Understanding and Promoting Parent-Child Sexual Health Communication

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Digital Object Identifier: https://doi.org/10.13023/ETD.2017.464

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Shannon Phelps, Student
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Dr. Margaret Bausch, Director of Graduate Studies
Understanding and Promoting Parent-Child Sexual Health Communication

_____________________________________________________

DISSERTATION

_____________________________________________________

A dissertation submitted in partial fulfillment of the
Requirements for the degree of Doctor of Philosophy in the
College of Education at the University of Kentucky

By

Shannon Phelps

Winchester, Kentucky

Director: Dr. Kristen P. Mark, Associate Professor of Health Promotion

Lexington, Kentucky

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ABSTRACT OF DISSERTATION

UNDERSTANDING AND PROMOTING PARENT-CHILD SEXUAL HEALTH COMMUNICATION

Parent-child sexual health communication (PCSHC) can have a positive impact on adolescents’ sexual health choices, outcomes, and capabilities for communicating with others about sexual health. Many parents are hesitant and feel unprepared for and uncomfortable with communicating about sexual health with their children. Other parental factors as well as child factors can impact the quality, frequency, coverage, and effectiveness of PCSHC. Some adolescent sexual health outcomes have improved, however, teen birth rates in the United States are elevated compared to other developed countries and half of all sexually transmitted infection (STI) diagnoses are made to adolescents and emerging adults. This emphasizes the importance of PCSHC as a protective factor for children and opportunity for them to develop understanding and skills for good sexual health decision-making. While challenging to recruit and retain participants, parent sex education programming designed to promote PCSHC can instill a sense of parental necessity and responsibility, and equip parents with knowledge and skills to confidently and successfully engage their children.

The theory of planned behavior (TPB) provided the framework for this mixed methods study designed to learn more about PCSHC, differences in PCSHC based on gender of children, parental beliefs about PCSHC, intentions for and actual engagement in PCSHC. Included in the literature review for this study is a systematic review of literature focused on parent education programming designed to improve PCSHC. Parents of children in grades 4 – 11 completed a pencil/paper or an electronic Qualtrics baseline survey containing questions about their perceptions of and engagement in PCSHC. The quantitative data collection instrument included items measuring TPB constructs of behavioral, normative, and control beliefs, intentions for and actual engagement in PCSHC and condom use instruction delivery, communication openness,
communication ability, sexual health topics discussed with children, and respondents’ demographics. Many of the respondents (N = 205) were residents of the program target community, Winchester/Clark County, Kentucky, and were eligible to participate in parent programming, as were all residents that were parents of children in grades 4 – 11. The program, *I’ll Have a Side of Sex Education*, was designed as a six-week series of 50 minute lunch time sessions with the intention to improve parents’ sense of comfort, confidence, and skills in communicating with their children in general, and particularly about sexual health. Of the 205 parents who completed the baseline survey, 50 enrolled in and attended some or all of one of five offerings of the six-week parent education series and were invited to complete a post-program and six-week follow up surveys. Post-program data were collected with a paper-pencil survey and six-week follow up data were collected with a Qualtrics survey.

The systematic review of parent sex education literature provided insight into components of programming related to successful program delivery and positive parental outcomes. The systematic analysis of the baseline data including examining PCSHC factors from the parental perspective and how these related to the gender of children and determining the usefulness of the TPB constructs for understanding PCSHC. Results of Chi-square tests of mean differences showed a significant difference in parents actually providing their children with instructions for correct condom usage, $\chi^2 (2, N = 203) = 6.96, p = 0.03$, and MANOVA results revealed the degree to which parents address certain sexual health topics with their children related to the gender of their children. Results of logistic regression showed behavioral beliefs having the greatest predictive power of parents’ intentions to give condom use instructions ($p < 0.01$) and actual delivery of condom use instructions ($p = 0.04$) and engagement in PCSHC, generally ($p = 0.03$).

The current study contributes to the greater body of literature addressing parental and child factors related to the promotion, delivery, and effectiveness of PCSHC and parent education programming designed to improve the quality, frequency, and impact of PCSHC. Its findings expand our understanding of how gender of children and parental beliefs relate to PCSHC and lend themselves to the consideration of the greater social influences impacting parents’ ability and motivation to engage their children in communication about sexual health. Differences in communication based on gender of children signal to a double standard in the messaging about sexual health and behaviors related to gender and these discrepancies leave adolescents and emerging adults, both males and females, vulnerable at worst to poor sexual health choices and outcomes and at least to being undereducated about sexual health topics. Although these findings give little support for the overall TPB model contributing to the understanding of parental intentions and behavior related PCSHC, the relationship between behavioral beliefs informed by attitudes about the value of PCSHC and parental intentions and behaviors does provide insight to health promoters and educators. Assessing parental attitudes toward PCSHC and tailoring messages and educational opportunities that may improve these attitudes and motivate parents to engage in and seek support for effective PCSHC holds promise. The piloting of a parent education program adapted from a previously evaluated parent sex education programming and the summative evaluation offered by
participants gives support for efforts on the part of health promotion and education professionals to invest time, energy, and resources into program design and delivery and recruitment and retention of parents.

KEYWORDS: Parenting, Sexual Health Communication, Theory of Planned Behavior, Program Planning, Adult Education
UNDERSTANDING AND PROMOTING PARENT-CHILD SEXUAL HEALTH COMMUNICATION

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12-15-17
I dedicate this dissertation to my late father, Jim Lynch. His adoration, love, emotional support, confidence in my abilities, and patronage of my academic pursuits enabled this great achievement.
ACKNOWLEDGMENTS

I am grateful to and for the following people who have offered opportunity, wisdom, guidance, time, consideration, love, support, and good humor throughout this process.

Thank you to Dr. Kristen Mark whose intelligence, determination, and great expectations have provided me the opportunity to learn, broaden my skill set, think more deeply, expand my reach, and elevate my own professional standards.

Thank you to Dr. Melody Noland for serving as my co-chair and supporting Dr. Mark’s advisement of my process. I am grateful for your kind reception of my presence in the department. Thank you to Dr. Melinda Ickes and Dr. Fred Danner for your willingness to serve on my committee and the provisions of positive encouragement and critical feedback.

Thank you to the Clark County Community Foundation and the Bluegrass Community Foundation for generously funding this study and programming. Your investment in this study has and will continue to serve as an investment in the health and well-being of families in Winchester/Clark County.

Thank you to Julie Maruskin and the Clark County Public Library, Brenda Considine and the Clark County Public Schools, the Clark Regional Medical Center, and Clark County Community Services for your support and willingness to help me recruit and engage community members.

Thank you to Dr. Martha Beagle, Dr. Jan Blythe, the Health and Human Performance faculty, and the Berea College community for your trust and confidence in
my abilities, gifts, and determination. A special offering of gratitude to the late Kelly Ambrose whose invitation brought me back to Berea College, once more.

Thank you to all of my brothers and sisters by blood, law, and choice. Your names are too many to list but know that each of you has impacted me in ways that contribute to this accomplishment, my sanity, and my overall success in life.

Thank you to Jeff, Peter, and James. I feel like this is your accomplishment too. I am unsure that I will ever be able to properly convey my gratitude to you for your endurance, patience, love, and support. I hope you are inspired to believe you are capable of great achievements with intention, commitment, determination, and hard work.

Thank you to my mother. You are my rock. You are my inspiration. Through your modeling and instruction, I work hard, stand tall, and love fiercely. I could not have completed this without all of your many offerings of support, prayers, encouragement, and love.
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Chapter 1

Background

While some adolescent sexual health outcomes are improving and teen birth rates are decreasing in the United States, these teen birth rates are higher than most industrialized countries around the world (SIECUS, n.d. b). Adolescents and young adults, ages 15 – 24, account for only a quarter of the sexually active population in the U.S., yet they are diagnosed with nearly half of sexually transmitted infections each year (Guttmacher, 2014). In 2015, teen birth rates in Kentucky had dropped to an all time low since 2005 from 47 births per 1,000 females, ages 15 – 19, (HHS, 2014) to 32.4 (The National Campaign, 2017), but remained higher than the national rate of 20.3 (The National Campaign, 2017). Worse, Clark County, Kentucky teen birthrate in 2015 was 46.2, higher than all other counties surrounding and including Fayette County (Kentucky State Data Center, 2017).

Although many parents struggle to communicate with their children about sexual topics and encourage their children to ask sexuality-related questions (Byers, Sears, & Weaver, 2008), parent-child sexual health communication (PCSHC) is positively related with adolescent risk reduction behaviors and attitudes (DiClemente et al., 2001; Guilamo-Ramos, Jaccard, Dittus, & Collins, 2008; Salazer et al., 2005; Troth & Peterson, 2000). Conversely, those adolescents who do not receive sexuality and sexual health education from their parents are generally at greater risk for negative sexual health outcomes (Crosby, Hanson, & Rager, 2009). A number of factors impact PCSHC including parents’ level of religiosity (DiIorio et al., 2000; Farringdon, Holgate, McIntryre, & Bulsara, 2014; Villarruel et al., 2008) and gender of children (DiIorio et al., 2000; Schouten, van
den Putte, Pasmans, & Meeuwesen, 2007; Wilson & Koo, 2010). Additionally, as children grow older, parents may be more inclined to educate them about sexuality and sexual health (Byers et al., 2008).

Parents in Winchester/Clark County, Kentucky may be providing their children with sexuality and sexual health information, as parents are often cited as a primary source of sexual health information among adolescents (Bleakley, Hennessy, Fishbein, & Jordan, 2009; Donaldson, Secor-Turner, Seiving, Eisenburg, & Skay, 2011; Schouten, van den Putte, & Meeuwesen, 2007). However, considering the poor adolescent sexual health outcomes in this geographical location there is support for learning more about PCSHC and components of sexuality education programming that can increase the frequency, quality, and effectiveness of parent-child sexual communication.

**Purpose**

Promoting PCSHC and providing parents with the knowledge and skills to become better and more active communicators with their children can lead to improved sexual health outcomes for young people in the United States, including Winchester/Clark County, Kentucky. Examining the many aspects of PCSHC is of interest for the promotion of adolescent health, as PCSHC is strongly associated with the engagement of risk reduction behaviors on the part of adolescents (DiClemente et al., 2001; Guilamo-Ramos et al., 2008; Salazer et al., 2005; Troth & Peterson, 2000; Widman et al., 2017). The purpose of this study was to learn more about PCSHC, parental factors that impact it, its relationship to gender of children, the predictive power of a theoretical model relating to parental intentions to and actions of PCSHC, and a variety of components of parent sexuality education programming that have positively and
productively impacted PCSHC. Learning more about PCSHC provides insight and
guidance for its promotion and the parent education planning process.

This study also sought to address the need for parent education and PCSHC with a
pilot of *I’ll Have a Side of Sex Ed*, a lunchtime learning program for Winchester/Clark
County parents of children in grades 4 – 11. The program was an adaptation of a worksite
wellness program (Schuster et al. 2008), intended to prepare parents as their children’s
primary sexuality educators and promote parent-child communication. The overall goals
of the program were to increase frequency and quality of PCSHC, improve parents’
comfort and confidence in PCSHC, increase openness of sexual communication between
parents and their children, and increase condom use instruction between parent and child.

The study is structured with the framework the theory of planned behavior (TPB)
(Ajzen, 1991), with the parent-extension of the theory of planned behavior (PETPB)
(Hutchinson & Wood, 2007). The expanded framework acknowledges that parent
initiated PCSHC can positively impact adolescent beliefs, intentions, and actual
behaviors, but also takes into equal consideration the parental beliefs and intentions that
can promote or impede the engagement of PCSHC on the part of parents. While the
PETPB is at the foundation of this study, it only considers factors that impact parental
intentions and behaviors, not those of children. Parental behavioral, normative, and
control beliefs about and intentions to engage, and actual engagement in PCSHC are TPB
constructs examined in this study.
Research Questions and Associated Hypotheses

Manuscript 1

(Q1) Are parental behavioral, normative, and control beliefs related to gender of child(ren)?

(H1a) Parent behavioral beliefs will differ significantly based on gender of children.

(H1b) Parent normative beliefs will differ significantly based on gender of children.

(H1c) Parent control beliefs will differ significantly based on gender of children.

(Q2) Is there a difference in the number of sexual topics discussed related to gender of child(ren)?

(H2) Parent participants will discuss significantly more sexual topics with daughters than sons.

(Q3) Is there a difference in the specific topics of discussion discussed related to gender of child(ren)?

(H3) There will be a significance difference in the specific topics discussed with children based on gender of children.

(Q4) Are parental self-ratings of communication ability and quality related to gender of child(ren)?

(H3a) Self-ratings of parent communication ability will be significantly different based on gender of their children.

(Q5) Are there differences in communication openness between parents and children based on gender of children?
(H4) Parent communication openness of parent will be significantly different based on the gender of child(ren).

(Q6) Are there differences in the intention to give condom use instructions related to gender of child(ren)?

(H5) Intentions to give condom use instructions to children will be significantly different based on gender of child(ren).

Manuscript 2

(Q7) To what extent do parents’ behavioral, normative, and perceived behavioral control beliefs predict intentions to initiate PCSHC?

(H7) Parents’ intention to initiate PCSHC will be significantly different based on behavioral, normative, and perceived behavioral control beliefs.

(Q8) To what extent do parents’ behavioral, normative, and perceived behavioral control beliefs predict actual PCSHC behavior?

(H8) Parents’ actual PCSHC will be significantly different based on behavioral, normative, and perceived behavioral control beliefs.

(Q9) To what extent do parents’ behavioral, normative, and perceived behavioral control beliefs predict intentions to instruct children how to use a condom?

(H9) Parents’ intention to give condom instructions will be significantly different based on behavioral, normative, and perceived behavioral control beliefs.

(Q10) To what extent do parents’ behavioral, normative, and perceived behavioral control beliefs predict parents’ actual condom instruction to children?

(H10) Parents’ actual condom instruction will be significantly different based on behavioral, normative, and perceived behavioral control beliefs.
Manuscript 3

The purpose of a systematic review of the literature was to gain a better understanding of the components and effectiveness of parent sex education programming. Questions guiding the review included:

(Q11) What program design features are included in parent sex education programming?
(Q12) What teaching methodologies are included in effective parent education programming?
(Q13) What theoretical frameworks and constructs are foundational to parent sex education programming?
(Q14) What parental outcomes are associated with or resulting from participating in parent sex education programming?
(Q15) What incentives are associated with higher enrollment, attendance, and participation in parent sex education programming?

Significance to the Study of Health Promotion

Within the framework of health promotion, health education endeavors seek to provide individuals with awareness, information, instruction, and the opportunity to develop confidence and skills for the purposes of better health and quality of life; sexuality education is no exception in this pursuit. With the sensitivity, discomfort, and confusion the U.S. cultural collective seems to feels about sexuality in general, and sexuality education for young people especially, (Byers et al., 2008) the parenting population is likely made up of many under and ill-educated individuals when it comes to sexual health knowledge and practices. Because many contemporary parents were not effectively educated about sexual health themselves, they may not be willing, prepared,
or confident enough to educate their own children (Byers et al., 2008; Eastman et al., 2005; Guilamo-Ramos et al., 2008; Woody et al., 2005), despite sexual health as an important lifelong component of one’s overall health. Parent sexuality education programs provide a re-education opportunity for parents, so they can be informed educators for their children. Potential benefits to individuals and families include increasing parent-child communication, providing parents with peer support for navigating this uncomfortable but necessary aspect of parenting, increasing knowledge while building skills, advocating for more community education and communication, and striving for better sexual health outcomes for youth (Guilamo-Ramos et al., 2008; Eastman et al., 2005).

**Theoretical Framework**

The most meaningful and solid explorations of health behaviors, attitudes, and intentions are grounded in theory. This study contributes to the literature addressing the theory-practice relationship and aims to provide further support and evidence of the soundness of the TPB. In its original conception as an extension of the theory of reasoned action (TRA) (Ajzen, 2012), the theory of planned behavior (TPB) (Ajzen, 1991) presented by Ajzen and colleagues is one that focuses on individuals’ intentions to engage in a behavior as informed by one’s beliefs regarding the performance of the behavior, others’ perceptions of one’s performance of the behavior, and perception of control over the behavior, as well as one’s actual control over the behavior (Ajzen, n.d.). Components of the TPB include behavioral beliefs determined by attitudes toward the behavior, normative beliefs determined by subjective norms, or beliefs that one holds about relevant others’ support or disapproval of the behavior, and control beliefs
determined by one’s perception of his/her control over changing the behavior. Attitude toward a behavior regards the determination of whether performance of the behavior is valued as positive or negative. Subjective norm refers to one’s perception of the social acceptability of a behavior and social pressure to engage in or abstain from a behavior. Perceived behavioral control speaks to one’s perception that he/she is capable of performing a behavior and has power over those factors that may enable or deter engagement in the behavior. Additionally, actual behavioral control as determined by skills and resources needed to actually perform the behavior are included in the model. Effective engagement in a behavior is not only dependent upon intentions but actual behavioral control (Ajzen, n.d.).

At the foundation of the TPB is the expectation that intention to engage in a behavior leads to actual performance of the behavior and intentions and behaviors are the result of the interaction of model components (Glanz, Lewis, & Rimer, 1997). The TPB has been used to predict a variety of health behavior changes including substance abuse treatment completion (Zemore & Ajzen, 2014), increased physical activity (French et al., 2005), and parenting intentions, including fathers’ involvement intentions (Perry & Langley, 2013), mothers’ intentions to vaccinate daughters against HPV (Askelson et al., 2010), and PCSHC (Burack, 2013; Schouten et al., 2007). See Figure 1.1 for a TPB diagram.

Hutchinson and Wood (2007) propose an expanded TPB to emphasize the influence and impact parents have on adolescents’ sexual risk attitudes, intentions, and behaviors and termed it the parent-based expansion of the theory of planned behavior (PETPB). The components of the original TPB are included to predict adolescent
engagement and intentions to engage in sexual risk behaviors as informed by their behavioral, normative, and control beliefs. The expansion to this model includes external influences of parent-child sexual communication on the adolescent derived from the added parent-based TPB components and initial external influences on the parent (Hutchinson & Wood, 2007). See Figure 1.2 for PETPB diagram.

Parent-based expansion of the theory of planned behavior is proposed as the theoretical framework to guide and support the program planning, delivery, and evaluation of the proposed study. Participation in parent sexuality education programming serves as the external influence on parents, which can impact parents’ behavioral, normative, and control beliefs. Planning and providing parents with educational experiences that promote positive attitudes toward the outcome of parent-child communication can impact behavioral beliefs. Bringing parents together for the purpose of learning and social support and providing them with information from individuals and groups they can trust can serve to present parent-child sexuality communication as socially acceptable and desirable, thereby impacting normative beliefs. Facilitating parents’ increase in knowledge of sexuality topics and sexual health and communication skills development functions to influence control beliefs and promote the perception that parents are capable of effectively communicating with their children about sexuality and impact their children’s behaviors positively.

**Delimitations**

Delimitations are the conscious choices a researcher makes about the literature review, methodologies, and study population to create boundaries for a study (Baltimore County Public Schools, 2010). The literature review of this study did not include
information about and evaluation of sexual health education programming for children and teens or parent education programming that is a smaller component of sexual health education programming designed primarily for children and/or teens. While it would allow for a connection between parent behavior and child behavior, the study did not ask for data from children/adolescents or related to children/adolescents’ sexual health behaviors. Asking sensitive questions of teens about their own behaviors might prohibit families from participating in the study with its primary focus of examining parent perceptions, intentions, and behaviors. While recruitment efforts were extended to online respondents, not limited by geography, recruitment attempts for the parent education intervention were limited to Winchester/Clark County residents as stipulated in the grant agreement with the funder of the study. The decision was made to provide a choice of survey completion, either online or using written hard copy to ensure the greatest amount of participation with the greatest amount of ease.

Limitations

Limitations are those aspects of a study that are out of the control of the researcher and can impact the methods, analysis, and conclusions of the study (Baltimore County Public Schools, 2010). Recruiting program participants was challenging because of the nature of the topic, schedule restraints, lack of interest, time commitments, and the requirement of being a resident of Winchester/Clark County. Only 35.6% of residents both work and live in Winchester/Clark County (KY Cabinet for Economic Development, n.d.) and as the program was intended as a lunchtime offering, only those living, working, and taking a traditional 12 – 1pm lunch break could be recruited and enrolled. As a result, one program series was offered on Saturday and two were offered in
the evenings. In order to gather more parent data, a convenience sample of online
respondents not limited by funding specifications completed an electronic version of the
survey. While it provided a bigger picture of PCSHC, expanding the recruitment region
may have introduced a shift in the parent perspective that moves away from reflecting
that of the population targeted for programming.

The findings from the baseline survey are not generalizable for a number of
reasons. Sampling techniques for both survey respondents and program participants were
non-random and convenience based. Nearly 65% (n = 129) of the individuals that
completed the survey were from Kentucky, with over 50% (n = 108) respondents from
Winchester/Clark County. However, because one of the most effective recruitment
techniques for program participation with baseline survey completion was word-of-
mouth, the sample is mostly homogenous and not entirely representative of the
Winchester/Clark County community.

Data were cross sectional and collected with a self-reporting tool. With all self-
reported data there is the threat of socially desirable responses, where a participant offers
the answer he/she thinks the researcher wants versus responding truthfully. Participants
uncomfortable with sexuality related topics and/or self-conscious about parenting may be
even more apt to provide socially desirable responses. Additional consideration needs to
be given to the sensitive nature of the data collected from participants, the qualities and
characteristic of those willing to answer questions about sexuality, and how difference in
those willing to participate and those not willing potentially skews the data.

As was expected, the majority of subjects identified as female and mothers. With
so few father participating, data analysis by gender of parents was unavailable. Without
the voice of fathers in research about PCSHC we are left to wonder where fathers are in this arena or worse, make assumptions that they are not active and present in the enactment of PCSHC. Fathers’ engagement in and experience with PCSHC continues to be a gap in the literature.

**Definition of Terms**

The following terms and their definitions were used in the current study:

**Sexual health** – the degree to which one is well in relation to sexuality (WHO, 2017); sexual health promotion includes education about sexual behaviors and preventative measures to avoid STIs and unintended pregnancy but also information about healthy relationships, sexual identity, and ways to make good sexual decisions for one’s self.

**Sexuality topics** – content related but not limited to sexual development, sexual behaviors, risk reduction behaviors, sexual identity, sexual pleasure. See Table 1.1 for a list of sexuality topics used in this study.

**Parent child sexual health communication (PCSHC)** – verbal exchanges between parent and child related to sexuality and sexual health. Includes but is not limited to communication about anatomy/physiology of reproductive systems, puberty, relationships, and risk reduction.

**Pre-adolescents** – children, ages 9 to 11

**Early adolescents** – children, ages 12 - 14

**Late Adolescents** – children, ages 15 - 17

**Emerging adults** – people, ages 19 - 25

**Behavioral beliefs** – personal views that link behavior to expected positive or negative outcome, which creates an attitude toward behavior (Ajzen, n.d.).
Normative beliefs – one’s perception of the behavioral expectations that important, valued individuals and groups have for him/her that contribute to subject norm (Ajzen, n.d.).

Subjective norm – made up of one’s normative beliefs and one’s motivation to comply with the perceived social pressures to or not to engage in behaviors (Ajzen, n.d.).

Control beliefs – perception of the existence of factors that can impact behavioral performance; these perceived factors can promote or hinder behaviors (Ajzen, n.d.).

Perceived behavioral control – made up of control beliefs and perceived power of each factor that can contribute to or hinder the enactment of a behavior; this may represent actual control therefore can be used as a predictor for behavior (Ajzen, n.d.).

Actual behavior control – having skills, resources, and other fundamentals needed to perform a behavior; successful enactment of behavior is dependent on actual behavioral control, not just favorable intentions (Ajzen, n.d.).

Intention – precedes actual behavior; indicator of readiness to perform behavior (Ajzen, n.d.).

Religiosity – quality and quantity of religious beliefs, observances, and activities (Manlove, 2008).

Conclusion

Parents influence many of their children’s behaviors and beliefs, including those related to sexuality and sexual health, and while it is important to examine the influence of parents on children, of equal importance is understanding that which influences parents’ behaviors and beliefs. While parents themselves may have been under or poorly educated in the area of sexuality and sexual health this does not excuse their
responsibilities of enabling their own children to make informed and wise choices regarding sexual health and grow into being sexually healthy adults. The key to any healthy relationship is communication. This study sought to understand PCSHC from the parents’ perspective, how parental beliefs and characteristics impact PCSHC intentions and behaviors, and how children’s characteristics relate to parents’ enactment of PCSHC. Parent sex education holds promise of increasing parental comfort and confidence in their abilities to engage in PCSHC and raising their awareness to the necessity of PCSHC as a protective factor for their children’s health. Further, this study included consideration of components and qualities of parent sex education programming designed for increasing initiation, frequency, and quality of PCSHC.

The parent-based expansion of the theory of planned behavior (PETPB) served as the theoretical framework for this study, guiding design, research questions and hypothesis, and providing constructs to operationalize for the purposes of better understanding parents’ intentions for and behaviors enacting communicating with their children about sexuality and sexual health. Sexual health outcomes for Winchester/Clark County adolescents reflect a need for additional and innovative approaches to sexual health promotion and education.
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<th>Table 1.1</th>
<th>Sexuality Topics</th>
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<td>how boys’ bodies change physically as they grow up</td>
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<td>what do to if your partner does not want to use a condom</td>
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<td>the importance of not pressuring other people to engage in sexual behaviors, reasons why people like to have sex</td>
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<td>reasons why you should not have sex</td>
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<td>how will you know if you are in love</td>
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<td>how to say no if someone want to engage in sexual behaviors with you and you don’t want to.</td>
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<td>how boys’ bodies change physically as they grow up</td>
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Figure 1.1 The theory of planned behavior diagram

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Figure 1.2 Parent-Based Expansion of the Theory of Planned Behavior (Hutchinson & Wood, 2007)
CHAPTER 2

LITERATURE REVIEW

The purpose of this review is to consider and examine existing literature regarding the potential impact of parent-child sexual health communication (PCSHC) on adolescent health, the application of the theory of planned behavior in the area of PCSHC, parental, child, and communication qualities that are related to PCSHC and those that serve as a deterrent for PCSHC, and strategies for the promotion of PCSHC and parent sex education programming. The review was conducted in databases including ERIC (U.S. Dept. of Education), MEDLINE/PubMed (NLM), ProQuest Dissertation & Theses: Global, ProQuest Education Journals, Proquest Social Science Journals, EBSCOhost Academic Search Complete, EBSCOhost CINAHL with Full Text, EBSCOhost Psychology and Behavioral Science Collection, Science Digest Journals, American Public Health Association, SAGE Complete, and PubMed Central article selection was limited to, with few exception, publication dates between 2005 – 2016. Additional online sources were included at the discretion of the PI including those from reputable health-related institutions and organizations. Search terms included a combination of the follow words and terms: parent, child, sexuality, sexual health, communication, adult, education, programming, intervention, HIV, prevention, risk, reduction, adolescent, gender, age, religion, religiosity, barriers, and strategies.

Background

About half of all high school students in the United States are sexually active (National Campaign, 2015b). While some adolescent sexual health outcomes in the United States are improving, teen pregnancy rates are higher than most industrialized
countries around the world (SIECUS, n.d.). While adolescents and young adults, ages 15 to 24, account for only a quarter of the sexually active population in the U.S., they are diagnosed with nearly half of sexually transmitted infections each year (Guttmacher, 2014). Roughly half of all pregnancies, teen and adult, are unplanned (National Campaign, 2015b). In 2010, 9.4 billion dollars were spent on teen childbearing in the U.S. (National Campaign, 2015b). The cost for those individuals born to adolescents are beyond monetary as their educational, behavioral, and health outcomes are worse throughout their lives compared to those people born to older parents (HHS, 2015).

Although many parents struggle to communicate with their children about sexual topics and encourage their children to ask sexuality-related questions (Byers, Sears, & Weaver, 2008), parents are often cited as a primary source of sexual health information among adolescents (Bleakley, Hennessy, Fishbein, & Jordan, 2009; Donaldson, Secor-Turner, Seiving, Eisenburg, & Skay, 2011). Parent-child sexual communication is positively related to adolescent risk reduction behaviors and attitudes (DiClemente et al., 2001; Salazer et al., 2005; Troth & Peterson, 2000). Adolescents who received sexual health information from parents are more likely to hold beliefs that lead to the likelihood they will delay intercourse (Bleakley et al., 2009) and more protected against early pregnancy and risky sexual behaviors (Secor-Turner et al., 2011). Adolescents who talked less or not at all with their parents about sex were less likely to negotiate safer sex with partners, practice safer sex (DiClemente et al., 2001), and use birth control (Clawson & Reese-Weber, 2003). Parkes et al. (2011) found a negative association between PCSHC and delayed initiation of sex but acknowledged this could be a result of PCSHC being initiated after children’s sexual debut or permissive attitudes about sexual
behavior related to those parents who engage in PCSHC more frequently. Nonetheless, their findings connect parental attitudes, intentions, and actions with children’s behaviors.

Parental characteristics, perceptions, and experiences have a great impact on beliefs about their ability to provide their children with sexuality education. Parents’ comfort with sexuality (Lefkowitz & Stoppa, 2006) and experience with their own adolescent sexuality education (Byers et al., 2008; Eastman et al., 2005; Woody, Randall, & D’Souza, 2005) are related to their parents’ sense of their ability to educate their children. Additional reasons parents cite that make engaging in sexual communication with their children difficult include lack of effective communication methods, adolescents’ resistance, doubts, and uncertainties about what to say and how much to say (Eastman et al., 2005), and well as privacy, confidentiality, and social constraints (Kirkman et al., 2005). Parental belief systems about sexuality impact how they share related messages with their children (Lefkowitz & Stoppa, 2006). As primary sources of sexuality education, parents have the opportunity to transmit their values related to sexuality, which may increase the chances their children will adopt safe and healthy behaviors (Schouten, van den Putte, Pasmans, & Meeuwesen, 2007).

Parental expectations and perceived needs can incite parents to engage in parent-child sexual communication (Evans, Blitstein, & Davis, 2011; Miller et al., 2011), and providing them reasons to communicate may further increase their motivation to do so (Schwartz, 2009). Many parents must feel their children are ready to learn about sex before they are motivated to communicate about it (Miller et al., 2011) and perceive an increased need for communication about sexuality topics when they believe their children have entered into romantic relationships (Eisenberg et al., 2006). Because many parents
perceive it easier to convey messages about waiting until marriage before having sex, they may be more motivated to introduce this topic much earlier, well before their children are romantically or sexually involved, and revisit it more often than discussing ways to prevent unwanted outcomes of sexual behaviors (Eisenberg et al., 2006). Motivation to attend parent sexuality education program increases when parents understand their need for new knowledge and skills, have desire to come out of isolation and seek support (Thomas, 1996), realize their children’s need for earlier education (Miller et al., 2011), and overcome discomfort talking about sex and sexual guilt (Woody, 2007).

While rural geographical regions, like the one containing Winchester/Clark County, are associated with “conservativism” (Noone & Young, 2009), many rural parents believe they should be their children’s primary sexuality educators, formal sexuality education should begin before seventh grade, and despite being religious, information about contraception should be included in sexuality education (Jordan, Price, & Fitzgerald, 2000). However, perceived lack of privacy, confidentiality, and anonymity, coupled with less exposure to diversity and new ideas in rural regions, makes seeking sexuality education a challenge for parents (Noone & Young, 2009).

Parents need to be able access resources and support that will assist and motivate them in educating their children about sexuality education. In rural communities where barriers to access include dependable transportation and financial problems (Noone & Young, 2009), school health educators (Jordan et al., 2000) and access to accurate information online can assist parents in their endeavors. Even when parents are interested in seeking sexuality education, time (Heinrichs et al., 2005; Mendez et al., 2009; Person
et al., 2010; Schneider, et al., 2003), work schedules, childcare issues (Mendez et al., 2009), location of programming, (Person et al., 2010) and privacy concerns (Eastman et al., 2005; Heinrichs et al., 2005) present barriers. The social environment not only impacts parents’ ability to seek support, it impacts children’s reception of messages from parents (Secor-Turner et al., 2011) and service seeking behaviors (Hall et al., 2012).

**Parent-Child Sexual Health Communication**

Communication that takes place between parents and their children regarding sexuality is referred to as parent-child sexual health communication (PCSHC). This type of communication is not limited to risk reduction communication but includes that which enhances children’s understanding of sexuality and all its dimensions (Schouten et al., 2013) and promotes healthy sexual development. Family communication about sexuality can encourage positive attitudes, norms, and control beliefs about healthy sexual practices (Malcolm et al., 2005).

**Theory of Planned Behavior**

To examine the relationship between parents’ intentions to and beliefs about talking with their children about sexuality topics so as to better understand how to enable and facilitate PCSHC, the framework provided by the theory of planned behavior (TPB) with the parent-based expansion of the theory of planned behavior (PETPB) served as the foundation of the rationale for the inquiry. Components of the TPB include behavioral beliefs determined by attitudes toward the behavior, normative beliefs determined by subjective norm, or beliefs that one holds about relevant others support or disapproval of the behavior, and control beliefs determined by one’s perception of his/her control over changing the behavior. The TPB accounts for intentions, but also individuals’ abilities to
act on their intentions (Perry & Langley, 2013). Actual behavioral control as determined by skills and resources needed to actually perform the behavior are included in the model (Ajzen, n.d.). The TPB is rooted in the expectation that intention to engage in a behavior leads to actual performance of the behavior and intentions and behaviors are informed by the belief components of the model. The TPB has been used to predict a variety of health behavior changes including substance abuse treatment completion (Zemore & Ajzen, 2014), increase physical activity (French et al., 2005), safe pedestrian behaviors (Zhou et al., 2016) and parenting intentions, including fathers’ involvement intentions (Perry & Langley, 2013), mothers’ intentions to vaccinate daughters against HPV (Askelson et al., 2010), and PCSHC (Burack, 2013; Schouten et al., 2007). Regarding parents’ intentions to engage in PCSHC, the TPB implies that those who intend to communicate with their adolescents have positive attitudes about PCSHC, believe significant others approve of the communication, and believe they are capable of communicating with their child about sexual topics (Villarruel, Cherry, Cabrailes, Ronis, & Zhou, 2008).

Behavioral Beliefs

Behavior beliefs are determined by the attitude one has regarding the performance of the behavior and whether or not the behavior is valued as being positive or negative (Bracke & Corts, 2012). Attitudes that determine behavioral beliefs can be strong predictors of intention to engage in health protective behaviors (Askelson et al., 2010). While most all parents believe their participation in their children’s education is important, their valuation and beliefs can be shaped by their own encounter with educational experiences (Bracke & Corts, 2012). Prevention programs can strive to promote positive attitudes toward parent-child sexual health communication (Carmack et
al., 2015) and active roles of parents’ in the education and lives of children (Bracke & Corts, 2012). Previous research presents evidence that adolescents’ beliefs about PCSHC can serve as a predictors of the frequency of communication (Schouten, 2007) but investigating parental beliefs regarding communication has been limited.

**Normative Beliefs**

Normative beliefs are determined by subjective norm, which are referred to as the typical rules of behavior that are based on the perceptions of what others think and do (Bracke & Corts, 2012). Normative beliefs are most strongly influenced by those individuals who are deemed important and influential and inspire a willingness to comply (Askelson et al., 2010). If parents perceive that other parents are involved and good parenting behavior includes taking an active role in their children’s education they are more likely to take an active role (Bracke & Corts, 2012). Subjective norms also influence parents’ intentions to engage their children in health protective behaviors (Askelson et al., 2010; Perry & Langley, 2013) and is a significant predictor of values based PCSHC (Schouten et al., 2007). Understanding parental involvement as a social endeavor influenced by norms can serve efforts to bridge intentions and actual behaviors of PCSHC (Bracke & Corts, 2012).

**Control Beliefs**

Control beliefs are determined by the amount of control a person perceives he/she has over performing a behavior (Askelson et al., 2010) and can be likened to the construct of self-efficacy in Bandura’s social cognitive theory (Schouten et al., 2007). Control beliefs impact confidence in one’s ability and motivation to engage in behaviors and are highly predictive of PCSHC intentions (Cederbaum, Hutchinson, Duan, &
Jemmott, 2013) and behaviors (DiIorio et al., 2000). While some parents do not feel they have the ability to help their children (Bracke & Corts, 2012), those who feel able to engage in PCSHC are more likely to do so (DiIorio et al., 2000).

**Intentions**

Intentions to engage in behaviors are directly related to enacting behaviors (Askelson et al., 2010) and are predicted by behavioral, normative, and control beliefs (Perry & Langley, 2013). Intentions to engage in PCSHC can also be influenced by parents’ perception of their children’s risk for negative sexual health outcomes (Askelson et al., 2010). While some parents underestimate their children’s engagement in risk behaviors (O’Donnell et al., 2008) those who have been affected directly or vicariously by negative sexual health outcomes are more likely to intend on promoting their children’s risk reducing behaviors (Askelson et al., 2010).

**Actual Behavioral Control**

The TPB accounts for intentions, but also individuals’ abilities to act on their intentions (Perry & Langley, 2013) and actual behavior control (Ajzen, n.d.). Actual behavioral control is determined by skills and resources needed to actually perform the behavior are included in the model (Ajzen, n.d.). When control beliefs are congruent with reality, they may serve as a measure of actual behavioral control, however, when circumstances or conditions are uncontrollable but not perceived as such, they can interfere with intentions becoming actual behaviors (Mayhew et al., 2009).

