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Grand Challenges in School Social Work: Collaboration and Constraint in School Social Workers' Sexuality Support for Children with Disabilities

Sharon J. Bolin, Heidi Adams Rueda, and Kristen F. Linton

Children with disabilities (CWD) face challenges to the development of their sexuality, in part due to a lack of appropriate, tailored sexual education in schools, role ambiguity regarding provision of sexual health services, and widespread discomfort with the topic. However, CWD have unique sexual health needs, an increased vulnerability to sexual and other forms of violence, and desire for skills and knowledge to build relationships. Using a phenomenological lens, authors conducted semistructured interviews with eight school social workers to understand how they are working with other professionals to support sexual and relational health of CWD (ages three to 11). Results indicate that school social workers collaborated with other professionals, although they also described multiple contexts in which other professionals had sole responsibility for sexual education and deferred to their expertise. Role ambiguity, policy restrictions, proscribed roles, and discomfort with the topic limited provision of needed services. Findings can assist school social workers seeking to build interdisciplinary collaboration, reduce role ambiguity, foster comfortable environments, and advocate for appropriate formats to support the sexual and relational health and well-being of CWD. They also suggest areas for policy change so that sexual support services are inclusive of all youths.

KEY WORDS:

developmental disabilities; interdisciplinary collaboration; phenomenology; positive sexuality; sex education

Approximately 12.9 percent of the 50 million children in U.S. public elementary and secondary schools have a disability, as measured by their receipt of special education services (U.S. Department of Education, National Center for Education Statistics, 2016). Although the majority of public school students receive sex education (Centers for Disease Control and Prevention [CDC], 2015), a national study found that only 43 percent of students receiving special education services received it. The rates for those with moderate to profound intellectual disability were significantly lower at 16 percent (Barnard-Brak, Schmidt, Chesnut, Wei, & Richman, 2014). However, the need for professional sexual health services among children with disabilities (CWD) is great given their unique needs and experiences. These include intersections between individual disability type and severity (Nguyen, Liamputtong, & Monfries, 2016; Nichols & Blakeley-Smith, 2010), their increased vulnerability to sexual and other violence (see McDaniels & Fleming, 2016, for a review), and their similar rates of sexual activity to those of adolescent peers without disability (see Murphy & Young, 2005, for a review).

Sexuality is a broad construct that includes social, emotional, and physiological factors, as well as self-esteem, relationships, body image, privacy and safety, and physical maturation and functioning (Murphy & Young, 2005). Sexual citizenship for people with disabilities is a basic human right, and support for healthy sexuality is informed by social work values of dignity and worth of the person, the importance of human relationships, and social justice (National Association of Social Workers [NASW], 2015). It is important that sexuality be privileged across the developmental spectrum, beginning in childhood (Murphy & Young, 2005). Ensuring healthy development for all youths is an identified grand challenge for social work by the American Academy of Social Work and Social Welfare (Uehara et al., 2015).

SEXUAL HEALTH EDUCATION IN THE UNITED STATES

Schools are central to protecting and fostering the sexual health of young people (CDC, 2015). However, curricula vary along a continuum to include content commonly referred to as “comprehensive sex education” and “abstinence only” (Landry, Darroch, Singh, & Higgins, 2003). Despite policy requiring that education be adapted (Individuals with Disabilities Education Improvement Act of 2004 [IDEA] [P.L. 108-446]), CWD often have limited understanding or ability to contextualize the sexual health information they are provided (McDaniels & Fleming, 2016) and may not receive individualized adapted instruction (Barnard-Brak et al., 2014). Only some states, such as California, provide the option that comprehensive sex education, including discussion of healthy and safe relationships, be offered for children in kindergarten through grade 12 in addition to mandating that curricula be adapted to meet the needs of students with disabilities (AB-

329 Pupil Instruction: Sexual Health Education, 2015). Educating early and conceptualizing sexuality to include discussion of self-esteem, body image, gender identity, and in the context of relationships is supported by research, including for CWD (Ballan, 2012; Rueda, Bolin, Linton, Williams, & Pesta, 2017; Rueda, Linton, & Williams, 2014).

