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Staff Views Towards the Sexuality of Adults with Mild Intellectual and Developmental Disabilities: The Role of Experience and Job Position

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Abstract: Staff attitudes towards the sexuality of adults with mild intellectual and developmental disabilities may influence how the sexuality of service users is dealt with. The present study aimed to examine these attitudes in a Spanish context. A total of 102 staff members from service facilities for adults with intellectual and developmental disabilities, including direct-care and professional staff, responded to an online version of the Attitudes Towards the Sexuality of Individuals with Intellectual Disabilities Scale. In general, the participants demonstrated an understanding that adults with intellectual and developmental disabilities have sexuality. They reported favourable attitudes towards some self- and other-oriented sexual behaviours and sex education. Intermediate scores and variability on some items revealed concerns about these adults' ability to control their sexual urges, perceptions of sexual abuse, pornography use, and contraception. Some differences appeared in relation to socio-demographic variables, experience and job position. Although generally favourable, differences in dispositional attitudes, such as talking about sexuality, were related to years of experience in the field. Professional staff reported greater acceptance of some sexual behaviours compared to direct-care staff. These findings are relevant to understanding variability in staff perceptions. The need for support to respond to service users' sexuality, especially among direct-care professionals, is discussed.

Keywords: sexuality; intellectual and developmental disability; intellectual disability; attitudes; sexual behaviour; sexual rights

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1. Introduction

Like any other person, adults with intellectual and developmental disabilities (IDD) can be interested in romantic and sexual relationships. According to previous literature, between 75% to 84% of adults with mild IDD have had some sexual experience [1,2]. These experiences, at lower rates, are also reported by those with moderate IDD [3]. Adults with IDD can express their sexual desires, needs, and attitudes [4], and it should be clear that they have the right to live a healthy affective and sexual life if they wish to do so. However, adults with IDD themselves report facing significant social and cultural barriers when it comes to their sexuality [5].

These perceived barriers include others' perceptions about the sexuality of adults with IDD (including how they react to or support their sexuality) and sexuality knowledge [6]. Some of these perceptions include the assumption that people with IDD are less interested

in sexuality, that they lack the ability to exercise sexual self-control, or that they are more vulnerable to abuse [7,8]. This is particularly problematic given that adults with IDD frequently rely on others, such as service providers or professional caregivers, to provide resources or information about sex [9,10]. Indeed, when available, sexual education is typically provided by health or education professionals [11] and it has been suggested that agencies offering services should continue providing information and education on sexuality [12]. In general, both educators and health professionals seem to be supportive of individuals with IDD with regard to their sexuality and the provision of sexuality education [13,14]. However, it is not always provided. Misconceptions about the sexual development of adults with IDD have been identified as barriers to its provision [15], as have concerns regarding the capacity of people with IDD to give consent [14]. The need for targeted training for both health and education professionals has been emphasised [13,14].

Additionally, direct-care staff play a crucial role in supporting the sexuality of adults with IDD [16]. They are an integral part of the daily lives of these individuals in residential facilities, acting as first responders for their behaviours and sex education needs. They are in a position to provide the skills and experiences needed for their sexual development [17]. However, these professionals report limited training on how to support adults with IDD in matters concerning their sexuality [16,18], as well as a lack of policies addressing the sexuality of residential users [18]. Therefore, staff members express cautious attitudes towards the sexuality of these adults [19], grappling with conflicting views on their role as both facilitators and protectors [20,21].

When training staff to understand and respond to service users' sexuality, it is essential to address their attitudes towards it. According to the current consensus, staff attitudes are important and appear to be a common first theme within good practice guidelines related to the provision of support in this area [22]. Prior research has posited that the acceptance of the sexual rights of people with IDD can influence the display of adequate sex education [23,24] and that staff attitudes can pose a barrier to sexual expression [25]. Staff attitudes have a potential direct influence on the sexuality of adults with IDD [26], guiding professional actions across a range of daily scenarios. Furthermore, these attitudes can even impact the attitudes and perceptions of adults with IDD about their own sexuality [27].