**Parent-Based Expansion of the Theory of Planned Behavior**

Hutchinson and Wood (2007) propose an expanded TPB to emphasize the influence and impact parents have on adolescents’ sexual risk attitudes, intentions, and
behaviors and termed it the parent-based expansion of the theory of planned behavior (PETPB). The components of the original TPB are included to predict adolescent engagement and intentions to engage in sexual risk behaviors as informed by their behavioral, normative, and control beliefs. The expansion to this model includes external influences of PCSHC on the adolescent derived from the added parent-based TPB components and initial external influences on the parent (Hutchinson & Wood, 2007). Through PCSHC parents have the opportunity to positively impact their children’s attitudes, norms, and beliefs about health promoting sexual behaviors (Malcolm et al., 2005). While a similar expansion of the TPB based on the PETPB, the family-based expansion of the TPB, has been used to examine and predict adolescent beliefs, subjective norm, and perception of control regarding PCSHC (Schouten et al., 2007), this study focuses on the parent-based TPB components to better understand parental beliefs about and intentions to engage their children in PCSHC as force to influence their children’s beliefs, intentions, and ultimately behaviors. See Appendix B for diagram of PETPB.

**PCSHC and Gender of Parents and Children**

Parent child sexual health communication differs based on gender of the child and parent (DiLorio et al., 2000; Wilson & Koo, 2010). Parents often engage daughters in PCSHC earlier (Beckett et al., 2009; Pluhar, DiLorio, & McCarty, 2008) and more often (Afifi et al., 2008; Kapungu et al., 2010) than they do with sons. Male and female children talk more with mothers than fathers (Afifi et al., 2008; Holman & Kellas, 2015; Thompson et al., 2015) Mothers report they are more likely to engage in PCSHC with daughters (DiLorio et al., 2000). Female children report more PCSHC with parents.
(Schouten et al., 2007), while male children report finding it less important to talk with parents about sexuality (Schouten et al., 2007). Girls express greater information needs than boys (Schouten et al., 2007). Attitudes about adolescent sexual behavior are related to gender of the child, as parents were more likely to believe sexual activity would have a harmful impact on their daughter and were less approving of daughters’ sexual activity compared to sons’ (Wilson & Koo, 2010). In addition to being more likely to engage in PCSHC with daughters, parents feel more capable and effective when communicating with them (Wilson & Koo, 2010). While this study does not specifically seek to overcome barriers to PCSHC with sons, low levels of communication with (Wilson & Koo, 2010) and lack of instruction for (DiLorio et al., 2000) boys is an area in need of further exploration.

Constructs of the TPB have been used to explore parental and child gender differences in PCSHC. Predicting parent involvement, both maternal and paternal, involves the consideration of attitudes, subjective norms, and perceived control and how these impact intentions to be involved in their children’s lives (Perry & Langley, 2013). To increase their perceived control fathers may need more guidance regarding the timing of PCSHC and reassurance that they can positively impact their children’s sexual decision making, especially daughters (Wilson et al., 2010). Daughters may be influenced by subjective norms more than sons (Schouten et al., 2007).

**Parental Communication Openness**

Because they are engaging in more PCSHC with children communication openness may seem more important for mothers than fathers (White et al., 1995), which may contribute to more adolescent communication with mothers rather than fathers.
(Schouten et al., 2007). However, to promote effective PCSHC with both male and female children, openness would seem to be an equally important quality in both mothers and fathers. Openness in communication with adolescent males and their parents can decline during early adolescence and stabilize at low levels of child willingness to disclose and parental solicitation and high levels of child secrecy, while female children report open patterns of parent-child communication from middle adolescence into adulthood (Keijsers & Poulin, 2013). While high quality mother-child relationships should include open and thoughtful discussions about sexuality with direct discussion about sexual health, including birth control and safer sex (Riggio et al., 2014), this should hold true also for father-child relationships. While openness may promote more frequent and varied PCSHC, Hadley et al. (2009) did not find it significantly related to adolescent safer sex behavior.

**PCSHC Topics**

The older children grow the more topics parents discuss with them. Byers et al. (2008) found that while topic number grew, parents were addressing them in general terms only without detail, regardless of the developmental appropriateness of the topics. Parents often discuss more sexuality topics with daughters than sons (Kapungu et al., 2010; Miller et al., 2011; White et al., 1995). Parents’ communication with daughters about sexual health tended to focus on abstinence for now or until marriage (Sneed et al., 2013) with parents disproving of female adolescent sexual behaviors, holding the belief that they would be more harmful for daughters compared to sons (Wilson & Koo, 2010). Some parents teach daughters prevention and promote abstinence specifically, while others communicate more generally about sexuality, including love in the conversations.
about sexual health (Lefkowitz & Stoppa, 2006). Sneed et al. (2013) found parent-child conversations for female children were focused on avoiding and delaying sexual activity, specifically until marriage, while discussion with male children were about prevention while engaging in sexual activity with discussions significantly more likely to include information about condoms. Parent child sexual health communication addressing condom use was associated with a greater likelihood of adolescents using condoms consistently (Hadley et al., 2009). Sneed et al., (2013) found male children were significantly more likely to be engaged in PCSHC that addressed condoms, but overall findings support the patterns revealed in previous research where parents tend to avoid discussing their children’s personal sexual behaviors (Sneed et al., 2013).

White and colleagues (1995) found fathers were likely to communicate more comprehensively with daughters, discussing factual and value-based topics, while Wilson and colleagues (2010) found that fathers were as likely to talk to sons as daughters about a number of topics with the exception of being more likely to discuss dating and relationships with daughters. Highlighting a gender divide, when discussing menstruation fathers reported they would more likely to discuss negative aspects of the menstrual cycle with sons compared to daughters, offering advice for coping with the mood swings of those who menstruate to sons while making no mention of this topic to daughters (Erchull & Richmond, 2015). Further evidence to differences in gender expectations, fathers are expected to be more effective communicators with their sons (Rosenthal et al., 2001) and are often expected to have “man to man” talks about topics considered more relevant to males (Feldman & Rosenthal, 2000). However, fathers may perceive the need to serve as gatekeepers to their daughters’ sexuality (Lefkowitz & Stoppa, 2006).
Even for parents who intend to and actually engage in PCSHC, there are certain topics they are not comfortable addressing (Morawska et al., 2015), including wet dreams and spontaneous erections (Kapunga et al., 2010). Aside from these topics, parents are more likely to engage in PCSHC that provides children with education about development during puberty and other informational topics such as abstinence and sexuality in the media and less likely to address personal topics related to children’s present and/or future engagement in sexual behaviors such as safer sex and sexual decision making (Byers & Sears et al., 2012; Sneed et al., 2013). When selecting topics for discussion parents may address the negative consequences of sexual behavior, including unintended pregnancy, sexually transmitted infections, and non-consensual sex in greater depth (Afifi et al., 2008).

**Timing of PCSHC**

Communication patterns between parents and their adolescent children shift during this developmental stage with primary pursuits of autonomy and independence for the child during early adolescence (12 – 14 years old) and connectedness with parents in late adolescence (14 – 19 years old), however some differences in PCSHC appear in late adolescence that may be attributed to gender (Keijsers & Poulin, 2013). While children’s interest in communicating with parents during early adolescence may be impacted by the desire for autonomy and independence, their comfort level communicating with parents may be greater during this stage rather than later in adolescence (Levin, 2012).

Barriers or prompts to engaging in PCSHC may impact both male and female children (Pariera et al., 2016). Barriers to earlier communication is the parent perception that children are too young to learn about sex, which is often replaced as children get
older with the perception that the child is not receptive to education from parents (Pariera et al., 2016). Perceptions that children are too young may cause parents to delay initiating PCSHC when children might benefit the most (Poulsen et al., 2010). Some mothers communicate about sexuality well before they expect their children to engage in sexual behaviors, while other may choose to initiate discussions only when they believe their children are approaching sexual debut, which often occurs earlier than expected (Marhefka et al., 2009). While parents may believe their initiation of PCSHC is well timed when they perceive readiness in their children (Poulsen et al., 2010) or when daughters reaches menarche (Erchull & Richmond, 2015), they may be missing opportunities to provide children with valuable and necessary information in preparation rather than in response to adolescent sexual development and activity. Fathers can be effective educators if discussions are timely, however those who perceive sexual activity as developmentally appropriate for older adolescents may not feel the need to engage in sexual communication with their children, assuming children have already acquired the knowledge needed to make sexual decision (Clawson & Reese-Weber, 2003). While parents engage more in PCSHC with older children (Pluhar DiIorio, & McCarty, 2008), they also report engaging in PCHSC earlier with daughters than sons (Beckett et al., 2009; Erchull & Richmond, 2015; Pluhar et al., 2008).

Male children may be impacted more negatively by parents’ perception of appropriate timing for PCSHC. As males grow into late adolescence they report less initiation of communication on the part of parents and less parental control compared to females (Keijsters & Poulin, 2013), and may find themselves at elevated risk for negative sexual health outcomes when they have difficulty communicating with parents (Levin et
al., 2012). Parents can perceive male adolescents as already or at risk for engaging in sexual behaviors with a partner (Sneed et al., 2013; Wilson & Koo, 2010) and coupled with parent-child relationships centered around independence, high levels of secrecy and low levels of disclosure on the part of male children during late adolescence (Keijsers & Poulin, 2013), these perceptions may create a barrier to initiating and having meaningful conversations with male children about risk reduction and partner communication.

**PCSHC and Religiosity**

Parents’ religious affiliation, religiosity, one’s religious practices and beliefs, (Regnerus, 2005) and commitment (Landor et al., 2011) can influence parental practices and beliefs about PCSHC (Dilorio et al., 2000; Villarruel et al., 2008). While Snider, Clements, and Vaszsonyi (2004) determined parental religiosity was associated with enhanced parent-child relationships, Farringdon et al. (2014) found mothers who exhibited high levels of religiosity reported feeling uncomfortable discussing sexual health issues, especially controversial topics including abortion, condoms, contraception, and masturbation (Farringdon et al., 2014). In an examination of national longitudinal data, Regnerus (2005) found that mainline Protestants were less likely to talk about sex and experience greater unease in trying to do so when compared to those affiliated with another Christian group or religiously unaffiliated. Additional, those who reported a greater degree of religiosity with perhaps a greater sense of religious conservatism reported greater unease with PCSHC and communication that focuses primarily on morality (Regnerus, 2005) rather than risk reduction and healthy sexual development.
Sex Education for Parents

As many contemporary parents were not privy to quality, on-going, comprehensive sex education in their homes, schools, and/or community settings, including faith communities, during their developmental years, they would likely benefit from parent education programming that could equip and comfort them in their role as sexuality educator. While attending parent sexuality education can enable parent-child communication, program planners need to take into account a number of factors that will increase enrollment and participation. Multiple sessions are more effective (Miller et al., 2011; Person et al., 2010; Schuster et al., 2008; Wight & Fullerton, 2013) but delivery is best during the lunch hour rather than before or after the workday (Eastman et al., 2005). Program content has greater potential for impact when it involves skill building, practice, feedback, and family activities (Eastman et al., 2005; Miller et al., 2011), addresses and respects personal and emotional barriers of parents (Woody et al., 2005), religious influences, culture (Thomas, Strickland, DiClemente, Higgins, & Haber, 2012), and diverse perspectives and values (Eastman et al., 2005). While more challenging (Wight & Fullerton, 2013), involving fathers in programming can be beneficial to children (Parke & Coltrane, 2011).

A variety of strategies can facilitate parents’ motivation to access sexuality education programming. Normalizing the domain of sexuality (Woody et al., 2005) and parent training (Heinrichs et al., 2005), while emphasizing parents’ stake in promoting their children’s sexual health (Woody, 2007) and reducing the stigma of seeking help and imparting to parents they are not alone (Eastman et al., 2005), may lead to greater attendance in parent sexuality education programming. Outreach to potential participants
needs to consciously combat initial avoidance reactions while emphasizing the supportive and collaborative nature of programming (Woody et al., 2005). Program marketing strategies should include articles in newspapers and newsletters, distribution of posters and flyers (Person et al., 2010), radio and newspaper advertisements, and large-scale mailings (Schneider et al., 2003). Social marketing campaigns can provide a cue for parents to seek more in-depth sexual health information and shift social norms that promote parent-child communication (Evans et al., 2011). Providing parents with pertinent and effective training and the opportunity to seek support from other participants (Eastman et al., 2005), as well as multiple electronic modes of communication, branded campaigns, and health fairs (Wilhide, Hayes, & Farah, 2008) can serve to recruit and retain program participants.

In their review of sex education curricula that were stand-alone parent programs or programs for youth with a parent component, Wright and Fullerton (2013) found that most all included the intention of promoting and improving parent-child communication about sex. Of the programs that were part of experimental design and measured parental outcomes, evidence showed improvements in parent-child communication and parental regulation. Reviewers believe community-based programming is the most promising for parent sexuality education (Wright & Fullerton, 2013). This summary of best practices primarily includes information about and from three evidence-based programs: the parent component from Get Real: Comprehensive Sex Education that Works, and two parent focused programs, Parents Matter Program and Talking Parents, Healthy Teens, that have shown increase parent-child sexual communication, comfort, openness, and parents’
self-efficacy. Increasing openness, a willingness to answer questions and be responsive, is a key to good family communication (Kirkman et al., 2005).

Parent sex education programming focusing on promoting parent-child communication is best provided before adolescents become romantically involved and/or sexually active (Beckett et al., 2009; Dittus, Miller, Kotchick, & Forehand, 2004; Eisenberg et al., 2006; Grossman, Tracy, Charmaraman, Ceder, & Erkut, 2014). While this benefits adolescents and prepares them for healthy future relationships and decision making, reaching parents with curricula like Get Real, Parents Matter Program, and Talking Parents, Healthy Teens that contain messages to communicate early and frequently (Dittus et al., 2004; Grossman et al., 2014) alleviates parental confusion of discussion timing and the perceived need for over-involvement in their children’s relationships (Eisenberg et al., 2006). Sexuality education programming for parents can encourage, prepare, and give permission to begin conversations with their children about sexuality before their children reach the need to make decisions about their own sexual health. Educational design for parent programming should provide parents with opportunity to develop a grasp of their children’s nature and understanding of relationships, center their relationships with their children in sensitivity, responsiveness, reciprocity, and support, and become better aware of their own perceptions and values (Thomas, 1996).

Providing parents with a list of sexual topics to discuss and what they might say about these is a practical way to provide guidance (Beckett et al., 2009). Potential coverage of specific topics and skills is vast and varied. Most programs include providing parents with sexual and reproductive health information, communication skills
development and practice, including active listening and positive reinforcement provisions, parental monitoring, parental values clarification, how to convey values to children, and helping children make decisions (Dittus et al., 2004; Eastman, Corona, & Schuster, 2006; Miller et al., 2011; Wright & Fullerton, 2013).

Teaching strategies and program activities include discussions among facilitator and participants as a way of increasing parents’ self-efficacy and comfort while building communication skills and role play that allow for skills practice (Eastman et al., 2006; Miller et al., 2011; Pluhar et al., 2008). Homework assignments for parents and children are a critical component to sex education programming (Miller et al., 2011), and these work to strengthen parent-child relationships (Schuster et al., 2008), designate parents as primary sex educators, provide the opportunity for parents to share their values, and increase comfort and openness of both parents and children while communicating about sexual topics (Grossman, Frye, Charmaraman, & Erkut, 2013). Family homework topics include healthy and unhealthy relationships, media images and sexuality, and assertiveness skills (Eastman et al., 2006; Grossman et al., 2013).

**Gaps in the Literature**

A recommendation in parent sexuality education literature is to examine communication differences in relation to child and parent gender (Beckett et al., 2009; White, Wright, & Barnes, 1995). While it is difficult to examine differences in gender of parents, as most often mothers are the ones to participate in data collection and programming, examining the differences related to gender of children is feasible and informative. And while there is a large body of literature that examines similarities and differences in PCSHC according to the gender of children, expanding the understanding
of the differences in topics covered and considering how this and parental attitudes and beliefs can impact communication is worthy of further investigation. Studies addressing PCSHC and gender of children often examine results in a binary fashion, with reports about parents communicating with daughters versus sons. Erchull & Richmond (2015) present this as a limitation and suggest comparing data by three subgroups, female only, male only, or female and male children. The current study examines differences in the PCSHC patterns of parents with male only, female only, and male and female in grades 4–11.

Best practices in the field of health promotion and education is to have research and practice be guided and informed by theory. While the TPB has been used to examine a number of health behaviors in adults and adolescents and has been used PCSHC research, it holds promise of revealing more about parental perceptions and beliefs that drive them to engage or not in the behavior of communicating with their children about sexuality and sexual health. Understanding those parental aspects that serve as motivators and those that serve as hindrance for PCSHC give health education professionals a better chance of reaching parents with promotional messages about PCSHC and recruiting and retaining participants for parent education programming.

Developing a better understanding of the child and parental factors that are related to PCSHC is valuable for health professionals, as is exploring key components and strategies used in effective parent sex education programming. While a number of systematic examinations have been conducted to learn more about PCSHC, including reviews of intervention effectiveness on PCSHC and sexual health outcomes of children (Downing et al., 2011, Gavin et al., 2015; Wight & Fullerton, 2013), conducting a
systematic review of the components of parent education programming, some designed to serve hard to reach populations, is a worthy expenditure of planning time and energy for creating parent programming for a specific population. Narrowing the focus of a review to parental outcomes related to increased PCSHC and the pragmatic aspects of recruitment and retention of participants is fitting and needed for planning and evaluation purposes.

Summary

While teen birth rates are improving in the United States, efforts to reduce unintended teen pregnancy and adolescent STI rates are necessary for the sexual and overall health of adolescents and emerging adults. While some school and community programs are designed and delivered to educate young people about sexual health, these offering are often incomplete and/or disjointed and leave out important topics. Parents are the first and primary sexuality educators of their children and deserve the opportunity and need to embrace the responsibility of being effective in this one of their many parenting roles. Health promotion and education professions dedicated to sexual health benefit from understanding and impacting parental perceptions, beliefs, and skills.
CHAPTER 3

DISSERTATION METHODS

Research Design

The design of the current study involved an exploratory mixed methods approach of systematic literature review, cross-sectional quantitative data collection and analysis, and intervention planning, recruitment, and implementation. The systematic review of parent sex education program interventions provided an in depth consideration of program components and parental outcomes which contributed to the development of a pilot parent sex education program. For cross-sectional analysis baseline data were collected from 205 parents of children enrolled in grades 4 – 11 during 2016 – 2017 with the intent of developing a better understanding of PCSHC, considering child and parental factors that contribute to or serve as a detriment, and examining PCSHC through a framework inspired by the theory of planned behavior.

From that sample 50 participated in the intervention, the pilot parent sex education program. For the purposes of distinguishing subjects, respondents refers to all those who completed the baseline survey and participants refers to the those who completed the baseline survey, participated in programming, and may or may not have completed post-program and six-week follow surveys. While beyond the scope of this work, post-intervention and six-week follow up data and summative program evaluation data were collected from many intervention participants and will be examined and used for future program evaluation.
Study Population

Those who qualified for baseline data collection needed to be the parent of at least one child in grades 4 – 11 during the 2016 – 2017 school year. For the purpose of this study, an individual was considered a parent if the child(ren) lived with him/her at least three days of the week. Respondents were recruited to voluntarily complete a paper or online baseline survey. Those respondents who completed the online survey were recruited through an online posting on Facebook (see Appendix A). Targeted recruitment methods for baseline survey completion and program enrollment included mailing letters to parents of students enrolled in the local public school system (see Appendix B), posting flyers at the local public library (see Appendix C) and emails sent to employees and tabling outreach at the local hospital. Subjects who completed the baseline survey were not excluded based on gender, race/ethnicity, or location of residence. Funding restrictions limited potential program participants to residents of Winchester/Clark County, Kentucky.

A total of 205 respondents completed the baseline survey. The average age of participants was 42 (SD = 5.9; range 24 - 67) with 193 (94.1%) identifying as female and 12 (5.9%) identifying as male. The sample categorized by race/ethnicity included 185 (90.7%) identifying as white, 11 (5.4%) African American, 4 (2.0%) Hispanic, and 4 (2.0%) as other. The racial/ethnic makeup of the sample is reflective of the population of the target community (U.S. Census, 2015). In regards to education level, 86 respondents (42%) reported holding graduate degrees, 43 (21.0%) bachelor’s degrees, and 29 (14.1%) had graduated from high school and taken some college courses. Nearly 10% (n = 20) of subjects did not complete the questions asking about religious affiliation, but of those
who did, just over 25% (n = 47) identified as non-religious, 43.2% (n = 80) as Christian, non-Catholic, and 11.4% (n = 21) identifying as Catholic. Nearly 75% (n = 153) of participants attended a religious or spiritual service at least once in the last year, with 30.7% (n = 63) participants attending at least once a week. Parents were classified into groups according to the gender of their children with 75 participants (36.6%) have only male children in grades 4 – 11, 77 (37.6%) have only female children, and 53 (25.9%) have both male and female children. For descriptive purposes only parents were also categorized by the developmental stage of their oldest child in grades 4 – 11. Of the with 20% (n = 36) categorized as having pre-adolescent children, ages nine - 10, 56.1% (n = 105) as having early adolescent children, ages 11 - 14, and 23.9% (n = 46) as having late adolescent children, ages 15 – 17. Of all respondents, just over 75% (n = 154) reported being married, 15.8% (n = 32) divorced from parenting partner and single, 1.5% (n = 3) single, never married, 3.9% remarried (N = 8), and 3% cohabiting (n = 6). Of all respondents who completed the baseline survey, 52.7% (N = 108) were residents of Winchester/Clark County, Kentucky. 

Of the 205 respondents, 101 completed paper/pencil survey and 104 completed the online survey. See Table 3.1 for a comparison of demographic variables for the two classification of respondents. Independent samples t tests were used to compare group means to determine any significant demographic differences in the two groups. Of all demographic data provided, the only significant differences between respondents who completed the paper and pencil and online surveys were found for gender of respondents and respondents’ children. Of respondents who completed the online survey, nearly 40% (n = 41) had male only children, 35.6% (n = 37) had female only children, and 25% (n =
26) had both male and female children. Of those who completed the paper and pencil survey, 33.7% (n = 34) had male only children, nearly 40% (n = 40) had female only children, and 26.7% (n = 27) had both male and female children.

More fathers completed the paper pencil survey (n = 8) compared to the online survey (n = 4), and more mothers completed the online survey (n = 100) than the paper pencil survey (n = 93). Independent samples t tests were also conducted to determine if there were any significant differences in demographics and the response patterns based on survey completion mode. Two significant demographic differences were identified with paper group (M = 4.30, SD = 1.92) having a significantly lower level of education than the online group (M = 6.13 , SD = 1.24) (t(203) = -8.08 , p < 0.001), and the paper group reporting a significantly higher level of religiosity (M = 3.25 , SD = 1.30) than the online group (M = 2.44, SD = 1.21) (t(183) = 4.35 , p < 0.001).

There were no significant differences in responses to intention and actual behavior questions based on the way in which respondents completed the survey. When total scores for communication openness ability, behavioral beliefs, normative beliefs, control beliefs, and topics total were compared the only significant differences were found in communication ability and openness. Online respondents (M = 0.74 , SD = 0.16) reported greater communication ability (t(183) = -2.71 , p < 0.01) (equal variances not assumed) than those who completed the paper survey (M = 0.68, SD = 0.18). Online respondents (M = 1.78 , SD = 0.05) also reported greater communication openness (t(183) = -3.05 , p < 0.01) than those who completed the paper survey (M = 1.75, SD = 0.05).
A total of 50 participants enrolled in and completed all or some of the parent education program. Of program participants whose baseline data were included in the current study (N = 50), 88% (n = 44) were female, 94% (n = 47) were white, and 70% (n = 35) were married, and just over 50% (n = 26) had at least a bachelor’s degree and nearly all (n = 46) were high school graduates. See Table 3.2 for demographics of program participants. Programming took place in community-based settings including the local public library, the local hospital, and a local community service organization. To address potential barriers to attendance, participants were provided lunch from local food vendors and in the case where the need presented itself, childcare was provided. Some data included in this study were collected from participants who took part in one of five series of the educational program offered between March 2016 – August 2017.

Measures

The instrument used to gather quantitative baseline data consisted of 10 demographic questions, five scales intended to measure parental openness and TPB beliefs, sexuality topics discussed, one question each to measure parents’ self-perceptions of their ability to communicate about sexuality topics, intentions to engage in and actual enactment of PCSHC, and intentions to give and actual delivery of condom instructions. All measures being piloted were either constructed for the current study or modified from their original versions for applicability. As a result, previous reliability statistics on original measures that have been modified are not relevant to the current study. Data were collected using paper and electronic versions of the survey. See Appendix D for the full survey. Most of the questions and scales created to operationalize the TPB constructs were crafted using the guidance of Ajzen (n.d. a).
Variables included in Instrument

**Demographics.** Participants were asked their age, gender, race/ethnicity, marital status, highest level of education, occupation, religious affiliation, and the number of, age, and gender of children. Subjects’ degree of religiosity was measure with one question, “How often do you attend religious or spiritual services?.”

**Gender of child(ren).** Parents were included in one of three groups based on the gender of their child(ren) in grades 4 to 11 during the 2016/2017 school year. Groupings were male only, female only, and male and female. Respondents’ children in grades below fourth and above eleventh were not included in the analytic sample as the investigation was focused on PCSHC with late pre-adolescent and adolescent children.

**Communication openness.** The Open Sexual Communication scale (Miller, Kotchick, Dorsey, Forehand, & Ham, 1998) is used to assess openness of sexual communication between parent and child. The original subscale was modified from a four point to seven-point scale (7 = agree, 1 = disagree) to be consistent with the other Likert scale items in this study. After reverse coding items with negative language, scores from the ten items were summed for a scale score ranging from 10 – 70 with higher scores indicating more openness and receptivity to PCSHC. (α = 0.66)

**Behavioral beliefs.** The behavioral beliefs scale consisted of seven items (α = 0.61) recommended by Schouten et al. (2007) for measuring children’s beliefs and was modified to collect parent beliefs about engaging in PCSHC. Five of the seven items were reverse coded. It is appropriate and typical to use seven point bipolar scales to measure TPB constructs (Ajzen, n.d. a; Orbell, Hodgkins, & Sheeran, 1997). The seven point scale (7 = agree, 1 = disagree) score for each item is added together to provide a
total scale score ranging from 7 to 49 with higher scores indicating more positive beliefs about PCSHC. Items include 1) it is important to me that my child can talk to me about sexuality, 2) I would/do feel embarrassed talking about sexuality with my child, 3) my child is not likely to want to talk to me about sexuality, 4) it is not necessary to talk to my child about sexuality, because he/she already knows enough about it, 5) my child would feel embarrassed talking about sexuality with me, 6) I feel it is important that I can talk to my child about sexuality, and 7) I am afraid of encouraging sexual activities if I talk to my child about sexuality.

**Normative beliefs.** The normative belief scale consisted of five items ($\alpha = 0.64$) designed to measure one’s subjective norm with questions related to values of important referents and the importance of the referents opinions. Specific referents for this study were family, friends, and faith community. Items for each referent are 1) My (referent) thinks I should talk with my child about sexuality and 2) The opinion of my (referent) is important to me. Total scores were obtained by multiplying first items (what referents think) by second items (importance of referent’s opinion) and adding the three products (family, friends, church community) (Schouten et al., 2007). Total scores ranged from three to 147 with higher scores indicating greater importance of referents and referent opinions.

**Control beliefs.** The control belief scale consisted of three items ($\alpha = 0.44$) designed to measure perceived behavioral control. One item came from the literature, “It is easy to talk with my child about sexuality” (Schouten et al., 2007), and two were added to this study based on the recommendation of Ajzen (n.d.), and “It is up to me to talk to my child about sexuality” and “I believe talking to my child about sexuality topics will
help them avoid unintended pregnancy and sexually transmitted infections”. The seven point scale (7 = agree, 1 = disagree) score for each item is added together to provide a total scale score ranging from 4 to 28 with higher scores indicating more perceived control over engaging in PCSHC.

**Sexuality topics.** A list of 23 sexuality topics made up the sexuality topics subscale (α = 0.95). While Schuster et al. (2008) analyzed sexual topics as count variables, the current study used a four-point response scale (4= a great deal, 3 = a moderate amount, 2 = somewhat; 1 = not at all) with participants indicated to what degree they discussed with their children a number of sexuality related topics (Eisenberg et al., 2006). Sexuality topics were considered individually and a total score was calculated; both were used in data analysis.

**Communication ability.** Parents respond to the question, “How would you rate your ability to communicate with your child about sexuality topics?” on a seven point scale (7 = excellent , 1 = terrible). This measure was used to assess parents’ perceptions of their communication ability in the evaluation of the *Talking Parents, Healthy Teens* curriculum (Schuster et al., 2008).

**PCSHC intentions.** Parents indicate with a yes/no response to the statement “I intend to talk with my child repeatedly about many topics related to sexuality and sexual health.”

**PCSHC behavior.** Parents indicate with a yes/no response to the statement “In the past 6 weeks I talked with my child repeatedly about many topics related to sexuality and sexual health.”
**Condom instruction intentions.** Parents indicate with a yes/no response to the statement “I intend to review the steps of how to use a condom with my child” (Ajzen, n.d.).

**Condom instruction behavior.** Parents indicate with a yes/no response to the statement “I have reviewed the steps of how to use a condom with my child” (Schuster et al., 2008).

**Reliability**

Cronbach’s alpha was used to measure the reliability of subscales included in the survey. The $\alpha$ coefficient ranges from 0 to 1, with higher coefficients indicating shared covariance and a greater chance of measuring the same construct (Goforth, 2015). Acceptable minimum coefficients usually range between 0.65 and 0.80, with less than 0.50 considered unacceptable (Goforth, 2015). Alpha coefficient for each subscale is included above.

**Validity**

Assurances of validity of measures require the consideration of whether or not what is being measured is that which is intended to be measured (Johnson & Christensen, 2014). As many of the items used for measurement in the current study were adapted or created new from suggestions in the literature and from previous research a good part of the survey was being piloted. Comparing the items with an informed understanding of the constructs being operationalized the measures seemed to have face validity, however Cronbach’s alpha reported above speaks to the need for an examination of the psychometric properties of the measures and a revision to the survey. Additionally,
including multiple measures of each construct and then comparing them would afford greater confidence in the validity of measures.

**Intervention**

*I’ll Have a Side of Sex Ed* was adapted from *Talking Parents, Healthy Teens*, a worksite wellness lunch and learn program series (Eastman et al., 2006; Schuster et al., 2008). The adapted curriculum used in the current study consisted of a series of six weekly 50-minute sessions designed for lunchtime delivery. All lessons were designed to enable parents to become better and motivated communicators, generally, and specifically about sexual health, and teach skills, facts, and options while recognizing and respecting diverse experiences, backgrounds, and values (Eastman et al., 2006). In addition to attending sessions, participants were strongly encouraged to complete homework assignments. See Table 3.3 for a list of topics covered in each program session and Appendix E for the full curriculum. Evaluation of the effectiveness of the curriculum and delivery of it included a summative evaluation (See Appendix F), post-intervention survey including all items from baseline survey except for demographic questions, and a six-week follow up survey identical to the post-intervention survey. The intervention was planned and delivered by the primary investigator of this research, who is also a resident and community member of Winchester/Clark County, Kentucky.

**Data Collection Procedures**

Systematic review data were collected from 12 databases between August 2015 – December 2016 using search terms parent sex education programs, communication programs, HIV prevention parent programs, theory of planned behavior parent program, increasing parents' comfort when taking with kids about sex, parent sex education, and
parent communication program, adolescent sexual health, and parent-child sexual health communication. For further details regarding systematic review data selection and extraction methods, see Chapter 6.

Quantitative data were collected from March 2016 – November 2016. Participants completing a written survey completed and submitted it at one of the approved sites including local schools, library, hospital, and community services in the target community. Those completing the paper survey signed a written consent form that also served as consent if they chose to enroll in programming (See Appendix G). Respondents who completed baseline data as part of their participation in parenting programming were compensated with a $5 gift card upon completion of the survey. Respondents who were not enrolled in programming were not compensated. Respondents completing the online survey through Qualtrics software, a secure survey database, were provided with a cover letter (See Appendix H) explaining the purpose of the study and minimal risks related to taking part in the study, which served as a waiver of written consent. For a detailed description of the data collection timeline, see Table 3.4.

**Human Subjects Protection**

After a full protocol review by the University of Kentucky Institute Review Board (IRB) the initial research design was approved on November 30, 2015 (see Appendix I for approval letter) and the IRB granted a continuation of approval on October 19, 2016 (See Appendix J for continuation approval). Throughout the study minor revisions were made to the protocol and approved including a change in criteria for participation from parents of 5 – 10 grader during the 2015 – 2016 school year to parents of 4 – 11 graders during
the 2016 – 2017 school year, an expansion to online recruitment for baseline data
collection, and an addition to recruitment and program delivery sites.

**Data Analysis**

The purpose of the systematic review of the literature was to learn more about the
components of effective parent education programming. Titles, abstracts, and full articles
were reviewed and assessed according to the inclusion/exclusion criteria. Extracted data
included location, author, year of publication, sample description and size, research
design, recruitment methods, dosage/duration of intervention, intervention strategies,
intervention content focus, incentives to participate in interventions, theoretical
framework for program and/or study design, and parental and child outcomes.

Quantitative data analysis was completed using SPSS 23 with a significance or
alpha level of 0.05 and 95% confidence intervals (CI) for all hypothesis testing. The unit
of analysis was parent and when group comparisons were made the unit of analysis was
the group. Prior to quantitative analysis, frequency distributions, graphical displays,
distribution shapes, measures of central tendency, and variability of responses were
examined. Appendix K displays the data analysis plan for Chapters 4 and 5.

**Data Cleaning**

The data set was examined to detect and correct any entry errors. Examining
missing data included a visual check and review of frequencies. Missing data were
handled in one of two ways. For cells missing data related to demographics, including
religious affiliation and religiosity, and respondents’ normative faith scores, 99 was
entered as the code for missing data. A pattern was detected in the missing data related to
questions about religion, religiosity, faith community, and importance of faith
community’s perception, in that respondents who did not answer one religion related question often did not answer any religion-related questions. An additional pattern of missing data for religious affiliation and religiosity measures was detected in the program participant group. Further examination of the paper survey revealed the placement of these items on the page made them easy to overlook. For all other cells missing data the mean series default setting for missing data in SPSS.

**Assumptions of Statistical Tests**

Mean differences in responses to dependent variables related to gender of children were tested with MANOVA and Chi-square tests of independence procedures. Before proceeding with MANOVA analyses, assumptions of independence of observations and adequate sample were tested and found tenable. To examine the assumption of normal distribution of the data normality plots, stem-and-leaf plots, skewness and kurtosis results and Kolmogorov-Smirnov and Shapiro-Wilk statistics were assessed. As the assumption for normal distribution of data was not met, transformation were made of dependent variables included in the analysis to create a more normal distribution. The assumption of homogeneity of variance-covariance matrices was not met therefore the homogeneity of variance was considered for individual dependent variables. A second MANOVA was utilized to examine differences in the degree to which sexuality topics were discussed with children (RQ5). When the initial test of homogeneity was not met, an examination of Levene’s test of equality of error variances identified the individual topics not meeting this assumption. When those topics were removed from the analysis, the assumption of homogeneity of variance-covariance matrices was met and MANOVA and post hoc Tukey-Kramer and Fischer’s LSD results were examined. Other mean differences were
analyzed using the Chi-square test of independence and the data met assumptions as variables used were categorical and each variable consisted of two or more independent groups (Corty, 2014).

Logistic regression was used to examine theory of planned behavior (TPB) constructs and select demographic variables as a way of determining the applicability of the TPB in understanding and promoting PCSHC. Logistic regression is appropriate for determining the goodness of fit between theoretically derived model and the sample data (Byrne, 2001) and identify independent predictors of health behaviors (Booth et al., 2000). Logistic regression does not assume linearity, normal distribution, or equal variances within each group (Burns & Burns, 2008). The data met the assumptions of logistic regression including independence of observations, a dichotomous dependent variable, and groups being mutually exclusive and exhaustive (Burns & Burns, 2008). Power analysis, following guidelines established in Lipsey & Wilson (2001) and G*Power 3.1.7 (Faul et al., 2013), for logistic regression based on a two-tailed alpha (\(\alpha\)) value of 0.05, a power of 0.80, and a medium effect size (OR = 1.72) generated a recommended sample size of 177.

