

**THE BIG TALK: EXPLORING PARENTS' ATTITUDES, BELIEFS, AND
APPROACHES TOWARD DISCUSSING SEXUALITY WITH THEIR CHILDREN**

by

Brittany L. Littlejohn

B.S., Slippery Rock University, 2008

Submitted to the Graduate Faculty of
The Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2010

UNIVERSITY OF PITTSBURGH

Graduate School of Public Health

This thesis was presented

by

Brittany L. Littlejohn

It was defended on

Friday, December 3, 2010

and approved by

Thesis Advisor:

Martha Ann Terry, PhD
Assistant Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Member:

Jessica Burke, PhD
Assistant Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Member:

Sara Goodkind, PhD
Assistant Professor
School of Social Work
University of Pittsburgh

Copyright © by Brittany L. Littlejohn

2010

THE BIG TALK: EXPLORING PARENTS' ATTITUDES, BELIEFS, AND APPROACHES TOWARD DISCUSSING SEXUALITY WITH THEIR CHILDREN

Brittany Littlejohn, MPH

University of Pittsburgh, 2010

Background: Engaging in sexual behavior at an early age increases a person's number of lifetime partners, which consequently increases the risk for contracting an STI. Early sex initiation has been identified as a risk factor for teen pregnancy. Teen pregnancy is a public health issue as it is a risk factor for disease, poverty, and poor educational outcomes (Corcoran, 1998). Previous studies have found discussions between parents and children about sexual activity to have a positive effect on a child's decision-making regarding sex and condom use. However, few studies have examined the content of such conversations and factors considered by parents when deciding what will be discussed. **Objective:** The purpose of this study is to explore the ways in which parents communicate with their children about sexuality and to gain a better understanding of what parents think their children should know about sexual intercourse and related issues such as pregnancy, birth control, HIV/AIDS and other STIs. **Methodology:** Nine one-on-one interviews were conducted with parents of children between the ages of nine and 17 from Pittsburgh, Pennsylvania and surrounding areas. Participants were recruited through community organizations and informal social networks. All interviews were recorded, transcribed, and coded. Analysis used Grounded Theory. **Results:** Most parents felt it was important to talk to their children about sex, pregnancy, HIV and other STI's. However, multiple social factors served as barriers to this discussion. Overall, parents considered the maturity of the child as an important factor to consider. They also understood their child's autonomy regarding

making decisions about when to initiate first sex and noted the importance of being open and honest with their children. Cultural and gender differences were also discussed. **Conclusions:** Parents should be encouraged to talk openly and honestly with their child about sexuality. Interventions with this aim should consider coaching parents on what should be discussed at each stage of development. **Public Health Significance:** Rates of sexual activity, pregnancy, HIV/AIDS, and sexually transmitted diseases are considerably high among adolescents. Conversations that parents have with their children about sexuality have been shown to positively affect adolescents' decision-making regarding sexual behavior. By examining the content of these conversations public health professionals will be able to identify facilitators and barriers to these types of discussions and develop interventions with a focus on increasing parents' motivation and ability to effectively communicate with their children about sexuality. Thereby decreasing rates of adverse health effects associated with risky sexual behavior among adolescents.

TABLE OF CONTENTS

PREFACE	X
1.0 INTRODUCTION	1
2.0 BACKGROUND	3
2.1 EARLY SEX INITIATION	3
2.2 TEEN PREGNANCY	4
2.2.1 National statistics	4
2.2.2 Allegheny County, PA statistics	5
2.3 HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES (STIS)	6
2.3.1 National statistics	6
2.3.2 Allegheny County, PA statistics	7
2.4 RACIAL DISPAIRITIES	8
2.4.1 Early sex initiation	8
2.4.2 Teen pregnancy	9
2.4.3 HIV/AIDS and STIs	10
2.5 PARENT/CHILD DISCUSSIONS REGARDING SEX	11
3.0 METHODOLOGY	14
3.1 PERSONAL INFLUENCE	14

3.2	STUDY DESIGN	15
3.3	RECRUITMENT	16
3.4	INTERVIEW GUIDE	17
3.5	ANALYSIS	19
4.0	RESULTS	21
4.1	GROUNDING THEORY	22
4.2	THEMES REGARDING APPROACH.....	23
4.2.1	What should be discussed	24
4.2.2	Maturity.....	25
4.2.3	Child’s autonomy.....	26
4.2.4	Honesty	28
4.2.5	Times have changed.....	29
4.2.6	Cultural differences.....	31
4.2.7	Gender differences.....	32
4.2.8	Facilitators and barriers to discussion	34
5.0	DISCUSSION	38
5.1	WHAT SHOULD BE DISCUSSED?	38
5.2	MATURITY	41
5.2.1	Child’s autonomy.....	42
5.2.2	Honesty	43
5.2.3	Times have changed.....	44
5.2.4	Cultural differences.....	44
5.2.5	Gender differences.....	45

5.2.6	Facilitators and barriers to discussion	46
6.0	CONCLUSIONS	47
6.1	LIMITATIONS.....	49
6.2	RECOMMENDATIONS.....	50
	APPENDIX A: INTERVIEW SCRIPT AND GUIDE	52
	APPENDIX B: LETTER OF SUPPORT FROM MYDC.....	55
	BIBLIOGRAPHY	57

LIST OF TABLES

Table 1. Participant Demographics.....	22
--	----

PREFACE

First, I would like to thank my parents who are my best role models and support system. I would also like to thank my committee members, Dr. Martha Ann Terry, Dr. Jessica Burke, and Dr. Sara Goodkind who have been so supportive through this process. Finally I'd like to thank Tammy Thomas who has been very encouraging and a true "life saver."