Various factors can influence the attitudes or beliefs about the sexuality of adults with IDD. Previous literature suggests that staff age [10,17,24,28,29] or gender [18] may act as a mediator in attitudes, although not all studies have replicated these results for age [18,26] or gender [28]. It is reasonable to expect associations with age, given the existence of generational differences in sexuality that are linked to shifts in shared social norms. [30]. The findings suggest that younger participants exhibit a more favourable attitude towards the sexuality of adults with IDD. In contrast, the potential impact of gender remains uncertain [7]. The presence of a family member with a disability has been associated with a more favourable perception of the sexual self-control ability of the person with IDD [18]. This may be attributed to the influence of everyday experiences at home with these individuals. In addition, job position [28,31] and education [10,31] have been identified as potential correlates, with less favourable attitudes observed among those in direct-care or support roles and those without a university education. Finally, the cultural context is of significance, as this has been related to the acceptance of the sexual rights of people with IDD, as well as to the perception of their ability in terms of sexual self-control [32]. The ideological and thinking differences related to cultural variables have been proposed as an explanation. The number of studies conducted in Spain is limited, and usually compare different samples, e.g., [33–35], without an in-depth analysis of staff attitudes. Adjusted representations of staff attitudes should take these variables into account so support can be more accurately targeted.

Considering the relevance of staff attitudes in the provision of sexuality support for adults with IDD, the present study aimed to (1) examine current attitudes towards different aspects of a person's sexuality (concerning those with an IDD) among Spanish staff members and (2) identify what factors may be related to differential attitudes among these staff members. In particular, this study assesses the possible relationship of these attitudes with age, gender, years of experience, job position, and having a family member with an IDD. This should provide professionals who support or train staff to respond to service users' sexuality with information to target training or guidelines appropriately.

2. Materials and Methods

2.1. Participants

Initially, 134 responses from staff members from service facilities for adults with IDD were recorded. The following inclusion criteria were applied for this study: (1) having responded to the full set of items of the ASEXID scale (30 participants excluded); and (2) providing data on their age, gender, years of experience, and job position (2 participants excluded). Therefore, the final sample was composed of 102 staff participants.

2.2. Procedure

Data were collected through an online survey using the Qualtrics^{TM} platform between June 2022 and July 2022 through the collaboration of four service networks for adults with IDD (providing residential, occupational, and day-care services) in two autonomous communities in Spain. An email explaining the aim of this study and the need for collaboration was sent to each network coordinator. Further explanations were provided if necessary. Once accepted, additional information with the link and QR to the informed consent and online survey was sent for each network coordinator to distribute. The study complied with the ethical principles of the Declaration of Helsinki, and this procedure was approved by the Ethics Review Board for Clinical Research of the region.

2.3. Instruments

Sociodemographic questionnaire. Participants were asked about their gender (female, male, other), age, whether they currently worked in a resource for people with IDD, years of experience working with people with IDD, and job position ("direct-care", "technicians", or "coordinators/managers"). In Spain, direct-care staff are professional carers who do not require a graduate degree but must have completed primary and professional studies. They provide support to these adults in their daily lives. On the other hand, "technicians" and "coordinators or managers" should have a minimum qualification of a university graduate degree. These positions can include nurses, educators, social workers, or psychologists, among others. They will be referred to throughout the text as two groups, "direct-care staff" and "professional staff". It was also asked if they had a family member with an IDD.

Assessment of Attitudes Toward Sexuality of People with Intellectual Disability (ASEXID). This scale was developed by Gil-Llario et al. [33] to assess attitudes towards different aspects of the sexuality of adults with IDD. The development of the scale involved experts in the fields of disability and health and sexuality psychology, who conducted an initial theoretical review. Subsequently, professionals and family members of individuals with IDD participated in a pilot administration, which facilitated the revision and enhancement of the scale items. The final version of the scale was validated in Spain, incorporating a sample of 1103 participants, including staff, families of people with IDD, and members of the general population. Cronbach's alpha values for the scale factors ranged from 0.68 to 0.86. The scale consists of eighteen items categorised into three factors: the "Normalising attitude" factor (seven items related to the belief that the sexuality of people with IDD has

the same characteristics as the sexuality of people without IDD), α for this sample = 0.74; the "Negative attitude" factor (five items related to beliefs that people with IDD have less interest in sexuality, or that it is unnecessary or even dangerous to talk about it), α for this sample = 0.50; and the "Paternalistic attitude" factor (six items related to concerns about the lack of sexual self-control of adults with IDD and associated risks) α for this sample = 0.68. 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 IDD when answering the whole scale.

