University of Nebraska at Omaha
DigitalCommons@UNO

Social Work Faculty Publications

School of Social Work

4-22-2014

School Social Workers' Needs in Supporting Adolescents with Disabilities toward Dating and Sexual Health: A Qualitative Study

Heidi Adams Rueda

Kristen Faye Linton

Lela Rankin Williams

Follow this and additional works at: https://digitalcommons.unomaha.edu/socialworkfacpub

Part of the Social Work Commons

Please take our feedback survey at: https://unomaha.az1.qualtrics.com/jfe/form/SV_8cchtFmpDyGfBLE

UNO LIBRARIES
LIBRARY.UNOMAHA.EDU

School Social Workers' Needs in Supporting Adolescents with Disabilities toward Dating and Sexual Health: A Qualitative Study

Heidi Adams Rueda, Kristen F. Linton, and Lela Rankin Williams

School social workers approach their direct practice from ecological systems and justice- oriented perspectives. As such, they may hold a critical role in providing needed sexual health and dating education and services to adolescents with disabilities. Thirteen high school social workers who work closely with adolescents with disabilities were interviewed to identify their needs and challenges in supporting such adolescents toward dating and sexual health. Mesosystemic challenges at the school level evidenced three themes: (1) the desire for school-based comprehensive sexual education for all adolescents, (2) a multitiered and ancillary approach to educating adolescents with disabilities about dating and sexual health, and (3) increased time (that is, via additional funding) to provide social work services to adolescents with disabilities. Exosystemic needs and challenges were reflected in discussions about com- munity resources that social workers deemed integral to their work with adolescents with disabilities. Finally, dialogue reflective of macrosystemic needs and challenges included environmental factors that adolescents with disabilities brought with them to school and that affected social workers' intervention efforts. Consistent with social workers' dialogue, recommendations for social work education, policy reform, and programs for adolescents with dis- abilities are presented.

KEY WORDS: *adolescence; disability; qualitative; school social work; sexuality*

Romantic and sexual experimentation is a developmental component of adolescence (Collins, 2003). Approximately half of U.S. teenagers have had sex by the time they are in high school (Eaton et al., 2011). Although the majority of high schools offer one form or another of sexual education, the content and timing vary considerably (Kann, Brener, McManus, & Wechs- ler, 2012), and the within-group variability is likely not accounted for (Lofgren-Martenson, 2011; Swango-Wilson, 2011). Adolescents with disabilities may be at particular risk of not receiving sexual health education that is tailored to their needs; for example, there are assumptions that they experience an asexual identity (Murphy & Elias, 2006). However, adolescents with a range of disabilities, including cognitive, physical, and emotional, engage in dating and sexual activity at similar or higher rates as other adolescents (Donenberg, Emerson, Brown, Houck, & Mackesy-Amiti, 2012; Mandell et al., 2008; Murphy & Elias, 2006). School social workers approach interventions using an ecological systems perspective (Bronfenbrenner, 1979); they provide school-based individual and group interventions at the microsystem and meso- system levels, refer students to community resources at the exosystem level, and advocate for students at the macrosystem level (Bronstein, Ball, Mellin, Wade-Mdivanian, & Anderson-Butcher, 2011). Social workers provide services for adolescents with the following disabilities according the Individuals with Disabilities Education Improvement Act of 2004 (IDEIA) (P.L. 108–446): mental retardation, hearing impairments, speech or language impairments, visual impairments, serious emotional disturbance, autism, traumatic brain injury, specific learning disabilities, and other health impairments. Thirteen percent (N = 6,483) of children in schools have disabilities (U.S. Department of Education, National Center for Education Statistics, 2011), and there are approximately 25,000 school social workers in the United States (NASW, 2012). School social workers thus hold a pivotal role in their ability to address the sexual health needs of adolescents with disabilities, al- though the challenges they face and their needs in doing so remain unexplored. Thirteen school social workers were interviewed for this study using a phenomenological study design to give voice to their perspectives in supporting adolescents with disabilities to develop healthy dating and sexual selves.

DATING AND SEXUAL NEEDS OF ADOLESCENTS WITH DISABILITIES

Prevalence studies specific to the dating and sexual activity of adolescents with disabilities are scarce, although research suggests that these students are at higher risk than other adolescents. One study of 59,249 children with disabilities found that they were 36 to 37 percent more likely to have sexually transmitted infections (STIs) than their peers without disabilities. Adolescents with disabilities are more vulnerable to experience forced sex, in part because of the high prevalence of low self- esteem and difficulty with

communicating in this population (Doyle, 2008). Moreover, adolescents with disabilities who find it challenging to interact socially with others, such as those with autistic spectrum disorders, often face increased frustration and despair in processing social cues related to sexuality (Ray, Marks, & Bray-Garretson, 2004).

Families often have a strong influence in the dating and sexual health decisions of adolescents with disabilities. Previous research demonstrates, how- ever, that adolescents with disabilities have unique sexual health needs that may be too complicated for family members to understand without help (Zacharin, 2008). In addition, one study found that mothers are less likely to discuss sexuality with their adolescents with intellectual disabilities and are more apprehensive about their use of contraceptives (Pownall, Johada, & Hastings, 2012). Given that adolescence is a critical developmental period for the establishment of healthy dating and sexual relationships (Collins, 2003; Erikson, 1968), all adolescents need education and support toward this aim. Adolescents with disabilities may need ancillary services to further accommodate their unique needs.

