UNDERSTANDING SCHOOL PSYCHOLOGISTS' ROLES IN ASSURING ADEQUATE SEX EDUCATION FOR STUDENTS WITH DISABILITIES

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ABSTRACT

Due to current sex education practices, students with disabilities (SWDs) are often misinformed about sexual matters, are at higher risk of sexual abuse and unsafe sexual practices, and experience lower life satisfaction in regard to relationships. Despite the need for better and more accessible sex education for SWDs, research on this topic and on the barriers SWDs face is sparse. The ineffective provision of sex education indicates the need for involvement of school psychologists, who may be uniquely prepared to address the gap given their skills and job roles. Thus, the purpose of this study was to explore the potential for a school psychologist role in sex education. School psychologists in New Jersey public schools were surveyed in order to understand their current, potential, and desired roles in sex education for SWDs. A total of 145 participants completed the survey, representing an overall response rate of 10%. Data was analyzed using descriptive statistics, chi square tests to compare observed and expected sample distribution, and thematic analyses of open ended responses. Results of the study indicate only 3% of school psychologists are currently involved in sex education, although 68% of school psychologists report they should be involved. The highest rated methods of involvement for school psychologists in sex education for SWDs were advocating for appropriate education (70%) and consulting on developmentally appropriate activities and instruction (66%). Facilitators to involvement in sex education included existing consultation roles, relationships with SWDs and parents, availability of counseling, and training. Barriers to involvement in sex education included cultural norms, sex education being the responsibility of another staff member, and lack of time, support, and training. Limitations of the study, as well as implications for practice and future research directions, are discussed.

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Chapter I: Literature Review

Introduction

School-based sex education in the United States has been a source of contention for many decades. Throughout history, the debate has alternated between two major ideologies: abstinence-only until marriage and comprehensive sex education. The perceived need for sex education emerged in the early 1900s due to spread of venereal diseases and sexual promiscuity (Huber & Firmin, 2014). Early sex education focused primarily on prevention, using fear of contagion to scare students into abstaining from sex (Carter, 2001; Jensen, 2010). As social norms and sexual attitudes changed, advocates of sex-positive sex education fought to provide students with a comprehensive understanding of sex and the autonomy to develop their own values regarding sex (Huber & Firmin, 2014; Lamb, 2013).

Dependent on the social, political, and public health climate of the times, the goal of sex education has greatly varied over the years. Since sex education is not federally mandated, standards are determined by the state and content is determined by the local school board. For many years, this inconsistency, as well as others, made it difficult to determine whether sex education was actually effective (Somerville, 1971). In recent times, a large number of program evaluations have been conducted and data has shown comprehensive sex education to be the most effective method (Kirby, 2008; Lamb, 2013). Despite the many comprehensive, evidence-based programs that have been developed for the use of general education students, an evidence base has not yet been established with SWDs because SWDs have historically been excluded from sex education (Boehning, 2006).

The Individuals with Disabilities Education Improvement Act (IDEIA, 2004) mandates all SWDs receive free and appropriate education. In 24 states and the District of Columbia, state

policies require schools to provide sex education and HIV education; thus, a free and appropriate education in those states includes sex education instruction. See Table 1 for a summary of general sex education requirements by state. Research indicates IDEIA is often violated, as SWDs are frequently excluded from or do not receive developmentally appropriate sex education (Boehning, 2006). Sex education, when modified in accordance with students' needs, empowers children with disabilities to protect themselves from sexual abuse, unplanned pregnancies, and sexually transmitted diseases (Murphy & Young, 2005).

Table 1
General Sex Education Requirements by State

State	Sex Education Mandated	HIV Education Mandated	Sex or HIV Education Must:	
			Be Medically Accurate	Be Age Appropriate
Alabama		X		X
Arizona				X
California	X	X	X	X
Colorado			X	X
Connecticut		X		
Delaware	X	X		
District of Columbia	X	X		X
Florida				X
Georgia	X	X		
Hawaii	X	X	X	X
Idaho				
Illinois		X	X	X
Indiana		X		
Iowa	X	X	X	X
Kentucky	X	X		
Louisiana				X
Maine	X	X	X	X
Maryland	X	X		
Massachusetts				
Michigan		X	X	X
Minnesota	X	X		
Mississippi	X			X
Missouri		X		X
Montana	X	X		
Nevada	X	X		X

Table 1 - Continued

State	**Sex Education Mandated**	**HIV Education Mandated**	**Sex or HIV Education Must:**	
			Be Medically Accurate	**Be Age Appropriate**
New Hampshire		X		
New Jersey	X	X	X	X
New Mexico	X	X		
New York		X		X
North Carolina	X	X	X	X
North Dakota	X			
Ohio	X	X		
Oklahoma		X		
Oregon	X	X	X	X
Pennsylvania		X		X
Rhode Island	X	X	X	X
South Carolina	X	X		X
Tennessee	X*	X		X
Texas				X
Utah	X	X	X	
Vermont	X	X		X
Virginia				X
Washington		X	X	X
West Virginia	X	X		
Wisconsin		X		

*Sex education is required if pregnancy rate for girls ages 15-17 is at least 19.5% or higher
Adapted from Guttmacher Institute (2018)

Despite its obvious importance, current sex education is generally too indirect, often relying on euphemisms and vague expressions, to be of use to SWDs (Boehning, 2006). Additionally, society's perception of SWDs as childlike, asexual, or sexually deviant often poses a barrier to access to sex education (Howard-Barr et al., 2005; Murphy & Elias, 2006; Rohleder, 2010; Sweeny, 2007). Howard-Barr et al. (2005) found that beliefs teachers hold regarding their students' need for sex education predict the content that is taught, thus information regarding sexual behavior is often excluded, as it is thought to be least necessary. Additionally, studies exploring sex education training of special educators have revealed many teachers feel ill-

equipped in teaching such content to their students (Ellery & Rabak-Wagener, 1997; Howard-Barr et al, 2005).

As a result, persons with disabilities are less informed about sexual matters than the general population and more susceptible to misinformation, sexual abuse, and unsafe sex practices, potentially leading to unwanted pregnancies and sexually transmitted diseases (Harader, Fullwood, & Hawthorne, 2009). Sullivan and Knutson (2000) found children with intellectual disabilities were four times more likely to be sexually abused; intellectual disabilities, communication disorders, and behavioral disorders appear to contribute to higher levels of risk, with multiple disabilities resulting in the highest levels. Such statistics further highlight the critical need for developmentally appropriate sex education for SWDs.

The current lack of effective practices of sex education indicate the need for involvement of school psychologists in providing sexual health knowledge to SWDs. In defining school psychology, the American Psychological Association (APA, n.d.) acknowledges that primary prevention programs to reduce sexual abuse and teenage pregnancy, as well as programs to promote children's well-being through more appropriate education and classroom accommodations, are within the parameters of professional practice for school psychologists. APA adds school psychologists are skilled in developing educational environments that meet diverse developmental needs and in coordinating educational, psychological, and behavioral health services by working at the interface of these systems. The National Association of School Psychologists' (NASP) official stance on sex education is it should be taught in schools and school psychologists have a responsibility to use their expertise to facilitate these programs (McClung & Perfect, 2012). NASP also states school psychologists have knowledge and skills in consultation and collaboration, special education services, and prevention and intervention

services, as well as diversity in development and learning. With these collective skills and job roles, it appears school psychologists possess appropriate training and are uniquely fit to address the gap in sex education for SWDs.

History of Sex Education

Steeped in political and social controversy, sex education in the United States has historically faced debate regarding whether and how much students should learn about their sexual health. Traditionally thought to be the exclusive responsibility of family and church, sex education was first introduced into schools in the early 1900s (Huber & Firmin, 2014; Jensen, 2010). The need for sex education in the United States emerged from concerns regarding spread of venereal diseases, prostitution, and overall perceived moral decline of society (Huber & Firmin, 2014). Such concerns prompted the “social-hygiene” movement which, founded by Prince A. Morrow in 1905, aimed to educate citizens about sex, as he believed sexual problems arose from ignorance (Bigelow, 1916, Huber & Firmin, 2014; Jensen, 2010). To make his message more palatable for the public and evade controversy, Morrow used euphemisms and ambiguous language in his discussions (Jensen, 2010). He claimed his movement was value-neutral, based in eugenics and a desire to save the race from diseases and damage. Though this helped make sexual instruction more accessible for some, it continued to be exceptionally difficult for marginalized groups to access such information.

As the social-hygiene movement continued to gain traction, public schools were becoming better attended and thus perceived as viable arenas for social activism and change (Huber & Firmin, 2014). Social-hygienists reasoned it would be better to teach the young about chastity before they formed bad habits, and with school attendance being high, teachers were in the best position to disseminate such information (Jensen, 2010). At the time, this was met with

concern from the public, as many people feared sex education would corrupt youth and encourage promiscuity (Carter, 2001). Despite these concerns, in 1912, and again in 1914, the National Education Association passed resolutions in favor of training teachers to provide sexual instruction in schools, acknowledging cooperation of parents and community organizations would be crucial to its success (Bigelow, 1916). This support coupled with government involvement in sex education, in response to the spread of syphilis and gonorrhea in World War I, catapulted sex education into schools. By 1920, 40% of high schools reported offering some form of sex education, though the content was limited and largely improvised (Carter, 2001). Of that number, 16% of the schools reported offering sex education that was integrated into their curriculum, aimed at helping students to develop sound understandings, attitudes, and ideals regarding sex. The rest of the schools providing sex education generally only covered the basics of puberty, conception, and sexually transmitted infections.

Stemming from the social-hygiene movement, much of early sex education was rooted in fear of contagion (Carter, 2001; Jensen, 2010). It was reportedly common for sex educators to distress students to the point of fainting while trying to emphasize the seriousness of venereal disease; some even suggested that any contact between two people could be fatal (Carter, 2001). This raised concern about the reception of sex education and whether the knowledge of contagion would disrupt the potential for healthy marriages (Carter, 2001). As public outrage moved away from venereal diseases to sexual morality, the content of sex education followed suit. Through the 1940s and 1950s sex education became integrated into "education for personal and family living" (Lamb, 2013). The focus of sex education turned from disease prevention to promotion of monogamous marriage, reproduction, and child rearing (Carter, 2001; Huber & Firmin, 2014). With opponents of sex education fearing knowledge of sex could lead to

promiscuity and/or prevent healthy marital relationships, schools kept sex education hidden within other academic areas, often teaching it unbeknownst to parents (Huber & Firmin, 2014).

With the changing sexual attitudes and beliefs of youth in the 1960s and 1970s, along with the introduction of birth control pills, rise in teen pregnancy rates, and creation of the Sexuality Information and Education Council of the United States (SIECUS), sex education once again faced controversy (Halls, Sales, Komro, &Santelli, 2016; Huber & Firmin, 2014). Founded in 1964, SIECUS supported comprehensive sex education. The organization attempted to convey the message sex is a natural part of life, not a problem needing to be controlled (Lamb, 2013), as well as the notion that students should have autonomy in regard to sexual decision making (Huber & Firmin, 2014). At the same time, a new type of sex education program, "family life and sex education," became popular across schools in the country. The goals of the program were consistent with SIECUS's message; sex education was to be value neutral and student centered, providing students with the comprehensive information necessary to develop their own value system (Lamb, 2013). The majority of students wanted to learn about methods of contraception and emotional aspects of sex (Balanko, 2002). Sex education moved away from abstinence-only toward a more comprehensive education, including information on safe sex and prevention of pregnancy (Huber & Firmin, 2014). Public support for sex education decreased and the debate about sex education became politicized, as values of sex education no longer aligned with traditional, conservative values (Huber & Firmin, 2014; Lamb, 2013).

Although there was a drop in public support, the White House Conferences on Children and Youth in the 1960s and 1970s recommended implementation of sex instruction in public schools from elementary school through high school (Huber & Firmin, 2014; Somerville, 1971). The conferences did not provide support beyond this recommendation for implementing a plan

for action at the federal, state, or local levels; thus, sex education continued to be inconsistent and locally regulated, making it difficult to prove its effectiveness (Somerville, 1971). Another major barrier to sex education that surfaced in this era was the lack of teacher preparation and inconsistency in training programs, further making it difficult to prove effectiveness (Somerville, 1971). Barriers aside, the 1960s and 1970s created significant growth in sex education. This era sparked the introduction of a sex-positive perspective, which shifted focus from reinforcing shame and guilt associated with sex to embracing agency and choice within a person's own sexuality. It also expanded the curriculum of sex education and increased the depth of coverage (Balanko, 2002).

The AIDS crisis in the 1980s strengthened support for sex education. Along with right-wing conservatism and inconsistency among sex education advocates, it hindered the continuing development of sex positivity (Balanko, 2002; Huber & Firmin, 2014). The goal of sex education once again came into conflict as the debate between abstinence-only and comprehensive sex education increased. At the federal level, President Reagan signed the Adolescent Family Life Act into law, providing funding for abstinence-only education (Huber & Firmin, 2014; Saul, 1998). This Act was meant to counteract the Title X family planning program. Created in 1970, Title X was amended to include funding for services and community-based sex education for adolescents (Huber & Firmin, 2014). Advocates of the Adolescent Family Life Act believed Title X undermined family values and promoted adolescent sexual activity (Saul, 1998). A lawsuit was filed against the Adolescent Family Life Act, claiming it was violating the separation of church and state, as much of its funding went exclusively to conservative and religious groups (Huber & Firmin, 2014; Saul, 1998). The lawsuit was overturned, with the provision that any direct references to religion be removed from programming, (Huber & Firmin,

2014) and the Adolescent Family Life Act marked the first of many government approaches to encourage "abstinence-only until marriage (AOUM)" (Halls et al., 2016). By the end of the1980s, 17 states mandated sex education in public schools. The content of sex education still varied by district, as local school boards had control over the content that was taught (Huber & Firmin, 2014).