**Summary**

The research design of the current study involved different approaches to provide greater understanding of PCSHC and contributing parental and child factors and components of intervention programs to improve parents’ abilities and confidence for engaging their children in conversations about sexuality and sexual health. As the quantitative measures used for Chapters 4 and 5 and the intervention program design
were being piloted, this study is exploratory in nature with room for improvement and expansion.
Table 3.1

Demographic characteristic of sample by survey completion method

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Paper/Pencil n = 101</th>
<th>Online n = 104</th>
<th>Total N = 205</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8 (7.9)</td>
<td>4 (3.8)</td>
<td>12 (5.9)</td>
</tr>
<tr>
<td>Female</td>
<td>93 (92.1)</td>
<td>100 (96.2)</td>
<td>193 (94.1)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>9 (8.9)</td>
<td>2 (1.9)</td>
<td>11 (5.4)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0 (0.0)</td>
<td>4 (3.8)</td>
<td>4 (2.0)</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>90 (89.1)</td>
<td>95 (91.3)</td>
<td>185 (90.2)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1.0)</td>
<td>3 (2.9)</td>
<td>4 (2.0)</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>74 (73.3)</td>
<td>80 (76.9)</td>
<td>154 (75.1)</td>
</tr>
<tr>
<td>Divorced, single</td>
<td>19 (18.8)</td>
<td>13 (12.5)</td>
<td>32 (15.6)</td>
</tr>
<tr>
<td>Single, never married</td>
<td>2 (2.0)</td>
<td>1 (1.0)</td>
<td>3 (1.5)</td>
</tr>
<tr>
<td>Remarried</td>
<td>0 (0.0)</td>
<td>8 (7.7)</td>
<td>8 (3.9)</td>
</tr>
<tr>
<td>Cohabitating</td>
<td>4 (4.0)</td>
<td>2 (1.9)</td>
<td>6 (2.9)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some high school</td>
<td>7 (6.9)</td>
<td>0 (0.0)</td>
<td>7 (3.4)</td>
</tr>
<tr>
<td>High school graduate</td>
<td>12 (11.9)</td>
<td>0 (0.0)</td>
<td>12 (5.9)</td>
</tr>
<tr>
<td>Some college</td>
<td>23 (22.8)</td>
<td>6 (5.8)</td>
<td>29 (14.1)</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>10 (9.9)</td>
<td>6 (5.8)</td>
<td>16 (7.8)</td>
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<tr>
<td>Bachelor’s degree</td>
<td>23 (22.8)</td>
<td>20 (19.2)</td>
<td>43 (21.0)</td>
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<tr>
<td>Some grad school</td>
<td>3 (3.0)</td>
<td>9 (8.7)</td>
<td>12 (5.9)</td>
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<tr>
<td>Graduate degree</td>
<td>23 (22.8)</td>
<td>63 (60.6)</td>
<td>86 (42.0)</td>
</tr>
<tr>
<td>Age of Oldest Child (grades 4 – 11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-adolescence (9 – 11)</td>
<td>24 (23.8)</td>
<td>42 (40.4)</td>
<td>66 (32.2)</td>
</tr>
<tr>
<td>Early adolescence (12 – 14)</td>
<td>51 (50.5)</td>
<td>39 (37.5)</td>
<td>90 (43.9)</td>
</tr>
<tr>
<td>Late Adolescence (15 – 17)</td>
<td>26 (25.7)</td>
<td>23 (22.1)</td>
<td>49 (23.9)</td>
</tr>
<tr>
<td>Gender of Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male only</td>
<td>34 (33.7)</td>
<td>41 (39.4)</td>
<td>75 (36.6)</td>
</tr>
<tr>
<td>Female only</td>
<td>40 (39.6)</td>
<td>37 (35.6)</td>
<td>77 (37.6)</td>
</tr>
<tr>
<td>Male and female</td>
<td>27 (26.7)</td>
<td>26 (25.0)</td>
<td>53 (25.9)</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-religious</td>
<td>9 (8.9)</td>
<td>38 (36.5)</td>
<td>47 (22.9)</td>
</tr>
<tr>
<td>Christian, non-Catholic</td>
<td>50 (49.5)</td>
<td>30 (28.8)</td>
<td>80 (39.0)</td>
</tr>
<tr>
<td>Catholic</td>
<td>8 (7.9)</td>
<td>13 (12.5)</td>
<td>21 (10.2)</td>
</tr>
<tr>
<td>Jewish</td>
<td>1 (1.0)</td>
<td>8 (7.7)</td>
<td>9 (4.4)</td>
</tr>
<tr>
<td>Muslim</td>
<td>2 (2.0)</td>
<td>0 (0.0)</td>
<td>2 (1.0)</td>
</tr>
<tr>
<td>Other</td>
<td>11 (10.9)</td>
<td>15 (0.0)</td>
<td>26 (12.7)</td>
</tr>
<tr>
<td>Religiosity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>7 (6.9)</td>
<td>25 (24.0)</td>
<td>32 (15.6)</td>
</tr>
<tr>
<td>Once or twice a year</td>
<td>20 (19.8)</td>
<td>37 (35.6)</td>
<td>57 (27.8)</td>
</tr>
<tr>
<td>Monthly</td>
<td>15 (14.9)</td>
<td>18 (17.3)</td>
<td>33 (16.1)</td>
</tr>
<tr>
<td>Weekly</td>
<td>28 (1.0)</td>
<td>21 (20.2)</td>
<td>49 (23.9)</td>
</tr>
<tr>
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<td>11 (11.9)</td>
<td>3 (2.9)</td>
<td>14 (6.9)</td>
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Table 3.2

Demographic characteristic of program participants

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<thead>
<tr>
<th>Characteristic</th>
<th>N = 50</th>
<th>%</th>
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<td>Gender</td>
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<tr>
<td>Male</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>44</td>
<td>88</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
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<td>African American</td>
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<tr>
<td>White/Caucasian</td>
<td>47</td>
<td>94</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Relationship Status</td>
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<td></td>
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<tr>
<td>Married</td>
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<td>70</td>
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<tr>
<td>Divorced, single</td>
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<td>26</td>
</tr>
<tr>
<td>Cohabitating</td>
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<td>4</td>
</tr>
<tr>
<td>Education</td>
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<tr>
<td>Some high school</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>High school graduate</td>
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<td>10</td>
</tr>
<tr>
<td>Some college</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Associate’s degree</td>
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<td>8</td>
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<tr>
<td>Bachelor’s degree</td>
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<tr>
<td>Graduate degree</td>
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<td>20</td>
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<tr>
<td>Age of Oldest Child (grades 4 – 11)</td>
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<td></td>
</tr>
<tr>
<td>Pre-adolescence (9 – 11)</td>
<td>17</td>
<td>34</td>
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<tr>
<td>Early adolescence (12 – 14)</td>
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<tr>
<td>Late Adolescence (15 – 17)</td>
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<td>Gender of Children</td>
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<td>Male only</td>
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<td>24</td>
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<tr>
<td>Female only</td>
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<td>Male and female</td>
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<td>Non-religious</td>
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<tr>
<td>Christian, non-Catholic</td>
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<td>50</td>
</tr>
<tr>
<td>Catholic</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Muslim</td>
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<td>2</td>
</tr>
<tr>
<td>Other</td>
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<td>16</td>
</tr>
<tr>
<td>Religiosity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Once or twice a year</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Monthly</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Weekly</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>More than once a week</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Session Title</td>
<td>Topics/Skills</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Positive Parent-Child Relationships and Effective Communication</td>
<td>Communication = connection Open-ended questions</td>
<td></td>
</tr>
<tr>
<td>Introduction to Communication with Your Child about Sexual Health</td>
<td>Teachable moments and conversation starters</td>
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</tr>
<tr>
<td>Listening to Learn</td>
<td>Active listening</td>
<td></td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Assertiveness and S.T.O.P.</td>
<td></td>
</tr>
<tr>
<td>More Communication Skills</td>
<td>S.T.O.P. and correct condom use instructions</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.4  
Data collection timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study proposed to and approved by doctoral committee</td>
<td>February 2016</td>
</tr>
<tr>
<td>Recruitment for study began</td>
<td>February 2016</td>
</tr>
<tr>
<td>Baseline data collection began</td>
<td>April 2016</td>
</tr>
<tr>
<td>Intervention series 1, 2, 3 with baseline and post data collection and summative evaluation</td>
<td>April – May 2016</td>
</tr>
<tr>
<td>Intervention series 1, 2, 3 six-week follow up</td>
<td>July 2016</td>
</tr>
<tr>
<td>Intervention series 4, 5 with baseline and post data collection and summative evaluation</td>
<td>June – July 2016</td>
</tr>
<tr>
<td>Intervention series 4, 5 six-week follow up</td>
<td>August 2016</td>
</tr>
<tr>
<td>Online baseline data collection began</td>
<td>September 2016</td>
</tr>
<tr>
<td>Intervention series 6 with baseline and post data collection and summative evaluation</td>
<td>February – March 2017</td>
</tr>
<tr>
<td>Intervention series 6 six-week follow up</td>
<td>May 2017</td>
</tr>
<tr>
<td>Recruitment for study ended</td>
<td>July 2017</td>
</tr>
<tr>
<td>Intervention series 7 with baseline and post data collection and summative evaluation</td>
<td>July 2017 – August 2017</td>
</tr>
<tr>
<td>Intervention series 7 six-week follow up</td>
<td>September 2017</td>
</tr>
<tr>
<td>All data collection ending</td>
<td>September 2017</td>
</tr>
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CHAPTER 4

Manuscript 1: The Role of Gender of Child in Parent-Child Sexual Health Communication

Proposed journal: *Family Relations*

Secondary journal: *Journal of Health Communication*
Abstract

Parent-child sexual health communication (PCSHC) can play a critical role in fostering healthy sexual development in adolescents and reducing the risk of negative sexual health outcomes. To understand more about PCSHC the current exploratory cross-sectional study gives consideration to parental beliefs, intentions, and behaviors and child factors, specifically gender, that may hinder or encourage parents to engage their children in PCSHC that can promote overall adolescent health. Parents of children in grades 4 – 11 completed measures of the TPB constructs, the range of sexuality topics covered with their children, and parental self-ratings of ability and openness, which were examined in relation to the gender of their children. Significant differences related to the gender of children were found with certain sexuality topics and actual condom instruction delivery. The few significant findings may signal to some of the persistent and detrimental ways in which parents differentiate PCSHC for their children based on gender.

Keywords: Adolescent health, communication, gender, parents, sexual health
The Role of Gender of Child in Parent-Child Sexual Health Communication

Introduction

Adolescent and young adult sexual health outcomes are often influenced by their knowledge and understanding of sexuality, sexual health, and risk reduction practices. Education and learning can come from a variety of sources including family members, friends, media, religious leaders (Bleakley, Hennessy, Fishbein, & Jordan, 2009), teachers, and healthcare providers (Donaldson, Lindberg, Ellen, & Marcell, 2013). Parents are often cited as a primary and preferred source of sexual health information among adolescents (Bleakley, et al., 2009; Donaldson, Lindberg, Ellen, & Marcell, 2013; Secor-Turner, Seiving, Eisenburg, & Skay, 2011; Schouten, van den Putte, & Meeuwesen, 2007; Thompson et al., 2015). Of the many roles and responsibilities of parents, teaching children about sexuality and sexual health can provide great benefit to children but may be challenging for parents. A number of communication barriers for parents have been cited in the literature including questions about one’s ability to communicate (Byers et al., 2008), uncertainty about what and when to communicate, lack of communication strategies (Eastman et al., 2005), and discomfort with sexuality (Lefkowitz & Stoppa, 2006).

Although many parents struggle with communicating with their children about sexuality topics and encouraging their children to ask sexuality-related questions (Byers, Sears, & Weaver, 2008), parent-child sexual health communication (PCSHC) is positively related to adolescent risk reduction behaviors and attitudes (DiClemente et al., 2001; Guilamo-Ramos, Hall, Moreau, & Trussell, 2012; Jaccard, Dittus, & Collins, 2008; Kapungu et al., 2010; Salazer et al., 2005; Troth & Peterson, 2000). Adolescents who talk
less or not at all with their parents about sex are less likely to negotiate safer sex with partners, practice safer sex (DiClemente et al., 2001), or use birth control (Clawson & Reese-Weber, 2003). While certain parental factors impact PCSHC, child factors and their impact on parents’ perceptions may inform how parents approach PCSHC. Of the many factors impacting PCSHC that warrant investigation, a recommendation in parent sexuality education literature is to examine the differences in communication with regard to gender (Beckett et al., 2009; White, Wright, & Barnes, 1995) as PCSHC can differ based on gender of the child and parent (DiLorio et al., 2000; Keijsers & Poulin, 2013; Wilson & Koo, 2010).

Negative sexual health outcomes for young people, including unintended pregnancy and sexually transmitted infections (STIs), are consequences of inadequate education about sexuality and sexual health (Phipps, 2008). Many adolescents who engaged in romantic relationships, intercourse, and other sexual behaviors did so before, if ever, communicating with parents about preventing pregnancy and safer sex practices (Beckett et al., 2009; Byers, Sears, & Weaver, 2008; Eisenberg, Sieving, Bearinger, Swain, & Resnick, 2006). While some parents rely on schools providing children with sexuality education, many school programs funded and delivered in the U.S. over the last 25 years have been abstinence only until marriage (SIECUS, n.d.) or abstinence with supplemental contraceptive information (Advocates for Youth, 2008). Programs focusing only on abstinence have failed to give evidence of positively impact adolescent sexual behaviors (Kirby, 2007).

As potential primary sources of sexuality and sexual health information, parents have an important role in addressing the educational needs of their children (Afifi,
Joseph, & Aldeis, 2008; Poulsen et al., 2010) and the opportunity to transmit their values related to sexuality, which may increase the chances their children will adopt safe and healthy behaviors (Schouten, van den Putte, Pasmans, & Meeuwesen, 2007). Further, parents have the opportunity to promote and teach gender equality through the content they include and the manner in which they address it. A step in the progress toward equal education for both male and female children is to learn more about how their gender relates to their parents’ approach to sexual health communication. The purpose of this study was to examine from a parental perspective the relationship between the gender of children and constructs related to PCSHC, including those that make up the theory of planned behavior (TPB) framework (Ajzen, 1991), to better understand how to promote positive and effective PCSHC.

**Literature Review**

Communication exchanges that take place between parents and their children regarding sexuality are referred to as parent-child sexual health communication (PCSHC). This type of communication is not limited to risk reduction communication and sexual behaviors but includes that which enhances children’s understanding of sexuality and all its dimensions (Jerman & Constantine, 2010; Schouten et al., 2013). Parent-child sexual health communication includes discussion of topics related to human development, nonsexual relationships, decision making, talking with potential partners about choices related to sexuality and sexual health, and safer sex options.

**Parent-Child Sexual Health Communication and Gender**

Generally, parents engage in more communication with daughters, especially during middle to late adolescence (Kapungu et al., 2010; Keijsers & Poulin, 2013).
Specific to PCSHC, girls are likely to hold more positive beliefs about the behavior than boys, and talk more with parents and siblings about sexuality (Schouten et al., 2007). While some research presents male children reporting more PCSHC than girls (Sneed et al., 2013) and no differences in the number of sexual health topics discussed with male compared to female children (Wilson & Koo, 2010), parents and children more often report more frequent communication (Kapungu et al., 2010; Keijsers & Poulin, 2013; Wilson & Koo, 2010) and a greater number of sexual topics discussed with female children (Miller et al., 2011; White et al., 1995).

Communication patterns between parents and their adolescent children shift during this developmental stage with primary pursuits of autonomy and independence for children during early adolescence (12 to 14 years old) and connectedness with parents in late adolescence (14 to 19 years old), however some differences in PCSHC appear in late adolescence that may be attributed to gender (Keijsers & Poulin, 2013). While children’s interest in communicating with parents during early adolescence may be impacted by the desire for autonomy and independence, their comfort level communicating with parents may be greater during this stage rather than later in adolescence (Levin, 2012).

Barriers or prompts to engaging in PCSHC may impact both male and female children (Pariera et al., 2016). Barriers to earlier communication is the parent perception that children are too young to learn about sex, which is often replaced as children get older with the perception that the child is not receptive to education from parents (Pariera et al., 2016). Perceptions that children are too young may cause parents to delay initiating PCSHC when children might benefit from it the most (Poulsen et al., 2010). Research in mothers has indicated that they may communicate about sexuality well before they expect
their children to engage in sexual behaviors, or choose to initiate discussions only when they believe their children are approaching sexual debut, which often occurs earlier than expected (Marhefka et al., 2009). Fathers can be effective educators if discussions are timely, however those who perceive sexual activity as developmentally appropriate for older adolescents may not feel the need to engage in sexual communication with their children, assuming children have already acquired the knowledge needed to make sexual decision (Clawson & Reese-Weber, 2003). While parents may believe their initiation of PCSHC is well timed when they perceive readiness in their children (Poulsen et al., 2010) or when a daughter reaches menarche (Erchull & Richmond, 2015), they may be missing opportunities to provide children with valuable and necessary information in preparation rather than in response to adolescent sexual development and activity. Parents engage more in PCSHC with older children (Pluhar DiLorio, & McCarty, 2008) and report engaging in PCHSC earlier with daughters than sons (Beckett et al., 2009; Erchull & Richmond, 2015; Pluhar et al., 2008).

Male children may be impacted more negatively by parents’ perception of appropriate timing for PCSHC. As males grow into late adolescence they report less initiation of communication on the part of parents and less parental control compared to females (Keijzers & Poulin, 2013), find it less important to talk with parents about sexuality (Schouten et al., 2007), and may find themselves at elevated risk for negative sexual health outcomes when they have difficulty communicating with parents (Levin et al., 2012). Parent perceptions that can perceive male adolescents as already at risk for engaging in sexual behaviors (Sneed et al., 2013; Wilson & Koo, 2010) may lead parents to believe they would be ineffectual in helping to reduce these risks. This perception
coupled with parent-child relationships where children, especially males, exhibit high levels of independence, high levels of secrecy and low levels of disclosure (Keijsers & Poulin, 2013) may create a barrier to initiating and having meaningful conversations with male children about risk reduction and partner communication.

**Topics of Parent-Child Sexual Health Communication**

The older children grow the more topics parents discuss with them. Byers et al. (2008) found that although topic number grew as children aged, parents were only addressing them in general terms without detail, regardless of the developmental appropriateness of the topics. Parents often discuss a greater number of sexuality topics with daughters than sons (Kapungu et al., 2010; Miller et al., 2011; White et al., 1995). Parents’ communication with daughters about sexual health tended to focus on abstinence for now or until marriage (Sneed et al., 2013) with parents disproving of female adolescent sexual behaviors, holding the belief that they would be more harmful for daughters compared to sons (Wilson & Koo, 2010). Some parents teach daughters prevention and promote abstinence specifically, while others communicate more generally about sexuality, including topics such as the experience of romantic love in conversations about sexual health (Lefkowitz & Stoppa, 2006).

Parent child sexual health communication that specifically addresses condom use has been associated with a greater likelihood of adolescents using condoms correctly and consistently (Hadley et al., 2009). Sneed et al. (2013) found male children were significantly more likely to be engaged in PCSHC that addressed condom use, however, a systematic review of the impact of PCSHC on adolescent behavior concluded the association between PCSHC and actual contraceptive and condom use was significantly
stronger for adolescent females than males (Widman et al., 2016). While some parents are talking specifically about correct and consistent condom use, others tend to avoid discussions that involve their children’s personal sexual behavior (Sneed et al., 2013). Avoiding direct conversions with children, male and female, about their personal sexual behaviors, may impede children’s safer sex practices.

The occurrence and topics of PCSHC are related to gender roles and expectations. Mothers’ adherence to more egalitarian gender roles, where they feel as equally responsible as fathers for communicating with their children about sexual topics, was associated with more sexual communication with sons (McKee et al., 2007). White and colleagues (1995) found fathers were likely to communicate more comprehensively with daughters, discussing factual and value-based topics, while Wilson and colleagues (2010) found that fathers were as likely to talk to sons as daughters about a number of topics with the exception of dating and relationships with daughters. Highlighting a gender divide, when discussing menstruation fathers reported they would more likely to discuss negative aspects of the menstrual cycle with sons compared to daughters, offering advice for coping with the mood swings of those who menstruate to sons while making no mention of this topic to daughters (Erchull & Richmond, 2015). Further evidence to differences in gender expectations, fathers are expected to be more effective communicators with their sons (Rosenthal et al., 2001) and are often expected to have “man to man” talks about topics considered more relevant to males (Feldman & Rosenthal, 2000). However, fathers may perceive the need to serve as gatekeepers to their daughters’ sexuality (Lefkowitz & Stoppa, 2006), which may not result in the communication of accurate information.
Even for parents who both intend to and actually engage in PCSHC, there are certain topics they are not comfortable addressing (Morawska et al., 2015), including wet dreams and spontaneous erections (Kapunga et al., 2010). Aside from these topics, parents are more likely to engage in PCSHC that provides children with education about development during puberty and other informational topics such as abstinence and sexuality in the media and less likely to address personal topics related to children’s present and/or future engagement in sexual behaviors such as safer sex and sexual decision making (Byers & Sears et al., 2012; Sneed et al., 2013). When selecting topics for discussion parents may address the negative consequences of sexual behavior, including unintended pregnancy, sexually transmitted infections, and non-consensual sex in greater depth (Afifi et al., 2008).

Possible contributing explanations for more PCSHC with female children may be that parents report feeling more capable and effective at communicating with daughters (Wilson & Koo, 2010), lacking knowledge and skills for communicating with sons (Guilamo-Ramos et al., 2008), and less effective impacting sons’ behaviors (O’Donnell et al., 2005). Because they are engaging in more PCSHC with children communication openness may seem more important for mothers than fathers (White et al., 1995), which may contribute to more adolescent communication with mothers rather than fathers (Schouten et al., 2007). However, to promote effective PCSHC with both male and female children, openness would seem to be an equally important quality in both mothers and fathers. Openness in communication with adolescent males and their parents can decline during early adolescence and stabilize at low levels of child willingness to disclose and parental solicitation and high levels of child secrecy. Conversely, female
children report open patterns of parent-child communication from middle adolescence into adulthood (Keijsers & Poulin, 2013). While high quality mother-child relationships should include open and thoughtful discussions about sexuality with direct discussion about sexual health, including birth control and safer sex (Riggio et al., 2014), this should hold true also for parent-son relationships. While openness may promote more frequent and varied PCSHC, Hadley et al. (2009) did not find it significantly related to adolescent safer sex behavior.

**Theoretical Framework**

Constructs of the theory of planned behavior (TPB) (Figure 1.1), including attitudes, subjective norms, and perceived behavioral control have been used to explore parent-child relationships, predict intentions of parental involvement (Perry & Langley, 2013), and PCSHC (Byers & Sears, 2012; Pariera et al., 2016). Behavioral beliefs are comprised of attitudes toward and assessment of the value of a behavior (Ajzen, 1991). Normative beliefs are determined by the evaluation of those relevant others’ appraisal of and support or disapproval of a behavior (Ajzen, 1991). Perceived behavioral control is established through one’s degree of confidence in their ability to perform a behavior (Ajzen, 1991). The TPB accounts for intentions, but also individuals’ abilities to act on their intentions (Perry & Langley, 2013). Actual behavioral control as determined by skills and resources needed to actually perform the behavior are included in the model (Ajzen, n.d.). At the foundation of the TPB is the expectation that intention to engage in a behavior leads to actual performance of the behavior and intentions and behaviors are the result of an interaction of model components (Glanz, Lewis, & Rimer, 1997). Actual engagement in PCSHC can promote positive attitudes, norms, and control beliefs about
healthy sexual practices (Malcolm et al., 2005). Examining PCSHC through the lens of the TPB allows for a deeper understanding of the intentions of parents and any differences in beliefs and/or communication patterns based on the gender and age of children.

Parents who hold positive attitudes toward PCSHC are found to be more active communicators with their children (Byers & Sears, 2012) and as parents continue to perceive value in PCSHC, its frequency and quality increases (Pariera et al., 2016). Conversely, negative parental attitudes toward teaching children about sexuality serve as a barrier to engaging in PCSHC (Byers et al., 2008). Gender of children may influence behavioral beliefs and the attitudes that inform them. Holding the beliefs that sexual activity is potential more harmful to and less acceptable for daughters can impact PCSHC (Wilson & Koo, 2010). Byers and Sears (2012) found that while mothers of dating adolescents lacked social support for engaging in PCSHC, intentions were inspired by their daughters’ romantic involvement. Normative beliefs may hold more power over female than male children (Schouten et al., 2007).

Control beliefs are based in parents’ perception of factors that impede or promote the intentions and performance of parenting behaviors (Perry & Langley, 2013), including PCSHC. Levels of knowledge (Byers et al., 2008; Morawska et al., 2015), confidence, comfort (Morawska et al., 2015), and self-efficacy (Nielsen et al., 2013; Wyckoff et al., 2008) can inform PCSHC, with higher levels being associated with frequency and effectiveness of behavior performance (Poulsen et al., 2010). Feeling knowledgeable about sexuality does not alleviate parental discomfort related to discussing certain topics about sexuality (Morawska et al., 2015) but both greater
knowledge and comfort, at least on the part of mothers, is related to more active engagement in PCSHC (Byers & Sears, 2012). Parents may be comfortable with and sensitive and responsive to certain aspects of their children’s sexuality, but struggle with initiating PCSHC and accessing and providing sexual health resources for their children (Morawska et al., 2015). Mothers also report greater discomfort discussing sexuality and sexual health with their sons compared to fathers (Kapungu et al., 2010).

Communication self-efficacy is negatively associated with barriers to PCSHC (Pariera et al., 2016) and positively associated with more active PCSHC on the part of mothers (Byers & Sears, 2012). Self-efficacy levels may vary dependent on gender of child. Wilson & Koo (2010) found parents had a higher level of self-efficacy when talking with daughters about how to say no to sex compared to sons. McKee and colleagues (2007) found that gender role beliefs and adherence on the part mothers impacts PCSHC, with more gender egalitarian perspectives being associated with more frequent PCSHC regardless of the gender of the children. While foundational to the TPB is that intentions predict actual behavior, parents can establish the intention to engage in PCSHC but perceive a lack of social support embedded in normative beliefs, which can prevent the transformation from intention to action (Byers & Sears, 2012).

While children report talking more with mothers than fathers (Afifi et al., 2008; Holman & Kellas, 2015; Thompson et al., 2015), parents often engage daughter in PCSHC earlier (Beckett et al., 2009; Pluhar, DiIorio, & McCarty, 2008) and more often (Afifi et al., 2008; Kapungu et al., 2010) than they do with sons. It seems females, mothers and daughters, are move active communicators than males. Mothers report they are more likely to engage in PCSHC with daughters (DiIorio et al., 2000), and female
children report greater information needs than boys and more PCSHC with parents (Schouten et al., 2007).

**Current Study**

The purpose of the current study was to give consideration to parental beliefs, intentions, and behaviors and child factors, specifically gender, that may hinder or encourage parents to engage their children in PCSHC that can promote overall adolescent health. Studies addressing PCSHC and gender of children often examine results in a binary fashion, with reports about parents communicating with daughters versus sons. Erchull & Richmond (2015) present this as a limitation and suggest comparing data by three subgroups, female only, male only, or female and male children. The current study examined differences in the PCSHC patterns of parents with male only, female only, and male and female children in grades 4 to 11. Due to patterns of women, particularly mothers, being more likely to participate in research studies than men (or fathers), we did not expect to have a sufficient sample of fathers to conduct meaningful analysis regarding sex-of-parent effects (Feldman & Rosenthal, 2000). We obtained information from parents to answer the following research questions: 1) Are parental behavioral, normative, and control beliefs related to gender of child(ren)? 2) Is there a difference in overall sexuality topics scores related to gender of child(ren)? 3) Are parental self-ratings of communication ability related to gender of child(ren)? 4) Are there differences in communication openness of parents based on gender of child(ren)? 5) Are there differences in specific sexuality topics discussed related to gender of child(ren)? 6) Are there differences in the intention to engage in PCSHC, actual PCSHC, intention of giving condom use and actual condom use instructions related to gender of child(ren)?
Method

Participants and Procedures

For the purpose of this study, an individual was considered a parent if the child(ren) lived with him/her at least three days of the week. Subjects were recruited to voluntarily complete a paper ($N = 101$) or online survey ($N = 104$). Subjects completing the paper survey signed a written consent form while those completing the online survey were provided with a cover letter explaining the purpose of the study and minimal risks related to taking part in the study. When they clicked to proceed to the next page, this served as informed consent. Some subjects were recruited through an online posting on Facebook, while targeted community recruitment methods for respondents residing in the rural Southeastern county included letters mailed to parents of students enrolled in county schools of target community, flyers posted at the local public library, and emails sent to employees and tabling outreach at the local hospital. Data were collected from March 2016 – November 2016. Parents of children in grades 4 – 11 during the 2016 – 2017 school year whose children stayed with them at least an average of at least three nights a week were eligible to complete baseline data. The survey took respondents 10 – 20 minutes to complete.

Measures

Measures were designed to learn more about parents’ intention to engage and actual participation in PCSHC, beliefs about PCSHC, and perceptions of communication ability and openness. While certain questions ask about sexuality topics they are intended to measure sexual health communication from parents’ perspective. The discrepancy in the language was intentional to avoid parents perceiving “sexual health topics” as being
limited to only those related to STI and unintended pregnancy risk reduction. In addition to demographic variables where parents were asked to report their age, gender, race/ethnicity, marital status, educational level, and number of children, and age of oldest child in grades 4 - 11, the following measures were used to answer the research questions of interest:

**Gender of child(ren).** Parents were included in one of three groups based on the gender of their child(ren) in grades 4 to 11 during the 2016/2017 school year. Groupings were male only, female only, and male and female. Respondents’ children in grades below fourth and above eleventh were not included in the analytic sample as the investigation was focused on PCSHC with late pre-adolescent and adolescent children.

**Behavioral beliefs.** The behavioral beliefs subscale consisted of seven items ($\alpha = 0.61$) recommended by Schouten et al. (2007) for measuring children’s beliefs and modified to collect parent beliefs about engaging in PCSHC. Five of the seven items were reverse coded. The seven point scale (7 = agree, 1 = disagree) scores for each item were added together to provide a total scale score ranging from 7 to 49 with higher scores indicating more positive beliefs about PCSHC. Two examples of items include are “it is important to me that my child can talk to me about sexuality” and “I would feel embarrassed talking about sexuality with my child.”

**Normative beliefs.** The normative belief subscale consisted of five items ($\alpha = 0.64$) designed to measure one’s subjective norm with questions related to values of important referents and the importance of the referents opinions. Specific referents for this study were family, friends, and faith community. Items for each referent are 1) My (referent) thinks I should talk with my child about sexuality and 2) The opinion of my
(referent) is important to me. Total scores were obtained by multiplying first items (what referents think) by second items (importance of referent’s opinion) and adding the three products (family, friends, church community) (Schouten et al., 2007). Total scores ranged from three to 147 with higher scores indicating greater importance of referents and referent opinions.

**Control beliefs.** The control belief subscale consisted of three items ($\alpha = 0.44$) designed to measure perceived behavioral control. One item came from the literature, “It is easy to talk with my child about sexuality” (Schouten et al., 2007), and two were added to this study based on the recommendation of Ajzen (n.d.), and “It is up to me to talk to my child about sexuality” and “I believe talking to my child about sexuality topics will help them avoid unintended pregnancy and sexually transmitted infections”. The seven point scale (7 = agree, 1 = disagree) score for each item is added together to provide a total scale score ranging from 4 to 28 with higher scores indicating more perceived control over engaging in PCSHC.

**Sexuality topics.** A list of 23 sexuality topics made up the sexuality topics subscale ($\alpha = 0.95$). Using a four-point response scale (4 = a great deal, 3 = a moderate amount, 2 = somewhat; 1 = not at all) participants indicated to what degree they discussed with their children a number of sexuality related topics (Eisenberg et al., 2006). Sexuality topics were considered individually and a total score was calculated; both were used in data analysis.

**Communication ability.** Parents responded to the question, “How would you rate your ability to communicate with your child about sexuality topics?” based on a seven point scale (7 = excellent, 1 = terrible). This measure was used to assess parents’
perceptions of their communication ability in the evaluation of a parent-child
communication curriculum (Schuster et al., 2008).

**Communication openness.** The Open Sexual Communication subscale (Miller,
Kotchick, Dorsey, Forehand, & Ham, 1998) consisted of 10 items ($\alpha = 0.66$) and was
used to assess openness of sexual communication between parent and child. Miller et
al.’s original subscale was modified from a four to seven-point scale (7 = agree, 1 =
disagree). Four items were reverse coded. Scores from the ten items were summed for a
scale score ranging from 10 to 70. Higher scores indicated more openness and receptivity
to PCSHC.

**Communication Intentions and Behaviors.** Parents indicated with a yes/no
response to the following statements: “I intend to talk with my child repeatedly about
many topics related to sexuality and sexual health,” “In the past 6 weeks I talked with my
child repeatedly about many topics related to sexuality and sexual health,” “I intend to
review the steps of how to use a condom with my child” (Ajzen, n.d.), and “I have
reviewed the steps of how to use a condom with my child(ren).”

**Analysis**

Parent groupings based on gender of children were male only, female only, and
both male and female for all analyses. To examine differences in parents’ TPB
communication beliefs, total sexuality topics scores, and communication ability and
openness related to gender of child(ren) in grades 4 to 11, a multivariate analysis of
variance (MANOVA) was utilized (RQ 1, 2, 3, and 4). A second one-way MANOVA
was conducted to determine differences between parent groups in their communication
about specific sexuality topics. Before proceeding with analyses, assumptions of
independence of observations and adequate sample were tested and found tenable. As the assumption for normal distribution of data was not met, transformations were made of dependent variables included in the analysis to create a more normal distribution. When the assumption of homogeneity of variance-covariance matrices was not met, Tabachnick & Fidell (2001) advises that if sample sizes are unequal and the p value associated with Box’s M test is greater than 0.001 it is acceptable to continue with the analysis. The homogeneity of variance was considered for individual dependent variables. In the case where individual variables did not meet the assumption of homogeneity of variance with Levene’s test of equality of error variances, results from Tamhane’s post hoc test was examined, which does not assume equal variances. For those topics that did meet the assumption of homogeneity or variance Tukey-Kramer and Fischer’s LSD post-hoc test results were examined.

Chi-square tests of independence were used to compare parental intentions and actual behavior of PCSHC in parents of female child(ren) only, male child(ren) only, and mixed-gender groupings of children (RQ6). The data met the assumptions of variables being categorical and each variable consisting of two or more independent groups (Corty, 2014). Analyses of whether gender of child(ren) and parental intentions to and actual behavior of PCSHC and parental intentions and actual behavior of giving children correct condom use instructions were independent of one another.

Results

Table 4.1 presents descriptive statistics for the 205 respondents classified in parent groupings by gender of children. The average age of participants was 42 (SD = 5.9; range 24 – 67). Nearly all participants were female (94.1%), white (90.2%), and just
over three-quarters reported being married (75.1%). The majority of respondents reported holding at least a bachelor’s degree (68.9%), with 42% of the entire sample having earned a graduate degree. The sample was fairly distributed into gender of children groupings with parent with 36.6% parents of male only children (N = 75), 37.6% female only (N = 77), and 25.9% male and female (N = 53. The average age of oldest child was 12.7 years old (SD = 2.31; range 9 - 17).

Behavioral belief scores were similar across parent groups. Of a maximum score of 49 for behavioral beliefs, with higher scores indicating a more positive attitude toward PCSHC, parents of male only child(ren) had a mean score of 40.50 (SD = 5.45; range = 26 - 49), female only child(ren), 40.52 (SD = 5.43, range 27 - 49 ), and both 40.92 (SD = 5.22; range 30 - 49). Control belief scores were also similar but with parents of both male and female children scoring slightly lower than parents of male only and female only child(ren). Of a maximum score of 21 for perceive control beliefs, with higher scores perceiving greater control over the enactment of PCSHC, mean scores for parents of male only children, 18.44 (SD = 2.33; range 12 – 21), female only, 18.23 (SD = 2.32; range 12 – 21) and both, 17.87 (SD = 2.47; range 10 – 21). Normative belief scores varied more based on parent group with parents of female only child(ren) scoring lower than parents of male only and those of both male and female children. Of a maximum score of 154 for normative beliefs, with higher scores indicating greater perceived support for PCSHC from referents, the mean score for parents of male only child(ren) was 59.17 (SD = 31.25; range 4 - 154), female only, 49.87 (SD = 26.33; range 9 – 12), and both, 60.71 (SD = 29.35; range 14 – 153). The majority of parents who completed the survey had intentions to engage in PCSHC (188; 91.7%) and condom instruction review (152; 74.1%) and
reported actually engaging in PCSHC with children (130; 63.4%), however, only 31 (15.1%) had reviewed steps for how to use a condom, with 172 (83.9%) reporting they did not have intentions to do so. Sample mean and standard deviation scores for sexuality topics are presented in Table 4.2 and also reported according to the development level of oldest child in grades 4 - 11 in Table 4.3. With the exception of a decrease in the score for discussing wet dreams with child(ren) in early adolescence to late adolescence, all sexuality topic scores increased with age of child(ren).

The multivariate tests of a one-way MANOVA revealed that gender of children did not have a significant effect on behavioral, normative, and control beliefs, parental self-ratings of communication ability, openness, and total sexuality topics scores. The second one-way MANOVA indicated a significant difference in sexuality topics discussed based on gender of child(ren), $F(46, 360) = 4.61, p < 0.001$; Wilk’s $\Lambda = 0.40$, partial $\eta^2 = 0.37$. See Table 4.4 for significant results from univariate analyses. There were significant mean score differences between parent groups in the degree to which they had discussed how girls’, $F(2,) = 27.38, p < 0.001$, and boys’, $F(2,) = 17.13, p < 0.001$, bodies change physically as they grow up, menstruation, $F(2,) = 31.21, p < 0.001$, reasons why you should not have sex $F(2,) = 3.11, p = 0.05$, and how to say no if someone wants to engage in sexual behaviors and you are not interested $F(2,) = 6.71, p < 0.01$. Post hoc test results allowed further examine the differences among the parent group means of these sexuality topics.

Parents of male only children ($M = 2.26, SD = 0.85$) covered girls’ bodies and how they change significantly less than those of female only ($M = 2.26, SD = 0.85$) and both male and female children ($M = 2.26, SD = 0.85$). This same gender of child(ren)
pattern is found with the topics of menstruation. Parents of male only children \((M = 2.26, SD = 0.85)\) covered menstruation significantly less than parents of female only \((M = 2.26, SD = 0.85)\) and male and female children \((M = 2.26, SD = 0.85)\). The reverse was found with regards to talking about how boys bodies change physically as they grow up. Parents of female children \((M = 2.26, SD = 0.85)\) discuss boys’ bodies and development significantly less than parents of male children \((M = 2.26, SD = 0.85)\) and male and female children \((M = 2.26, SD = 0.85)\).

Parents who had both male and female children \((M = 2.26, SD = 1.02)\) shared significantly more with their children reasons why their children should not have sex when compared to parents who only had male \((M = 2.22, SD = 1.07)\) or female children \((M = 2.23, SD = 1.14)\). For the item “how to say no if someone wants to engage in sexual behavior with you and you do not want to” the mean score for parents of male only children \((M = 2.01, SD = 1.11)\) was significantly lower than parents of female only \((M = 2.52, SD = 1.13)\) and those of male and female children \((M = 2.61, SD = 1.08)\).