SEXUAL EDUCATION POLICIES AND PROCEDURES

Current policies and procedures in schools may prevent adolescents with disabilities from receiving adequate sexual health education. Thirty-eight states have mandated abstinence-only sex education policies (Stanger-Hall & Hall, 2011). Abstinence- only education teaches that sex should be delayed until marriage, and discussion of birth control is limited to statements about ineffectiveness (Kohler, Manhart, & Lafferty, 2008). Although abstinence- only curricula are ubiquitous in the United States, they are ineffective compared to comprehensive sex education in thwarting the initiation of sexual inter- course and teenage pregnancy (Kohler et al., 2008; Stanger-Hall & Hall, 2011). Moreover, Hogben, Chesson, and Aral (2010) found that states without abstinence mandates (n = 18) had the lowest mean rates of STIs among adolescents and the overall population, whereas states with abstinence man- dates had the highest mean rates of STIs.

Qualitative research has suggested that, even when schools provide sexual health education, adolescents with disabilities may be excluded from receiving it. Swango-Wilson (2011) found that young adults with intellectual or developmental disabilities, reflecting on their experience with sexual education in school, reported that they either did not receive it or did not understand it. Another study of adolescents in special education in Sweden found that that the majority of participants found it difficult to remember whether they had received sexual education or not. Of those who could remember receiving it, many reported that it was difficult to comprehend (Lofgren-Martenson, 2011). Despite unique challenges in this population, sex education provided to adolescents with disabilities often mirrors normative development and

assumes that their intellectual, physical, and psychological growth is proceeding at the expected rate (Tissot, 2009). Adolescents with disabilities are, however, entitled to adapted sexual education and services, according to the IDEIA. The IDEIA (2004) does not specify that education about sexuality should be adapted for students with disabilities; however, it does mandate that education be adapted to meet students' needs.

SCHOOL AND COMMUNITY RESOURCES

In addition to classroom-based sexual education, school nurses, counselors, and social workers often provide informal sex education to students in a group or individualized format that attends to their heterogeneous needs (Alicea-Alvarez, Hellier, Jack, & Lundberg, 2011; Choate & Curry, 2009). Community resources may also provide free or reduced- cost sexual health and family planning services for adolescents, although providers may feel somewhat uncomfortable administering information to adolescents with disabilities (Rohleder, 2010). This stigma may limit the availability of these resources. Recent state laws that ban funding for Planned Parenthood also limit access to affordable birth control, medical exams, and sex education (Weiner, 2012). School nurses and counselors often coordinate health education in schools. For example, research has suggested that school nurses may provide STI testing and education for pregnant or parenting teenagers (Alicea-Alvarez et al., 2011). However, one-third to one-half of health educators received less than four hours of training on pregnancy, HIV, other STIs, and violence prevention in the previous two years before the survey (Centers for Disease Control and Prevention, 2000). Similar to school counselors, school social workers spend a majority of their time in individual and group counseling roles (Agresta, 2004), and thus, they may be an additional resource for sex education among adolescents with disabilities. The social work profession emphasizes the assessment of an individual within his or her environment, and multilayered systems are considered as points of entry for inventions (NASW, 2005). School social workers conduct microsystemic interventions, such as direct counseling and mental health support, as well as mesosystemic interventions, such as creating positive school culture. In addition, they connect students to exosystemic resources, such as Planned Parenthood (Bronstein et al., 2011). It has been argued that school social workers should also play a fundamental role in advocating for educational policy change at the macrosystemic level (Hare, 1994). The roles of school social workers are com- plex and often wrought with competing demands (Agresta, 2004; Bronstein et al., 2011).

THE PRESENT STUDY

A review of the few studies on disabilities demonstrates that, across type of disability, adolescents with disabilities are at greater risk for maladaptive out- comes associated with dating and sexuality. To our knowledge, no studies have sought to under- stand whether and to what extent adolescents with disabilities discuss sexual and dating concerns with school social workers or to identify school social workers' perceived needs in their direct practice working with these adolescents toward experiencing healthy dating and sexual relationships. This study thus explored the perspectives of school social workers who work directly with high school–age adolescents with disabilities. The aim was to high- light social workers' needs and challenges in their direct practice with adolescents with disabilities.

A priori hypotheses were not developed given the exploratory nature of this study. Using a phenomenological approach, this study sought to describe, rather than to explain or predict, the perceived needs of school social workers in their pro- vision of dating and sexual health services to adolescents with disabilities (Creswell, Hanson, Clark-Plano, & Morales, 2007; Padgett, 2008). Individual interviewing was chosen as a way to obtain information due to its ability to provide high-quality data, the opportunity to probe based on participants' responses to questions, adequate time to discuss detailed descriptions of thoughts and experiences, and a high degree of confidentiality that would be otherwise unaffordable through other methods (for example, focus groups) (Padgett, 2008). Interviews were semistructured and contained open-ended questions that progressed from broad to more specific to build rapport with participants (Padgett, 2008) and to explore a wide range of possibly contextual variables that might influence social workers' practice with adolescents as suggested by the literature (for example, issues of race/ethnicity, gender, disability type and severity) (see Table 1). After an in-depth discussion of sexual and dating experiences and needs of adolescents with disabilities as perceived by school social workers, interviews ended with more a specific discussion about their practice challenges and needs (for example, "What are your challenges or needs to support adolescents with disabilities toward the development of healthy dating and sexual relationships?"), which formed the basis for this analysis.