The AOUM movement continued to grow throughout the 1990s. Under Title V of the Personal Responsibility and Work Opportunity Reconciliation Act, signed into law by President Clinton, the government increased funding to states for abstinence-only programs, with 49 states accepting funds (Halls et al., 2016; Huber & Firmin, 2014; Lamb, 2013). The act provided a strict definition of abstinence, with an outline of eight tenets of abstinence education that should be used to teach students (Huber & Firmin, 2014; Lamb, 2013). In general, the act stated abstinence education should teach the social, psychological, and health gains to be had by abstaining from sex, that abstinence is the expected standard for human sexuality outside of marriage, and that sexual activity outside of marriage is likely to have harmful effects (Social Security Administration, 2009). Although the AOUM movement was receiving the majority of federal backing, advocates of comprehensive sex education continued to strengthen their cause and rally against abstinence-only education (Huber & Firmin, 2014; Lamb, 2013). In 1991, SIECUS published the first edition of Guidelines for Comprehensive Education, a curriculum for school-based sex education programs for students in kindergarten through twelfth grade. Lessons included topics such as masturbation, contraception, abortion, and sexual orientation (Huber & Firmin, 2014).

In 2000, the Community-Based Abstinence Education (CBAE) program was created, further propelling the AOUM movement. Whereas Title V allowed states to choose which

programs to fund and which of the tenets to emphasize in the instruction, the CBAE program was more restrictive. The CBAE program allowed Congress to bypass the states and give federal funding to programs of their choice, requiring these programs to teach all eight tenets and prohibiting them from providing any information regarding contraception (Lamb, 2013). Although funding was substantially increasing for abstinence-only education, in a 2001 report issued by Surgeon General David Satcher, the data on the effectiveness of sex education programs concluded that comprehensive sex education, including discussion of abstinence, was most effective (Lamb, 2013). Following the 2001 report, additional research was conducted and published, denying the efficacy of AOUM programs. By 2009, half of the states declined funding from Title V (Lamb, 2013).

During President Obama's time in office, support for comprehensive sex education programs grew substantially. President Obama called for elimination of all funds devoted to abstinence-only education and in its place, proposed funding for comprehensive sex education programs (Huber & Firmin, 2014). The Personal Responsibility Education Program (PREP) and the Teen Pregnancy Prevention Program (TPPP) were created to provide funding and support for evidence-based, comprehensive sex education (Lamb, 2013). Although funding for AOUM continued to exist, the amount was drastically reduced, with funding going to PREP and TPPP instead. PREP and TPPP require all funded programs to be evidence-based, medically accurate, and age appropriate (Lamb, 2013). In his last year in office, President Obama once again proposed cutting funding for AOUM programs due to their ineffectiveness and the harm caused by withholding information about contraception and stigmatizing adolescents with nonconforming sexual identities (Halls et al., 2016). Despite the data to prove that abstinence-only sex education is ineffective and potentially harmful, congress blocked President Obama's

attempt and the government has continued and increased funding for AOUM programs (Halls et al., 2016). Under the current presidential administration, it is likely that this trend will continue as in 2017, the United States Department of Health and Human services announced that funding for the TPPP would be entirely discontinued by July 2018 (Charo, 2017). Aiming to move away from comprehensive sex education and back to abstinence-only education, the Trump administration has also been a vocal opponent of birth control and lobbied for elimination of funding for Planned Parenthood clinics (Charo, 2017; McKee, Greer, & Stuckler, 2017).

Current state of sex education for SWDs. As a result of its contentious history, prevailing attitudes towards sex education have moved much like a pendulum, from one extreme to the other; the direction dependent on the social and political climate of the era. With the continuous debate regarding information typically developing students should be given about their sexual health, there has been little focus on the state of sex education for SWDs. Between 2011 and 2013, more than 80% of adolescents reported receiving formal sex education (Breuner & Mattson, 2016). Students with disabilities, however, are often excluded from sex education. The sex education they receive is either developmentally inappropriate or it is too vague for them, as the instruction contains many euphemisms (Boehning, 2006). As was the case in the era of the social hygiene movement, sex education continues to be exceptionally difficult for marginalized groups to access. Similarly, while training is now available for sex educators, there is little to no focus on teaching SWDs in these programs. Additionally, while there is now an abundance of evidence-based, comprehensive, sex education programs available for typically developing students, no such program exists for SWDs.

Sexuality & Disability

Sexuality, regardless of disability, is an essential component of human development, as it contributes to an individual's personality and sense of self, while also offering the potential for intimacy, including feelings of comfort, security, support, and love (Howard-Barr, Rienzo, Pigg, & James, 2005), as well as value and attractiveness (Murphy & Young, 2005). The World Health Organization (WHO, 2006a) defines sexuality as encompassing not only sex, but gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, reproduction, and sexual identity. Sexuality covers a range of basic human needs and rights. In sum, sexuality and its expression are critical components of identity, emotional health, and overall quality of life (Milligan & Neufeldt, 2001).

Although the definition of sexuality is broad, societal norms tend to neglect its multidimensionality, only to focus on sexual behavior as the defining quality of sexuality (Sweeney, 2007). Throughout history the stigmatization of sexuality and sex has bred controversy and confusion around the topic of sex education and the meaning of sexual health, especially for persons with disabilities. According to WHO (2006a):

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled. (p.5)

A full understanding of sexuality requires it to be considered in a context extending beyond sex to include gender-role socialization, maturation and body image, and social relationships and aspirations (Murphy & Elias, 2006).

Society often perceives persons with disabilities as childlike and incapable of sexual development or as inappropriately sexual (Murphy & Young, 2005). Unfortunately, due to society's unidimensional views of both sexuality and persons with disabilities, persons with disabilities are limited in their opportunities to both learn about and safely express their sexuality. Although persons with disabilities are often mistakenly perceived as asexual, research suggests most children with disabilities, similar to their typically developing peers, aspire to futures including marriage, children, and satisfying sex lives (Harader et al., 2009; Murphy & Young, 2005). Additionally, research suggests adolescents with disabilities are participating in sexual relationships at similar rates to typically developing peers; although adolescents with disabilities generally do not possess the necessary knowledge and skills to keep themselves healthy, safe, and satisfied (Murphy & Young, 2005). Compared to the general population, people with mental or physical disabilities demonstrated lower levels of sexual knowledge and higher levels of negative attitudes toward sex, while also reporting stronger sexual needs (McCabe, 1999). Galea, Butler, Iacono, and Leighton (2004) found individuals with intellectual disabilities demonstrated lower levels of knowledge than their typically developing peers on topics particularly relating to puberty, menstruation, menopause, sexuality, safer sex practices, sexually transmitted infections, sexual rights, and contraception. Lower levels of sexual knowledge appear largely to be a result of inaccessible sex education, rather than an inability to learn, as Dukes and McGuire (2009) found the capacity to make sexuality-related decisions in

people with intellectual disabilities can improve through appropriate, individually tailored sex education.

Due to their lack of sexual knowledge, persons with disabilities are at a higher risk of sexual abuse and violence, as well as unwanted pregnancies, and sexually transmitted infections than those who do not have a disability (Boehning, 2006; Howard-Barr et al., 2005; Murphy & Young, 2005; Sweeney, 2007). Sullivan and Knutson (2000) found children with intellectual disabilities were four times more likely to be sexually abused than their peers without disabilities. Similarly, according to data accumulated by the U.S. Department of Justice, persons with disabilities were 3.5 times more likely to be raped or sexually abused than persons without disabilities (Harrell, 2017). While it seems the presence of any type of disability increases the risk of victimization, intellectual disabilities, communication disorders, and behavioral disorders appear to contribute to higher levels of risk, with multiple disabilities resulting in the highest levels (Sullivan & Knutson, 2000). From 2011 to 2015, 65% of rapes or sexual assaults against persons with disabilities were committed against those with multiple disabilities (Harrell, 2017). Such statistics further highlight the need to provide SWDs with adequate sex education and preventative instruction in order to encourage safety.

By exclusion from sex education, SWDs are placed at increased risk for sexual abuse, socially unacceptable sexual behavior, unplanned pregnancies, and sexually transmitted infections (Galea et al., 2004; Milligan & Neufeldt, 2001; Murphy & Young, 2005). As SWDs mature into adulthood, they lack the skills necessary for adult relationships, as well as an understanding of their sexual identity and its contributions to their emotional and physical well-being. Receiving comprehensive sex education can contribute to overall quality of life, as it can

be used to empower persons with disabilities to protect themselves while also providing them with skills necessary to facilitate healthy, romantic relationships.

SWDs' Access to Free and Appropriate Sex Education

Exclusion from sex education or exposure to sex education without the proper accommodations and modifications is a violation of SWDs' rights to a free and appropriate public education (FAPE). Under IDEIA (2004), all SWDs are entitled to an education that is equitable to their typically developing peers. This Act mandates SWDs receive an educational program that will meet their needs, as well as prepare them for further education, employment, and independent living. SWDs' Individualized Education Programs (IEP) must include transition plans identifying appropriate employment and post-school living goals for the student as early as age fourteen.

Although sex education is often not seen as a priority by schools, especially because it is not a core academic subject, it is still a content area protected by IDEIA. This was evidenced by the outcome of a due process hearing filed against the Pasadena Independent School District in 2012 (Eggert & Minutelli, 2013). A SWD who had been receiving services from the school district from an early age was denied sex education, as the IEP team felt the student was incapable of understanding sex education. The student's parents requested sex education related goals be entered into the IEP. While the IEP team eventually approved the request, the family filed for due process, alleging the District failed to assess and address their child's needs for sex education. The District was found to be in violation of FAPE and ordered to train relevant staff members on how to teach sex education to SWDs.

Because school psychologists play an integral role on the IEP team and in developing IEPs, their involvement in assuring adequate sex education practices for SWDs is crucial. In

addition, their in-depth training of both diverse student learning and human development make them uniquely fit to address the gap in school based sex education for SWDs. The following section explores this notion in more detail.

School Psychologists' Potential Roles for Intervention

Although there is no known research on the role of school psychologists in sex education, much of the information regarding school psychologists' training and roles within schools suggests school psychologists could be useful contributors to school based sex education. Broadly speaking, the job of a school psychologist is to help students succeed academically, behaviorally, and emotionally by providing direct educational and mental health services, in addition to working with parents, teachers, and other professionals to create supportive learning and social environments for all students (NASP, 2010). Additionally, NASP's official stand in regards to sex education is it should be taught in schools and it is school psychologists' responsibility to use their expertise to assist in facilitation of the programs (McClung & Perfect, 2012). With that in mind, it appears school psychologists could be involved in the following three areas of sex education instruction: planning of the sex education curriculum, delivery of sex education, and evaluation of sex education (See Figure 1).

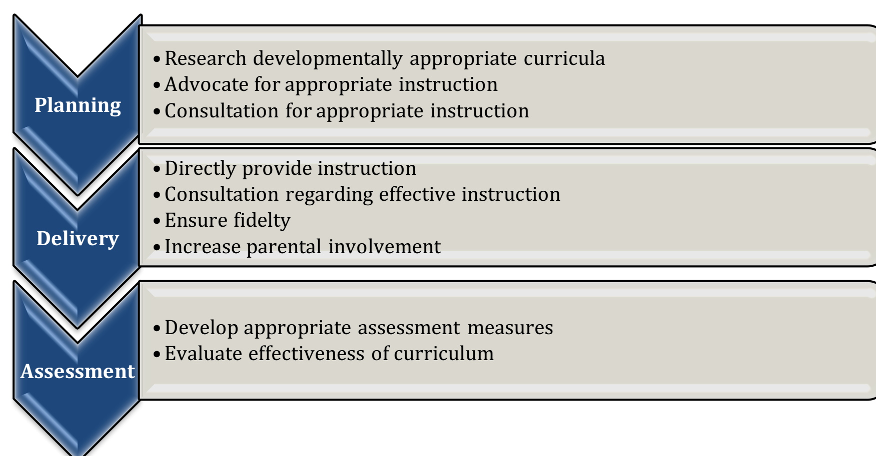

Figure 1. Potential Roles in Planning, Delivery, and Evaluation of Sex Education

In regards to planning of sex education curriculum, school psychologists could research appropriate, evidence informed curriculum, advocate and gather support for appropriate and adequate instruction, and provide consultation around developmentally appropriate activities and instruction. For delivery of sex education, school psychologists could provide direct sex education instruction to SWDs, provide consultation around the most effective instruction practices for the students' levels of functioning, ensure fidelity of program implementation, and increase parental involvement in reinforcing sex education concepts at home. In assessing sex education, school psychologists could develop appropriate measures to check for student understanding and evaluate overall effectiveness of the curriculum being used. School psychologists' unique training in the developmental, psychological, and educational needs of SWDs make them a good fit to address the gap in sex education for this population.

In 2010, NASP implemented a formal model of practice intended to improve consistent implementation of school psychological services in schools nationwide. The various domains included in the model are meant to inform the range of knowledge and skills school psychologists can provide. While NASP recognizes that individual school psychologists will likely have areas of specialization, all school psychologists are expected to have at least a basic level of competency in each of the domains listed in the model (2010).

The first domain outlined is "Data-Based Decision Making and Accountability." According to NASP, school psychologists are equipped with knowledge of varied assessment and data collection methods for identifying strengths and needs of programs, developing effective programs, and measuring progress (2010). In terms of professional practice, school psychologists should be able to evaluate the effectiveness of current sex education programs being implemented within their school districts, as well as evaluating and identifying the need

for modifications to appropriate implementation of sex education for SWDs. Due to the lack of evidence-based resources available for sex education of SWDs, this is an area of great need, one of which school psychologists are uniquely trained to address.

The next applicable domain is "Consultation and Collaboration." According to NASP, school psychologists possess skills to consult, collaborate, and communicate with individuals, families, schools, and systems to promote effective implementation of services. In application to professional practice, school psychologists should be able to use a consultative problem-solving process to plan, implement, and evaluate sex education services; and to advocate for needed change at various levels, including individual, classroom, building, and district. Additionally, school psychologists should be able to facilitate effective communication and collaboration between teachers, parents, and other members involved in providing sex education to students.