It is noteworthy that the Cronbach's alpha value for the negative attitude factor is below the recommended minimum value of 0.65 [36]. The items included in this factor (1, 2, 3, 4, and 14) exhibited mean scores between 1.06 and 1.43, with some displaying lower variability compared to other items on the scale. This may have negatively affected alpha values. Separate interpretations will be provided for each item rather than a factorial interpretation.

2.4. Data Analysis

First, a descriptive analysis was performed both within each attitudinal factor and each of the eighteen ASEXID items, to provide a comprehensive overview of current attitudes towards the sexuality of adults with an IDD within this staff sample.

To determine if staff characteristics may relate to these attitudes, a regression analysis was performed for each attitudinal factor to examine the possible relationship with the study variables (years of experience in the field, job position, and whether they had a family member with an IDD), controlling by sociodemographic variables of age and gender. Second, this analysis was performed within the eighteen items of the ASEXID scale to determine whether differences were significant, so useful data for practitioners could be gathered.

For both regression analyses, gender, having a family member with an IDD, and job position were coded in dummy variables (Gender: 0—female, 1—men; Family member with IDD: 0—No, 1—Yes; Job position: 0—Direct-care staff, 1—Professional staff). Variance Inflation Factors (VIF) were checked to assess potential multicollinearity [37]. The VIF values in this study did not exceed 2.343, so multicollinearity was not a concern. No missing data treatment was needed, as cases with missing data were excluded. Data were examined using the SPSS statistics 25 package.

3. Results

3.1. Descriptive Data

3.1.1. Sample Descriptives

The final sample comprised 102 participants aged between 18 and 62 years (M_{age} = 37.98; SD = 10.41), with a mean of 10.44 (SD = 9.97) years of experience working with people with IDD. Distribution by gender, having or not having a family member with an IDD, and job position according to level of qualification is shown in Table 1.

3.1.2. ASEXID Distribution

For the present sample, favourable attitudes were found according to high scores in the normalising attitude factor (M = 31.43, SD = 3.40; possible score range from 7 to 35) and low scores in the negative attitude factor (M = 6.19, SD = 1.58; possible score range from 5 to 25). On the other hand, intermediate scores were found for the paternalistic attitude factor (M = 14.24, SD = 4.31; possible score range from 6 to 30). The totality of mean scores and standard deviations for each ASEXID scale item are presented in Table 2.

Table 1. Descriptive data.

	Mean (SD)	N (%)
Gender		Women = 84 (82.4%) Men = 17 (16.7%) Other = 1 (1%)
Age	37.98 (10.41)	
Family member with IDD		Yes = 23 (22.5%) No = 79 (77.5%)
Years of experience	10.44 (9.97)	
Job position		Direct-care staff = 59 (57.8%) Professional staff = 43 (42.2%)

Table 2. Mean item scores and standard deviations for the ASEXID scale items.

Item	Mean	SD
1. People with ID have less interest in sexuality than people without ID	1.43	0.637
2. Sexual education should only be provided to people with ID when they demand it	1.34	0.724
3. Talking to people with ID about sex is to encourage them to practice it	1.25	0.624
4. Masturbation can harm people with ID	1.10	0.330
5. It seems good to me that people with ID masturbate	4.66	0.777
6. A person with ID can live their sexuality as anyone else	4.37	0.843
7. People with ID can control their sexual impulses	3.58	1.147
8. People with ID should have their privacy	4.90	0.411
9. People with ID can have a partner	4.68	0.747
10. It seems good to me that people with ID kiss or caress with another person	4.84	0.439
11. It seems good to me that people with ID have sex as long as there is no penetration	1.91	1.252
12. It seems good to me that people with ID have sexual intercourse even with penetration	4.63	0.730
13. People with ID need another adult guardian to decide about their sexuality	1.58	0.801
14. People with ID are always heterosexual	1.06	0.275
15. People with ID perceive the danger of sexual abuse	2.98	1.143
16. It is normal for people with ID to see pornography	3.35	1.208
17. People with ID are able to use condoms properly to prevent infections	3.75	1.112
18. We should prevent women with ID from becoming pregnant through the use of contraceptives	3.10	1.397