METHOD

Sampling and Procedure

Purposive sampling techniques were used to reach high school social workers who had experience and knowledge concerning adolescents with disabilities (Padgett, 2008). To participate, interviewees had to meet the following criteria: Their primary caseload consisted of high school–age adolescents with disabilities, and they had a master's degree in social work and at least two years of practice experience in a school setting.

School social workers were told that, for this study, adolescents with disabilities were defined as adolescents experiencing any level of intellectual, developmental, physical, emotional, or mental impairments. We define disability widely, as it is not uncommon for social workers' caseloads to consist of adolescents with various dis- ability types. Social workers were also asked to dis- cuss how they define disability in the context of where they work; most described working either with emotionally disabled adolescents ("ED kids"), intellectually disabled adolescents (that is, often in special education, or the "sped kids") who had individual education plans (IEPs), or both. Padgett (2008) recommended eight to 10 inter- views for phenomenological analyses; saturation is met when data bring redundancy and no new information. Others have found that major themes may be present after six interviews but that 12 is more typical of thematic saturation (Guest, Bunce, & Johnson, 2006). Although a small sample size limits generalizability, it allows for in-depth exploration in interviews and is appropriate for under- researched areas of inquiry (Padgett, 2008). We aimed to interview a minimum of 12 eligible participants. Following approval from the governing institutional review board, potential participants (*n* = 18) from a large metropolitan area in a southwestern state were located using school Web sites and were sent an e-mail outlining the relevant study details. Respondent participants (*n* = 8) were sent a consent form and were scheduled for an interview with either the first or second author. Initial interviews resulted in the recruitment of five additional social workers via word of mouth. The authors consulted the data for themes after interviews were transcribed and agreed that saturation was met after interviews were conducted with 13 participants. Interviews (*n* = 13) primarily took place at the schools where the social workers practiced, with the exception of one interview that was held in a private corner of a coffee shop. At the time of the interview, social workers were provided with a detailed explanation of the study's purpose, the potential benefits and costs to their participation, and a guarantee of confidentiality. All decided to continue with the interview, and written consent was obtained from each participant. All interviews were digitally recorded, transcribed verbatim, and checked for reliability by a team of trained research assistants.

Table 1: Interview Discussion Guide

Question Type	Posed Question	Probes
Introductory	[Preface: Our definition of disability] Do you or your school also define disability this way?	How do you define disability in your work with adolescents?
Key questions	How often do students come to you with issues regarding sexuality and dating?	What specific issues do they approach you with?
	What do you believe are their most pressing needs pertaining to dating and sexuality?	How do their needs and experiences differ based on their individual disability diagnosis and severity? How does culture, race, or ethnicity influence the dating or emerging sexuality needs of adolescents with disabilities? How does the gender or age of the adolescent influence his or her needs in this area?
	What services for socialization do you provide specifically for adolescents with disabilities?	Do any of these services specifically target dating and sexuality?
	What kinds of sexual health and dating education do adolescents with disabilities receive?	Do they receive these services along with peers not having disabilities? Do you feel these services are helpful and/or appropriate for

		these adolescents?
	Do you feel that more services should be provided for the sexual and dating needs of adolescents with disabilities?	What kinds of services? What kind of information should be provided, and what is the best way to communicate this information?
Ending questions	What are your challenges or needs to support adolescents with disabilities toward the development of healthy dating and sexual relationships?	Are there any other areas that the questions we have asked have not addressed regarding the sexuality and dating needs of adolescents with disabilities? Or your ability to provide them with support toward developing healthy relationships?

Note: The present study was conducted with the highlighted text in mind.

The resulting sample consisted of a diverse range of school social workers; they had from four to 33 years (*M* = 14.8, *SD* = 8.8) of experience in school settings and two to 27 years (*M* = 8.8, *SD* = 6.6) working with adolescents with disabilities. The majority of the sample was white (*n* = 9; one male), but the sample also included one female Chinese American, two male Italian Americans, and one female multiracial participant. Participants ranged in age from 30 to 54 years. Interviews ranged in length from 30 to 90 minutes (*M* = 49). Some social workers held caseloads consisting of adolescents with and without disabilities; these interviewees were told to think of adolescents with disabilities when answering interview questions and/or to compare their experiences working with such adolescents to other adolescents they had served.