The "Family-School Collaboration Services" domain expands upon the expectation for school psychologists to effectively communicate and collaborate with family systems in order to enhance family influences on children's learning and mental and behavioral health. According to NASP, school psychologists are equipped with the necessary skills to design, implement, and evaluate services that are culturally and contextually responsive, as well as the skills to build strong family-school partnerships in order to enhance academic and social-behavioral outcomes for children. Practically, this enables school psychologists to increase parent involvement in their children's sex education.

The next applicable domain is "Interventions and Mental Health Services to Develop Social and Life Skills." According to NASP, school psychologists are equipped with knowledge of biological, cultural, and social influences and their impacts on learning and life skills, as well as evidenced based strategies to promote social-emotional functioning and mental and behavioral

health. Additionally, they possess skills to use assessment and data collection methods to implement and evaluate services. In terms of professional practice, school psychologists should be able to facilitate the design and delivery of curricula to help students develop life skills. They should also be able to use their knowledge of assessment and data collection methods to evaluate whether the design and delivery of the curricula are developmentally appropriate for the students who are receiving them.

Similarly, the "Research and Program Evaluation" domain supports the idea that school psychologists should be able to use research to implement appropriate services and then collect data to determine the effectiveness of said services. NASP states that school psychologists have sufficient knowledge of statistics and program evaluation to utilize existing research as the foundation of effective implementation of interventions, as well as of data collection techniques used to evaluate services at the individual, group, and systems levels. This skillset should allow school psychologists to review research on sex education programs for SWDs, determine the most appropriate sex education programs, implement services with fidelity, and collect and analyze data to evaluate efficacy of the selected sex education programs.

The final applicable domain is "Preventive and Responsive Services" which posits that school psychologists possess the skills to promote and support services that enhance learning, mental and behavioral health, safety, and physical well-being utilizing their knowledge of resilience and risk factors. As previous domains have outlined, such knowledge can contribute to developing, implementing, and evaluating various prevention and intervention programs. In practice, school psychologists' knowledge of protective and risk factors should help them to address problems such as risky sexual behavior, teen pregnancy, and sexual abuse within schools.

The American Psychological Association (APA), which is responsible for accrediting doctoral level school psychology training programs, outlines many of the same skills and responsibilities as NASP in their definition of the practice of school psychology. APA states that school psychologists are skilled in developing educational environments that meet diverse developmental needs and in coordinating educational, psychological, and behavioral health services by working at the interface of these systems (n.d.). While APA does not appear to have a formal position on school psychologists' responsibility to facilitate sex education, it is mentioned that school psychologists are responsible for implementing primary prevention programs to reduce the incidence of sexual abuse and teenage pregnancy.

Barriers to Sex Education for SWDs

Although it is essential for SWDs to receive sex education, it is often a neglected topic, with access to such information being vastly limited. Most of the barriers to attaining this vital information are raised by the attitudes of society and individuals, rather than the disabilities themselves (Groce, Izutsu, Reier, Rinehart, & Temple, 2009). One of the barriers that prevents SWDs from gaining appropriate access to sex education is society's perception of them (Howard-Barr et al., 2005). Persons with disabilities are often mistakenly perceived as childlike, asexual, or sexually deviant, and thus not encouraged to explore their sexuality (Howard-Barr et al., 2005; Murphy & Elias, 2006; Rohleder, 2010; Sweeny, 2007). Due to these misconceptions, sexuality is commonly perceived as a problem in these individuals, rather than an affirming part of life (Sweeny, 2007).

Howard-Barr et al. (2005) conducted a quantitative study on beliefs, preparation, and practices of special education teachers in regards to teaching sex education to students classified as "educable mentally disabled." This classification includes exceptional students identified with

the least amount of mental impairment. Participants in the study included current, Florida special education teachers who held a Bachelor of Science degree in special education ($n = 206$). The majority of respondents were female (89%). Of the 206 teachers in the sample, 49% taught elementary school, while 32% taught middle school, and 19% taught high school. Approximately half of the respondents taught special education for 12 or more years (51%). Participants completed a three section, 94 item instrument ($\alpha = .95$), regarding 36 sex education topics recommended by SIECUS as defining comprehensive sex education. The 36 topics were divided into the following 6 key concepts: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. The first section of the instrument assessed participants' beliefs about teaching sexuality. The second section assessed whether participants actually taught each of the 36 topics. The third section assessed the professional preparation of participants, in addition to demographics.

Results from Howard-Barr et al.'s (2005) study demonstrated that beliefs teachers hold regarding their students' need for sex education predicted the content that was taught. Data from regression analyses conducted for each content area indicated beliefs teachers held significantly predicted actual instruction under the following five out of six concepts: human development ($\beta = .13$, $p = .00$), personal skills ($\beta = .13$, $p = .00$), sexual behavior ($\beta = .04$, $p < .005$), sexual health ($\beta = .10$, $p = .00$), and society and culture ($\beta = .07$, $p = .00$). Howard-Barr et al. (2005) found 67% of teachers believed sex education should be offered to SWDs at the elementary, middle, and high school levels and 96% believed sex education should be offered to SWDs at the middle and high school levels. Information regarding sexual behaviors was thought to be least necessary for SWDs and thus went untaught. Fewer than 10% of teachers taught their students about any topics pertaining to sexual behavior, with the exception of abstinence which was

taught by 23% of teachers. Additionally, teachers in the study reported it was more important for SWDs to receive lessons regarding personal skills topics such as assertiveness, communication, and friendship instead of regarding human development.

Similarly, Rohleder (2010) found that while teachers generally supported the need for sex education for people with learning disabilities, their fears and anxieties surrounding the perceived consequences of sex education inhibited them from proper implementation. Results of the study revealed that teachers feared providing sex education would lead to problematic sexual behaviors, thus teachers taught sex education in a way that portrayed sex as bad and dangerous, emphasizing abuse (Rohleder, 2010). Overall, these findings suggest a continued lack of understanding of the sexual needs and capabilities of persons with disabilities, which in turn makes comprehensive sex education largely inaccessible for SWDs.

Perhaps the most concerning barrier teachers face in teaching sex education is their lack of professional preparation. In a qualitative study on the pre-service preparation of sex education teachers, Eisenberg, Madsen, Oliphant, Sieving, and Resnick's (2010) findings suggest that training programs are falling short in their effort to prepare sex educators in terms of both content and pedagogy. The study was conducted using seven focus groups, including a total of 41 sex education teachers for grades 4-12 in urban, suburban, and rural areas of Minnesota. Using an interdisciplinary team with expertise in areas such as adolescent health, epidemiology, nursing, and education, Eisenberg et al. developed an interview guide which contained nine questions. The questions assessed the type of training teachers received regarding sex education, additional training that teachers would have found helpful prior to teaching sex education, and teachers' reactions to teaching sex education. Teachers with relevant backgrounds, such as health education, reported inadequate training and teachers from other disciplines, such as special

education, reported no training in the area. Additional studies exploring the sex education training of special educators have found many of these teachers feel ill-equipped in teaching such content to their students (Ellery & Rabak-Wagener, 1997; Howard-Barr et al, 2005). Howard-Barr et al. (2005) found that 93% of the special education teachers surveyed indicated receiving no professional preparation dealing specifically with teaching sex education to SWDs. In addition, the New Jersey Department of Education does not require schools to provide professional development regarding instruction in health and family sciences, nor does it mandate any specific requirements for teacher training in health or family life education (2014).

Currently, standard 2.4 of the New Jersey Core Curriculum Content Standards for Comprehensive Health and Physical Education (NJ Department of Education [DOE], 2014) requires instruction regarding human relationships and sexuality. The standard is divided into three sections: relationships, sexuality, and pregnancy and parenting. Each section includes objectives that must be learned by students by the end of a specific grade. For example, under the sexuality section, students concluding eighth grade are expected to know that "responsible actions regarding sexual behavior impact the health of oneself and others." (NJ DOE, 2014). Although the standards provide specific content knowledge that must be acquired by students at certain grade levels, there is no further guidance or regulations on how these topics should be taught. The inclusion of grade levels allows teachers to easily identify the content that is developmentally appropriate for typical students. There is no mention of SWDs or how to appropriately modify content for their unique needs.

In addition to the lack of sex education training, educators responsible for the sex education of SWDs are further disadvantaged by the dearth of evidence based sex education curricula designed for students with special needs. The Sexuality Information and Education

Council of the United States (SIECUS) compiled a list of the most common, high quality sex education programs being implemented in the United States (n.d.). Many of the programs are touted as being proven effective on the basis of rigorous research. The only two programs listed that are inclusive of SWDs (Positive Prevention and Family Life and Sexual Health (FLASH)) are simply science based. This means development of the curriculum was informed by the successful components of other programs but the curriculum has not been evaluated or proven to work in general or for SWDs. The High School version of FLASH was reportedly undergoing evaluation from 2011 through 2014, with results expected in 2015 (SIECUS, n.d.). The FLASH curriculum website currently states the program has not yet been rigorously evaluated (About the FLASH Curriculum, 2017). Without a properly evaluated curriculum, SWDs and their teachers are being done a great disservice.

Electronic Surveys

With 88% of U.S. adults using the internet (Pew Research Center, 2017), researchers have gained access to electronic surveying as a viable method of data collection. The internet as a tool of data collection allows researchers to quickly and cost effectively collect a large amount of data, while also reducing the time and error involved in data entry (Bethlehem & Biffignandi, 2012; Dillman, Christian, & Smyth, 2014; Hoonakker & Carayon, 2009). Additionally, in comparison to mail based surveys, electronic surveys have been found to yield higher response quality, such as lower item nonresponse and longer open-ended responses (Hoonakker & Carayon, 2009; Kwak & Radler, 2002).

Although electronic surveys can be more time and cost effective than other methods, and provide higher response quality, some research has shown that mail based surveys typically receive a higher overall response rate from participants (Couper & Miller, 2008; Kwak & Radler,

2002). A lower response rate in using electronic surveys is speculated to be a function of survey design factors, such as lack of anonymity, ease with which one can ignore/discard emails, or nondeliverable mail due to outdated email addresses (Hoonakker & Carayon, 2009). The continued existence of a meaningful discrepancy between mail and electronic surveying is debatable. Hoonakker and Carayon's (2009) analysis of American studies comparing single mode surveys found the average response rate for mail surveys versus electronic surveys was 52 % versus 51% respectively. A study examining responses to surveys among school professionals in particular found a response rate of 16% for web-based surveys (Yetter & Capaccioli, 2010).

With knowledge of the various factors that can influence response rates, there are measures that can be taken to increase the success of an electronic survey prior to and during its implementation. Dillman et al. (2014) provided several suggestions for increasing survey success. To increase the perceived benefits of a survey for participants, and thereby increase participation, researchers should make special effort to explain the potential benefits of the survey results, craft interesting questions, ask for the participants' help, appear to provide limited opportunities to respond, and convey that other participants have already responded. For example, when the initial request for survey participation is sent, the researcher may want to include a short synopsis on the purpose of the study and how the results of the study can positively influence a community or organization. Describing the benefits of a survey in this way can improve participation, even if the participants themselves are not directly benefitting. Additionally, asking for participants' help in the initial invite evokes a positive feeling and increases participation, as respondents feel their contribution is valued. Stressing that opportunities to respond are limited further increases the perceived value of contribution, as

participants feel they are included in an opportunity only afforded to some people. Furthermore, if the survey contains interesting questions, participants are more likely to enjoy the experience and feel they are benefitting from answering them. It is important to focus on relevant questions that may be interesting to the surveyed population and to order them from most to least interesting. To improve participation, reminder notifications should include acknowledgment that a certain number of people have already responded, as people tend to behave in a way that is consistent with others in groups in which they belong. Although the aforementioned steps may seem minimal, people tend to reciprocate special efforts even if the efforts are only theoretically beneficial.

Conversely, it is equally important for a researcher to diminish costs by reducing the length and complexity of the survey, minimizing requests for personal information, and making responding as convenient as possible (Dillman et al., 2014). It is also essential to establish trust with participants, allowing them to feel confident the data they provide will remain anonymous and secure (Dillman et al., 2014; Hoonakker & Carayon, 2009). To establish trust, Dillman et al. (2014) suggest researchers provide participants with contact information they can use to assess the survey's authenticity or clarify any questions or concerns. Finally, once the initial invitation has been sent, subsequent follow-up emails should be sent to participants who have not yet completed because doing so tends to increase response rate (Hoonakker & Carayon, 2009; Shih & Fan, 2008). Exact timelines for sending reminder notifications vary, though there is agreement that reminder emails have an early saturation rate and should not be sent consecutively (Dillman et al., 2014).

Summary

Sexuality is a fundamental component of identity, emotional health, and overall quality of life (Milligan & Neufeldt, 2001). For SWDs, sexuality is often viewed as a problem, rather than an affirming part of life (Sweeny, 2007). SWDs are often perceived as childlike and incapable of sexual development or as sexually deviant (Murphy & Young, 2005). Thus, SWDs have historically been excluded from sex education. SWDs typically do not receive developmentally appropriate instruction when exposed to sex education, as the instruction is often left unmodified and sex education teachers are not equipped with the training necessary for teaching SWDs. This is a violation of the IDEIA (2004), which requires all SWDs receive appropriate education. The current state of sex education for SWDs indicates the need for involvement of school psychologists, as they are trained in human development, program development and implementation, and modification of instruction for SWDs, amongst other useful skills for involvement in sex education.

Using a survey design, the current study was designed to explore the extent to which school psychologists were involved in sex education and hypothesized that school psychologists could be involved in the following three areas of sex education instruction: planning of the sex education curriculum, delivery of sex education, and evaluation of sex education.

This study attempted to answer the following questions:

(1) Do school psychologists believe SWDs are currently receiving adequate sex education with appropriate accommodations?

(2) What are school psychologists' perceptions regarding their roles in providing sex education to SWDs?

(3) Do school psychologists perceive themselves as qualified to provide sex education to SWDs?

