more normalising attitude than family members (model 2, $\beta = .203$, $p = .018$; model 5, $\beta = .175$, $p = .027$). When introduced, beliefs that people with intellectual disabilities are a 'nuisance' were related to a less normalising attitude ($\beta = -.244$, $p < .001$) and greater disposition to interact with people with intellectual disabilities related to a more normalising attitude ($\beta = .207$, $p = .001$). A lower percentage of correct answers on the sexuality questionnaire was associated with a less normalising attitude ($\beta = -.190$, $p = .003$). These trends remained significant in subsequent steps up to Model 5 (see Table 3).

Based on the changes in R^2, the three additional sets of variables increased the percentage of the total variance accounted for in the normalising attitude factor (see Table 3), from 14.5% in the second step (including age, gender and familiarity) to 27.9% in the final step (considering stereotypes, social distance and sexuality knowledge).

3.4.2 | Negative attitude

Only models 1 to 3 were found to be significant (see Table 3). The inclusion of social distance and sexuality knowledge did not add relevant information and negatively affected the predictability of the regression models. Considering Steps 1 to 3, being male was related to a more negative attitude (Model 1, $\beta = .180$, $p = .005$; model 3, $\beta = .135$, $p = .025$). The same was observed for the general population compared to families (model 2, $\beta = .210$, $p = .020$; model 3, $\beta = .185$ $p = .032$). Higher agreement with stereotypes that adults with intellectual disabilities are 'friendly' ($\beta = .264$, $p < .001$) and are a 'nuisance' ($\beta = .242$, $p < .001$) was related to a more negative attitude towards their sexuality.

TABLE 2 Mean scores, standard deviation and correlations for the ASEXID, stereotype-trait-rating scale and social distance scale.

	Min-max range[a]	Mean (SD)	1	2	3	4	5
1. Normalising attitude	5–35	30.75 (3.71)					
2. Negative attitude	5–25	6.77 (2.25)	−.466***				
3. Paternalistic attitude	5–30	14.44 (4.16)	−.561***	.398***			
4. Stereotypes 'friendly'	5–25	19.41 (3.90)	.108	.202***	−.054		
5. Stereotypes 'nuisance'	5–25	10.57 (3.40)	−.260***	.188**	.349***	−.321***	
6. Social distance	5–25	22.61 (2.81)	.322***	−.212***	−.384***	.112	−.343***

Note: ***$p \leq .001$, **$p \leq .01$, *$p \leq .05$.

[a]Minimum and maximum global scores for the subscale.

TABLE 3 Hierarchical regression models.