ROLE AMBIGUITY AND RELUCTANCE

Sex education in public schools is often formally administered by physical education teachers, other teachers (biology, health), and school nurses (Sweifach & LaPorte, 2007) and also informally provided by school nurses, counselors, and social workers in small group and individualized formats (Alicea-Alvarez, Hellier, Jack, & Lundberg, 2011; Choate & Curry, 2009; Rueda et al., 2017). One study found that social workers played key roles in uniquely adapting sex education and providing individualized sexuality support for CWD; however, this is often done in contexts of sexually problematic behaviors (Rueda et al., 2017). Other research has pointed to school professionals as often feeling or being unprepared or uncomfortable to teach sexual education content, including to youths with disabilities (East & Orchard, 2014; Fader Wilkenfeld & Ballan, 2011; Lindau, Tetteh, Kasza, & Gilliam, 2008). Some research has supported collaborative sex education, including that of Sweifach and LaPorte (2007), who found that social workers endorsed themselves across socioemotional (for example, gender stereotypes, sexual pressure, relationships) and pragmatic and environmental (for example, sexual orientation, communication with parents, pregnancy) domains, but felt that nurses were better suited to provide physiological information. The role of sexual health educator for CWD is at times ambiguous or deferred from one professional to another within school settings (East & Orchard, 2014; Fader Wilkenfeld & Ballan, 2011). At the same time, parents of CWD may feel underequipped or apprehensive or lack effectiveness in this role (Ballan, 2012; Nichols & Blakeley-Smith, 2010). It follows that youths with a variety of disabilities report receiving inadequate sexual health information (Nguyen et al., 2016).

THE PRESENT STUDY

School social workers who serve CWD are in a unique position to inform our understanding of how we can support this population's sexual and relational health. Using a phenomenological study design to privilege the perspectives of social workers (Padgett, 2008), the purpose of the present study was to better understand how school social workers in a specific geographic area of the United States are intersecting with parents, teachers, and other professionals to meet the sexual and relationship health needs of CWD within school contexts. This article directly addresses the grand challenges for school social work practice by

enhancing our understanding of role ambiguity and constraint and highlighting how social workers are creatively working in collaborative and solution-focused ways to provide needed services to CWD.

METHOD

Sampling and Procedure

This study was conducted in an urban area of a large southern state with a majority Hispanic population and rates of disability similar to state and national proportions (Brault, 2011). Institutional review board approval was obtained prior to this study, whereby purposive sampling methods were used to recruit social workers serving CWD in various settings. Eligibility criteria required that participants hold a BSW or MSW degree from an accredited institution and have worked with CWD (ages three to 11). CWD were defined as those in receipt of special education services or as defined by the social worker or their place of employment.

Participant	Current Placement	Population Served (years)
1	Community family social services agency	All ages
2	Private practice	All ages
3	Elementary school social worker	4–11
4	Elementary school social worker, parent liaison	4–11
5	School for children with emotional disabilities	5–18
6	School for children with physical disabilities	0–18
7	Elementary school social worker	4–11
8	Community family social services agency	All ages

Notes: Social workers interviewed also held past experience in schools (SW1, SW2, and SW8), adoption or postadoption services ($n = 2$), sex offender treatment provision ($n = 1$), forensic social work ($n = 1$), program and grant administration ($n = 2$), Child Protective Services ($n = 1$), and early childhood intervention ($n = 1$).

Convenience and snowball sampling were used to recruit social workers from school Web sites and local agencies providing services for people with disabilities and from those we knew from practice settings. A total of 23 potential participants were invited to participate initially with an e-mail, which provided the study purpose, criteria, and our contact information. Some participants did not respond ($n = 5$) and some declined participation ($n = 5$). One additional interview was excluded from the study, as the participant did not meet inclusion criteria. In total, we interviewed 12 social workers; our present analysis is narrowed to the eight who currently or previously worked in schools. Of these, one had a BSW degree and the others had MSW degrees (two were LCSWs; one had a PhD). Participants had 13 to 38 years of experience working with CWD ($M = 23.25$; $SD = 8.51$). They ranged in age from 43 to 61 years, and were diverse in ethnicity (Hispanic = 3; black = 2; multiracial = 2; white = 1), and gender (female = 4; male = 4). The first author and a second researcher conducted semi-structured interviews in social workers' offices. A signed written consent with permission to record was obtained prior to starting the interview. Key questions were kept consistent and pertained to CWD experiences across each of the areas included in our broad definition of sexuality. Data for this study resulted from final questions concerning how social workers worked with families, educators, and other professionals to support the sexual and relationship needs of CWD and their challenges in doing so. Participants were compensated \$5 for their time.

