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Sexual Health Education for Young Adults Diagnosed with Severe Mental Illness, Intellectual Disability, and Autism: A Pilot Study on the eITPoSA Psycho-Educational Intervention

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Abstract: Young adults diagnosed with severe mental illness (SMI), intellectual disability (ID), and autism spectrum disorder (ASD) often experience significant barriers in accessing sexual health education, contributing to poor sexual and relational well-being. The Educational Intervention and Training Program on Sexuality and Affectivity (eITPoSA) was developed to address this gap through a structured psycho-educational approach tailored to their cognitive and emotional needs. A pilot study was conducted with 12 participants diagnosed with SMI, ID, and ASD, who attended the training sessions covering topics such as body knowledge, genital sexuality, privacy, and hygiene. Pre- and post-intervention assessments were carried out using structured monitoring grids, with data analyzed through descriptive statistics, paired-samples *t*-tests, and Cohen's d to evaluate effect sizes. Results demonstrated statistically significant improvements across all domains, particularly in body knowledge (31.43% to 86.65%), genital sexuality (15% to 90%), and hygiene (47.27% to 96.36%). These findings suggest that the eITPoSA program effectively enhances sexual and relational competencies in young adults diagnosed with SMI, ID, and ASD. Future research should focus on expanding the sample size and exploring long-term retention of educational outcomes to further validate the program's efficacy.

Keywords: sexuality; young adults; intellectual disability; autism; severe mental illness; sexual education; affectivity; intimacy

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1. Introduction

Despite the growing recognition of sexual health and well-being as fundamental aspects of overall health, adolescents and young adults diagnosed with severe mental illness (SMI) (including schizophrenia spectrum disorders and psychosis), intellectual disabilities (including genetic syndromes), and autism spectrum disorder (ASD) continue to face significant stigma and human rights violations [1–4]. These challenges, compounded by their unique cognitive and social characteristics, can negatively impact self-esteem, hinder the formation of meaningful relationships, and restrict opportunities for sexual expression [4–6].

Extensive research indicates that the sexual and reproductive health outcomes of individuals with disabilities are significantly poorer compared to the general population [4,7–9].

For individuals with SMI and mild intellectual disabilities, this disparity increases vulnerability to gender-based violence, risky sexual behaviors, and exploitation [4,10,11]. Similarly, young individuals with ASD experience profound difficulties in developing and maintaining romantic relationships, engaging in courtship, and navigating sexual encounters [12]. Cognitive and social impairments associated with ASD further hinder sexual health knowledge acquisition, contributing to higher risks of sexual victimization, abuse, and sexually transmitted infections [13,14]. These vulnerabilities are exacerbated by self-stigmatization, social isolation, and cognitive deficits, which collectively impact emotional and sexual well-being. Individuals with severe intellectual disabilities, including those with genetic syndromes, often exhibit a strong desire for social interactions but struggle to grasp social boundaries, increasing the risk of exploitation, abuse, and victimization due to inadequate education on relational dynamics and sexuality [9,15].

Importance of Comprehensive Sexuality Education (CSE)

Sexual health education is a critical component of adolescent and young adult development, particularly for individuals with disabilities who require tailored interventions. Providing knowledge and skills to navigate relationships and make informed sexual and reproductive health decisions is essential to reducing risks and counteracting misinformation [4,7,16]. Despite this evidence, there remains a substantial gap in sexual health education that adequately addresses the specific needs of young people with SMI, intellectual disabilities, and ASD [4,8,17]. Bridging this gap necessitates a multifaceted approach that includes policy reform, educator training, and increased community engagement.

Comprehensive sexuality education (CSE) has been shown to play a crucial role in addressing these challenges and promoting self-determination, independence, and overall well-being among young people with disabilities. However, several barriers hinder the effective delivery of CSE to these populations. Societal attitudes, deeply rooted in stigma, often assume that individuals with disabilities are either asexual and unfit for sexuality education or, conversely, hypersexual and in need of behavioral control [18–20]. These misconceptions contribute to shame, social exclusion, and the systematic denial of education about relationships and sexuality.

A significant barrier to CSE access for individuals with intellectual and developmental disabilities is the lack of ownership, self-efficacy, and preparedness among educators in delivering sexuality education [21–25]. This lack of self-efficacy among professionals may stem from insufficient training [24,26,27] and uncertainty regarding the appropriateness of specific topics within sexuality education [26,28,29]. Additionally, professionals often encounter challenges in tailoring instruction to the specific needs of individuals with intellectual and developmental disabilities [30]. These difficulties are exacerbated by the fact that most sexuality education curricula are originally designed for nondisabled individuals, rendering them less accessible to this population [29]. Furthermore, in educational, rehabilitation, and community settings, CSE programs often face constraints such as limited curriculum time, a shortage of trained educators, and perceived parental opposition [16,31,32]. Parents of children with disabilities frequently express concerns that CSE may inadvertently encourage premature or inappropriate sexual behavior despite empirical evidence refuting this assumption [33].

Moreover, sexuality education for individuals with intellectual and developmental disabilities is frequently provided in a reactive manner, typically in response to problematic behaviors rather than proactively to foster prosocial sexual expression [34].

However, research highlights the ability of CSE to support individuals in developing fulfilling sexual health and relationships [19], including recognizing unhealthy relationship dynamics and ensuring personal safety in dating contexts (Graff et al., 2018) [35].

Furthermore, individuals with intellectual disabilities have expressed a clear desire to learn about romantic relationships, same-sex relationships, intimacy, friendship formation, and social communication [36]. Topics of significant interest also include gender identity, societal norms surrounding sexuality, sexual anatomy and hygiene, and safe dating practices [19,35]. Addressing these topics in an inclusive and accessible manner strengthens the case for implementing a robust CSE curriculum tailored to diverse cognitive and social needs.

Another crucial aspect in the delivery of CSE is the intersectionality of social factors such as race, class, gender, and sexual orientation, all of which shape individual experiences. These factors call for culturally sensitive educational strategies that incorporate perspectives on gender and sexual minorities, ensuring representation and inclusivity in sexuality education programs [16,37].

Despite the evident benefits of CSE, numerous practical challenges persist in its implementation. Within educational and community settings, CSE programs often face constraints such as limited curriculum time, lack of trained educators, perceived parental opposition, and insufficient differentiation of disabilities in day-care, educational, and recreational centers [16,31,32]. Additionally, financial limitations frequently prevent institutions from accessing adequate technological and pedagogical resources, further hindering effective program development. The clinical heterogeneity of individuals with intellectual disabilities and mental health conditions also complicates the creation of inclusive curricula that address a broad range of diagnoses and cognitive abilities [16,31,32].

These limitations are particularly pronounced in Italy, where individuals with disabilities—especially those diagnosed with intellectual disabilities, autism, and SMI—encounter significant barriers to accessing appropriate sexual education. This issue is especially urgent for adolescents and young adults, who are at a crucial stage of forming their understanding of sexuality and relationships [38]. Recent studies have highlighted that individuals with disabilities in Italy experience poorer sexual and reproductive health outcomes compared to the general population [39]. This is in line with the observation that Italy is one of the few European countries where sexual education is still not included in school curricula. It remains at the discretion of individual heads of schools in Italy whether or not to endorse school policies promoting it [40]. The majority of school programs in Italy focus only on the prevention of sexually transmitted infections through single-session activities [41]. This issue becomes particularly concerning in the context of disability. Lo Moro et al. (2023) [42] found that disability remains one of the least addressed topics in Italian sexuality education programs, appearing in only 17% of surveyed initiatives—highlighting a critical gap in inclusive educational practices. Similarly, Ginevra et al. (2016) [43] pointed to the lack of sex education, especially for individuals with autism spectrum disorders.

Addressing this disparity requires targeted educational initiatives that not only provide essential knowledge but also challenge existing societal prejudices and institutional barriers, ensuring that all individuals, regardless of disability status, receive equitable access to sexual health education and resources.

In light of these challenges, this article presents the findings of a pilot study evaluating the effectiveness of the Educational Intervention and Training Programme on Sexuality and Affectivity (eITPoSA), specifically designed for young adults diagnosed with severe mental illness (SMI), intellectual disability (ID), and autism spectrum disorder (ASD).

This broader research initiative is supported by the Italian Ministry of Research as part of a Ph.D. program in Public Administration and Innovation for Disability and Social Inclusion, endorsed by FISH (Federazione Italiana per il Superamento dell'Handicap).

2. Materials and Methods

2.1. Design of the Study and Participants

The eITPoSA curriculum was developed to overcome the challenges of providing comprehensive sexuality education (CSE) to individuals with intellectual and psychiatric disabilities. Given the need for an accessible and adaptable approach, the program is designed to address cognitive, emotional, and relational needs while considering the resource constraints of educational and rehabilitative settings. Drawing on the existing literature [19,20,35,36,44–46], it identifies essential learning objectives and educational tools tailored to individuals with intellectual disabilities, severe mental illness (SMI), and autism spectrum disorder (ASD).

