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ABSTRACT

This booklet addresses the plight of pregnant teenagers and teenage parents, especially those in special education, and the role of program developers and practitioners in responding to their educational needs. After a brief introduction, a research synthesis notes similarities of predictors, extent, and consequences of teenage pregnancy and parenting for youths in regular and special education, as well as increased vulnerability among special education students. Implications for program development are presented next, including the need for a broad-based local team addressing the complex issues associated with creating sound family life/sex education/prevention programs for this population. The importance of administrative involvement and support is covered in the following section. Teachers of family life education programs are encouraged to increase their knowledge of this topic and to improve their assessment skills, teaching strategies, and access to support networks. Administrators are urged to take responsibility for policy, teacher education and support, collaboration with parents and community agencies, budgeting, evaluation, and monitoring. The book includes 45 references, a resource list of teaching materials, and a description of the Scarborough principle of teaching sex education to the mentally handicapped. (DB)

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Double Jeopardy:

Pregnant and Parenting Youth in Special Education

Lynne Muccigrosso
Marylou Scavarda
Ronda Simpson-Brown
Barbara E. Thalacker

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Double Jeopardy:

Pregnant and Parenting
Youth in Special Education

Lynne Muccigrosso
Marylou Scavarda
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Foreword

EXCEPTIONAL CHILDREN AT RISK CEC Mini-Library

Many of today's pressing social problems, such as poverty, homelessness, drug abuse, and child abuse, are factors that place children and youth at risk in a variety of ways. There is a growing need for special educators to understand the risk factors that students must face and, in particular, the risks confronting children and youth who have been identified as exceptional. A child may be at risk *due to* a number of quite different phenomena, such as poverty or abuse. Therefore, the child may be at risk *for* a variety of problems, such as developmental delays; debilitating physical illnesses or psychological disorders; failing or dropping out of school; being incarcerated; or generally having an unrewarding, unproductive adulthood. Compounding the difficulties that both the child and the educator face in dealing with these risk factors is the unhappy truth that a child may have more than one risk factor, thereby multiplying his or her risk and need.

The struggle within special education to address these issues was the genesis of the 1991 CEC conference "Children on the Edge." The content for the conference strands is represented by this series of publications, which were developed through the assistance of the Division of Innovation and Development of the U.S. Office of Special Education Programs (OSEP). OSEP funds the ERIC/OSEP Special Project, a research dissemination activity of The Council for Exceptional Children. As a part of its publication program, which synthesizes and translates research in special education for a variety of audiences, the ERIC/OSEP Special Project coordinated the development of this series of books and assisted in their dissemination to special education practitioners.

Each book in the series pertains to one of the conference strands. Each provides a synthesis of the literature in its area, followed by practical suggestions—derived from the literature—for program developers, administrators, and teachers. The 11 books in the series are as follows:

- *Programming for Aggressive and Violent Students* addresses issues that educators and other professionals face in contending with episodes of violence and aggression in the schools.
- *Abuse and Neglect of Exceptional Children* examines the role of the special educator in dealing with children who are abused and neglected and those with suspected abuse and neglect.
- *Special Health Care in the School* provides a broad-based definition of the population of students with special health needs and discusses their unique educational needs.
- *Homeless and in Need of Special Education* examines the plight of the fastest growing segment of the homeless population, families with children.
- *Hidden Youth: Dropouts from Special Education* addresses the difficulties of comparing and drawing meaning from dropout data prepared by different agencies and examines the characteristics of students and schools that place students at risk for leaving school prematurely.
- *Born Substance Exposed, Educationally Vulnerable* examines what is known about the long-term effects of exposure *in utero* to alcohol and other drugs, as well as the educational implications of those effects.
- *Depression and Suicide: Special Education Students at Risk* reviews the role of school personnel in detecting signs of depression and potential suicide and in taking appropriate action, as well as the role of the school in developing and implementing treatment programs for this population.
- *Language Minority Students with Disabilities* discusses the preparation needed by schools and school personnel to meet the needs of limited-English-proficient students with disabilities.
- *Alcohol and Other Drugs: Use, Abuse, and Disabilities* addresses the issues involved in working with children and adolescents who have disabling conditions and use alcohol and other drugs.
- *Rural, Exceptional, At Risk* examines the unique difficulties of delivering education services to at-risk children and youth with exceptionalities who live in rural areas.

- **Double Jeopardy: Pregnant and Parenting Youth in Special Education** addresses the plight of pregnant teenagers and teenage parents, especially those in special education, and the role of program developers and practitioners in responding to their educational needs.

Background information applicable to the conference strand on juvenile corrections can be found in another publication, *Special Education in Juvenile Corrections*, which is a part of the CEC Mini-Library *Working with Behavioral Disorders*. That publication addresses the demographics of incarcerated youth and promising practices in responding to their needs.

1. Introduction

Teenage pregnancy and parenting places the adolescent and the American educational system in double jeopardy.

An estimated 1 million teenage girls in the United States become pregnant each year. Pregnancy rates for U.S. adolescents are dramatically higher than those of other developed countries (21% compared to 14-15% elsewhere), and abortion and live birth rates are also among the highest in the world (Brindis, 1990). Long-term individual and societal costs are escalating. Pregnant and parenting teens, including adolescent fathers, are at high risk for school dropout, repeated pregnancies during their teen years, increased barriers to employment, and extended welfare dependency. Teenage mothers have a higher incidence of premature delivery and low-birth-weight infants, frequently resulting in developmental delay (Adams, Adams-Taylor, & Pittman, 1989).

Teenage pregnancy places a double burden on the American educational system. On the one hand, the schools strive to provide relevant prevention and/or parenting education for students currently demonstrating special education needs. On the other, they strain to prepare themselves to serve an increasing number of children born to young nondisabled parents who may make up the next generation of special education students. The number of students enrolled in special education nationwide is already rising, with 4.7 million children with disabilities served in special education and early intervention programs during the 1989-1990 school year, the largest 1 year increase since 1980 and a 2.2% increase over the 1988-1989 school year (Dey, 1991).

While statistics are readily available to document the incidence and complexity of teenage pregnancy and parenting in the general population, comparative data are sparse for youths in special education—students who have mental retardation; hearing, visual or speech impairments; serious emotional disturbances; orthopedic disabilities; and other health impairments and those with specific learning disabilities.

Limited documentation of pregnant or parenting teens in special education indicates that the problems of this group of adolescents are similar to, if not greater than, those of the non-special-education student. This may be due in large measure to their increased vulnerability caused by specific factors that hinder learning. There is some evidence to suggest that the percentage of pregnant students in special education may be disproportionately high. Furthermore, pregnancy may be occurring at a slightly younger age among this group than among teenagers in the general population (Kleinfeld & Young, 1989).

Persons with disabilities are often perceived to be asexual (i.e., lacking sexual drives altogether) or incapable, because of their disabilities, of expressing themselves sexually. At the other extreme, they are sometimes considered to be prone to excessive sexual aggression. Disabilities that hinder learning are frequently equated with an inability to comprehend information about basic sexual processes. People who have mental retardation are assumed to have little potential for establishing intimate relationships, including a satisfying and functional marriage (Knight, Bullard, et al., 1980). These and other myths about the sexuality of individuals with disabilities are common, and they contribute to a dearth of opportunities for formalized education and counseling rewarding sexuality as well as normal opportunities for responsible and meaningful sexual expression.

Like everyone else, students in special education are sexual beings from birth to death. They require information and skill-building experiences in order to mature to their full potential. They cannot be expected to make responsible and rewarding choices in this part of their lives or to guard themselves from sexual exploitation without an education that nurtures their self-esteem and their communication and decision-making skills and that provides them with basic information about their sexual selves.

2. Synthesis of Research

Not only does the literature demonstrate similarities of predictors, extent, and consequences of teenage pregnancy and parenting for youths in regular and special education, it also implies increased vulnerability among students in special education.

Teens at Risk

A review of the literature reveals the complex nature of risk factors associated with adolescent pregnancy and parenthood. Social, psychological, and economic factors combine to create a problem that is both serious and challenging. When the dynamic interplay of these factors is examined, it becomes apparent that successful prevention and intervention require a public response that matches the complexity of the problem.

In the mid 1980s, the pregnancy rate per thousand teenagers (ages 15-19) for the United States was 110; for Canada it was 45. The live birth rate for the same age group in the United States was 51 per 1,000, while in Canada it was 23 per 1,000 (Singh & Wulf, 1990). One half of the U.S.

adolescents continued their pregnancies to live birth, and one third of these were girls under 18 years of age. Ten thousand of them were 14 years old and younger (National Center for Health Statistics, 1988).

Among U.S. females aged 15-19, the proportion who had ever had sexual intercourse rose from 47% to 53% between 1982 and 1988. . . . Both the number of births to young women under age twenty and the teen birth rate increased in 1988. Of particular concern is the birth rate among teens aged 15-17, which rose 10% between 1986 and 1988. This increase follows a decade in which the birth rate among teens stayed fairly stable. (Moore, 1990, p. 1)

Contrary to popular belief, teenage pregnancy and parenthood cut across the racial, economic, and ethnic spectrum in every part of the nation. Two thirds of these teen parents are white. Most do not live in large cities or come from poor homes. Nevertheless, youths from disadvantaged and minority group backgrounds are disproportionately represented among teen parents. For example, while African-American teens made up 15% of the adolescent population in this country in 1986, they comprised almost 30% of teenagers giving birth (Pittman & Adams, 1988). In 1984, the fertility rate for white and African-American females aged 15 to 19 was 44.6 and 95.7 per 1,000 respectively. The male fertility rate per thousand for whites was 14.8 per 1,000, and the African-American rate was 41 per 1,000 (National Center for Health Statistics, 1988).

Trussel (1988) cited two primary reasons for adolescent pregnancy: lack of knowledge about pregnancy prevention and failure to anticipate the likelihood of sexual intercourse (and thus the need to use birth control). According to Flick (1984), conscious or unconscious decision making at four critical points results in teenage parenthood. These include the decision to (1) become sexually active, (2) use birth control, (3) continue or terminate the pregnancy, and (4) raise or place the child after birth.