Since I started this project, nearly every person with whom I have discussed it has asked me what has inspired my choice in topic. I have maintained an interest in sexual health education since my earlier experiences as a peer health educator at Slippery Rock University of Pennsylvania. As a peer health educator I presented programs to many students who would often ask questions about sex-related issues such as HIV/AIDS, sexually transmitted infections (STIs), and pregnancy. A significant number of students would anonymously ask about STIs and family planning services. Many of the questions they asked were ones that I personally had learned the answers to in my sixth grade health class. This fact made me wonder where they were getting their information and what exactly they were being told. In particular, I wanted to know how much or how little parents were sharing and in what ways parents might be encouraged to initiate the "The Big Talk." As a social worker by training, I was enticed to think of the range of social factors that could influence how, when and why a parent would approach this topic with his/her child. I designed a study that would answer all my questions. What I have captured is but a

snapshot of the issue, but I hope it will in some way enhance the knowledge of parents, social workers, and health professionals who have also struggled to find answers to these questions.

1.0 INTRODUCTION

In 2009, the Centers for Disease Control and Prevention (CDC) published a Surveillance Summary of the sexual and reproductive health of persons aged 10-24 years. This summary was reported that among participants aged 15-19 years, 13.1% females and 14.8% males stated they had first sex at an age less than 15 years. Among adolescents in this same age group, 39.8% males and 42.5% females claimed to have had sexual intercourse in the previous 12 months. According to this and other literature, adolescents are not only engaging in sexual activity, but a significant proportion of them are engaging in risky sexual behaviors (CDC, 2009; Benson & Torpy, 1995; Glenn et al., 2010; Robert & Sonenstein, 2009). Furthermore, it has been noted that minority adolescents bear a disproportionate burden of HIV/AIDS and other sexually transmitted infections (STIs) (CDC, 2009). Parent-child communication has been shown to have a positive impact on risky sexual behavior among this group (DiIorio et al., 2000; DiIorio et al., 1999). However, few studies have directly examined parents' methodology and ideology regarding discussions of sexual behavior and sexually transmitted infections (STIs) with their children.

The aim of this study was to identify facilitators and barriers to this type of discussion and to note any significant differences in these factors as they apply to race and gender; in other words, how race and gender affect if or how the parent discusses these issues with his/her child.

Few studies have focused specifically on how parents' beliefs and ideology towards sexually transmitted infections and sexual behavior affect how they discuss sex and sexual health issues with their children. It has been shown that adolescents receive most of their sexual education from social networks. As socially conservative policies are limiting the scope of sexual education curriculum in school systems, it is expected that adolescents will receive more of their knowledge of these topics through social networks (Duberstein, Lindberg, & Singh, 2006). It is imperative that parents recognize the significant role they play in their child's social network in that they can be a key source of their child's sexual health information.

This paper discusses what the parents in this study thought should be communicated during parent-child conversations about sexuality. It specifically identifies factors that parents consider when deciding to initiate such conversations with their children. First, epidemiological data will be discussed to highlight early sex initiation, pregnancy, and prevalence of sexually transmitted diseases as significant public health issues among American adolescents. Next, a review of the literature discussing parent-child communication about sexuality including factors parents consider prior to initiating conversations about sex and related issues such as pregnancy, HIV/AIDS and other STIs with their children. Finally, comments made by parents in this study will be analyzed and compared to what has been seen in the literature.

2.0 BACKGROUND

American youth are at great risk for poor adverse health effects due to risky sexual behavior. The CDC defines risky sexual behavior as that which results in poor health outcomes such as unwanted pregnancy, HIV, and other STIs (CDC, 2010) This includes early sex initiation, having multiple sex partners, and engaging in unprotected sex (CDC, 2010). In this section, epidemiological data concerning these issues will be discussed.

2.1 EARLY SEX INITIATION

Engaging in sexual behavior at an early age increases a person's number of lifetime partners, which consequently increases the risk for contracting an STI. According to a national report (CDC, 2009) on the sexual and reproductive health of persons between the ages of 10 and 24 years, adolescents are becoming sexually active at early ages. Among teens between the ages of 15 and 19 years, 13.1% females and 14.8% of males report first sex at an age less than 15 years. Among females between the ages of 15 and 17 years, 30.0% report having ever engaged in sexual activity. This number is slightly higher for males aged 15-17 years (31.6%). However, there is a significant difference in the percentage of females aged 18-19 years who report having

ever engaged in sexual activity (70.6%) compared to males (64.7%) in this same category (CDC, 2009).