Analysis

All interviews were transcribed, and NVivo 10 (QSR International, 2014) was used to help manage and analyze a large amount of data. The first author used inductive content analysis to create a codebook in which meaningful themes and sub-themes were operationalized and linked conceptually. The first codebook included data from the broader sample of 12 social workers, whereby the broad themes of this study were supported. However, data from the subset of school social workers highlighted important contexts (for example, policies, role constraints) unique to the school social workers ($n = 8$) that warranted deeper exploration and separate study. A separate codebook was then created as unique to the school social workers in our study, and the first and second authors corroborated through multiple iterations to ensure its trustworthiness in clearly communicating the lived experiences of those in our study. The third author then independently assessed the clarity of the finalized codebook, and the first author coded all data from it. Some data were double-coded across two or more themes and subthemes. Weight was given to frequency, depth, and emotionality of the examples and stories provided.

The trustworthiness of this study was ensured by use of reflexivity, observer triangulation, and peer de-

briefing, and by keeping an audit trail. We hold expertise in various areas of research and practice, and we engaged in collaborative dialogue concerning research decisions. Participants were also encouraged to provide thick descriptions, that is, rich examples of their practice experience. This supports credibility and transferability of the findings by allowing for an understanding of the contexts of the findings and how they may be applied elsewhere (Creswell & Miller, 2000; Lietz & Zayas, 2010).

RESULTS

School social workers often collaborated with other professionals to support and educate CWD concerning sexual and relationship health. They also felt that other professionals were often responsible for providing these services and at times deferred to them. Policies, proscribed roles, and an environment of discomfort around the topic of sexuality inhibited multiple professionals' ability to reach CWD with effective sex education and services. Given these constraints, social workers, teachers, and other professionals enacted diverse and intersecting roles; in turn, findings point to CWD and their families as potentially coming into contact with a number of professionals in various sexuality-related contexts and to receiving inadequate support for sexuality development. We expand on these themes here, using a numeric system that links specific social workers to their respective practice settings (see Table 1; the first person listed in the table will be referred to as SW 1, and so on). In this manner, we stay close to the data in our use of direct quotations from social workers.

Collaboration

School social workers were sometimes approached by other professionals, including school counselors, school psychologists, nurses, educators, administrators, and specialists outside the school system regarding sexuality support for CWD. They worked collaboratively to help CWD develop strong peer relationships, enhance self-esteem, develop good hygiene, navigate sexual development, feel safe, and address sexual behavior problems. Many of these were intertwined and intersected with the child's unique characteristics in part reflective of one or more co-occurring disabilities.

Collaborations often related to supporting peer relationships, "so colleagues approach me . . . even through fifth grade, it's peer relationships and getting along with each other" (SW 4). Social workers reflected on this as important to later intimacy: "Well, if they don't learn those skills [affection sharing, boundaries] through school or through services in the home, I think it will just be harder for them to be able to get into a relationship" later (SW 6). Respondents supported teachers with skill development: "We do a lot

of our work in class- rooms, and so giving, passing on those skills to the teachers so they can support those children” (SW 8). Social workers reported frequently collaborating with teachers and counselors to address self- esteem concerns, including those related to body image: “The teachers do bring them . . . they’re like fourth or fifth grade—even at that age their esteem is dependent upon how they look and their weight” (SW 4). One social worker spoke specifically about how her collaborations included helping CWD to develop good hygiene (“We’re trying to do her hair and do some things for her” [SW 5]) and navigate sexual development concerns (“We track her periods because we know when it’s time, she attacks people. She’s a little autistic girl . . . and our nurse has to teach how to put the pads on and how to do those things” [SW 5]). Social workers also worked with other school professionals on behalf of CWD who had experienced sexual trauma:

She doesn’t feel safe with the male staff, and so I’ve arranged that the female staff always be present with her. We’ve talked to the teacher. We’ve sat down and talked with him so that she feels safe because she was sexually abused. (SW 5)

Another social worker described collaboration with school and city officials to increase the safety of a child who was experiencing bullying:

So . . . we’ve got one little boy, he had muscular dystrophy . . . he was in a chair. And they lived in an area that was not very safe in general so being picked on, being bullied at different times we had to work with the housing authority office as well as the school, because there has to be a safe place for this kid. (SW 1)

Integrating services at the intersection of sexuality and disability was complex and required knowledge of interdisciplinary roles. This was reflected by a school social worker who collaborated with autism specialists, an out-of-school therapist, a psychiatrist, school staff, and the child’s family for a student with a sexual behavior concern:

Well, we have some autism specialists [who] are working with him and they’re giving the staff instructions about what to do. We remind him. We have some picture cues and we stop the behavior [masturbation] right away cuz he can get arrested for that. Working with the mom and the therapist that’s outside. We work with them. . . . We’re changing his medication, also. That has helped some. (SW 5)

Some social workers reflected challenges in collaboration, related to different value systems and sometimes goals for the child. Social workers discussed how their professional values, including dignity and worth of the person, played into their collaborative work with other professionals, such as “helping

support other peoples' reactions, responses, and their support to those children" (SW 8), including teachers, "just reminding the teachers to look at the strengths in the kids" (SW 5). In collaborative work with teachers, a social worker reflected on supporting their worth as well: "Our teachers are hit; they're kicked. We've taught the same skill over and over. That wears on them . . . we do a lot of positives for staff here to help them" (SW 5).

Other Professionals

Although social workers served in collaborative roles to provide sexuality support to CWD, they also indicated that other professionals were responsible for this support, particularly special education teachers: "It's usually the special ed teacher because it's a self-contained group that person can actually address body smells, umm, hygiene issues" (SW 1). Nurses, school counselors, and specialist providers were also included. Special education teachers provided social skills training, often in special class- room settings such as alternative learning environment (ALE) and behavior management classrooms:

The teachers, each elementary and middle school . . . there's a time period when you work on social skills. It's specifically for that [sexuality and relationships] and a lot of the things are addressed then—hygiene, appropriate touch. (SW 5)

The role of school counselors as responsible for sexual and relationship support for CWD was also highlighted ("As far as sexual education, he, well, they have access to the counselor" [SW 1]), especially with respect to relationships and bullying: "Our counselor does a lot of groups with the kids, all working on safe and healthy relationships . . . she does some groups on bullying" (SW 5). School nurses held important roles in sexual education, particularly in supporting CWD to better understand the scientific information presented in class: "I don't do so much with reproduction. The nurse does a lot . . . they do the film for the kids, and she does a lot of one-on-one" (SW 5). Of note, one social worker reflected on the lack of contextualizing relationship information in the nurse's curriculum: "The information they give them is very biological . . . what it is that your body is going to go through and understanding your body" (SW 7). This social worker also noted the importance she places on social services agencies to "educate parents and let them know, 'OK, this stage is where your child is at, this is what you're looking for, this is how you can help your child'" (SW 7).

The role of specialists was also noted, especially when addressing sexuality needs for children with autism:

With the kids with disabilities, a lot of times we have to rely on the clinician . . . specifically those

kids [who] are autistic and already have ABA [Applied Behavior Analysis] therapy, because those kids—they're working on a level they understand. (SW 1)

Role Deferral

At times, social workers indicated that they deferred sexuality support to other professionals or to parents. This theme, distinct from the previous theme highlighting other professionals as responsible, captured social workers' hesitancy to provide these services themselves. Some did not view this kind of support as within their professional role ("No, no. That would be the teacher concern or a counselor, teachers or counselors would be the ones" [SW 7]) or deferred to outside resources when approached by parents for sexuality support ("I can give them information, like, outside agencies that might help the parents with that" [SW 7]). A school social worker at a nonprofit school for CWD also stated that he "would definitely direct [a sexuality-related concern] to the teachers or the parents" (SW 6). Another indicated that she deferred to a medical provider for a parent's question about the sexual maturation of her son with autism:

I told the parent . . . your specialist, your doctor would be the one to answer those questions—depending on the maturity, depending on what level your child is at, neurologically . . . and what is he feeling and what changes his body is going to go through, and what will be some of the things that you will be seeing. (SW 7)

Constraint

The following subthemes are best contextualized within environmental constraints experienced by social workers in attempting to support the sexuality of CWD, because of policy limitations, proscribed roles, and discomfort around the topic of sexuality.

Policy Constraint. Policies at the district level limit the ability of social workers to address sexuality with CWD (and all children): "I couldn't deal with anything sexually while working in the school. If boys acted out in some way sexually, all I could do was read to them from the school manual . . . proper behavior and improper behavior" (SW 2).