Sexual Activity

Economic status, educational goals and attainment, perceived life options, parental involvement, and familial role models are among the most influential factors associated with adolescent sexual activity. Values of independence and achievement, level of self-esteem, and peer influence are also cited in the literature as factors related to the decision to be sexually active. Sexual activity occurs at a younger age among male and female adolescents living in poverty, teenage girls who have low educational achievement (and girls whose mothers and older sisters had low

educational achievement), and male youths with low educational goals and achievement (Foster, 1986).

Young men and women—white, Black, or Hispanic—with poor basic academic skills are more than three times as likely to be parents as are those with average or better basic academic skills. Furthermore, racial and ethnic differences in rates of early childbearing completely disappear once both family poverty and individual academic skills are taken into account. Regardless of race or ethnicity, 20% of young women with below-average skills from families with below-poverty incomes become parents compared to about 4% of those with average academic skills coming from nonpoor families. (Pittman, 1986, pg. 32)

Family factors are also associated with decision making about sexual activity. Some studies indicate that teenagers with working mothers and from single-parent families may be more like to be sexually active (Flick, 1984). Girls whose older sisters serve as adolescent parental role models, and those who come from large families, appear to be more sexually active, beyond the effects of income and educational status. The extent of sexual activity among male and female teenagers is directly related to the quality of parent-child communication in the home. The more involved parents are in the lives of their teenage children, the less likely are their sons or daughters to be sexually active (Foster, 1986; Paget, 1988).

Contraceptive Use

The decision to use birth control is complex. Age at the onset of sexual activity, family income, and belief in the risks associated with unprotected sexual activity are critical factors. Family- and couple-related communication and the availability of confidential contraceptive services are also important. Adolescents who are older when they initiate sexual activity tend to use birth control more than those who become sexually active at a younger age. Those living in poverty are less likely to continue using birth control than those from families having higher incomes and fathers with higher-status occupations. Young women who have experienced a pregnancy are more likely to use birth control than those who have never conceived (Hofferth, 1987). The average teenage contraceptive user believes that there is an 80% chance of conception during unprotected sexual activity, that contraception is not dependent on luck, and that it will not compromise later fertility (Foster, 1986).

Positive communication between teenage daughters and their mothers and among family members in general leads to an increased use of contraceptives. Adolescent girls who use birth control at the onset of sexual activity more often include their mothers in the contraceptive decision-making process. Partner communication also affects the willingness of teenage girls to use birth control. Those who discuss the use of contraception with their partners before first intercourse are more likely to use birth control throughout the relationship. This is especially true when the girl perceives her partner to be in favor of using birth control (Foster, 1986).

Extended use of contraceptives is more likely among teens who find using birth control convenient. Confidentiality, location, and type of setting contribute to the perception of convenience. Perhaps because of the comfortable, youth-oriented atmosphere, school-based clinic programs appear to be most effective in their efforts to reduce teenage pregnancy (Foster, 1986).

Continuation or Termination of Pregnancy

Girls under the age of 16 who have poor basic academic skills are five times more likely to continue pregnancy to motherhood than those who have average basic skills. Those with poor to fair basic skills are four times more likely to bear more than one child during their teenage years than peers with average basic skills (Children's Defense Fund, 1986). Although a majority of these births are to white adolescents, a teenager from a minority group, especially one who is unmarried, is more likely than a nonminority teenager to continue pregnancy to birth. This can be attributed to the cumulative differences in the decision-making process, including choices about sexual activity, contraceptive use, abortion, and marriage (Adams, Adams-Taylor & Pittman, 1989).

Special Education Teens at Risk

While few studies provide data to substantiate the prevalence of these issues among and their impact on adolescents in special education, the evidence available indicates that the incidence of pregnancy among girls in special education may be higher than would be expected in the general population. Furthermore, the limited research seems to imply a greater number of pregnant teenagers in special education than districts are currently funded to serve (Kleinfeld & Young, 1989).

Of the adolescent girls who participated in the Kleinfeld-Young study, 20% had been special education students (see Public Law 94-142) in San Diego, California. By comparison, only 10% of all students enrolled throughout this school district participated in special education at that time. The study sample was drawn at random from the census tracts

in that county that exhibited the highest number of teenage pregnancies. Of these young women, 55.6% were African-American, 29.6% were Hispanic, 9.5% were white, 3.7% were Indo-Chinese, and 1.5% were Filipino. This demographic breakdown differs dramatically from that of the nation as a whole. As stated previously, two thirds of all teen parents are white.

At the time of intake, 94% of the Kleinfeld sample was unmarried; 13.3% lived with the fathers of their babies; 67.4% lived with their parents; and another 11.9% lived with other relatives. By comparison, in 1988, 65.5% of all women under age 20 who gave birth in the United States were unmarried. Of these young mothers, 30% lived with their husbands, 50% lived with relatives, and an additional 5% lived with husbands and relatives (Moore, 1990).

"Based on chronological age, 97.3% of the Kleinfeld teens would have entered the ninth grade, but only 79.3% had made it that far. . . . Of the total sample, 63.7% had dropped out of school" (Kleinfeld, 1989, p. 36). The mean dropout age for students in special education in this study was 1 year younger than that for participants in regular education. These teens in special education experienced their first pregnancy when slightly younger (15.2 years) than their counterparts in regular education (15.5 years).

While the Kleinfeld and Young study provides limited documentation of pregnancy among students in special education that has not been previously addressed in the literature, and while the findings do suggest an increased risk among these teens, the factors that might contribute to this increased risk were not examined.

Learning Characteristics of Students in Special Education

Students in special education comprise a diverse group of young people with a wide range of abilities and disabilities. As noted previously, problems that hinder learning and qualify an individual for special education are defined in Public Law 94-142. While these students resemble their nondisabled peers in more ways than they differ from them, and their particular needs must be assessed on an individual basis (Shapiro, 1981), it is possible to identify a number of learning characteristics that many, if not all, share to a greater or lesser extent.

Most of these students have difficulty learning as easily and comprehensively as other people. Many do not readily understand concepts presented in the abstract. Often the ability to generalize from experience is absent or greatly reduced. Sometimes this is due to below average intelligence, ranging from mild to profound mental retardation (Kempton, 1988). Often, however, learning impairment is a function of emotional disturbance, a physical disability, or an unspecified disability.

These learning characteristics, together with significant social skill deficits (i.e., poor communication and decision-making skills, a limited socialization repertoire, and low self-esteem), increase the special education student's vulnerability to sexual abuse as well as unwanted pregnancy, premature parenthood, and sexually transmitted disease, including human immunodeficiency virus (HIV).

It is estimated that persons with developmental disabilities (a large percentage of students in special education) are four times more likely than their nondisabled peers to be sexually abused. A majority of abuse (99% of reported incidents) is perpetrated by people known to the victim, not by strangers (Finkelhor, Hard, & Ryerson, cited in Muccigrosso, 1991).

Because of their disabilities, many students in special education live more protected lives than do adolescents without disabilities. This over-protection often heightens the risk of abuse. Lack of knowledge, habitual overcompliance, limited assertiveness, and undifferentiated trusting are frequent by-products of this so-called "protected" lifestyle (Muccigrosso, 1991).

Frequently the following curriculum adaptations enhance the learning of students in special education:

- Simplified but age-appropriate reading materials or media that do not require reading, hearing, vision, or mobility, depending on the specific disability.
- Use of a variety of concrete teaching strategies to reinforce the information presented (e.g. written materials, audiovisual materials, role playing, interactive games, opportunities for practice, etc.).
- Learning strategies that closely approximate real life.
- Opportunities for interaction with nondisabled peers and role models.
- Repeated opportunities for ongoing learning (Kempton, 1988).

Youth In Special Education Need Sex Education

All people are sexual and need to understand this aspect of themselves. "In all areas of life, including the sexual sphere, disabled persons have a great deal in common with their non-disabled peers" (Shapiro, 1981, p. 25).

In describing the needs for sexual learning faced by some adolescents with disabilities, Sol Gordon wrote:

Exceptional children experience the same physical and emotional changes that regular children do, as well as the same anxiety which often accompanies adolescence. Thus, they must cope with all the emotional conflicts of their normal teenage counterparts in addition to those produced by their handicaps. (Shapiro, 1981, pp. 25-26)

Price (1987) declared in support of this position,

They are influenced by the same pressures affecting the sexual decision making of every adolescent and teen, such as peer pressure, movies and television. The differences lie in the [disabled] person's lack of appropriate information about physical and emotional changes of adolescence, sexuality and birth control. (p. 154)

In the last decade, there has been an increase in sensitivity, acknowledgment, and affirmation of the sexual rights of youth and adults with developmental disabilities (Committee on Sexuality, 1975). This has resulted in an increase in the number of new families being headed by individuals with intellectual and physical limitations (Bakley, 1986).

As students in special education are accepted more fully into the mainstream, they are more likely to be affected by the negative influences associated with integration and to suffer the same behavioral consequences as youth without disabilities; early, unwanted pregnancy, premature parenting, and disease. The problems associated with early pregnancies for nondisabled youths are well documented in the literature (Hofferth, 1986; Loomis & Simpson-Brown, 1990). However, little research has been conducted to ascertain whether or not students in special education face similar and/or additional difficulties.

Learning styles may be different for the teen in special education than for the adolescent without disabilities; learning needs, however, are similar, and they may exceed those of the nondisabled teen.