Early sex initiation among girls has been associated with several factors including lack of comprehensive sexual health education, early menarche and the media's portrayal of women as "klutzes" or "dizzy" beings who are nothing more than the sexual objects of men (Foster, 1997; Doswell et al., 2002). The literature regarding early sex initiation among adolescent boys is scarce. Corcoran (1998) cites as one reason is that the male sexual partners of these young girls are often not adolescents themselves. Most females aged 15-19 years report their first sexual partner was more than four years their senior (CDC, 2009). Although it is more commonly seen among females than males, early sex initiation remains a risk factor for disease and unwanted pregnancy for both genders (CDC, 2009).

2.2 TEEN PREGNANCY

2.2.1 National statistics

Early sex initiation has been identified as a risk factor for teen pregnancy (Miller et al. 2009). According to the Guttmacher Institute's statistical data on United States pregnancy (Guttmacher Institute, 2010), 82 percent of teen pregnancies are unplanned; they account for about one-fifth of all unintended pregnancies annually. In 2006, sexually active adolescent girls aged 15 to 19 years accounted for 435,436 live births. A significant proportion of these births (approximately

one-third) were to mothers aged 15 to 17 and less than 1% were to mothers less than 15 years of age (CDC, 2009). The United States (U.S.) has consistently had high levels of teen pregnancy that far exceed those in other developed nations (Nicoletti, 2004; Darroch, Singh, Frost, & Team, 2001; Foster 1997; Jones, et al., 1985).

In 1996, President Clinton initiated the National Campaign to Prevent Teen Pregnancy (NCPTP). Its mission was to reduce the U.S. teen pregnancy rate by one-third by 2005 via implementation of progressive programs which focused not only on abstinence but also on sexual responsibility and character development (Hoyt & Broom, 2002; Foster, 1997). This rate has decreased in recent years but so has that of other countries. Despite the efforts of the NCPTP, U.S. teens are still less likely than those in other developed nations to use a birth control method (Henshaw, 2000).

Teen pregnancy is a public health issue as it is a risk factor for disease, poverty, and poor educational outcomes (Corcoran, 1998). Young mothers are at greater risk for complications during pregnancy and are more likely to miscarry or deliver babies with developmental disorders or mental retardation (Corcoran, 1998). It is critical to the health of our nation, that we encourage programs that promote comprehensive sex education and facilitate effective decision-making skills (Nicoletti, 2004; Hoyt & Broom, 2002).

2.2.2 Allegheny County, PA statistics

According to Census data for Allegheny County, PA (2000), 31 of 14, 249 (0.2%) births, were to girls younger than 15 years, 410 (2.9%) were to girls aged 15-17, and 756 (5.3%) were to women

aged 18-19. While these numbers are relatively small, they are significant given the age demographic. Furthermore, the fact that these data only indicate the number of births, not the total number of sexually active adolescent females or males should be considered.

2.3 HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES (STIS)

2.3.1 National statistics

Young people aged 15-24 represent only 25% of the U.S. population that is sexually active (CDC, 2009). However, it is estimated that about half of all newly acquired cases of STDs will be to individuals in this age group (CDC, 2009). Risky sexual behavior is among other risk factors (such as biologic susceptibility) that explain this increase (CDC, 2009).

Federal legislation mandates that all cases of HIV/AIDS, chlamydia, gonorrhea, and syphilis be reported to the CDC through the National Notifiable Diseases Surveillance System (NNDSS) (CDC, 2010). In 2006, most people diagnosed with HIV or AIDS were aged 20-24 years (80% of females and 71% of males). Among persons aged 10-24 years, 2,194 (668 females and 1,526 males) were diagnosed with AIDS (CDC, 2009).

The primary risk factor for chlamydia is age (Navarro, Jolly, Nair, & Chen, 2002). In 2006, the most commonly reported STI among all age groups was chlamydia. In the same year, 13,602 cases were reported among adolescents aged 10-14 years, with the number significantly higher among girls (n=12,364) than boys (n=1,238) in this age group (CDC, 2009). Gonorrhea was the second most commonly reported STI with a reported 3,574 cases among girls aged 10-14

and 675 cases among boys in this age group. Syphilis was the least reported among both girls (n=11) and boys (n=2) aged 10-14 years (CDC, 2009).

2.3.2 Allegheny County, PA statistics

Data on these four nationally notifiable diseases (HIV/AIDS, gonorrhea, syphilis, and chlamydia) are reported locally to the Allegheny County Health Department (ACHD) (ACHD, 2009). Similar to national statistics, chlamydia was the most commonly reported STI among all age groups in Allegheny County. According to the 2008 Annual STD Summary (ACHD, 2009), young adults and adolescents are the most at risk for acquiring chlamydia. In 2008, 38.4% of cases occurred among males aged 15-19 years. Females aged 15-19 represented 29.7% of all chlamydia infections in Allegheny County. The lack of a screening program to detect chlamydia in males may explain this disparity (ACHD, 2009).