		Normalising attitude					Negative attitude					Paternalistic attitude				
		R^2_{adj}	ΔR^2	β (SE)	β	*p*	R^2_{adj}	ΔR^2	β (SE)	β	*p*	R^2_{adj}	ΔR^2	β (SE)	β	*p*
Step 1		.120					.026					.101				
	Age			**−.102 (.018)**	**−.351**	**< .001**			.008 (.011)	.047	.455			**.104 (.020)**	**.316**	**< .001**
	Gender			−.604 (.526)	−.069	.252			**.966 (.338)**	**.180**	**.005**			.991 (.604)	.100	.102
Step 2		.145	**.032**				.077	**.058**				.097	.004			
	Age			**−.103 (.018)**	**−.354**	**< .001**			.015 (.011)	.087	.170			**.105 (.021)**	**.319**	**< .001**
	Gender			−.466 (.522)	−.053	.373			**.836 (.331)**	**.156**	**.012**			.933 (.609)	.094	.127
	Staff_fam			**1.515 (.636)**	**.203**	**.018**			−.214 (.403)	−.047	.597			−.526 (.742)	−.062	.479
	Genpop_fam			.261 (.636)	.035	.682			**.947 (.404)**	**.210**	**.020**			.000 (.742)	.000	.999
Step 3		.205	**.066**				.154	**.082**				.197	**.105**			
	Age			**−.098 (.017)**	**−.338**	**< .001**			.012 (.011)	.068	.260			**.097 (.019)**	**.294**	**< .001**
	Gender			−.195 (.507)	−.022	.701			**.723 (.319)**	**.135**	**.025**			.535 (.578)	.054	.356
	Staff_fam			**1.541 (.617)**	**.206**	**.013**			−0.14 (.389)	−.003	.971			−.404 (.704)	−.048	.567
	Genpop_fam			.411 (.615)	.056	.505			**.835 (.387)**	**.185**	**.032**			−.258 (.702)	−.031	.713
	Friendly			.037 (.058)	.040	.517			**.151 (.036)**	**.264**	**< .001**			.072 (.066)	.068	.273
	Nuisance			**−.264 (.067)**	**−.244**	**< .001**			**.160 (.042)**	**.242**	**< .001**			**.425 (.076)**	**.346**	**< .001**
Step 4		.238	**.036**				.163	.012				.259	**.063**			
	Age			**−.091 (.017)**	**−.314**	**< .001**			.010 (.011)	.054	.371			**.087 (.019)**	**.263**	**< .001**
	Gender			−.042 (.498)	−.005	.933			**.668 (.319)**	**.125**	**.037**			.304 (.558)	.031	.586
	Staff_fam			**1.522 (.604)**	**.204**	**.012**			−.007 (.387)	−.002	.985			−.376 (.677)	−.044	.579
	Genpop_fam			.633 (.605)	.086	.297			.755 (.388)	.168	.053			−.593 (.678)	−.071	.383
	Friendly			.033 (.057)	.035	.561			**.153 (.036)**	**.266**	**< .001**			.079 (.063)	.074	.212
	Nuisance			**−.194 (.068)**	**−.179**	**.005**			**.135 (.044)**	**.204**	**.002**			**.320 (.077)**	**.260**	**< .001**
	Social distance			**.268 (.079)**	**.207**	**.001**			−.096 (.051)	−.122	.058			**−.404 (.088)**	**−.275**	**< .001**
Step 5		.279	**.045**				.173	.017				.322	**.067**			
	Age			**−.080 (.017)**	**−.274**	**< .001**			.005 (.011)	.030	.622			**.070 (.018)**	**.212**	**< .001**
	Gender			.167 (.489)	.019	.733			.594 (.320)	.111	.064			−.046 (.539)	−.005	.932
	Staff_fam			**1.311 (.590)**	**.175**	**.027**			.071 (.386)	.015	.855			−.093 (.650)	−.011	.886
	Genpop_fam			.540 (.590)	.073	.361			**.791 (.386)**	**.176**	**.041**			−.515 (.649)	−.061	.429
	Friendly			.077 (.056)	.082	.176			**.136 (.037)**	**.237**	**< .001**			.036 (.062)	.034	.558
	Nuisance			**−.157 (.068)**	**−.145**	**.021**			**.121 (.044)**	**.185**	**.007**			**.291 (.075)**	**.236**	**< .001**
	Social distance			**.242 (.077)**	**.187**	**.002**			−.087 (.050)	−.110	.087			**−.369 (.085)**	**−.251**	**< .001**
	Knowledge 100_91			.544 (.484)	.069	.262			−.159 (.317)	−.033	.615			**−1.677 (.533)**	**−.186**	**.002**
	Knowledge 82_91			**−1.531 (.509)**	**−.190**	**.003**			.597 (.333)	.121	.074			**1.260 (.560)**	**.138**	**.025**

Note: Bold data correspond with significant results $p \leq .05$. Step 1 predicts ASEXID attitudes by age and gender (coded 0–1) variables. Step 2 consider group of reference. Groups have been nested, with family groups as group of reference (staff—1, family—0, general population—1). Step 3 includes scores in the 'friendly' and 'nuisance' factor of the stereotypes scale. Step 4 includes the general social distance score. Step 5 includes the percentage of correct answers on the general sexuality knowledge questions, referenced to intermediate number of correct answers in nested variables (100% correct answers—1, 91% correct answers—0, 82% or less correct answers—1).