[For special education students, there are] two major contributions made by the knowledge and skills that are gained in effective school based sex education: (a) the life-enhancing opportunities that such knowledge and skills open up to students and (b) the destructive experiences they help students avoid. . . . [Remembering that] the overarching goal of sex education for any student is to achieve a positive, healthy perception of one's own sexuality. . . . the needs of mentally handicapped students for intensive help in developing this sort of self-image surpass the needs of most nonhandicapped students. Poor self esteem, reduced skill in coping with stress

and lower reading levels limit their access to accurate information and make them prey to myths and unreasonable fears. Their most available models for behavior toward the opposite sex tend to come from television commercials and films. (Kempton & Stiggall, 1989, p. 205)

Educational Program Models

Prevention Education

Most professional educators believe it is important for school systems to implement comprehensive K-12 sexuality education programs, with the subject matter and content of the material appropriate to each grade and developmental level. In the earlier grades, sexuality education topics can be integrated into comprehensive health education programs and can help children learn about family relationships, growth and development, self-esteem, and good health habits. These programs can help children begin to identify peer pressure and develop decision-making skills. In the later grades, programs should focus more upon human sexuality, should discuss topics such as birth control methods in greater detail and should provide greater practice in skills. (Kirby & Haffner, 1991)

The National Research Council has supported these recommendations, and further stated that family life education should be culturally sensitive, be coordinated with community services such as family planning and counseling, and include the topics of child development and parenting (Brindis, 1990).

Dryfoos (1990) has maintained that successful pregnancy prevention program models fall primarily into three categories: school curricula, special services in schools, and community-wide multicomponent programs. The model curricula combine an interest in life skills and life planning with instruction in social skills and decision making. Collaborative arrangements are made to bring staff into schools from outside organizations or to provide training for teachers and youth workers on a variety of issues including sexual development.

Education, Training & Research Associates, Inc. (ETR Associates, 1991) has identified four undergirding principles that should be woven throughout sexuality education as intrinsic facets of the learning process: (1) enhancing parental involvement, (2) promoting abstinence from sexual intercourse, (3) creating multiculturally relevant learning experiences, and (4) increasing student self-esteem.

Within the last few years, a practical, concrete, skill-based, sex education curriculum that uses role plays and incorporates refusal skills has been piloted with California teens (Barth, 1989).

The impact of the curriculum was evaluated with an experimental design in which classes of students were randomly assigned and followed for 18 months. The results indicate that among those students who had not yet initiated sex prior to the program, the curriculum significantly reduced unprotected sex, mostly by delaying onset of sexual intercourse, and partially by increasing use of birth control. (D. Kirby, personal communication, May 15, 1991)

Other program models nationwide incorporate additional elements in their designs. Abstinence programs; multitarget models; programs with parent-child involvement, peer education, mentors, or role models; and those that provide comprehensive school-based health services are the most notable. These approaches cluster around two concepts associated with adolescent pregnancy prevention: increasing the life options available to young people and enhancing the decision-making capability of adolescents (Brindis, 1990).

Parenting Education There are various models for parenting education in community settings. While most school districts offer special in-school programs for pregnant and parenting students in regular education, none specific to the needs of students in special education were discovered during an exhaustive search by the authors. Among the most notable of the community-based programs are the following: The Young Moms Program (Catholic Center for Learning, Buffalo), Eastern Nebraska Community Office of Retardation (ENCORE), the YWCA Program for Disabled Teens (New Orleans), the Family Life Support Center (Sonoma, CA), and the UCLA Neuropsychiatric Institute Parenting Program (Los Angeles). The strategies employed by these programs appear in Chapter 3.

Summary

Most of the research to date that addresses teenage pregnancy and parenting has not focused specifically on adolescents in special education. We were able to find only one study that did so, Kleinfeld and Young (1989), the findings of which were reported here. Obviously, data collected about teenage pregnancy and parenthood in national surveys do not identify those adolescents who happen to be served by special education. The failure to do so has both positive and negative effects. It is probably helpful, for the most part, that these teenagers are not labeled

as having disabilities in yet another public arena. On the other hand, it is difficult to ascertain the extent of the problem among youths in special education without such documentation. Furthermore, it is difficult to make the case for needed services without such information.

Nonetheless, it seems appropriate to infer from the literature that adolescents in special education may, indeed, be at greater risk of early pregnancy and parenthood than their peers without disabilities. Learning characteristics of learners with disabilities inhibit their opportunities to acquire and apply relevant and comprehensible information about sexuality and family life. Yet, because of the trend to integrate these students into the mainstream in all areas of their lives, they are increasingly exposed to the same risks as nondisabled adolescents and are less prepared to handle them. It is critical that students with special learning needs receive family life education as part of a comprehensive health education curriculum and that the programs offered to them reflect their particular learning characteristics.

There is a need for more research in this area to determine the extent of the problem of early, unwanted, pregnancy and premature parenting for adolescents in special education. Some questions for future research include the following:

- What factors lead to increased risk of pregnancy among adolescents in special education?
- What are the specific needs of adolescents in special education with regard to family life education and prevention education?
- How are teachers being prepared to teach this subject matter? Is there a need for more teacher training programs?
- What curriculum models are effective and how is this measured?
- How effective are parenting education programs?
- Who are the fathers of the babies born to mothers in special education? (E.g., 46% of the males fathering babies conceived by teenagers in 1984 were over 21 [National Center for Health Statistics, 1988].) Is this trend the same for mothers in special education? If so, there may be implications for stronger education in the prevention of sexual abuse.

3. Implications for Program Development

Program developers, working in concert with a broad-based local team, must address a variety of complex issues in order to create sound family life sex education/prevention programs for students in special education.

Developing a family life education/sex education/prevention program (referred to hereafter in this book as family life education) for students in special education is a large task. For the program developer to meet the particular needs of families, students, and the school district in any subject area is a challenge, but the complexity of this topic raises more emotion and discussion than most others. It requires the utmost sensitivity and a careful, thoughtful approach.

As discussed in Chapter 2, the limited studies available seem to indicate probable increased risks of teenage pregnancy and early parenting to individuals with special learning needs. In addition, and more important, there is considerable documentation that persons with disabilities are at greater risk for sexual abuse and exploitation than are individuals without disabilities. Experts agree that education and training in the prevention of sexual abuse are the best remedies for this problem. Frequently, parents cite this as the primary motivator for requesting that the school develop a family life education program.

While this book focuses on family life education, program developers will do best to place their programs within the context of comprehensive health education, with special emphasis on human sexuality and prevention of abuse.

To develop a sound program, the program developer must take into account the risk factors associated with early pregnancy that are documented in the literature for *all* students, as well as the particular risk factors for students in special education (see Chapter 2). The most prominent risk factors contributing to early pregnancy for all teens are lack of knowledge and failure to anticipate sexual behavior. Other factors that influence early sexual activity include membership in a minority group, low socioeconomic status, limited goals, poor school performance, lack of parental involvement, a low level of self-esteem, limited understanding of consequences, restricted perception of life options, and peer influence.

The complex interplay of these risk factors requires special finesse by the program developer. The educational program cannot merely be an attempt to help the students acquire knowledge (as in most other topic areas); it must assist the students in developing decision-making, communication, and social skills and provide them with opportunities to

enhance self-esteem. Planning a program with so many influencing factors requires slow, methodical steps. The wise program developer will convene a family life education task force composed of a wide range of interested parties including teachers, parents, and local community service agency representatives. This task force may work on the following tasks:

1. Research the problems of teenage pregnancy, noting the risks and listening to recommendations from field experts.
2. Research problems related to significant vulnerability issues for students in special education.
3. Conduct a local needs assessment of the community to determine specific needs and to see what, if any, research applies to this group.
4. Examine successful program models that:
 - a. Promote parental involvement.
 - b. Address flexible learning styles, building on the students' range of cognitive ability, and promote achievement.
 - c. Emphasize strategies to overcome the special vulnerabilities of this student group.
 - d. Concentrate on providing information to the student that is selective, relevant, and presented in concrete terms.
 - e. Create multiculturally relevant learning experiences.
 - f. Increase student self-esteem.
 - g. Combine interest in life skills and life planning.
 - h. Promote abstinence.
 - i. Provide instruction in social skills and decision making.
 - j. Promote learning in community settings (community-based education).
 - k. Include flexible, integrated education settings and support mainstream teachers who provide this education to special education students. (These teachers may require extra assistance in understanding the learning styles of special education students.)
 - l. Provide opportunities for students to recognize the external and internal influences on their behaviors.
 - m. Assist the students in perceiving personal risks.

n. Allow for reinforcement and maintenance of learning (ETR Associates, 1991).

Where possible, providing special services such as health clinics and contraceptive counseling on school sites can enhance the effectiveness of the education program.

Items 1 and 2 are discussed in greater detail later in this chapter under "Family Life Education Programs."

The program may be divided into two parts: (1) family life education program (which incorporates pregnancy, sexually transmitted diseases, and abuse prevention) for *all* students, including students in special education and (2) parenting education program for students who either are parents already or are pregnant. Kirby and Haffner (1991) have suggested that the family life education program is likely to cover topic areas such as sexual development, reproductive health, interpersonal relationships, affection and intimacy, body image, and gender roles. The program is much more than instruction in the anatomy and physiology of reproduction.

Family Life Education Programs

Given the increasing number of students served in special education and the trend in education toward mainstreaming, full inclusion, transitioning, and community-based services, what kind of programs need to be developed? How can our education system best meet the growing and changing needs of the students in special education today? The following steps should be considered in developing a family life education program.

First, the developer needs to assess the overall climate. How do parents, teachers and the general community view sexuality education for students in special education? It is important to keep in mind that while many parents advocate for sex education for their sons and daughters, many others are less than enthusiastic.

Some parents anticipate the social rejection their children may encounter or foresee limited outlets for their expression of sexual feelings. In order to protect their children from disappointment, pain, and frustration, some parents ignore and stifle the sexual curiosity of their offspring in the hopes that an asexual existence will bring less pain. . . . other parents fear that their children will be exploited sexually. (Shapiro, 1981, p. 27)

The community is frequently [another] barrier, seeing the disabled child as a threat and incorrectly believing that the sexuality of persons with disabilities is basically different from

other people, thus not needing information about sexuality, pregnancy and parenting. (Shapiro, 1981, p. 27)

Second, the developer must document the need: The program planner will be wise to begin documenting why a sex education program is necessary locally. "Using needs of individual students as guides, program content must be specifically defined and presentations developed with clarity and sensitivity" (Grosse, 1980, p. 3). Teachers might be asked to respond to a short questionnaire: "Are you seeing signs of sexual curiosity? Are you seeing inappropriate behaviors of a social-sexual nature? How often? What kind of questions do you hear? Assess your students' needs." The developer can suggest that teachers keep track of inappropriate behaviors for a month (anonymously). These are the kinds of incidents that may be corrected by a good sex education class.