The development of the eITPoSA training was preceded by a 60-day period of participant observation (March 2024–May 2024) at Centro Argo, part of the FOQUS Foundation in Naples. The center, located within the historic Montecalvario Institute, is a private, multi-functional day habilitation facility that serves children, adolescents, and young adults diagnosed with SMI and intellectual and developmental disabilities (IDD), including genetic syndromes, as well as their families. This observational phase aimed to build rapport with the selected participants in the pilot study, establish a trusting and respectful environment, and gather relevant information to tailor the intervention to their specific clinical and personal conditions. During this period, the research team observed daily activities at Centro Argo and conducted semi-structured interviews to assess participants' psychosexual and relational knowledge as well as their cognitive abilities. The collected data were analyzed thematically and used to refine the program design, ensuring that the content and methodologies were adapted to the participants' cognitive, emotional, and relational capacities. Additionally, participant observation facilitated the identification of potential communication barriers or specific difficulties, allowing for further adjustments to better meet individual needs.

The final version of the eITPoSA training program was developed by the lead researcher, a psychologist with expertise in gender issues, sexuality, inclusion, and special education for individuals with disabilities, particularly those diagnosed with SMI, autism, and intellectual disabilities. It was developed under the scientific supervision of the SInAPSi Team—Section on Anti-Discrimination and the Culture of Differences—of the University of Naples Federico II. The program integrates the principles of comprehensive sexuality education [47], the accessible sexual and reproductive health recommendations by Roden et al. [4], and the needs analysis derived from the semi-structured interviews and participant observation reports. This adaptation ensures that the intervention aligns with the CSE's emphasis on tailoring educational programs to the specific needs of learners, guaranteeing accessibility and relevance for the selected target group [47]. Furthermore, it aligns with the principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which advocates for the full and equal enjoyment of human rights by persons with disabilities as well as the promotion of their dignity and autonomy.

Only one participant in the pilot study had participated in previous educational interventions regarding issues of affectivity and sexuality. The rest of them had never participated in previous educational interventions concerning these themes and the information available to them regarding sexuality was obtained through informal means such as television programs or the internet. One participant is privately followed by a psychotherapist for issues related to sexual behavior.

Descriptive statistics and qualitative analysis were used to analyze data from this study.

2.1.1. Ethics

Informed consent was obtained from service users who were able to understand it and express their willingness to take part in the study. Additionally, as an extra precaution, authorization was also sought from their parents or legal guardians, who signed an informed consent form for their children or dependents to participate in the study. This additional step was deemed necessary given the sensitive nature of the topic being addressed. The research team felt it was important that parents were fully informed about the project and its objectives and that they approved and consented to the participation of their children or dependents.

The study followed the guidelines of the Declaration of Helsinki and was approved by the Ethical Committee of Psychological Research of the Department of Humanities of the University of Naples Federico II (protocol no. 13/2024).

Of the 40 service users identified by the Centro Argo as potential participants for the pilot study, only 15 met all the established inclusion criteria required for participation.

2.1.2. Participants

Inclusion Criteria

Eligible participants for the pilot study were recruited from the population afferent to the Argo Centre of the "Fondazione Quartieri Spagnoli onlus" considering the following criteria: (1) verified diagnosis of intellectual disability (including genetic syndromes), autism, and/or severe mental illness according to the criteria of the of the ICD-10 [48], ICD-9 [49], Diagnostic and Statistical Manual of Mental Disorders 5th edition [50], DSM-IV-TR [51]; (2) receiving services related to such disability; (3) aged between 18 and 40 years; (4) personal consent to participate in the study provided; (5) consent provided by parents or a legal guardian; and (6) sufficient verbal and textual comprehension skills to understand the informed consent and to participate in the training.

Participants were not excluded based on gender, race, ethnicity, sexual orientation, educational level, religion, and/or socioeconomic status.

Socio-demographic characteristics of the participants are presented in Table 1. Each participant is presented with a code (F for female participants; M for male participants) in order to preserve their anonymity. For this study, no standard selection procedures were followed, and the identified target group can be considered a criterion-based convenience sample.

Table 1. Socio-demographic characteristics of the participants.

Case	Range of Age	Type of Disability/ Diagnosis	Educational Qualification	Relationship Status	Living Status	First Intercourse	Previous Training
F1	Between 25 and 30 years	Delusional disorder in subject with mental retardation and obsessive-compulsive personality traits	High school diploma	In a romantic relationship	Parental unit	No	No
F2	Between 25 and 30 years	Delusional disorder in subject with mental retardation and obsessive-compulsive personality traits	High school diploma	In a romantic relationship	Parental unit	No	No

Table 1. *Cont.*

Case	Range of Age	Type of Disability/ Diagnosis	Educational Qualification	Relationship Status	Living Status	First Intercourse	Previous Training
F3	Between 25 and 30 years	Behavioral disorder in subject with average-grade intellectual disability	High school diploma	In a romantic relationship	Parental unit	No	No
F4	Between 25 and 30 years	Medium-severe mental retardation from birth asphyxia	High school diploma	Single	Parental unit	No	No
F5	Between 31 and 40 years	Down syndrome	High school diploma	In a romantic relationship	Parental unit	No	No
F6	Between 25 and 30 years	Medium-severe intellectual disability	High school diploma	In a romantic relationship	Parental unit	No	No
F7	Between 25 and 30 years	Autism	High school diploma	Single	Parental unit	No	No
F8	Between 18 and 24 years	Autistic disorder	High school diploma	Single	Parental unit	No	No
M1	Between 25 and 30 years	Fragile X syndrome with psychotic symptoms	High school diploma	In a romantic relationship	Parental unit	No	No
M2	Between 31 and 40 years	Williams syndrome with mild intellectual disability	High school diploma	In a romantic relationship	Parental unit	No	No
M3	Between 25 and 30 years	Down syndrome	High school diploma	In a romantic relationship	Parental unit	No	Yes
M4	Between 31 and 40 years	Down syndrome	High school diploma	In a romantic relationship	Parental unit	No	No
M5	Between 18 and 24 years	Schizophrenic-type graft psychosis	High school diploma	Single	Parental unit	No	No
M6	Between 18 and 24 years	Medium-severe intellectual disability	High school diploma	In a romantic relationship	Parental unit	No	No
M7	Between 25 and 30 years	Moderate to severe intellectual disability and obsessive-compulsive disorder with psycho-emotional immaturity	High school diploma	Single	Parental unit	No	No

2.1.3. Procedures

As a preliminary step, Centro Argo convened a meeting in the third week of March 2024 with the parents and/or legal guardians of eligible individuals for the pilot study. The meeting aimed to introduce the project and the research team, clarify its objectives, and distribute informed consent forms. Similarly, during the same week, another meeting was held with the services users who met the inclusion criteria, during which the research team presented the project, explained its voluntary nature, and read aloud the informed consent and reformulated it where necessary to ensure comprehension, discussed its contents, and collected signed consent forms from those who expressed interest in participating.

Both meetings took place in the presence of the Scientific Director of Centro Argo, the coordinator of the educators' team, and the educators scheduled for those days.

The six modules of the eITPoSA program were developed in twelve sessions, each lasting about 60 min, implemented over six weeks (May 2024–July 2024). The sessions were conducted in a private room within Centro Argo, separate from common areas, ensuring a focused and comfortable learning environment.

Participants were divided into small groups of up to four people, separated by gender. The scheduling of sessions took into account both participants' availability and their days of presence at the center. To enhance comprehension, a clear language approach was adopted, and contents were reformulated when necessary to accommodate participants' needs [52]. Each session was led by the trainer in collaboration with an observer, who was responsible for completing monitoring and evaluation grids to assess the progress and engagement of participants throughout the intervention.

The eITPoSA training was preceded by an introductory meeting with the participants, during which socio-demographic data were collected. Researchers also outlined the structure of the training sessions, the total duration of the program, the materials to be used, and the overarching goals of the study. Additionally, participants were reminded of the voluntary nature of their involvement and their right to withdraw at any time. During this meeting, the group also collaboratively established a set of rules to be followed throughout the workshops, ensuring a safe, respectful, and inclusive learning environment.

2.2. Materials

This section describes the materials and tools used in the eITPoSA program, designed to provide accessible and structured sexuality education for young adults diagnosed with severe mental illness (SMI), intellectual disability (ID), and autism spectrum disorder (ASD). The curriculum is based on the existing literature on CSE for people with disabilities (McCann et al., 2019; Graff et al., 2018; Chrastina & Večeřová, 2018, Coyle et al., 2021;) [19,35,36,44] and follows international guidelines for accessible sexual and reproductive health education (Roden et al., 2020) [4], which are summarized in five key points in Figure 1.