Gonorrhea was also more commonly reported among women than men with 58.7% of all reported cases being among women (ACHD, 2009). Females aged 14-24 years made up 42% of all reported cases, while males in the same age group accounted for only 9% of the total number of reported cases (ACHD, 2009). There were no reported cases of syphilis among adolescents aged 15-19 years (persons aged <15 were not included in these data). However, the number of reported cases among men (n=67) far exceeded that of women (n=22) (ACHD, 2009). AIDS cases were most commonly diagnosed among persons aged 30-44 years. However, many of these cases were most likely acquired during the adolescent and young adult (early twenties) years (ACHD, 2009).

2.4 RACIAL DISPARITIES

The purpose of this paper is not to discuss the health disparities that exist among adolescents in regards to pregnancy and rates of disease. However, it would be remiss to not address these issues as they exist in each of the aforementioned categories: Early Sex Initiation, Pregnancy, HIV/AIDS and other STIs.

2.4.1 Early sex initiation

Among adolescent females aged 15-19 years, 40.4 % of Hispanic females, 57.0% of African-American females and 46.4% Caucasian females reported having ever had sex while 8.2% Caucasian, 10.8% African American and 5.1% Hispanic females report having four or more lifetime partners (CDC, 2009) Within this group, 22.9% African-American and 11.6% of Caucasian adolescent females report being less than age 15 at first sex (no data were listed for Hispanic adolescent females in this category). Among females aged 15-19, Hispanic girls (35.2%) were more likely than Caucasian girls (19.6%) and African-American girls (19.0%) to report having first sex with a partner more than four years their senior (CDC, 2009).

Among adolescent males aged 15-19 years, 41.1% Caucasians, 63.4% African-Americans and 55.5% Hispanics report having ever had sex while 29.6% African Americans, 25.4% Hispanics, and 12.1% Caucasians reported having had four or more lifetime sexual partners (CDC, 2009). Use of condoms among males aged 15-19 at first and last intercourse was reportedly higher among African American males (85.3% and 86.1% respectively) than

Caucasian males (68.6% and 69.2% respectively) and Hispanic males (66.5% and 59.9% respectively) (CDC, 2009).

2.4.2 Teen pregnancy

Among girls aged 15 to 19 years, teen pregnancy rates were the highest among Hispanic (132.8/1,000) and African-American (128.0/1,000) girls (CDC, 2009). These rates were compared to that of Caucasian girls (45.2/1,000) in the same age group (CDC, 2009). The proportion of unwanted pregnancies among girls in this age group also varies according to race with Caucasian females representing 22.2%, African-Americans; 26.8% and Hispanic; 18.0%. Such high rates have been associated with poor access to reproductive health care or lack of knowledge of sexual and reproductive health (Hunte, Bangs, & Thompson, 2002).

Teenage pregnancy has been viewed as a social problem which promotes poverty and poor health outcomes (Corcoran, 1998). This perspective has been questioned by Geronimus (2003), who argues that teen pregnancy is not the cause of poverty, but a consequence of it. She claims that in impoverished urban communities, and particularly among African-Americans, early childbearing may facilitate the strength of the community. She explains that within African-American families, members of several generations are expected to share in the upbringing of a child. Given the fact that life expectancy is low among low-income families, it is more advantageous to have children at a young age to ensure there will be adequate support in raising the child (Geronimus, 2003). This is not the view of the greater society in which a child is born and raised primarily by its biological parents. She further states that the fact that the normative views of other cultures are not considered perpetuates other social problems such as

racism and inequality, specifically between African-Americans and Caucasians (Geronimus, 2003).

2.4.3 HIV/AIDS and STIs

Rates of HIV/AIDS and other STIs are especially high among racial and ethnic minorities both nationally and locally. African Americans in particular bear a disproportionate burden of disease. In 2006, African Americans accounted for approximately 13% of the population and 45% of newly infected HIV cases in the United States (CDC, 2010). In 2006, among adolescents aged 15-19 years, 52.9/100,000 African American males were living with HIV/AIDS compared to 11.0/100,000 Hispanic males and 2.4/100,000 Caucasian males. In this same age group, 49.6/100,000 African American females were living with HIV/AIDS compared to 12.2/100,000 Hispanic females and 2.5/100,000 Caucasian females (CDC, 2010). Rates of gonorrhea, chlamydia, and syphilis were also higher among minority men and women (CDC, 2010).

In the year 2000, Allegheny County was comprised of 1,281,666 people, of whom 1,080,800 were Caucasian, 159,058 were African American, and 41,808 were listed as “Other” (ACHD, 2009). The percentage of notifiable STIs among African Americans *(gonorrhea=86%, chlamydia=75%, AIDS=38%) far exceeded that of Caucasians *(gonorrhea=11%, chlamydia=19%, AIDS=22%), the majority race (ACHD, 2009).