Analysis

Data were analyzed through a form of inductive content analysis, whereby initial codes were raised to recurrent and prominent themes across participants (Ryan & Bernard, 2003). Weight was given to comments on the basis of frequency, emotion and extensiveness, stories, and personal examples. The first and second

authors created an initial set of codes of a full interview transcript using NVivo (QSR International, 2008) software. For every segment of text, one or more codes could have been assigned, and all text was analyzed for expressed needs or challenges (that is, not only after solicitation). The first author continued to code the remaining interviews in the same manner, adding additional codes where applicable until clear themes began to emerge. Multiple codes were subsumed by larger categories identified as "tree nodes," and all authors revised the codebook several times until agreement was reached and broad themes were apparent. An independent researcher coded all text pertaining to social workers' perceived challenges and needs using the created code- book to assess interrater reliability. A kappa of .9 was reached.

RESULTS

In the context of rich dialogue about school social workers' experiences in working with adolescents with disabilities, a number of needs and challenges emerged that pertained to their direct practice with such adolescents. All school social workers said that adolescents with disabilities came to them with issues about dating and sexuality, although some also noted that such adolescents were less likely to advocate for themselves. Social workers' needs in working with these adolescents were reflective of Bronfenbrenner's (1979) ecological model, whereby social and structural systems over- lap and mutually influence each subsequent systemic tier.

Mesosystem: School

Comprehensive Sexual Education. "I would have a big fishbowl with condoms next to the thing of lollipops." The most prominent theme found in discussions with school social workers was their desire for adolescents to be educated comprehensively about their sexuality—both in the classroom and in practice situations. Social workers wanted a removal of abstinence-only restrictions that disallowed them from discussing issues concerning safe sex in their direct practice with adolescents. This issue was raised by each of the 13 school social workers interviewed. Regardless of societal desires for adolescents to remain sexually abstinent, they felt that "real life" did not mirror such policies: "When you say 'abstinence only,' they will laugh in your face. They know it's a joke." Social workers reiterated that their most pressing need was "knowing that it's okay that I can talk to them about it [sex] . . . to answer their questions and, like I said, to give them resources and to not have restrictions put on me." All school social workers initiated discussion within this category, and most felt that abstinence policies not only affected their direct work with adolescents, but also affected their ability to provide outside resources (for example, "that I'm not going to get in

trouble if I happen to have to send a kid to Planned Parenthood").

Restrictions hampered school social workers' ability to educate adolescents in a manner that met their sexual needs; instead these restrictions diminished their effectiveness as they sidestepped policies and tried to help the best they could and in their "own little way." For example, many framed their discussions with adolescents carefully to circumvent sexual education restrictions (for example, limiting discussion to anatomy, "stuff from biology class, I try to use that . . ."), or they referred the discussions to a nurse ("they could put up anything on the walls") or used indirect questioning:

> Sometimes I feel hesitant about what I can share. Um, and it's hard because the school obviously promotes abstinence, so it's kind of . . . it's hard in regard to, you know, I'll ask somebody, "I hope you're using something" and they say "yes."

Others opened themselves up more fully for such discussions despite the policies in place (for example, "I wouldn't go tell my administration that we're talking about that [sex] in group"). Some couched their tendency to go against policy as a moral and ethical responsibility within the social work profession itself (for example, "that kind of ties into my own morals and values and my social work beliefs"). The following quote illustrates a felt hesitation to admit culpability in going against district and school policies, analogizing it to that of a tightrope:

> I think the social workers, just from our own ethical perspectives, we believe strongly that if, you know, we have a student that's struggling with something that we need to provide the services for them . . . even though we still have to go over—we still are employees of a district that believes in abstinence only. So . . . we're just kind of walking that tightrope of, you know, our own social work values and then the policies that the district has in place. So it's kind of a hard little rope to walk but we do the best that we can.

A similar ambiguity was captured by another social worker:

> We can't officially do it but we do what we know we need to do.

Enhanced Dating and Sexual Health Services: A multiprong approach to the education and services. Social workers felt that adolescents with disabilities presented unique sexual and dating health needs that would best be met via a multilayered and tailored approach to services ("I think the kids with more severe disabilities need to be talked [to] at a very different level and [in] a very different format, and the information needs to be at their cognitive level"). Social workers discussed how certain dis- abilities (attention deficit/hyperactivity disorder, emotional disabilities including borderline personality) were associated with increased sexual impulsivity, a propensity to not think through or understand possible consequences (pregnancy, STIs), or the inability to

fully comprehend sexual health information at a level similar to that of their peers.

Thus, they thought that it would be beneficial to have groups with students that, you know, have disabilities after the mainstream spiel. To be able to process and go through those things.

Many social workers discussed how, with experience, they were learning to shape their services to meet the unique sexual and dating health needs of adolescents with disabilities:

> You know, difficulty learning, average to below average intelligence . . . As a social worker working with these high-risk kids, you have to really tailor it to their level.

Another social worker reiterated that:

> Part of it is creating a learning environment for a lot of these emotionally disabled students. They are difficult to teach. So while cognitively they may have average or above average intelligence, they operate at first-, second-, or third-grade levels . . . perhaps also just being a social worker versus a special education teacher . . . but they are a difficult audience to teach.