(4) What facilitators/barriers exist to school psychologist involvement in sex education?

(5) To what extent are school psychologists involved in directly providing sex education to SWDs? To what extent are school psychologists involved in developing curricula or consulting with teachers who provide sex education to SWDs?

(6) Are school psychologists' perceptions regarding involvement in sex education for SWDs related to perceptions regarding involvement in sex education for SWODs?

Chapter II: Method

Participants

The participants in this study were practicing school psychologists (*n* = 145) in New Jersey. A power analysis was conducted to determine the minimum sample size needed to detect a medium effect size (*w* = .30). The survey developed for this study consisted of several rating questions with a maximum of five possible answer choices. In using the chi square goodness of fit test, there are four degrees of freedom. To detect a medium effect in the population at $\alpha = .05$, 133 participants were needed. Participants were recruited through contact information provided on school districts' websites, which were collected by the PI.

Demographics of the sample. The sample in this study consisted of school psychologists currently employed in New Jersey public schools. A total of 1577 school psychologists were invited to participate via email. Of that number, 132 school psychologists did not receive the email in their inbox, as the email "bounced back," meaning it was not successfully transmitted to the recipient. Of the 1,445 school psychologists who successfully received the invitation email (i.e., the message did not bounce back), 119 initiated the survey following the initial invite, and of that number, 77 finished the survey before the second reminder was sent. After the reminder email was sent, 68 additional responses were accrued. At the end of the two weeks, the total number of responses received was 145. The response rate was 10%.

The sample was predominantly female (79%) and European American (76%). A Specialist's degree was the highest held degree for 38% of the sample, followed by a Doctoral degree (33%). "Other" responses (5%) included Doctoral degree in progress, Professional Diploma, and Master's +30. Years of experience as a school psychologist ranged from 1 to 40 years. The average number of years of experience was 13.8 years (SD = 8.18). Respondents

primarily served grades 9-12 (34%) or multiple levels (31%). These demographics are similar to the demographic data acquired by NASP in their 2015 membership survey. Table 2 depicts the demographic characteristics of the current sample with a side by side comparison of demographics from 2015 NASP data (Walcott & Hyson, 2018).

Table 2
School Psychologist Demographics (n = 145)

	Current Sample		**NASP Sample**	
	n	%	*n*	%
Gender				
Female	115	79%	1,032	84%
Male	30	21%	200	16%
Other	0	0%	1	0.1%
Ethnicity				
African-American (non-Hispanic)	8	6%	62	5%
Asian American/Pacific Islander	6	4%	35	3%
European American (non-Hispanic)	109	76%	1,079	88%
Latino American	6	4%	73	6%
Other	15	10%	46	4%
Highest degree earned in school psychology				
Master's	35	24%	235	19%
Specialist	55	38%	680	55%
Doctoral	48	33%	312	25%
Other	7	5%	-	-
Years in practice				
1-5 years	26	18%	-	-
6-10 years	32	22%	-	-
11-15 years	28	19%	-	-
16+ years	58	40%	-	-
Primary grade level served				
Pre-K	2	0.1%	-	-
Elementary (K-5)	21	15%	-	-
Middle school (6-8)	28	19%	-	-
High school (9-12)	49	34%	-	-
Multiple levels	45	31%	-	-

Additionally, data was collected on the various job roles held by school psychologists in New Jersey public schools. Respondents were asked to select all job roles that applied to their position from a list of potential roles; they were also given the option to enter their own response. "Other" responses included case management, postvention, and supervision. Table 3 depicts the job roles of the current sample.

Table 3
School Psychologist Job Roles

Job Roles	***n***	**%**
Assessment	141	97%
Behavior Planning	118	81%
Consultation	140	97%
Counseling	125	86%
Crisis Intervention	130	90%
Program Development	67	46%
Program Evaluation	41	28%
Prevention	72	50%
Other	12	8%

Data was also collected regarding the various staff members with whom the sample consulted as a part of their job. Again, respondents were asked to select from a list all of the staff members with whom they consulted; they were also given the option to enter their own response. "Other" responses included all administrators, behaviorists, related service providers, school resource officers, student assistance counselors, and paraprofessionals. Table 4 depicts the staff members with whom the respondents consult.

Although the survey was designed to collect data on nonrespondents by allowing anyone who followed the link to the survey to enter demographic information regardless of consent, no such data is available. All participants who followed the link and began the survey consented to taking the survey; thus, data on respondents vs. nonrespondents could not be analyzed.

Table 4
Staff Members with Whom School Psychologists Consult

Staff Member Job Titles	*n*	%
General Education Teacher	143	99%
Learning Disabilities Teacher- Consultant	141	97%
Nurse	138	95%
Principal	138	95%
School Counselor	139	96%
Social Worker	140	97%
Special Education Teacher	145	100%
Others	104	72%

Measure

The variables of interest were related to school psychologists' involvement in providing sex education to SWDs, school psychologists' satisfaction with current practices of sex education for SWDs, school psychologists' perceived role and competence in providing sex education to SWDs, and school psychologists' anticipated barriers or facilitators to involvement in sex education for SWDs. As no known measure exists that can be used to assess these variables, a 35-item survey was developed by the study investigator specifically for use in this study. A copy of the survey can be found in Appendix A. The first section (7-items) of this survey addressed demographic information of the respondents, including gender, race, degree earned, years of experience, grade level served, and job role. Participants who did not consent to the survey were directed to this section, allowing them an opportunity to provide their demographics, before exiting the survey. The second section (3-items) addressed school psychologists' basic knowledge of sex education practices within their school district. The third section (4-items) assessed school psychologists' training and familiarity with sex education. The fourth section (16-items) pertained to the previously mentioned variables of interest. This section required participants to answer the questions regarding sex education for SWDs specifically and

incorporated parallel questions regarding students without disabilities (SWODs). "Students with disabilities" was defined as students with Individualized Educational Plans. SWDs only characterized students meeting criteria for one of the thirteen categories of special education classification included under IDEA; students with section 504 plans only were not included. The concluding section (4-items) focused on differences between sex education for SWDs and sex education for SWODs. Across the sections, a majority of the questions were presented in a Likert scale format. Questions regarding type of involvement in sex education and anticipated barriers/facilitators were presented in either a list format, allowing respondents to select all responses that apply, or an open-ended format.

Procedure

First, a comprehensive list of contact information for school psychologists currently working in New Jersey public schools was compiled by the PI. The PI compiled the list using the New Jersey Department of Education's list of all public school districts in the state and using Google search engine to access the school webpages, and subsequently the child study team contact information for each district. Through Google searches, the PI was able to find email addresses for 1577 school psychologists in New Jersey.

Before disseminating the survey to participants, the survey was piloted by three school psychology graduate students. The purpose of the pilot was to collect data on the average amount of time the survey required to complete. Exact completion times for the three pilot participants were as follows: 08:14, 13:27, and 07:27. Thus, it was estimated the survey averaged 10 minutes to complete.

After IRB approval was granted, all school psychologists on the compiled list were invited to participate in the study using personalized email messages through the mailing feature

of Qualtrics, web-based survey software. The initial email, which can be found in Appendix B, included a brief description of the purpose of the current study, information on the time period the survey would be available and the amount of time it would take to complete, a unique URL link to the survey, and the PI's contact information. By clicking the link that was contained in the email, participants were led directly to the survey on the Qualtrics website, beginning with the informed consent page. This page, again, described the survey and its purpose, indicated the survey would be anonymous, and provided the approximate length of time participation would take. To ensure anonymity, participants were not asked to provide identifiable, personal information. Additionally, IP address tracking was disabled and data was protected through TLS encryption to further ensure data could not be traced back to participants.

Once each participant indicated his or her consent, he or she was directed to the survey. In cases in which the participant did not indicate consent, he or she was asked to complete the demographic portion of the survey so the researcher could address whether respondents were comparable to non-respondents. Each participant was able to skip any questions of his or her choosing or withdraw from the survey at any time without penalty. There was no reward for completing the survey, but participants were given the opportunity to request a summary of the results, if interested.

One week after participants received the initial invitation, a follow-up email was sent to those who had not yet completed the survey. The reminder email, which can be found in Appendix B, included the same information as the invitation; the information was slightly condensed and specified it would be the last reminder. The survey remained open for an additional week after the reminder was sent.

Data Analysis

This study was designed to examine school psychologists' current and potential roles in providing adequate sex education to SWDs. Data analysis was conducted using SPSS Statistics version 24.0. Basic descriptive statistics, such as means and frequencies of responses, were used to analyze the data. To assess for missing data, pre-analysis data screening was conducted, prior to conducting chi square analyses. Missing data was less than 5% for each applicable survey item. List-wise deletion was used for each independent analysis, as the amount of missing data was low and continued to meet requirements of the power analysis. Chi-Square goodness of fit tests were used to compare the observed sample distribution with the expected sample distribution for applicable survey items. Chi-Square tests for independence were used to compare the sample distribution of parallel SWD specific items and SWOD specific items. Additionally, A chi-square test for independence was used to determine whether there was a relationship between the highest degree earned by respondents in school psychology and indication of training regarding sexual development in graduate school programs. For open ended survey items, responses were examined qualitatively and sorted accordingly using thematic analysis.

Chapter III: Results

Comparison of Observed vs Expected Sample Distribution

Chi-square goodness of fit tests were used to compare the observed sample distribution to the expected sample distribution for items using a Likert scale format. This applies to items 14, 17, and 18. As no known data exists on this topic, the expected sample distribution was divided by the number of response options, reflecting the assumption each response option had an equal chance of being selected.

Item 14 required participants to rate their familiarity of the New Jersey Student Learning Standards for Comprehensive Health and Physical Education. All participants responded to this item, thus there was no missing data. A chi-square goodness of fit test was calculated comparing the actual distribution of ratings of school psychologists' familiarity with the learning standards with the hypothesized distribution. See Table 5 for results. Significant deviation from the hypothesized values was found, $\chi^2(3) = 85.5$, $p < .05$. Thus, the null hypothesis was rejected, and it was concluded school psychologists' familiarity with the learning standards was not equally distributed in the population. Familiarity with the learning standards for health and physical education seemed low in the actual distribution of responses. Almost half of the sample responded slightly familiar. Close to 90% responded either slightly familiar or not familiar at all.

Table 5
Chi-Square Analysis of School Psychologists' Familiarity with PE/Health Learning Standards

Response option	Observed *n*	Observed %	Expected *n*	Expected %
Not familiar at all	54	37%	36.3	25%
Slightly familiar	71	49%	36.3	25%
Moderately familiar	20	14%	36.3	25%
Extremely familiar	0	0%	36.3	25%

Item 17 required participants to rate how often SWDs are provided with learning accommodations in sex education classes. Approximately 95% of the sample responded to this item; missing data was handled via listwise deletion. A chi-square goodness of fit test was calculated comparing the actual distribution of provision of learning accommodations for SWDs with the hypothesized distribution. Results are depicted in Table 6. Significant deviation from the hypothesized values was found, $\chi^2(3) = 13.4$, $p < .05$. Thus, the null hypothesis was rejected, and it was concluded provision of learning accommodations to SWDs was not equally distributed in this sample. The actual distribution of responses seemed somewhat normal. Half of the sample reported SWDs are either frequently or always provided with learning accommodations in sex education. Only 14% of the sample reported that SWDs never receive learning accommodations.

Table 6

Chi-Square Analysis of Provision of Learning Accommodations to SWDs in Sex Education

Response option	Observed *n*	Observed %	Expected *n*	Expected %
Never	20	14%	34.5	25%
Occasionally	49	36%	34.5	25%
Frequently	39	28%	34.5	25%
Always	30	22%	34.5	25%

Item 18 required participants to rate how often sex education was addressed in the IEP. Approximately 97% of the sample responded to this item; missing data was handled via listwise deletion. A chi-square goodness of fit test was calculated comparing the actual distribution of sex education being addressed in the IEP with the hypothesized distribution. See Table 7 for results. Significant deviation from the hypothesized values was found, $\chi^2(3) = 198.8$, $p < .05$. Thus, the null hypothesis was rejected, and it was concluded the occurrence of sex education being addressed in the IEP was not equally distributed in this sample. The frequency with which sex

education is reportedly addressed in IEPs seems low according to the actual sample distribution. Almost three fourths of the sample reported sex education is never addressed in the IEP. Additionally, 99% reported sex education is never or only occasionally addressed.

Table 7
Chi-Square Analysis of How Often Sex Education is Addressed in IEPs

Response option	Observed *n*	Observed %	Expected *n*	Expected %
Never	103	73%	35.3	25%
Occasionally	37	26%	35.3	25%
Frequently	1	1%	35.3	25%
Always	0	0%	35.3	25%

Satisfaction with Sex Education for SWDs

Survey items 16, 17, and 18 focused on school psychologists' satisfaction with sex education for SWDs, and more specifically, whether SWDs received adequate sex education with appropriate accommodations. This data was analyzed using descriptive statistics and Chi-Square analysis as applicable; valid results are depicted in Table 8. Respondents were asked to rate their satisfaction or dissatisfaction with current sex education for SWDs on a scale from extremely dissatisfied to extremely satisfied. Responses were somewhat normally distributed around a mean of response of "Neutral." This item was designed as a parallel question, providing respondents the opportunity rate their satisfaction with sex education for SWODs as well. Ratings were similar for SWDs and for SWODs.

Respondents were asked to indicate how often SWDs are provided with learning accommodations in sex education classes. Response options ranged from never to always. The distribution of responses was somewhat normal, with half of the population indicating SWDs receive accommodations in sex education never or occasionally, and the other half of the population indicating SWDs receive accommodations frequently or always.

Similarly, respondents were asked to rate how often sex education is addressed in the IEP. Again, response options ranged from never to always. 73% of the sample indicated sex education is never addressed in the IEP, 26% indicated it was occasionally addressed, and 1 % indicated it was frequently addressed.