Based on the changes in R^2, only the first two additional sets of proposed variables increased the percentage of the total variance accounted for in the negative attitudes subscale (see Table 3), from 7.7% in the second step up to 15.4% in the third step.

3.4.3 | Paternalistic attitude

Older age related to a more paternalistic attitude (model 1, $\beta = .316$, $p < .001$; model 5, $\beta = .212$, $p < .001$). When introduced, agreement with beliefs that people with intellectual disabilities are a 'nuisance' related to a more paternalistic attitude ($\beta = .346$, $p < .001$), greater disposition to interact with people with intellectual disabilities to a less paternalistic attitude ($\beta = -.275$, $p < .001$), and having less knowledge about sexuality with a more paternalistic attitude (lower % of correct answers vs. intermediate, $\beta = .138$, $p = .025$; 100% correct answers vs. intermediate, $\beta = -.186$, $p = .002$). These trends remained significant in subsequent steps up to Model 5 (see Table 3).

Based on the changes in R^2, the last three sets of variables significantly increased the percentage of the total variance accounted for in the paternalistic attitude subscale (see Table 3), from 9.7% in the second step up to 32.2% in the final step.

4 | DISCUSSION

There is a need to understand what factors may be associated with attitudes towards the sexuality of adults with intellectual disabilities, in order to develop tailored interventions. The present study sought to explore how stereotypical beliefs and attitudes towards people with intellectual disabilities, as well as general knowledge about sexuality, might be related to these attitudinal systems. A greater agreement with stereotypical beliefs about adults with mild intellectual disabilities being a 'nuisance' was found to be associated with a less normalising and more negative and paternalistic attitudes. Agreement with stereotypes about adults with intellectual disabilities being 'friendly' was associated with a more negative attitude. Less willingness to interact with these adults was associated with a less normalising and more paternalistic attitude. Finally, a higher percentage of incorrect answers to general questions about sexuality was particularly related to a more paternalistic and less normalising attitude. These results, organised for each block of attitudes (normalising, negative, paternalistic), are discussed.

The normalising attitude factor measured the understanding that the sexuality of adults with intellectual disabilities is the same as that of adults without a disability. In line with findings of younger participants being more favourable towards adults with intellectual disabilities sexual rights (Meaney-Tavares & Gavidia-Payne, 2012), sexual expression (Cuskelly & Bryde, 2004) and sexual behaviours (Swango-Wilson, 2008), younger participants presented higher scores on the normalising attitude. Staff in comparison to families also scored higher, replicating previous findings (Gil-Llario, Díaz-Rodríguez, & Ballester-Arnal, 2021; Gil-Llario, Fernández-García, et al., 2021). Qualitative research has found that parents tend to report ambivalent feelings towards their children with an intellectual disability relating romantically with others (Charitou et al., 2023). Family members frequently express concerns about abuse (Charitou et al., 2023; Evans et al., 2009), and doubts about their family members with intellectual disabilities respecting social norms in their sexual approaches (Dupras & Dionne, 2014). These concerns may affect their perception of their sexual possibilities or abilities. Conversely, while staff members report a more normalising attitude, their ability to respond to the sexual behaviour of adults with intellectual disabilities may be constrained by the general policies, and divergent values and culture of disability services in this regard (Charitou et al., 2021).

Higher agreement with stereotypical beliefs about adults with mild intellectual disabilities being a 'nuisance' and a lower disposition to interact with these people were associated with a less normalising attitude. This stereotypical negative view of people with intellectual disabilities could be in line with previous findings in which they are perceived as vulnerable or perpetrators of inappropriate sexual behaviour (Medina-Rico et al., 2018). Therefore, they would be perceived as less able to manage a normalised sexuality and their sexuality would be interpreted as different from the sexuality of non-disabled people. Together with the finding of social distance, it could be understood that a higher level of stigma is behind the less normalising attitude. Stigma recognises differences based on a distinguishing characteristic and involves a devaluation of the other person (Dovidio et al., 2000). It makes sense, therefore, that those who hold these stereotypes and social distance scores would have more difficulty equating characteristics about the sexuality of both populations, with and without intellectual disabilities.