Some social workers voiced that they could benefit from additional training or support in working with adolescents with disabilities ("I probably would try to get my skills honed in terms of, you know, how to best work with adolescents around those issues and you know, take some classes or go to a conference and work on that"), particularly concerning their direct practice around sexuality and dating issues ("So when you're hit with it, I think most social workers are just floundering . . . because it is so complicated"). Many social workers discussed working in collaboration with special education teachers, nurses, and other social workers to meet students' needs, including the design of tailored curricula ("On the whole I'd say the majority of kids have pretty unhealthy relationships, and we even developed a course called 'healthy relation- ships'") and the running of life skills groups that they felt tangentially supported dating and sexual choices ("I try to approach this in a group setting because that's when I usually meet with my [special] ed students just in terms of information on sexuality"). As a final point, social workers felt that adolescents would benefit from having "someone come into the school" to talk about "different aspects of relationships" (for example, self-esteem, life skills) or to share their experiences ("I think that's such an impact for students to see someone that's gone through it [pregnancy]").

Funding for School Social Work. "I'm part-time at each school, which means I'm part-time for the student." In addition to their educational concerns, social workers expressed a need for more time to provide services. Social workers felt that "so much of it has to do with funding," which resulted in them having an overabundance of adolescents on their caseloads ("I have 400 kids this year") or in a lack of social work services for certain districts ("70,000 students and no social workers"). Funding for social work services was

cut in times of eco- nomic hardship, resulting in a reduction in support service staff and often allowing only part-time appointments:

> We have myself who deals with the high- profile difficult kids and we have another social worker part-time here to provide additional support to special ed students. So last night in the board meeting, they are eliminating two of the three positions.

Time restrictions were even more pressing given the additional services needed by adolescents with disabilities:

> The more challenges that the student with a dis- ability has, it's harder for them. We can only do so much. And then you split me part time and it's like that's even more.

Although social workers felt that students often did come to them, some discussed the unlikelihood of individuals receiving services pertaining to their dating and sexual lives. This was due to both the social workers' lack of availability given time constraints ("How are the kids supposed to access them about sexuality and dating issues?") and the adolescents' inability to advocate for themselves— thus falling through the cracks ("A student will have to be assertive, have to take those steps to self-advocate. And teaching students with disabilities to self-advocate is much later"). Sexual and dating issues often fell at the bottom of a long list of other priorities ("Where does sexuality and dating come in? . . . It's a time thing, a staffing and a time thing"). Social workers discussed these missed opportunities as having a life-changing effect for the adolescents with whom they worked:

> I guess I don't talk to them enough . . . There's no time for that. And then you hear that they're pregnant. Oh, we missed that window.

This situation was frustrating for social workers, given that they were inundated with needs that exceeded the time they had to provide adequate services ("I mean I barely have time to write down notes on the presenting problems let alone time to follow up with the kids.").

Exosystem: Community

The lack of time social workers had to work with students resulted in their dependence on community referrals:

> So I do some individual, but not weekly. I just don't have the time to do that. So usually I'll refer out. I will give them all their resources.
>
> I will always encourage them to speak with as many people as possible so they can make an informed decision.

The same budget cuts that left social workers without adequate time to work with adolescents often left the community without needed services:

> I understand that budget is tight, but we are destroying vital programs. Social services are being cut. If there's anything I need, that's what I need.

Compounded risk factors also made it difficult for families who were experiencing economic hardship ("The resources out there are limited for anyone who doesn't have insurance."). Regard- less of availability of resources, and contrary to earlier dialogue stressing the likelihood of referral, sending adolescents with disabilities into the com- munity put them at risk for experiencing difficulty in successfully navigating organizations and required additional work on behalf of the social worker:

> I am very thankful that I have a good group of support of people I can network with so we share resources and I have good connections to the community. So, I feel that I'm on top of it. But, sometimes I'm not. So, if I send a student somewhere, I may have lost that door because if that place is closed or doesn't offer what they need. Resiliency doesn't come immediately . . .
>
> [What do you mean about resiliency?]
>
> They will give up. They need a lot of hand- holding and a lot of support. I believe it pertains to disability but all the other factors — home life, environment, cultural, economic, all those things.

Macrosystem: Environment

When social workers were asked to describe their needs in supporting adolescents with disabilities, they frequently mentioned risk factors that the students brought to school as needs that were "outside of my control" and that resulted in "potential for disaster in so many ways." One such risk factor was parents:

> So you're dealing with a student who is so low functioning and then you're bringing in a parent for the IEP meetings and they are so low func- tioning that they might even be lower than the child is . . . so this is a problem we would have is that the child would get in trouble for some kind of relationship-oriented thing, then you have to bring the parent in and explain to them. The parents don't really understand it.

Similarly, social workers discussed the difficulty in transmitting healthy relationship messages to an adolescent witnessing a plethora of experiences to the contrary:

> They come from homes of violence, abuse, horrible role models . . . they go home to sub- stance abuse, violence, gangs, you know. . . .

Poverty was also discussed as a risk factor layered with ability level:

> Well, if you think of [name of school district], I think 70 percent is free lunch. That's how you measure poverty . . . When you throw in the special ed, that disability, that just sums it up to another level of risk.