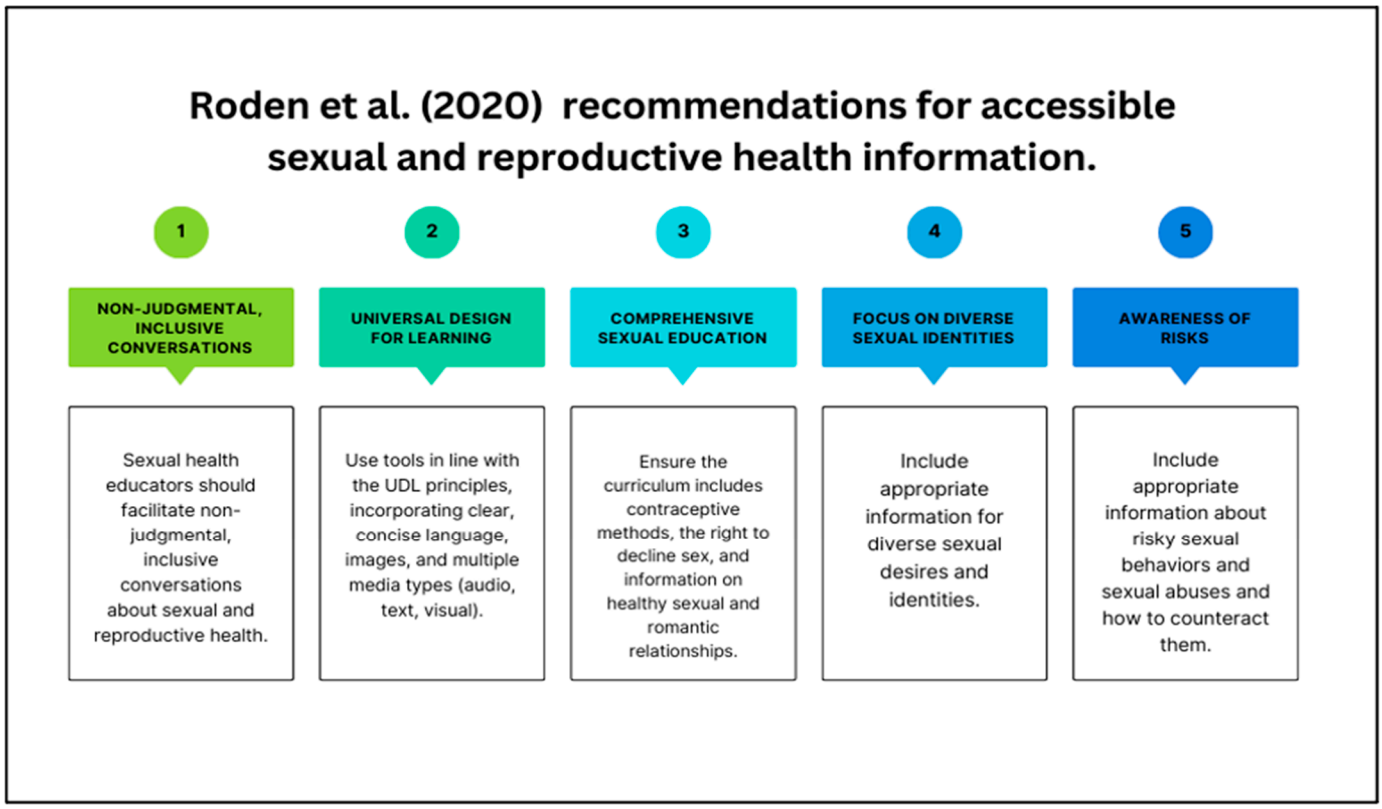


Figure 1. Five-point summary of the recommendations for accessible sexual and reproductive health information by Roden et al. [4] (2020).

2.2.1. Structure and Content of the eITPoSa Program

The eITPoSA program consists of six modules, each centered around a core topic and designed with specific learning objectives aimed at enhancing participants' understanding of sexuality, relationships, and personal well-being. Each module includes a set of activities that are structured to be delivered within a single session. However, depending on the complexity of the topic, participants' prior knowledge, their level of engagement, and their cognitive, emotional, and attentional needs, a module may be divided into multiple sessions to ensure full comprehension and active participation. Additionally, the expertise and confidence of trainers in handling the material influence the pacing of instruction, as

more experienced trainers may be able to adapt the content more effectively to the needs of the group.

To facilitate the delivery of the program, each module includes a structured plan, designed to be intuitive and user-friendly for trainers. The lesson plan outlines all planned activities, the rationale behind each, the materials and tools required, and the questions to stimulate discussion. It also details the key content to be explained and specifies which monitoring and evaluation grids should be used to assess the achievement of minimum learning outcomes.

The implementation of the program involves a two-person team: a trainer, responsible for delivering and managing the intervention, and an observer, whose role is to complete the monitoring and evaluation grids assigned to each module. This collaborative approach ensures that the sessions are conducted effectively while systematically tracking participants' progress and engagement.

Regardless of whether a module is completed in one or multiple sessions, each session follows a fixed three-phase format, as illustrated in Figure 2: (1) an introductory phase, which includes initial greetings and participant engagement; (2) the core training phase; and (3) a concluding phase, where final observations are documented and feedback gathered using a designated form in which the trainer records participants' verbal responses.

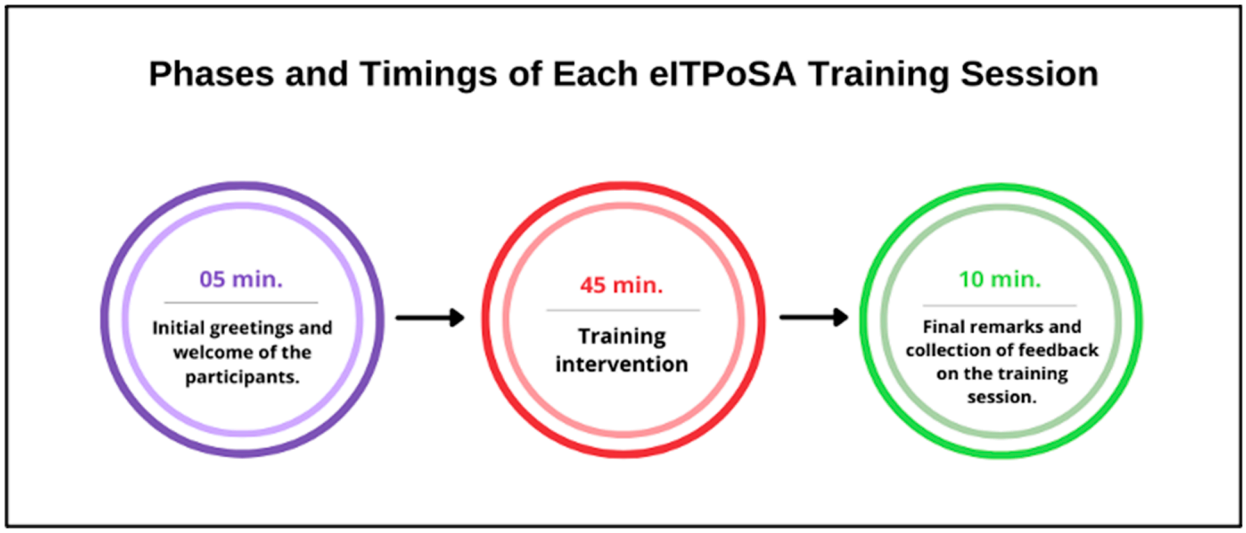


Figure 2. Scheme of the phases and timings of each eITPoSA modules session.

Whether a module is delivered in a single session or spread across multiple sessions, each session must not exceed 60 min and must adhere to the standardized structure. If a module is divided into multiple sessions, the feedback form is administered only at the end of the entire module. Regardless of the number of sessions, training must always be conducted in small, gender-divided groups of up to four people.

Furthermore, the training program is designed to be accessible to individuals with varying levels of cognitive functioning, including those with severe cognitive impairments. To ensure inclusivity, the materials, activities, and assessment tools have been adapted to accommodate different learning styles, with an emphasis on visual supports, simplified language, and interactive methodologies that enhance comprehension and engagement. Table 2 presents a summary of the structure of the eITPoSA programme.

Table 2. Structure of the eITPoSA for young adults diagnosed SMI, ID, and ASD.