A higher rate of incorrect answers to the sexuality knowledge questionnaire was associated with less normalising attitudes towards the sexuality of adults with mild intellectual disabilities, consistent with findings of more favourable attitudes when human sexuality training is provided to staff (Pebdani, 2016) and students (Franco et al., 2012). Sexuality can be experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships (World Health Organization, 2002), and is important regardless of age (Macleod & McCabe, 2020). However, sexuality tends to be associated with a reductionist view centred on youth and full physical and mental capacity (Gil-Llario, Fernández-García, et al., 2021). The understanding of sexuality beyond intercourse and across the lifespan are assessed in the sexual knowledge questions of this study and may be behind the greater difficulties in thinking of people with disabilities as sexual beings, beyond their difficulties.

In terms of the negative attitude factor, a more negative view was found among the general population compared to family members, in contrast to previous studies (Gil-Llario, Díaz-Rodríguez, & Ballester-Arnal, 2021). No associations were found with other sociodemographic variables. In subsequent regression steps, only stereotypes were related to this attitude. Higher agreement with

stereotypical beliefs that adults with intellectual disabilities are a 'nuisance' and 'friendly' was associated with a more negative attitude. The relationship between the 'nuisance' factor and a more negative attitude may be in line with the explanations provided for the normalising attitude. However, the relationship with the stereotypical view that they are 'friendly' is quite interesting. This factor includes beliefs that these people are 'friendly', 'sociable', 'affectionate' and 'happy' (Pelleboer-Gunnink et al., 2021), while the negative attitude factor measured beliefs about these adults having less interest in sex or that access to sex education should be limited (Gil-Llario, Fernández-García, et al., 2021). The traits of the 'friendly' factor, although positive, may be related to a childish view of adults with intellectual disabilities, leading to an infantilisation of both their person and their sexuality. It is therefore not surprising that such beliefs make it difficult for respondents to see the adult with mild intellectual disabilities as having the same interest in sex as their peers without disabilities. Indeed, infantilisation has already been linked to a denial of sexuality in adults with autism spectrum disorders (Lo Bosco, 2023), and this could be replicated in other conditions such as intellectual disabilities.

The paternalistic attitude (including concerns about pregnancy or abuse, or the need for legal guardians intervening) was related to a significant number of variables. Older age was associated with a more paternalistic attitude, consistent with previous studies that found older participants to be less favourable towards these people parenting (Jones et al., 2010; Oliver et al., 2002). However, the greatest increase in the percentage of the total accounted variance for this attitude occurred when stereotypes were included (significance was found for the 'nuisance' factor). As proposed for the normalising attitude, these stereotypes may be consistent with perceptions of vulnerability to abuse or altered sexual behaviour in the negative perception of the adult with intellectual disabilities. Less disposition to interact with adults with intellectual disabilities was also associated with a more paternalistic attitude. According to previous literature, greater social distance towards people with disabilities or special needs is associated with lower knowledge about them (Firat & Koyuncu, 2022; Mathias et al., 2018). If lower knowledge is to be expected among those who report a higher preference for social distance, it is not surprising that they are unaware of these people's ability to self-manage their sex life.

Finally, a higher rate of correct answers to the sexual knowledge questions was associated with a less paternalistic attitude. Explanations for this finding may be similar to those for the normalising attitude. If people with intellectual disabilities do not fit into reductionist conceptions of sexuality (Gil-Llario, Fernández-García, et al., 2021), sexuality can be interpreted as being partly out of reach for these individuals, potentially leading to overprotection. Promoting adequate knowledge about sexuality may allow people to perceive the sexuality of adults with intellectual disabilities with a kinder perspective, relying more on their ability to live it in a functional way or to provide support for it.