Finally, social workers talked about how difficult it was "combating culture," including unhealthy relationship influence form peers, media, music, and television:

> I think the culture of media and what they see on TV, reality TV and you know . . . the whole show is about them having sex with people, like hooking up with different people, drinking, partying, and going out to bars and stuff. That kind of stuff is so prevalent . . . And so guys would pressure them into giving them blow jobs and saying "Well it's not really sex, it's . . ." You know . . . I just think that there are a lot of messages that kids get from so many places about what relationships are.

DISCUSSION

Inductive content analysis confirmed that school social workers approach their direct practice with adolescents using a multisystemic lens (NASW, 2005) and that they need support and changes to occur within meso-, exo-, and macrosystems to adequately provide services for adolescents with disabilities on issues concerning dating and sexuality. The most prominent need social workers expressed was that all adolescents should receive school-based comprehensive sexual education. School social workers in this study worked in a state with an abstinence-only sex education policy (Stanger-Hall & Hall, 2011), and they felt that adolescents learned about sexuality and dating from peers, parents, and media outlets. This study con- firmed previous findings that sex education received by adolescents with disabilities often mirrors normative development or is not modified to fit their needs. As such, it may have limited effectiveness (Tissot, 2009). The IDEIA (2004) mandates that education be adapted to meet the needs of students with disabilities, although school social workers may not be aware of this policy in such a way that would allow for them to advocate for educational changes (Bronstein et al., 2011).

Other studies have identified discomfort among educators and counselors in the delivery of sex education for adolescents with disabilities (Parritt & O'Callaghan, 2000; Rohleder, 2010). Some social workers mentioned that they needed more training to support adolescents with disabilities on dating and sexuality issues, although discussions were largely couched within advocacy desires to reach such adolescents with needed information and sup- port. Social workers acknowledged that interventions would need to be adapted based on disability diagnosis. For example, adolescents with severe cognitive

disabilities may need an intervention that is concrete, direct, interactive, and brief to account for their short attention spans and minimal grasp of abstract concepts. Many of social workers' experiences with adolescents with disabilities reflected mild impairments, such as learning or emotional disabilities; fewer social workers reported experiences working with people with severe dis- abilities, such as moderate or severe mental retardation. Social workers felt that adolescents with disabilities suffer from low self-esteem, a finding that is consistent with other research (Doyle, 2008) and that highlights the need to address this component within sexual education. Discussion of needs or challenges pertaining to practice with physically disabled adolescents was rare, although some research has found that individuals with severe physical impairments experience lower sexual self- worth (McCabe, Taleporos, & Dip, 2003). Physically disabled adults have benefited from education pertaining to sexual adjustments (for example, oral sex, naked cuddling) (McCabe et al., 2003), but teaching adolescents about this is likely to be controversial.

Concerns about the rights of adolescents with disabilities are complex and fought on moral and ethical grounds. Social workers abide by the NASW *Code of Ethics* (2008), which requires that they "strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people" (p. 5). To the contrary, abstinence-only policies limit social workers' ability to provide sexual health education to adolescents; adolescents with disabilities are at particularly high risk of life- altering outcomes. Numerous case examples were discussed whereby an adolescent with a disability did not understand basic sexual health information, including how pregnancy occurs or how STIs are transmitted. Furthermore, using a therapeutic framework that supports self-determination (Field, Sarver, & Shaw, 2003; Gilson & DePoy, 2004), social workers are faced with the challenge of allowing students with disabilities to make their own decisions, including ones that may place them at heightened health risks. The NASW *Code of Ethics* further prioritizes vulnerable populations. Research findings that adolescents with disabilities are at heightened risk for sexual violence (Doyle, 2008) further exemplify the ethical nature of social workers' role demands. Social workers expressed the challenge they faced in balancing their professional ethics with constrictive abstinence-only policies; their dialogue reflected a lived struggle whereby adherence to professional ethics required that they jeopardize their employment. This often resulted in their circumventing policies and providing outside resources covertly.

Social workers' perspectives highlight the urgency for policies at the school, state, and federal levels to be aligned to allow for appropriate health service provision to adolescents with disabilities. Social workers felt that comprehensive sexual education would serve as a foundation for effective direct practice with adolescents with disabilities, including individual follow-up to ensure comprehension and to address

socioemotional concerns (for example, appropriate progression of sexual activity, impulsivity). Similar to other studies of cross-disciplinary collaboration in school settings (Agresta, 2004; Bronstein et al., 2011), interviewees provided examples of working closely with nurses and teachers to provide sexual information to students with disabilities or to develop relationship education curricula. In the provision of tailored ser- vices, some social workers expressed that they would have liked to have additional education specific to the dating and sexual health of students with disabilities. Most advanced practice social work programs do not, however, provide training on dis- ability content (Laws, Parish, Scheyett, & Egan, 2010). Furthermore, funding cuts resulted in insufficient staffing and, thus, limited the time available to work with students. Similar to a domino effect, social workers thus relied on limited and ever- changing community resources and did so hesitantly under abstinence-only mandates. Moreover, federal cuts limited the availability of community resources such as Planned Parenthood (Weiner, 2012).