Table 8
School Psychologists' Satisfaction with Sex Education

	SWDs		SWODs	
	n	%	*n*	%
Satisfaction with sex education				
Extremely dissatisfied	13	9%	6	4%
Somewhat dissatisfied	28	20%	16	11%
Neutral	71	51%	82	59%
Somewhat satisfied	26	19%	30	22%
Extremely satisfied	2	1%	5	4%
Learning accommodations				
Never	20	14%	-	-
Occasionally	49	36%	-	-
Frequently	39	28%	-	-
Always	30	22%	-	-
Sex education in IEP				
Never	103	73%	-	-
Occasionally	37	26%	-	-
Frequently	1	1 %	-	-
Always	0	0%	-	-

Perceived Role in Sex Education

Survey items 20 and 22 focused on school psychologists' perceptions of their role in sex education for SWDs. Both items allowed respondents to provide answers for both SWDs and SWODs. Data was analyzed using descriptive statistics and Chi-Square analysis as applicable; results are depicted in Table 9. Only valid results are reported.

Table 9

School Psychologists' Perceived Role in Sex Education

	SWDs		SWODs		Chi-Square	
	n	%	*n*	%	*p*	Phi
Involvement in sex education						
I should be involved	95	68%	39	28%	< .05	.31
Method of involvement						
Researching appropriate evidence informed curricula	47	32%	23	16%	< .05	.59
Advocating for appropriate instruction	101	70%	37	26%	< .05	.25
Consultation regarding developmentally appropriate activities and instruction	95	66%	39	27%	< .05	.31
Directly providing sex education	10	7%	2	1%		
Ensuring fidelity of implementation of sex education programs	24	17%	13	9%		
Increasing parental involvement in sex education at home	46	32%	14	10%		
Developing appropriate measures to check for student understanding	65	45%	21	15%	< .05	.30
Evaluating effectiveness of curricula	28	19%	13	9%		
Other	4	3%	1	0.7%		
None	12	8%	39	27%		

Respondents were asked to report how they view their involvement in sex education, choosing between "I should not be involved" or "I should be involved." Approximately two

thirds of respondents indicated they should be involved. Although a majority of respondents indicated they should have involvement in sex education for SWDs, the opposite was true for SWODs. An association between school psychologists' perception of involvement in sex education regarding SWDs and SWODs was observed, $\chi^2(1) = 13.48$, $p < .05$. Most school psychologists reported they should be involved in sex educations for SWDs and should not be involved for SWDs.

Respondents were then shown a follow up question, asking them to select ways in which they believed school psychologists should be involved in sex education. Response options are listed in Table 9. The majority of respondents indicated school psychologists should be involved in advocating for appropriate instruction (70%) and in consultation regarding developmentally appropriate activities and instruction (66%) for SWDs. Other methods of involvement offered by respondents included counseling; consultation with administrators regarding program implementation, fidelity, and evaluation; and providing modifications and accommodations during sex education, as needed. Similar to participants' responses on the parallel SWD item, two of the most selected response choices for SWODs indicated school psychologists should be involved in advocating for appropriate instruction (26%) and in consultation regarding developmentally appropriate activities and instruction (27%) for SWODs. The third most selected response indicated that 27% of respondents felt they should have no involvement in sex education for SWODs.

A significant association was observed between SWD and SWOD specific responses on the following response options: researching appropriate evidence informed curricula, advocating for appropriate instruction, consultation regarding developmentally appropriate activities and instruction, and developing appropriate measures to check for student understanding. School

psychologists indicated they should be involved in researching appropriate evidence informed curricula for SWDs and should not be involved for SWODs. Asked about advocacy for appropriate instruction and consultation regarding developmentally appropriate activities and instruction, most school psychologists reported both of these methods of involvement as appropriate only when concerning SWDs and did not endorse involvement for SWODs. Similarly, school psychologists indicated they should not be involved in developing measures to check for understanding for SWODs and should be involved in this way for SWDS.

Perceived Competence in Sex Education

Survey items 11, 12, 14, and 24 focused on school psychologists' competence in filling a role in sex education. This data was analyzed using descriptive statistics and Chi-Square analysis as applicable; valid results are depicted in Table 10. Respondents were asked to indicate whether they received education regarding sexual development in their formal, university based School Psychology training. Only 32% of the sample indicated receiving such education. Those who responded yes were asked to provide a description of the type of training received. Largely, respondents indicated such training was provided within a human development course.

Respondents were then asked to indicate whether they received education about sexual development outside of their school psychology training; 38% responded yes. Again, respondents who reported that they had received such education outside of their school psychology training were asked to provide a description. A majority of the responses indicated the education about sexual development they had received occurred in high school or in undergraduate courses they chose to take.

Respondents were asked to indicate their familiarity with the New Jersey Student Learning Standards for Comprehensive Health and Physical Education. Of the respondents, the

majority indicated they were either not familiar at all (37%) or only slightly familiar (49%). No respondents indicated they were extremely familiar with the standards.

Respondents were asked to rate how qualified they do, or would, feel providing sex education to SWDs. Only 4% of the sample population reported feeling highly qualified, 43% reported feeling moderately qualified, and 53% reported feeling not qualified. This item was designed to allow respondents an opportunity to rate how qualified they do, or would, feel providing sex education to SWODs also. School psychologists provided similar ratings for SWDs and SWODs on this item.

Table 10
School Psychologists' Competence in Sex Education

	SWDs		**SWODs**	
	n	%	*n*	%
Sexual development education in school psychology training				
Yes	46	32%	-	-
Sexual development education outside of school psychology training				
Yes	55	38%	-	-
Familiarity with Learning Standards				
Not familiar at all	54	37%	-	-
Slightly familiar	71	49%	-	-
Moderately familiar	20	14%	-	-
Highly familiar	0	0 %	-	-
Perceptions of Qualification				
Highly qualified	6	4%	6	4%
Moderately qualified	61	43%	50	36%
Not qualified	74	53%	82	59%

Current Involvement in Sex Education

Survey items 19, 21, and 23 focused on the extent of school psychologists' current involvement in sex education for SWDs. This data was analyzed using descriptive statistics; results are depicted in Table 11. Respondents were asked to indicate whether they are involved in sex education by choosing from the following options: "Yes, I am currently involved," "No, I am not involved, but have been in the past," and "No, I have never been involved." Only 3% of respondents indicated being currently involved in sex education for SWDs, while 78% of respondents reported they have never been involved. For SWODs, 94% of respondents indicated they have never been involved. All school psychologists' who indicated no involvement in sex education for SWDs indicated no involvement in sex education for SWODs as well.

Respondents were later asked to select ways in which they are involved in sex education for SWDs. Response options are listed in Table 11. Approximately half of the population indicated no involvement in sex education. The most selected responses with regards to sex education for SWDs were involvement in advocating for appropriate instruction (25%) and in consultation regarding developmentally appropriate activities and instruction (23%). Other methods of involvement reported by respondents included counseling and providing accommodations or modifications in the IEP (5%). On the parallel SWOD item, each method of involvement was selected by less than 5% of participants. The most selected response indicated no involvement in sex education for SWODs (61%). A significant relationship was observed between SWD and SWOD specific responses on the "none" response option. More school psychologists reported no role in sex education for SWODs than for SWDs.

Respondents were also asked to indicate whether they provide counseling to SWDs on issues related to sexuality. Half of the sample reported they do provide counseling around

sexuality. Respondents who indicated they did not provide counseling were asked to provide the job title of the person who is responsible for this role, if any. School counselor, social worker, nurse, and student assistance counselor were frequently mentioned.

Table 11
School Psychologists' Involvement in Sex Education

	SWDs		**SWODs**		**Chi-Square**	
	n	%	*n*	%	*p*	Phi
Involvement in sex education						
Yes, I am currently involved	5	3%	2	1%		
No, I am not involved, but have been	27	19%	7	5%		
No, I have never been involved	111	78%	132	94%		
Method of involvement						
Researching appropriate evidence informed curricula	5	3%	1	0.7%		
Advocating for appropriate instruction	36	25%	5	3%		
Consultation regarding developmentally appropriate activities and instruction	34	23%	4	3%		
Directly providing sex education	10	7%	3	2%		
Ensuring fidelity of implementation of sex education programs	1	0.7%	0	0%		
Increasing parental involvement in sex education at home	12	8%	2	1%		
Developing appropriate measures to Check for student understanding	14	10%	3	2%		
Evaluating effectiveness of curricula	1	0.7%	0	0%		
Other	7	5%	3	2%		
None	74	51%	89	61%	< .05	.74
Counseling regarding topics of sexuality						
Yes	73	53%	-	-		

Barriers/Facilitators of Role in Sex Education

Survey items 25 and 26, which were presented in an open-ended format, focused on barriers and facilitators to school psychologists' involvement in sex education. More than half of the sample chose to respond to these items. See Table 12 for data on frequencies of response.

Table 12
Frequencies of Response for Open-ended Items regarding Facilitators and Barriers to School Psychologist Involvement in Sex Education for SWDs

Items	***n***	**%**
Item 25: Barriers	115	76%
Item 26: Facilitators	79	55%

Survey item 25 asked respondents to provide barriers to school psychologist involvement in sex education for SWDs and whether barriers would differ for SWDs vs SWODs. Since the focus of this study was on understanding school psychologists' roles in sex education for SWDs, only the first part of item 25 was analyzed. Very few respondents addressed the second part of the item, thus only data regarding SWDs was analyzed. Several themes emerged from the 115 responses provided. The most notable barriers were lack of time due to the number of responsibilities school psychologists already hold; lack of support, both from parents and administrators; lack of training; cultural norms; and that sex education was another staff member's responsibility, within the standards for physical education/health. Additionally, a number of respondents seemingly misread the question, as many of the responses included barriers SWDs experience in accessing sex education, rather than barriers to school psychologist involvement. It is also possible some respondents misinterpreted the question as barriers to school psychologists teaching sex education, as many responses voiced concern regarding teaching a course without having a teaching certification.

Survey item 26 asked respondents to provide facilitators to school psychologist involvement in sex education for SWDs and whether facilitators would differ for SWDs vs SWODs. Very few respondents addressed the second part of the item, thus only data regarding SWDs was analyzed. Several themes emerged from the 79 responses provided. Many of the respondents indicated they did not understand the question or know of any facilitators. The most notable facilitators listed were the consultation role of school psychologists' jobs; existing relationships with SWDs and parents; availability of counseling or opportunities to work one on one; and school psychologist training.

Barriers. Several reoccurring themes emerged from analyzing school psychologists' reports of barriers to their participation in sex education. The first notable theme was lack of time due to the amount of responsibilities already held by school psychologists. Many respondents noted they are already performing too many roles within the school and did not feel as though they could acquire another role:

> "School psychologists are asked to perform many roles within school districts, as a result, we have limited time to devote to other areas which could benefit from our involvement, such as Sex Education."
>
> "Barriers include the amount of time in the day and the current role of the school psychologist. School Psychologists are currently involved in a myriad of tasks and hold numerous responsibilities. While I like the idea of having more involvement in such instruction and/or the development of such curricula, it is not possible currently."
>
> "I think this falls very low on the list of priorities for a school psychologist. With case management, testing, consultation, crisis intervention, and all other responsibilities, becoming involved in sex education seems not very feasible. There is probably more

need for SP's to be involved in sex ed for SWD's, at least in terms of modifying and differentiating appropriately, however, it still falls low on the list of priorities."

Other respondents reported a lack of support from parents or administrators presented a barrier to school psychologist involvement in sex education. It appeared as though many respondents saw a need for contributing to sex education, though they felt constrained by the responsibilities given to them by administrators who may not understand the full function of a school psychologist:

"Barriers include parental resistance for SWDs (they sometimes view sex education as unnecessary exposure to uncomfortable topics, rather than a source of information about normal human processes)."

"School administration do not understand that school psychologists have training in human development and can assist in developing developmentally appropriate curricula not just in the area of sex education but in all areas of education."

"District's misunderstanding and under use of school psychologist's role and function"

Respondents also reported a lack of training in the area of sex education; therefore, feeling they would be unqualified to contribute to sex education:

"School psychologists do not receive updated training on this topic."

"Broadly child development is part of the curriculum in school psych programs. However, specific training around sexual development was not part of my training."

Furthermore, several respondents appeared to misinterpret the question to mean barriers to school psychologists teaching sex education, rather than broadly discussing school psychologist involvement. As such, several school psychologists' voiced concerns about their inability to teach courses because they do not hold a teaching certificate:

"I am NOT a certified teacher and therefore I am extremely against creating a role in which I provide direct instruction. We already have a broad role in the schools, therefore adding additional roles is not realistic. It would possibly turn into teaching other subjects as well. I address issues of sexuality with students in counseling, but psychoeducation is not instruction"

"I believe in order to instruct a class at the high school level, you must have a teaching certification in that particular area, therefore, I don't think School Psychologists can just teach a high school course on sex education without proper certification."

School psychologists also expressed concern regarding cultural norms and the issue of sex education continuing to be a taboo topic:

"The topic is still taboo for many families in the school setting."

"If it were to happen, I personally have reservations about openly speaking with students about this topic due to the high level of sensitivity in the environment around certain issues. Also, there seems to be an unusually high number of accusations towards people who may or may not be at fault for wrongdoing towards others in a sexual manner. I feel that it would be difficult to complete sex education in the current environment we are living in at this time."

A number of respondents also listed that sex education was already covered by another staff member's job role, thus creating a barrier for school psychologist involvement:

"If we stepped in for either group that would suggest that we think our colleagues teaching health are unqualified, not a positive thing to suggest."

"I do not think that this is currently thought of as a school psychologist's role. In our district, it belongs to the nurses and physical education teachers."

Facilitators. As with barriers, several reoccurring themes emerged from analyzing school psychologists' reports of facilitators to their participation in sex education. Less respondents answered this item as compared to the item on barriers. Many indicated not understanding the question or not knowing how to respond.