* No data for syphilis were listed

2.5 PARENT/CHILD DISCUSSIONS REGARDING SEX

Previous studies have found discussions between parents and children about sexual activity to have a positive effect on a child's decision-making regarding sex and condom use (Rosenberger et al., 2010; Woodhead, 2009; Glen et. al, 2007). One study (Glen & Kimble, 2008) that examined fathers' influence on sons' self-efficacy towards remaining abstinent or practicing safer sex found that the greater the father's ability to communicate standards and attitudes about sex with his son, the greater the son's self-efficacy for abstinence. Research has also shown that children whose parents have talked to them about sex and related issues are more likely to use safer sex practices (Kapungu et al., 2010) and are less likely to contract an STI (Woodhead, 2009). Furthermore, Rosenberger (2010) found that adolescents prefer to receive information about such topics from their parents and view parents as a reliable, trustworthy source of information.

Miller et al. (2009) found conversations with a child of the same gender to typically include topics such as reproduction, physical and sexual development and methods of birth control. Adolescents who reported having had sex-related conversations with their mother more commonly noted conversations about reproduction, pressures to have sex, condoms, choosing sex partners and when to start having sex. Similarly, those who reported having sex-related conversations with their fathers were most likely to report discussions of condoms, pressures to have sex, choosing sex partners, when to start having sex, reproduction and birth control. HIV or AIDS and STIs are reportedly the most commonly discussed topics among adolescents who have sex-related conversations with both mothers and fathers (Miller et al., 2009).

Similar findings were reported by Kapungu et al. (2010), who found that mothers more commonly discussed timing of sexual intercourse (i.e. most appropriate age to initiate sexual intercourse), attitudes about sex and dating. Another study (DiIorio, 2000) that produced comparable results concluded that mothers would more readily talk with their daughters about sex because they believe that by informing their daughters, they are protecting them from having to face possible negative outcomes, namely pregnancy (DiIorio, 2000). Additionally, the common aspects of being a woman that mothers share with their daughters (i.e., menstruation, menarche) serve as conversation starters (DiIorio, 2000).

Maturity of the child was one of the factors that determined when and how parents contemplated initiating conversations about sex with their children (Beckett, et al., 2010). Beckett et al. (2010) found that parents would choose which topics to discuss with their children based on the child's stage of development and sexual experience. Adolescents who had not moved beyond what was labeled as the "pre-sexual" stage, (e.g., hand-holding and kissing) commonly reported having conversations with their parents about abstinence, male/female anatomy and relationships (Beckett, et al., 2010). Conversations progressed and became more detailed as age and sexual experience of the child increased (Beckett, et al., 2010). Triggers related to age and puberty were commonly cited as motivators to discussion about sexual health issues (Beckett, et al., 2010; Wilson, 2010; Miller, 2009). However some parents felt that their child was too young to learn about sexual intercourse during the onset of his or her pubescent years (aged 10-12 years) (Wilson, 2010).

Previous studies that have focused on the accuracy with which children say their parents have discussed sex-related issues have found that adolescents whose parents communicate more frequently with them about these topics are more likely to practice sexual responsibility (Martino

et al., 2008). The more honest the parent is in his or her discussion, the stronger the child's perceived bond with that parent (Wilson, 2010). The term "connectedness" has been used to describe such bonds between adolescents and members of their social networks such as parents, relatives, peers and members of their communities. This has been recognized as a protective factor for early sexual initiation and other risk factors (Markham, 2010; Resnick, et al., 1997).

3.0 METHODOLOGY

This study was designed to explore the ways in which parents communicate with their children about sex and to gain a better understanding of what parents think their children should know about sex and related issues such as pregnancy, birth control, HIV/AIDS and other STIs. More specifically, the objectives of this study were to identify factors parents consider when deciding to discuss sexuality with their children, also to point out any differences in these factors as they apply to race and gender, finally to identify facilitators and barriers to parent-child discussions about sexuality. This section outlines the study design and gives background information on collaborative partners.

3.1 PERSONAL INFLUENCE

Given the fact that rates of HIV/AIDS and sexually transmitted diseases are especially high among minority adolescents, it was pertinent to this study that persons of any race or ethnicity would be eligible to participate. This was especially important to me, being an African-American woman and having personally witnessed differences in the parenting styles of African-American parents compared to parents of other races. I was particularly interested in finding out if and how persistent these cultural differences might be. I am aware that these circumstances undoubtedly

influenced the way this study was conducted and also analysis of the results. For instance, because of my background and interests, I may have identified themes that may not have been as apparent to a person of a different cultural background or gender. In addition, participants may have responded to me keeping in mind my status as a young, childless African-American graduate student. Although I have tried to remain unbiased in my methods I ask that the reader consider my personal background when reviewing the methods and results of this study.