It is also valuable to listen to the opinions of the students themselves in designing the program. This may be best accomplished by hosting small discussion meetings, rather than through the written questionnaires that are often used with regular education students. Results from a study titled "Family Life Education Needs of Mentally Disabled Adolescents" (Schultz & Adams, 1987) revealed high interest and a strong unmet need in the following topic areas: (a) the decision to parent, (b) careers and work, (c) marriage and parenthood, (d) decision making, and (e) goal setting. According to Schultz and Adams (1987), "Existing curricula need to consider placing emphasis on these topic areas that generally are not being addressed in programs for this audience" (p. 22).

Third, the developer should build support gradually, starting on a small scale. Virtually *all* parents and teachers share the concerns of personal safety and appropriate, responsible behaviors, and most do not want their sons and daughters to become parents at this time in their lives. A good sex education program starts with these concerns as the basis for its objectives. Starting with points of agreement like these will enhance the acceptability of a program. The developer must make sure that all people know that the intention is not merely to develop a course on reproductive plumbing; rather, it is to be a comprehensive health and well-being class covering topics such as those listed at the end of this section.

Fourth, the developer should convene a curriculum committee to integrate the family life education task force results into a district curriculum and implementation plan. The curriculum committee should be composed of interested teachers (regular education and special education, when appropriate), parents (representing the pro and the con attitudes about sex education), appropriate community agency personnel, ancillary staff, and student representatives.

Fifth, at this first meeting, an expert consultant and/or a video tape should be available to assist in the discussion of this sensitive topic. All

of the issues should be raised, including reports that document the need for such a program. The developer should ask the group for assistance in developing the program and reassure them that they will be assisted in finding training on the best ways to teach these topics. If possible, each member should be allowed to choose the level of participation that is best for him or her (active writer, reviewer, can't attend meetings but want to receive notes, etc.).

Sixth, the developer should have the curriculum committee work on the following tasks:

1. Investigate local and state regulations to ensure compliance.
2. Explore policies of adjacent districts or county offices of education. Develop policy recommendations for the Board of Education.
3. Research existing curricula and teaching materials (both for students in special education and for those in regular education).
4. Attend training programs on how to teach this difficult subject.
5. Explore ways to link with regular education teachers.
6. Explore appropriate community resources.
7. Design a back-to-school night to inform parents.

The developer should not wait until the program is completely designed. Sending or handing out a draft outline of topics and asking for parental input and feedback can build support.

8. Work out some sample individualized education program (IEP) goals and discuss them with selected families.
9. Build a draft of topics, scope, and sequence. Submit it for approval for use as a pilot program. Or, if the group has found a published curriculum guide that is suitable for a wide range of student abilities and fits the group's criteria, then simply purchase this curriculum (It has not been our experience that any one curriculum will do the job; rather, an assemblage of materials and strategies from several different curricula usually proves to be more successful in meeting students' needs.)
10. Pilot the curriculum with an especially needy group (perhaps graduating seniors) and have an enthusiastic, skilled teacher begin. Team teaching, male and female, is ideal.
11. Evaluate the results of the pilot program and make appropriate changes in design.
12. Develop ongoing monitoring and evaluation systems.
13. Acquire schoolboard approval and administrative sanction.

14. Train staff, then implement the program with all appropriate students (Loomis & Simpson-Brown, 1990).

Not all of these steps will be appropriate for all schools or districts. The idea behind them is to involve all the key people and to proceed as thoughtfully and cautiously as possible. The process may take a year, perhaps longer. The exact amount of time it will take depends on many variables (e.g., motivation and energy of committee members, unforeseen obstacles, etc.). The time spent is valuable in building commitment and comfort. (Note: It will be important for the program developer to find funds to support the paid staff's role on this committee.)

The finished program must be comprehensive, broadbased, and relevant to the learning styles and needs of the students to be served. Some of the essential topics include self-esteem, identifying feelings, gender identification, personal safety, socialization skills, private and public behaviors, growth and development, decision making, social and romantic relationships, dating, communication skills, gender roles, anatomy and reproduction, marriage and parenting, birth control, sexually transmitted diseases, HIV/AIDS, community health care, and prevention of exploitation.

Excellent resource materials for teaching sexuality education to *all* students are listed in the Resources section at the end of this book. Remember, the teaching techniques and strategies that are most useful with students in special education will probably *not* be paper and pencil assignments. Rather, materials and strategies such as visual aids, models, role plays, and repetition have proved to be most successful with these concrete learners (Kempton, 1988).

Parenting Programs

While all of the recommendations listed for developing a family life education program would certainly be useful in developing a parenting education program as well, the numbers of parenting teens in special education is so small or underrecorded that it may be impractical in many school districts to develop a special education parenting program. It is more likely that it will be necessary to help the special education student who is a parent to integrate into the district or county parenting education program. Perhaps a special aide will need to attend these classes with the special education student for extra help and assistance. Special attention will be necessary to retain the special education teen who is a parent, because dropout rates are high for this population.

While classroom education is important and offers essential socialization opportunities with other young mothers, in-home, hands-on education is a critical component in successful parenting education. The traditional model in parenting education has been to educate ex-

clusively in the classroom, probably because in-home education is more expensive in the short run. In the long run, the cost to society will be less with effective in-home education. The schools need not be the sole provider of this education. Community agencies and church programs may be called in to assist in a collaborative arrangement.

Many youths served by special education have completed schooling when they become parents. However, this does not mean that they have been prepared for the job of parenthood or that they are developmentally ready to become parents. Mastering the tasks of adolescence seems to extend beyond 20 years of age with many students with disabilities. The special parenting education programs found by these authors are located in community agencies and churches, not in school settings, and there are few of these.

Several notable community-based program models were mentioned in Chapter 2.

The following specific strategies have proved to be successful in these programs:

1. In-home services on a frequent, regular basis.
2. Both parent and child intervention strategies.
3. Simply designed lessons to ensure parent comprehension.
4. Modeling of intervention techniques, with many opportunities for practice until all skills are mastered.
5. Modeling of parent-child interactions by mothers without disabilities.
6. Long-range services beyond infancy.
7. Covering special topics such as the following: discipline, nutrition and food preparation, child development, when and where to access medical care, hygiene, shopping, and money management.
8. Linking other community services to the program. (LaFazia, 1988; Whitman & Accardo, 1990)

ENCOR, of Omaha, Nebraska, has published a parenting curriculum, *The Best Parent I Can Be*, which is useful for helping parents who have mental retardation (see "Resources").

Alternative schools, which typically conduct the public schools' pregnancy and parenting programs, would do well to look at these model programs and strategies for ideas about adapting information on critical parenting skills for learners with special needs.

It is also important to recognize that community support services need education and information about persons with disabilities. Child

Protective Services, the District Attorney's Office, and other such agencies are often uninformed about this population, and this ignorance frequently leads to unnecessary intervention with parents who are in special education. This could be avoided with good, proactive education.

On an encouraging note, departments of education in many parts of the United States have begun to acknowledge the need for parenting education. State coordinators for parenting education are being appointed, and print and film resources are being developed. Linkages are being established with community agencies such as YWCAs and other not-for-profit organizations.

4. Implications for Program Administration

Successful implementation of a family life education program requires administrative involvement and support from the outset.

Successful implementation of a family life education program "is most likely with top administrative support" (Voydanoff & Donnelly, 1990, p. 96). Those responsible for program administration will generally be involved in all of the phases described in Chapter 3, if only to monitor progress. Ultimately, the program administrator is responsible for the following tasks:

1. Ensuring that the family life task force and the curriculum committee include all key players and reflect broadbased representation; their tasks must be clearly stated.
2. Acting as liaison to the school board for program sanction and development of policy, to ensure longevity of the program.
3. Coordinating teacher selection and teacher preparation.
4. Scheduling to ensure program availability to *all* students.
5. Establishing guidelines for purchase and approval of materials.
6. Developing evaluation and monitoring plans for the program.

Teacher Selection

The topics included in family life education programs are not always covered in a teacher's preservice education. Human sexuality, family planning, self-esteem building, and communication and decision-making skills development have been included in the curriculum in teacher preparation colleges in recent years, but this has not always been

the case. Even when teachers have had the opportunity to enroll in such classes, it cannot be assumed that they are ready to teach these topics. At present, there is no credential for teaching family life education. Teachers are certified as being able to teach special education, biology or life sciences, social sciences, home economics, physical education, or health. Probably one of the best questions to ask when trying to decide who should teach the program is, "Which teachers or staff members do the students consult most, confide in most?"

The following attributes, described by Dickman (1982) in *Winning the Battle for Sex Education*, are likely to be found in such a teacher:

- A high degree of empathy and sensitivity, the ability to establish rapport with students, an obvious caring about them and their concerns
- An ability to communicate effectively with young people, beginning with the ability to listen first, and to understand—and speak—their language
- The understanding and restraint not to impose his/her viewpoints and values on students simply because he/she has the authority and the longevity to do so, but rather to act as a catalyst, to help students work through and identify their own values
- Other personal qualities: emotional stability ("unflappability"), patience, flexibility and a sense of humor. (pp. 37–38)

Dickman (1982) went on to suggest that a sex education teacher should have the following characteristics:

- A desire—or at least a willingness—to teach in the program
- A healthy acceptance of his/her own sexuality and of the fact that all humans are sexual from birth
- A lack of embarrassment in discussing sexuality and sexual terms
- The respect and trust, not only of students, but of their parents and the community. (p. 38)

One strategy for discovering teacher interest that has been used in many special education programs is to host an awareness session for all staff during inservice training hours. The topic of this session is family life education for students in special education. A guest expert (perhaps

from a local family planning or health clinic) is invited to speak about the particular needs of these students for clear, direct, and concrete information in this topic area. Resource materials are displayed and teachers are engaged in a dialogue about their concerns. It has been our experience that at least one or two teachers will emerge with stated interest in teaching this topic by the conclusion of such a program.