Policy restrictions also reflected the need to adhere to a preapproved curriculum. Referencing the fourth- and fifth-grade maturation film, one social worker said, "It's through our health services department, so it's the only thing they can show. It's been approved or whatever the process is through the district" (SW 3). This social worker questioned the appropriateness of this curriculum for some CWD she served: "All the kids in our ALE unit . . . I'm sure they do go into the film, I don't know how much

they comprehend” (SW 3). Most social workers noted that policy limited the role of the school itself as a provider of sexual education: “There’s very limited opportunity to . . . do more of the life skill preparation or relationship- type preparation, because it’s the school setting and education is the emphasis” (SW 4).

The inability to provide sexual health information to support the safety of CWD was frustrating for one social worker:

Sometimes you want to do a lesson on, like, “good touch, bad touch,” but . . . they don’t even want us to do that . . . [quiet voice]. I would say the district is so hands off on that. (SW 3)

Social workers felt that parents are often limited in their ability to meet the sexual health needs of their CWD; without appropriate school-level intervention, CWD often receive little to no sexual health education. One of our participants spoke in an animated voice:

We are not allowed to tell them . . . no one is teaching them. Parents want to say, “We don’t want the schools to do it,” “We don’t want some stranger to do it,” but they don’t even know [about sexual health] themselves. (SW 2)

Proscribed Roles. Although social workers found creative ways of providing sexuality support in part through collaborative work, none stated that they had a role in the formal sexual education of children. Proscribed roles were described as creating silos for sexual education, limiting or curtailing collaboration. Some reported being unaware of the sex education curriculum (“There is [a reproduction curriculum]—I don’t know what it is. The nurse would know” [SW 5]) or even being excluded:

I want to go in [to the film on maturation] and just see what we’re showing the kids, and the nurses we had before would be like, “No you’re not allowed to go in there—it’s just supposed to be me and the parents.” (SW 3)

This social worker expressed frustration about the limits placed on her to support CWD because of these proscribed roles: “So they have all these questions, but we are supposed to say, ‘Go ask the nurse,’ or ‘Go talk to your parents’” (SW 3). However, she recognized the unique ability of a social worker to preserve privacy and confidentiality if only the limits were removed:

Sometimes they don’t want to talk to their parents. And I mean, that’s normal too, and they have like . . . more questions about puberty they want to know. But you’re so limited on what you can tell them. (SW 3)

Social workers indicated a desire for greater clarity in their roles, “knowing what we can talk about and we can’t talk about” (SW 3), and flexibility to be able to work together: “I work a lot with the counselors, and the only thing we’ve talked about is, how we wish we could talk more about sex, in an educational . . . way, or with

kids that have questions” (SW 3). They also desired a curriculum beyond the minimal sexual education (for example, videos) currently provided, to address both relationship health and sexual health in a more narrow sense (for example, maturation, puberty). On relationship health: “So more work definitely needs to be done in teaching healthy lifestyles, healthy relationships . . . whether it’s kids with disabilities or kids that are not” (SW 4). On puberty:

If there were more of . . . a curricular component in schools . . . where you could start having those conversations. . . . Kids are hitting puberty so early now. I can imagine for a student with more of a severe disability not knowing what’s going on. (SW 3)

Discomfort. Many social workers indicated that constraint was fueled by an environment of discomfort around the topic of sexuality: “We don’t educate our kids [about sex], we’re not open” (SW 8). A social worker indicated that teachers’ discomfort with sexuality was a barrier to collaboration:

They create games and they’re inappropriate games and teachers don’t know how to deal with that. They don’t want to talk about it . . . they’re afraid to call the parents they even have a hard time telling me about it. I think it’s just discussing sex or anything sexual . . . they’re uncomfortable . . . with the topic. (SW 3)

This discomfort extends to the intersection of sexuality and disability:

In some ways, there’s a parallel between society talking about sex and society talking about disabilities. We’re not very open about talking about disabilities, and in the same way, we’re not very open about talking about sexuality. (SW 8)

Discomfort also included normative sexuality contexts for CWD, such as maturation, even though they’re not mentally functioning at their age, you know, their body still continues to grow and develop and they go through puberty, so teachers just being really uncomfortable . . . and then being afraid to talk to parents. (SW 3)

A school social worker at a nonprofit school for CWD seemed to indicate his own and perhaps parents’ discomfort: “I don’t bring up, ‘We’re gonna talk about sexual health,’ stuff like that” (SW 6). Yet he reflected that parents are desirous of this information: “Parents there, they want to know these things about how—what will we do, how you do this [hygiene, maturation support]?” (SW 6).