One of the more notable facilitators mentioned was school psychologists' existing role as consultants. Many respondents voiced that serving as a consultant to sex education providers was the appropriate place for school psychologist involvement:

> "Some teachers are eager to consult with school psychologists to receive help in broaching potentially challenging topics, such as sex education."
>
> "I think that typically school psychologists, or case managers in general, would get involved in sex education if the general or special education teacher came to us for help in modifying the curriculum or content to be better understood by students with disabilities."
>
> "I think having good relationships with those teaching sex education can only help the students. This allows the ability to provide input, if needed, and consult on the best ways to approach these topics with specific students."

Others indicated an important facilitator was the existing relationships school psychologists' have with both their students and the families of students:

> "School Psychs often have more personal relationships with SWDs."
>
> "…My aim is to have conversations that increase student's level of care and safety with regards to sex and sexuality. I have had the pleasure of guiding students and parents to and through very beneficial conversations via my role as school psychologist."

"…I speak to parents directly alerting them of some of the difficulty their student may experience so they can pre-teach some of the information."

Similarly, some respondents indicated school psychologists' role in providing counseling to SWDs was an important facilitator. Many respondents noted availability of school-based counseling, and opportunities to work one on one with students, provided the ideal avenue for exploring issues regarding sex education:

"…The opportunity to work one-on-one with students as needed if they continue to have questions or feel awkward/uncomfortable with some topics (this is especially important for normalizing the process of sexual development)."

"Addressing sexual health on an individual basis setting is appropriate for a school psychologist."

Some school psychologists also indicated their training/expertise was an inherent facilitator to their involvement in sex education:

"…I think School Psych. have a unique expertise in understanding all that is involved in sex education and its interplay with culture, personality, experiences, esteem, and normal vs abnormal development."

"Our training in program planning and development as well as knowledge of child development and cognitive development in particular are facilitators. Broadly, I am devoted to all aspects of learning for SWDs and even SWODs. I am willing to provide guidance/assistance in modifying content or providing accommodations for any class."

"I think SP's are arguably one of the most equipped professionals to be involved in facilitating and supporting sex education, specifically with SWD's. SP's should know how

students may or may not be equipped to receive this type of content and the most appropriate ways of tackling a relatively difficult batch of material."

Chapter IV: Discussion

This study explored school psychologists' current and potential roles in assuring that SWDs receive adequate and appropriate sex education. It also examined school psychologists' satisfaction with current sex education for SWDs and potential barriers or facilitators to school psychologists' roles in sex education. Since there are currently no known studies that focus on school psychologists' interactions with sex education, 145 practicing school psychologists in New Jersey public schools were surveyed regarding this area. The demographics of the current sample are comparable to NASP membership demographics (Walcott & Hyson, 2018). Both samples are predominantly European-American and female, with the highest earned degree in school psychology at the specialist level. Survey data was analyzed both quantitatively and qualitatively.

Quality of Sex Education for SWDs

According to existing literature, sex education for SWDs is lacking. SWDs are often unable to access high quality sex education due to barriers such as indirect or developmentally inappropriate instruction (Boehning, 2006), society's perceptions of SWDs as either asexual or sexually deviant (Howard-Barr et al., 2005; Murphy & Elias, 2006; Rohleder, 2010; Sweeny, 2007), or limited sex education training specific to SWDs for sex educators (Ellery & Rabak-Wagener, 1997; Howard-Barr et al, 2005). Additionally, no sex education curricula that is both evidence based and specific to the unique needs of SWDs exists. Given this information, it can be deduced that school psychologists, who are advocates for SWDs, would likely be dissatisfied with the current state of sex education for this population.

Yet, in the current study, a majority of school psychologists who were asked to rate their satisfaction with current sex education practices for SWDs reported feeling neither satisfied nor

dissatisfied. Close to half of the respondents rated their satisfaction with sex education for SWDs as "neutral." With that said, there were more respondents on the dissatisfied end of the spectrum (29%) than there were on the satisfied end of the spectrum (20%), which seems to be in line with assumptions made from the literature. School psychologists were also asked to rate their satisfaction with current sex education practices for SWODs. Similar to their ratings of sex education for SWDs, a majority of school psychologists responded neutrally. Although, in this analysis, there were more respondents on the satisfied end of the spectrum (26%) than the dissatisfied end of the spectrum (15%).

Another surprising finding in light of the literature was that 50% of school psychologists indicated SWDs are always or frequently provided with learning accommodations for sex education. This data appears to be out of line with the literature, as research suggests that SWDs do not generally receive learning accommodations in sex education (Boehning, 2006). It is possible that school psychologists may not be the most accurate reporters of whether learning accommodations are provided in the classroom, especially since 73% of the sample indicated sex education is never addressed in the IEP. Only one respondent indicated that sex education is frequently addressed in the IEP. Thus, it appears whatever learning accommodations SWDs are receiving are not mandated by the IEP and are given at the teacher's prerogative. Or school psychologists are assuming that general learning accommodations listed in the IEP are also applied to the setting in which sex education is taught. This is potentially problematic as the literature indicates teachers who are responsible for teaching sex education to SWDs often do not have the proper training to work with SWDs, nor have the proper resources to effectively teach SWDs (Eisenberg et al., 2010; Ellery & Rabak-Wagener, 1997; Howard-Barr et al, 2005).

Potential Involvement in Sex Education

While the literature on job roles and training standards indicates school psychologists are fit to address the gap in sex education for SWDs, this study briefly explored school psychologists' own perceptions on this matter. Of the 145 school psychologists who were asked to report how they viewed their own involvement in sex education, 68% of the sample agreed they should be involved, while 32% indicated they should not be involved. It is possible that this item was misinterpreted by respondents to read involvement as sole responsibility for sex education, as some school psychologists' who reported they should not be involved later indicated ways in which they should be involved. School psychologists were also asked to rate whether they should be involved in sex education for SWODs; 72% of respondents indicated school psychologists should not be involved. Thus, it appears school psychologists perceive their role and function in school specific to SWDs. This is likely because the majority of school psychologists in New Jersey are employed as a part of a Child Study Team, thus limiting their role to special education. Additionally, school psychologists reported being overwhelmed by the number of roles they hold within special education, so it is not surprising that many of them would not want to be involved in an area concerning SWODs.

According to NASP and APA, which are the two major organizations responsible for accrediting school psychology training programs, school psychologists should have some degree of involvement in sex education. In fact, NASP's official stance regarding sex education is it is school psychologists' responsibility to use their expertise in the facilitation of sex education programs (McClung & Perfect, 2012). While APA does not have a formal statement about school psychologist involvement in sex education it is mentioned on their website that school psychologists are responsible for implementing primary prevention programs to reduce the

incidence of sexual abuse and teenage pregnancy. Also, more broadly, school psychologists have a responsibility to help students succeed academically, behaviorally, and emotionally by providing direct educational and mental health services while working in conjunction with parents, teachers, and other professionals to create supportive learning and social environments for all students.

In order to gather information on the methods of involvement school psychologists thought would be feasible, participants were asked to select the ways in which they believed school psychologists should be involved in sex education. Only 8% of respondents maintained that there should be no involvement on the part of school psychologists in sex education for SWDs. More than half of the sample indicated that school psychologists should be involved in advocating for appropriate instruction (70%) and consultation regarding developmentally appropriate activities and instruction (66%). Close to half of the population also indicated school psychologists should be involved in developing appropriate measures to check for student understanding (45%). Approximately one third of the population saw fit for school psychologists to be involved in researching appropriate evidence informed curricula (32%) and increasing parental involvement in sex education at home (32%). This data supports that school psychologists should hold some degree of involvement in sex education. It appears the majority of school psychologists also recognize their potential to address gaps in sex education for SWDs. For SWODs, on the other hand, 62% of school psychologists maintained that they should not be involved. Though, similar to their ratings for SWDs, the top two selected methods of involvement were advocating for appropriate instruction (26%) and consultation regarding developmentally appropriate activities and instruction (27%).

Competence in Sex Education

In addition to exploring school psychologists' perceived roles in sex education, this study also investigated school psychologists' perceived competence in filling such roles. In rating their perceived competence in providing sex education instruction to SWDs, 43% of school psychologists indicated they feel moderately qualified. Respondents were also asked to indicate how competent they felt in providing sex education instruction to SWODs. The ratings were similar for both SWDs and SWODs.

To further understand the qualifications of school psychologists in relation to sex education, school psychologists were asked to indicate whether they received any training regarding sexual development in their school psychology training programs. Approximately one third (32%) of the sample population indicated receiving some form of training regarding sexual development. Those who responded affirmatively were also asked to describe the type of training received. A majority of the respondents reported receiving education around sexual development training in a human development course. A very small number of school psychologists reported having a course specifically devoted to sexual development or participating in workshop trainings regarding the topic.

Much like the studies conducted on teacher training in the area of sex education (Eisenberg et al., 2010; Ellery & Rabak-Wagener, 1997; Howard-Barr et al, 2005), it appears school psychology training programs are not uniform in the content knowledge they provide. It is concerning that such a large portion of the sample population reported never receiving instruction on sexual development as a part of their training, as this is an area of typical human development, which is a required standard for school psychologist credentialing according to NASP. Additionally, given that NASP and APA both appear to support school psychologists'

involvement in sex education, it is detrimental for training programs not to include instruction on such a topic. It is evident that some school psychologists require additional training regarding sexual development in order to maximize the effectiveness of their potential role in sex education.

School psychologists were also asked if they had received training about sexual development outside of their school psychology program. Slightly more than a third of the sample population (38%) reported they had received such training. Again, respondents were asked to indicate the type of training. Largely, respondents indicated they received education about sexual development in their own high school sex education classes or in undergraduate courses they had chosen to take. Only a small number of school psychologists reported participating in professional development or workshop trainings of their own volition.

It is concerning that school psychologists may be relying on knowledge from high school sex education or even undergraduate courses for their involvement in this role. Such courses were likely not held to the same rigorous training standards as a graduate school program. High school sex education classes especially would not provide a student with the skillset or training necessary for educating others on the topic. Additionally, it is known from the literature that sex education varies greatly at the high school level, thus if school psychologists' knowledge of sex education is limited to the content taught in their own high school classes, it is not guaranteed that they received all of the accurate or necessary information themselves.

Current Involvement in Sex Education

In order to gage the feasibility of school psychologist involvement in sex education, school psychologists were asked to report on their current involvement in sex education. Only 3% of the sample indicated currently being involved in sex education for SWDs, 19% indicated

being involved in the past, and 78% indicated never being involved. In regard to involvement in sex education for SWODs, only 1% of school psychologists indicated being currently involved, 5% indicated being involved in the past, and 94% indicated never being involved. As with the question regarding school psychologists' perception of their role, it is possible that this item was misinterpreted by some school psychologists. Respondents who indicated they have never been involved in sex education went on to report, on a different item, ways in which they are involved in sex education. Additionally, 51% of respondents maintained having no involvement in sex education for SWDs and 61% maintained having no involvement in sex education for SWODs. Respondents may have erroneously equated school psychologist involvement in sex education with school psychologist delivery of sex education.

Asked to select ways of involvement from a list of potential methods, the response option most frequently selected for SWDs was advocating for appropriate instruction (25%). Consultation regarding developmentally appropriate activities and instruction followed closely with 23% of respondents indicating this form of involvement. Both of these top-rated methods of involvement are integral parts of the school psychologist role in general. This was evidenced by the results of the demographic item which required respondents to select all job roles that applied to their current position. The second most selected option was consultation (97%). Additionally, by virtue of the position, job roles school psychologists hold are largely based in their advocacy for SWDs to receive a Free and Appropriate Public Education. Thus, not surprisingly, each method of involvement on the SWOD side was selected by less than 5% of school psychologists.

Again, while 78% of the sample originally indicated no involvement with sex education for SWDs, 53% of respondents reported providing counseling to SWDs regarding topics of sexuality. Many of the respondents may have confused involvement in sex education with

teaching a sex education course; thus, multiple respondents originally reported no involvement and later indicated some degree of involvement.

From this sample, it appears the majority of school psychologists do not currently hold a direct role in sex education. While some school psychologists did report providing direct instruction, the majority of school psychologist involvement comes from consultation and advocacy for appropriate instruction. Additionally, at least half of school psychologists provide SWDs with support related to sex education through a counseling role. This data supports that school psychologists can be a viable resource for sex education.

Facilitators/Barriers of School Psychologist Role in Sex Education

It seems by virtue of school psychologists' role and expertise, their involvement in sex education for SWDs is a natural fit. As many respondents voiced, school psychologists hold unique training and skillsets that put them in a position to address several different needs in this area. Specifically, school psychologists are already functioning within school districts as consultants to teachers, supporting them in maximizing the accessibility of instruction for SWDs. Additionally, as case managers, school psychologists have existing school-family connections, allowing them to build relationships with students and parents which could facilitate conversations around sensitive topics such as sex education. Furthermore, many respondents indicated opportunities for counseling and ability to work with students one on one which would allow for an ideal time and space to address sex education.

Although findings from this study suggest school psychologists' training and job roles do make them a good fit to fill various roles in the planning, delivery, and evaluation of sex education, barriers to involvement do exist. Several reoccurring themes emerged from analyzing school psychologists' reports of barriers to their participation in sex education. Predictably, many

school psychologists reported that time was a major issue for them due to the many roles they already had to perform as a part of their position. From their responses, it appears many school psychologists feel protective of their role, as it is already quite broad, and are concerned about gaining additional responsibilities due to time constraints. While some school psychologists believe involvement in sex education fits under their job role, they are too overburdened or discouraged by the roles assigned by administration to become involved in sex education. Conversely, several school psychologists do not feel qualified to be involved in sex education. Many of them also voiced concerns about lacking certification to provide any sex education instruction. Some are hesitant due to cultural norms and fear of addressing sensitive topics in today's society. Others feel as though there is no place for school psychologists in sex education, as it is already covered by other staff members within the school.