Module	Title	Content Description	Specific Learning Objectives	Materials	Measurement Tools
One	Discovering Our Body and the Body of the Other	This module introduces sexual development, focusing on the physical and psychological changes that occur in the bodies of men and women. It explains the anatomy and functions of the male and female genital organs as well as the concept of intimate and private body parts.	(a) Understand the concept of sexual development and the physiological, emotional, and psychological changes that occur during this process. (b) Learn about the structure and functions of male and female genital organs. (c) Recognize and describe intimate and private body parts.	Printed and laminated images from the DESEM [1] project activity books. Books: All About Your Body [53]; Sexuality Explained to Children [54]; The Little Atlas of Intimacy: Vulva, Vagina, Period and More [55]; The Little Atlas of Intimacy: Penis, Testicles, Erections and More [56].	• Designed assessment and monitoring grids pre-intervention and post intervention. • Designed open-ended questions.
Two	What Are the Genital Organs For? An Introduction to Affectivity and Sexuality	This module explores the first experiences of sexual intimacy, the mechanics of penetrative genital sex, and the process of pregnancy. It addresses parental responsibilities, LGBTQI+ sexuality, non-normative sexual practices (such as masturbation and intimacy without genital involvement), and prevention of sexually transmitted infections (STIs).	(d) Understand the concept of penetrative genital sex and its function. (e) Learn about pregnancy and the reproductive process. (f) Identify parental responsibilities toward children. (g) Understand the diversity of sexuality, including non-normative sexual orientations (LGBTQI+). (h) Recognize alternative forms of intimacy and sexuality (e.g., masturbation, petting, desire for intimacy without genital involvement, etc.). (i) Learn about the prevention of sexually transmitted infections (STIs).	Printed and laminated images from the DESEM [1] project activity books. Books: Sexuality Explained to Children [54]; The Little Atlas of Intimacy: Vulva, Vagina, Period and More [55]; The Little Atlas of Intimacy: Penis, Testicles, Erections and More [56].	• Designed assessment and monitoring grids pre-intervention and post intervention. • Designed open-ended questions.
Three	Support for Acquiring Privacy: Education on Private Places and Spaces.	This module teaches the distinction between public and private spaces, emphasizing appropriate behaviors in each setting. It introduces strategies for maintaining privacy in private spaces.	(a) Differentiate between public and private spaces and understand the behaviors appropriate for each. (b) Learn behaviors to ensure privacy in personal spaces, such as closing doors or knocking.	Printed and laminated images from the DESEM [1] project activity books.	• Designed assessment and monitoring grids pre-intervention and post intervention.

Table 2. *Cont.*

Module	Title	Content Description	Specific Learning Objectives	Materials	Measurement Tools
Four	Support for Acquiring Privacy: Education on Protecting Personal Privacy	This module focuses on personal boundaries and the concept of body as personal space. It covers the importance of consent in personal space interactions, abusive intimate behaviors, and ways to prevent and counteract such behaviors. It also educates about positive, healthy intimate relationships and the right to decline unwanted sexual encounters or approaches.	(a) Understand the concept of personal space and the importance of respecting others' personal space. (b) Learn about consent and its role in maintaining personal privacy and boundaries. (c) Recognize abusive intimate behaviors and understand actions to prevent or counteract them. (d) Understand the right to say "no" to unwanted sexual relations and learn about healthy intimate relationships	Printed and laminated images from the DESEM project activity books. Books: The Little Atlas of Intimacy: Vulva, Vagina, Period and More [55]; The Little Atlas of Intimacy: Penis, Testicles, Erections and More [56].	• Designed assessment and monitoring grids pre-intervention and post intervention.
Five	Personal Boundaries and Levels of Relationship: Working on the Circles.	This module uses the "Circles" tool to help participants visualize and understand the different levels of relationships based on trust, intimacy, and care. It teaches personal boundaries and how to behave appropriately according to the closeness and nature of each relationship.	(a) Understand the concept of personal boundaries and learn to distinguish between different levels of relationships. (b) Learn how to use the Circles tool to categorize relationships based on trust, intimacy, and care. (c) Understand the appropriate behaviors for each level of relationship and respect others' boundaries.	1. Hard copies of the "Circles". 2. Personal photos of friends and relatives. 3. Pictures of celebrities from newspapers. 4. Emre's Story from the DESEM project.	• Designed assessment and monitoring grids. • Designed list of questions to stimulate guided conversation. • List of behaviors and attitudes to classify. • List of people to classify.
Six	Taking Care of Your Body as a Sign of Self-Love: Support for Hygiene and Personal Care	This module emphasizes the importance of hygiene and personal care, particularly for intimate areas, to prevent discomfort and illness. It teaches independent washing techniques and personal care routines, including menstruation management and alternative menstrual products. Information about sexual health services and contraceptive methods are given.	(a) Understand the importance of maintaining hygiene for intimate body parts to prevent health issues. (b) Learn how to perform personal care routines independently, including showering, using deodorant, and selecting clean clothes. (c) Learn about hygiene practices during menstruation and after genital intercourse. (d) Understand alternative menstrual management options. (e) Learn about contraceptive methods and available sexual health services.	Printed and laminated images from the DESEM project activity books. Books: Sexuality Explained to Children [54]; The Little Atlas of Intimacy: Vulva, Vagina, Period and More [55]; The Little Atlas of Intimacy: Penis, Testicles, Erections and More [56].	• Designed assessment and monitoring grids pre-intervention and post intervention. • Designed open-ended questions.

[1] Further information regarding the objectives, tools, and outcomes of the European project DESEM can be found at the following link: https://www.desemproject.eu/ (accessed on 2 March 2024).

2.2.2. Educational Materials and Tools

To enhance comprehension and engagement, the program incorporates a variety of visual and textual materials that are easy to obtain and cost-effective. Images and videos developed by the European project DESEM (Developing Sexual Education Models for Mentally Disabled People) were used for each eITPoSA training module. Further information regarding the objectives, tools, and outcomes of the European project DESEM can be found at the following link: https://www.desemproject.eu/ (accessed on 2 March 2024). Additionally, four illustrated books in their Italian editions were selected to convey explicit information on gender identity, sexuality, sexual development, the genital sex act, contraceptive methods, and sexually transmitted diseases:

- *All About Your Body*—Pauline Oud [53];
- *Sexuality Explained to Children*—Arturo Martin and El Taller, illustrated by Tatio Viana [54];
- *The Little Atlas of Intimacy: Vulva, Vagina, Period and More*—Mathilde Baudy and Tiphaine Dieumegard, illustrated by Mathilde Baudy; [55]
- *The Little Atlas of Intimacy: Penis, Testicles, Erections and More*—Mathilde Baudy and Tiphaine Dieumegard, illustrated by Mathilde Baudy [56].

The suitability of these materials for the eITPoSA project was reviewed by psychologists and psychotherapists from the SInAPSi Team—Section on Anti-Discrimination and the Culture of Differences—at the University of Naples Federico II. To enhance theorical content comprehension, a clear language approach was adopted, and contents were reformulated when necessary to accommodate participants' needs and requests [52].

To support participant interaction, printed and laminated images from the DESEM project activity books were used to create educational games, particularly for modules three, four, five, and six. A video featuring Emre's Story was incorporated into module five to introduce the Circles model. Additionally, four physical copies on cardboard of the Circles conceptual drawing [57,58] were constructed collaboratively with the participants to familiarize them with the framework before its application in the fifth training session.

2.2.3. The Circles

The Circles program [57,58] is a structured approach designed to teach individuals with intellectual disabilities (ID), including adolescents and adults, how to categorize and manage social relationships effectively. This model enhances participants' ability to navigate social environments by providing a clear framework for understanding different levels of intimacy and social interaction. Using a system of concentric circles, each associated with specific colors and behaviors, the circles visually and physically represent social boundaries, making abstract social concepts more comprehensible to individuals with ID.

As illustrated in Figure 3, the Circles framework consists of six levels:

1. Purple circle (private circle): focuses on personal boundaries, reinforcing that the individual is the most important person and has control over their personal space;
2. Blue circle (hug circle): includes close relationships, such as family and friends, emphasizing consent and mutual affection;
3. Green circle (faraway circle): covers extended family and friends, promoting appropriate social gestures like hugs and pats on the back;
4. Yellow circle (handshake circle): represents acquaintances, encouraging gestures such as handshakes to maintain comfortable social distances;
5. Orange circle (wave circle): pertains to distant acquaintances, highlighting the appropriateness of non-intrusive gestures like waving;
6. Red circle (stranger circle): includes strangers, reinforcing that physical contact should be avoided unless in a professional or emergency context.