Chi-square tests of independence statistics were calculated to examine if there were differences in parent groups with regard to intentions to engage in PCSHC, actual PCSHC engagement, intentions to give condom instructions, and actual delivery of condom instructions. A significant difference was found between parent groups in actual communication of condom instructions \(\chi^2(2, N = 203) = 6.96, p = 0.03\). Parents who had both male and female children \((M = 2.26, SD = 0.85)\) were more likely to give condom instructions to their children than parents of male only \((M = 2.26, SD = 0.85)\) or female only children \((M = 2.26, SD = 0.85)\). Another significant difference in actual communication of condom instructions was found based on age of oldest child, ages 9 -
17, $\chi^2(8, N = 203) = 29.93, p < 0.001$, with nearly 75% ($N = 23$) parents who reported giving correct condom instructions giving them to children ages 12 – 15.

**Discussion**

The findings in the current study reinforce the general need for increased communication between parents and child regarding sexuality and sexual health. Mean scores indicate that while parents may be address many sexuality and sexual health topics a little to a moderate amount with their child(ren), parents aren’t reporting a lot of conversations with their child(ren) about these important topics. The significant findings in the current study may signal to greater issues of gender equality for both male and female children in PSCHC, which can ultimately leave male and sometimes female children out of important conversations about sexual health, especially if they do not have siblings or have only same-sex siblings. Although these significant findings warrant further consideration, that there were not significant differences in coverage of many of the sexuality topics included in the current study related to gender of children reinforces past research that found weaker to no gender-based differences (Jerman & Constantine, 2010; Pariera, 2016). Regarding parental perceptions related to PCSHC, while Guilamo-Ramos et al. (2008) found mothers’ felt limited in their capabilities in communicating with sons due to lack of knowledge and skills, the current study found no significant difference in parents’ self-ratings of communication ability. Additionally no significant relationships were found between gender of child(ren) and parental openness, behavioral, normative, and control beliefs, intentions for PSCHC and delivery of condom instructions and actual PCSHC in the current study. While parents did not exhibit differences in their perceptions, beliefs, and intentions, the significant differences in topic coverage that were
gender-based may signal the perpetuation of gender-based, sexual double standards and the protective power of being part of a family with mixed-gendered siblings.

Teaching children only about the ways in which their own bodies will change during puberty, rather than about all bodies, can convey the message that it is only important to learn about and care for one’s own body. It seems parenting only male or female children serves as a disadvantage to those children in that parents may not recognize the need to address sexuality topics that are perceived as inconsequential based on gender. However, these topics are pertinent, regardless of gender as teaching children about the changes to the bodies of all sexes promotes the importance of understanding of and care for bodies, regardless of sex.

While female children without brothers and male children without sisters may be missing important physiology lessons related to pubescent development, the current study shows parents with male only children are talking significantly less with them about how to assert themselves when they are uninterested in another’s sexual advances. If parents of male only children are not conveying messages to their children how to say no it may be that they are also not conveying the message that it is okay to say no. To understand this, further research is needed. Parent of male only children may talk less about declining invitations or advances from someone else and delaying or abstaining from sexual activity because they don’t feel that their PCSHC would actually reduce the likelihood that their children would be sexually active (Wilson & Koo, 2010). While the current study did not specifically seek to overcome barriers to PCSHC with sons, low levels of communication with (Wilson & Koo, 2010) and lack of instruction for (DiLorio et al., 2000) boys is an area in need of further exploration. Because male adolescents are
more likely to engage in sexuality communication with friends and have low interaction with adults they may be at greater risk for misinformation (Thompson et al., 2015). Compared to girls, boys may be less likely to hold positive beliefs about PCSHC and find it less important (Schouten et al., 2007). Sons would benefit from parents being aware of and having the confidence to initiate and/or increase communication about sexuality and how sexual activity impacts boys (Wilson et al., 2010).

Prior research has found that sexual health messages are communicated from mother to daughter more frequently than mother to son and the messages are more protective (Kapungu et al., 2010) with daughters being held to stricter moral standards than sons (Martin & Luke, 2010). Previous findings also show parents feeling less confident and effective in engaging in PCSHC with sons, especially in encouraging male children to delay sexual activity and teaching them the language and skills to refrain from and/or decline invitations to sexual activity (Wilson et al., 2010). This may be a possible explanation for the current finding that parents of male only children talking less than parents of female only or male and female children about ways to decline sexual advances from others. Talking with one’s child about how to decline invitations to sexual behaviors is a protective measure. If parents of sons only are talking significantly less about it compared to parents of females only and female and male children, this gap in communication can increase adolescent males’ risk of negative sexual health outcomes (Sneed et al., 2013) and engaging in sexual behaviors before feeling ready.

In the current study parents of male and female children were more communicative about certain sexuality topics when compared with parents of female only and male only children. It may be that when parents are parenting both boys and girls,
they have a broader perspective, are more aware of the need to share this information with all children, regardless of gender, and recognize sexuality topics have relevance, even when they are not directly related to the anatomy and physiology of their child(ren). It may also be that parents who are parenting both male and female children acknowledge all children’s need for communication about how to protect themselves and this type of PCSHC should not be exclusive to female children in the case of why they should not have sex and male children in the case of how to use a condom correctly.

With condom use instructions, again, it may be that parents who are parenting both male and female children are more aware of and responsive to the sexual health needs of children, regardless of gender, should they decide to engage in partnered sexual behaviors. Previous research has produced conflicting results about parental condom instruction and adolescent condom use and gender of children. One study found that parents were more likely to engage in condom use communication with male children (Sneed et al., 2013), however, a review of a number studies investigating PCSHC found a stronger association between PCSHC and actual condom use among female adolescents (Widman et al., 2016). While some parents find it easier to discussion sexual health with their children in general, more objective terms (Sneed et al., 2013), direct communication about condoms and correct usage is an important contributor to safer sex behaviors among adolescents (Hadley et al., 2009). To encourage more direct parental communication about correct condom usage it may be helpful for health promoters and educators to raise parental awareness to the understanding that teaching their children skills will not encourage partnered sexual behaviors but encourage safer engagement in behaviors when adolescents make the decision to so. Parents can also be encouraged to
provide sexual health skills instruction to adolescents, regardless of their gender, as a way to emphasize that engaging in safer sexual behaviors is the responsibility of all parties involved.

Considering the gender makeup of the current study sample and that so few fathers participated in the current study speaks to the need to also engage fathers in the education of and communication with sons (Feldman & Rosenthal, 2000) with the awareness that fathers may need more support and resources (Wilson et al., 2010). The current study participant makeup reinforces previous findings that mothers rather than fathers are much more willing to respond to recruitment for survey research exploring PCSHC (Byers & Sears, 2012). Mothers are also more likely to seek assistance in parent-child sexual communication (Beckett et al., 2009; Mendez, Carpenter, LaForett, & Cohen, 2009) and participate in parent education interventions (Vandenboudt et al., 2010). Fathers who perceive sexual activity as developmentally appropriate for older adolescents and believe their children have already acquired the knowledge needed to make protective sexual decisions may not feel the need to engage in PCSHC (Clawson & Reese-Weber, 2003). Fathers’ reports reveal perceptions that PCSHC is based in gendered relationships where, for the most part, male children should learn from males and female children should learn from females (Erchull & Richmond, 2015). If fathers are not engaging in PCSHC then who is talking to male children? Fathers’ attitudes toward their involvement in their children’s lives, the social support they receive to be involved, and their ability to control circumstances that foster/deter parent-child relationships impact fathers’ intentions to initiate PCSHC (Perry & Langley, 2013).
While parents should be encouraged to address multiple topics about sexuality and sexual health with their children, they should be cautioned against taking a checklist approach. Instead, parents would benefit from introducing sexuality topics and then engaging in multiple discussions about these topics to grow and expand their child’s understanding (Crosby et al., 2009; Martino et al., 2008). While not to be treated as a checklist, the list of sexuality topics used in the current study can serve as a good beginning and guide for parents to use in determining the content they would like and need to cover in their many conversations with their children.

In order to reach and have a greater influence on male children and their sexual health practices, parents likely need training to equip them to adapt their approach to PCSHC (Widman et al., 2016). While there is no need to tailor separate programming for parents of male children and parents of female children (Pariera et al., 2016), interventions should emphasize the equal importance of communicating with sons about sexuality and sexual health (Wilson & Koo, 2010) and navigating PCSHC in a way that is consistent for both sons and daughters (Widman et al., 2016).

In efforts to encourage PCSHC, health promoters can strive to counteract the perception that it is inevitable that boys will have sex and raise parents’ awareness of negative consequences of boys engaging in early sexual activity before they are ready (Wilson & Koo, 2010), without the negative consequences being the overall focus or theme to PCSHC for boys. As parents tend to focus on the negative consequences of sex in their PCSHC (Jerman & Constantine, 2010), it important for health promoters and educators to raise parental awareness to the positive consequences of sexual behaviors, including building intimacy, connection, and experiencing sexual pleasure. Both sons and
daughters may benefit most from being honestly and objectively prepared for a healthy sexual life and given the opportunity to perceive their own and others’ sexuality in a positive way.

**Limitations**

While contributing greater understanding of PCSHC based on gender of children and of the population targeted for program planning, the results of this study should be considered in the context of the methodology employed. With a cross-sectional design the data only provide a limited parenting perspective that likely shifts over the development of their children and with individual circumstances. This study only examined gender of children through dichotomous measures, ignoring the potential of how PCSHC may vary over a broader gender spectrum. Additionally, because this study targeted one specific community, the results are not generalizable to other communities.

Although confidential and anonymous self-report through the use of surveys has been shown to be a reliable and ideal way to collect data on sensitive topics such as sexuality, it also introduces the potential of recall bias and social desirability. Prior research has demonstrated that parents may report more PCSHC than their adolescent children confirm (DiLorio, Kelley, & Hockenberry-Easton, 1999; Hadley et al., 2009; McKee et al., 2007; Poulsen et al., 2010) and this discrepancy illuminates the concern that if children do not perceive occurrences of PCSHC then any potential positive effects and opportunity for health promotion are weakened (Kapungu et al., 2010). It would have strengthened the findings and been beneficial for this study to account for children’s report of PCSHC. However, the current study was focused on parent’s perception, not child’s perception, and when aiming to inform parent program design, parent-reported
data are most appropriate (Poulsen et al., 2010) with the awareness of the potential that parents’ self-evaluation is more positive than their children’s evaluation of them (Feldman & Rosenthal, 2000; Rosenthal et al., 2001). In addition to the child report, it may have been beneficial to include measurement of parental monitoring. Previous research has found that parents monitor female children more than male (Landor et al., 2011), so the consideration of this construct may have provided additional context regarding differences in the ways parents approach monitoring related to gender of children..

While control beliefs imply a certain sense of self-efficacy, including items to measure parental self-efficacy may lend to greater understanding of PCSHC and how parents’ self-perceptions impact their perception of and actual capabilities to communicate with sons and daughters. In the current study, the control beliefs scale total score was intended to be a measure of perceived behavioral control of parents related to PCSHC. As the score was made up of responses to only three questions, which may have contributed to a low alpha level in the measure of reliability, using a self-efficacy subscale with more items might provide more insight to parents’ perceptions of the control they have over engaging their children in sexual health communication. Self-efficacy is also a concept that has been widely operationalized and used in health promotion literature, including PSCHC (Byers & Sears, 2012; Pariera et al., 2016) and it relationship with gender of children (Wilson & Koo, 2012). Measuring self-efficacy in relation to PSCHC can serve as a measure of control beliefs. In the evolution of the theory of reasoned action (Ajzen, 2012) to the theory of planned behavior when Ajzen
(1991) contributed perceived behavioral control, he referred to it as a construct of self-efficacy belief.

Finally, although it is a strength that this study relied on a number of validated measures and did not rely exclusively on single-item measures like some prior research has in the past, it is important to consider that some of the subscales had low Cronbach alpha scores. The utility of the Cronbach alpha has certainly been criticized in the past (REF), and there are a number of factors that contribute to the strength of a Cronbach alpha score, including number items (Graham, 2006), poor interrelatedness between items (Tavakol & Dennick, 2011), and scale score options. While low Cronbach alpha scores are of concern and warrant investigation, researchers acknowledge the limitations of it being derived from a single test administration (Sijtsma, 2009) and it use in preliminary research situations, so much that Peterson (1994) claims the acceptability of a Cronbach alpha of .5 - .6 in such situations. Regardless, there is room for improvement in the ways in which we measure theory of planned behavior constructs, communication ability, and communication openness, and we encourage future researchers to explore more in depth psychometric evaluation of these measurement tools that is beyond the scope of this study.

**Conclusion**

While PCSHC and sexuality education should be a collaborative endeavor for the benefit of children (Neilsen et al., 2013), adhering to traditional gender roles often dictates that addressing sexuality topics with children is the responsibility of mothers (Nielsen et al., 2013; Wyckoff et al., 2008). Traditional gender roles and societal double standards still pervade and contribute to parental attitudes that disapprove of female
children having sex more than male children and the perception that the consequences of sex are more concerning for daughters than sons (Wilson et al., 2010). An emphasis on educating daughters about sexuality topics and risks coupled with the nature of mother/child relationship often leaves fathers and sons with less support for and attention to communication. There has been less emphasis on and exploration of perceptions of roles and responsibilities for fathers, however their participation in PCSHC should be accepted and fostered (Nielsen et al., 2013; Wyckoff et al., 2008). Teaching male and female children about the same sexual health topics can promote equality among and respect for all people, in general, in parent-child relationships, and in the romantic and sexual relationships adolescents share with each other. Further, engaging male children in the broader, more comprehensive and protective sexual health conversations prepares future fathers for doing the same with their own children.
Table 4.1  
Demographic characteristics of sample by gender of child(ren)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
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<td>n = 75</td>
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<td>--</td>
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<td>53 (25.9)</td>
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<td>Hispanic</td>
<td>1 (1.3)</td>
<td>3 (3.9)</td>
<td>0 (0.0)</td>
<td>4 (2.0)</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>67 (89.3)</td>
<td>71 (92.2)</td>
<td>47 (88.7)</td>
<td>185 (90.7)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1.3)</td>
<td>1 (1.3)</td>
<td>2 (3.8)</td>
<td>4 (2.0)</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>52 (69.3)</td>
<td>61 (79.2)</td>
<td>41 (77.4)</td>
<td>154 (75.1)</td>
</tr>
<tr>
<td>Divorced, single</td>
<td>15 (20.0)</td>
<td>8 (10.4)</td>
<td>9 (17.0)</td>
<td>32 (15.6)</td>
</tr>
<tr>
<td>Single, never married</td>
<td>3 (4.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>3 (1.5)</td>
</tr>
<tr>
<td>Remarried</td>
<td>3 (4.0)</td>
<td>3 (3.9)</td>
<td>2 (3.8)</td>
<td>8 (3.9)</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>2 (2.7)</td>
<td>3 (3.9)</td>
<td>1 (1.9)</td>
<td>6 (2.9)</td>
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</table>
Table 4.2
Mean and Standard Deviation of Sexuality Topic Scores

<table>
<thead>
<tr>
<th>Topic</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>how girls’ bodies change physically as they grow up</td>
<td>3.02</td>
<td>0.95</td>
</tr>
<tr>
<td>how boys’ bodies change physically as they grow up</td>
<td>2.78</td>
<td>0.99</td>
</tr>
<tr>
<td>menstruation</td>
<td>2.80</td>
<td>1.12</td>
</tr>
<tr>
<td>wet dreams</td>
<td>1.51</td>
<td>0.79</td>
</tr>
<tr>
<td>how women get pregnant</td>
<td>2.82</td>
<td>0.91</td>
</tr>
<tr>
<td>how women have babies</td>
<td>3.00</td>
<td>0.85</td>
</tr>
<tr>
<td>what qualities are important in choosing close friends</td>
<td>3.47</td>
<td>0.74</td>
</tr>
<tr>
<td>how to ask someone out on a date</td>
<td>1.97</td>
<td>0.98</td>
</tr>
<tr>
<td>how to make decisions about whether or not to have sex</td>
<td>2.20</td>
<td>1.16</td>
</tr>
<tr>
<td>what it feels like to have sex</td>
<td>1.50</td>
<td>0.78</td>
</tr>
<tr>
<td>homosexuality/people being gay</td>
<td>2.85</td>
<td>0.91</td>
</tr>
<tr>
<td>consequences of getting pregnant/getting someone pregnant</td>
<td>2.52</td>
<td>1.12</td>
</tr>
<tr>
<td>how well birth control can prevent pregnancy</td>
<td>2.10</td>
<td>1.13</td>
</tr>
<tr>
<td>how well condoms can prevent STIs</td>
<td>2.04</td>
<td>1.10</td>
</tr>
<tr>
<td>how to choose a method of birth control</td>
<td>1.69</td>
<td>0.93</td>
</tr>
<tr>
<td>how to use a condom, how people prevent getting STIs</td>
<td>1.67</td>
<td>0.92</td>
</tr>
<tr>
<td>symptoms STIs</td>
<td>1.61</td>
<td>0.88</td>
</tr>
<tr>
<td>what do to if your partner does not want to use a condom</td>
<td>1.48</td>
<td>0.89</td>
</tr>
<tr>
<td>the importance of not pressuring other people to engage in sexual behaviors</td>
<td>2.14</td>
<td>1.17</td>
</tr>
<tr>
<td>reasons why people like to have sex</td>
<td>1.92</td>
<td>0.97</td>
</tr>
<tr>
<td>reasons why you should not have sex</td>
<td>2.34</td>
<td>1.10</td>
</tr>
<tr>
<td>how will you know if you are in love</td>
<td>2.23</td>
<td>0.97</td>
</tr>
<tr>
<td>how to say no if someone want to engage in sexual behaviors with you and you don’t want to</td>
<td>2.36</td>
<td>1.13</td>
</tr>
</tbody>
</table>
Table 4.3
Mean and Standard Deviation of Sexuality Topic Score by Developmental Stage of Oldest Child, ages 9 – 17

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pre – Adolescence (n = 41)</th>
<th>Early Adolescence (n = 115)</th>
<th>Late Adolescence (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>how girls’ bodies change physically as they grow up</td>
<td>2.95 0.92</td>
<td>3.00 0.98</td>
<td>3.14 0.91</td>
</tr>
<tr>
<td>how boys’ bodies change physically as they grow up</td>
<td>2.37 0.99</td>
<td>2.83 0.96</td>
<td>3.00 0.96</td>
</tr>
<tr>
<td>menstruation</td>
<td>2.39 1.09</td>
<td>2.85 1.10</td>
<td>3.00 1.12</td>
</tr>
<tr>
<td>wet dreams</td>
<td>1.16 0.48</td>
<td>1.63 0.87</td>
<td>1.49 0.71</td>
</tr>
<tr>
<td>how women get pregnant</td>
<td>2.46 0.98</td>
<td>2.79 0.89</td>
<td>3.17 0.78</td>
</tr>
<tr>
<td>how women have babies</td>
<td>2.90 0.94</td>
<td>2.90 0.87</td>
<td>3.29 0.65</td>
</tr>
<tr>
<td>what qualities are important in choosing close friends</td>
<td>3.24 0.77</td>
<td>3.44 0.78</td>
<td>3.71 0.50</td>
</tr>
<tr>
<td>how to ask someone out on a date</td>
<td>1.34 0.66</td>
<td>1.89 0.93</td>
<td>2.67 0.90</td>
</tr>
<tr>
<td>how to make decisions about whether or not to have sex</td>
<td>1.29 0.59</td>
<td>2.22 1.18</td>
<td>2.92 1.00</td>
</tr>
<tr>
<td>what it feels like to have sex</td>
<td>1.17 0.38</td>
<td>1.56 0.82</td>
<td>1.65 0.88</td>
</tr>
<tr>
<td>homosexuality/people being gay</td>
<td>2.46 0.92</td>
<td>2.91 0.86</td>
<td>3.02 0.93</td>
</tr>
<tr>
<td>consequences of getting pregnant/getting someone pregnant</td>
<td>1.73 0.98</td>
<td>2.48 1.08</td>
<td>3.27 0.81</td>
</tr>
<tr>
<td>how well birth control can prevent pregnancy</td>
<td>1.24 0.58</td>
<td>2.01 1.04</td>
<td>3.04 1.00</td>
</tr>
</tbody>
</table>

*Note. Pre-adolescence = ages 9 – 11, early adolescence = ages 12 - 14, and late adolescence = ages 15 – 17*
### Table 4.3 (cont.)
**Mean and Standard Deviation of Sexuality Topic Score by Developmental Stage of Oldest Child, ages 9 – 17**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pre – Adolescence (n = 41)</th>
<th>Early Adolescence (n = 115)</th>
<th>Late Adolescence (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>how well condoms can prevent STIs</td>
<td>1.10 0.30</td>
<td>2.05 1.08</td>
<td>2.79 0.98</td>
</tr>
<tr>
<td>how to choose a method of birth control</td>
<td>1.07 0.26</td>
<td>1.59 0.85</td>
<td>2.42 0.98</td>
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<tr>
<td>how to use a condom, how people prevent getting STIs</td>
<td>1.49 0.22</td>
<td>1.66 0.85</td>
<td>2.20 1.12</td>
</tr>
<tr>
<td>symptoms STIs</td>
<td>1.02 0.16</td>
<td>1.57 0.88</td>
<td>2.18 0.91</td>
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<tr>
<td>what do to if your partner does not want to use a condom</td>
<td>1.00 &lt;0.001</td>
<td>1.42 0.82</td>
<td>2.02 1.27</td>
</tr>
<tr>
<td>the importance of not pressuring other people to engage in sexual behaviors</td>
<td>1.32 1.32</td>
<td>2.12 1.15</td>
<td>2.86 1.10</td>
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<tr>
<td>reasons why people like to have sex</td>
<td>1.29 0.46</td>
<td>1.95 0.99</td>
<td>2.39 0.95</td>
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<tr>
<td>reasons why you should not have sex</td>
<td>1.39 0.49</td>
<td>2.41 1.06</td>
<td>2.96 1.02</td>
</tr>
<tr>
<td>how will you know if you are in love</td>
<td>1.83 0.83</td>
<td>2.21 0.98</td>
<td>2.61 0.93</td>
</tr>
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<td>How to say no if someone wants to engage in sexual behaviors with you and you do not want to</td>
<td>1.70 0.96</td>
<td>2.41 1.13</td>
<td>2.80 1.06</td>
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*Note. Pre-adolescence = ages 9 – 11, early adolescence = ages 12 - 14, and late adolescence = ages 15 – 17*
<table>
<thead>
<tr>
<th>Sexuality topic</th>
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<th>Parent Group by Children</th>
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<td>Changes-girls</td>
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<td>2.03</td>
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<td>M &amp; F</td>
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<td>Changes-boys</td>
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<td>203</td>
<td>17.13***</td>
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<td>2.65</td>
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<td>M &amp; F</td>
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<td>Reasons why people should not have sex</td>
<td>2</td>
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<td>Male</td>
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<td>1.76</td>
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<td>How to say no to sex</td>
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</tbody>
</table>

*p < 0.05, **p < 0.01, ***p < 0.001
CHAPTER 5

Manuscript 2: Using the Theory of Planned Behavior to Understand Parent-Child Sexual Health Communication

Primary proposed journal: *Health Education & Behavior*

Secondary proposed journals: *American Journal of Health Behavior*
Abstract

*Introduction.* Parent-child sexual health communication (PCSHC) serves as a protective factor for adolescent sexual health. Examining PCSHC through the theory of planned behavior (TPB) framework provides insight for motivating parents to prepare themselves for and engage in PCSHC. *Methods.* This exploratory cross-sectional survey design included a sample of 205 parents with children in grades 4 to 11 who completed measures assessing TPB behavioral, normative, and control beliefs, intention to and actual engagement in PCSHC, and demographic variables. Logistic regression models were used to predict the likelihood of intending to and actually engaging in PCSHC, including condom use instructions, based on belief constructs of the TPB.

*Results.* In the four logistic regression models, behavioral beliefs were most predictive of the probability that parents would intend to give condom use instructions and actually engage in PCSHC, including giving condom use instructions. Age of oldest child was also significantly associated with the likelihood of actual PCSHC and delivery of condom use instructions. Factors related to religion were associated with actual PCSHC and intentions to give condom use instructions.

*Conclusion.* These findings give support for the moderate power of the TPB to predict parental intentions of and actual engagement in PCSHC. Health promotion professionals may be more effective in reaching parents with education and skill building opportunities by examining, impacting, and capitalizing on the influence behavioral beliefs and attitudes about PCSHC and by raising parental awareness that they are capable of positively impacting their children’s health and well-being through PCSHC.
Keywords: adolescent sexual health, parent-child communication, theory of planned behavior
Using the Theory of Planned Behavior to Understand Parent-Child Sexual Health Communication

**Background**

Parent-child sexual health communication (PCSHC) is positively related to adolescent risk reduction behaviors and attitudes (DiClemente et al., 2001; Guilamo-Ramos et al., 2008; Salazer et al., 2005; Troth & Peterson, 2000; Widman et al., 2017). Adolescents who received sexual health information from parents are more likely to hold beliefs that lead to the likelihood they will delay intercourse (Bleakley et al., 2009) and are more protected against early pregnancy and risky sexual behaviors (Secor-Turner et al., 2011). Parent-child sexual health communication is not limited to risk reduction communication but includes that which enhances children’s understanding of sexuality and all its dimensions (Schouten et al., 2013). This type of communication between parent and child holds the opportunity to discuss sexual behaviors and the risks inherent in their enactment but also, and among other topics related to sexuality, nonsexual relationships, respect, decision-making, and sexual pleasure (Jerman & Constantine, 2010). Family communication about sexuality can promote positive attitudes, norms, and control beliefs about healthy sexual practices (Malcolm et al., 2005). Although many parents struggle to communicate with their children about sexual topics and encourage their children to ask sexuality-related questions (Byers, Sears, & Weaver, 2008), parents are often cited as a primary source of sexual health information among adolescents (Bleakley, Hennessy, Fishbein, & Jordan, 2009; Donaldson, Secor-Turner, Seiving, Eisenburg, & Skay, 2011). Adolescents who talked less or not at all with their parents
about sex were less likely to negotiate safer sex with partners, practice safer sex (DiClemente et al., 2001), and use birth control (Clawson & Reese-Weber, 2003).

Parental characteristics, perceptions, and experiences have a great impact on beliefs about their ability to provide their children with sexuality education. Parents’ comfort with sexuality (Lefkowitz & Stoppa, 2006) and experience with their own adolescent sexuality education (Byers et al., 2008; Eastman et al., 2005; Woody, Randall, & D’Souza, 2005) are related to their sense of their ability to educate their children. Additional reasons parents cite that make engaging in sexual communication with their children difficult include lack of effective communication methods, adolescents’ resistance, doubts, and uncertainties about what to say and how much to say (Eastman et al., 2005), and well as privacy, confidentiality, and social constraints (Kirkman et al., 2005). Parental belief systems about sexuality impact how they share related messages with their children (Lefkowitz & Stoppa, 2006). As primary sources of sexuality education, parents have the opportunity to transmit their values related to sexuality, which may, or may not, increase the chance their children will adopt safe and healthy behaviors (Schouten, van den Putte, Pasmans, & Meeuwesen, 2007). For professionals planning parent sexuality education opportunities, understanding parental belief systems can provide insight into parents’ intentions and actual engagement in PCSHC and ways to positively impact their beliefs about PCSHC.

**PCSHC and the Theory of Planned Behavior**

In its original conception as an extension of the theory of reasoned action (TRA), the theory of planned behavior (TPB) presented by Ajzen and colleagues (n.d.) is one that focuses on individuals’ intentions to engage in a behavior as informed by one’s beliefs
regarding the performance of the behavior, others’ perceptions of one’s performance of
the behavior, perception of control over the behavior, as well as one’s actual control over
the behavior (Ajzen, n.d.; Zhou et al., 2016). Using these components in the
consideration of the promotion of PCSHC provides a theoretical foundation to explain
and understand parents’ motivation for engaging in or avoiding the health behavior of
PCSHC. See Figure 1.1 for a diagram of the TPB.

Perry and Langley (2013) provide support for the use of the TPB model to better
understand parental involvement. Regarding parents’ intentions to engage in PCSHC, the
TPB implies that those who intend to communicate with their adolescents have positive
attitudes about PCSHC, believe significant others approve of the communication, and
believe they are capable of communicating with their child about sexual topics
(Villarruel, Cherry, Cabriales, Ronis, & Zhou, 2008). Behavior beliefs are determined by
the attitude one has regarding the performance of the behavior and whether or not the
behavior is valued as being positive or negative (Bracke & Corts, 2012; Zhou et al.,
2016). Attitudes that determine behavioral beliefs can be strong predictors of intention to
engage in health protective behaviors (Askelson et al., 2010), however, when parents do
not believe that they have much influence on their children’s behavior they may not
attempt to impact their behaviors, and this may be particularly relevant with adolescent
sexual behavior (Carlson & Tanner, 2006). While most all parents believe their
participation in their children’s education is important, their valuation and beliefs can be
shaped by their own encounter with educational experiences (Bracke & Corts, 2012).
Prevention programs can strive to promote positive attitudes toward parent-child sexual
health communication (Carmack et al., 2015) and active roles of parents’ in the education
and lives of children (Bracke & Corts, 2012). Previous research presents evidence that adolescents’ beliefs about PCSHC can serve as a predictor of the frequency of communication (Schouten, 2007) but investigating parental communication beliefs has been limited.

Normative beliefs determined by one’s subjective norm, refer to the typical rules of behavior and social pressure to engage in or abstain from a behavior that are based on the perceptions of what others think and do (Bracke & Corts, 2012) and are influenced by those individuals who are deemed important (Zhou et al., 2016), and inspire a willingness to comply (Askelson et al., 2010). If parents perceive that other parents are involved and good parenting behavior includes taking an active role in their children’s education they are more likely to take an active role (Bracke & Corts, 2012). Subjective norm also influence parents’ intentions to engage their children in communication about health protective behaviors (Askelson et al., 2010; Perry & Langley, 2013) and is a significant predictor of value-based PCSHC (Schouten et al., 2007). Understanding parental involvement as a social endeavor influenced by norms can serve efforts to bridge intentions and actual behaviors of PCSHC (Bracke & Corts, 2012).

Control beliefs are determined by the amount of control a person perceives he/she has over performing a behavior (Askelson et al., 2010; Zhou et al., 2016) and can be likened to the construct of self-efficacy in Bandura’s social cognitive theory (Schouten et al., 2007). Perceived behavioral control speaks to one’s perception that he/she is capable of performing a behavior and has power over those factors that may enable or deter engagement in the behavior (Ajzen, n.d.). Control beliefs impact confidence in one’s ability and motivation to engage in behaviors and are highly predictive of PCSHC.
intentions (Cederbaum, Hutchinson, Duan, & Jemmott, 2013) and behaviors (DiLorio et al., 2000). While some parents do not feel they have the ability to help their children (Bracke & Corts, 2012), those who feel they do have the ability to engage in PCSHC are more likely to do so (DiLorio et al., 2000).

At the foundation of the TPB is the expectation that intention to engage in a behavior leads to actual performance of the behavior and intentions and behaviors are predicted and influenced by behavioral, normative, and control belief components of the model (Askelson et al., 2010; Perry & Langley, 2013; Zhou et al., 2016). Intentions to engage in PCSHC can also be influenced by parents’ perception of their children’s risk for negative sexual health outcomes (Askelson et al., 2010). While some parents underestimate their children’s engagement in risk behaviors (O’Donnell et al., 2008), those who have been affected directly or vicariously by negative sexual health outcomes are more likely to intend on promoting their children’s risk reducing behaviors (Askelson et al., 2010).

The TPB accounts for intentions, but also individuals’ abilities to act on their intentions (Perry & Langley, 2013) and actual behavior control (Ajzen, n.d.). Actual behavioral control is determined by skills and resources needed to actually perform the behavior (Ajzen, n.d.). When control beliefs are congruent with reality, they may serve as a measure of actual behavioral control, however, when circumstances or conditions are uncontrollable but not perceived as such, they can interfere with intentions becoming actual behaviors (Mayhew et al., 2009).

The TPB has been used to predict intentions and enactment of a variety of health behavior changes including substance abuse treatment completion (Zemore & Ajzen,
increased physical activity (Booth et al., 2000; Burack et al., 2013; French et al., 2005), safe pedestrian behaviors (Zhou et al., 2016) and parenting intentions, including fathers’ involvement intentions (Perry & Langley, 2013), mothers’ intentions to vaccinate daughters against HPV (Askelson et al., 2010), and PCSHC (Schouten et al., 2007). The current study uses the components of the TPB including behavioral beliefs determined by attitudes toward the behavior, normative beliefs determined by subjective norm, or beliefs that one holds about relevant others support or disapproval of the behavior, and control beliefs determined by one’s perception of his/her control over changing the behavior to better understand how to enable and facilitate PCSHC. The TPB implies that those who intend to communicate with their adolescents have positive attitudes about PCSHC, believe significant others approve of the communication, and believe they are capable of communicating with their child about sexual topics (Villarruel, Cherry, Cabriales, Ronis, & Zhou, 2008).

**Aims**

The purpose of this study was to examine parents’ behavioral, normative, and control beliefs, and whether these theory-based factors could predict the likelihood of parents’ intentions and actual parent behaviors as they related to PCSHC within the framework of the PETPB. The following is the primary research question that guided the study: What is the likelihood that parents would 1) intend to engage in PCSHC, 2) actually engage in PCSHC, 3) intend to teach their children how to use condoms correctly, and 4) actually give children instructions about how to use condoms correctly related to their behavioral, normative, and control beliefs? It was hypothesized that behavioral, normative, and control beliefs influence the probability that parents’ intend to
and actually engage in PCSHC. Additionally, the study considered whether parental educational attainment, religious affiliation, religiosity, and age of oldest child in grades 4 to 11, impacted the likelihood that parents would intent to and actually engage in PCSHC, including instructions for correct condom usage. This study also sought to determine the fit of the theoretical constructs and framework of the TPB in determining intentions and enactment of PCSHC as a health behavior. The consideration of these constructs can aid in determining how to approach parents with the intentions of motivating them to enact the behavior of participating in parent sexuality education programming. Participation in parent sexuality education programming can serve as the external influence on parents, which can impact parents’ behavioral, normative, and control beliefs about and intentions to engage in PCSHC. The TPB has the promise to inform program planners and recruiters of ways to impact potential participants’ perceptions and attitudes of and motivation and willingness to engage in PCSHC and seek out resources and educational opportunities for this purpose.

**Methods**

The current study was a part of a larger endeavor to understand more about PCSHC, promoting it and recruiting and planning for parent education programming designed to increase frequency and quality of PCSHC. Cross-sectional data were collected using a survey administered to a convenience sample of 205 respondents who were parents of children in grades 4 to 11 during the 2016 to 2017 school year. Individuals met the criteria of being a parent respond if their child(ren) lived with them at least three days a week. Of the total sample 101 respondents completed a paper-pencil survey and were residents of the programming target community, a rural town located in
the Southeastern United States. Through Qualtrics, an online version of the survey was completed by 104 respondents. Of online respondents 17.3% (n = 18) resided in the target community, 18.3% (n = 19) in Kentucky outside of the targeted community, 62.5% (n = 65) in the United States, outside of Kentucky, and 1.9% (n = 2) outside of the U.S. Respondents who completed the paper survey signed a written consent form, which also served as their consent to participate in a parent education intervention if they volunteered and were eligible. Those completing the online survey were provided with a cover letter explaining the purpose of the study and minimal risks related to taking part in the study, which served as a waiver of documented consent. Respondents were recruited through an online posting on Facebook. Targeted recruitment methods included a mailing letters to parents of students enrolled in the local public school system, flyers posted at the local public library, and emails sent to employees and tabling outreach at the local hospital, all within the target community. The study protocol which involved research of human subjects was approved by the Institutional Review Board committee of the University of Kentucky (15-0821-F4S).

Measures

The average time it took participants to complete the survey was 10 – 20 minutes. The survey instrument was designed to collect information and to learn more about parents’ intention to and actual participation in PCSHC and beliefs about PCSHC. The demographic variables considered in the current study included parental educational attainment, age of oldest child in grades 4 to 11, parental religious affiliation and religiosity. Parents of older children were expect to have a greater likelihood of intending
for and engaging in PCSHC as they may perceive older adolescents as ready for PCSHC (Poulsen et al., 2010).

Parents’ religious affiliation, religiosity, one’s religious practices and beliefs, (Regnerus, 2005) and commitment (Landor et al., 2011) can influence parental practices and beliefs about PCSHC (DiLorio et al., 2000; Villarruel et al., 2008). While Snider, Clements, and Vaszsonyi (2004) determined parental religiosity was associated with enhanced parent-child relationships, Farringdon et al. (2014) found mothers who exhibited high levels of religiosity reported feeling uncomfortable discussing sexual health issues, especially controversial topics including abortion, condoms, contraception, and masturbation (Farringdon et al., 2014). In an examination of national longitudinal data, Regnerus (2005) found that mainline Protestants were less likely to talk about sex and experience greater unease in trying to do so when compared to those affiliated with another Christian group or religiously unaffiliated. Additional, those who reported a greater degree of religiosity with perhaps a greater sense of religious conservatism reported greater unease with PCSHC and more communication that focused primarily on morality (Regnerus, 2005) rather than risk reduction and healthy sexual development.

The following measures were used to explore the constructs of the TPB in relation to one another and other independent variables and their value predicting parental intentions to and actual engagement in PCSHC. It is appropriate and typical to use seven point bipolar scales to measure TPB constructs (Ajzen, n.d. a; Orbell, Hodgkins, & Sheeran, 1997).

**Behavioral beliefs.** The seven of the original 10 child belief scale items retained by Schouten et al. (2007) were modified to collect parent beliefs about engaging in
PCSCHC ($\alpha = 0.61$). The seven point scale (7 = agree, 1 = disagree) score for each item is added together to provide a total scale score ranging from 7 to 49 with higher scores indicating more positive beliefs about PCSCHC. Items included 1) it is important to me that my child can talk to me about sexuality, 2) I would feel embarrassed talking about sexuality with my child, 3) my child is not likely to want to talk to me about sexuality.