Implications for Practice

Results from the current study support that school psychologists hold the appropriate skill set to assist in bridging the gap for SWDs in sex education. It was hypothesized school psychologists' training and expertise would make them a good fit for addressing the following three areas of sex education instruction: planning, delivery, and evaluation. Planning of sex education curricula could involve researching developmentally appropriate curricula, advocating for appropriate instruction, and consulting for appropriate instruction. Delivery of sex education could involve directly providing instruction, consulting with other staff members regarding effective instructional practices, ensuring fidelity of program implementation, and increasing parental involvement in reinforcing sex education concepts at home. Assessment of sex education could involve developing appropriate assessment measures and evaluating effectiveness of the curriculum being used.

Unfortunately, at the time of the study, only 3% of school psychologists reported being currently involved in sex education, though 68% reported they should be involved. Qualitative data revealed that school psychologists believed their training, and roles within schools, allow them the opportunity to encourage parental involvement, consult with teachers, provide counseling, create modifications to instruction, etc. The highest rated methods of involvement for school psychologists in sex education were advocating for appropriate education (70%) and consultation regarding developmentally appropriate activities and instruction (66%). In order to maximize their effectiveness, school psychologists would likely require additional training in sexual development, especially given that many school psychologists (68%) indicated their training programs did not provide opportunities for education on sexual development.

With that said, although school psychologists appear to have the ability to address the gap in sex education, qualitative data revealed that there are several existing barriers to school psychologists' role in sex education. The largest barriers seemed to be time and the misuse of the school psychologist role. More specifically, the overutilization of school psychologists as simply case managers, which in turn prevents school psychologists from involvement in areas that could benefit from their unique skillset and expertise, such as sex education. In order to use school psychologists as a resource for sex education, schools would need to adjust their perspective of a school psychologist's function.

As this appears to be a systems' issue and change is unlikely at the individual level, a potential solution would be the use of a hub-and-spoke model. In such a model, a statewide team specializing in best practices for sex education instruction, for both SWDs and SWODs, would be developed to serve as the hub. This team would be responsible for continuing research in the field of sex education, compiling high quality resources, and training select staff members within

schools who would then serve as the spokes. Staff members who served as spokes would then turnkey a condensed version of the training to other key personnel within schools. This method of training would likely be the most efficient and cost-effective for schools. Theoretically, only one staff member in each school would need to attend trainings at the hub in order to provide any number of staff within the school with training at more convenient times. Teachers would not have to miss an entire day of instructional time with their students in order to receive training, rather it could be worked into their daily schedules or regularly scheduled department meetings.

Limitations

The generalizability of the current study is limited, as the surveyed population only included a small number of school psychologists exclusively from New Jersey public schools. School psychologists who work in New Jersey public schools may have different job roles and training criteria as compared to school psychologists who work in other states or in private settings. This could affect responses to many of the questions on the survey. Thus, results from this study are likely representative of school psychologists in New Jersey and may not be generalizable to the total population of school psychologists.

Furthermore, contact information for potential participants was collected through internet searches of New Jersey school district websites. While most websites were easily accessible, a small fraction of the websites did not work, because the school districts' servers were malfunctioning, thus contact information for school psychologists at those schools could not be collected. It is also possible that random errors could have been made in the collection process. Additionally, it is possible that contact information was incorrectly posted or may not have been changed to reflect any changes in employment, such as leave of absence or retirement. Alternatively, updates to contact information could have been made after the list was already

compiled. Thus, some school psychologists may not have received an invitation to participate in the study.

Additionally, use of survey methodology, particularly web-based surveying, also poses several limitations. The ease with which an email invitation for a web-based survey can be ignored or discarded may have impacted the response rate. While the email was distributed at 7:00 AM to maximize the possibility of school psychologists viewing the message before their school day began, it is possible that some school psychologists do not check their email in the morning. The email could have been skimmed past or left forgotten and unopened in a long list of emails. Additionally, some school psychologists may have deleted the invitation, as it was sent from an unfamiliar sender. Alternatively, email accounts may be set to filter settings that automatically block messages from unfamiliar senders or flag messages as spam whenever they appear to be mass produced or include links. The current study was designed to collect information addressing differences in respondents vs. nonrespondents by allowing those who did not provide consent to submit only demographic information. All participants who followed the link to the survey provided consent, thus data on respondents vs. nonrespondents was not obtained. Given the low response rate, the risk of nonresponse bias is high. It is possible that respondents were distinctly different from nonrespondents, thus impacting the validity of the results and interpretation of results. Without demographic data for non-responders, it is difficult to gauge the impact of non-response bias on this study.

Survey methodology was also a limitation because certain items may have been confusing for participants to understand or subjective in their interpretation. Thus, impacting the interpretability of results. For example, the open-ended question regarding facilitators of

involvement in sex education yielded many responses which indicated that respondents did not understand the question.

Additionally, results of several of the Chi-Square analyses could not be reported because the obtained data set violated the assumptions of the test. This limited interpretation of potential relationships between school psychologists' responses for SWDs and SWODs. Data regarding type of degree and indication of sexual development education in graduate training programs could not be interpreted for this reason, as well.

Results from this survey may also be susceptible to the effect of social desirability. For example, the invitation used to recruit participants stated, "As school psychologists, we hold a responsibility to guarantee all students with disabilities receive a free and appropriate education." While this statement was intended as a gentle reminder to school psychologists of their responsibility to SWDs and as encouragement to contribute to the betterment of SWD education, it may have inadvertently influenced responses. With that statement in mind, school psychologists may have been less willing to reveal their lack of involvement in sex education for SWDs, as it could be construed as negligence.

Future Directions

While this study has succeeded in laying the initial foundation for exploring school psychologists' role in sex education, further exploration of this topic is clearly needed. Future studies should feature larger sample sizes, including school psychologists from other geographic locations so that results may be more generalizable. Results from such studies could also compare the roles of school psychologists from different states and explore whether participating in sex education is more feasible in some states than others. Similarly, data can be collected from school psychologists working in private or specialized schools for SWDs to compare whether a

role in sex education is more or less feasible. Additionally, given that many school psychologists identified other staff members' perceptions of school psychologists' role as a barrier to involvement in sex education, it may be useful to collect data on other staff members' perceptions.

Since the current study was exploratory in nature, the survey used was broad and covered many different areas related to sex education. Future studies would benefit from narrowing their focus to specific areas of interest. For example, a study focusing entirely on barriers and facilitators, or a study focusing entirely on school psychologists' training relevant to sex education, would provide richer implications for practice than the current study is able to provide. Additionally, a study focusing on the evaluation of graduate school training programs could help in developing a better understanding of how school psychologists can best be trained to address the gap in sex education for SWDs.

It may also be beneficial for future studies to focus on the current state of sex education for SWDs. Existing literature indicates that SWDs are often excluded from sex education or do not receive appropriate accommodations/modifications. Conversely, a majority of respondents in the current study reported that SWDs are provided with learning accommodations and some even reported that sex education was addressed in the IEP. It would be useful to explore the types of accommodations and modifications that SWDs are receiving, as well as the effectiveness.

Conclusions

In sum, findings from this study suggest that the majority of school psychologists are neutral in regard to their satisfaction with sex education for SWDs (51%). At the time of data collection, only 3% of school psychologists reported being currently involved in sex education for SWDs. Involvement by school psychologists may not be direct; 25% of respondents indicated

being involved in advocating for appropriate sex education instruction and 23% indicated being involved in consultation regarding developmentally appropriate activities and instruction. Two thirds of the sample population indicated school psychologists should be involved in sex education for SWDs. Even so, a majority of school psychologists indicated a number of barriers to their involvement in sex education. The most reported barrier was a lack of time due to the numerous job roles school psychologists already hold. Fewer respondents provided facilitators to school psychologists' involvement in sex education. The most reported facilitator was that school psychologists already hold a consultation role as a part of their job responsibilities. Thus, while school psychologists are theoretically fit to address the gap in sex education and current findings do indicate that the majority of school psychologists are interested in serving in this role, several barriers exist to its feasibility, namely the time constraints of school psychologists' current roles.

References

About the Family Life and Sexual Health (F.L.A.S.H.) curriculum. (2017, July 27). Retrieved from https://www.kingcounty.gov/depts/health/locations/family-planning/education/FLASH/about-FLASH.aspx

American Psychological Association (n.d.). Parameters to define professional practice in school psychology. Retrieved from http://www.apa.org/ed/graduate/specialize/school.aspx

Balanko, S. L. (2002). Good sex? A critical review of school sex education. *Guidance and Counseling*, *17*(4), 117-23.

Bethlehem, J. G., & Biffignandi, S. (2012). *Handbook of Web Surveys*. Hoboken, N.J.: Wiley.

Bigelow, M. A. (1916). *Sex-education: A series of lectures concerning knowledge of sex in its relation to human life*. Macmillan.

Blanchett, W., & Wolfe, P. (2002). A review of sexuality education curricula: Meeting the sexuality education needs of individuals with moderate and severe intellectual disabilities. *Research & Practice For Persons With Severe Disabilities*, *27*(1), 43-57.

Boehning, A. (2006). Sex education for students with disabilities. *Law and Disorder, 1,* 59-66.

Breuner, C. C., & Mattson, G. (2016). Sexuality Education for Children and Adolescents. *Pediatrics, 138*(2), 1-11.

Carter, J. (2001). Birds, bees, and venereal disease: Toward an intellectual history of sex education. *Journal of the History of Sexuality, 10*, 213–249.

Charo, R. (2017). The Trump administration and the abandonment of Teen Pregnancy Prevention Programs. *JAMA Internal Medicine*, 177(11), 1557-1558.

Couper, M. P., & Miller, P. V. (2008). Web survey methods. *Public Opinion Quarterly*, *72*(5), 831.

Dillman, D. A., Christian, L. M., & Smyth, J. D. (2014). *Internet, Phone, Mail, and Mixed-Mode Surveys : The Tailored Design Method*. Hoboken: Wiley.

Dukes, E., & Mcguire, B. (2009). Enhancing capacity to make sexuality-related decisions in people with an intellectual disability. *Journal of Intellectual Disability Research*, *53*(8), 727-734.

Eggert, D. B., & Minutelli, A.M. (2013). How to Safely Cross the Intersection Between Special Education: A Review of Recent Rulings. Retrieved from http://www.wadleighlaw.com/wp-content/uploads/dlm_uploads/2015/02/Special-Education-Case-Law-An-Overview-of-Recent-Decisions-April-2013.pdf

Eisenberg, M. E., Madsen, N., Oliphant, J. A., Sieving, R. E., & Resnick, M. (2010). "Am I Qualified? How Do I know?" A Qualitative Study of Sexuality Educators' Training Experiences. *American Journal of Health Education*, *41*(6-), 337-344.

Ellery, P. J., & Rabak-Wagener, J. (1997). Special educators who teach health education. *Remedial & Special Education*, *18*(2), 105.

Galea, J., Butler, J., Iacono, T., & Leighton, D. (2004). The assessment of sexual knowledge in people with intellectual disability. *Journal of Intellectual & Developmental Disability*, *29*(4), 350-365.

Groce, N. E., Izutsu, T., Reier, S., Rinehart, W., & Temple, B. (2009). Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note.

Guttmacher Institute. (2018, November 1). State Laws and Policies: Sex and HIV Education. Retrieved from: https://www.guttmacher.org/state-policy/explore/sex-and-hiv-education

Hall, K. S., Sales, J. M., Komro, K. A., & Santelli, J. (2016). The State of Sex Education in the United States. *The Journal of Adolescent Health : Official Publication of the Society for Adolescent Medicine*, *58*(6), 595–597.

Harader, D., Fullwood, H., & Hawthorne, M. (2009). Sexuality among adolescents with moderate disabilities: promoting positive sexual development. *Prevention Researcher*, *16*(4), 17-20.

Harrell, E. (2017). Crime against persons with disabilities, 2009-2015. Statistical tables. *Washington: Bureau of Justice Statistics*.

Hoonakker, P., & Carayon, P. (2009). Questionnaire Survey Nonresponse: A Comparison of Postal Mail and Internet Surveys. *International Journal of Human-Computer Interaction*, *25*(5), 348-373.

Howard-Barr, E. M., Rienzo, B. A., Pigg, R. J., & James, D. (2005). Teacher Beliefs, Professional Preparation, and Practices regarding Exceptional Students and Sexuality Education. *Journal of School Health*, *75*(3), 99.

Huber, V. J., & Firmin, M. W. (2014). A history of sex education in the United States since 1900. *International journal of educational reform*, *23*(1), 25-51.

Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. §§ 1400 (2004).

Jensen, R. E. (2010). *Dirty words: The rhetoric of public sex education, 1870-1924*.

Kirby, D. B. (2008). The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research & Social Policy: Journal Of NSRC*, *5*(3), 18.

Kwak, N., & Radler, B. (2002). A comparison between mail and web surveys: Response pattern, respondent profile, and data quality. *Journal of Official Statistics*, *18*(2), 257.

Lamb, S. (2013). Just the Facts? The Separation of Sex Education from Moral. Education. *Educational Theory*, *63*(5), 443.

McCabe, M. (1999). Sexual knowledge, experience and feelings among people with disability. *Sexuality & Disability*, *17*(2), 157-170.

McClung, A. A., & Perfect, M. M. (2012). Sexual health education: Social and scientific perspectives and how school psychologists can be involved. *Communique*, *40*(6).

McKee, M., Greer, S. L., & Stuckler, D. (2017). What will Donald Trump's presidency mean for health? A scorecard. *Lancet, 389*(10070), 748-754.

Milligan, M. S., & Neufeldt, A. H. (2001). The myth of asexuality: A survey of social and empirical evidence. *Sexuality and Disability*, *19*(2), 91-109.

Murphy, N. A., & Elias, E. R. (2006). Sexuality of children and adolescents with developmental disabilities. *Pediatrics*, *118*(1), 398-403.

Murphy, N., & Young, P. C. (2005). Sexuality in children and adolescents with disabilities. *Developmental Medicine and Child Neurology, 47*(09), 640–644.

National Association of School Psychologists Model for Comprehensive and Integrated School Psychological Services. (2010). *School Psychology Review*, *39*(2), 320-333.