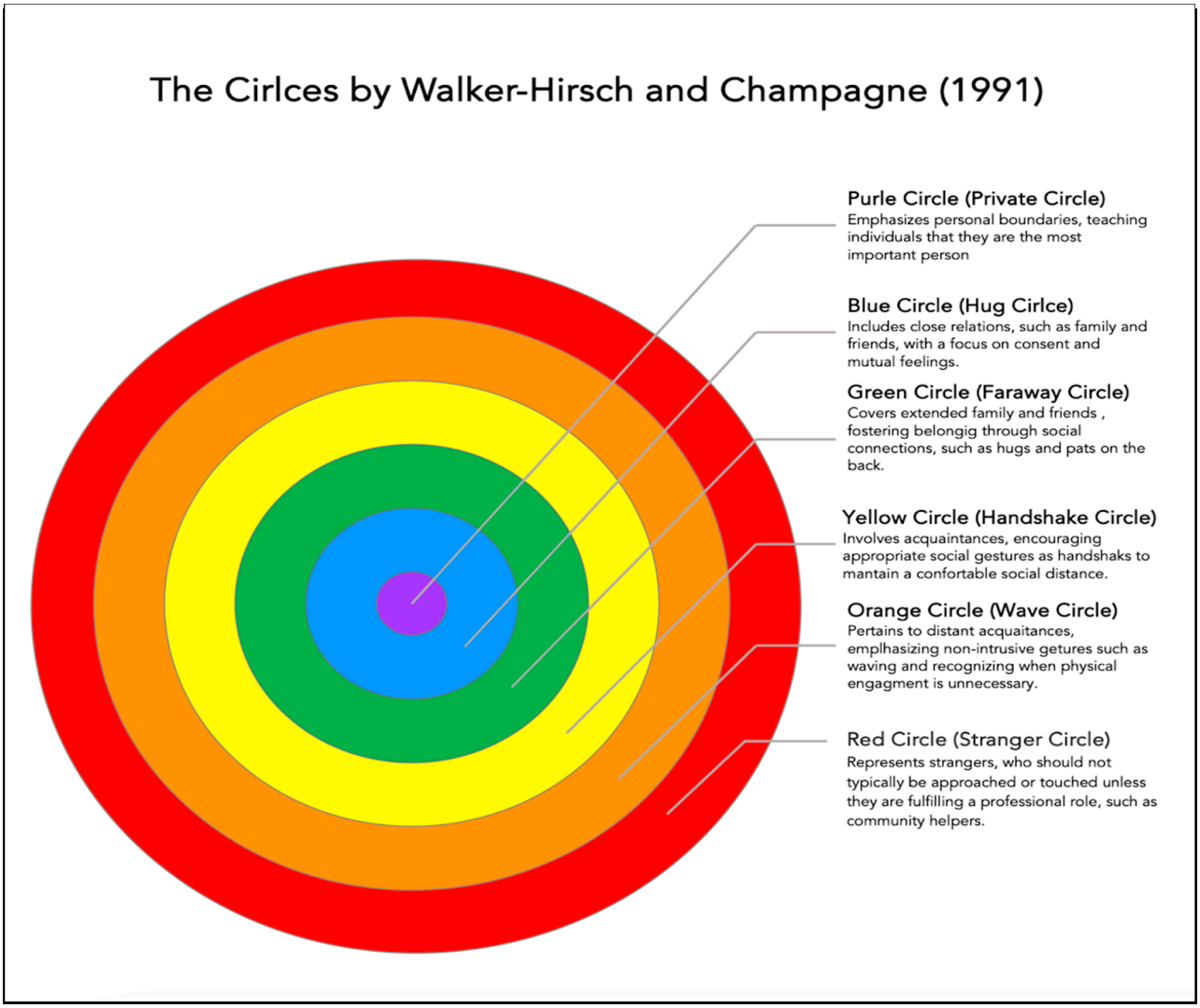


Figure 3. Visual representation of the Circles by Walker-Hirsch and Champagne [57] (1991).

The Circles was selected for the eITPoSA program to instill a sense of self-protection, assertiveness, and awareness of social norms among individuals diagnosed with ID, SMI, and ASD. By categorizing relationships effectively, participants develop essential skills to prevent social misunderstandings and exploitation while also learning to differentiate between various forms of affection and interpersonal connections. This approach fosters healthy social development and self-esteem, reinforcing the program's broader objective of promoting autonomy and informed decision making in affective and sexual relationships [57,58]. These materials and frameworks were selected and adapted to ensure accessibility and effectiveness for the target population, forming the foundation for the subsequent phases of the study.

2.3. Mesures

2.3.1. Monitoring and Evaluation Grids

Monitoring and evaluation grids were used to collect objective and detailed data on participants' skills, competencies, and behaviors during the training intervention [59–62]. These tools are particularly useful for individuals with cognitive, verbal, reading, comprehension, or attention limitations that make it difficult to complete pre- and post-training questionnaires [63,64]. The use of structured grids ensures reliable and valid data collec-

tion by standardizing the observation process, minimizing subjective bias, and improving comparability across sessions and participants [65,66].

Each training module had specific learning objectives, defined based on the existing literature on CSE for people with disabilities [35,36,44]. To assess knowledge acquisition, structured monitoring and evaluation grids were designed for each module of the eITPoSA program, aligning with these objectives. To assess participants' knowledge acquisition, structured monitoring and evaluation grids were developed for each module of the eITPoSA program, designed in accordance with the specific learning objectives. Their validity was confirmed through a review conducted by the SInAPSi Team—Section on Anti-Discrimination and the Culture of Differences—at the University of Naples Federico II.

Each grid focused on the key learning objectives of the corresponding module, defining essential knowledge, and skills that participants were expected to acquire. For each concept, a set of expected correct responses was established to assess whether the topic was understood.

Participants' knowledge was assessed through pre-intervention and post-intervention grids, which contained (a) standardized questions evaluating knowledge on the specific module topics; (b) predefined correct responses based on educational objectives; and (c) observer-coded answers, where each correct response was assigned a score of 1 point, while incorrect or missing responses were noted for qualitative analysis. Table 3 presents an example of a grid used for one of the key topics in Module 1, along with instructions for the observer.

Table 3. Example of a grid used for one of the key topics in Module 1, along with instructions for the observer.

Module 1—Discovering Our Body and the Body of the Other
Grid Activity 1.3.

Instructions: Place an X in the box corresponding to the correct answers given. In case of "I don't know" or an incorrect answer, transcribe the responses provided by each participant. Gestures indicating body parts should also be considered as given responses. Indicate, in addition, whether this is a pre-intervention or post-intervention recording.

Question to ask: Which body parts are generally considered private or intimate?

Assessment: Pre-intervention [ ];
Post-intervention [ ]

Participant Code	Face	Genitals	Breast	Buttocks	Don't know/Incorrect answer	Score
						__/4
						__/4

Data analysis was performed using a multi-method approach: quantitative analysis, comparing pre- and post-intervention scores to assess improvements, and qualitative analysis, examining incorrect responses to identify recurring patterns of misconceptions and conceptual difficulties.

These grids allowed for a direct comparison of pre- and post-intervention conditions, highlighting the changes and improvements resulting from the eITPoSA program.

2.3.2. Qualitative Data Collection

In addition to the monitoring and evaluation grids, qualitative data were collected through open-ended questions designed for Modules 1, 2, and 6, as detailed in Table 4, and through the information gathered during the Circles exercise in Module 5. The open-ended questions were specifically designed to be accessible and understandable for individuals with intellectual disabilities, autism, and severe mental illness. Each set of questions was tailored to the specific goals of the training modules: (1) Module 1 (Discovering Our Body and the Body of the Other) aimed to explore participants' understanding of gender differences and physical development; (2) Module 2 (What Are the Genital Organs For? An Introduction to Affectivity and Sexuality) assessed knowledge and perceptions regarding sexuality; and (3) Module 6 (Taking Care of Your Body as a Sign of Self-Love) focused on evaluating hygiene habits and self-care awareness.

Table 4. Visual scheme of the eITPoSA open questions divided by module.

	Open Question
Module 1: Discovering Our Body and the Body of the Other.	• What is the difference between males and females? • What is the difference between the body of a child and that of an adult?
Module 2: What Are the Genital Organs For? An Introduction to Affectivity and Sexuality	• Do you know how to make love? • What is sexuality?
Module 6: Taking Care of Your Body as a Sign of Self-Love: Support for Hygiene and Personal Care	• Do you wash yourself? In what manner? Describe the steps you follow when taking a shower. • Do you know why and when it is important to wash your body and your intimate areas?

Participants were also encouraged to actively engage by asking questions and exploring relevant topics related to each module.

Participants' responses were analyzed using thematic analysis (Braun & Clarke, 2006) [67], allowing for the identification of key themes related to body knowledge, sexuality, personal care, relationship boundaries, gender dynamics in family roles, and parasocial relationships. This qualitative approach helped explore individual misconceptions, gaps in knowledge, and personal experiences.

The qualitative results are further discussed in Section 3.3.

2.3.3. Feedback Survey

Two feedback forms were developed to assess participant satisfaction: one administered at the end of each module (Module Feedback Survey) and another upon completion of the entire program (Final Program Feedback Survey).

The Module Feedback Survey consisted of six open-ended questions designed to gather participants' immediate reactions to each module. The questions focused on various aspects, such as general satisfaction with the module (Did you like this session?), key takeaways (What did you like the most?), the comprehensibility of the topics (Was it easy or difficult to understand the topics?), the effectiveness of the trainer (Did the trainer explain things well?), and areas for improvement (What needs to be improved?). Participants' responses were recorded and transcribed verbatim by the observer. The final program

feedback survey, on the other hand, was designed to gather insights into participants' overall experience. It included questions on their satisfaction with the program (Did you like this program?), its perceived usefulness (Was the program useful? If yes, how?), challenges in comprehension (What was difficult to understand?), and interest in further training (Would you like to participate in more training on this topic?). Responses were not quantified but were grouped thematically to assess social validity and inform future adaptations of the program.

Both surveys were administered verbally, with the observer recording and transcribing the responses.