3.2 STUDY DESIGN

Persons over the age of 18 who were parents, guardians, siblings and/or any other relation of a child between the ages of nine and 17 years were eligible to participate in one-on-one interviews. Parents of children between the ages of nine and 17 were chosen because studies have shown that parents should start communicating with their child about sex and dating at early ages (Beckett, et al., 2010). Furthermore, it seems that parents have a short window of opportunity as children gain more independence and rely less on their parents for knowledge and guidance as they mature into adulthood (Morgan, Thorne, & Zurbriggen, 2010). During the interviews, parents were asked questions about the ways in which they communicated with their children about sexuality, including questions about the content of the conversations they had with their children and their personal ideals regarding sexual health education and their children. The P.I. was the sole interviewer on the project. No one under the age of eighteen participated in the study.

3.3 RECRUITMENT

Recruitment was conducted using a flyer, which explained the subject matter to be discussed, participant qualifications and how participants would be compensated. It also informed the reader of the study's affiliation with the University of Pittsburgh. Each flyer contained ten individual tabs, each with the Principal Investigator's (P.I.) contact information and University affiliation. The flyer instructed interested persons to take a tab and contact the P.I. personally to make arrangements for an interview.

Participants were recruited from Manchester Youth Development Center (MYDC), an organization located in Manchester, a community on the North Side of Pittsburgh. The center offers a summer program, intramural sports and an after-school program for children who range from preschool to high school age. It also shares space with the Manchester Academic Charter School, which serves grades K-9. MYDC takes a holistic approach as it attempts to meet the academic, social and physical needs of each child while serving as a "safe place" within the community it serves.

As a trusted organization within this community, with over 40 years of history and service to youth and families, MYDC was ideal for this project. Parents of children in the program received a flyer when they arrived to pick up and/or drop off their children. The flyer was also posted on the bulletin board in the facility and was distributed to staff. In total, 26 flyers were distributed to MYDC as a collaborative partner, MYDC was expected to post the flyer on its primary bulletin board, distribute the flyer to adult patrons and staff and record the number of flyers posted and distributed. A letter of support outlining these responsibilities was signed by the organization's director, Mrs. Cheryl Walker (see Appendix B). Once the letter was

obtained, it was submitted as a part of the application for approval to the University of Pittsburgh's Institutional Review Board (IRB). The approval number assigned to this project is PRO10060238.

It was initially assumed that all participants would come from MYCD; however, as the study progressed, there was no participation by MYDC staff or patrons. As such, it became necessary to recruit through other sources, so the flyer was shared through informal social networks. It was sent via e-mail and Facebook©. Flyers were posted throughout the University of Pittsburgh's Graduate School of Public Health as well as the School of Social Work, the School of Medicine and in local eateries and businesses in the community of Oakland. Oakland was chosen as it is a community that is centrally located in Pittsburgh. The population of residents is diverse. There are also three major hospitals and four universities in or nearby Oakland so there is a constant flow of traffic and people.

3.4 INTERVIEW GUIDE

Questions for the interview guide were formed subsequent to a review of the literature regarding parent-child communication of sexual health and related issues. The questions included in the guide were based on the topics that were most commonly highlighted in the literature, which include:

1. Gender-based differences in parent-child communication about sex-related issues (Kapungu, 2010; DiIorio, 2000; Henshaw, 2000);

2. The influence of peer/social networks on a child's knowledge and understanding of sex-related issues; (Markham, 2010; Pistella & Bonati, 1998);
3. The influence of factors such as age and maturity on a child's decision-making capabilities; (Kapungu, 2010; Rosenberger, 2010; Wilson E. D., 2010);
4. Parent's comfort in discussing sex-related issues with his/her child; (Wilson E. D., 2010; Miller, 2009); and
5. Child's comfort level in discussing sex-related issues with his/her parent (Woodhead, 2009; Martino, 2008).

It was important that the questions were structured in a way that was clear and relevant for the participants. As such, the guide was pilot tested with two parents who were not participants in the study (one male, one female). The two parents were asked to critique the guide to be sure that each question was clear and objective.

These questions were used as a guide during the interview. However, the questions asked during the interviews were not exclusively limited to those in the guide. Based on responses, some parents were asked additional questions. Questions that were added during the interview process are included as "additional questions" at the bottom of the guide (see Appendix A). It should be noted that the title "parent" was given to all participants, regardless of the adult's actual relation to the child in question.

All interviews were audio-recorded and transcribed by the P.I. The transcriptions were read multiple times and were coded using open coding methods described by Glaser (1992) resulting in a code book.

3.5 ANALYSIS

The analysis was an on-going process, which took place both during and after the interviews. During the interview, notes were written, which were then incorporated with the rest of the analysis. Themes were identified through an inductive process. These themes emerged after the interviews were transcribed and coded. Open coding was used, in which the transcripts from the interviews were read multiple times (Glaser,1992). Parents' responses were highlighted and color-coded according to their connecting theme. Initially, the categories were: Boys versus Girls, Dating, Family History, Misinformation, Sources of Influence, Child's/Parent's Comfort level, Religion, and Triggers.