In general, participants reported high agreement with items 5, 6, 8, 9,10, and 12, with mean item scores ranging from 4.37 to 4.90 (maximum possible score = 5) and low agreement with items 1, 2, 3, 4, 13, and 14, with mean item scores ranging from 1.06 to 1.58 (minimum possible score = 1). Standard deviations for the last cited items ranged from 0.275 to 0.843. Based on the content of these items (shown in Table 2), this would reflect favourable attitudes towards understanding that adults with IDD have sexuality, intimacy, and self-oriented and other-oriented sexual and affective behaviours.

On the other hand, items 7, 11, 15, 16, 17, and 18 reflect more intermediate mean item scores, ranging from 1.91 to 3.75, with a greater variability range according to standard deviations of the items, ranging from 1.112 to 1.397. Based on the content of these last items (shown in Table 2), this could reflect intermediate attitudes or some concerns, and less consensus, towards perceptions of adults with mild IDD ability to self-control their sexual impulses, sexual relationships conditioned to no penetration, perception of the risk for sexual abuse, pornography consumption, the ability for condom use and pregnancy prevention.

3.2. Regression Models

3.2.1. ASEXID Factors (Normalising, Negative, and Paternalistic Attitude)

The regression results for the three factors of the ASEXID can be found in Table 3. According to the regression models, older age was related to less normalising (β = −0.306, p = 0.038) and more negative (β = 0.356, p = 0.021) and paternalistic (β = 0.376, p = 0.012) attitudes, according to the general factor scores. Regardless of age and gender, years of experience working with people with IDD related to a less general negative attitude (β = −0.314, p = 0.041), and working as direct-care staff related to a less general normalising attitude (β = −0.275, p = 0.008). No relationships were found depending on whether they have a family member with an IDD or not.

Table 3. Regression results for the three ASEXID factors.

	Age	Gender	Years of Experience	Family Member with an IDD	Job Position
			B		
Normalising attitude	**−0.306 ***	−0.102	−0.024	−0.076	**−0.275 ****
Negative attitude	**0.356 ***	0.110	**−0.314 ***	−0.049	0.067
Paternalistic attitude	**0.376 ***	0.106	−0.029	−0.029	0.197

Note. Bold data indicate statistically significant results. * < 0.05; ** < 0.01. Dummy variables codification: Gender, 0—women, 1—men; Family member with an ID, 0—No, 1—Yes; Study qualification required for the job position, 0—Professional staff, 1—Direct-care staff.

3.2.2. ASEDIX Items

The regression results for the eighteen items of the ASEXID scale can be found in Table 4. Older age was related to less disposition towards sexual education (item 2, β = 0.438, p = 0.004), the belief that talking about sex encourages people with IDD to practice it (item 3, β = 0.368, p = 0.014), less agreement with people with mild IDD consuming pornography (item 16, β = −0.323, p = 0.032), less agreement with the statement that people with IDD can use a condom for preventing STIs (item 17, β = −0.369, p = 0.012), and higher agreement with the belief that women with IDD should be prevented from getting pregnant (item 18, β = 0.499, p = 0.001). On the other hand, being male is also related to item 3 (β = 0.237, p = 0.016), and to the agreement with people with IDD having sexual relationships conditioned to no penetration (item 12, β = −0.247, p = 0.012).

Table 4. Regression results for the ASEXID items.