While flexibility in staffing is more important with this topic than with any other (Dickman, 1982), many staffing configurations have been successful, depending on the physical settings and the needs of the students. In some schools, one team (male-female, if possible) or an individual teacher provides the program to all the students on a rotation basis, with other staff covering the teacher's regular classes. Other schools use the primary teacher and supplement with guest experts for certain topics that are difficult for that teacher.

One school district developed the system of mainstreaming all the students in special education into a family life program for the students in regular education. Most of the teaching strategies used required students to read and write. The students with disabilities were not engaged in learning; they showed boredom to the point of disruption. After the family life classes were concluded, these students returned to their special education homeroom class without follow-up plans. After taking a course in family life education for learners in special education, the curriculum coordinator recommended an important change to the district: The core special education teacher should teach family life education to his or her students, using special materials designed to enhance learning with this group. The students could also continue to attend the mainstream family life education classes; this is good for social interactions. Students who took both classes found them to be a successful combination (Muccigrosso, personal interview with Alum Rock School District teacher, 1991).

A final word regarding teacher selection: Teachers who do not want to teach family life classes should not be forced to do so, because they do not perform well when unmotivated or uncomfortable with the topic. Sometimes after a training course reluctant teachers become more comfortable and willing, sometimes not. Administrators must be cautious with teacher assignments for this sensitive topic area. A teacher who is truly uncomfortable with the topic will not do a good job of educating the students and may cause political problems for the administrator.

Teacher Preparation

Preparing teachers to provide sex education to students in special education can be accomplished in a variety of ways. Training courses are frequently made available by family planning agencies, health clinic

staff, and community or state colleges. Hiring private or public consultants or employing skilled resource specialists to offer inservice training is another way to accomplish this goal. Education, Training and Research Associates, Inc. (ETR), in Santa Cruz, California; Stiggall & Associates in Los Gatos, California, and the Moonstone Group in Yorktown Heights, New York, offer teacher training courses. The Committee on Sexuality, based in Danville, California, offers annual symposia on this topic. Winifred Kempton of Haverford, Pennsylvania, is well known as an expert in this area. Courses seem to be more available in larger communities, so teachers in smaller communities may have to travel.

Whichever of these training opportunities is chosen, administrator support for staff development is critical to the success of the program. Administrators should stay involved and let the teachers know that they are behind them (Compton, Duncan, & Hruska, 1987).

Some schools have used coaching or modeling as a second step after the teachers have received basic family life education training. A consultant sits with a teacher and plans the lessons, carefully selecting from approved materials and following the guidelines appropriate to the setting. The consultant may also assist with Parent Night, helping the teacher present the materials to the families. Then the consultant teaches several classes with the teacher present as an assistant. Gradually, the consultant moves into the assistant role and the teacher assumes increasing responsibility for teaching the class independently. An advantage of this training method is that the consultant is able to monitor teacher progress and comfort and provide feedback to the teacher at the conclusion of each class. This coaching process may extend over a 5- or 6-week period, and it serves to build comfort and confidence in the teacher. Other teachers are allowed to come in to observe, with permission. This modeling phase seems to ensure longevity of the program because it builds commitment (Bonin & Stiggall, 1989; Renslow & Muccigrosso, 1991). Other schools have assigned to this topic a mentor teacher who is responsible for the preparation of other teachers and works much in the same way as the consultant.

Family life education is best offered to students in group settings. When students are assigned to a resource specialist, (i.e., "pulled out" for certain aspects of education), we recommend that the specialist sit in the classroom during the family life instruction and then offer individual tutoring to the special education student afterwards. Offering this instruction strictly on a one-to-one basis heightens the student's self-consciousness and does not allow for social interaction which is critical to the student's growth (Stiggall, 1989).

Administrators can also show their support by encouraging teachers to develop a support network with other family life education teachers in the community. Teachers who offer family life education

frequently express a sense of isolation; colleagues often tease them. This intensifies the need for support and collaboration with other family life educators. District-wide distribution of a list describing each program or the particular expertise of each instructor would be helpful. The support network can serve as a problem-solving group and provide an opportunity for teachers to learn about new teaching strategies and materials. Periodic, continued staff training opportunities should also be scheduled. Updated information in various topic areas such as HIV/AIDS, STDs, and contraception is essential.

Student Access to Family Life Education

The important concept for administration is that *each* student be offered the opportunity for this critical education. There are a variety of rules, regulations, and laws governing the offering of family life courses across the country. Administrators must be knowledgeable about relevant governing regulations and ensure that their programs are in compliance.

Many families and teachers are using the IEP process to ensure access to appropriate family life education. The administrator should make sure that the social-sexual domain is automatically considered along with other domains during each student's IEP meeting. This may mean advocating for change. Using the IEP process clearly sets up the possibility for individual student evaluation.

However the system works, students and their families must be offered this education. A rotation system is one procedure that makes it possible to teach students in homogeneous groups. The California School for the Blind has set up a system in which students with similar skills and of similar ages get together once a week for family life education. The family life teacher may or may not be the students' primary teacher. A comfortable spot other than the classroom is selected as a site for these classes. This helps set the tone for a relevant, sharing class that is not heavily academic in content (Renslow & Muccigrosso, 1991). If students from special education classes are mainstreamed into a regular family life course, it is important to make sure that the materials and techniques used are appropriate for them.

Monitoring and Evaluation

Much has been published about evaluation of family life education programs for adolescents. Of particular note is the publication *Evaluating Your Adolescent Pregnancy Prevention Program: How to Get Started* (Philiber, 1989). The importance of "selling" the need for evaluation and accountability should not be underestimated. Teachers are frequently intimidated by required evaluations, perhaps because many evaluation tools have been designed without specific programs in mind. The cur-

riculum committee (described in Chapter 3) may be able to customize an evaluation so that it accurately measures program effectiveness and some teachers on the committee may need help in writing measurable, achievable objectives.

When teachers understand that evaluative data provide the information required by funding sources, in addition to helping them design the most effective program possible, their cooperation tends to be greater. Providing opportunities for parents, teachers, and students to evaluate the program will enhance continued commitment, in addition to giving the administrator needed information about certain parts of the program that need strengthening, revision, or deletion.

Parenting Programs

Administrators who host parenting programs on site have additional tasks. They must ensure that pregnant or parenting teens in special education are accepted, accommodated, and offered appropriate education that is relevant to their individual learning style and needs. It may be necessary to purchase special materials, employ part-time aides, and provide special training for the teachers in these programs.

5. Implications for Teachers

Teachers' knowledge of the topic, assessment skills, mastery of a variety of teaching strategies, and access to support networks contribute to the success of family life education programs.

It is important for teachers to understand that the sensitive nature of family life education may make it difficult for families to request the inclusion of this topic in their child's educational program. Teachers should not wait for parents to ask; they should initiate conversation in a way that encourages mutual exchange of concerns.

What Teachers Need to Know

Teachers need to know the learners' characteristics and learning styles. This may be easier for special education teachers dealing with one classroom of several students with disabilities than for regular classroom teachers who have students from special education mainstreamed into their classes on a periodic basis. Optimally, teachers will find a way to adapt materials to accommodate the particular needs of students in special education. This may require that an instructional aide or helper be in

the class to provide extra assistance to students with special needs. Many paper-and-pencil activities are adaptable to small-group or large-group discussion, a strategy that may be more meaningful for most students, whether they are in special or regular education.

The teachers need to decide what to teach. Much of this decision depends on the student, the age, the setting, and the teacher. Teachers who have taught dozens of groups of learners with special needs have said that they *always* begin by assessing the group's learning styles and needs before planning the lessons. Just as there is no one perfect curriculum guide, there is no one perfect way to teach. Kempton (1988) has suggested that the instruction be practical, lively, and not grim. In most instances, it is best to use the IEP to establish goals and objectives for a specific student. Having students help select the topics assists the teacher in setting group objectives (Stiggall, 1989). Teachers' creativity in developing ways to constantly assess student learning and adapt materials is key.

Developing Lesson Plans and Curriculum Materials

It is not likely that one curriculum will suit the wide range of students' needs. Instead, teachers must assess particular students' needs and draw from the list of approved curriculum materials established by the curriculum committee and school board to develop their lesson plans.

Assessment

Assessment (pre-, ongoing, and post-) is a critical feature of a good family life education program. There are several published assessment tools listed in the "Resources" section at the end of the book. Systematic assessment to establish appropriate goals and objectives for each student can ensure the use of appropriate intervention techniques, materials, and curricula; indicate the need for modification of curricula; encourage individual growth as well as long-term, generalized learning; and stimulate planning of appropriate follow-up activities.

Categories of assessment include the student's (a) current and past living situation, (b) social skill development, (c) basic knowledge of sexuality facts, (d) current and future opportunities to express himself or herself sexually, (e) level of independence and decision making, and (f) receptive and expressive communication skills. Family life education for students in special education focuses strongly on the empowerment of the individual and the prevention of sexual exploitation; it is important to assess what makes each individual vulnerable to exploitation (Scavarda & Simons, 1990). It is also important to consider age-appropriate social skills, level of experience, understanding of what exploitation is, relationships with authority figures, ability to generalize from one situation to

another, physical disabilities, affect, and assertiveness (Scavarda & Simons, 1990).

Techniques for assessment include pre- and posttests (administered orally 1:1 when appropriate); interviews with students, families, and other significantly involved people; group discussion; observation; review of records; role play; and fieldtesting.

Pacing the Lessons: the Scarborough Method

The Scarborough teaching method (Scarborough, 1975, cited in Kempton, 1988) has particular relevance. Designed originally for use in classes of students with mental retardation, this approach has logical applications for *all* students. The figure shown in the appendix to this book illustrates the simple mechanics of the Scarborough method, which begins with specific and basic concepts and then moves outward as far as the individual is capable. Since many students in regular education are already familiar with basic concepts and their applications in health, self-care, and social behavior, these are often taken for granted by the teacher who is eager to move past the practical issues to values, philosophical issues, and ethical concerns. By keeping in mind the diagram of Scarborough's teaching method, teachers will ascertain each student's level of concept comprehension so that individualized instruction, peer support, repeated examples, or additional teaching materials can be used to encourage ongoing learning and integration of new information by students with special needs (Shapiro, 1981).