A lack of family support and lower socioeconomic status were also described as environmental risk factors that interfered with social workers' ability to provide services to adolescents with dis- abilities. Social workers desired more time and resources to reach out to families in need, but they often faced competing and urgent case-by-case demands. Thus, while their desires reflected multi- systemic change efforts, their ability to intervene with families was limited. Moreover, research demonstrates that sexual health issues may be complex and risky for adolescents with disabilities (Zacharin, 2008) and that parents may be reluctant to educate themselves about their adolescents' sexual health and dating needs (Pownall et al., 2012). Parents may exert direct influence; one study, for example, found that some parents of adolescent girls with intellectual disabilities choose to make long-term decisions regarding their daughter's reproductive potential. Some decisions included extreme changes, such as a hysterectomy, and others included intra- muscular birth control, such as Depo-Provera (Zacharin, 2008). Parental and environmental in- fluences clearly intersect with social workers' aim to empower adolescents toward comprehensive sexual health. Together with other research, findings from this study indicate that parents of adolescents with disabilities may require support and education to optimize the dating and sexual health experiences of their children.

Limitations

The goal of this phenomenological analysis was to explore school social workers' experiences in pro- viding dating and sexual health services to adolescents with disabilities (Padgett, 2008). The trustworthiness of this study was enhanced by practices that were utilized to ensure the credibility and auditability of the research (Lincoln & Guba, 1985). The confirmability of the study was strengthened by the use of multiple

perspectives to analyze inter- views; the researchers specialize in different areas (that is, disability and adolescent dating and sexuality), making theme agreement particularly credible (Padgett, 2008). Adolescents were not interviewed; however, this would have added to the depth of our understanding concerning their experiences via the triangulation of data (Golafshani, 2003). In addition, it may be considered a limitation that a wide definition of disability was invoked; results, how- ever, highlight the presence of blurred lines across disability type (for example, "the high-profile difficult kids") and demonstrate the need for methods that parallel the complexity of social workers' roles. Future research about dating and sexual experiences of adolescents with disabilities should examine differences across disability type and severity. More- over, the small sample size of this study limits its ability to be generalized to other social workers' experiences. Its exploratory nature serves as a starting point from which to conduct larger confirmatory studies.

Conclusion

School social workers expressed a desire for and have a professional responsibility to provide dating and sexual health resources and support to adolescents who are in need of it and who may otherwise risk life-altering consequences. Perhaps most saliently, social workers' needs and concerns resonated at the policy level through their plea for enhanced freedom to discuss and address issues of sexuality and dating among the adolescents with whom they work. Findings highlight the wide- spread effects of multisystemic policies and the pivotal role that school social workers may hold in advocating on behalf of reform. The findings also expound role demands and a lack of time that limits social workers' ability to meet these demands. Funding for school social workers and sexual health community resources are limited, yet this study demonstrates the importance of both in ensuring the dating and sexual health of adolescents with disabilities.

REFERENCES

Agresta, J. (2004). Professional role perceptions of school social workers, psychologists, and counselors. *Children & Schools, 26*, 151–163.

Alicea-Alvarez, N., Hellier, S. D., Jack, L. W., & Lundberg, G. G. (2011). A pilot study of chlamydia screening among high school girls. *Journal of Nurse Practitioners, 7*, 26–28.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Bronstein, L. R., Ball, A., Mellin, E. A., Wade-Mdivanian, R., & Anderson-Butcher, D. (2011). Advancing collaboration between school- and agency-employed school-based social workers: A mixed-

methods comparison of competencies and preparedness. *Children & Schools, 33*, 83–95.

Centers for Disease Control and Prevention. (2000). Surveillance for characteristics of health education among secondary schools–school health education programs, 1998. *Morbidity and Mortality Weekly Report, 49*(SS08), 1–41.

Choate, L., & Curry, J. R. (2009). Addressing the sexualization of girls through comprehensive programs, advocacy, and systemic change: Implications for professional school counselors. *Professional School Counseling, 12*, 213–222.

Collins, W. A. (2003). More than myth: The developmental significance of romantic relationships during adolescence. *Journal of Research on Adolescence, 13*, 1–24.

Creswell, J. W., Hanson, W. E., Clark-Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *Counseling Psychologist, 35*, 236–264.

Donenberg, G. R., Emerson, E., Brown, L. K., Houck, C., & Mackesy-Amiti, M. E. (2012). Sexual experience among emotionally and behaviorally disordered students in therapeutic day schools: An ecological examination of adolescent risk. *Journal of Pediatric Psychology, 37*, 1–10.

Doyle, J. (2008). Improving sexual health information for young people with learning disabilities. *Journal of Pediatric Nursing, 20*, 26–28.

Eaton, D. K., Lowry, R., Brener, N. D., Kann, L., Romero, L., & Wechsler, H. (2011). Trends in human immunodeficiency virus- and sexually transmitted disease-related risk behaviors among U.S. high school students, 1991–2009. *American Journal of Preventive Medicine, 40*, 427–433.

Erikson, E. H. (1968). *Youth in crisis*. New York: W. W. Norton.

Field, S., Sarver, M. D., & Shaw, S. F. (2003). Self- determination: A key to success in postsecondary education for students with learning disabilities. *Remedial and Special Education, 24*, 339–349.