**Normative beliefs.** Beliefs related to one’s subjective norm were measured with seven questions related to values of important referents and the importance of the referents opinions ($\alpha = 0.64$). Specific referents for this study are family, friends, and church community. Items for each referent are 1) My (referent) thinks I should talk with my child about sexuality and 2) The opinion of my (referent) is important to me. Total scores were obtained by multiplying first items (what referents think) by second items (importance of referent’s opinion) and adding the three products (family, friends, church community) (Schouten et al., 2007). Total scores range from three to 147 with higher scores indicating greater importance of referents and referent opinions. For purposes of the current study referent group scores were analyzed as a total score and as three separate scores, family, faith community, and friends.

**Control beliefs.** These three items were designed to measure perceived behavioral control ($\alpha = 0.44$). Two items come from the literature, “It is hard for me to talk to my child about sexuality” and “It is easy to talk with my child about sexuality” (Schouten et al., 2007), and two were added to this study based on the recommendation of Ajzen (n.d.), “I am confident that I can talk to my child about sexuality” and “It is up to me to talk to my child about sexuality”. The seven point scale (7 = agree, 1 = disagree)
score for each item is added together to provide a total scale score ranging from 4 to 28 with higher scores indicating more perceived control over engaging in PCSHC.

**PCSHC intentions.** Parents indicated with a yes/no response to the statement “I intend to talk with my child repeatedly about many topics related to sexuality and sexual health.” Using a dichotomous response is one way to measure behavioral intentions (White & Wellington, 2009) and self-report of actual behavior (Schouten et al., 2007).

**PCSHC behavior.** Parents indicated with a yes/no response to the statement “In the past 6 weeks I talked with my child repeatedly about many topics related to sexuality and sexual health.” A further, more detailed measure of discussions about sexuality topics is included below as sexuality topics.

**Condom instruction intentions.** Parents indicate with a yes/no response to the statement “I intend to review the steps of how to use a condom with my child” (Ajzen, n.d.).

**Condom instruction behavior.** Parents indicate with a yes/no response to the statement “I have reviewed the steps of how to use a condom with my child” (Schuster et al. (2008).

**Data Analysis**

Using SPSS 23, four multilevel logistic regression models were constructed to examine the effects of the constructs of the TPB and demographic variables on parents’ intentions to engage in PCSHC, actual engagement in PCSHC, intentions to provide child(ren) with instructions for correct condom usage, and actual provisions of instructions for correct condom usage. Each logistic regression model was fitted to the data to test the research hypotheses regarding the relationship between the likelihood that
parents would intent to and actually engage in PCSHC, including condom usage instructions, and parental behavioral, normative, and control beliefs and certain demographic factors, including parental educational attainment, religious affiliation, religiosity, and age of oldest child. Each model began with the null (intercept-only) model, demographic variables were added for block one, and TPB construct scores were added for the full model in block two.

To examine each model, tests included overall model evaluation, goodness-of-fit statistics, validations of predicted probabilities, and statistical tests of individual predictors (Peng et al., 2002). The overall models were evaluated with an omnibus $\chi^2$, comparing the -2LL, the estimate of model fit, of the full models with the null models, which only contained the intercepts. Nagelkerke $R^2$ was used to evaluate the goodness of fit of the logistic regression models and classification tables were examined to provide validations of predicted probabilities. Individual regression coefficients, $\beta$s, were tested for significance using the Wald chi-square statistic.

Logistic regression is appropriate for determining the goodness of fit between theoretically derived model and the sample data (Byrne, 2001) and identify independent predictors of health behaviors (Booth et al., 2000). Power analysis, following guidelines established in Lipsey & Wilson (2001) and G*Power 3.1.7 (Faul et al., 2013), for logistic regression based on a two-tailed alpha ($\alpha$) value of 0.05, a power of 0.80, and a medium effect size (OR = 1.72) generated a recommended sample size of 177.

**Results**

Table 5.1 presents descriptive statistics for the 205 respondents based on the developmental stage of their oldest child in the age range of 9 - 17. Groupings were pre-
adolescent, ages 9 – 11, early adolescence, ages 12 – 14, and late adolescence, 15 – 17. More parents were classified in the early adolescence group (n = 90), than the pre-adolescence (n = 66) or the late adolescence group (n = 49). The average age of respondents was 42 (SD = 5.9; range 24 – 67). Nearly all participants were female (94.1%), white (90.7%), and just over three-quarters reported being married (75.1%). The sample was fairly distributed into gender of children groupings with 75 respondents parenting only male children (36.6%), 77 respondents parenting only female children (37.6%), and 53 respondents parenting both male and female children (25.9%). The average number of children for each parent was 2.4 (SD = 0.96; range 1 - 7). Demographic variables used in the logistic regression modeling included parental educational attainment, religious affiliation, religiosity, and age of oldest child. The majority of respondents reported holding at least a bachelor’s degree (68.8%), with 42% of the entire sample having earned a graduate degree. Over one-third of respondents identified themselves as Christian, non-Catholic (39.0%) and nearly a quarter identifying as non-religious (22.9%). Of those who responded the religiosity question (n = 185), over half (59.9%) reported attending religious or spiritual services only a monthly basis or less. The average age of oldest child was 12.7 years old (SD = 2.31; range 9 - 17). The majority of respondents had intentions to engage in PCSHC (91.7%) and review condom instructions (74.1%) and reported actually engaging in PCSHC with children (63.4%), while only 31 respondents (15.1%) had reviewed steps for how to use a condom.

Of the 205 study participants, data from 183 were included in the four logistic regression models used to determine the effects of demographic variables and measures of constructs of the TPB on the likelihood that respondents intend to and actually engage
their children in PCSHC and intend to and actually give condom usage instructions to their children. The full model for intentions to engage in PCSHC was not statistically significant, $\chi^2 (20) = 16.79, p = 0.67$. The model explained 20.3% of the variance and correctly classified 93.4% of cases. Looking at individual variables contribution to the model, PCSHC normative belief scores related to friends was significantly predictive of intention to engage in PCSHC. By separating the normative belief scores by referents, the results indicated that all referent groups contributed significantly to the model. Respondents with higher friend normative scores were 0.93 times less likely to intend to engage in PCSHC.

The full model constructed to assess the effect of TPB constructs on the likelihood that respondents actual engage in PCSHC was statistically significant, $\chi^2 (20) = 45.13, p = 0.01$. The model explained 30.1% of the variance in actual PCSHC and correctly classified 72.7% of the cases. Behavioral belief scores, Christian, non-Catholic religious affiliation, and age of oldest child contributed significantly to the model. Those with higher behavioral belief scores were 1.09 times more likely to have engaged in PCSHC and those with older children were 1.26 times more likely to do so. Respondents reporting Christian, non-Catholic religious affiliation were 0.25 times less likely to have engaged in PCSHC.

The model to examine the relationship between TPB constructs and likelihood of holding intentions to provide children with instructions for correct condom usage was statistically significant, $\chi^2 (20) = 43.85, p < 0.01$. The model explained 32.3% of the variance in intentions to give condom usage instructions and correctly classified 80.3% of the cases. Behavioral beliefs and parents’ level of religiosity were individual variables
that contributed to the model. Higher behavioral belief scores were associated with a 1.14 times greater likelihood of having intentions to give condom usage instructions. Those parents who reported greater frequency in religious or spiritual service attendance were 0.72 times less likely to intend to give their children instructions for correct condom usage.

The last logistic regression model was performed to determine the likelihood of respondents actually giving their children instructions for correct condom usage. The full model was statistically significant, $\chi^2 (20) = 46.75, p < 0.01$, while explaining 38.7% of the variance and correctly classifying 86.9% of the cases. Of the demographic variables, age of oldest child significantly contributed to the model, with parents of older children being 1.47 times more likely to report giving their child(ren) condom use instructions. Of the TPB model constructs, behavioral beliefs contributed significantly. Respondents with higher behavioral belief scores were 1.13 times more likely to report actually giving their children instructions for correct condom usage. A significant relationship was found between having less than a high school diploma and the likelihood of giving instructions for correct condom usages, however, this subsample only consisted of seven respondents, with the majority indicating that they had given condom use instructions. This finding is consistent with research that found respondents with less than a high school diploma were more likely to support more comprehensive content coverage in schools, including HIV, gender, and sexual orientation education (Barr, Moore, Johnson, Forest, & Jordan, 2014). See Tables 5.2 and 5.3 for all logistic regression model results.
Discussion

Examining health behaviors through a theoretical lens provides a better understanding of the beliefs about and motivations for certain health practices and the opportunity to test the helpfulness and practicality of frameworks constructed from health promotion/education theory. The current study revealed the usefulness of the TPB, particularly the ability of parental behavioral beliefs to predict the likelihood of intentions to give condom use instructions and the enactment of this behavior and PCSHC generally. While significant findings are limited to behavioral beliefs and friend normative beliefs being predictive of the likelihood to hold intentions to engage in PCSHC, the operationalization of the TPB framework, in this case, is restricted in its capability to contribute to the understanding of the relationship between PCSHC and normative and control beliefs. Or it may be that these beliefs are not as important to PCSHC. After behavioral beliefs, age of oldest child showed the greatest predictive power in the logistic regression models as it contributed to the likelihood that parents had engaged in PCSHC, generally, and specifically had given correct condom use instructions to their child(ren). Intentions for PCSHC including condom instruction may not be dependent on age of child(ren), however, when it comes to enacting behaviors, parents in this study were more likely to wait until children are older. While in some cases this is appropriate, like giving children instructions for proper condom usage, with other topics parents may be missing opportunities for preventative messaging.

Religious affiliation and religiosity were limited in their predictions of likelihood for intentions and actual engage of PCSHC.
Holding beliefs that PCSHC is a worthwhile and necessary endeavor can serve as a motivator for parents to intend to and actual engage in sexual health communication with their children. Having positive attitudes about PCSHC can help parents appreciate the experience with their child and recognize and focus on, even in their discomfort and uncertainty, the benefits of this behavior. Sustained positive attitudes toward PCSHC can increase comfort, which is highly predictive on parents actually engaging in this behavior (Jerman & Constantine, 2010). Parents in the current study who reported more positive attitudes towards PCSHC had a greater likelihood of actually engaging PCSHC and having intentions to and actually giving instructions for correct condom usage. More negative attitudes about PCSHC may lead to parents issuing warnings and using scare tactics, which may have effects opposite of those intended. Coley et al., (2013) found greater parental warnings about the negative consequences of sexual behaviors was predictive of greater sexual partner accumulation, rather than the parental intention of limiting the sexual behaviors and partner accumulation of their children. Impacting parental attitudes toward PCSHC in ways that promote more positive behavioral beliefs may prevent parents from simply issuing warnings and promote meaningful, practical, and effective communication.

While previous research found subjective norms influential in parent-child communication about health protective behaviors (Askelson et al., 2010; Perry & Langley, 2013) the only relationship in this current study was between friend normative beliefs and intention to engage in PCSHC. Higher friend normative belief scores were associated with less likelihood parents intended to engage their children in PCSHC. The score is made up of response to the questions about friends support for PCSHC and the
importance of friend’s opinion. It may be the friend normative scores were more influenced by high scores for the importance of friends’ opinions rather than scores related to friends endorsing communication about sexuality and sexual health.

Of the many sexual health topics, sharing skill instruction regarding the correct use of condoms may be one of the most difficult yet effective topics for parents to broach with their children. Adolescent children who report talking with parents about condoms were significantly more likely to use condoms consistently (Hadley et al., 2009). The challenge in providing children with condom usage instructions may be that parents’ are acknowledging that their children’s personal behavioral choices may necessitate the actual use of condoms. The finding that parents with older children had a greater likelihood of giving condom instructions and reported engaging in PCSHC is supported in the literature (Pluhar DiIorio, & McCarty, 2008). It is understandable that parents might be more likely to engage in PCSHC including delivery of condom usage instructions when they perceive that their child needs the information in the immediate or near future.

Perceiving that children are too young for PCSHC is a barrier to PCSHC (Pariera, 2016) and may cause parents to delay initiating PCSHC when children might benefit the most (Poulsen et al., 2010). This perception is a likely explanation for why many adolescents are not communicating with parents about sexuality and sexual health prior to their sexual debut (Beckett et al., 2010; Pariera, 2016) and parents engage more in PCSHC with older children (Pluhar DiIorio, & McCarty, 2008). The current study supports these perceptions and practices and would suggest the benefit of reaching parents with the messages related to the purpose and importance of talking with children
early and often throughout their developmental years. Age of children and normative beliefs might also be a consideration of messaging as parents of younger children reported a more conservative approach to PCSHC in part because of the perceived vulnerability to criticism and judgment of being a ‘bad parent’ if they gave their children too much and/or inappropriate information about sexuality (Stone et al., 2013). While children’s interest in communicating with parents during early adolescence may be impacted by the desire for autonomy and independence, their comfort level communicating with parents may be greater during this stage rather than later in adolescence (Levin, 2012). Assuring parents that younger adolescents and pre-adolescents can be comfortable with and capable of PCSHC that prepares them for their sexual debut behaviorally and affords them healthy sexual development may motivate earlier and more PCSHC.

While the contributions religiosity and religious affiliation made to the regression models were limited, the findings warrant some consideration of how relationships parents have with their faith communities and how in which they identify religiously impact PCSHC. Attending religious/spiritual services more frequently was associated with the decreased likelihood the respondent intended to give children instructions for correct condom usage. Being more involved in a faith community and attending services with regularity may be related to a greater adherence to a belief in the power of divine will over the enactment of risk reducing behaviors, or the reasoning behind this finding may be related more to parental discomfort and confusion about what is and is not appropriate to teach children about sexuality and sexual health. Another possibility might be that these parents believe in abstinence until marriage and teaching their children how
to use a condom would conflict with this belief. That those respondent who identified as Christian, non-Catholic were significantly less likely to report engaging in PCSHC support previous findings that mainline Protestant, when compared to Catholics, Mormons, and religiously unaffiliated, talked least about sex and with the greatest discomfort (Regnerus, 2005). These findings indicate a need for greater understanding of the relationship between religious/spiritual identity, especially those affiliated with organizations, and perceptions of sexuality and sexual health. They may also signal a need and opportunity for providing sex education through faith communities.

Limitations

While lending greater understanding of PCSHC the results of this exploratory study are not generalizable. Other limitations of this study include a cross-sectional design with a smaller convenience sample providing self-reported data. Socially desirable responses are a limitation of self-reported data collection methods and special consideration should be given when items or questions are sensitive in nature (Lewis-Beck, Bryman, & Liao, 2004), as in the case with inquiry related to PCSHC.

While the findings do not suggest a rejection of the TPB derived model in understanding PCSHC, lower reliability statistics for TPB belief subscales are indicative of the need to refine the behavioral, normative, and control belief subscales and the items that make up these scales, and add additional measures for each construct of the TPB model. Further, the operationalization of TPB constructs needs revision and improvement, which will benefit the revision and selection of items used to measure these constructs. A number of TPB belief items, especially those measuring behavioral beliefs, were reverse-coded which could contribute to the lower reliability. Additionally,
asking about actual behaviors and intentions to engage in these behaviors at the same
time point does not present the opportunity to examine whether or not intentions to enact
behaviors actually lead to actual behaviors.

While previous research has shown control beliefs predictive of PCSHC
intentions (Cederbaum, Hutchinson, Duan, & Jemmott, 2013) and actual PCSHC (DiLorio
et al., 2000), the current study found no significantly relationships between perceived
behavioral control and intentions for and behaviors of PCSHC. Measures of control
beliefs included in the survey presented with low reliability and contained too few items.
Examining the psychometric properties of the control belief subscale and all TPB
subscales and improving measures will allow for a better understanding of parental
perceptions of the control they have over communicating with their child(ren) about
sexuality and sexual health. The current study attempted to measure perceived
behavioral control on the part of parents, however, it did not formally examine factors
that may impact actual behavioral control.

Although identical in items and measures, data were collected from some
respondents with a paper-pencil survey and others responded via an electronic survey.
Two significant demographic differences were identified with paper group (M = 4.30, SD
= 1.92) having a significantly lower level of education than the online/paper group (M =
6.13 , SD = 1.24) (t(203) = -8.08 , p < 0.001), and the paper group reporting a
significantly higher level of religiosity (M = 3.25 , SD = 1.30) than the online group (M
= 2.44, SD = 1.21) (t(183) = 4.35 , p < 0.001).
Strengths

While not all of the sample was made up of respondents from the target location for programming, nearly half of subjects were, making these results and what they reveal pertinent to understanding more about the parent population being targeted for a parent education intervention designed to motivate and empower participants to engage in PCSHC. Recognizing the relationship between beliefs, especially those informed by attitudes toward engaging in PCSHC, and parental intentions and behaviors offers insight into developing and refining sexuality and communication education opportunities.

Implications for Developing Interventions

The results of the current study not only contribute some understanding of PCSHC but also insight for parent education program planning and promotion. The TPB has something to tell us about parental beliefs, in this case, behavioral beliefs that can impact their intentions of and actual engagement in PCSHC. The examination of these beliefs and their predictive nature afford health educators insight into the attitudes toward the value of PCSHC and perceptions of social support and control for PCSHC, which can inform practices of these professionals in the recruitment for and delivery of parent programming.

Parents report often feeling isolated in making decisions about how to address their children’s questions about sexuality (Stone et al., 2013). This feeling of isolation can also contribute to the decision of whether or not to seek support for initiating PCSHC and developing the skills to be effective sexuality educators of their children. Motivation to attend parent sexuality education program can increase when parents understand their need for new knowledge and skills, have desire to come out of isolation and seek support.
(Thomas, 1996), realize their children’s need for earlier education (Miller et al., 2011), and overcome discomfort talking about sex and sexual guilt (Woody, 2007).

Regarding parental perceptions of PCSHC, thought and effort can be put into promoting a shift in behavioral and other beliefs that fosters an understanding of the need for and motivation to greater knowledge and access to resources for being better communicators with their children, especially about sexual health. Planning and providing parents with educational experiences that promote positive attitudes toward the outcome of parent-child communication can impact behavioral beliefs. Addressing parental concerns related but not limited to embarrassment for both parent and child, feeling like one’s child(ren) already know about sexuality and sexual health, maybe more than the parent, and the fear of inadvertently encouraging sexual behavior can serve as the catalyst for parents to increase intentions for and actual behaviors of PCSHC. Promoting PCSHC as a parental behavior with positive outcomes for children can help to balance the barrier of perceiving PCSHC communication as being difficult (Guilamo-Ramos et al., 2008) and motivate parents to seek the support they need to become more informed and empowered educators.

Bringing parents together for the purpose of learning and social support and providing them with information from individuals and groups they can trust can serve to present parent-child sexuality communication as socially acceptable and desirable, thereby impacting normative beliefs. Facilitating parents’ increase in knowledge of sexuality topics and sexual health and communication skills development functions to influence control beliefs and promote the perception that parents are capable of effectively communicating with their children about sexuality and impact their children’s
behaviors positively. Program planners may also consider factors that impact actual behavioral control for parents as these resources and relationships may also impact parents’ motivation and willingness to participate in educational opportunity designed to promote and enable PCSHC.

Interventions designed to educate parents about PCSHC and adolescent sexual health should encourage parents to begin communicating with children when they are young and before they become involved in romantic relationships (Eisenberg et al., 2006). Communication patterns between parents and their adolescent children shift during this developmental stage with primary pursuits of autonomy and independence for the child during early adolescence (12 – 14 years old) and connectedness with parents in late adolescence (15 – 19 years old) (Keijsers & Poulin, 2013). Providing parents with greater insight into characteristic of developmental stages can help them navigate their children’s development and understand that while those in early adolescence seek greater autonomy and independence from parents they may be more comfortable establishing PCSHC patterns with parents. Growing into late adolescence, children’s sexual health needs potentially change, they seek more connectedness with parents, and if PCSHC has been established and practiced, parents may have more opportunity to provide more in depth information and contribute more meaningfully to these important conversations.

The PETPB (Hutchinson & Wood, 2007) adds to the TPB the external influences that impact beliefs about PCSHC. Participation in parent sexuality education programming can serve as the external influence on parents, which can impact parents’ behavioral, normative, and control beliefs. Focusing on impacting parental behavioral
beliefs can serve as the catalyst for parents to serve as the external influence on adolescents’ intentions and behaviors for sexual health.

**Conclusion**

Parent-child sexual health communication can be one of the most accessible, feasible, and effective ways to educate young people about sexuality and sexual health. When parents assess the act of PCSHC as being one that can positively influence their children’s sexual health and recognize the benefit to adolescent sexual health decision making of talking with children starting early and continuing often throughout their adolescence they are more likely to initiate and respond positively opportunities to educate their children. Determining the usefulness of the TPB framework in predicting the likelihood of parental intentions for and behaviors of PCSHC contributes to the literature connecting theory to its practical application in the field of health promotion and education. The current study gives support for the predictive power of parental attitudes toward the intention and enactment of PCSHC and specifically condom usage instructions. Better understanding parental attitudes that make up their behavioral beliefs toward PCSHC gives guidance to health promoters and program planners in their efforts to recruit parents for educational interventions. Raising parents’ awareness that PCSHC is important and necessary and prepares children to make good sexual health decisions, and parent education interventions can help alleviate the parental and child discomfort that is common to the practice of PCSHC. By actively promoting PCSHC and offering opportunities for parents to develop skills to be better communicators can serve to improve sexual health knowledge, choices, and outcomes for pre-adolescent, adolescent, and emerging adult individuals.
Table 5.1
Demographic characteristics of sample by developmental stage of oldest child, 9 – 17 years old

<table>
<thead>
<tr>
<th></th>
<th>Pre-adolescence</th>
<th>Early adolescence</th>
<th>Late adolescence</th>
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<td>n = 49</td>
<td>N = 205</td>
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<td></td>
<td>n (%)</td>
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<tr>
<td>Gender of Child(ren)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>23 (34.8)</td>
<td>40 (44.4)</td>
<td>12 (24.5)</td>
<td>75 (36.6)</td>
</tr>
<tr>
<td>Female</td>
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<td>30 (33.3)</td>
<td>16 (32.7)</td>
<td>77 (37.6)</td>
</tr>
<tr>
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<td>12 (18.2)</td>
<td>20 (22.2)</td>
<td>21 (42.9)</td>
<td>53 (25.9)</td>
</tr>
<tr>
<td>Parent Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3 (4.5)</td>
<td>4 (4.4)</td>
<td>5 (10.2)</td>
<td>12 (5.9)</td>
</tr>
<tr>
<td>Female</td>
<td>63 (95.5)</td>
<td>86 (95.6)</td>
<td>44 (89.8)</td>
<td>193 (94.1)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some high school</td>
<td>--</td>
<td>3 (3.3)</td>
<td>4 (8.2)</td>
<td>7 (3.4)</td>
</tr>
<tr>
<td>High school graduate</td>
<td>1 (1.5)</td>
<td>10 (11.1)</td>
<td>1 (2.0)</td>
<td>12 (5.9)</td>
</tr>
<tr>
<td>Some college</td>
<td>8 (12.1)</td>
<td>13 (14.4)</td>
<td>8 (16.3)</td>
<td>29 (14.1)</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>3 (4.5)</td>
<td>9 (10.0)</td>
<td>4 (8.2)</td>
<td>16 (7.8)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>12 (18.2)</td>
<td>18 (20.0)</td>
<td>13 (26.5)</td>
<td>43 (21.0)</td>
</tr>
<tr>
<td>Some graduate school</td>
<td>7 (10.6)</td>
<td>3 (3.3)</td>
<td>2 (4.1)</td>
<td>12 (5.9)</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>35 (53.0)</td>
<td>34 (37.8)</td>
<td>17 (34.7)</td>
<td>86 (42.0)</td>
</tr>
<tr>
<td>Religious Affiliation*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-religious</td>
<td>21 (31.8)</td>
<td>17 (18.9)</td>
<td>9 (18.4)</td>
<td>47 (22.9)</td>
</tr>
<tr>
<td>Christian, non-Catholic</td>
<td>20 (20.3)</td>
<td>33 (36.7)</td>
<td>27 (55.1)</td>
<td>80 (39.0)</td>
</tr>
<tr>
<td>Catholic</td>
<td>8 (12.1)</td>
<td>8 (8.9)</td>
<td>5 (10.2)</td>
<td>21 (10.2)</td>
</tr>
<tr>
<td>Jewish</td>
<td>6 (9.1)</td>
<td>3 (3.3)</td>
<td>--</td>
<td>9 (4.4)</td>
</tr>
<tr>
<td>Muslim</td>
<td>--</td>
<td>2 (2.2)</td>
<td>--</td>
<td>2 (1.0)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (10.6)</td>
<td>15 (16.7)</td>
<td>4 (8.2)</td>
<td>2 (1.2)</td>
</tr>
<tr>
<td>Religiosity (attend services)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>14 (21.2)</td>
<td>12 (13.3)</td>
<td>6 (12.2)</td>
<td>32 (15.6)</td>
</tr>
<tr>
<td>Once or twice a year</td>
<td>20 (30.3)</td>
<td>24 (26.7)</td>
<td>13 (26.5)</td>
<td>57 (27.8)</td>
</tr>
<tr>
<td>Monthly</td>
<td>16 (24.2)</td>
<td>11 (12.2)</td>
<td>6 (12.2)</td>
<td>33 (16.1)</td>
</tr>
<tr>
<td>Once a week</td>
<td>11 (16.7)</td>
<td>21 (23.3)</td>
<td>17 (34.7)</td>
<td>49 (23.9)</td>
</tr>
<tr>
<td>More then once a week</td>
<td>1 (1.5)</td>
<td>10 (11.1)</td>
<td>3 (6.1)</td>
<td>14 (6.9)</td>
</tr>
</tbody>
</table>
Table 5.2
Logistic Regression Models Estimating Effects of Constructs of the TPB on Parents’ Intentions for and Actual PCSHC

<table>
<thead>
<tr>
<th>Variables</th>
<th>Education</th>
<th>Intention to Engage in PCSHC</th>
<th>Actual PCSHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 205, yes = 183</td>
<td>n = 205, yes = 141</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>SE</td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school diploma (graduate degree)</td>
<td>-1.51</td>
<td>1.59</td>
<td>0.22</td>
</tr>
<tr>
<td>High school diploma (graduate degree)</td>
<td>-1.36</td>
<td>1.30</td>
<td>0.26</td>
</tr>
<tr>
<td>Some college (graduate degree)</td>
<td>-0.41</td>
<td>1.19</td>
<td>0.67</td>
</tr>
<tr>
<td>Associates degree (graduate degree)</td>
<td>-0.24</td>
<td>1.27</td>
<td>0.79</td>
</tr>
<tr>
<td>Bachelor’s degree (graduate degree)</td>
<td>-0.20</td>
<td>0.83</td>
<td>0.82</td>
</tr>
<tr>
<td>Some graduate school (graduate degree)</td>
<td>-1.40</td>
<td>1.04</td>
<td>0.25</td>
</tr>
<tr>
<td>Gender of Children</td>
<td>Male only (male and female)</td>
<td>-0.46</td>
<td>0.83</td>
</tr>
<tr>
<td></td>
<td>Female only (male and female)</td>
<td>-0.79</td>
<td>0.85</td>
</tr>
<tr>
<td>Age of Oldest Child (age range)</td>
<td>-0.09</td>
<td>0.14</td>
<td>0.91</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td>Non-religious (other)</td>
<td>&lt; -0.01</td>
<td>1.32</td>
</tr>
<tr>
<td></td>
<td>Christian, non-Catholic (other)</td>
<td>0.20</td>
<td>1.07</td>
</tr>
<tr>
<td></td>
<td>Catholic (other)</td>
<td>-1.82</td>
<td>1.26</td>
</tr>
<tr>
<td>Religiosity</td>
<td>0.06</td>
<td>0.29</td>
<td>1.06</td>
</tr>
<tr>
<td>TPB Constructs</td>
<td>Behavioral Beliefs</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Normative Beliefs – family</td>
<td>&lt; -0.01</td>
<td>0.02</td>
<td>1.00</td>
</tr>
<tr>
<td>Normative Beliefs – friends</td>
<td>-0.07</td>
<td>0.03</td>
<td>0.93*</td>
</tr>
<tr>
<td>Normative Beliefs – faith community</td>
<td>&lt; -0.01</td>
<td>&lt; -0.01</td>
<td>1.00</td>
</tr>
<tr>
<td>Control Beliefs</td>
<td>0.03</td>
<td>0.14</td>
<td>1.03</td>
</tr>
<tr>
<td>(Constant)</td>
<td>3.26</td>
<td>3.68</td>
<td>1.2 Log Likelihood</td>
</tr>
</tbody>
</table>

- $\chi^2 (df = 20) = 16.79, p = 0.67$  
- $\chi^2 (df = 20) = 45.13, p = 0.01$

*Nagelkerke R²  
- 20.3%  
- 30.1%

*p < 0.05, ** p < 0.01
Table 5.3  
Logistic Regression Models Estimating Effects of the TPB on Parents’ Intentions to and Giving Children Instructions for Correct Condom Usage

\( n = 205, \text{yes} = 158 \)  \( n = 205, \text{yes} = 33 \)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Intention to Give Instructions</th>
<th>Actual Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than HS diploma</td>
<td>1.38</td>
<td>1.36</td>
</tr>
<tr>
<td>HS diploma</td>
<td>0.61</td>
<td>1.16</td>
</tr>
<tr>
<td>Associate’s degree</td>
<td>-0.28</td>
<td>0.74</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>1.28</td>
<td>0.97</td>
</tr>
<tr>
<td>Some graduate school</td>
<td>-0.39</td>
<td>0.52</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>-0.44</td>
<td>0.83</td>
</tr>
<tr>
<td>Gender of Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male only (male and female)</td>
<td>0.35</td>
<td>0.53</td>
</tr>
<tr>
<td>Female only (male and female)</td>
<td>0.62</td>
<td>0.57</td>
</tr>
<tr>
<td>Age of Oldest Child (age range)</td>
<td>-0.13</td>
<td>0.10</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-religious (other)</td>
<td>-0.18</td>
<td>0.85</td>
</tr>
<tr>
<td>Christian, non-Catholic (other)</td>
<td>0.44</td>
<td>0.71</td>
</tr>
<tr>
<td>Catholic (other)</td>
<td>0.73</td>
<td>0.91</td>
</tr>
<tr>
<td>Religiosity</td>
<td>-0.44</td>
<td>0.22</td>
</tr>
<tr>
<td>TPB Constructs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Beliefs</td>
<td>0.14</td>
<td>0.05</td>
</tr>
<tr>
<td>Normative Beliefs – family</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>Normative Beliefs – friends</td>
<td>&lt; 0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>Normative Beliefs – faith community</td>
<td>&lt; 0.01</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Control Beliefs</td>
<td>0.16</td>
<td>0.10</td>
</tr>
<tr>
<td>(Constant)</td>
<td>-4.78</td>
<td>2.40</td>
</tr>
</tbody>
</table>
| -2 Log Likelihood          |      |      |      | \( \chi^2 (df = 20) = 43.85, p < 0.01 \)\( \chi^2 (df = 20) = 46.75, p < 0.01 \)
| Nagelkerke R\(^2\)         |      |      |      | 32.3%        |      |      |      | 38.7%        |

*p < 0.05, ** p < 0.01
CHAPTER 6

Manuscript #3: Components of Parent Interventions Designed for Promoting Parent–Child Sexual Health Communication

*Proposed Journal: American Journal of Sexuality Education*

*Secondary Proposed Journal: Sex Education*

Accompanying statement: This manuscript has not been published elsewhere and has not been submitted simultaneously for publication elsewhere. [Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for transfer of copyright to the publisher.]
Abstract

Parent-child sexual health communication (PCSHC) is a most practical and feasible way of educating children about sexuality and sexual health. Educational programming designed to prepare parents to engage their children in PCSHC has positively impacted parental outcomes related to PCSHC and child outcomes related to their sexual health. The purpose of this systematic review of the literature is to identify parental outcomes related to participating in interventions and examine the components of these interventions that practically contribute to their effectiveness. After searching 12 databases and applying inclusion/exclusion criteria 18 articles were reviewed. Implications and recommendations for programming design are addressed.

Keywords (5 or 6): parent-child communication, parent sex education, program planning, incentives, sexual health
Components of Parent Interventions Designed for Promoting Parent–Child Sexual Health

Communication

Introduction

Many adolescents in the U.S. are sexually active (National Campaign, 2015b) and while some adolescent sexual health outcomes are improving, U.S. teen pregnancy rates are higher than most industrialized countries around the world (SIECUS, n.d.). Roughly half of all pregnancies in the U.S., youth and adult, are unplanned (National Campaign, 2015b). The negative consequences for individuals born out of teen pregnancy impact them monetarily, educationally, and behaviorally, with worse health outcomes throughout their lives compared to people born to older parents (HHS, 2015). Negative consequences of teen sexual activity go beyond issues of unintended pregnancy and birth. While adolescents and young adults, ages 15 to 24, account for only a quarter of the sexually active population in the U.S., they are diagnosed with nearly half of sexually transmitted infections each year (Guttmacher, 2014).

In efforts to improve adolescent sexual health outcomes a variety of programs have been designed for the delivery of sexuality education for children, including adolescents, in school and community settings, with and without parent involvement (Downing, Jones, Bates, Sumnall, & Bellis, 2011; Gavin, Williams, Rivera, & Lachance, 2015; Wight & Fullerton, 2013). The actual implementation and effectiveness of these programs designed primarily for adolescents can vary from one community to the next depending on resources, values, and priorities. While providing sexuality education for children in schools and other community settings can provide knowledge and skill building opportunities for youth and improve adolescent sexual health outcomes, a
primary focus on improving and enhancing parental knowledge and communication skills also holds great potential to constructively impact the sexual health of adolescents.

Parent-child sexual health communication (PCSHC) is positively related to adolescent risk reduction behaviors and attitudes (DiClemente et al., 2001;). Adolescents who received sexual health information from parents are more likely to hold beliefs that lead to the likelihood they will delay intercourse (Bleakley, Hennessy, Fishbein, & Jordan, 2009) and more protected against early pregnancy and risky sexual behaviors (Secor-Turner et al., 2011). Adolescents who talked less or not at all with their parents about sex were less likely to negotiate safer sex with partners, practice safer sex (DiClemente et al., 2001), and use birth control (Clawson & Reese-Weber, 2003). As primary sources of sexuality education (Bleakley et al., 2009; Donaldson, Secor-Turner, Seiving, Eisenburg, & Skay, 2011), parents have the opportunity to transmit their values related to sexuality, which may increase the chances their children will adopt safe and healthy behaviors and attitudes (DiClemente et al., 2001; Salazer et al., 2005; Schouten, van den Putte, Pasmans, & Meeuwesen, 2007; Troth & Peterson, 2000). The social environment not only impacts parents’ ability to seek support, it can impact children’s reception of messages from parents (Secor-Turner et al., 2011) and service seeking behaviors (Hall et al., 2012). Parents need to be able access resources and support that will assist and motivate them in educating their children about sexuality and sexual health. In rural communities, especially, barriers to access include dependable transportation and financial problems (Noone & Young, 2009), school health educators (Jordan et al., 2000). In these cases, access to accurate information online can assist parents in their endeavors. Even when parents are interested in seeking sexuality
education, time (Heinrichs et al., 2005; Mendez et al., 2009; Person et al., 2010; Schneider, et al., 2003), work schedules, childcare issues (Mendez et al., 2009), location of programming, (Person et al., 2010) and privacy concerns (Eastman et al., 2005; Heinrichs et al., 2005) present barriers.

**Rationale for Review**

While previous reviews related to effectiveness of intervention on sexual outcomes in young people (Downing et al., 2011), interventions with some parental involvement and outcomes (Wight & Fullerton, 2013), and programs designed to increase parent-child communication specifically about reproductive health (Gavin et al., 2015), the current review contributes to the understanding of the programming components that contribute to the effectiveness of parent education programs designed to promote and improve parents’ comfort, knowledge, skills, and attitudes for engaging in PCSHC. Special attention was paid to programs designed for underserved populations, including those in rural settings, as further investigation for curriculum development and program recruitment and delivery focused on a rural community located geographically in a characteristically conservative region of the United States. Considering the barriers to parents accessing educational opportunities and anticipating reluctance on the part of parents to enroll and participate in parent sex education programming, examination of literature addressing ways to incentivize adult education enrollment and attendance was also included.
Methods

Selection

Systematic searches were conducted in 12 databases including ERIC (U.S. Dept. of Education), MEDLINE/PubMed (NLM), ProQuest Dissertation & Theses: Global, ProQuest Education Journals, Proquest Social Science Journals, EBSCOhost Academic Search Complete, EBSCOhost CINAHL with Full Text, EBSCOhost Psychology and Behavioral Science Collection, Science Digest Journals, American Public Health Association, SAGE Complete, and PubMed Central. The search took place between August 2015 - December 2016 and was limited to articles published between 2005 – 2016 to ensure more current literature and findings. Searches identified studies examining parent sex education programs, communication programs, HIV prevention parent programs, theory of planned behavior parent program, increasing parents' comfort when taking with kids about sex, parent sex education, and parent communication program, adolescent sexual health, and parent-child sexual health communication.

Inclusion criteria for this review included primary data collection, parent only education program/intervention and/or evaluation of parent component of larger program, peer reviewed, and published between January 2005 – December 2016 in selected databases, available in English, and outcome based. As the purpose of the review was to learn more about effective parent education programming, parent outcomes were emphasized, with child outcomes considered secondary and not required. Studies primarily focused on child-based educational programming with parent supplemental materials and/or programming, were excluded from this review. The review of interventions was not limited based on geographical location of intervention setting.
Data Extraction

Titles and abstracts were reviewed according to inclusion/exclusion criteria (Downing et al., 2011) and when criteria could not be fully evaluated based on the title and abstract, full articles were retrieved. Extracted data included location, author, year of publication, sample description and size, research design, recruitment methods, dosage/duration of intervention, intervention strategies, intervention content focus, incentives to participate in interventions, theoretical framework for program and/or study design, and parental and child outcomes. The main results are summarized in table form (see Table 6.1) and with a systematic narrative review focusing on components of interventions.