There are several important rules of thumb to follow in conducting classes:

1. Be flexible. If the students have a particular event on their minds (maybe someone's aunt or sister has just had a baby) and the teacher has planned to teach a topic that will not capitalize on their interest, the teacher should wait, if possible, and teach the prepared lesson at another time.
2. Take advantage of the teachable moments.
3. Be askable! It is also important to maintain a sense of humor and to be creative.

Teaching Techniques and Strategies

Following is a list of some of the most effective teaching techniques, strategies, and materials:

1. Draw out what the students already know (or think they know). This is important for correcting myths and misinformation, and it

provides indicators of how much time to spend on each topic. Do not pump in information; use the drawing-out method instead. For instance, show a picture of a boy or girl and ask the student what they see. Ask them to describe how they know the picture is of a boy or a girl. Do this instead of introducing the picture by saying, "This is a picture of a boy [or girl]." Or, ask the students to help make a list of all the questions they have about sexuality; draw their ideas out. This gives the students a sense of power in the class (a self-esteem booster), and it provides a way to constantly stay in touch with their interests and needs (Kempton, 1988).

2. Establish ground rules to make it safe to talk about sexuality as a topic. Methods for establishing ground rules can be found in many of the curricula listed in the "Resource" section. Examples of ground rules include (a) No put downs; (b) Don't share other students' comments with others on the school grounds; (c) Everyone can pass; (d) No private stories; (e) Show respect for one another; and (f) All questions are good questions.
3. Agree on commonly understood vocabulary to use in class. "Doctor words," or simple clinical words are preferable to street vocabulary. This does not mean street slang will never be heard in class, but it provides a mechanism for redirecting to more acceptable terminology. Teach language discrimination, when possible. Help the students decide when they may use less formal terms.
4. Use visual aids such as models, dolls, puppets, videos, and slides. The slide series "Life Horizons I and II" is an excellent teaching aid (see "Resources"). Slides have the advantage of being edited easily so that inappropriate photos are deleted. Also, the teacher can pace the presentation based on student feedback. Videos are effective for students with mild disabilities. Make sure these are not out of date or out of style!
5. Create opportunities for role play or dramatic play. This reinforces learning, as well as being enjoyable. Students may need some help (teacher modeling) to get started, but the method is effective for assessing learning (Kempton & Stiggall, 1989).
6. Incorporate group discussions and cooperative learning groups. Some students can read better than others. Have a reader read the problem and the whole group work together to solve it. This is good practice for life.
7. Field testing is sometimes a good way to evaluate learning. The teacher needs to know the basics for setting up field tests and should

involve the families when possible. The use of field testing is demonstrated in the film *Street Safe* (Stiggall, 1986) (see "Resources").

8. Be as concrete as possible. Demonstrate. Illustrate. Check the students' learning to see whether or not you need to find another way to teach. Use a variety of materials to teach the same concepts.
9. Repeat and repeat, with sensitivity, being careful not to insult the students' dignity. Check learning by asking for feedback. ("I'm not sure I described that clearly; could you tell me back what you heard me say?")
10. When possible, have coeducational groups. Demonstrate that it is acceptable to talk about this topic with both genders. Depending on the age of the students, it may be a good idea to offer one or two sessions with just same-sex students.
11. Team teach, male and female whenever possible. If this is not possible, try to have as a guest speaker someone of the opposite gender, for balance and modeling.
12. Start with topics that are comfortable to you and the students. It is not necessary to start with reproductive anatomy. The topics of self-esteem, communication, decision making, gender roles, and friendship skills should come before reproductive anatomy and birth control. Beginning with these topics allows time for building trust and safety within the group, ingredients that will enhance the effectiveness of teaching the more sensitive topics.

PLISSIT Model

Because sex education is such a sensitive area, there may be times when a student's question or behavior falls beyond the realm of the classroom teacher. A model developed by Jack Anon, called the PLISSIT model, may be helpful in discriminating teacher parameters and determining when it is time to refer to a counseling expert. This is a conceptual scheme for differentiating and treating sexual problems and concerns that might respond to sex education or possibly brief sex therapy from problems that would require more intensive psychotherapy. It outlines four levels of intervention:

- | | |
|----|----------------------|
| P | Permission |
| LI | Limited Information |
| SS | Specific Suggestions |
| IT | Intensive Therapy |

Permission. Some potential problems can be eliminated simply by giving permission. People need to know they are normal in their sexuality. "All girls have periods. It's normal and part of being a girl. It means you are growing up and that's exciting!" (Maksym, 1990, p. 109). This level may be helpful for relieving anxiety over sexual thoughts, fantasies, and arousal (Kempton, 1988).

Limited Information Keep it simple. "Some bleeding comes from the vagina each month. It comes from the uterus inside the girl's body" (Maksym, 1990, p. 110). This is helpful for dispelling myths and concerns about genital size and masturbation (Kempton, 1988).

Specific Suggestions. "This is how we take care of ourselves when we're having a period. See? Watch what I do. [Demonstrate on a plastic model.] Now you try." "Having a period is a private thing. You can talk about it just with Mom or your teacher, or your good friend. Not to people on the bus, or people you don't know" (Maksym, 1990, p. 110).

Intensive Therapy. You will not use this level unless you have been trained in both the physical and psychological aspects of human sexuality and disability. It is at this level that most instructors would refer students to certified professionals.

Other Suggestions for Teachers

As was discussed in Chapter 3, it is strongly recommended that family life teachers who work with adolescents in special education develop a support network of parents and other teachers who are involved in this work. This keeps teachers fresh, provides them with new ideas, and offers opportunities to problem solve with colleagues. When there are troubles, a teacher has a peer group with which to discuss and develop solutions. In California there is a group called The Committee on Sexuality: Advocating for Persons with Developmental Disabilities. In New York there is the Sexuality and Disability Coalition. Both groups were formed in response to the need for networking.

Use community resources! Call upon local health departments and family planning clinics for presentations and/or consultations. Invite staff from rape crisis centers, HIV/AIDS clinics, police departments, and women's or men's counseling clinics to assist in bridging the school-community gap. (Know and follow your administration's policy for inviting guest speakers.)

Teachers are asked to do an enormous amount of work. Theirs is sometimes an overwhelming and thankless job. It is not always possible to see the long-range impact teachers have on their students. This may be especially true for the students in special education.

6. Implications for Administrators

Administrative support for family life education programs includes responsibility for policy, teacher education and support, collaboration with parents and community agencies, budgeting, evaluation, and monitoring.

Administrators are the persons to whom the proverbial buck is finally passed—the persons who will be held accountable to the school board. The program has been adopted and is in place. Chapter 4 dealt with implications for program development administration. This chapter discusses implications for the administrator of an already established program. The following is a list of concerns the administrator must address:

1. *District Policy.* If there is a district policy regarding sex education, pregnancy prevention programs, or family life education, it is the administrator's responsibility to see that it is carried out consistently and that appropriate revisions to the policy are adopted by the school board in a timely manner. Working with the board and key staff to update the policy so that it reflects your current program will serve as a legacy if you terminate your relationship with the program. It will also protect you on the issue of liability. Your policy should include a statement of philosophy, the policy itself, definitions of terms, guidelines for implementation, and evaluation mechanisms. A brief history of the process used to develop the policy, as well as a description of persons and organizations instrumental in its development, provides a useful companion document. Such documents have many advantages: They demonstrate your thoughtful process, showing how inclusion of all groups transpired, thereby making lawsuits unlikely. A strong policy will help you avoid unfavorable publicity, and it will be a clear and reassuring message to parents. Be sure that you obtain legal advice and counsel as the policy is developed.
2. *Ongoing education for teaching staff.* There is a need for continuing education for the teachers who are providing family life education. Support their knowledge base and teaching skills by referring them to appropriate training programs. Find ways to improve the program's sensitivity to multicultural issues, young men's issues, and issues for gay and lesbian youth. These are three areas that are frequently neglected (Abbey, 1991). Support other teachers' interest in becoming involved in this education.

3. *Support for networking.* Teachers of family life courses are isolated, usually without peer support. Provide an opportunity for them to network with other teachers from outlying districts and with community service providers. This will enhance their ability to teach the students. New strategies and problem-solving opportunities keep teachers motivated, in spite of the lack of support or weak support they may feel in their home schools.
4. *Collaboration.* Develop a way for regular education and special education teachers to collaborate. This becomes more and more critical as the population of students in special education increases and is more fully integrated. Improved communication and shared responsibilities among teachers will enhance the students' opportunities to receive a relevant, meaningful education.
5. *Scheduling.* Assist teachers in finding ways to team teach—male and female whenever possible—through rotation systems, innovative scheduling and the like, to maximize participation of all students.
6. *Working partnerships with community agencies.* Letters of agreement with appropriate community agencies can enhance the program. Community services will be an integral part of the students' lives. Help bridge the gap between the school and the community by bringing appropriate community service representatives on campus to meet and talk with the students. This helps both classroom teachers and students. It also helps the agencies to stay current with student needs and interest.
7. *Parent involvement.* Reach out sincerely to parents. Involve them in program development and monitoring. Have them help with other parents who may not express any interest or who are opposed to family life education. Offer education in selected topics to parents. (Parents often worry about sex education because they do not feel knowledgeable enough on this subject.) Provide food and child care for evening meetings.
8. *Budget.* Be sure that there is money budgeted for acquisition of current teaching materials and audiovisual aids. Students are likely to laugh a teacher right out of the classroom when they see films that are 15 years old! This does not make for good learning in this topic area. Current, high-quality teaching materials can offer positive models for students.
9. *Evaluation and monitoring.* Be sure that your evaluation mechanism is ongoing and can provide you with the information you need. Consult experts, if necessary, to make these workable tools. Include

only measurable objectives. This may mean that you will need to beef up staffing to assist in this important process.