New Jersey State Department of Education. (2014). Core curriculum content standards in comprehensive health and physical education. Retrieved from http://www.state.nj.us/education/cccs/2014/chpe/standards.pdf

Rohleder, P. (2010). Educators' ambivalence and managing anxiety in providing sex education for people with learning disabilities. *Psychodynamic Practice*, *16*(2), 165-182.

Saul, R. (1998). Whatever Happened to the Adolescent Family Life Act?. *The Guttmacher Report on Public Policy*, *1*(2), 5-10.

Sexuality Information and Education Council of the United States (n.d.). Evidence-based and more comprehensive approaches to pregnancy-, HIV/STD-prevention and sexuality education. Retrieved from http://www.siecus.org/index.cfm?fuseaction=page.viewPage&pageID=1342&nodeID=1

Shih, T., & Fan, X. (2008). Comparing response rates from Web and mail surveys: A meta-analysis. *Field Methods*, *20*(3), 249-271.

Social Security Administration. (2009). *Separate program for abstinence education.* Retrieved from http://www.ssa.gov/OP_Home/ssact/title05/0510.htm

Somerville, R. (1971). Family Life and Sex Education in the Turbulent Sixties. *Journal Of Marriage And Family*, (1), 11.

Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: a population-based epidemiological study. *Child Abuse & Neglect*, *24,* 1257-1273.

Sweeney, L. (2007). The importance of human sexuality education for students with disabilities. *Exceptional Parent*, *37*(9), 36-39.

Walcott, C. M., & Hyson, D. (2018). Results From the NASP 2015 Membership Survey, Part One: Demographics and Employment Conditions.

World Health Organization. (2006a). Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002. Geneva, World Health Organization.

Yetter, G., & Capaccioli, K. (2010). Differences in responses to Web and paper surveys among school professionals. *Behavior Research Methods*, *42*(1), 266-272.

Appendix A

School Psychologist Involvement in Sex Education Survey

Welcome to the School Psychologist Involvement in Sex Education survey!

You are invited to participate in a dissertation research study that is being conducted by Khyati Desai, who is a doctoral student in the Graduate School of Applied and Professional Psychology Department at Rutgers University. The purpose of this research is to determine school psychologists' role in assuring adequate sex education for students with disabilities (SWDs) using a survey study. The survey should only take 10 minutes to complete.

This research is anonymous. Anonymous means that I will record no information about you that could identify you. There will be no linkage between your identity and your response in the research. This means that I will not record your name, address, phone number, date of birth, etc. Your name will appear only on a list of subjects, and will not link your responses back to you. Therefore, data collection is anonymous.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept for three years.

There are no foreseeable risks to participation in this study. In addition, you may receive no direct benefit from taking part in this study, other than the opportunity to learn from results of the study; indirect benefits of the study may include learning more about your own thoughts on this important topic, as well as contributing to knowledge in the field.

Participation in this study is voluntary. You may choose not to participate, and you may withdraw at any time during the study procedures without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable.

If you have any questions about the study or study procedures, you may contact myself at kdesai92@gsapp.rutgers.edu or (724) 313-4468. You can also contact my faculty advisor Dr. Ryan Kettler at r.j.kettler@rutgers.edu or (615) 772-1184.

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-2866

Email: human-subjects@ored.rutgers.edu

Please retain a copy of this form for your records. By participating in the above stated procedures, you then agree to participation in this study.

If you are 18 years of age or older, understand the statements above, and will consent to participate in the study, select "I consent" to begin the survey. If not, please select "I do not consent" which will allow you an opportunity to complete the demographic portion of the survey, if you would be kind enough to do so, before exiting.

- ○ I consent
- ○ I do not consent

---

1. I identify my gender as…

- ○ Female
- ○ Male
- ○ Other (Please explain) ______________________________

2. The racial or ethnic group with which I most identify is…

- ○ African American (non-Hispanic)
- ○ Asian American/Pacific Islander
- ○ European American (non-Hispanic)
- ○ Latino American
- ○ Other (Please explain) ______________________________

3. My highest degree earned in school psychology is…

- ○ Master's degree
- ○ Specialist degree
- ○ Doctoral degree
- ○ Other (Please explain) ______________________________

4. How many years of experience do you have as a practicing school psychologist?

____

5. Please select the grade level(s) with which you primarily work.

- ☐ Pre-K
- ☐ K-5
- ☐ 6-8
- ☐ 9-12
- ☐ Other (Please explain) ______________________________

6. As a school psychologist, which of the following job roles do you hold? Select all that apply.

- ☐ Assessment
- ☐ Behavior planning
- ☐ Consultation
- ☐ Counseling
- ☐ Crisis intervention
- ☐ Program development
- ☐ Program evaluation
- ☐ Prevention
- ☐ Others (Please explain) ____

7. As a school psychologist, which of the following staff members do you consult with? Select all that apply.

- ☐ General Education Teacher
- ☐ Learning Disabilities Teacher-Consultant
- ☐ Nurse
- ☐ Principal
- ☐ School Counselor
- ☐ Social Worker
- ☐ Special Education Teacher
- ☐ Others (Please explain) ____

Sex education is defined as lessons that explore puberty, human reproduction, sexuality, dating, abstinence, sexual behavior, prevention of sexually transmitted infections, and pregnancy prevention.

8. Which grade level(s) receive sex education in your district?

- ☐ Pre-K
- ☐ K-5
- ☐ 6-8
- ☐ 9-12
- ☐ Other (Please explain) ____

9. How is sex education generally taught in your school?

- ○ Sex education is its own course
- ○ Sex education is incorporated within another course
- ○ Special lessons are taught independent of a course
- ○ Don't know

10. Are students required to take sex education?

- ○ Required
- ○ Optional
- ○ Don't know

11. In your formal, university-based School Psychology training, did you receive education about sexual development?

- ○ No
- ○ Yes (Please describe type of training)

____

12. Did you receive education about sexual development outside of your School Psychology training?

- ○ No
- ○ Yes (Please describe type of training)

____

13. Would you like to receive additional training in relation to sexual development?

- ○ Yes
- ○ No

14. How familiar are you with the New Jersey Student Learning Standards for Comprehensive Health and Physical Education?

- ○ Not familiar at all
- ○ Slightly familiar
- ○ Moderately familiar
- ○ Extremely familiar

"Students with disabilities (SWDs)" is defined as students with Individualized Educational Plans (IEPs). "Students without disabilities (SWODs)" is defined as students in general education who do not have IEPs.

15. How are SWDs currently taught sex education within your district?

16. Indicate your level of satisfaction or dissatisfaction with the current sex education instruction provided in your district.

	Level of satisfaction or dissatisfaction for **SWDs**	Level of satisfaction or dissatisfaction for **SWODs**
Extremely dissatisfied	○	○
Somewhat dissatisfied	○	○
Neutral	○	○
Somewhat satisfied	○	○
Extremely satisfied	○	○

17. How often are SWDs provided with learning accommodations in sex education classes in your district?

- ○ Never
- ○ Occasionally
- ○ Frequently
- ○ Always

18. How often is sex education addressed in the IEP?

- ◯ Never
- ◯ Occasionally
- ◯ Frequently
- ◯ Always

19. Are you involved in sex education?

	Involvement in sex education for **SWDs**	Involvement in sex education for **SWODs**
Yes, I am currently involved	◯	◯
No, I am not involved, but have been in the past	◯	◯
No, I have never been involved	◯	◯

20. How do you view your involvement in sex education?

	Involvement in sex education for **SWDs**	Involvement in sex education for **SWODs**
I should not be involved	◯	◯
I should be involved	◯	◯

21. What are some of the ways in which you are involved in sex education in your district? Select all that apply.

	Involvement in sex education for **SWDs**	Involvement in sex education for **SWODs**

Researching appropriate, evidence informed curricula	☐	☐
Advocating for appropriate instruction	☐	☐
Consultation regarding developmentally appropriate activities and instruction	☐	☐
Directly providing sex education instruction	☐	☐
Ensuring fidelity of implementation of sex education programs	☐	☐
Increasing parental involvement in sex education at home	☐	☐
Developing appropriate measures to check for student understanding	☐	☐
Evaluating effectiveness of curricula	☐	☐
Other (Please explain)	☐	☐
None	☐	☐

22. What are some of the ways in which you believe a school psychologist should be involved with sex education? Select all that apply.

	Involvement in sex education for **SWDs**	Involvement in sex education for **SWODs**

Researching appropriate, evidence informed curricula	☐	☐
Advocating for appropriate instruction	☐	☐
Consultation regarding developmentally appropriate activities and instruction	☐	☐
Directly providing sex education instruction	☐	☐
Ensuring fidelity of implementation of sex education programs	☐	☐
Increasing parental involvement in sex education at home	☐	☐
Developing appropriate measures to check for student understanding	☐	☐
Evaluating effectiveness of curricula	☐	☐
Other (Please explain)	☐	☐
None	☐	☐

23. Do you provide counseling for SWDs on issues related to sexuality? If no, please indicate whether another staff member within the district holds this responsibility and the job title of that staff member.

○ Yes

○ No ____

24. How qualified do you (or would you) feel providing sex education?

	Providing sex education to	Providing sex education to

	SWDs	**SWODs**
Highly qualified	○	○
Moderately qualified	○	○
Not qualified	○	○

25. What are some ***barriers*** for school psychologist involvement in sex education? Do ***barriers*** differ for SWDs vs SWODs?

26. What are some ***facilitators*** for school psychologist involvement in sex education? Do ***facilitators*** differ for SWDs vs SWODs?

27. Within school districts, who do you believe should be responsible for the ***development*** of appropriate sex education curricula for SWDs?

28. Within school districts, who do you believe should be responsible for the ***implementation*** of sex education for SWDs?

29. Within school districts who do you believe should be responsible for ***evaluating*** the effectiveness of sex education curricula for SWDs?

Sexual Assault Prevention (N.J.S.A. 18A:35-4.3) requires the development of a sexual assault prevention education program that should be adapted to the age and understanding of the students for full and adequate treatment of the subject.
30. In your district, what position is responsible for adapting content to be developmentally appropriate?
31. What accommodations and/or modifications are provided to students?

32. Does sex education differ for SWDs vs SWODs?

- ◯ Yes
- ◯ No
- ◯ Don't Know

33. In what ways does sex education differ for SWDs vs SWODs?

34. Do you believe sex education should be different for SWDs vs SWODs?

- ◯ Yes
- ◯ No

35. In what way(s) should sex education be different for SWDs vs SWODs?

Thank you for your time spent taking this survey! Your response has been recorded.

To request a summary of results from the survey, when available, please send an email to kdesai92@gsapp.rutgers.edu.

Appendix B

First Email: Invitation-

SUBJECT: Let's Talk About Sex…Education (Dissertation Study)

Dear **[INSERT SCHOOL PSYCHOLOGIST NAME HERE]**,

You are invited to participate in a dissertation research study surveying school psychologists in New Jersey public schools. The goal of this study is to understand the role that you, as a school psychologist, can play in sex education for students with disabilities.

As school psychologists, we hold a responsibility to guarantee all students with disabilities receive a free and appropriate education. Unfortunately, research has shown that students with disabilities are often unable to access sex education. As a result, they are ***less informed about sexual matters*** and ***more susceptible to misinformation, sexual abuse, and unsafe sex practices***. Research has found children with intellectual disabilities were ***four times more likely to be sexually abused*** than their peers without disabilities. While the presence of any type of disability increases the risk of victimization, ***intellectual disabilities, communication disorders, and behavioral disorders appear to contribute to higher levels of risk, with multiple disabilities resulting in the highest levels***. Such statistics further highlight the need to provide our students with adequate sex education and preventative instruction in order to encourage safety. Findings from this study will hopefully lead to increased access to developmentally appropriate sex education for students with disabilities.

If you are interested in participating in this survey, please click this link:

[INSERT LINK TO SURVEY]

The survey will remain open for **2 weeks** from today. The survey is estimated to take 10 minutes to complete. Your participation is voluntary and you may choose to withdraw at any point without penalty. Additionally, you may skip any questions that you prefer not to answer. Your answers will remain anonymous.

I truly appreciate your contribution, both to my dissertation and to the field of school psychology. If you have any questions or concerns, please email me at kdesai92@gsapp.rutgers.edu.

Thank you,

Khyati Desai, PsyM, NJCSP
School Psychology Doctoral Candidate
Graduate School of Applied & Professional Psychology
Rutgers, The State University of New Jersey

Second Email: Reminder-

SUBJECT: Last Chance to Help Explore School Psych Role in Sex Ed

Dear **[INSERT SCHOOL PSYCHOLOGIST NAME HERE]**,

Last week you received an email requesting your participation in my dissertation research study. While many school psychologists have already completed the survey, I am hoping that you will choose to contribute to this study as well. Again, the goal of this study is to understand the role that you, as a school psychologist, can play in sex education for students with disabilities. **Your input is extremely valuable!** Currently, many of our students with disabilities are excluded from or do not receive developmentally appropriate sex education. ***As a result, their safety and well-being is compromised***. To better serve our students, it is important that we gain insight into our current and potential roles in sex education. Findings from this study will hopefully lead to increased access to developmentally appropriate sex education for students with disabilities.

The link below will provide you access to the survey.

[INSERT SURVEY LINK HERE]

This email will be your **last** reminder. The survey will remain open for **1 week** from today. Please complete it as soon as possible. The survey is estimated to take only 10 minutes to complete. Your participation is voluntary and you may choose to withdraw at any point without penalty. Additionally, you may skip any questions that you prefer not to answer. Your answers will remain anonymous.

I thank you for taking time out of your busy schedules to contribute to my dissertation, and in turn, the field of school psychology. If you have any questions or concerns, please email me at kdesai92@gsapp.rutgers.edu.

Sincerely,

Khyati Desai, PsyM, NJCSP
School Psychology Doctoral Candidate
Graduate School of Applied & Professional Psychology
Rutgers, The State University of New Jersey