Results

Of the 67 articles reviewed, 18 studies are the focus of this literature review, with 11 interventions being examined. Eleven of the studies examined parent only interventions (61%) with seven including data collection from children (39%). Of the 18 studies, two designs included children in the last session of the program (11%) The Strong African American Families Program included a joint follow up session after separate parent and child sessions.

Sample and Design

Most study samples consisted of a combination of parents from different ethnic/racial groups, nearly 50% of programs reviewed were designed for and delivered to African-American participants (45%). Some samples of parents were classified by age of children while others were classified by grades of children. A single program (9%)
was designed to address parents of infants through pre-adolescents, two for parents of preadolescents (18%), and one for parents of adolescents (9%).

One program targeted parents of children in intermediate grades (9%), one targeted parents of only high school students (9%), and two programs combined some combination of parents of intermediate, middle, and/or high school students (18%). Most programming was designed for all parents, while one program was designed for African American mothers (9%) and one for fathers only (9%).

Over half of the studies were conducted as randomized control trials where participants were randomly assigned to an intervention or control group (56%). Stratification of subjects included language-, county-, school-, and site-based. Two designs were quasi-experimental (11%), where subjects volunteering to complete a baseline survey were invited to participate in the intervention. A pre-, post-, follow-up intervention design was used in three studies (17%). A single study employed the semi-structured interview method pre- and post-intervention to measure outcomes (6%), three (17%) used audio computer-assisted self-interviews and two studies used home visitors (11%) for data collection. A single study (6%) used telephone interviews for follow up data collection. Of the studies that reported follow up results, 53.8% (n = 7) reported nearly or over 90% success rate in collecting post, short and long term follow data.

Setting

A variety of intervention settings were in the 18 studies including schools, community, worksite, and multi-settings, and home. Nearly a quarter of the studies used multi-sites, including community settings for interventions (22%), and nearly another quarter included only community settings (22%). Three studies used the children’s
schools at the intervention site (17%), while a single study used a university campus for its intervention site (6%). In attempts to reach parents in places they regularly spend time, two interventions took place in worksite settings (18%) and two were intended for at home use (18%). A special education and rehabilitation center was the site for one intervention (9%). Twelve studies took place in the U.S. (67%) with one study also set in a U.S. territory (6%). Interventions in one-third of the studies took place outside of the United States in South Africa, Kenya, Mexico, and Turkey. Over half of the studies took place in urban areas (67%) with three of those studies including suburban or semi-rural sites. Just over 20% of study sites were rural (22%), and the rurality or urbanality of two site was not reported.

**Program Duration**

Parents may be expected and willing to participate in multisession programming that fosters and PCSHC (Miller et al., 2010). All parent interventions (100%) reviewed consisted of multiple educational sessions varying in number of sessions and length of each session, with most organized as weekly meetings or multi-session workshops. A minimum of five weekly sessions appeared to be the norm in program design (50%). Some interventions were delivered in a workshop format with Campero et al. (2010; 2011) *Tools for Talking with Your Adolescent* four workshops series with each session lasting three hours and Klein et al. (2005) *Parents as Primary Sexuality Educators* four core workshops with two optional. Woody et al. (2007) provided a one time six hour Saturday session as an alternative to four weekly evening sessions. Just over 25% of programs were independent study through the use of CDs or computer-based series designed for multiple sessions (27%). Of the eight studies reporting attendance rates,
most participants made it to at least 50% of the sessions. Retain rates in these studies varied from participants completing 97% of sessions to only 45% completion of sessions.

**Theoretical Framework**

Of all interventions reviewed, nearly 75% used some sort of theoretical basis for application or evaluation purposes and of those 88% used some health promotion and education and behavior change theory as foundation and framework for program design and evaluation. The *Talking Parents, Healthy Teens* curriculum and its modification, *Let’s Talk*, curriculum are based on an integration of various influential behavior change concepts from behavior change theories including skills, ability, intention, environmental barriers, and emotional response (Bogart et al., 2013; Eastman et al. 2005; Schuster et al., 2008). Social learning/cognitive theory was used to guide study design and intervention development for four programs (36%). Program planners also consider the theory of reasoned action and its subsequent theory of planned behavior the design of four curricula (36%). Behavioral, normative, and control beliefs, constructs of the TPB, significantly mediated the effects of a parent education interventions on general and sexual risk communication and comfort with PCSHC (Villarruel et al., 2008).

*Saving Sex for Later* also considered the importance of parents’ in shaping their children’s behaviors through the lens of social development theory and used the diffusion of innovation theory to consider how parents will best receive instruction and opportunities for skill development (O’Donnell et al., 2005). To further consider the family influence on adolescent sexual health behaviors Villarruel et al., (2010) added the ecodevelopment theory to guide in the development of a computer-based parent education program. *Strong African American Families Program* was developed based on
Gibbons and Gerrards’ cognitive model of adolescent health risk behavior [Brody; Murry], that seeks to identify ways to facilitate parent-child processes and relationships that enhance child development of self-control (Brody et al., 2005; Murry et al., 2011).

Three of program descriptions did not include theory as informing program design and evaluation (27%).

**Parental Outcomes**

A variety of parental outcomes were measures to assess the effectiveness of interventions and determine if they met program goals and objectives. The overall mission of parent sex education programming is to encourage parents to communicate with their children. DiLorio (2007) found an increase in parental intentions to communicate with children about sexual health. Evaluation of the impact various curricula had on actual communication about sexual health found that over half of the programs were associated with increased PCSHC (55%), A single program (6%) was related to an increase in the frequency of parents initiating conversations with their children. While participating in *Let’s Talk* was associated with increased parental condom use self-efficacy and actual condom usage (Bogart et al., 2013), participating in *Talking Parents, Healthy Teens* was related to increased condom instruction delivery (Schuster et al., 2008). Interventions that were associated with increased parental comfort with PCSHC included *Let’s Talk, Parents as Primary Sexuality Educators, Families Matter! Program, ¡Cuidaté!* and it’s computer based adaptation, *Cuidalos*, while participating in *Talking Parents, Healthy Teens* was related to increased communication openness.

Participating in a parent program designed to promote PCSHC may not always have a significant impact on communication but can change parent attitudes and
behaviors. Campero et al. (2011) found that while participating in *Tools for Talking with your Adolescent* did not significantly impact the frequency of PCSHC among participants, there was a shift in parents’ understanding of the benefit of sharing contraceptive information with their children and an increase in the number of parents providing condoms to their adolescent children.

**Intervention Strategies**

Most all interventions reviewed included some sort of skills practice opportunity. Four curricula (36%) including *Tools for Talking with Your Adolescent* (Campero et al., 2010; 2011), *REAL Men* (DiLorio et al., 2007), *Parents Matter! Program* (Forehand et al., 2007), *and Family Matters! Program* (Vandenhoudt et al., 2010), and *¡Cuidaté!* (Villaruel et al., 2008) provide participants with time to develop skills through the process of role play. *The Strong African American Families Program* (Brody et al., 2005; Murry et al., 2011) provided parents the opportunity to role play and practice communication skills with their children in the follow-up joint session. *Talking Parents, Healthy Teens* (Schuster et al., 2008) included a one-on-one session with a facilitator where participant and facilitators role playing is videotaped, reviewed, and used to devise a communication improvement plan (Eastman et al., 2006). Some interventions (27%) also included the use of premade videos to highlight and demonstrate target communication behaviors. One particular target behavior, giving instructions or correct condom use, was modeled for parent participants in three interventions, *Tools for Talking with your Adolescent* (Campero et al., 2011; Campero et al., 2010), *Talking Parents, Healthy Teens* (Schuster et al., 2008), and its adaptation, *Let’s Talk* (Bogart et al., 2013).
Homework for parents provides the opportunity to reflect, practice, and connect with their children to promote PCSHC. Of the eleven curricula reviewed, 55% included homework activities for parents to complete independently and with their children. Homework assignments to promote general parent-child communication included noticing positive child behaviors and verbally praising them, question and answer games (Eastman et al., 2006), discussion prompts (Eastman et al., 2006; Villaruel, 2010), and practicing effective communication skills with children (Villaruel, 2008).

**Incentives**

Ideally, intervention and research participants are intrinsically motivated to take part in these endeavors, fulfilling the desire to contribute to their own understanding and the greater body of knowledge. Realistically, more participants will be recruited and retained using extrinsic incentives. People need motivation to act (Schwartz, 2009) and as parents are reluctant to be involved in prevention programs geared toward their children’s health (Heinrichs et al., 2005; Snow, Frey, & Kern, 2002), incentives are appropriate motivators for (Moyer & Brown, 2008; Wilhide, Hayes, & Farah, 2008) and play an important role in the recruitment and retention of participants (Graziotti et al., 2012).

Incentive literature presents a strong argument that monetary incentives are the most effective for the recruitment and retention of study participants (Alexander et al., 2008; Cawley & Price, 2013; Kohls, Peltzer, Herpertz-Dahlmann, & Konrad, 2009; Wilhide et al., 2008), however, Snow and colleagues (2002) found financial incentives made no significant impact in participation and retention. Increasing the amount of monetary incentives throughout a study is recommended (Person, Colby, Bulova, & Eubanks, 2010). In the current review, monetary incentives for completing baseline, post,
and follow up surveys were included in 50% of the research designs. Let’s Talk, participants were awarded monetary incentives for survey completion (Bogart et al., 2013) and those participating in the at home program with audio CDs, PASS, were given a monetary gift for completing the program (Weekes et al., 2014). Talking Parents, Healthy Teens incentives included raffle prizes as incentives for weekly attendance (Schuster et al., 2008).

Positive program features that motivate greater involvement include free childcare (Rydin & Pennington, 2000; Schneider et al., 2003) and meals during workshops (Campero et al., 2011). In the current review childcare and food were provided during the group parent sex education workshop (Woody et al., 2007) while only food was used as an attendance incentive in the REAL Men program (DiIorio et al., 2007). Childcare was provided during Parents Matter! Program when delivered at U.S. and Puerto Rico urban sites (Miller et al., 2010). Other program qualities that promoter greater parental involvement include zero program costs for participants (Schneider et al., 2003), the opportunity for both parents to attend simultaneously (Coatsworth, et al., 2006; Snow et al., 2002), and providing or paying for transportation (Campero et al., 2011).

While money may be most effective, alternatives and/or supplements to monetary incentives can benefit participation and retention. Schneider and colleagues (2003) describes themes that have surfaced in considering non-monetary incentives, including health and psychological benefits and positive program features. Psychological incentives for participant retention can be derived from the opportunity for meaningful socialize (Coatsworth et al., 2006; Rydin & Pennington, 2000; Schneider, Eveker, Bronder, Meiner, & Binder, 2003) with other parents. Regardless of the type of incentive, timely
distribution throughout the programming timeline can further impact retention and positive behavior change (Hand et al., 2014).

**Discussion**

The present review highlights component of and strategies used in the recruitment for and delivery of parent sexuality education programming intended to prepare parents to engage in sexual health communication with their children. Allowing parents to identify their personal values and beliefs through the process of parent sexuality education can help them better communicate these values to their children (Klein et al., 2005). Increasing communication comfort, skills, and confidence can improve parenting practices, which in turn can positively impact and protect at risk youth (Murry et al., 2011). Parent education interventions that promote PCSHC have shown to be useful tools for impacting and improving ASHO (Campero, 2011) and promoting positive and effective PCSHC (Klein et al, 2005; Miller et al., 2010). Recruitment for programming took place in community settings (Brody, Forehand, Villaruel, DiLorio, Woody), children’s schools (Villaruel, 2008; Murry, O’Donnell, Vandenhoudt) and the workplace (Bogart, Shuster). While Wight and Fullerton (2013) concluded that community-based programming is the most promising for parent sexuality education, parent sex education programming might benefit from being attached to already existing community agencies, schools, faith communities, and/or worksites (Woody, 2007). Working with employers that allow employees to be released from work to attend programming can increase enrollment and participation in worksite parent interventions (Bogart et al., 2013). Research has demonstrated that programming is most effective when delivered via multiple sessions (Miller et al., 2011; Person et al., 2010; Schuster et al., 2008; Wight &
Fullerton, 2013). Program delivery is best during the lunch hour rather than before or after the workday (Eastman et al., 2005). When it is challenging or impossible for participants to attend session, parent education program design should allow an ongoing learning process that is independent in nature, and explores innovative delivery formats that limits in-person meeting times (Woody, 2007).

While attending parent sexuality education can enable parent-child communication, program planners need to consider several factors that will increase enrollment and participation. Before exerting active recruitment efforts, it might be helpful to program planners to strategize and implement ways to normalize parent training (Heinrichs et al., 2005) and sex education while emphasizing parents’ stake in promoting their children’s sexual health (Woody, 2007) and raising parental awareness to the need for PCSHC [Miller, 2011]. Additionally, reducing the stigma of seeking help and imparting to parents they are not alone (Eastman et al., 2005), may lead to greater recruitment for and attendance in parent sexuality education programming. Outreach to potential participants needs to consciously combat initial avoidance reactions while emphasizing the supportive and collaborative nature of programming (Woody et al., 2005). Program advertising needs to move through a variety of channels (Woody, 2007). Program marketing strategies should include articles in newspapers and newsletters, distribution of posters and flyers (Person et al., 2010), radio and newspaper advertisements, and large-scale mailings (Schneider et al., 2003). Social marketing campaigns can provide a cue for parents to seek more in-depth sexual health information and shift social norms that promote parent-child communication (Evans et al., 2011).

Providing parents with pertinent and effective training and the opportunity to seek
support from other participants (Eastman et al., 2005), as well as multiple electronic modes of communication, branded campaigns, and health fairs (Wilhide, Hayes, & Farah, 2008) can serve to recruit and retain program participants.

Reluctant participants may be motivated to enroll in and attend programming with incentives, including those with monetary value, gift cards and/or cash. Pragmatically, time is often cited as a barrier to attending community based parent programming (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005; Mendez, Carpenter, LaForett, & Cohen, 2009; Person, Colby, Bulova, & Eubanks, 2010; Schneider, Eveker, Bronder, Meiner, & Binder, 2003), so programs that can be planned as a lunch and learn with meal provisions may remove obstacles to attendance and make participation more feasible. Preparing and utilizing trained community residents as volunteer program facilitators (Klein et al., 2005) can serve to increase comfort, interest, and commitment of harder to reach subpopulations.

It is important that parents are informed of the prevalence of youth sexual behaviors, view their children as being ready to learn about sexuality (Miller et al., 2011), and share preventative messages with their children before they begin engaging in sexual behaviors with partners (Miller et al., 2011; Vanderhoudt et al., 2010) therefore parent sex education programming focusing on promoting parent-child communication is best provided before adolescents become romantically involved and/or sexually active (Beckett et al., 2009; Dittus, Miller, Kotchick, & Forehand, 2004; Eisenberg et al., 2006; Grossman, Tracy, Charmaraman, Ceder, & Erkut, 2014). While this benefits adolescents and prepares them for healthy future relationships and decision making, reaching parents with curricula like Parents Matter Program and Talking Parents, Healthy Teens that
contain messages to communicate early and frequently (Dittus et al., 2004; Grossman et al., 2014; Miller et al., 2011; Schuster et al., 2008) alleviates parental confusion of discussion timing and the perceived need for over-involvement in their children’s relationships (Eisenberg et al., 2006). Sexuality education programming for parents can encourage, prepare, and give permission to begin conversations with their children about sexuality before their children reach the need to make decisions about their own sexual health. This can be particularly helpful in communities where youth are early initiator of sexual behaviors (O’Donnell et al., 2005).

Educational design for parent programming should provide parents with opportunity to develop a grasp of their children’s nature and understanding of relationships, center their relationships with their children in sensitivity, responsiveness, reciprocity, and support, and become better aware of their own perceptions and values (Thomas, 1996). Most programs, including those in this review, provide parents with sexual and reproductive health information, communication skills development and practice, including active listening and positive reinforcement provisions, parental monitoring, parental values clarification, how to convey values to children, and helping children make decisions (Dittus et al., 2004; Eastman, Corona, & Schuster, 2006; Miller et al., 2011; Wright & Fullerton, 2013). Program content has greater potential for impact when it involves skill building, practice, feedback, and family activities (Eastman et al., 2005) and addresses and respects personal and emotional barriers of parents (Woody et al., 2005), religious influences, culture (Thomas, Strickland, DiClemente, Higgins, & Haber, 2012), and diverse perspectives and values (Eastman et al., 2005).
Teaching strategies and program activities include discussions among facilitator and participants as a way of increasing parents’ self-efficacy and comfort while building communication skills and role play that allow for skills practice (Eastman et al., 2006; Miller et al., 2011; Pluhar et al., 2008). Providing parents with a list of sexual topics to discuss and what they might say about these is a practical way to provide guidance (Beckett et al., 2009; Schuster). Talking Parents, Healthy Teens and Let’s Talk provide parents with a list of sexual health topics they can discuss with their children (Bogart, Shuster). To make the task of communicating with and educating about sexual health with children, print and non-print media is recommended for aiding parents (Weekes et al., 2013).

Homework assignments for parents and children are a critical component to sex education programming (Miller et al., 2011), and these work to strengthen parent-child relationships (Schuster et al., 2008), designate parents as primary sex educators, provide the opportunity for parents to share their values, and increase comfort and openness of both parents and children while communicating about sexual topics (Grossman, Frye, Charmaraman, & Erkut, 2013). Family homework topics can include healthy and unhealthy relationships, media images and sexuality, and assertiveness skills (Eastman et al., 2006; Grossman et al., 2013). Planned and guided activities to be completed at home are recommended to grow parental self-efficacy for PSHC (Weekes et al., 2013).

Limitations

Many of the limitations identified within this body of literature are those that are often present in much social science and health promotion research design involving data collection and intervention participation. These restrictions include but are not limited to
sampling and selection bias, self-reported data, and length of follow up data collection points. Particular to the health behavior of engaging children in PCSHC and present in this review is the lack of fathers’ participation in data collection and interventions designed for the purpose of understanding and promoting PCSHC. While a single intervention was designed for fathers or father figures (6%) and one included more male parents than female (6%), nearly all studies in this review included mostly or only mothers (89%). Interestingly, a single study included both male and female parents in the first phase, with more female participation, but required both parents to participate in the intervention, thereby limited mothers without available parenting partners to participate in the intervention (Kok et al., 2015).

Many of the studies included in this review indicated their results and work would be strengthened by larger sample sizes. Recruiting a large number of participants for parent education programming may be challenging because of the pressures and time constraints of parenting and especially when the content of the programming addresses PCSHC and asks parents to perceive their children as sexual beings. Having a large number of participants may also not be feasible because of funding and space limitations and lack of support from family, friends, and community. Limiting the number of participants limits data collection, which limits the ability to conclude intervention effectiveness (Bogart et al., 2013; Woody et al., 2007). This and other factors lead to convenience sampling, which limits generalizability of findings. Convenience sampling methods, especially for an intervention addressing a sensitive topic such as sexuality, lends itself to a non-representative sample and one that is likely more open to and comfortable communicating about sexuality initially. Many of the study designs reviewed
entailed convenience sampling and even when random sampling techniques were applied
the voluntary nature of participation potentially contributing to selection bias, as more
motivated and less reluctant parents are the ones more likely to accept invitations to
participate in parent education. While recruitment can be challenging, motivating parents
to attend (Klein et al., 2005), participate (Campero et al., 2011), and complete
interventions (Campero et al., 2011; Forehand et al., 2007) is also difficult. Poor
attendance and high attrition rates of participants will lessen the meaningful impact of
interventions.

Self-reported data were used in all (100%) of the studies reviewed. Self-reported
data are vulnerable to social desirability bias in responses, and social desirable responses
are of special concern when items or questions are sensitive in nature (Lewis-Beck,
Bryman, & Liao, 2004) as is the case with instruments intended to measure constructs
related to PCSHC and adolescent sexual behaviors and health.

The descriptions of interventions, recruitment methods, and outcome data varies
in this collection of studies, with some providing inadequate descriptions of each and
limiting an understanding of the full scope of interventions and their impact. While most
studies included a theoretical framework, most authors did not take into consideration the
effectiveness of these models for informing planning, delivery, and evaluation practices.
While some designs included multiple follow up data collection points beyond one year
post interventions, nearly 40% of authors report the need for longer follow up periods
(39%).

Limitations of this current review of literature related to parent education
programming and research design include the exclusion of child outcomes and a limited
number of interventions reviewed. As the ultimate goal of PCSHC is to impact adolescents’ intentions and behaviors by not including child outcomes, part of the story is missing. This review is relying on previous evidence that PCSHC does in have a positive impact on adolescent sexual health outcomes. While the number of interventions reviewed was a limited based on parent programming only and especially those designed for underserved populations, this restriction excluded studies and interventions that would likely have contributed to a greater understanding of PCSHC, its impact on adolescent sexual health outcomes, and intervention components that contribute to PCSHC.

**Conclusions**

Parents serve as children’s first and primary educators, whether parents are fully aware and accepting of this or not. While asking schools and community and faith organizations to provide children with sexuality education is appropriate and supportive of families and youth, training parents to be better educators and communicators about sexuality and sexual health for their children could positively impact parent child relationships and adolescent sexual health outcomes. While determining program effectiveness is challenging for a variety of reasons including research design, length and frequency of follow up data collection, small sample sizes, and participant attrition, examining parent education program components is important for future program design and the improvement of overall evaluation endeavors. Designing, delivering, and evaluating programming to improve parents’ communication skills can increase the chances they can support their children in making healthy sexuality-related decisions (Klein et al., 2005). Empowering parents to engage in PCSHC is foundational to future
generations being safe and healthy and good decision makers in their relationships (Murry et al., 2011). Sexuality education programming holds the promise of empowerment and effectiveness for parents.
<table>
<thead>
<tr>
<th>Author; year; location; program name</th>
<th>Sample; design</th>
<th>Program Setting; Recruitment Strategies</th>
<th>Program Duration</th>
<th>Theoretical Framework or Constructs</th>
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<th>Incentives</th>
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<tbody>
<tr>
<td>Bogart et al., (2013) Cape Town, South Africa; <em>Let’s Talk</em></td>
<td>Parents of 11–15 year old children (N = 66); RCT stratified by language, BL &amp; 2 week F/U computer assisted self-interviews</td>
<td>Worksite; onsite information sessions, flyers, emails</td>
<td>5 weekly, 2 hour group sessions</td>
<td>Combination of 8 behavior change factors</td>
<td>comfort (+), comm. about 16 sex related topics (+), parents' condom use self-efficacy (+) and condom use behavior (+)</td>
<td>Motivational interviewing communication principles, skills practice, role play, group discussions, homework</td>
<td>Parents received equivalent of $15 for each interview completion</td>
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<td>Brody et al., (2005), rural Georgia; <em>Strong African American Families</em></td>
<td>African American mothers (n = and their 11 year old children; RCT with BL &amp; post-intervention collected by home visitor</td>
<td>Community venue; families were selected randomly from lists obtained from child’s school</td>
<td>7 weekly 2 hour sessions; each session: 1 hour parents and children are separate and 1 hour family</td>
<td>Gibbons and Gerrards' cognitive model of adolescent health risk behavior</td>
<td>Parenting behaviors (+)</td>
<td>skills practice, videos demonstrating target behaviors</td>
<td>Families received $100 for each data collection</td>
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<td>Campero et al. (2011); Semi-rural &amp; urban Morelos, Mexico; <em>Tools for Talking with Your Adolescent</em></td>
<td>Parents of first year HS students (N = 971); quasi-experimental, BL, post, 6 month F/U</td>
<td>Child’s school; invitations sent through schools</td>
<td>4 workshops, 3 hours each</td>
<td>social learning; TPB; TRA</td>
<td>Comm. frequency; condom provision (+)</td>
<td>&quot;Prevention Pack&quot;, short group activities, subject specific presentations, role playing, pair activities, homework, whole group homework discussion</td>
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<tr>
<td>Campero et al. (2010); Semi-rural &amp; urban Morelos, Mexico; <em>Tools for Talking with Your Adolescent</em></td>
<td>Parents of 10th graders (N = 66); semi-structured interviews, post intervention and five month F/U</td>
<td>Child’s school; parents were selected for the intervention sample (see Campero et al., 2011)</td>
<td>4 workshops, 3 hours each</td>
<td>social learning; TRA; TPB; social gender construction</td>
<td>Effective comm. (+); parent to parent comm. (+); content (+)</td>
<td>short group activities, subject specific presentations, development of skills, role play; &quot;prevention pack&quot;; homework assignments, and whole group homework discussion</td>
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<td>DiLorio et al. (2007); Metro Atlanta, GA; <em>REAL Men</em></td>
<td>Father and non-biological father figures of boys (N = 227), 11 – 14 years old; RCT with BL, 3, 6, &amp; 12 month F/U interviews</td>
<td>Community center; Boys &amp; Girls Club of Metro Atlanta</td>
<td>7 sessions, 2 hours each, last session with sons</td>
<td>SCT</td>
<td>Comm. about sex (+); father's intentions to comm. (+)</td>
<td>Videos demonstrating targeted behaviors; lecture, discussion, games, role play; homework; review and whole group homework discussions review of personal goals; participant manual</td>
<td>Parents received dinner during each session; $25 for completing each of 4 survey; certificate of completion</td>
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<td>Forehand et al. (2007); Georgia &amp; Arkansas; <em>Parents Matter!</em></td>
<td>Afr. Amer. parents of children in grades 4 – 5 (N = 1155); RCT with BL, post-, 6 &amp; 12 month F/U</td>
<td>Multi-site community venues; flyers, referrals, and community events</td>
<td>5 sessions, 2.5 hours each, children attend last session</td>
<td>SCT; problem behavior theory; TRA</td>
<td>Sexual comm. (+); parental response. (+)</td>
<td>Structured learning experiences, discussion, videotapes, modeling, role playing, group exercises, and HW assignments</td>
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<td>Klein et al. (2005); Rochester, NY; <em>Parents as Primary Sexuality Educators</em></td>
<td>Parents of infants – 12 years old (N = 174); single group BL, post intervention, and 10 week telephone F/U</td>
<td>Multi-site (schools, churches, community centers); invited workshop series participants</td>
<td>4 core and 2 optional workshops, delivered over a period of approx. 1 month</td>
<td>parental attitudes toward comm (ND), frequency of initiation of comm (+), comfort (+); awareness of community resources(+)</td>
<td>Trained, volunteer community facilitators; discussion, values clarification; locating resources</td>
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<td>Kok et al. (2015); Turkey</td>
<td>Parents with 10 – 19 year old children with intellectual disabilities (N = 42); BL &amp; 1 month post intervention F/U</td>
<td>Special education rehabilitation centers; recruited from semi-structured interview respondents</td>
<td>4 modules, 1 hour each</td>
<td>self efficacy</td>
<td>general self-efficacy scale(+); knowledge (+)</td>
<td>Warm up exercises, lecture, Q &amp; A, example evaluation</td>
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<td>Miller et al. (2011); Atlanta, GA &amp; Little Rock, AK; <em>Parents Matter!</em></td>
<td>African American parents of pre-adolescents (N = 339); RCT on three conditions with BL, 6 &amp; 12 month post-intervention audio computer-assisted interviews</td>
<td>Multi-site (schools, hospital, community center); recruited at intervention sites</td>
<td>5 weekly 2.5 hour sessions</td>
<td>SCT; problem behavior theory; TRA</td>
<td>Sex comm. topics (); sex comm. (); parent perceptions of child readiness for sexual comm. (); responsiveness ()</td>
<td>Structured learning experiences, discussion, videotapes, overhead projection, modeling, role-playing, group exercises, and homework assignments</td>
<td>Parents received $25 for the completion of each baseline, 6 &amp; 12 month post intervention interviews</td>
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<td>Miller et al. (2010); urban sites in U.S. &amp; Puerto Rico; <em>Parents Matter!</em></td>
<td>Parents (N = 294); post-intervention evaluation data</td>
<td>Multi-site (schools, community center, faith-based org.); enrolled in intervention</td>
<td>5 evening sessions; multi-site: community, schools, faith based venues</td>
<td>SCT; problem behavior theory; TRA</td>
<td>Satisfaction (+); information &amp; skills (+); usefulness; recommend to others (+)</td>
<td>See above</td>
<td>Inter. sites received $5000 for each series offered; childcare and HW help for children</td>
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<td>Murry et al., (2011); rural counties in Georgia; <em>Strong African American Families</em></td>
<td>African American mothers of 11 year old children (N = 332); RCT with home visits for BL, post-intervention, 27 &amp; 65 month F/U</td>
<td>Community centers; schools provided lists of contact information for families of 11 year old students</td>
<td>7 weekly 1 hour sessions</td>
<td>involved-vigilant parenting ( ), adaptive racial socialization ( ), general comm. ( ), parental-child comm. about sex ( )</td>
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<td>Lecture, comm. skills practice with child, family activities</td>
<td>Families received $100 for each of the 4 data collection home visits</td>
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<td>O'Donnell et al., (2005) New York City; <em>Saving Sex for Later</em></td>
<td>Parents of 5 – 6 graders (N = 674); RCT with BL and 3 month post intervention F/U</td>
<td>Child’s school; parents of all 5th &amp; 6th grade students were given a recruitment fact sheet</td>
<td>3 CDs; one CD every 10 weeks; designed to be listened to in sequential order;</td>
<td>social development theory; diffusion of innovation; TPB</td>
<td>comm about specific topics( ); self-efficacy (+); parental oversight (+)</td>
<td>Audio self-directed lessons</td>
<td>$15 for returned consent; $25 for baseline and follow up surveys; children received $5 for consent and $5 for each completed survey</td>
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<td>Schuster et al., (2008); Southern California; <strong>Talking Parents, Healthy Teens</strong></td>
<td>Parents of 6 - 10 graders (N = 569); RCT with BL, 1 week post intervention, 3 &amp; 9 month F/U surveys</td>
<td>Worksite; emails and flyers at the worksites</td>
<td>8 weekly 1 hour lunchtime sessions</td>
<td>Combination of 8 behavior change factors</td>
<td>list of sexual topics (+); condom instruction (+); comm. ability (+); openness (+)</td>
<td>Skills practice, homework, handouts, one-on-one videotaped role play with facilitator</td>
<td>Raffle prizes each session; certificate of completion</td>
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<tr>
<td>Vandenhoudt et al., (2010); rural Kenya; <strong>Families Matter!</strong></td>
<td>Parents and other primary caregivers of children ages 10 - 12 (N = 321); BL &amp; 1 year post-intervention audio computer-assisted self-interviews</td>
<td>Community venues; invited by Ministry of Education village reporters to meeting held at selected schools</td>
<td>5 weekly 3 hour sessions; children attend last session with parent</td>
<td>SCT; problem behavior theory; TRA</td>
<td>attitudes toward sex ed of preteens (+); parent-child relationship (ND), monitoring (+); comm. frequency (+); parental knowledge, comfort, skill (+) and confidence</td>
<td>Structured learning experiences, discussion, videotapes, modeling, role playing, group exercises, and homework assignments</td>
<td></td>
</tr>
<tr>
<td>Author; year; location; program name</td>
<td>Sample; design</td>
<td>Program Setting; Recruitment Strategies</td>
<td>Program Duration</td>
<td>Theoretical Framework or Constructs</td>
<td>Parental Outcomes</td>
<td>Teaching strategies</td>
<td>Incentives</td>
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<tr>
<td><strong>Villarruel et al. (2010); Southwest Detroit; Cuidalos</strong></td>
<td>Latino parents of children ages 13 – 18 (N = 130); RCT with baseline &amp; 3 month post intervention follow up surveys</td>
<td>Computer-based program; recruited through community organizations</td>
<td>60 minute intervention (session 1: 40 min., session 2: 20 minutes), one per week</td>
<td>Eco-development theory; TRA; TPB</td>
<td>general parent-child comm (+), parent-adolescent sexual risk comm(+), comfort (+)</td>
<td>Computer-based self-directed lessons, digitized case studies; homework</td>
<td>Parents receive up to $60 for survey completion; adolescents receive up to $40 for survey completion</td>
</tr>
<tr>
<td><strong>Villarruel et al. (2008); Mexico; ¡Cuidaté!,</strong></td>
<td>Parents of children ages 14 – 17 (N = 791); RCT with BL, post-intervention, 6 &amp; 12 month F/U surveys</td>
<td>Child’s high school; 2 weekly 3 hour sessions conducted over two consecutive Saturdays</td>
<td>TRA; TPB</td>
<td>general comm. (+); sexual risk comm (+); comfort with comm. (+) *TPB mediating effects</td>
<td>small group discussion, videos, role playing, skill building activities, homework</td>
<td>Up to $35 for completing intervention and surveys</td>
<td></td>
</tr>
<tr>
<td>Author; year; location; program name</td>
<td>Sample; design</td>
<td>Program Setting; Recruitment Strategies</td>
<td>Program Duration</td>
<td>Theoretical Framework or Constructs</td>
<td>Parental Outcomes</td>
<td>Teaching strategies</td>
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<tr>
<td>Weekes et al. (2014); urban Michigan; <em>Parents Addressing Sexuality with their Adolescent Sons (PASS)</em></td>
<td>African American parents with sons in grades 4 – 9 (N = 61); Mixed-method; BL, post-intervention survey, &amp; opened questions</td>
<td>At home audio CDs; convenience and snowball</td>
<td>5 audio tracks completed over 3 weeks</td>
<td>SCT</td>
<td>outcome expectations (+); sex comm. self-efficacy (+)</td>
<td>Audio CDs, home, homework, parent guidebook, handouts</td>
<td>$25.00 gift card and thank you letter for participating in study</td>
</tr>
<tr>
<td>Woody (2007); metropolitan university campus</td>
<td>Parents of adolescent children (N = 37); quasi-experimental, BL &amp; post intervention</td>
<td>University campus; newspaper &amp; newsletter advertisements &amp; emails</td>
<td>4 weekly evening 1.5 hours sessions OR 6 hour Saturday session</td>
<td>knowledge, attitudes (+) and comfort (+); child sex. learning, moral beliefs about sex, personal sexual guilt(+), and prep. for comm. (+)</td>
<td></td>
<td>Workbook assignments; mini-lectures, videotapes, small group discussion, communication exercises</td>
<td>childcare and refreshments</td>
</tr>
</tbody>
</table>
CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to learn more about parent-child sexual health communication (PCSHC), parental and child factors that are related to PCSHC, and how to motivate, educate, and empower parents to become better communicators with their children, especially about sexual health. The theoretical framework of the theory of planned behavior (TPB) served as the foundation for the current research and many of the studies and interventions used in building this study. Collecting baseline data allowed for better understanding of how the TPB constructs contribute to our understanding of PCSHC and parental intentions and behaviors. The TPB further contributed to the investigation of parental perceptions, intentions, and behaviors related to the gender of their children and PCSHC. This study also entailed putting research into practice as it included modifying an existing parent education curriculum and piloting it.

Summary of Results

Parent-child sexual health communication can be challenging for both parents and children. While children report parents as primary educators and parents seem to understand the importance of this role in their children’s lives, sexual health outcomes of adolescents suggest parents can improve in preparing their children as informed, responsible, and confident sexual decision makers. The current study showed no significant differences in TPB behavioral, normative, and control beliefs, or in parental self-rating of communication ability, openness, and total sexuality topics scores related to gender of child(ren). This coupled with the significant findings related to specific topic scores and actual delivery of condom instruction related to gender of child(ren), may
indicate parental differences related to gender of their child(ren) are more content focused rather than based in parental perceptions. The differences in the way parents approach PCSHC related to gender of children in the current study speaks to the need of health promoters and education to raise parental awareness to the necessity of communication that covers sexuality and sexual health much more comprehensively and equally for all people. When looking through a binary gendered lens, rather than considering the sexual educational and communication needs of children and adolescents as human, parents are at risk for omitting or incompletely addressing certain topics that can be important to their development and state of sexual health in the immediate and long term. If parents perceive that their children only need to learn about their own bodies and developmental processes based on their gender this perpetuates the dangerous message that one need only be concerned with understanding and caring for him/herself or at most those who share the same gender identity. This mentality certainly contributes to gender inequity and sexual violence. While we often focus on how females are being treated and received unfairly or unjustly, the results of the current study shed light on ways in which male children, especially if they do not have female siblings, are also at risk for receiving harmful messages about what it means to be a gendered sexual being. That parents discussed how to say no to sex significantly less with male only children compared to female only and male and female children may reveal a sexual double standard and the expectation male children will inevitably have sex. The pressures and poor decision-making that accompany that expectation can be and likely are detrimental to females, males, and society. It seems, though, parents with both male and female children.
Understanding additional factors that impact and potentially influence parents’ decisions about engaging in PCSHC and reaching out for resources and support can help health promoters and educators assess parental perspective and then, if need, put forth effort in broadening or shifting these perspectives to support the enactment of effective and quality PCSHC. In the current study behavioral beliefs were the strongest predictor of intentions to give condom use instruction and actually delivering condom use instructions and holding intentions to engage in PCSHC, generally. While the TPB was limited in its utility otherwise, the strong connection between parental behavioral beliefs and intentions for and behaviors of PCSHC provide confidence that improving parental attitudes about the benefit of PCHSC can serve to motivate this behavior and parents’ efforts to seek educational and skill building opportunities for improving their experience with PCSHC and effectiveness in communicating with their children.

While expected to have a stronger relationship with factors related to PCSHC, religious affiliation and religiosity were significantly associated with intentions to engage in PCSHC and intentions to give correct condom use instructions, respectively. While working with faith communities might not inspire parents to discuss all topics, particularly condom use instructions, from the perspective of increasing PCSHC communication overall seeking to deliver parent education through faith communities warrants further investigation.