10. *Title IX regulations.* Remember, Title IX of the 1972 Education Amendments mandates equitable treatment (e.g., a special education student can attend regular education pregnancy programs).
11. *Staff release time.* Give your staff time to attend inservice training sessions and support meetings.
12. *Belief in the program.* Maintain your sense of humor and the belief that this is important life education for the students. The students might not ever have such a positive way to receive this clear, direct, and important information outside of the school setting. Give yourself a pat on the back for offering this critical program to your students.

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Resources

Teaching Resource Materials: Social-Sexual Education for Students and Adults with Disabilities

Compiled by Lynne Muccigrosso

Comprehensive Curriculum Programs

Being Me. Sexuality guide for individuals with developmental disabilities by J. Edwards & S. Wapnick (1981). Ednick Communications, Box 3612, Portland, OR 97208.

Education for Adulthood. (1987). Elizabeth Pouch Center for Special People, 657 Castleton Avenue, New York, NY 10301. Cost: \$50.00 + \$4.00 handling.

Family Education Program Manual: A Curriculum and Training Manual for Teaching Sexuality, Self-Esteem and Abuse Prevention to Students with Developmental and Learning Disabilities, Katherine Simpson, Ed. The Family Stress Center, 2086 Commerce Avenue, Concord, CA 94520. 415-827-0212. Cost: \$40.00.

Family Life Education: Curriculum Guide (Rev. ed.), edited by Steven Bignell (1980). Not for special education but many activities adaptable. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.

Family Life Education: Resources for the Elementary Classroom, by L. Despelder & A. Strickland (1982). Not for special education, but adaptable. Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830.

Family Life Education: Special Education. (1991). Breakdown of goals and objectives for all age groups of special education, divided by students with mild to more severe disabilities. Not matched with teaching activities or lesson plans. Virginia Department of Education, P. O. Box 6-Q, Richmond, VA 23216-2060.

Family Life/Health Education: A Special Education Curriculum for the Developmentally Delayed. (1988). Los Angeles County Office of Education, Room 104A, ECE 9300 East Imperial Highway, Downey, CA 90242, Attn: Ray Guillame. Cost: \$24.00 + tax. 213-923-2413.

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- Feeling Free. Sexuality guide for individuals with disabilities* by J. Edwards & S. Wapnic (1982). Ednick Communications, Box 3612, Portland, OR 97208.
- Health Education Curriculum.* (1989). Irvine Unified School District, 5050 Barranca Parkway, Irvine, CA 92714, Attn: Liz Krogdsdale. Cost: \$25.00.
- Human Sexuality: Values and Choices* by J. Forliti et al. (1986). Not for the special learner, but a good junior high program paired with videotapes—adaptable with many special groups. The Search Institute, 122 West Franklin, Suite 525, Minneapolis, MN 55404.
- Life Horizons Vols. 1 and 2,* by Winifred Kempton (1990). 12 parts, with 1,000 slides to counsel and teach socialization and sexuality to students who have developmental and learning disabilities. James Stanfield Publishing Co., P. O. Box 41058, Santa Barbara, CA 93140. 800-421-6534 for catalog.
- Life Planning Education: A Youth Development Program.* (1985). Not designed for special education, but a practical, good program; adaptations possible. This curriculum focuses on two important tasks teens face: preparing for the world of work and dealing with their sexual and reproductive development, feelings, and behaviors. Center for Population Options, 1025 Vermont Avenue NW, Suite 210, Washington, DC 20005. Cost: \$35.00 + 15% handling.
- Parent Education Workbook for Mainstreamed Students.* (1985). Contemporary Parenting Choices Module 4, Iowa State University Press, Ames, IA 50010.
- Personal Development and Sexuality: A Curriculum Guide for the Developmentally Disabled* by Planned Parenthood (1978; rev. ed. 1983). 813 South K Street, #200, Tacoma, WA 98405.
- Personal Growth and Development* by D. Lippin & D. Randall (1986). 12-58 Edward Street, Fair Lawn, NJ 07410. Cost: \$17.00.
- The PET Project, Sexuality/Human Development Curriculum* by Susan Thompson (1988). 2231 D Via Esmarca, Oceanside, CA 92054. Cost: \$50.00.
- Sexuality Education: A Curriculum for Adolescents* by P. Wilson & D. Kirby (1984). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Sex Education Teacher's Guide* by S. Bignell (1982). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Socialization and Sex Education: The Life Horizons Curriculum Module* by G. Rodriguez & C. Birch (1991). (Companion to the *Life Horizons* series.) James Stanfield Co., P. O. Box 41058, Santa Barbara, CA 93140. 800-421-6534.

Specialized Curriculum Programs

- Being with People* (1990), a social skills training program featuring videomodeling by the New Eticats. A funny, very effective teaching aide for friendship and dating skills. James Stanfield Publishing Co., P. O. Box 41058, Santa Barbara, CA 93140. 800-421-6534.
- Changes in You*. Curriculum and booklets about puberty for girls and boys by Peggy Siegel (1991). Beautifully illustrated, simply worded explanations of the changes. Family Life Education Associates, P. O. Box 7466, Richmond, VA 23221.
- Circles I: Intimacy and Relationships* (1983); *Circles II: Stop Abuse* (1986); *Circles III: Safer Ways* (communicable disease, including HIV/AIDS) (1988) by L. Walker-Hirsch & M. Champagne. James Stanfield Publishing Co., P. O. Box 41058, Santa Barbara, CA 93140. 800-421-6534.
- The Dating Skills Program: Teaching Social-Sexual Skills to Adults with Mental Retardation* by D. Valenti-Hein & K. Mueser (1990). International Diagnostic Systems, 15127 South 73rd Avenue, Orland Park, IL 60462.
- Entering Adolescence*. A series of curriculum books in the Contemporary Health Series (1988-1991) focusing on a variety of family life topics for the middle school student. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Family Life Education: Homework for Parents and Teens* by Nancy Abbey. (1984). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Families in Touch Series* (1991). For parents and children 5-15, in Spanish and English. Series of booklets to foster communication between parents and children; includes Teacher's Guides. Parents in Touch Project, 343 Dodge Avenue, Evanston, IL 60202.
- Into Adulthood* A series in the Contemporary Health Series (1988-1991) for the older student. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Life Facts I: Sexuality* (1989, 1990) and *II: Abuse Prevention* (1990). James Stanfield Publishing Co., P. O. Box 41 58, Santa Barbara, CA 93140. 800-241-6534. Curriculum and large black and white drawings, laminated. Cost: \$199 ea.
- Preventing Sexual Abuse* by Carol Plummer (1984). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Preventing Sexual Abuse of Persons with Disabilities* by Bonnie O'Day (1984). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830. 800-421-6534

- Positive Images* by Peggy Brick & Carolyn Cooperman (1987). Planned Parenthood of Bergen County, New Jersey. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Postponing Sexual Involvement: An Educational Series for Young People* by Marion A. Howard. (1983). Atlanta, GA: Grady Memorial Hospital.
- Reducing the Risk: Building Skills to Prevent Pregnancy* by Richard Barth. (1989). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- SAFE: Stopping AIDS Through Functional Education*, by Judith Hylton (1990). Includes lessons, video segments and more. CDC Publications, CDR/OHSU, P. O. Box 574, Portland, OR 97207-0574. Cost \$60.00.
- Sexual Abuse and Self-Protection*. (1980). Good curriculum with film and audiotape. Seattle Rape Relief Developmental Disabilities Project, 1825 South Jackson, Suite 102, Seattle, WA 98144. 206-325-5531. Cost: \$495 per kit; individual parts available.
- Sexual Abuse Prevention: Five Safety Rules for Persons Who Are Mentally Handicapped* [video and guide]. Agency for Instructional Technology, Box A, Bloomington, IN 47402. 800-457-4509. Cost: \$180.00.
- Sexuality Education for Persons with Severe Developmental Disabilities*, by B. Brekke (1988). Slides and curriculum guide. Very simple. James Stanfield Publishing Co., P. O. Box 41058, Santa Barbara, CA 93140. 800-421-6534.
- Take Charge of Your Life* by The Salvation Army Booth Memorial Center (1988). A workbook for teens or young adults. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome* by M. Quackenbush & P. Sargent (1990). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Teaching Safer Sex* by Peggy Brick, et al. (1990). Planned Parenthood of Bergen County, New Jersey. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- The Woodrow Project* (1986). Sexual abuse curriculum, manual and videotape. Rape & Abuse Crisis Center of Fargo-Moorhead, P. O. Box 2984, Fargo, ND 58108. 701-293-7273. Cost: \$99.95.
- The Woodvale Sexuality Assessment with companion Curriculum Guide* (1989). Woodvale Management Services, P. O. Box 1047, Austin, MN 55912. 507-433-7301. Cost: \$165.

Visual Aids:

Jackson Pelvic Models. 33 Richards Avenue, Cambridge, MA 02140. 617-864-9036.

Life-Sized Instructional Charts. Planned Parenthood of Minnesota, 1965 Ford Parkway, St. Paul, MN 55116. Cost: about \$65.00.

Portfolio: Human Sexuality for the Mentally Retarded (1974). Large illustrations on 11 x 17 plate cards. The back of each card has suggestions for the educator. Planned Parenthood of Seattle-King Company, 2211 East Madison, Seattle, WA 98112. Cost: about \$25.00.

SOCIAL L.I.F.E Game by Dorothy Griffiths et al. for teaching functional social competency. York Management Services, York Central Hospital, Richmond Hill, Ontario, Canada L4C 4Z3.

Teach-a-Bodies. Instructional Dolls, whole families. June Harnest, 3509 Acorn Run, Fort Worth, TX 76109. 817-923-2380.

Victoria House Dolls. Anatomically correct dolls (adult-like). Victoria House, P. O. Box 663, Forestville, CA 95436.

Audiovisual Aids for Use with Parents or for Staff Development Programs

Board and Care. Academy award winning documentary video showing the romance between two people who have Down syndrome. Pyramid Film Co., P. O. Box 1048, Santa Monica, CA 90406.

Learning to Talk About Sex When You'd Rather Not [video]. Good for bringing up the topic with parents and staff. Special Purpose Films, 416 Rio del Mar, Aptos, CA 95003. 408-688-6320.