	Age	Gender	Years of Experience	Family Member with an IDD	Job Position
			B		
1. People with ID have less interest in sexuality than people without ID	−0.145	−0.054	0.036	−0.091	0.114
2. Sexual education should only be provided to people with ID when they demand it	**0.438 ****	0.070	**−0.384 ***	−0.053	0.009
3. Talking to people with ID about sex is to encourage them to practice it	**0.368 ***	**0.237 ***	**−0.356 ***	−0.008	0.055
4. Masturbation can harm people with ID	0.167	−0.058	−0.111	0.047	−0.060
5. It seems good to me that people with ID masturbate	−0.116	0.004	−0.187	−0.003	**−0.264 ***

Table 4. *Cont.*

	Age	Gender	Years of Experience	Family Member with an IDD	Job Position
			B		
6. A person with ID can live their sexuality as anyone else	−0.170	−0.081	−0.111	−0.041	−0.175
7. People with ID can control their sexual impulses	−0.157	−0.112	0.089	0.083	−0.046
8. People with ID should have their privacy	−0.255	−0.021	**0.341** *	−0.094	−0.006
9. People with ID can have a partner	−0.035	−0.029	−0.143	−0.057	−0.199
10. It seems good to me that people with ID kiss or caress with another person	−0.209	0.026	0.042	−0.087	**−0.243** *
11. It seems good to me that people with ID have sex as long as there is no penetration	0.100	0.037	0.050	−0.043	0.095
12. It seems good to me that people with ID have sexual intercourse even with penetration	−0.281	**−0.247** *	0.074	0.051	−0.201
13. People with ID need another adult guardian to decide about their sexuality	0.121	0.049	0.001	0.038	0.167
14. People with ID are always heterosexual	0.194	0.100	0.063	0.031	0.045
15. People with ID perceive the danger of sexual abuse	0.085	−0.027	0.067	−0.013	0.085
16. It is normal for people with ID to see pornography	**−0.323** *	−0.070	0.042	−0.119	−0.153
17. People with ID are able to use condoms properly to prevent infections	**−0.369** *	−0.179	0.026	−0.084	**−0.207** *
18. We should prevent women with ID from becoming pregnant through the use of contraceptives	**0.499** ***	0.048	−0.095	−0.061	0.148

Note. Bold data indicate statistically significant results. * < 0.05; ** < 0.01; *** < 0.005. Dummy variables codification: Gender, 0—women, 1—men; Family member with an ID, 0—No, 1—Yes; Study qualification required for the job position, 0—Professional staff, 1—Direct-care staff.

Independently from age or gender, fewer years of experience related to higher agreement with beliefs that sexual education should only be provided if demanded (item 2, $\beta = -0.384$, $p = 0.012$), and that talking about sex encourages people with IDD to practice it (item 3, $\beta = -0.356$, $p = 0.017$). It also related to less agreement with the intimacy statement (item 8, $\beta = 0.341$, $p = 0.028$). Finally, job position related to agreement with masturbation (item 5, $\beta = -0.264$, $p = 0.013$), agreement with adults with IDD kissing or caressing (item 10, $\beta = -0.243$, $p = 0.023$), and confidence with condom use (item 17, $\beta = -0.207$, $p = 0.042$). No relationships were found depending on whether they have a family member with an IDD or not.

4. Discussion

The present study sought to examine the current perceptions, opinions, and attitudes towards the sexuality of adults with IDD among Spanish staff from service facilities for these adults, while also investigating the potential associations of personal variables (age, gender, family member with ID, job position and years of experience) with these views. Results reveal that, for this sample, attitudes were favourable towards those aspects related to understanding that adults with IDD have sexuality, the right to intimacy and sexual information or education, and the expression of self- and other-oriented sexual behaviour. The low level of agreement with the assumption of heterosexuality suggests that this staff sample was also aware of the existence of sexual and gender diversity in adults with IDD. This finding is encouraging, given that previous studies have indicated that adults with IDD may encounter barriers to coming out due to the responses of their support network, including staff [38].

In contrast, items about the consequences or associated risks of sexual interactions were found to elicit somewhat concerning responses, with intermediate item scores and higher variability. Before analysing these results, it should be noted that variability on item 11 ("It seems good to me that people with IDD have sex as long as there is no penetration") may be related to how the item is phrased, as results were inconsistent with the favourable attitudes towards the rest of the explored sexual behaviours.