In addition to the literature review necessary for framing this work, the systematic review of the literature related to parent sexuality education resulted in a better understanding of best practices and pragmatic consideration of programming components. While providing both parents and children with meaningful learning
experiences and opportunities related to PCSHC, parent only education promises to serve as an influence on parents who influence their children for the betterment of adolescent sexual health. Programming components most widely used include homework activities to complete with children, role play activities to provide parents with skills practice, group discussion that connect parents, bring them out of isolation, and increases comfort and confidence. Multiple session delivery gives parents time to process their learning, practice skills with support and opportunity for feedback, and develop and/or enhance their parenting community in ways that support PCSHC.

While the design and piloting of a parent education program took place as part of this study, formal data analyses and program evaluation are beyond its scope. Preliminary findings and observations suggest that once the challenges of recruitment and enrollment are addressed and overcome parent education programming is a promising and feasible vehicle for the promotion and enactment of PCSHC, building parenting communities that support PCSHC, and giving parents the permission they seem to need to communicate comprehensively and meaningfully with their children about sexuality and sexual health. See Appendix L for excerpts from participants’ summative evaluations of *I’ll Have a Side of Sex Education*. Health education endeavors like the parent education program derived and implemented as part of the current study seek to directly and systematically improve parental confidence, knowledge, and skills, while greater understanding of parental perceptions about this health behavior can inform health promotion efforts intended to impact community attitudes, awareness, and norms regarding the importance and protective value of PCSHC.
Limitations

As sexuality and sexual health are multi-dimensional and many ideas are interrelated and interdependent, determining what concepts to examine, operationalize, analyze can be challenging. Because the vocabulary of sexuality holds so many words and concepts with multiple meanings and interpretations, being able to operationalize and clearly measure sexual health concepts is even more difficult. Further, the broad choice of variables to examine in relation to PCSHC reflects the complexity of intending to and enacting this behavior. When choosing to operationalize certain constructs for a study, inevitably the researcher leaves a number of variables out and different combinations of different variables will yield different conclusions about the nature of PCSHC.

To gain a better understanding of PCSHC generally, a much larger study with much greater enrollment with random sampling techniques employed would need to be conducted. While multiple and various efforts were made to recruit participants for baseline data collection and programming, convenience sampling led to a non-representative sample of even the small, rural community targeted for programming. The demographics of the respondents and program participants limit the generalizability of the results. Most of parents reported being married (75%), however, they were not asked to indicate whether or not they were married to their parenting partner. Although respondents could choose remarried as a relationship status, the structure of this question did not fully gather information about parents’ relationships status that could impact parent-child relationships and communication. While promoting and rewarding gift cards and other incentives was helpful for recruiting and retaining program participants, including them in the study design may have introduced and/or strengthen selection bias.
Participants attending programs for the sake of learning and personal gain, rather than external motivators and rewards, can contribute to the feasibility and face validity of the intervention (Klein et al, 2005).

Because the funding agent for this study limited participation in parent education programming to residents of Winchester/Clark County, Kentucky many potential participants in lunchtime programming were excluded because over 60% of the workforce in this county do not reside in it (Kentucky Cabinet for Economic Development. (n.d.). Preliminary research and inquiry with local employers revealed the challenge of resident-only participants, which was made more evident when target recruitment began through local schools and the local hospital and interested parties disclosed their counties of work and residence.

A major weakness of this study was the limited and less reliable measures used in the operationalization of constructs related to parental perceptions of PCSHC including ability, openness, and the TPB framework. Rather than piloting the data collection instrument in the current study, a close examination of the measures and their psychometric properties would have revealed the weakness of scale items, scales, and one item measures, allowed for revisions, and strengthened the results of the study. Many of the constructs being measured were done so with single items, some dichotomous, or scales with very few items. Because parent-child communication is a complex process, using single-item measures of parent-child communication is less than ideal (Widman et al., 2016).

The quantitative analyses conducted in this study were basic and while they provided opportunity to improve understanding and skill building related to statistics,
there are certain variable and test that were left out of this study that may have contributed to a greater understanding of those factors that impact and promote PCSHC. In the MANOVA and univariate tests for mean differences related to PCSHC topics based on gender of child(ren) it likely would have been more revealing to incorporate age of oldest child as a co-variate or take the analysis a step further and test interactions. The original intention was to collect data for those children, ages 12 to 17, however, so few parents followed up with the request this aspect of the study was dropped.

**Strengths**

This study reveals much about the complexity and multidimensional nature of PCSHC. Although it only looks at the parent perspective the examination is thorough and provides health promotion and education professionals with greater understanding of how they might focus on parental perceptions and communication as a way of reaching adolescents and improving their sexual development and health. Being able to examine PCSHC parental factors while planning and piloting an intervention afforded the observations of the theoretical being transformed into practice and evidence from previous research being reinforced through practice.

Having the opportunity to engage a small, rural community and its members with this study allowed for this practice in research design and implementation to have real world implications and impacts. Although the subsample from Winchester/Clark County that completed baseline data was in many ways homogenous, that over 50% of respondents were from the target community for programming offered specific insight into some of the attitudes and beliefs about PCSHC among community members. In addition to the mostly homogenous subpopulation that participated in programming,
working with Clark County Community Services provided some underserved community members in need the opportunity to take part in the intervention.

**Implications for Researchers and Health Promotion Professionals**

While recommendations for educators and promoters include encouraging parents to communicate comprehensively with their children about sexuality and sexual health, regardless of their child’s gender identity, research in the area of gender of children and PCSHC with respect to perceiving and accepting gender identity on a continuum is needed to be able to better understand and meet the needs of both children and their parents. While professional continue to sort through PCSHC related to binary identities of gender, this endeavor requires expanded investigations and considerations of the expanding identities of individuals.

Health promotion researchers and practitioners need to devise more innovative and successful strategies for engaging fathers in their investigations and interventions. Previous research gives evidence fathers’ roles in their children’s sexuality education are often minimal (Feldman & Rosenthal, 2000; Wilson et al., 2010; Wyckoff et al., 2008), which was reinforced by this study. Research purposely involving fathers can improve professionals’ understanding of their personal characteristics and perceived support related to sexual communication and how to engage fathers in educational processes (Coatsworth et al., 2006; Woody et al., 2005) designed to promote PCSHC. While it is evident fathers are a hard to reach population, putting forth the effort and overcoming the challenges to engage them offers the potential for a more complete picture of PCSHC.

Health promoters and educators have the skills and powers to positively impact parents, and thereby their children, by impressing upon them the necessity for PCSHC.
and preparedness for this behavior. While often professionals are discouraged from taking an authoritative stance when working for the betterment of communities, in the case of promoting PCSHC when program participants are trusting and valuing of the knowledge of and assistance from trained educators they seek and benefit from receiving permission to address topics that incite discomfort yet are critical for the healthy development of adolescent and adult sexual health perceptions and practices. When presented with the opportunity to engage parents in programming, professionals can impart key PCSHC wisdom including the benefits of repeated conversations about sexual health topics (Martino et al., 2008), approaching children in a non-judgmental ways that promotes honest and meaningful discussion (Eisenberg et al., 2006) enhances the effectiveness of their efforts. Health promoters and educator need also emphasize at all stages of research and practice that children and parents are not the only responsible beneficiaries of PCSHC and schools, churches, and the community also have a stake in promoting children’s sexual health and values.

Conclusions

A recent report published by Harvard University Making Caring Common project reported that emerging adults are struggling with initiating and maintaining romantic relationships while contending with the widespread misogyny and sexual harassment (Weissbourd, Anders, Cashin, & McIntryre, 2017) that have been commonplace in our United States culture since its inception. That misogyny and sexual harassment are so prevalent, especially in more rural, conservative regions like that of the setting of this study, speaks to the critical need for multifaceted and innovative research and programming designed to promote sexual health. While reasonable to imaging direct
education opportunities for young people would improve these societal ills, the noncontroversial strategy of engaging parents in prevention efforts that benefit their children (Vandenhoudt et al., 2010) may be a more realistic and effective strategy. Promoting sexual health communication among not only young people but their parents, most of whom were unlikely to have positive, informative, and pertinent sexuality education experiences themselves, provides a re-education opportunity for adults. This research points to the need to progress to a place where it is the norm for parents to want to be able to be the best sexuality educators they can be, without hesitation, seek out opportunities to increase their knowledge and build their skills, and talk openly and freely about this parental responsibility.

The difficulties that parents face in their communication with their children about sexual health exist within the greater challenge of acknowledging and accepting that their children will make sexual health decisions autonomously. Health promoter and educators also face challenges in their work with parents related to adolescent sexual health as parents face barriers of under- and mis-education, lack of confidence, and not knowing how to balance desire to inform and protect their children at the same time (Campero et al., 2010). Teaching parents skills for effective communication with their children, especially about sexual health, gives parents the tools to learn more about their children’s perceptions, attitudes, and beliefs and the opportunity to share their own knowledge, values, and beliefs about sexuality. Promoters, educators, and parents need to be mindful that PCSHC not only address risk reducing attitudes and actions related to partnered sexual behaviors but also speak to and about healthy relationships with one’s self and others and sexual pleasure. Despite the focus on the hook up culture of adolescents and
emerging adults young people are eager for guidance about developing caring and lasting romantic relationships (Weissbourd et al., 2017). Providing opportunities for parents to develop and enrich communication skills and a sense of empowerment for PCSHC is a sensible and viable step in a series to providing young people with the guidance, education, and opportunities they need and deserve to develop into sexually and relationally healthy individuals.
Appendix A

Electronic Recruitment Flyer

**UNIVERSITY OF KENTUCKY RESEARCH**

**Are you the parent of at least one child in grades 4-11?**

If the answer is **YES**, please consider completing an online survey to contribute to the understanding of parent-child sexual health communication. The survey will take 10 - 15 minutes to complete.

To participate, please contact Shannon Phelps, doctoral student, at [shannon.phelps@uky.edu](mailto:shannon.phelps@uky.edu) or Dr. Kristen Mark at [kristen.mark@uky.edu](mailto:kristen.mark@uky.edu)
February 15, 2016

Greetings.

My name is Shannon Phelps and I am a doctoral student at the University of Kentucky, under the advisement of Dr. Kristen Mark, Assistant Professor. The purpose of this letter is to let you know about a research study, *Implementing Lunchtime Parent Sex Education Programming in Clark County, Kentucky*, which aims to improve the amount and quality of parent-child sexual health communication.

Because you are the parent of at least one student enrolled in grades 5 – 10 in Clark County, you are invited to participate in the study. Participants will be randomly divided into two groups and one group will take part in a six-week lunchtime educational program this spring and the second group will take part in the program this summer. The goal of the program is to provide parents with the knowledge, skills, and confidence to communicate with their children, particularly about sexual health.

All participants, regardless of group assignment, will complete three questionnaires about parent-child sexual health communication. Participants who complete the first questionnaire will receive a $5.00 gift card. Participants who complete the second questionnaire will receive a $10.00 gift card. Participants who complete the third questionnaire will receive a $15.00 gift card. Each questionnaire should take 15 – 20 minutes to complete but possibly longer if a participant has multiple children in grades 5 – 10.

When study participants take part in the six-week educational programming, each week lunch will be provided and a drawing for a prize will take place. Additionally, for each session attended, individuals are eligible to enter their name in drawings for a $25.00 gift card; one drawing will take place after the third educational session and the other will take place after the sixth and final educational session.

Study participants will have the option to participate in the parent educational programming from 12:05pm – 12:55pm during work days at the Clark Regional Medical Center or during workdays or on Saturdays at the Clark County Public Library. Participants will specify location choice at the time of enrollment.

**While not a requirement of participation**, parents of children in grades 7 - 10 are asked to give permission for their child(ren) to complete a total of three
questionnaires at the same time periods parent participants complete questionnaires. The questionnaire the children will be asked to complete will be similar to those the parents complete, asking questions about parent-child sexual health communication.

If you are interested in participating or have additional questions, please contact me at shannon.phelps@uky.edu or 859-621-1065. You can also contact Dr. Kristen Mark at kristen.mark@uky.edu or 859-257-8935.

This research study is funded by the Clark County Community Foundation. Thank you in advance for your assistance with this important project as we strive to improve/enhance parent-child communication among Clark County residents.

Sincerely,

Shannon Phelps, MA, CHES, Doctoral Candidate

Department of Kinesiology and Health Promotion
College of Education
University of Kentucky
PHONE: 859-621-1065;
E-MAIL: shannon.phelps@uky.edu
Appendix C

Clark County Public Library Recruitment Flyer

Are you the parent of at least one child in grades 5 – 10? Do you live in Winchester or Clark County?

If you answer YES to all of these questions, please consider enrolling in a parent education research study. The purpose of the study is to learn more about parent-child sexual health communication and ways to increase and improve it.

As part of the study, you’ll be expected to:

- Complete a total of 3 questionnaires.
- Commit to and participate in 1 of 2 six-week “lunch and learn” parenting programs.

Weekday “Lunch and Learn” parenting programs will take place at the Clark County Public Library and Clark Regional Medical Center. A Saturday session will be held at the library for parents who are unable to attend a weekday session.

Incentives to participate include: A total of $30.00 in gift cards, lunch provided by local restaurants once a week for 6 weeks, and a chance to win prizes.

For more information, Contact Shannon Phelps, MA at Shannon.phelps@uky.edu or 859-621-1065

www.UKclinicalresearch.com
Appendix D

Baseline Survey Instrument

Today’s Date: ___________________

The first questions ask you about yourself.

Q1. What is your age? ___________

Q2. What is your gender?
   - Male
   - Female

Q3. Would you describe yourself as:
   - African American
   - Asian
   - Hispanic
   - Native American
   - White
   - Other (please specify)________________

Q4. What is your marital status?
   - Married
   - divorced, single
   - single, never married
   - remarried
   - cohabitating

Q5. Highest Level of Education:
   - less than 12th grade
   - high school graduate
   - some college
   - Associate degree
   - Bachelor’s Degree
   - some graduate school
   - graduate degree

Q6. What is your occupation? __________________________

Q7. Would you describe yourself as:
   - non-religious
   - Protestant
   - Catholic
   - Jewish
   - Muslim
   - other (please specify)__________________

Q8. How often do you attend religious or spiritual services?
   - Never
   - once or twice a year
   - monthly
   - once a week
   - twice a week
   - more than twice a week
   - everyday

Q9. Number of Children: __________

Q10. Ages and gender of children:
   - CHILD 1: age_______ gender_______ grade_______
   - CHILD 2: age_______ gender_______ grade_______
   - CHILD 3: age_______ gender_______ grade_______
   - CHILD 4: age_______ gender_______ grade_______
   - CHILD 5: age_______ gender_______ grade_______
For the rest of the questionnaire the answers you give will be about communication with your child(ren) in grades 4 – 11.

Q-11: How would you rate your ability to communicate with your child about sexuality topics?


<table>
<thead>
<tr>
<th>Circle the number that best represents your response.</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q-12: I don’t know enough about sexuality topics to talk to my child.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-13: I want to know my child’s questions about sexuality topics.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-14: I want to understand how my child feels about sexuality topics.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-15: When I talk to my child about sexuality topics, I warn and threaten him/her about the consequences.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-16: I know how to talk to my child about sexuality topics.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-17: My child can ask me questions he/she really wants to know about sexuality topics.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-18: My child and I talk openly and freely about sexuality topics.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>Q-19: I tell my child things about sexuality topics he/she already knows.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>Q-20: If my child talks to me about sexual behaviors I will think he/she is engaging in these behaviors.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>Q-21: I do not talk to my child about sexuality topics; I lecture him/her.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>Q-22: It is important to me that my child can talk to me about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-23: I would feel/do feel embarrassed talking about sexuality with my child.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-24: My child is not likely to want to talk to me about sexuality</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-25: It is not necessary to talk to my child about sexuality, because he/she already knows enough about it.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
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<tr>
<td>Q-26: My child would feel embarrassed talking about sexuality with me.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q-27: I feel it is important that I can talk to my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Q28: I am afraid of encouraging sexual activities if I talk to my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q29: My family members think I should talk with my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q30: The opinion of my family is important to me.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q31: My friends think I should talk with my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q32: The opinions of my friends are important to me.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q33: My church community thinks I should talk with my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q34: The opinions of my church community members are important to me.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q35: Most people like me talk about sexuality with their children in grades 5 – 10.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q36: It is easy for me to talk with my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q37. It is up to me to talk to my child about sexuality.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Q38. I believe talking to my child about sexuality topics will help them avoid unintended pregnancy and sexually transmitted infections.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>
The next items are about intentions to talk with your child and actual discussions you have had with your child(ren) in grades 4 – 11.

Q39. ______yes   ______no I intend to talk with my child repeatedly about many topics related to sexuality and sexual health.

Q40. ______yes   ______no In the past six months I talked with my child repeatedly about many topics related to sexuality and sexual health.

Q41. ______yes   ______no I intend to review the steps of how to use a condom with my child.

Q42. ______yes   ______no I have reviewed the steps of how to use a condom with my child.

Q43 – 65. The next items are about actual discussions you have had with your child(ren) in grades 4 – 11.

<table>
<thead>
<tr>
<th>How much have you and your child talked about: (Place an X in the box that best represents your response.)</th>
<th>not at all</th>
<th>a little</th>
<th>a moderate amount</th>
<th>a lot</th>
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</thead>
<tbody>
<tr>
<td>How girls’ bodies change physically as they grow up</td>
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<tr>
<td>How boys’ bodies change physically as they grow up</td>
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<tr>
<td>Menstruation/having a period</td>
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<tr>
<td>Wet dreams</td>
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<tr>
<td>How women get pregnant</td>
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<tr>
<td>How women have babies</td>
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<tr>
<td>What qualities are important in choosing close friends</td>
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<tr>
<td>How to ask someone out on a date</td>
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<tr>
<td>How to make decisions about whether or not to have sex</td>
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<tr>
<td>What it feels like to have sex</td>
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<tr>
<td>Homosexuality/people being gay</td>
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<tr>
<td>Consequences of getting pregnant/getting someone else pregnant</td>
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<tr>
<td>How well birth control can prevent pregnancy</td>
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<tr>
<td>How well condoms can prevent sexually transmitted infections (STIs)</td>
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<tr>
<td>How to choose a method of birth control</td>
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<tr>
<td>How to use a condom, how people prevent getting STIs</td>
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<tr>
<td>Symptoms of STIs</td>
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<tr>
<td>How much have you and your child talked about: (Place an X in the box that best represents your response.)</td>
<td>not at all</td>
<td>a little amount</td>
<td>a lot</td>
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<tr>
<td>What to do if your partner does not want to use a condom</td>
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<tr>
<td>The importance of not pressuring other people to engage in sexual behaviors</td>
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<tr>
<td>Reasons why people like to have sex</td>
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<tr>
<td>Reasons why you should not have sex</td>
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<tr>
<td>How will you know if you are in love</td>
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<tr>
<td>How to say no if someone wants to engage in sexual behaviors with you and you don’t want to</td>
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</table>
Appendix E

*I'll Have a Side of Sex Education* Curriculum

*I’ll Have a Side of Sex Education*

A Parent Education Program to Promote Parent-Child Sexual Health Communication

*I’ll Have a Side of Sex Ed* is an adaptation of *Talking Parents, Healthy Teens* curriculum (Eastman et al., 2006; Schuster et al., 2008). It consists of six 50 minutes sessions to be delivered during the lunchtime hour at the workplace or a community setting to parents of children in grades 4 – 11. All session lessons are designed to teach skills, facts, and options while recognizing and respecting diverse experiences, backgrounds, and values (Eastman et al., 2006). In addition to attending sessions, participants are strongly encouraged to complete homework activities. Because of the wide age range of children, throughout the program it is important to remind parents if the skill or activity does not seem appropriate at this point, they are filling their tool kit and some tools will be saved for later use.

**Sexual Health Defined by the World Health Organization:**

“…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” *(WHO, 2006)*
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Session 1: Positive Parent-Child Relationships and Effective Communication

Communication Skill: Opened-Ended Questions

**OBJECTIVES**

During this session parents will:

- Focus on their oldest child in grades 4 – 11 and identify and share at least one quality/characteristic of this child they admire and at least one quality/characteristic about this child that the parent finds challenging.
- Contribute and agree to program ground rules.
- Discuss the value of asking good questions, using opened questions, and avoiding lecturing when communicating with their child(ren).
- Determine ways in which they can use question and answer games to establish communication and connection with their child(ren).

**INTRODUCTION**

P: Receive a blank piece of paper and asked to record on one side a quality/characteristic they admire in their child (oldest of those in 4 – 11 grade) and the other side a quality/characteristic of their child that challenges them.

P: Shares this information with the whole group.

F: Explains that although participants’ backgrounds and life experiences may differ, they are gathered together in solidarity as parents and can learn from each other through their participation in this program. Explains the purpose of the program is to equip parents to communicate with their children about sexual health and most of the tools offered and lessons learned are helpful in all types of relationships and with many kinds of topics.

**DEVELOPMENT**

<table>
<thead>
<tr>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator’s Resource #1</td>
</tr>
<tr>
<td>Handout #1-A</td>
</tr>
</tbody>
</table>

F: Review and explain ground rules. Ask participants if they feel they need to add any to make the setting and experience more comfortable for them. Add accordingly.

See Facilitator’s Resource #1.

F: Ask participants to generate questions their children answer with one-word responses.

P: Give examples.

F: Acknowledge the frustration of one-word responses and explain how better COMMUNICATION fosters CONNECTION.
Review Handout #1 about asking opening ended questions.
From the examples provided previously, ask participants to turn it into an open-ended question.
P: Take turns changing their questions.

<table>
<thead>
<tr>
<th>F: Introduce “Would You Rather” and “20 Questions” handouts and explain that having prompts make it easier to engage and have fun with their children [COMMUNICATION = CONNECTION]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handout #1-B &amp; 1-C</td>
</tr>
</tbody>
</table>

P: Provide feedback regarding the feasibility and motivation to use these tools.

**CLOSURE**

F: Distributes slips of paper with suggested homework activities. Reviews each activity with participants.

**SUGGESTED HOMEWORK**

- Practice using open-ended questions with child.
- Give your child at least one compliment a day.
- Play question and answer games with your child.
- Discuss your child’s future life goals with him/her.
- Ask your child to choose a game and play it with him/her.

F = facilitator; P = participants
FACILITATOR’S RESOURCE #1
These are suggested ground rules for the program, modify, add, and/or delete accordingly.

Be kind.
Expect that others are coming from a place of kindness.

Be respectful of differences.

Oops & Ouch rule.

No interrupting.

No talking while someone else is talking.

No side conversations.

What is said here, stays here.*

*Share with others the valuable lessons you will learn but not the identity of your fellow participants.
HANDOUT #1-A

Asking Good Questions

<table>
<thead>
<tr>
<th>“Closed” Questions</th>
<th>“Open-ended” Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How was school?</td>
<td>What’s the biggest difference between this year and last year?</td>
</tr>
<tr>
<td>Did you have fun at school?</td>
<td>What was the best thing you did at school?</td>
</tr>
<tr>
<td>Do you like your teacher?</td>
<td>What was the most interesting thing your teacher said today?</td>
</tr>
<tr>
<td></td>
<td>What class rules did you teacher say are important?</td>
</tr>
<tr>
<td>Were the kids in your class nice?</td>
<td>Who did you enjoy talking with the most?</td>
</tr>
<tr>
<td></td>
<td>Did anyone have anything interesting to talk about?</td>
</tr>
<tr>
<td>Why are you being so difficult?</td>
<td>How could we work together to solve this problem?</td>
</tr>
<tr>
<td>Don’t you think it would be better to do your homework first?</td>
<td>How do you feel about doing your homework first?</td>
</tr>
</tbody>
</table>

**Good questions/conversation starters:**
Tell me about the best part of your day.
What was the hardest thing you had to do today?
Did any of your classmates do anything funny?
Tell me about what you read in class.

**Start questions with:** How, what, where, why, when

**Here are some common ways to start an open-ended question:**

- What would happen if...
- I wonder...
- What do you think about...
- In what way...
- Tell me about...
- What would you do...
- How can we...
- How did you...

**Avoiding Lecturing.**
When communicating with your child, be a partner, not the boss.
WOULD YOU RATHER...

Be the circus person that the knife thrower throws knives at—OR—the one who puts their head in the lion's mouth?

Slip your bare feet into a very moist pair of old bowling shoes—OR—walk barefoot in a gas station bathroom?

Wear a motorcycle helmet to bed every night—OR—always sleep with shoes and jeans on?

Have it rain rocks the size of baseballs—OR—rain darts?

Have five bottles stuck on the fingers of one hand for a year—OR—have a bucket stuck on your foot for a year?

Have all your friends be smarter than you—OR—have all your friends be much better looking than you?

Have a plugged nose—OR—perpetually plugged ears?

Have a nosy neighbor—OR—a noisy neighbor?

Have the ability to see 10 years into your own future—OR—one year into the future of the world?

Have to wear visible diapers for the rest of your life—OR—always have to drink and eat out of a bottle?

Sing every word you speak—OR—always speak in rhymes?

Be famous for being a genius—OR—for being good looking?

Suffer from unpredictable fainting spells—OR—from bouts of shouting?

Wind surf on shark inhabited waters—OR—hang glide over a forest fire?

Have one child who is totally out of control—OR—9 children who are well behaved angels?
Run across a hungry alligator's back—OR—run underneath an angry elephant?

As a man, have your grandmother's first name—OR—her haircut?

Eat a small can of cat food—OR—eat 7 whole lemons (seeds, pulp, juice, and rind)?

Go to your 20-year class reunion and have everybody comment on how old you look—OR—have nobody remember you at all?

Be known for your intelligence—OR—for your courage?

Live life in a small capsule in outer space—OR—in a small submarine at the bottom of the sea?

Paint a large wall with a toothbrush—OR—with a spoon?

Not be allowed to wash your hair for a month—OR—not be allowed to wash your hands for a month (not in the shower, not anywhere)?

Always have a little green piece of spinach stuck between your front teeth—OR—a little booger in your nose that moves when you breath?

Run a mile on a 6 inch deep bed of potatoes—OR—swim a quarter mile through maple syrup 12 feet deep?

Lose you wallet—OR—lose your keys?

Be 6 feet tall and ugly—OR—3 feet tall and beautiful?

Have to use a toilet that is unbelievable filthy and gross—OR—use one that's clean but has one dozen small jumping fish in it?

Win one hundred thousand dollars at age 20—OR—win ten million dollars at age 60?

Age only from the neck up—OR—age only from the neck down?

Spend every minute for the rest of your life indoors—OR—outdoors?
Have the power to read minds—OR—have the power to make anyone fall in love with you?

Trust everyone—OR trust no one?

Go back in time and magically prevent the Titanic from sinking—OR—magically prevent the Stock Market from crashing in 1929?

Live in a home without electricity—OR—in a home without running water?

Never be able to drive on the freeway again—OR—never again make a green light?

Have to learn to walk all over again—OR—learn to write all over again?

Try to pogo stick on ice—OR—skateboard down a steep slope covered with sand?

Get everywhere by crawling—OR—have to stand on your hands when you are stationary?

Have to spend a month with no explanation wearing a cape everywhere you go—OR—wearing an eye patch and carrying a walking stick?
50 Questions to Ask Your Children

1. What is the most amazing thing about you?
2. Which of your friends do you think I like the most? Why?
3. What would be the ideal allowance and how you spend use it?
4. Tell me about the best teacher you ever had?
5. If a genie would give you only one wish, which would you pick, and why?
6. When you feel sad, what cheers you up?
7. What punishment have I given you that you thought was really unfair? Why?
8. If you could change three things about yourself, what would they be?
9. What kinds of lies do your friends tell their parents?
10. What are the qualities that make a good friend?
11. Tell me about your favorite toy when you were little?
12. Tell me about something I never knew you did when you were little.
13. What do you say to comfort yourself when something scares you?
14. If you could decorate our whole house, what would it look like?
15. Looking at your pictures, when have you been the cutest so far?
16. What do you think are the characteristics that make a good parent?
17. What kind of sex education do you think kids ought to get in school?
18. What is the most enjoyable thing our family has done together this year?
19. At what age do you think kids fall in love?
20. What do you think is beyond the stars?
21. What is the nicest thing a friend has ever done for you?
22. Name two things we should do as a family on the weekend.
23. How do you think kids are affected by divorce?
24. Who is the meanest kid you know? Why?
25. Do you believe in heaven? If not, why? If so, what do you think it's like?
26. If you were going to have a weird, unusual pet, what would it be?
27. Do you think honesty is always the best policy? Why or why not?
28. What have you done, in school or sports or anywhere, that you are especially proud of?
29. Which of your friends are you proudest of? Why?
30. Have you ever had a dream that really scared you? What was it about?
31. Describe the most beautiful place you have ever visited?
32. How do you describe me to your friends?
33. Have you ever gotten really lost? If so, tell me about it. How did you feel?
34. Do you think you live in a dangerous neighborhood? Why or why not?
35. Not counting our religion, which religions do you find interesting? Why?
36. What is the grossest thing you can think of?
37. Is there anybody in history that you have read about that you would like to be?
38. What do you think is the right age for marriage? Why?
39. Tell me three things you remember about kindergarten.
40. What kids are popular in your grade? What do you think makes a person popular?
41. Has anyone ever tried to give you drugs? If so, what did you do?
42. If you knew a friend of yours had stolen something, what would you do about it?
43. If you could trade lives with somebody you know, who would it be?
44. How do you think you would feel if you thought you were going to be the first person to meet someone from outer space? What would you say or ask?
45. What would you do if you were invisible for a day?
46. What is your very earliest memory as a very little kid?
47. Do you think any of our neighbors are scary?
48. Do you ever have a dream that comes back over and over? If so, what is it like?
49. Why do you think some people don't like animals?

And the all time family favorite - What would you do if you won the lottery? - the BIG one.
### Session 2: Introduction to Communication with Your Child about Sexuality Health

**Communication Skills: Using Teachable Moments and Conversation Starters**

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th></th>
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<tbody>
<tr>
<td>During this session parents will:</td>
<td></td>
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<tr>
<td>• Share their homework and communication endeavors from the past week with the whole group.</td>
<td></td>
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<tr>
<td>• Review a list of sexual health topics and identify those which are most uncomfortable for them.</td>
<td></td>
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<tr>
<td>• Demonstrate their understanding of teachable moments and practice communication skills.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>HOMEWORK REVIEW</th>
<th>Materials Needed</th>
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</thead>
<tbody>
<tr>
<td>Ask parents if they were able to complete any of the suggested homework assignments.</td>
<td>Handout #2-A</td>
</tr>
<tr>
<td>Read HW #1 assignments back to parents:</td>
<td></td>
</tr>
<tr>
<td>• Practice using open-ended questions with child.</td>
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</tr>
<tr>
<td>• Give your child at least one compliment a day.</td>
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</tr>
<tr>
<td>• Play question and answer games with your child.</td>
<td></td>
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<tr>
<td>• Discuss your child’s future life goals with him/her.</td>
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<tr>
<td>• Ask your child to choose a game and play it with him/her.</td>
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<table>
<thead>
<tr>
<th>INTRODUCTION</th>
<th>Handout #2-B</th>
</tr>
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<tbody>
<tr>
<td>P: Receive the list of sexuality topics from the baseline survey and are asked to consider which of those topics they think are/would be most difficult to discuss with their children.</td>
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<tr>
<td>F: Asks parents to volunteer to share a topic and explain why they feel uncomfortable with this particular topic.</td>
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<td>P: Volunteers share; allow time for brief group discussion.</td>
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</table>

<table>
<thead>
<tr>
<th>DEVELOPMENT</th>
<th>Handout #2-C</th>
</tr>
</thead>
<tbody>
<tr>
<td>F: Give parents Session 2 handout; ask parents to think of ways in which media educates and gives message children/youth about sexuality</td>
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<tr>
<td>P: Give examples of sexual messages in the media</td>
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<tr>
<td>F. Introduces the Teachable Moment and Conversation Starters, explain difference between the two; encourage intrapersonal reflection regarding ROADBLOCKS and GETTING PERSONAL)</td>
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</tr>
</tbody>
</table>
*Values exploration can be helpful in overcoming roadblocks and allow parents to understand how their personal experience can be informing their PCSHC.

**ACTIVITY: Teachable Moments & Song Lyrics**

F. Introduce activity by brainstorming different types of media that provide teachable moments for PCSHC. Explain that most song lyrics share messages about sexuality.

Choose a selection of song lyrics from at least four popular songs. At least one selection needs lyrics that reflect qualities of an unhealthy relationship. At least one selection needs to include sexual and drug references.

P: Receive one set of lyrics and discuss in groups of two. Groups share lyrics with whole group and discuss the teachable moments presented in the lyrics.

F. After each group shares reinforce teachable moments you identified in each set of lyrics. Impact of drug use on sexual choices, drugs and sexual violence, signs of healthy and unhealthy relationships.

Give each participant a copy of *Families are Talking Newsletter*. Highlight the newsletter series and features of the newsletter.

**CLOSURE**

F: Distributes slips of paper with suggested homework activities. Reviews each activity with participants.

**SUGGESTED HOMEWORK**

- Let your child interview you and ask questions about what life/dating was like when you were growing up.
- Share with your child what you think are the qualities of a healthy relationship.
- Think about the sexuality messages you would like to communicate to your child(ren).

F = facilitator; P = participants
FACILITATOR’S RESOURCE #2

Teachable Moment: “everyday situations, such as watching a movie with a love scene, that provide opportunities to start discussion”; can be found in magazines, movies, television, music lyrics, etc.

Conversation Starter: “opening lines to start a conversation”; while teachable moments are presented by some external factor, using conversation starters are planned out by parent

Roadblocks: “what adolescents say to make it hard to talk about sex and strategies such as open-ended questions to get past them”; also considering personal qualities and characteristics of both parents and child(ren) that make it challenging to communicate.

Getting Personal: “identifying reasons they want to talk about sex with their children and learning how to avoid lecturing”; also considering how one’s personal history impact one’s parenting and perception of his/her child(ren)’s sexuality and sexual health. If you think you need help sorting through this, get it! Be prepared with professional local and internet resource information to share with participants.

(Direct quotes from Eastman et al., 2006, p. 5)
HANDOUT #2-A

Sexuality Topics to Discuss with Your Child(ren)

how girls’ bodies change physically as they grow up
how boys’ bodies change physically as they grow up
menstruation
wet dreams
how women get pregnant have babies
what qualities are important in choosing close friends
how to ask someone out on a date
who to make decisions about whether or not to have sex
what it feels like to have sex
homosexuality/people being gay
consequences of getting pregnant/getting someone pregnant
how well birth control can prevent pregnancy
how well condoms can prevent STIs
how to choose a method of birth control
how to use a condom, how people prevent getting STIs
symptoms STIs
what do to if your partner does not want to use a condom
the importance of not pressuring other people to engage in sexual behaviors, reasons why people like to have sex
reasons why you should not have sex
how will you know if you are in love
how to say no if someone want to engage in sexual behaviors with you and you don’t want to
4 STRATEGIES FOR INITIATING CONVERSATION &
CONVEYING YOUR VALUES

• TEACHABLE MOMENTS

• OTHER CONVERSATION STARTERS

• GETTING PAST ROADBLOCKS

• GETTING PERSONAL

(Eastman et al., 2006)

SOME HELPFUL WEBSITES

www.advocatesforyouth.org
www.answer.rutgers.edu
www.ashasexualhealth.org
www.kidshealth.org
www.thenationalcampaign.org
www.plannedparenthood.org

IMPORTANT NOTE: Preview all materials you share with you child(ren) before sharing it with them.
**HANDOUT #2-C**

**Values Exploration**

**Instrumental Values**

<table>
<thead>
<tr>
<th>Value</th>
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<tbody>
<tr>
<td>Ambitious (Hard-working, aspiring)</td>
</tr>
<tr>
<td>Broadminded (Open-minded)</td>
</tr>
<tr>
<td>Capable (Competent, effective)</td>
</tr>
<tr>
<td>Cheerful (Lighthearted, joyful)</td>
</tr>
<tr>
<td>Clean (Neat, tidy)</td>
</tr>
<tr>
<td>Courageous (Standing up for your beliefs)</td>
</tr>
<tr>
<td>Forgiving (Willing to pardon others)</td>
</tr>
<tr>
<td>Helpful (Working for the welfare of others)</td>
</tr>
<tr>
<td>Honest (Sincere, truthful)</td>
</tr>
<tr>
<td>Imaginative (Daring, creative)</td>
</tr>
<tr>
<td>Independent (Self-reliant, self sufficient)</td>
</tr>
<tr>
<td>Intellectual (Intelligent, reflective)</td>
</tr>
<tr>
<td>Logical (Consistent, rational)</td>
</tr>
<tr>
<td>Loving (Affectionate, tender)</td>
</tr>
<tr>
<td>Obedient (Dutiful, respectful)</td>
</tr>
<tr>
<td>Polite (Courteous, well-mannered)</td>
</tr>
<tr>
<td>Responsible (Dependable, reliable)</td>
</tr>
<tr>
<td>Self - controlled (Restrained, self discipline)</td>
</tr>
</tbody>
</table>
### Terminal Values

<table>
<thead>
<tr>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A world at Peace (free of war and conflict)</td>
</tr>
<tr>
<td>Family Security (taking care of loved ones)</td>
</tr>
<tr>
<td>Freedom (independence, free choice)</td>
</tr>
<tr>
<td>Equality (brotherhood, equal opportunity for all)</td>
</tr>
<tr>
<td>Self-respect (self esteem)</td>
</tr>
<tr>
<td>Happiness (contentedness)</td>
</tr>
<tr>
<td>Wisdom (a mature understanding of life)</td>
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<tr>
<td>National security (protection from attack)</td>
</tr>
<tr>
<td>Salvation (saved, eternal life)</td>
</tr>
<tr>
<td>True friendship (close companionship)</td>
</tr>
<tr>
<td>A sense of accomplishment (a lasting contribution)</td>
</tr>
<tr>
<td>Inner Harmony (freedom from inner conflict)</td>
</tr>
<tr>
<td>A comfortable life (a prosperous life)</td>
</tr>
<tr>
<td>Mature love (sexual and spiritual intimacy)</td>
</tr>
<tr>
<td>A world of beauty (beauty of nature and the arts)</td>
</tr>
<tr>
<td>Pleasure (an enjoyable leisurely life)</td>
</tr>
<tr>
<td>Social recognition (respect, admiration)</td>
</tr>
<tr>
<td>An exciting life (a stimulating active life)</td>
</tr>
</tbody>
</table>
Examples of Teachable Lyrics

I'm hurting, baby, I'm broken down
I need your loving, loving, I need it now
When I'm without you
I'm something weak
You got me begging
Begging, I'm on my knees
Read more: Maroon 5 - Sugar Lyrics | MetroLyrics

'Cause if you like the way you look that much
Oh baby you should go and love yourself
And if you think that I'm still holdin' on to somethin'
You should go and love yourself

But when you told me that you hated my friends
The only problem was with you and not them
And every time you told me my opinion was wrong
And tried to make me forget where I came from
Read more: Justin Bieber - Love Yourself Lyrics | MetroLyrics

You can find me in the club, bottle full of bub
Look mami I got the X if you into taking drugs
I'm into having sex, I ain't into making love
So come give me a hug if you into to getting rubbed

Read more: 50 Cent - In Da Club Lyrics | MetroLyrics

You take me to ecstasy
Without takin' ecstasy
It's exactly like ecstasy
When you layin' right next to me
I'm sexin' you
Sexin' you
You sexin' me
Sexin' me
It feels so damn natural
What we doin' so naturally
I'm likin' you rubbin' me
And you likin' me rubbin' you

Read more: Black Eyed Peas - Sexy Lyrics | MetroLyrics
## Session 3: Listening to Learn for Talking About Sexuality and Sexual Health

### Communication Skills: Active Listening

**OBJECTIVES**
During this session parents will:
- Share their homework and communication endeavors from the past week with the whole group.
- Take part in brainstorm session by verbally identifying reasons why or why not adolescents have sex.
- Define sex.
- Learn about and practice active listening skills.