Gilson, S. F., & DePoy, E. (2004). A model of self- determination. *Journal of Social Work in Disability and Rehabilitiation, 3*, 3–17.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *Qualitative Report, 8*, 597–607.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*, 59–82.

Hare, I. R. (1994). School social work in transition. *Social Work in Education, 16*, 64–68.

Hogben, M., Chesson, H., & Aral, S. O. (2010). Sexuality education policies and sexually transmitted disease rates in the United States of America. *International Journal of STD and AIDS, 21*, 293–297.

Individuals with Disabilities Education Improvement Act of 2004, P.L. 108–446, 118 Stat. 2647 (2004).

Kann, L., Brener, N., McManus, T., & Wechsler, H. (2012). HIV, other STD, and pregnancy prevention education in public secondary schools—45 states, 2008–2010. *Morbidity and Mortality Weekly Report, 61* (13), 222–228.

Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiative of sexual activity and teen pregnancy. *Journal of Adolescent Health, 42*, 344–351.

Laws, J., Parish, S., Scheyett, A., & Egan, C. (2010). Preparation of social workers to support people with developmental disabilities. *Journal of Teaching in Social Work, 30*, 317–333.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.

Lofgren-Martenson, L. (2011). "I want to do it right!": A pilot study of Swedish sex education and young people with intellectual disabilities. *Sexuality and Dis- ability, 30*, 209–225.

Mandell, D. S., Eleey, C. C., Cederbaum, J. A., Noll, E., Hutchinson, K., Jemmott, L. S., & Blank, M. B. (2008). Sexuality transmitted infection among adolescents receiving special education services. *Journal of School Health, 78*, 382–388.

McCabe, M. P., Taleporos, G., & Dip, G. (2003). Sexual esteem, sexual satisfaction, and sexual behavior among people with physical disability. *Archives of Sexual Behavior, 32*, 359–369.

Murphy, N. A., & Elias, E. R. (2006). Sexuality of children and adolescents with developmental disabilities. *Pediatrics, 118*, 398–403.

National Association of Social Workers. (2005). *NASW standards for clinical social work in social work practice*. Washington, DC: Author.

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author.

National Association of Social Workers. (2012). *School social work*. Retrieved from http://www.naswdc.org/pressroom/features/issue/school.asp

Padgett, D. K. (2008). *Qualitative methods in social work research*. Thousand Oaks, CA: Sage Publications.

Parritt, S., & O'Callaghan, J. (2000). Splitting the difference: An exploratory study of therapists' work with sexuality, relationships, and disability. *Sexual and Relationship Therapy, 15*, 151–169.

Pownall, J. D., Johada, A., & Hastings, R. P. (2012). Sexuality and sex education of adolescents with intellectual disability: Mothers' attitudes, experiences, and support needs. *Intellectual and*

Developmental Disabilities, 50, 140–154.

QSR International. (2010). NVivo qualitative data analysis software (Version 8) [Computer software]. (2008).Doncaster, Victoria, Australia: Author.

Ray, F., Marks, C., & Bray-Garretson, H. (2004). Challenges to treating adolescents with Asperger's syndrome who are sexually aggressive. *Sexual Addiction and Compulsivity, 11*, 265–285.

Rohleder, P. (2010). Educators' ambivalence and managing anxiety in providing sex education for people with learning disabilities. *Psychodynamic Practice, 16*, 165–182.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods, 15*, 85–109.

Stanger-Hall, K. F., & Hall, D. W. (2011). Abstinence-only education and teen pregnancy rates: Why we need comprehensive sex education in the U.S. *PLOS ONE, 6*(10), e24658.

Swango-Wilson, A. (2011). Meaningful sex education programs for individuals with intellectual/ developmental disabilities. *Sexuality and Disability, 29*, 113–118.

Tissot, C. (2009). Establishing a sexual identity: Case studies of learners with autism and learning difficulties. *Autism, 13*, 511–566.

U.S. Department of Education, National Center for Edu- cation Statistics. (2011). *Digest of education statistics, 2010* (NCES 2011–015). Retrieved from http://nces.ed. gov/fastfacts/display.asp?id=64

Weiner, R. (2012, May 7). Planned Parenthood fight continues at the state level. *Washington Post*. Retrieved from http://www.washingtonpost.com/blogs/the-fix/ post/planned-parenthood-fight-continues-at-state- level/2012/05/07/gIQA043X8T_blog.html

Zacharin, M. R. (2008). Puberty, contraception, and hormonal management for young people with disabilities. *Clinical Pediatrics, 48*, 149–155.

Heidi Adams Rueda, PhD, is assistant professor, Department of Social Work, University of Texas, San Antonio.

KristenF. Linton, PhD, is assistant professor, University of Hawai'i at Manoa. Lela Rankin Williams, PhD, is assistant professor, Arizona State University, School of Social Work, Tucson

Component. Address correspondence to Heidi Adams Rueda, University of Texas, San Antonio, Department of Social Work, 501 West Cesar Chavez Boulevard, San Antonio, TX 78207; e-mail: Heidi.Rueda@utsa.edu.

Original manuscript received March 13, 2012

Final revision received August 27, 2012

Accepted September 14, 2012

View publication stats