The label 'Boys versus Girls' was given to responses that highlighted comments parents made about the gender of their child and how that affected the content of conversations they had with their child about sexuality. 'Dating' became a category as some parents mentioned they had spoken to their children about dating or rules for dating. Boys versus Girls and Dating were combined under one heading, 'Gender Differences,' as the comments under these headings mostly discussed how the gender of the child affected what was discussed. 'Family History' came up more than once as a factor that influenced how parents chose to communicate with their children about sexuality. Also, 'Misinformaton' was highlighted as a category as that was concluded as a barrier. 'Sources of influence' was a category composed of all the references parents made about sources of information about sexual health information including literary resources, family members, peers, support groups and other adults in the child's life. Comments made by parents that were relevant to religion and how it affected what they taught their children about sexuality were highlighted as another category, 'Religion'. A final category labeled

‘Triggers’ includes comments related to cues to action, or events that motivated parents to discuss sex and related issues with their child. This included stories where parents described situations in which their child brought up a sex-related issue, such as pregnancy or masturbation.

After initial coding, these categories were collapsed into the final eight themes: What Should be Discussed, Maturity, Child’s Autonomy, Honesty, Times Have Changed, Cultural Differences, Gender Differences and Facilitators and Barriers.

4.0 RESULTS

Interested parents contacted the P.I., who was the sole interviewer on the project. Once it was confirmed that the person was in fact eligible to participate in the study, meeting date and time were scheduled. Nine one-on-one interviews were conducted at a place that was mutually agreed upon. During the interview, participants were asked seven open-ended questions and relevant probes regarding their personal experiences and thoughts about discussing sex and related issues such as pregnancy, birth control, HIV/AIDS and other STIs with their children.

Despite the fact that the study was open to parents, guardians and other relatives, only parents responded to the flyers, one of whom was an adoptive mother (see Table 1). Only two races were represented in this small sample, African-American and Caucasian. There were two male participants, one African American and the other Caucasian. Four Caucasian mothers and three African-American mothers also participated.

All interviews were audio-recorded for accuracy's sake. The participants were asked to answer the questions honestly and to the best of their ability. They were also informed that they could choose to stop the interview at any point. However, it was explicitly stated that once the interview was complete he/she no longer had the option to withdraw from the study as once the tape was transcribed, the data would be anonymous. No one except the P.I. could identify participants through their words.

Table 1. Participant Demographics

ID #	1	2	3	4	5	6	7	8	9
Zip Code	15010	15221	15085	15239	15147	15206	15147	15206	15214
*Race	C	C	C	C	AA	AA	AA	AA	C
Parent's Gender	F	M	F	F	F	M	F	F	F
Child's Age and Gender	10, F	15, F 17, M	13, M 13, M 14, F	11, M 11, M	14, M	13, F	10, M	16, F 16, F	10, M 13, M

Key: C= Caucasian, AA= African American, F= Female, M= Male; *Race= indicates both the parent and child's race

4.1 GROUNDED THEORY

This research was exploratory and was rooted in Grounded Theory (Glasser, 1992). As such, the theory was drawn from the data collected during the interviews. The aim was not to examine parents or guardians of adolescent children who may or may not be sexually active, but rather to explore their ideas and thought processes in regards to discussing sexuality and sexual health-related issues with their children. Grounded Theory and its constructs were used in order to reveal facilitators and barriers to this type of discussion.

Falling in line with the framework of Grounded Theory, there was no formal research question. According to Glaser (1992), Grounded Theory asks two questions:

1. What is the chief concern or problem of the people in the substantive area and what accounts for most of the variation in processing the problem?
2. What category or what property of what category does this incident indicate? (How can these differences be categorized?)

As outlined in the theory, it was imperative that the researcher not impart her own preconceived ideas when constructing the interview questions (Glaser,1992). Therefore, questions that were asked were very broad and were primarily used as prompts to generate critical thought from the participants. A comparative analysis of the data was necessary as the responses from the participants varied. It was important to see how, if at all, race or gender may have affected each individual's perspective and subsequently determined his or her approach (Glaser, 1992).

4.2 THEMES REGARDING APPROACH

Analysis of the data reveals eight themes which parents considered when deciding when and how to engage their child in sex-related conversations. They include: What Should be Discussed; Maturity; Child's Autonomy; Honesty; Times Have Changed; Cultural Differences; Gender Differences; as well as Facilitators and Barriers to parent-child conversations about sexuality. In this section I will discuss these themes using specific comments from the study participants.

4.2.1 What should be discussed

When asked *What is the most important information you wanted your child to know?* all parents described the safety and well-being of their child as their primary concern. It was of particular importance that the child be informed of STIs. Most parents had discussed this issue with their children. They felt that in order to be safe, their child needed to have the most accurate information. They recognized external influences such as friends and family members who could potentially relay inaccurate information.

Well, once they hit the school bus and there are sixth graders they hear everything so we have to have the conversation early on...all the sixth graders know about it, then my kids come home and ask questions about it and everything...Yeah, and then they would come home with misguided information from them so I had to have the conversation early on, probably in fourth grade about the birds and the bees.