5 | LIMITATIONS AND FUTURE STUDIES

Relevant findings are drawn, although these results should be considered in the context of some limitations. First, with regard to the study measures. It was only possible to examine the role of two stereotype blocks, as the remaining ones did not reach acceptable levels of reliability for the study sample. Knowledge about sexuality was assessed with only 11 questions, based on a previous study, and used as a preliminary indicator. Second, as this was a convenience sample, response bias is possible, and the representativeness of these results could be limited. Responses may be influenced by social desirability or a sense of political correctness. Third, although regression models were used to analyse the relationship between the survey variables and the three attitudinal factors, causality should not be assumed. This study should be seen as a preliminary, pilot study and future research should seek to explore these associations further.

Future studies should also examine the extent to which stereotypical and inaccurate views of people with disabilities affect attitudes, or even the provision of support in this area, when attitudes appear to be favourable. A desire for social distance was associated with less favourable attitudes. Perhaps other dispositional variables could also be investigated. For example, empathy has been associated with general attitudes towards people with intellectual disabilities (Parchomiuk, 2019), and this could be replicated in relation to their sexuality.

In the present study, a positive relationship was found between attitudes and general knowledge about sexuality. Therefore, future studies should explore this relationship in depth, using more comprehensive sexuality questionnaires, in order to clarify what misconceptions about general sexuality are behind this finding. It should be investigated if the reductionist view of sex discussed is behind the less favourable attitudes. Perhaps misconceptions that understand sexuality only in genital terms may play an important role.

Despite study limitations, the present work contributes relevant data to the field of research. It can be considered a novel study because, to our knowledge, it is the first to quantitatively assess the relationship between stereotypes and social distance towards adults with mild intellectual disabilities, and general sexual knowledge with the attitudes towards the sexuality of these individuals. Increases in the percentage of the total variance accounted for by the proposed models when these variables are included are modest but remarkable, especially for paternalistic attitudes (up to a 23.5% increase in the final model according to the sum of changes in R^2 values). Therefore, the relationship of the three sets of beliefs and knowledge (stereotypes, willingness to interact as measured by social distance, and knowledge of sexuality) with attitudes towards the sexuality of adults with intellectual disabilities is highlighted and should be considered when planning interventions to support adults with intellectual disabilities when it comes to their sexuality. More specifically, when intervening with their support networks to provide appropriate support.

6 | CONCLUSIONS

The present study offers a novel analysis of what may affect the attitudes towards the sexuality of adults with mild intellectual disabilities by quantitatively examining how stereotypes towards adults with mild intellectual disabilities, social distance, and general knowledge about human sexuality are related to attitudes towards the sexuality of adults with intellectual disabilities. The three sets of variables yielded significant results, with some differences between the attitudinal factors.

This should be particularly taken into account when programming interventions aimed at changing current attitudes towards the sexuality of adults with intellectual disabilities. Not only should the sexuality of these adults be addressed, but also misconceptions and stereotypes about who they are, how they behave, and how human sexuality is understood. These interventions are essential to improve the willingness of the support networks of individuals with intellectual disabilities to provide support for satisfying intimate and relational interactions, as well as the facilitation of sexuality education and access to information and resources.

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CONFLICT OF INTEREST STATEMENT

The authors have disclosed that they have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request. The data are not publicly available due to privacy restrictions.

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APPENDIX A

A.1 | SEXUALITY KNOWLEDGE QUESTIONS

	True	False
1. When we talk about sexuality, we only mean sexual intercourse.		
2. Sexuality is a way of relating to and communicating with another person.		
3. Our whole body is capable of experiencing pleasure, not just our genitals.		
4. Feelings of sexual pleasure in childhood are a sign of some kind of abnormality or perversion.		
5. Sexuality begins at puberty, when our bodies change and become adult.		
6. Older people can still have a pleasurable sexual life.		
7. Masturbation is a valid way of experiencing sexual pleasure.		
8. There are effective medical treatments for most sexually transmitted infections.		
9. The likelihood of transmitting sexually transmitted infections is greatly reduced by using a condom or latex barrier.		
10. Pregnancy is not possible during menstruation.		
11. Pregnancy can occur even if the man does not ejaculate.		