This environment of discomfort includes fear of reprisal. Some social workers reported a restrictive school environment and policies reflective of societal discomfort and fear around sexual health education in schools: “The principal told me, you can’t talk about anything specific about sexual stuff, all you can do is tell them what’s allowed and what isn’t allowed” (SW 2). One suggested that conservative values were limiting:

Our kids . . . are in bad shape in terms of education and support in their knowledge of relationships, intimate and not intimate . . . even in the worst shape . . . because of how conservative the state is. (SW 8)

Another spoke passionately about this environment as a restraint to supporting sexual health of CWD: “A very strong restraint. There were constant lawsuits against the school districts, for saying the wrong things to the kids or whatever” (SW 2). One respondent also described the need for caution: “You have to . . . tread very lightly because you probably know schools don’t like talking about sex, so you have to be very careful about how you phrase it and what you talk to the child about” (SW 3).

DISCUSSION

School social workers in this study described working with a range of professionals in and outside of school settings to support the sexual and relationship development of CWD. Social workers reported collaborating with teachers, counselors, nurses, specialists, and parents to support the children’s social development, self-esteem, hygiene, and maturation and to address sexual behavior problems. However, reflective of some ambiguity in their roles, they also noted that others were responsible for sexuality education, particularly special education teachers, and at times they deferred sexuality support when given the opportunity to provide it. It is important to note that policies communicated a societal and school- level discomfort in teaching children about sexuality, in turn limiting the services that social workers could and felt comfortable offering, including in collaboration with other professionals.

Social workers are uniquely suited to provide comprehensive positive sexuality services to CWD given their expertise in viewing the child within his or her environment, advanced knowledge of human development, and valuing of human relationships. Role ambiguity is indeed a grand challenge for social workers attempting to foster a school environment where sexual citizenry is accessible to all youths. Social workers in this study questioned whether sexual education presented was understandable and appropriate to CWD. This included lack of tailored content to meet the unique needs of each child with a disability, paralleling Barnard-Brak et al.’s (2014) findings, and biologically focused curricula that lack contextualizing relationship information, especially important to CWD who may face challenges in developing and being safe in relationships (McDaniels & Fleming, 2016; Murphy & Young, 2005). Furthermore, very little sexuality support was provided in the way of direct discussion with the child or family around gender identity, sexual pleasure, or sex within relationship contexts.

Role ambiguity is contextualized within restrictive policies concerning sexuality (for example, abstinence-

only education; Landry et al., 2003), which hold negative ramifications for CWD. Children with a range of disabilities often need sexuality support starting early, including for socioemotional skill development, as conceptualized within a broad definition of sexuality, and which prepares them to have healthy intimate partnerships later in life (Murphy & Young, 2005; Rueda et al., 2017). However, the absence of clear mandates as well as ambiguous roles and deferral from one professional to the next suggest the potential for CWD to fall through the cracks with regard to receiving appropriately adapted sex education as they should per IDEA (2004). Particularly in light of their increased vulnerability to sexual abuse, exploitation, and misinformation (McDaniels & Fleming, 2016), it is important that CWD receive sex education specific to their heterogeneous needs.

Limitations

Our study was limited to a specific geographical location, which limits its transferability. Roles proscribed for social workers and other professionals by the school districts further affect transferability; however, the themes found in this study reflect those of social workers working with adolescents with disabilities in another state (Linton, Rueda, & Williams, 2017). This study also used a broad definition of disability; however, this is consistent with school social workers' roles and IDEA (2004). Our original study design included social workers serving children in a variety of settings (for example, private practice, schools, communities); however, this limited our sample size within the school social worker subsample. Future research should consider social workers' and other professionals' delivery of sexuality support as influenced by policy restraints and seek to capture and replicate successful collaborative models among professionals and families.

Conclusion

We need to empower the collaborative work of multidisciplinary teams, including CWD, their parents, social workers, educators, counselors, specialists, nurses, and other medical providers, to advance the sexuality and relationship health of CWD. This can be supported through acknowledging and reducing role ambiguity in schools and through advancing interdisciplinary collaboration, including upholding unique areas of expertise, values, and ethics of various disciplines at institutes of higher learning and in practice settings. We must foster environments that enhance the ability of all professionals and families to feel safe and comfortable to support healthy sexuality for CWD, including through continued promotion of discourse on the topic across the life span. Furthermore, social workers' ethical duty to advocate should include advocacy against policy constraints that limit provision of service and for equal access to quality sexual health education for CWD, reflecting the values of social justice, the central importance of human relationships, and the inherent

dignity and worth of the person.

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