2.4. Data Processing and Statistical Analyses

2.4.1. Data Cleaning

Originally, 15 participants completed the training program. Those who attended less than 80% of the sessions were excluded (n = 3). The final sample consisted of 12 participants, three of whom missed some sessions but met the attendance threshold. To ensure comparability, values were converted into percentages. Normality tests (Kolmogorov–Smirnov [68,69] and Shapiro and Wilk [70]) indicated a non-normal distribution, leading to the use of a paired-samples t-test with bootstrapping (sample size = 1000).

To manage missing data, a listwise deletion approach was applied, where participants who attended less than 80% of the sessions were excluded from the final analysis. For those who met the attendance threshold but had missing responses in specific sessions, pairwise deletion was applied to maximize the use of available data while minimizing information loss.

2.4.2. Statistical Analyses

Descriptive statistics were conducted to explore dataset characteristics. Paired-samples t-tests with bootstrapped confidence intervals (sample size = 1000) assessed mean differences in sexual and relational knowledge scores pre- and post intervention. Cohen's d was used to estimate effect sizes, providing a measure of the magnitude of the observed differences.

The paired-samples t-test was chosen because it is appropriate for analyzing within-subject differences before and after an intervention. Given that the same participants were evaluated pre- and post training, this statistical approach allows for an effective assessment of knowledge improvement across the key domains. All analyses were performed using SPSS 27.

3. Results

3.1. Descriptive Statistics

After participating in the program, the subjects showed an improvement in their knowledge of constructs related to the relational and sexual dimension. In particular, four participants showed an increase of more than 30%, from 38.33% correct answers to 83.33% in the case of the largest increase (Figure 4). The mean values (SD) of Training Program on Sexuality and Affectivity, body knowledge, genital sexuality, privacy awareness, protection of personal privacy, and hygiene and personal care are shown in Tables 5 and 6. Descriptive analyses revealed that the average score increased by more than 30%. In this way, body knowledge, genital sexuality, privacy awareness, privacy protection, and hygiene and personal care mean scores improved post participation.

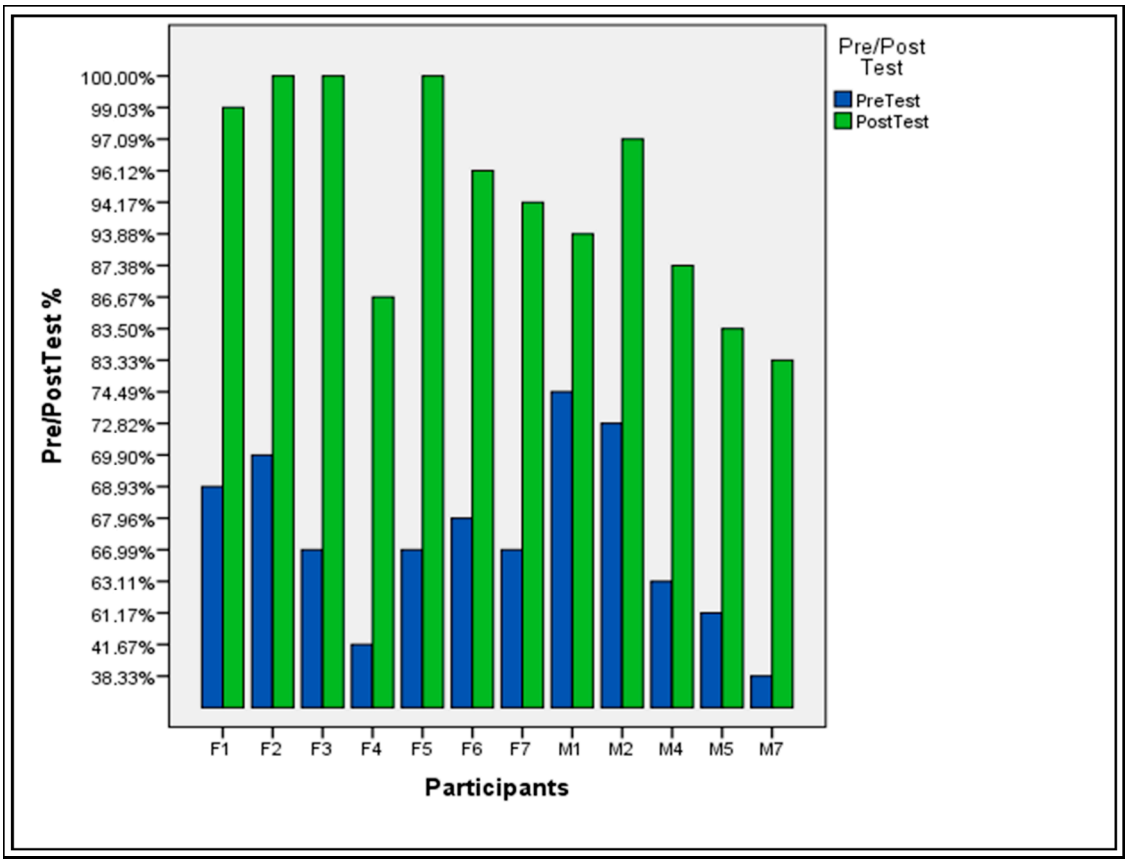


Figure 4. Cluster bar count of the pre/post test.

Table 5. Statistics of the eITPoSA.

	n	M (SD) Pre-Test	M (SD) Post Test	t	df	*p*	95%CI	Cohen's d
Educational Intervention and Training Program on Sexuality and Affectivity (eITPoSA)	12	63.27% (11.47%)	93.42% (6.50%)	12.94	11	0.000	[25.02%; 35.27%]	3.7

Note: *n* = number of participants; M = mean; SD = standard deviation; t = *t*-test statistic; df = degrees of freedom; *p* = significance level; 95% CI = 95% confidence interval; Cohen's d = effect size index.

Table 6. eITPoSA program modules statistics.

	n	M (SD) Pre-Test	M (SD) Post Test	t	df	*p*	95%CI	Cohen's d
Body knowledge	12	31.43% (25.18%)	86.65% (23.98%)	15.61	59	0.000	[48.13%; 62.28%]	2.0
Genital sexuality	12	15% (34.81%)	90% (24.00%)	15.08	59	0.000	[65.05%; 84.94%]	1.9
Privacy awareness	10	82.94% (25.106%)	98.75% (7.16%)	4.92	59	0.000	[9.37%; 22.23%]	0.6
Privacy protection	10	86.11% (29.65%)	95.95% (14.45%)	2.69	32	0.011	[2.40%; 17.28%]	0.4
Hygiene and personal care	12	47.27% (38.23%)	96.36% (12.06%)	4.64	10	0.001	[25.53%; 72.64]	1.4

Note: *n* = number of participants; M = mean; SD = standard deviation; t = *t*-test statistic; df = degrees of freedom; *p* = significance level; 95% CI = 95% confidence interval; Cohen's d = effect size index.

3.2. Pre–Post Analysis and ANCOVA

Paired-sample *t*-tests were conducted before and after the eITPoSA program on the five key modules to assess any change. The results are detailed in Tables 5 and 6. The eITPoSA program resulted in a significant increase in relational and sexual knowledge from pre-test to post test and represented a large effect size. In particular, substantial gains were observed in areas such as body knowledge, genital sexuality understanding, privacy awareness and protection, as well as in hygiene and personal care practices, as confirmed by the respective effect sizes. To gain a deeper understanding of the intervention's effects, an analysis of covariance (ANCOVA) was conducted using the pre-test score as a covariate, allowing for control of initial differences among participants. The model demonstrated overall significance ($R^2 = 0.961$, $p < 0.001$), indicating that 96.1% of the variance in the post test score was explained by the included variables. The results revealed the significant effect of module ($F(4222) = 46.312$, $p < 0.001$) and activity ($F(12,222) = 30.798$, $p < 0.001$), suggesting that both factors significantly influenced the final outcome. Additionally, the module and activity interaction was significant ($F(3222) = 53.844$, $p < 0.001$), highlighting that the effectiveness of activities varied depending on the specific module. The estimated marginal means, adjusted for pre-test scores, indicated significant differences among modules, with Module 3 and Module 4 associated with the highest post test scores ($M = 6.24$ and $M = 6.16$, respectively), while Module 2 exhibited the lowest score ($M = 2.06$). These findings emphasize the importance of considering both the module structure and the type of activities implemented to fully capture the intervention's effects, providing a more nuanced understanding of the influence of the examined variables.