**HOMEWORK REVIEW**
Ask parents if they were able to complete any of the suggested homework assignments. Read HW #2 assignments back to parents:
- Let your child interview you and ask questions about what life/dating was like when you were growing up.
- Share with your child what you think are the qualities of a healthy relationship.
- Write a written reflection about sexuality messages you would like to communicate to your child(ren).
- Practice active listening with a partner, co-worker, and/or friend.

**INTRODUCTION**

| P: Brainstorm reasons why or why not adolescents have sex. |
| F: Direct parents’ attention to the multiple meanings of world in the area of sexuality and sexual health. What is sex? What is love? Etc. |

**DEVELOPMENT**

| F: Reinforce responses to introductory activity and add to list to make more complete, if needed. Explain how important it is to communicate with children in ways that 1) promote connection, 2) gives children the opportunity to share and be heard without being judged, and 3) give parents the opportunity to learn more about their children’s identity, values, thoughts, and feelings. Give P the active listening handout and explain these strategies |

**ACTIVITY**

| Active Listening Role Playing |
| F: pass out the practice examples of things a child might tell his/her |

**Materials Needed**

| Handout #3-A |
| Handout #3-B |
parent in relation to sexuality and sexual health.

Explain to participants that they are going to work with a partner to practice active listening skills.

P: Work in groups of two or three and use prompts to practice active listening skills

<table>
<thead>
<tr>
<th>CLOSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: Share and discuss role playing activity.</td>
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</tbody>
</table>

Give parents a copy of *Virginity: A Very Personal Decision* and explain the challenges in using the word virginity.

Explain to P that this is an example of an article for teens from the KidsHealth website. This gives an idea of the content and writing style used to address sexual health needs of adolescents.

[SUGGESTED HOMEWORK](http://kidshealth.org/en/teens/virginity.html)

1. Brainstorm (with your parenting parent(s) and/or child ways to: 1) provide more supervision 2) allow greater freedom and independence.
2. Brainstorm with your child 1) five reasons adolescents/young adults might want to engage in sexual behaviors and 2) five reasons adolescents/young adults might want to wait until later to engage in sexual behaviors.
3. Look through magazines with your child and identify and discuss messages and images focused on sexuality (great time to talk about your response to the images in the context of your value system).
HANDOUT #3-A

ACTIVE LISTENING

Repeat: exact words

Paraphrase: similar words

Reflect: your own words

• "It sounds to me like you are saying...."
• "What do you mean when you say...?"
• "What I am hearing you say is...."
• "I gather than you felt _____ when ...."

Avoid jumping to conclusions

Work to not interrupt the flow of thoughts except to reflect and clarify

Avoid passing judgment and then tuning out
HANDOUT #3-B

Role Play Scenarios: Practicing Active Listening

1. My friend says that she is thinking about having sex with her boyfriend.

2. I heard some kids talking about blow jobs and I don’t know what they mean by "blow job", what is it?

3. My friend told his mom that he is in love with his girlfriend and his mom told him that there is no way teenagers can be in love, they are not mature enough.

4. My friend said she was hanging out with this guy and he said he wanted to have sex with her. She said she did not like him “that way” but she did not know how to tell him. I think that would be very uncomfortable.
### Session 4: Communication Skills: Assertiveness & S.T.O.P.

#### OBJECTIVES
- During this session parents will:
- Share their homework and communication endeavors from the past week with the whole group.
- Review and consider the *Assertiveness Bill of Rights* and discuss with whole group how this can and can’t be use with children.
- Learn about and how to use S.T.O.P. and practice the steps of the S.T.O.P. model with whole group.

#### HOMEWORK REVIEW
Ask parents if they were able to complete any of the suggested homework assignments. Read HW #3 assignments back to parents:
- Brainstorm (with your parenting parent(s) and/or child ways to: 1) provide more supervision 2) allow greater freedom and independence.
- Brainstorm with your child 1) five reasons adolescents/young adults might want to engage in sexual behaviors and 2) five reasons adolescents/young adults might want to wait until later to engage in sexual behaviors.
- Look through magazines with your child and identify and discuss messages and images focused on sexuality (great time to talk about your response to the images in the context of your value system).

#### INTRODUCTION

**F:** Give participants a copy of the “Assertiveness Bill of Rights”. Ask participants to read over this list and ask if they would be comfortable giving their children this bill of rights. Ask if there are any rights listed that would need some qualifiers.

**P:** Share thoughts about assertiveness bill of rights. Explain any right that would need qualifiers/conditions to be exercised. (Example: I have the right to say no. Yes, you have the right to say no in many cases (discuss these) but you do not have the right to say no when you are directed to clean up your room, do your homework, help your grandparent, etc.

Example: I have the right to feel and express anger. Explain the importance of impressing upon children that while they

| Materials Needed | Handout #4-A |
have the right to feel and express anger they must be mindful to know express anger in way that is harmful to self/others.

**DEVELOPMENT**

Introduce the “post-decision making” model: STOP (Eastman et al., 2006)

F: Explain to P that they can use the model repeatedly with their children to familiarize their children with the thinking patterns that promote good decision-making.

Highlight the ever important process of considering and talking about feelings and needs in parent-child communication and partner communication.

**ACTIVITY**

F: We are going to go to the “what if” world and discuss how STOP can be used with your children. Let’s say we have a (male/female)* child and he/she has come to use to say he/she has decided that he/she is not ready to engage in sexual behaviors with his/her romantic partner.

What do you say to your child?

P: Share potential responses

F. If participants do not mention open-ended questions and/or active listening, probe them about how they could use these skills.

Encourage participants to begin their responses to their children with a statement like “thank you for trusting me and talking with me about this”.

Explain that sometimes parenting requires a “poker face” and that they make feel very uncomfortable with their children sharing their personal information about their sexuality and sexual health, but that it is important for children to feel safe and not judged, this will strengthen the connection with children.
STOP model:
S: I am not going to engage in sexual behaviors with my boy/girlfriend right now.
T:
FEELINGS?
Relieved, nervous, fearful of rejection, empowered, etc.
NEEDS?
Strategies to combat peer pressure (refer to Assertiveness Bill of Rights); ways to express affections for romantic partner that are mutually satisfying; etc.

<table>
<thead>
<tr>
<th>CLOSURE</th>
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<tbody>
<tr>
<td>F: Distribute copies of <em>Families are Talking Newsletter, Vol. 2, Number 3</em>. Highlight helpful features of newsletter, including the scenario on back page about Sam and Theresa. This can be used as a conversation starter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUGGESTED HOMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents use several scenarios and questions to help teach their adolescent use S.T.O.P.</td>
</tr>
<tr>
<td>• Parents and children read the “Theresa and Sam” story from pg. 4 of <em>Families are Talking</em> newsletter and answer questions provided after the story.</td>
</tr>
<tr>
<td>• Parents talk to their kids about being assertive and share the Assertiveness Bill of Rights.</td>
</tr>
<tr>
<td>• Parents ask their children questions to help them think about what it means when someone says “no” and how to respect that person’s decision.</td>
</tr>
</tbody>
</table>

Resource #4-A
Assertiveness Bill of Rights

I have the right to...
  • Say no.
  • Be treated with respect.
  • Express my needs, feelings, thoughts, and ideas.
  • Be proud of my accomplishments.
  • Disagree in a respectful manner.
  • Feel and express anger.
  • Get help when I need it.
  • Feel supported.
RESOURCES #4-B

S.T.O.P.

State the decision

Talk about feelings and needs

Options – brainstorm and discuss

Pick best option and evaluate
### Session 5: Risk Reduction & Sexual Health

**Communication Skills: S.T.O.P. & Correct Condom Usage Instructions**

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>During this session parents will:</td>
<td></td>
</tr>
<tr>
<td>• Share their homework and communication endeavors from the past week with the whole group.</td>
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<tr>
<td>• Review the steps to S.T.O.P. and use them in another whole group activity.</td>
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</tr>
<tr>
<td>• Observe demonstrations with materials for safer sex practices.</td>
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</tr>
</tbody>
</table>

| HOMEWORK REVIEW | |
| Ask parents if they were able to complete any of the suggested homework assignments. | |
| Read HW #4 assignments back to parents: | |
| • Parents use several scenarios and questions to help teach their adolescent use S.T.O.P. | |
| • Parents talk to their kids about being assertive. | |
| • Parents ask their children questions to help them think about what it means when someone says “no” and how to respect that person’s decision. | |

| INTRODUCTION | |
| Review STOP with participants. For P who were absent last week, explain this model and how it can be used to teach children how to better think through their decisions. | |
| Explain/remind that last week the scenario used involved our child coming to use to inform us that he/she decided that he/she was not ready to accept the invitation of his/her boyfriend/girlfriend to engage in sexual behaviors. | |

| DEVELOPMENT | |
| F: This week we will use the STOP model to consider this scenario: Instead of our child coming to us and sharing that he/she has made the choice to abstain, the child says that he/she has decided to engage in sexual behaviors with his/her romantic partner. | |
| P: Brainstorm feelings and needs | FEELINGS? |
Scared, excited, nervous, guilty, etc.

**NEEDS?**
Safety, consent, pregnancy prevention, STI prevention, communicate with partner about parameters and likes and dislikes, etc.
F: If P do not mention STI prevention as a need, add it to the list.

**ACTIVITY**
Safer sex demonstration: finger condom, dental dam, female condom and male condom

**CLOSURE**
F: Pass out condom instruction game to participants and encourage them to use it with children or hold onto it until they feel it is appropriate to share with their children.

**SUGGESTED HOMEWORK**
- Parents and children come up with ways that adolescents who choose to engage in sexual behaviors protect themselves against sexually transmitted infections.
- Parents and children play the “Condom Game”.
- Parents and children read the “Theresa and Sam” story from pg. 4 of *Families are Talking* newsletter and answer questions provided after the story.
- Parents and children practice S.T.O.P.
- Parents and children have a conversation about social media, texting, and IM and discuss ways to stay protected and safe.
Check the expiration date.  

Check the package for an air bubble.  

Push the condom to one corner of the package while you open the other side.  

Penis with condom intact should be withdrawn while the penis is still erect.  

Remove the condom, starting from the base and contain the ejaculate in the condom while removing.  

Tie a knot at the end of the condom.  

Hold space at the tip of the condom as it is rolled down.  

Dispose of the condom, properly.  

Throw it in a garbage can.
## Session 6: Wrapping It Up

### OBJECTIVES
During this session parents will:
- Share their homework and communication endeavors from the past week with the whole group.
- Identify and verbalize at least one “next step” communicating with his/her child(ren).
- Practice communication skills with a partner.

### HOMEWORK REVIEW
- Parents and children come up with ways that adolescents who choose to engage in sexual behaviors protect themselves against sexually transmitted infections.
- Parents and children play the “Condom Game”.
- Parents and children read the “Theresa and Sam” story from pg. 4 of *Families are Talking* newsletter and answer questions provided after the story.
- Parents and children practice S.T.O.P.
- Parents and children have a conversation about social media, texting, and IM and discuss ways to stay protected and safe.

### INTRODUCTION
**F:** Welcome participants to last session. Explain that we are going to put all of our skills together for one last practice together but before then, we are going to think about and share next steps. Give participants Next Steps handout and ask them to share one next step they are going to take in their communication with their child(ren) about sexuality and sexual health.

**P:** Verbally share one “next step” with whole group.

### ACTIVITY
**F:** Divide participants into groups of two or three. Give each group a “child statement/question” and ask them to role play and/or discuss how they would respond using communication skills learned over the course of the program.

**P:** Work in small groups and then share with the whole group.

### CLOSURE:
Distribute certificates of completion; ask P to share any final questions or words; remind parents to be resourceful if they are uncomfortable or unknowing.
The next conversations I would like to have/intend to have with my child:

1.______________________________________________________________

2.______________________________________________________________

3.______________________________________________________________

It is important that I continue communicating with my child about sexual health because...
#1

CHILD: “What does it mean when people say they are queer?”

PARENT:

- Open-ended question
- “I” message
- Active listening (repeating, paraphrasing)
- STOP

#2

CHILD: “How do people know they have a sexually transmitted infection?”

PARENT:

- Open-ended question
- “I” message
- Active listening (repeating, paraphrasing)
- STOP

#3

CHILD: “Why do people have sex?”

PARENT:

- Open-ended question
- “I” message
- Active listening (repeating, paraphrasing)
- STOP
#4

CHILD: “I think I am in love. How do I know?”

PARENT:

• Open-ended question
• “I” message
• Active listening (repeating, paraphrasing)
• STOP

#5

CHILD: “I have decided to get on the Pill.”

PARENT:

• Open-ended question
• “I” message
• Active listening (repeating, paraphrasing)
• STOP

#6

CHILD: “What is a condom and why do people use them?”

PARENT:

• Open-ended question
• “I” message
• Active listening (repeating, paraphrasing)
• STOP
#7

CHILD: “My boyfriend says he wants to have sex with me.”

PARENT:

- Open-ended question
- “I” message
- Active listening (repeating, paraphrasing)
- STOP

#8

CHILD: “My girlfriend started talking about what it might feel like to have sex and I felt uncomfortable.”

PARENT:

- Open-ended question
- “I” message
- Active listening (repeating, paraphrasing)
- STOP
The next items are about the effectiveness of the parent education program.

<table>
<thead>
<tr>
<th>How effective were these educational strategies:</th>
<th>not very effective</th>
<th>somewhat effective</th>
<th>effective</th>
<th>very effective</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homework check in (at the beginning of each session)</td>
<td></td>
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<td>Music lyrics: Teachable moment activity</td>
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<tr>
<td>Scenarios for active Listening</td>
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<tr>
<td>Condom demonstration</td>
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<td>Whole-group discussion</td>
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<tr>
<td>Partner discussion</td>
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<tr>
<td>Homework</td>
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<tr>
<td>Free lunches</td>
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<tr>
<td>Session time (12:05pm – 12:55pm)</td>
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<table>
<thead>
<tr>
<th>How effective were these handouts:</th>
<th>not very effective</th>
<th>somewhat effective</th>
<th>effective</th>
<th>very effective</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Asking Open Ended Questions &amp; “I” Messages</td>
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<tr>
<td>50 questions</td>
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<tr>
<td>Would You Rather</td>
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<td>Virginity: A Very Personal Decision; article from kidshealth.org</td>
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<tr>
<td>Active Listening</td>
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<td>S.T.O.P. &amp; Assertiveness Bill of Rights</td>
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<td>Friendship, Dating, &amp; Love: Families are Talking Newsletter</td>
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<td>Abstinence: Families are Talking Newsletter</td>
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</table>
Rate the effectiveness of using the following communication skills with your child(ren) in grades 4 – 11.

<table>
<thead>
<tr>
<th>Skill</th>
<th>not very effective</th>
<th>somewhat effective</th>
<th>effective</th>
<th>very effective</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Open-ended questions</td>
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<tr>
<td>“I” messages</td>
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<tr>
<td>Teachable moments</td>
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<tr>
<td>Values clarification</td>
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<tr>
<td>Active listening</td>
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<tr>
<td>What to do if your partner does not want to use a condom</td>
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<td>The importance of not pressuring other people to engage in sexual behaviors</td>
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<tr>
<td>Reasons why people like to have sex</td>
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<tr>
<td>Reasons why you should not have sex</td>
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<tr>
<td>How will you know if you are in love</td>
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<tr>
<td>How to say no if someone wants to engage in sexual behaviors with you and you don’t want to.</td>
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</table>

The next items are about the usefulness of the homework options.

<table>
<thead>
<tr>
<th>Homework</th>
<th>Completed</th>
<th>Intend to complete</th>
<th>Do not intend to complete. Explain why you do not intend to complete this activity in the future.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice using your “I” messages and open-ended questions with child.</td>
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<tr>
<td>Give your child at least one compliment each day.</td>
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<tr>
<td>Play question and answer games with your child to connect with him/her– see handouts</td>
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<tr>
<td>Discuss your child’s future life goals with him/her.</td>
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<tr>
<td>Homework</td>
<td>Completed</td>
<td>Intend to complete</td>
<td>Do not intend to complete. Explain why you do not intend to complete this activity in the future.</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Play a game with your child that he/she chooses.</td>
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<tr>
<td>Let your child interview you and ask questions about what life/dating was like when you were growing up.</td>
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<tr>
<td>Share with your child what you think are the qualities of a healthy relationship.</td>
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<tr>
<td>Write a written reflection about sexuality messages you would like to communicate to your child(ren).</td>
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<tr>
<td>Practice active listening with a partner, co-worker, and/or friend.</td>
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<tr>
<td>Brainstorm (with your parenting parent(s) and/or child ways to: 1) provide more supervision 2) allow greater freedom and independence</td>
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</tr>
<tr>
<td>Brainstorm with your child 1) five reasons adolescents/young adults might want to engage in sexual behaviors and 2) five reasons adolescents/young adults might want to wait until later to engage in sexual behaviors</td>
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<td>Look through magazines with your child and identify and discuss messages and images focused on sexuality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents use several scenarios and questions to help teach their adolescent use S.T.O.P.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents talk to their kids about being assertive.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents ask their children questions to help them think about what it means when someone says “no” and how to respect that person’s decision.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Homework

<table>
<thead>
<tr>
<th>Completed</th>
<th>Intend to complete</th>
<th>Do not intend to complete. Explain why you do not intend to complete this activity in the future.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents and children come up with ways that adolescents who choose to engage in sexual behaviors protect themselves against sexually transmitted infections.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents and children play the “Condom Game”.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents and children read the “Theresa and Sam” story from pg. 4 of <em>Families are Talking</em> newsletter and answer questions provided after the story.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents and children practice S.T.O.P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents and children have a conversation about social media, texting, and IM and discuss ways to stay protected and safe.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The next items are your personal reflections about the program.

What are the most important things this program has taught you?

What communication skills are you most comfortable using?

What communication skills are the most difficult for you to use?

What motivated you to continue the program?

How could this program be improved?

Would you recommend this program to someone else? Why or why not?
Consent Form

Consent to Participate in a Research Study

IMPLEMENTING LUNCHTIME PARENT SEX EDUCATION PROGRAMMING IN CLARK COUNTY, KENTUCKY

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about parent-child sexual health communication. You are being invited to take part in this research study because you are the parent of a child in grades 4 – 11 in the 2016 – 2017 school year and a resident of Clark County, Kentucky. If you volunteer to take part in this study, you will be one of about 100 people to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Shannon Phelps, MA, CHES of University of Kentucky Department of Kinesiology and Health Promotion. Shannon is a doctoral student and is being guided in this research by her advisor, Dr. Kristen Mark, PhD, MPH

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to learn more about parent-child sexual health communication and offer and evaluate programming to increase the amount and quality of parent-child communication.

By doing this study, we hope to learn about the impact and effectiveness of parent education programming in promoting parent-child communication, specifically sexual health communication.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

If you do not reside in Clark County, Kentucky and/or you do not have a child in grades 4 – 11 who resides with you at least 3 nights a week, you can not take part in this study. Only one parent per child and only one parent per household may participate in this study.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

If you participate in the study you will have access to questionnaires online or they can be mailed to you through the United States Postal Service. You will participate in the parent education program late spring or summer 2017. When you participate in the parent education program you will need to come to the Clark Regional Medical Center, The Clark County Public Library, or another community setting for 6 educational sessions during the study. Each session will take about 50 minutes. The total amount of time you will be asked to volunteer for this study is about 8 hours over the next 5 months.
WHAT WILL YOU BE ASKED TO DO?

After you sign up for the study and have been determined eligible you will complete a questionnaire. You will then be assigned to one of two groups for parent education programming.

One group will participate in a six-week parent education program. After the program has concluded all participants will complete a second questionnaire. Three months after the program has concluded all participants will complete a third questionnaire. The second group will then have the opportunity to participate in the six-week parent education program.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

You may find some questions we ask you or information from educational sessions to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings.

In addition to the risks listed above, you may experience a previously unknown risk or side effect.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study. However, some people have experienced increased confidence in their ability to communicate with their child and increased communication with their child when participating in a parent sex education program. Your willingness to take part, however, may, in the future, help society as a whole better understand this research topic.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

IF YOU DON’T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to take part in the study, but are interested in learning more about parent-child sexual health communication there are other choices such reading a book about parent-child sexual health communication from the Clark County Public Library or taking part in parenting education provided by the Clark County Public Schools Family Resource Centers and the Clark County Health Department. For more information contact Shannon Phelps, MA, CHES at shannon.phelps@uky.edu or 859-621-1065.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in the study.
WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will receive a total of $30.00 in gift cards for taking part in this study. You will receive a $5.00 gift card for completing the first questionnaire, $10.00 for completing the second questionnaire, and $15.00 for completing the third and final questionnaire. Additionally, you will have the opportunity at each educational session to attend to receive a prize from a local business and put your name in a drawing for a $25 gift cards (a drawing for one at the midpoint of educational programming and one at the end) during the education program.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep confidential all research records that identify you to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. The data will be stored and accessed through password-enabled software on a University computer in an office that will be locked when not in use. All data will be coded and no names will appear on documents or surveys or other research data. Each participant will be assigned an ID number and no other identifying data will connect the participant to their responses.

Please be aware, while we make every effort to safeguard your data once received from online survey/data gathering company, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while still on the survey/data gathering company’s servers, or while en route to either them or us. It is also possible the raw data collected for research purposes may be used for marketing or reporting purposes by the survey/data gathering company after the research is concluded, depending on the company’s Terms of Service and Privacy policies.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky and the Bluegrass Community Foundation.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the agency funding the study decides to stop the study early for a variety of scientific reasons. If you need to withdraw from the study please contact Shannon
WHAT ELSE DO YOU NEED TO KNOW?

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

Contacting Research Subjects for Future Studies

Do you give your permission to be contacted in the future by Shannon Phelps regarding your willingness to participate in future research studies about how to communicate with your child about sexuality?

☐ Yes          ☐ No          ___________Initials

The Clark County Community Foundation of the Bluegrass Community Foundation is providing financial support and/or material for this study.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Shannon Phelps at 859-621-1065 or Dr. Kristen Mark at 859-257-8935. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8am and 5pm EST, Mon-Fri. at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

__________________________________________          ___________
Signature of person agreeing to take part in the study          Date

__________________________________________
Printed name of person agreeing to take part in the study

__________________________________________          ___________
Name of (authorized) person obtaining informed consent          Date
Appendix H

Waiver of Written Consent Cover Letter for Online Baseline Data Collection

To XXXXX:
The purpose of this research is to learn more about parent-child sexual health communication. You are asked to complete this questionnaire because you are the parent of at least one child in grades 4 – 11. Although you will not get personal benefit from taking part in this research study, your responses may help us understand more about parents’ beliefs and attitudes about communicating with their children about sexual health and their intentions to communicate.

Your answers are important to us. Of course, you have a choice about whether or not to complete the survey/questionnaire, but if you do participate, you are free to skip any questions or discontinue at any time.

The survey/questionnaire will take about 10 – 15 minutes to complete.

If you live in Winchester/Clark County, Kentucky and are interested in learning more about a parent education program designed to increase comfort and ability to engage in parent-child sexual health communication, include your name and contact information at the end of the survey or send an email to shannon.phelps@uky.edu.

Although we have tried to minimize this, some questions may make you upset or feel uncomfortable and you may choose not to answer them. If some questions do upset you, we can tell you about some people who may be able to help you with these feelings.

If you do not provide name and contact information at the end of the online survey our response is anonymous which means no names will appear or be used on research documents, or be used in presentations or publications. The research team will not know that any information you provided came from you, nor even whether you participated in the study.
If you include your name and contact information at the end of the survey, your response to the survey will be kept confidential to the extent allowed by law. When we write about the study you will not be identified.

Please be aware, while we make every effort to safeguard your data once received from the online survey/data gathering company, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while still on the survey/data gathering company’s servers, or while en route to either them or us. It is also possible the raw data collected for research purposes may be used for marketing or reporting purposes by the survey/data gathering company after the
research is concluded, depending on the company’s Terms of Service and Privacy policies.

If you have questions about the study, please feel free to ask; my contact information is given below. Or you may contact Dr. Kristen Mark at 859-257-8935. If you have complaints, suggestions, or questions about your rights as a research volunteer, contact the staff in the University of Kentucky Office of Research Integrity at 859-257-9428 or toll-free at 1-866-400-9428.

Thank you in advance for your assistance with this important project.
Sincerely,

Shannon Phelps, doctoral candidate
Department of Kinesiology & Health Promotion, University of Kentucky
PHONE: 859-621-1065
E-MAIL: shannon.phelps@uky.edu
Appendix I

IRB Approval

Initial Review

Approval Ends
October 28, 2016

TO: Shannon Phelps
Kinesiology - Health Promotion 210 College Street
Winchester, KY 40391
(859) 621-1065

FROM: Chairperson/Vice Chairperson
Non-medical Institutional Review Board (IRB) SUBJECT: Approval of Protocol
Number 15-0821-F4S DATE: December 2, 2015
On November 30, 2015, the Non-medical Institutional Review Board approved minor revisions requested at the convened meeting on October 30, 2015 for your protocol entitled:

Implementing Lunchtime Parent Sex Education Programming in Clark County, Kentucky

Approval is effective from October 30, 2015 until October 28, 2016 and extends to any consent/assent form, cover letter, and/or phone script. [If applicable, attached is the IRB approved consent/assent document(s) to be used when enrolling subjects. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review Report Form which must be completed and returned to the Office of Research Integrity so that the protocol can be reviewed and approved for the next period.

In implementing the research activities, you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol. It is the principal investigator's responsibility to ensure any changes planned for the research are submitted for review and approval by the IRB prior to implementation. Protocol changes made without prior IRB approval to eliminate apparent hazards to the subject(s) should be reported in writing immediately to the IRB. Furthermore, discontinuing a study or completion of a study is considered a change in the protocol's status and therefore the IRB should be promptly notified in writing.

For information describing investigator responsibilities after IRB approval has been obtained, download and read the document "PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research" from the Office of Research Integrity's RB Survival Handbook web page [http://www.research.uky.edu/ori/IRB-Survival-Handbook.html#Responsibilities]

Additional information regarding IRB review, federal regulations, and institutional policies may be found through ORI's web site [http://www.research.uky.edu/ori/]. If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at (859) 257-9428.

Chairperson/Robertson

[University Logo]
Appendix J
IRB Continuation Approval

Continuation Full Review

Ext., increased number of subjects, CF, assent form

Approval Ends IRB Number
October 6, 2017 15-0821-F4S

TO: Shannon Phelps
Kinesiology - Health Promotion 210 College Street
Winchester, KY 40391

FROM: Chairperson/Vice Chairperson
Non-medical Institutional
Review Board (IRB) SUBJECT:

Approval of Protocol Number 15-0821-F4S

DATE: October 25, 2016

On October 19, 2016, the Non-medical Institutional Review Board approved minor revisions requested at the convened meeting on October 7, 2016 for your protocol entitled:
Approval is effective from October 7, 2016 until October 6, 2017. This approval extends to any consent/assent document unless the IRB has waived the requirement for documentation of informed consent. If applicable, attached is the IRB approved consent/assent document(s) to be used when enrolling subjects. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review Report Form which must be completed and returned to the Office of Research Integrity so that the protocol can be reviewed and approved for the next period.

In implementing the research activities, you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol. It is the principal investigator's responsibility to ensure any changes planned for the research are submitted for review and approval by the IRB prior to implementation. Protocol changes made without prior IRB approval to eliminate apparent hazards to the subject(s) should be reported in writing immediately to the IRB. Furthermore, discontinuing a study or completion of a study is considered a change in the protocol’s status and therefore the IRB should be promptly notified in writing. If you have questions or need additional information, contact the Office of Research Integrity at 859-257-8315 (Medical) or 859-257-1639 (Nonmedical).

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research" from the Office of Research Integrity's IRB Survival Handbook web page [http://www.research.uky.edu/ori/IRB-Survival-Handbook.html#PIresponsibilities]. Additional information regarding IRB review, federal regulations, and institutional policies may be found through ORI's website [http://www.research.uky.edu/ori]. If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at (859) 257-9428.

N. Van Tubergen, PhD/ah
Chairperson/Vice Chairperson

see blue.

## Appendix K

### Data Analysis Matrix

<table>
<thead>
<tr>
<th>Manuscript</th>
<th>Research Question</th>
<th>Independent Variables</th>
<th>Dependent Variables</th>
<th>Types of scales</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Q1. Are parental behavioral, normative, and control beliefs related to gender of child(ren)?</td>
<td>Gender of children</td>
<td>Behavioral beliefs</td>
<td>categorical x 7-point Likert-scale total score</td>
<td>ANOVA</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>Gender of children</td>
<td>Normative beliefs</td>
<td>categorical x 7-point Likert-scale total score</td>
<td>ANOVA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Control beliefs</td>
<td>categorical x 7-point Likert-scale total score</td>
<td>ANOVA</td>
</tr>
<tr>
<td>1</td>
<td>Q2. Is there a difference in the number of sexual topics discussed with sons and daughters?</td>
<td>Gender of children</td>
<td>Sexuality topics total score</td>
<td>categorical x 7-point Likert-scale total score</td>
<td>ANOVA</td>
</tr>
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<td></td>
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<tr>
<td></td>
<td>Q3. Is there a difference in the specific topics of discussion discussed with sons and daughters?</td>
<td>Gender of children</td>
<td>Sexuality topics individual scores</td>
<td>categorical x 7-point Likert-scale total score</td>
<td>ANOVA</td>
</tr>
</tbody>
</table>

Parent behavioral beliefs will differ significantly based on gender of children. Parent normative beliefs will differ significantly based on gender of children. Parent control beliefs will differ significantly based on gender of children. Parent participants will discuss significantly more sexual topics with daughters than with sons.

There will be a significance difference in the specific topics discussed with
<table>
<thead>
<tr>
<th>Q4. Are parental self-ratings of communication ability and quality related to gender of child(ren)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-ratings of parent communication ability will be significantly different based on gender of their children.</td>
</tr>
<tr>
<td>Gender of children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5. Are there differences in communication openness between parents and children based on gender of children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent communication openness of parent will be significantly different based on the gender of child(ren).</td>
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<tr>
<td>Gender of children</td>
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</table>

<table>
<thead>
<tr>
<th>Q6. Are there differences in the intention to give condom use instructions related to gender of child(ren)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentions to give condom use instructions to children will be significantly different based on gender of child(ren).</td>
</tr>
<tr>
<td>Gender of children</td>
</tr>
</tbody>
</table>

|---|
parents’ beliefs, subjective norm, and perceived behavioral control predict intentions to initiate PCSHC?

Parents’ behavioral, normative, and perceived behavioral control beliefs will significantly predict intentions to engage in PCSHC.

Q8. To what extent do parents’ beliefs, subjective norm, and perceived behavioral control predict actual PCSHC behaviors?

Parents’ actual PCSHC will be significantly different based on behavioral, normative, and perceived behavioral control beliefs.

Q9. To what extent do parents’ beliefs, subjective norm, and perceived behavioral control predict intentions to instruct children how to use a condom.

Parental intention to give condom instructions will
Parents’ actual condom instruction will be significantly different based on behavioral, normative, and perceived behavioral control beliefs.

| Q10. To what extent do parents’ beliefs, subjective norm, and perceived behavioral control predict parents’ actual condom instruction to children? |
|---|---|---|---|---|
| Behavioral beliefs | Actual condom instruction | 7-point Likert-scale total score x dichotomous | Logistic regression |

| Q11. What program design features are included in parent sex education programming? |
|---|---|---|---|---|
| n/a | n/a | n/a | Systematic review |

| Q12. What teaching methodologies are included in effective parent education programming? |
|---|---|---|---|---|
| n/a | n/a | n/a | Systematic review |

| Q13. What theoretical frameworks and constructs are foundational to |
|---|---|---|---|---|
| n/a | n/a | n/a | Systematic review |
Q14. What incentives are associated with higher enrollment, attendance, and participation in parent sex education programming?
Appendix L

Summative Evaluation Results Provide by Spring and Summer 2016 I’ll Have a Side of Sex Education Participants

What are the most important things this program has taught you?

“This class has been extraordinary to me as a parent of a young child. It has taught me the value of communication and active listening is a vital part in raising my daughter and being able to guide her.”

“Open communication and the tools provided will be effective and have good long-term impacts on our children and family.”

“Having an open relationship with my child is the most important way to help them make good decisions.”

“How to feel more confident in talking to my daughter.”

“How to effectively and openly communicate with my children about decisions they make and options they have.”

“The most important thing that this program has taught me is that communication is the most important thing that I can master with my child. I also feel that I was reminded that my child learns what I teach her and what she sees from me and that is the most important thing I can remember so that I can make sure to teach her positive things in life.”

“That you can’t just lecture your kids about sex but instead strive for real honest open-discussion.”

“That just because you aren’t educated yourself about these things doesn’t mean you can’t and shouldn’t educate your children.”
Would you recommend this program to someone else? Why or why not?

“Absolutely yes! This class gives parents the platform and tools to help navigate a child through puberty, relationships, and choices.”

“Absolutely. It was extremely informative and effective. I could see the results immediately.”

“Yes, because it really gives you the tools to approach the subject on a much deeper level.”

“Yes – topic is important and yet uncomfortable these sessions increase the likelihood I will tackle this subject with children sooner rather than later.”

“Yes, everyone could learn something new and about other peoples’ perspectives on how to deal with difficult situations.”

“Yes! And I will because it really gave me the help I needed to address these topics with confidence.”

“Absolutely. I learned many things that need to be discussed that I had not thought about.”

“Absolutely! Great tools provided for communicating very tough topics with your children.”

“Definitely! Because it is a great way to refresh ourselves on our communication skills, and apply to all subjects, not just sex.”

“Yes! Anyone who has a child (teenager, pre-teen, young adult) would benefit from this program. It was very helpful for those that may not communicate well with their child. Even for those who do communicate well would benefit from this class.”

“Yes – the communication skills learned are invaluable.”
“Yes, because most parents don’t really take the time to listen to our children and educate them on their sexuality and the precautions they need to take on sexual abuse.”

“Absolutely, great support for all families. Parts should also be taught to high schools students.”
References


Byers, E. S. & Sears, H. A. (2012). Mothers who do and do not intend to discuss sexual
health with their young adolescents. *Family Relations, 61*, 851 – 863.


doi:10.1177/1049732310369915


doi:10.1007/s10464-015-9719-x


doi:10.1080/108107300126740


Theory of Planned Behavior: Predicting intention to increase physical activity.


Holman, A. & Kellas, J. K. (2015). High school adolescents’ perceptions of the parent-child sex talk: How communication, relational, and family factors relate to sexual
doi:10.1080/1041794X.2015.1081976


doi:10.1111/j.1545-5300.2010.01321.x


Nielsen, S. K., Latty, C. R., & Angera, J. J. (2013). Factors that contribute to fathers being perceived as good or poor sexuality educators for their daughters. *Fathering, 11*, 52 – 70. doi:10.3149.fth.1101.52


Shannon L. Phelps

Place of birth: Winchester, Kentucky

Education

2001 Master of Arts, New York University, New York, NY
  Major: Health Studies with specialization in Human Sexuality Education

1997 Bachelor of Arts, Bellarmine University, Louisville, KY
  Major: Elementary and Special Education

Professional Experience

Berea College, Instructor of Health (2015 – present)

University of Kentucky, Research Assistant (2013 – present)

University of Kentucky, Teaching Assistant, Lifetime Fitness Program (2013 – 2015)

Berea College, Instructor of Health (2012 – 2013)

Saint Agatha Academy, 4th & 5th Grade Teacher (2007 – 2012)

Professional Credentials

Certified Health Education Specialist (2012 – present)
  National Commission for Health Education Credentialing

Registered Yoga Teacher (2012 – present)
  Yoga Alliance Registry

KORU Mindfulness Teacher in Training (2016 – present)
  The Center for KORU Mindfulness


Kentucky Teaching Certificate PLDF, Provisional Certificate for Teaching of Exceptional Children – Learning and Behavior Disorders, Grades K – 12 (2008 – present)

Water Safety Instructor (WSI), American Red Cross (2013 – present)