Street Safe and You Have the Right to Say No. Videos designed to help staff learn how to teach self-protection skills. Special Purpose Films, 416 Rio del Mar, Aptos, CA 95003. 408-688-6320.

This Child Is Mine by Winter Shumacher. Video documentary about mothers with mental retardation. University of California Extension, Media Center, 2176 Shattuck Avenue, Berkeley, CA 94704.

Who's in Control? Video about socialized vulnerability. Planned Parenthood of Sacramento Co., 1507 21st Street, Sacramento, CA 95811.

Audiovisual Aids for Use with Student Groups

Birth Control: Myths & Methods. Churchill Films, 12210 Nebraska Avenue, Los Angeles, CA 90025-9816. 800-852-9818.

- Boy Stuff** (19 min. video). Hygiene and puberty concerns for boys; humor. Animation and live action. Churchill Films, 12210 Nebraska Avenue, Los Angeles, CA 90025-9816. 800-852-9818.
- First Things First** (30 min. video). Story of a teenage couple deciding to wait, delaying sex until they are both ready. Good discussion for gender roles, communication and peer pressure. Bill Wadsworth Productions, 1913 West 37th Street, Austin, TX 78731.
- He's No Hero**. Young men's issues. Snappy music. Intermedia, 1300 Dexter N., Seattle, WA 98109-9974.
- Human Growth IV, Adolescent Development**. Churchill Films, 12210 Nebraska Avenue, Los Angeles, CA 90025-9816. 800-852-9818.
- It Only Takes Once**. Danitra Vance of Saturday Night Live is a positive African-American role model. Real-life teen parents speak to how unplanned pregnancy alters life plans and dispels romantic myths about parenting. Intermedia, 1300 Dexter N., Seattle, WA 98109-9974.
- Smart Talk** (13 min.). (1988). Designed to trigger discussion among 12-14 year olds about sexually transmitted disease. Intermedia, 1300 Dexter N., Seattle, WA 98109-9974.
- Teen AIDS in Focus** (16 mins.). San Francisco Department of Public Health, AIDS Prevention Program, 25 Van Ness Avenue, San Francisco, CA 94102. 415-554-9000. Cost: \$89.00 for nonprofit organizations.
- 3-2-1 Contact Special: I have AIDS, Ryan White**. Available from Media Center, Santa Clara County Office of Education. Can be reproduced.

Articles, Books, and Reference Materials

- "AIDS Education for Individuals with Developmental, Learning or Mental Disabilities" by Lynne Stiggall. (1988). In M. Quackenbush, M. Nelson, & K. Clark (Eds.), *The AIDS Challenge: Prevention Education for Young People*. Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Building Self-Esteem in Persons with Developmental Disabilities*, by Roger Frank & Jean Edwards (1988). Ednick Communications, Box 3612, Portland, OR 97208.
- Changing Inappropriate Sexual Behavior*, by D. Griffiths, V. Quinsey & D. Hingsburger (1989). Paul H. Brookes, Baltimore, MD 21285-0624.
- Disability, Sexuality, and Abuse: An Annotated Bibliography* by D. Sobsey et al. (1991). Paul H. Brookes, Baltimore, MD 21285.

- Does AIDS Hurt?* by M. Quackenbush & S. Villarreal. (1988). Suggestions for teachers, parents and other care providers of children to age 10 (can be used for many older special education students). Network Publications, P. O. Box 1830, Santa Cruz, CA, 95061-1830.
- An Easy Guide to Loving Carefully* by W. Kempton, L. McKee, & L. Stiggall (1987). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Family Life Education Curriculum Guidelines*. (1990). The National Council on Family Relations, Minneapolis, MN 55421.
- Family Life/Sex Education Guidelines* (1987). Publications Sales, P. O. Box 271, Sacramento, CA 95082-0271. Cost: \$4.00.
- I Contact, Sexuality, and People with Developmental Disabilities* by D. Hingsburger (1990). Vida Publications, P. O. Box 587, Mountville, PA 17554.
- 100 Ways to Enhance Self-Concept in the Classroom* by J. Canfield & H. Wells (1976). Network Publications, P. O. Box 1830, Santa Cruz, CA 95061-1830.
- Sex Education and Counseling of Special Groups* by W. Johnson & W. Kempton (1981). Charles C Thomas, 2600 South 1st Street, Springfield, IL 62717.
- "Sex Education for Persons Who Are Mentally Handicapped" by W. Kempton & L. Stiggall. (1989). In *Sexuality Education: Theory into Practice*, 18(3), Summer, 1989. College of Education, University of Ohio, 174 Arps Hall, 1945 North High Street, Columbus, OH 43210.
- Sexual Assault: A Survivor's Handbook for People with Developmental Disabilities: Book I* (1985), for people who read best with few words; *Book II* (1985), for people with disabilities and their advocates; and *Book III* (1986), for family members, advocates, and care providers, by Nora Baladerian. Mental Health Consultants, P. O. Box T, Culver City, CA 90230-1690. 213-391-2420. \$20 ea.
- "Sexual Abuse Prevention Strategies and Programs for Persons with Developmental Disabilities" by L. Muccigrosso. (1991). *Journal of Sexuality and Disability*, 9(3).
- Sexuality and the Developmentally Handicapped* by W. Rowe & S. Savage (1987). Edwin Mellen Press, Box 450, Lewiston, NY 14092.
- Shared Feelings: A Parent Guide to Sexuality Education for Children, Teenagers and Young Adults Who Have a Mental Handicap: Discussion Guide to Shared Feelings*. (1989). The G. Allan Roehrer Institute, Downsview, Ontario. Cost: \$16.00 each for book & discussion guide.
- Talking with Your Child About Sex* by Mary Calderone & James Ramey. (1982). Random House, New York.

A Teacher's Guide: Sex Education for Persons with Disabilities That Hinder Learning by W. Kempton (1988). James Stanfield Publishing Co., P.O. Box 41058, Santa Barbara, CA 93140. 800-421-6534.

The Universal Childbirth Picture Book by Fran Hosken. (1988). Women's International Network News, 187 Grant Street, Lexington, MA 02173.

Vulnerable: Sexual Abuse and People with an Intellectual Handicap by Charlene Senn. G. Allan Roehrer Institute, Kinsman Building, York University, 4700 Keele Street, Downsview, Ontario. 416-661-9611.

When a Parent Is Mentally Retarded by B. Whitman & P. Accardo. (1990). Paul H. Brookes, Baltimore, MD 21285.

For good, free resources

California Comprehensive Health Education Resource Center, 321 Wallace Avenue, Vallejo, CA 94590. 707-557-1592. Catalog available.

Family Life Educator by Mary Nelson & Kay Clark. Santa Cruz, CA, National Family Life Education Network. Quarterly publication that surveys and summarizes the latest information on family life content areas.

Nonprint Resources

Cantalician Center for Learning, 3233 Main Street, Buffalo, New York 14214.

Committee on Sexuality: Advocating for Persons with Developmental Disabilities, P. O. Box 2608, Danville, CA 94526.

Eastern Nebraska Community Office of Retardation (ENCOR), 885 South 72nd Street, Omaha, NE 68114. 402-444-6500.

Education, Training, & Research Associates, Inc., P. O. Box 1830, Santa Cruz, CA 95061-1830. 408-438-4060.

Winifred Kempton, 3300 Darby Road, C-4404, Haverford, PA 19041.

The Moonstone Group, RD 1, Box 37, Yorktown Heights, NY 10598.

New Orleans YWCA, Teen Pregnancy Prevention, 601 South Jefferson Davis Parkway, New Orleans, LA 70119. 504-482-YWCA.

New York Sexuality and Disability Coalition, 122 East 23rd Street, NY 10010.

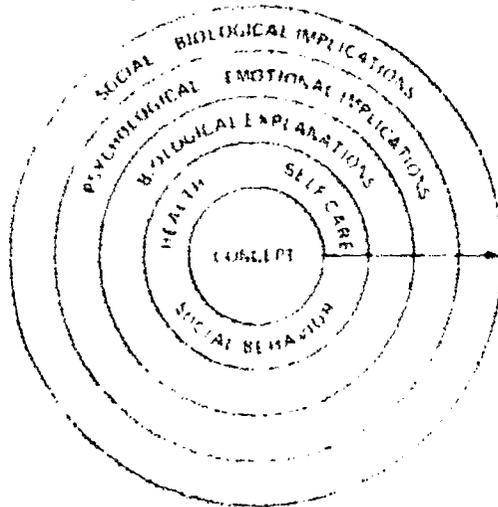
Stiggall & Associates, 21450 Bear Creek Road, Los Gatos, CA 95030.

Appendix: Description of the Scarborough Principle¹

The concept of teaching sex education to the mentally handicapped should begin with the specific and simple, and move outward as far as the individual can go. For example, in explaining the menses, one should begin with the simple teaching of health and self-care, such as changing the sanitary napkin in order to keep the body clean and free of odors. Also to guide her sense of emotional and social security, a girl should be taught that the menses are natural and are not to be feared or dreaded. However, if the student is capable of understanding more, she should be taught the correct social behavior when menstruating and what others expect of her; for example, she shouldn't lift her dress to show that she is menstruating or call attention to it verbally. Boys and girls of still higher intelligence should be taught some of the simple biological aspects of the menses.

The teacher should initiate the explanation at a level best understood by the students, where they may be expected to develop appropriate behavioral responses. This technique may be applied to many areas of human sexuality, always beginning with personal identity and self-care and moving outward to embrace a broader scope of maleness or femaleness. When applicable, instruction may extend to more complex topics or issues dealing with social or psychological aspects.

Following is a graphic illustration of this concept. One begins with the immediate needs of the individual and moves outward in relation to the complexity of the concept and the ability of the individual to grasp it.



¹This concept and the accompanying figure were described by Mrs. Willie Scarborough of the Chicago Public Schools at the Institute on Retardation and Sexuality, December 3 & 4, 1971, Philadelphia, PA, in a presentation titled "Sexuality and the Retarded." Reprinted by permission from Kempton (1988), pp. 101-103. Copyright 1988 by W. Kempton.

CEC Mini-Library

Exceptional Children at Risk

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