Agreement with the statement about adults with IDD's ability to control their sexual urges ("7. People with IDD can control their sexual impulses") was not as high as for other items, with greater variability among participants. It is acknowledged that some adults with IDD may display some inappropriate sexual behaviours [39], but this may be due to a poor understanding of concepts relating to adequate sexual behaviours. Low rates of sexual knowledge have been reported among people with IDD [10,40,41], so difficulties in guiding their sexual behaviour could be expected. On the other hand, assumptions that adults with IDD lack the cognitive capacity for sexuality [42] may be nurturing the idea of difficulties in sexual self-control, guiding to protective actions and limiting opportunities. People with IDD have reported restricted opportunities for sexual and romantic socialisation [43,44], due to the responses of their support networks.

For the present staff sample, perceptions that adults with IDD are not able to perceive the danger of sexual abuse (item 15) are reported. Previous studies have already reported this concern among staff populations [19]. People with IDD are indeed more vulnerable to abuse than the general population [45], with an estimated prevalence between 7% and 31% [46]. However, the focus should be on providing support and sex education. Staff recognise that this education would protect people with IDD [29], as protection should not deny their right to experience their sexuality [46].

Variability among items related to contraception suggests that there are differing opinions about the potential consequences of sexual intercourse. Perceived difficulties in these adults' ability to use condoms (item 17) is accurate, as it has been reported to be low and inconsistent in previous research among adults with IDD [47–49]. This may be related to the need for tailored information and skills [47]. Variability in agreement with the use of contraception among women with IDD (item 18) was not surprising. Previous studies have reported that staff are less supportive of parenthood for adults with IDD compared to other aspects of sexuality [24,26]. This is often linked to a focus on preventing pregnancy. Indeed, research has suggested that for women with IDD, the main reason to consult a gynaecologist is to obtain contraceptive prescriptions [50], highlighting broader concerns. Beyond the right to parenthood, it could be expected that ethical considerations may also play a part in these views on preventing pregnancy, given the implications of raising children. Current criteria for clinical diagnosis of IDD focus on difficulties in three domains, including conceptual, social, and practical skills [51]. These skills are necessary for daily life and adults with IDD should be provided with support when difficulties arise. In this regard, staff concerns about pregnancy and its consequences may arise from how these difficulties would impact raising a child.

Perceptions about the normalisation of pornography use among people with IDD (item 16) also offered higher variability in responses and intermediate scores. Diverse social implications of pornography have been discussed [52], and it has been reported to be an opportunistic source of sexual information among adults with IDD [53]. Pornographic content can contribute to unrealistic expectations of sexual encounters [54], which in the absence of adequate sexual education could lead to misconceptions about sexuality and problematic displays of sexual behaviour in adults with IDD. This may be a contributing factor to this perception or concern about pornography among staff members.

An important contribution of this study is not only the snapshot of current views towards different aspects of adults with IDD's sexuality among Spanish staff members but also how their personal variables may be related to some of these views. The age of the participants yielded significant results, in line with previous studies [10,17,24,28,29]. More specifically, older age was associated with lower scores on items related to dispositional attitudes (sex education, talking about sex), pornography use, and contraception. These results may reflect general differences in human sexuality already identified between different age cohorts concerning their sexual expression and attitudes [30].

Regardless of age, additional differences were identified according to years of experience working with adults with IDD for items related to sex education, disposition to talk about sex, and agreement with the right to intimacy. Those with greater experience in the field seem to exhibit a more favourable attitude. As has been previously stated, staff members often tend to present themselves as cautious about the sexuality of their service users and have reported difficulties in responding to the sexuality of individuals with IDD [19]. Those with greater experience in the field of IDD may be better equipped to handle these behaviours, which may give them greater confidence in dealing with them and resolving them positively. Furthermore, stereotypes and unadjusted beliefs about adults with IDD have been associated with less favourable attitudes toward the sexuality of adults with IDD [55]. It can therefore be surmised that more experience may provide a more accurate view of adults with IDD and increased confidence in supporting them with matters related to sexuality.