3.3. Qualitative Analysis and Additional Discoveries

The qualitative analysis followed Braun and Clarke's (2006) [67] thematic approach to examine open-ended responses from Modules 1, 2, and 6; the Circles exercise in Module 5; and participant's feedback. M.B. led the data preparation phase, anonymizing transcripts and conducting initial immersion through repeated readings. Both M.B. and V.G. independently performed open coding of the complete dataset, identifying initial patterns (e.g., "struggles with anatomical terms", enthusiasm for boundary discussions, etc.), which were progressively consolidated into broader themes through researcher discussions. A.L.A. served as arbitrator for unresolved discrepancies during weekly consensus meetings, facilitating discussion until full agreement was reached. An inductive approach prioritized participants' own framings, though coding was periodically checked against observational notes to contextualize feedback— for instance, when participants described Module 1 as "tough", field notes documented repeated explanations of key concepts (including iterations of the menstrual cycle explanation and clarifications of genital anatomy), confirming the need for additional time to reinforce terminology. This process, coupled with peer debriefing and reflexivity memos documenting assumptions about participants' baseline knowledge, reinforced analytic rigor. Three macro-themes ultimately were identified: (1) language and sexual knowledge, (2) autonomy and personal hygiene, and (3) perception of relationships and intimacy. Thematic boundaries were refined until achieving internal coherence, with exemplar quotes retained to ground interpretations in raw data. By cross-validating themes with session observations and maintaining an audit trail of coding decisions, the analysis balanced participant-centric emergence with methodological accountability.

3.3.1. Language and Sexual Knowledge

Open-ended responses revealed that almost all participants struggled to use appropriate language to describe their bodies and sexual functions. Many used childish or vulgar

terms, demonstrating a limited and fragmented understanding of puberty, reproduction, and intimate relationships.

For example, when asked "What is the difference between a child's body and an adult's body?", responses varied significantly. Some participants focused on superficial characteristics, such as F1, who stated, "The face changes, the shape of the lips", while others, like F2, provided a more detailed response: "As children, we are all the same, but as adults, we are not. Males also have a backside and a back. Males have a penis, not a pubis; they have mustaches, beards, chests, and sideburns, while we have breasts". In contrast, some participants demonstrated confusion, as seen in F3 and F7, who simply responded, "I don't know. One grows up".

Similarly, regarding the differences between males and females, some responses reflected misconceptions and gaps in knowledge. M5 stated, "The girl doesn't have a willy, she has a hoo-ha", and M6 added, "Males have the willy, females the breast and the hoo-ha. An adult has hair, a child does not".

Regarding the concept of sexuality and how to engage in sexual activity, responses were similarly varied and often inaccurate. F1 responded, "You need to undress completely, with the penis inside the vagina; she makes a 'poo-poo' and then the baby grows", illustrating a highly distorted understanding of reproduction. Others, like F3 and M1, resorted to gestures rather than verbal descriptions, indicating a lack of adequate vocabulary to discuss the topic. F5 added, "Yes, the breasts move and shake, then the girl and the boy undress, and after that, the belly grows", demonstrating a mix of factual knowledge and misconceptions.

These findings align with the existing literature, which emphasizes how individuals with intellectual and developmental disabilities and psychiatric disorders often experience excessive infantilization by their families and society [9,70–72]. This phenomenon affects their ability to access accurate sexual education, ultimately compromising their autonomy and well-being. The results underline the importance of tailored educational programs that address these knowledge gaps and provide clear, accessible, and comprehensive information on sexuality and reproductive health.

3.3.2. Autonomy and Personal Hygiene

Participants exhibited diverse levels of autonomy in managing personal hygiene, with notable differences based on gender and family support. While some demonstrated independence, others remained reliant on parental assistance, often without consideration for gender-appropriate caregiving.

For example, F1 stated, "When the babysitter is there, she makes me shower twice a week, but my parents only once. My dad washes my back and hair, helps me dry, and puts on talcum powder". Similarly, F2 reported, "When I am in the city, I don't always shower, but in summer, I do it both in the afternoon and evening. My father helps me with my back and drying my hair. When I have my period, I ask my mom to help me put on my underwear and bra". These accounts highlight not only a lack of autonomy but also potential privacy concerns related to gendered caregiving roles.

Conversely, some participants managed their hygiene independently. M2 described his routine in detail: "First, you relax, step into the shower, apply body wash, then take a sponge and scrub your entire body, including the genital area. Next, wet your hair and use shampoo. Rinse off, place the towel on the floor, then step out of the shower, put on a bathrobe, and dry yourself". Similarly, M4 stated, "I wash my head, face, arms, ass, armpits, legs, feet, hands, and also brush my teeth. I also apply perfume". These responses indicate a spectrum of autonomy among participants.

A particularly significant issue emerged concerning menstrual hygiene management. Many female participants struggled with changing sanitary products independently. Discussions led to the proposal of menstrual panties as an alternative. However, only F3′s family acted on the suggestion, while others dismissed it as unhygienic or unsuitable. F3 later reported increased confidence and self-sufficiency after switching to menstrual panties, illustrating the potential of different practical solutions for managing physiological needs in promoting autonomy.

These findings emphasize the need for continued efforts in fostering personal hygiene skills, especially among those who rely on familial support. Educational interventions should not only provide technical knowledge but also address privacy, gender sensitivity, and autonomy in self-care routines.

3.3.3. Perception of Relationships and Intimacy

The analysis of the Circles exercise provided valuable insights into how participants perceived and categorized their social relationships. Thematic analysis of the Circles exercise revealed three key sub-themes: (1) variable boundary awareness: while most participants (8/12) correctly placed acquaintances in the yellow circle, 3/12 struggled with parasocial relationships; (2) family dynamics over blood ties: participants often categorized family based on emotional closeness, not obligation; (3) behavioral consistency: all participants correctly matched behaviors (e.g., hugging, handshakes, etc.) to circle levels during guided discussions, indicating retained learning despite initial misclassifications.

On the subject of variable boundary awareness, most participants successfully placed their acquaintances and friends within the blue and green circles, indicating an understanding of different levels of trust and affection. However, notable exceptions emerged. One participant, M1, indiscriminately placed all suggested individuals—including acquaintances and distant relatives—within the blue circle, despite acknowledging weak or conflictual relationships with some of them.

The topic of celebrity relationships also emerged as a point of discussion. Some participants, including M4 and F5, continued to classify famous figures from movies and television within their blue circle (hug circle), failing to recognize that these were parasocial relationships (PSRs) rather than personal connections. In line with this, M4 said "E.S.R. [Italian actress] is a really good person"; similarly, F5 said "Oh, G.S. [Italian TV host] I like him... it makes you laugh... I like it! I'm putting him here (Blue Circle) because he's a good friend". This misconception persisted even after guided discussions, illustrating the rigidity of thought processes in some individuals. A particularly striking case was that of F1, who maintained an intense, delusional attachment to a well-known actor, believing she was in love with him. She expressed genuine difficulty in deciding whether to pursue an imagined relationship with the celebrity or a real-life friendship with someone from her group, as she explained "[...] I find myself two guys that I like and I don't know who to be with", underscoring the need for more targeted psychoeducational interventions.

Regarding the sub-theme of family dynamics over blood ties, a significant finding was that not all participants positioned their immediate family members in the blue circle (hug circle). Many categorized them based on the quality of their relationship rather than familial ties alone. For instance, M2 placed his brother in the green circle (faraway circle) and his father in the yellow circle (handshake circle), reflecting their distant relationship. Similarly, F6 placed her father in the green circle and her brother in the yellow circle, highlighting family dynamics influenced by gender roles and household responsibilities. She explained, "No, no, no, no, for the most part, I no longer have a relationship with my father; I don't talk to him anymore. [...] Because he has too strong a personality... I can't handle it, personality-wise, I just can't. And honestly, the fact that he smokes all the time

bothers me too. [. . .]". Regarding her brother, she also said, "Sometimes I get frustrated with cleaning the floor because even when my brother showers, I have to do it; he doesn't do anything and is so lazy. He makes a mess, and I have to clean up everything myself. I always have to do everything. I tell him, 'It's not just girls who do the chores; boys do too, you know!'".

Another relevant case was F3, who placed both her father and her brother's girlfriend in the yellow circle (handshake circle), signaling a sense of emotional distance and discomfort. This was particularly evident in participants from complex or conflictual family backgrounds, where trust and closeness were not necessarily dictated by blood ties but by personal experiences and emotional connections. For example, with respect to the girlfriend of her brother, F3 states "And my sister-in-law is a pain in the ass".

Regarding behavioral consistency, despite the challenges that emerged, all participants demonstrated competence in identifying appropriate behaviors for each relationship category. They correctly classified behaviors based on the intimacy and trust associated with each circle, distinguishing between consensual and non-consensual interactions. This competence was reinforced through open discussions and exercises facilitated by trainers, who guided participants in reflecting on social norms and personal boundaries. The list of behaviors and attitudes for classification as well as the list of people to classify are provided in the Appendix A, in Tables A1 and A2.

3.4. Participants Feedback

Participants provided written feedback at two timepoints: after each module and upon course completion. Their feedback was recorded and transcribed onto feedback forms. Thematic analysis revealed three consistent themes: (1) satisfaction with the course and teaching methods, (2) the relevance and challenges of the content, and (3) the desire for further training and its personal impact.