Finally, it was found that regardless of demographic factors, direct-care professionals reported less agreement with masturbatory behaviours and adults with IDD engaging in kissing or caressing with another person. Previous research has reported differences in attitudes between social workers and staff from residential and day-care centres, discussing that differences may be due to actually having to deal with the sexual behaviours of their service users [56]. Direct-care professionals are frequently expected to be the first to respond to these behaviours, as they are the main providers of support, particularly when it comes to those who are institutionalised. Therefore, this perception of responsibility may be related to how they perceive these behaviours. Furthermore, given that this position does not require a graduate degree, less sexuality knowledge or training could be expected. The results showed no differences based on having a family member with IDD, contrary to the findings of previous studies [18]. However, this could be due to the low percentage of participants who actually had a family member with IDD.

Although relevant results have been presented, some limitations should be taken into account. Participation in the study was modest, as this is still considered a sensitive topic, and no reward was offered. The distribution of the scale depended on each network coordinator, so the final number of potential participants could not be calculated. Among those who agreed to participate, there is a risk of response bias, which may have influenced a more favourable view due to a sense of political correctness. This study should be considered as mainly descriptive and caution should be exercised in generalising the results, due to a number of factors. Differences in sample size between male and female participants, and the low percentage of participants with a family member with an IDD may be affecting interpretation of the results. In addition, the interpretation of the "negative factor" scores should be taken with caution. Cronbach's alpha value does not reach the minimum value of 0.65 [36]. Therefore, interpretation and conclusions based on this factor are not recommended. It is hypothesised that a low alpha may be influenced by the low variability in responses to these factor items, resulting in very low scores. However, in the discussion section, each item has been individually commented on instead of being grouped according to factors.

In addition, the scope of the information presented in this study may have certain limitations. The ASEXID questionnaire was selected as the study measure due to its composition, which included perceptions about the sexuality of adults with IDD, as well as willingness to talk about sex or provide sex education, and perceptions about associated risks. In our opinion, this made the ASEXID more suitable for the purpose of our study compared to other instruments such as the ASQ-ID [57], the GSAQ-LD [58], or the POS [17] questionnaires, which may have a narrower focus or require modifications in their language to be more inclusive. Conversely, it is important to acknowledge that the ASEXID questionnaire offers less detailed information than other tools specifically designed to assess professionals' attitudes regarding the provision of sex education to individuals with IDD. These alternative instruments examine factors such as staff's perceived barriers to providing sexuality education [15] and health professionals' self-perceptions and confidence in providing sexuality-related information or support [13]. It is recommended that future research incorporate these aspects to improve the robustness and applicability of its findings.

Finally, future studies should also focus on the views towards adults with moderate and severe IDD and their sexuality. One would expect the attitudes to be less favourable than those reported in this study if we were to ask about adults with moderate or even severe IDD. Although less frequent, romantic and sexual experiences are also present among adults with moderate IDD [3] and should also be taken into account in order to adapt and provide support.

5. Conclusions

In general, favourable attitudes towards the sexuality of adults with IDD have been reported for this sample of Spanish staff. However, some variability and concerns have been found regarding those aspects related to the consequences of a sexual relationship or vulnerability to abuse. In addition, some personal variables such as years of experience and job position (differentiating between direct-care staff or 'carers' and professional or qualified staff) have shown a relationship with some aspects that may affect the willingness of staff to provide support, of which especially relevant are those related to educating or giving information about sex. Therefore, any actions or training designed to equip staff with the necessary resources to support adults with IDD regarding their sexuality in the Spanish context should take into account the specific characteristics of each staff population, adapting the contents to their needs and attitudes.

In particular, we would suggest the implementation of training programmes aimed at equipping different professionals with the skills necessary to respond effectively to a diverse array of potential scenarios that may arise in the personal and sexual relationships of service users. To achieve this objective, it would be beneficial to consider the specific concerns of the staff, taking into account their daily work experiences. This approach will facilitate the integration of real-life situations they may encounter and the development of appropriate supportive responses. For example, direct-care staff may encounter situations where two residents are touching each other in a public setting, such as a residential living room. On the other hand, professional staff may receive inquiries regarding sexual matters from service users, their families, or even direct-care staff. These scenarios require distinct actions and levels of responsibility. Ultimately, staff training should emphasise actions that prioritise support over prohibition, while ensuring that staff members possess the necessary competence to feel safe and supported in their responses. In light of the study findings, this training may be particularly pertinent during the initial training period for new professionals, as well as during the ongoing professional development of existing staff within disability resources.

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