All participants expressed a high level of satisfaction with the training course, emphasizing the clarity and adaptability of the trainers. They particularly valued the flexibility in tailoring the material to their needs and the opportunity to clarify and reformulate complex concepts. As one participant stated, "You explained everything very well" (M3), while another highlighted the trainer's ability to make difficult topics more accessible, saying, "You were great at explaining" (F2). Open discussion spaces were also highly appreciated, as they allowed for meaningful exchanges and guided conversations. One participant noted, "I enjoy talking about trust and understanding what it means, even if I don't like thinking about celebrities as strangers" (F7).

Regarding the relevance and challenges of the content, Modules 1 and 2 were frequently mentioned as particularly significant, as they addressed fundamental topics such as sexuality, reproduction, and psychosexual development—areas where participants felt they had limited prior knowledge. As one participant shared, "I liked the first two lessons because they talked about differences, sex, and making love" (F2), while another expressed, "I enjoyed talking about how love works and how one gets pregnant" (F5). However, these modules also presented difficulties, particularly in terms of memorization, as they required learning specialized anatomical vocabulary and biological processes. One participant remarked, "Modules 1 and 2 were tough, especially the parts about the male body and the intimate areas because you have to memorize all the names, and the menstrual cycle was hard to understand" (F2). Module 5, on the other hand, was particularly valued for its focus on personal boundaries and privacy. One participant described it as their favorite, stating, "My favorite lesson was the one on the circle of trust" (F1), while another emphasized, "I like talking about boundaries and personal space, I want my privacy" (F5).

Finally, all the participants consistently expressed a strong desire for further training, highlighting the depth and breadth of the topics covered. As one participant noted, "I really like how we went deep into the topics" (M3), while another reflected on the impact of discussing themes such as LGBTQ+ identities and parental responsibility, stating, "I liked that we talked about so many things, including the topics of gay and lesbian people, as well as becoming a parent, because you need to learn how to be responsible and raise children. Thanks to this I realized that I am interested in marriage and engagement, not in becoming a parent" (F1). The overall enthusiasm for the course translated into a collective wish to continue, with remarks such as "I would love to do another workshop like this" (F5) and "It was wonderful, I wish I could continue" (M2).

4. Discussion

Findings from the Educational Intervention and Training Program on Sexuality and Affectivity (eITPoSA) demonstrate significant improvements in the knowledge and skills of young adults with severe mental illness (SMI), intellectual and developmental disabilities (IDD), including autism spectrum disorder (ASD) and Down syndrome. These results align with the existing research highlighting the necessity of tailored sexual health education to combat stigma, enhance self-esteem, and foster meaningful relationships [1,2]. The program's effectiveness is evident in the participants' increased understanding of relational and sexual knowledge, body awareness, and privacy, addressing critical challenges faced by individuals with SMI, IDD, and autism, who generally experience poorer sexual and reproductive health outcomes [7,8].

Moreover, the improvements observed in knowledge related to genital sexuality and personal care underscore the program's role in bridging key informational gaps. This is particularly relevant given the heightened risk of engaging in unsafe sexual behaviors and experiencing exploitation among these populations [4,10]. Additionally, the program's emphasis on privacy and personal boundaries is significant, as individuals with intellectual disabilities and ASD often struggle with recognizing social boundaries, increasing their vulnerability to abuse [9,71]. The findings reinforce the effectiveness of comprehensive sexuality education (CSE), as endorsed by the World Health Organization [45], in providing scientifically accurate, realistic, and unbiased information to help individuals develop the necessary skills to form healthy relationships and make informed decisions [19,20,35,36,44–46].

In the Italian context, the study highlights the urgent need to improve access to sexual health education for people with disabilities. The historical absence of comprehensive sexuality education, particularly for students with disabilities, has contributed to disparities in sexual health outcomes, including higher rates of sexually transmitted infections (STIs) and sexual abuse [41,73,74]. The success of the eITPoSA program suggests that well-structured educational interventions can mitigate these inequalities by equipping individuals with disabilities with essential knowledge and skills for making informed sexual health decisions.

Furthermore, the program aligns with the broader objectives of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) by promoting personal autonomy, social inclusion, and dignity among individuals with SMI, IDD, and autism. The findings emphasize the need for policy reforms, educator training, and community engagement to ensure widespread accessibility and effectiveness of sexuality education for these populations. Expanding initiatives like eITPoSA is essential for addressing specific educational needs and fostering a more inclusive and equitable society.

Limitations and Future Research

The results of this pilot study support the need for future research with similar parameters to further evaluate the eITPoSA program. However, several limitations need to be considered. Firstly, the small sample size and the variability in the clinical conditions of the participants limit the generalizability of the results to the entire population of individuals diagnosed with SMI, intellectual disabilities, and developmental disorders. Furthermore, our study only included participants with adequate verbal and comprehension skills, excluding individuals with severe communication difficulties. Future studies should focus on designing educational programs that are also accessible to individuals with more severe impairments in these areas.

Another limitation is the lack of standardized and normative educational comprehensive sexuality education (CSE) models in educational settings specifically validated for the SMI population and individuals diagnosed with intellectual disability and autism (including cases of moderate to severe severity). This gap is important because intellectual disabilities of a moderate or severe degree often coexist with other psychiatric or developmental disorders. In fact, many studies [75–77] have consistently reported higher rates of psychotic disorders (e.g., schizophrenia) in individuals with ID compared to the general population. Furthermore, certain genetic conditions (e.g., 22q11.2 deletion, Down, and Fragile X syndromes) are linked to both ID and increased risk of psychosis [78–82]. To ensure the sexual well-being of this population group, it is essential to develop programs that are also valid for individuals with comorbid diagnoses and adaptable to educational contexts characterized by a wide diversity of clinical conditions among the individuals they serve.

Regarding the evaluation methodology, although detailed feedback was collected from participants at the end of each session and the entire training course, the exclusive use of satisfaction questionnaires may not have fully captured the subjective experiences and individual transformations of the participants. The integration of more detailed qualitative tools, such as in-depth interviews or post-intervention focus groups, could provide further insights into the perception of the effectiveness of the intervention and the changes experienced by participants. Moreover, this study relied exclusively on qualitative analysis for the Circles activity and participant feedback, which limits generalizability but provides nuanced insights into participants' subjective experiences. Future research could integrate mixed-methods approaches (e.g., coding frequency of thematic responses) to strengthen objectivity.

Additionally, the duration of the intervention does not allow for the assessment of long-term benefit retention. Longitudinal studies could examine the stability of the learning outcomes and the impact of the program on the daily lives of participants over time.

Despite these limitations, our study has significant strengths. Unlike many previous studies that have primarily focused on individuals with mild intellectual disabilities, this study included individuals diagnosed with various disorders and moderate to severe intellectual disabilities, often comorbid with other psychiatric conditions. Furthermore, it represents one of the few studies in the Italian context to implement an educational intervention on sexuality and affectivity for young adults diagnosed with SMI, intellectual disabilities (including genetic syndromes), and autism in educational settings.

Consequently, the eITPoSA program may be a potentially useful tool for promoting sexual and relational well-being in a wide range of young adults with different conditions and levels of functioning, including severe cases. However, further research is needed to generalize and expand the current findings.

5. Conclusions

The pilot study showed that the eITPoSA program demonstrated significant improvements in sexual and relational knowledge among young adults with severe mental illness (SMI), intellectual disabilities (ID), and autism spectrum disorder (ASD). The intervention effectively addressed critical gaps in body knowledge, genital sexuality, privacy awareness, and personal hygiene, empowering participants with essential skills for navigating social and sexual relationships. These findings highlight the importance of tailored sexual health education for individuals with disabilities, aligning with international guidelines and promoting autonomy, dignity, protection, and social inclusion. Future research should focus on expanding the program to include individuals with more severe communication difficulties and assessing long-term outcomes to ensure sustained benefits.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of Psychological Research of the Department of Humanities of the University of Naples Federico II (protocol code 13/2024 and approved by 15 March 2024).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

ASD	Autism spectrum disorder
CSE	Comprehensive sexuality education
ID	Intellectual disability
PSRs	Parasocial relationships
SMI	Severe/serious mental illness

Appendix A

Table A1. List of behaviors and attitudes given for classification in the Circles, Module 5.

Behaviors and Attitudes	• Hugging • Shaking hands • Patting on the shoulder • Sitting in close proximity • Sitting at a distance • Standing close during conversation • Standing apart during conversations • Dancing together • Taking a photograph together while hugging • Taking a photograph while maintaining physical distance • Kissing on the cheek • Kissing on the lips • Touching intimate parts • Entering the bathroom while it is occupied • Entering the bedroom while it is occupied • Accepting a ride in a car • Give out your phone number

Table A2. List of people given for classification in the Circles, Module 5.

People to classify	• High school teacher • Educators • High school classmates • Doctors • Therapists • Assistants or professional caregivers • Neighbors • Café employees • Retail or supermarket employees (clerks or cashiers) • Service providers (hairdresser or beautician) • People interacted with online or through social media but not personally known • Public service companies' personnel (e.g., electricians, plumbers, etc.) • Law enforcement (police officers, security officers, etc.) • Emergency services (firefighters, paramedics, or nurses) • Train personnel

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