- Caucasian mother, 15239

Churches, youth groups and schools were all viewed as trusted sources of information. Parents felt these were “safe” or trustworthy because they were typically held to some standards set by an accredited institution such as a board of education or a county health department. When specifically asked how they felt about the school’s involvement in their child’s sexual health education, all parents reported that they felt it was helpful as it only reinforced what they were already teaching their child at home. However, when asked to describe the methods or curriculum, several parents reported limited or no knowledge of the course as taught in their school district.

Parents who referenced churches as credible sources were asked to describe in what ways (if any) religion affected the messages to which they exposed their children regarding sex-related

issues. Most parents reported that they were not extremely religious; therefore, their religion did not dictate what they told their children. One parent, however, did share her desire to see religious entities become more progressive:

Saints have to realize that we did the same things. We all been down that road. We all made mistakes. The only difference now is that I believe things are more open and more bold. So let's just face the fact and talk to our kids. Don't scrunch your nose because they are doing this or because you see one of these young ones come in with a baby.

- African-American mother, 15147

Despite her disapproval of how some religious sects may view pre-marital sex, the moralistic underpinnings of her religion were used as a “golden standard”:

I respect the religious aspect because we raise our kids to know that abstinence is the best policy. Of course, kids don't practice that. But we will hold that over their heads, whether they want to go along with it or not. We always go back to what we believe. This is what we try to practice.

- African-American mother, 15147

One father in particular held strong convictions about how some religious sects choose to withhold certain information from adolescents:

I believe not telling them is a mistake, because if you lead them to believe that there's not this other information out there...Ya know, they're kids anyway...hormones are in a big, huge, uproar... it's gonna happen, ya know, so I would rather them have information and try to make their best decision, IF they're able to make a decision.

- Caucasian father, 15221

4.2.2 Maturity

When asked what they thought was an appropriate age to have “The Big Talk” with a child, all parents stated that it was dependent on the maturity of the child as well as his or her ability to

comprehend the information. Parents recognized that their child is unlike any other and therefore hesitated to answer this question with a general statement. Parents also realized that what may have worked for one of their children may not necessarily be the most effective approach for another.

Other parents felt it particularly important to consider the emotional maturity of the child. One father noted that his daughter's lack of self-esteem has made this topic a priority for discussion. He expressed his concern that his daughter may not be prepared emotionally to gauge her relationship with a young man:

I would like her to be involved with someone who she cares about and this person feels the same way. You know, I don't want her heart to get broken and it's like the guy figures, "I got what I want and I'm out!"

- African-American father, 15206

4.2.3 Child's autonomy

Parents viewed their children as individuals who could make decisions independent of themselves. When asked if they felt their child would know how to adequately protect themselves from STIs or an unwanted pregnancy, most parents felt their children had enough information to make responsible decisions. The question then arose, "Do you think your child would actually use the information you have provided to him or her?"

...keep in mind it's not guaranteed...all the love and nurturing is no guarantee. Once they step out this door, they have their own mind and conscience. It would be nice if they are able to reflect on what they learned growing up but we are human beings and we have our own mind, and emotions and feelings get in there. But as a parent as long as you told them that's the best you can do.

- African-American mother, 15147

“...you can’t control it, it’s a force of nature. They’re gonna be out there with their friends and they’re doing it.

- Caucasian mother, 15214

The overall consensus was that a parent must always be cognizant of the fact that a child has a choice, despite what he or she has been taught.

Most parents felt that if the opportunity presented itself, their child would most likely engage in sexual intercourse. Therefore, most parents focused more on prevention than abstinence. Overall, parents felt that giving their child all the facts would increase the likelihood that they would practice safer sex. When asked about chastity rings or “promise rings” parents stated:

It’s not, I mean the ring is not gonna do anything. Kids are gonna do what they want to do. If people wanna do that, go on and do it, but it’s no guarantee. That ring don’t mean nothing. It wouldn’t last...I wouldn’t even give it a week. [in reference to its effectiveness with her son]

- African-American mother, 15147

However, when asked if she trusted her child to “do the right thing” (use protection) she replied:

I trust him...he knows he’s gonna do the right thing. I know that for a fact. I know he doesn’t want to hear my mouth. I told him I was too young to be a grandma.

- African-American mother, 15147

I think at this point...yeah. I mean we’ve had the discussion about condoms, we’ve had the discussion about being in different situations you know... [referencing an incident when his son stayed overnight with his girlfriend] “I want you to know that I trust you to be an adult and [trust] that you are going to make the best decisions that you can make.” I said, “because I’m not there, but I trust you to make the correct decisions.” And he’s like, “Yes,Ddad, I will”. And nothing did happen.

- Caucasian father, 15221

Most parents felt that their children had adequate education and maturity to practice sexual responsibility (i.e. abstinence or condom use). When participants were asked if they felt their child would be comfortable to talk to them when considering engaging in sexual activity they replied:

Oh, yeah, they would come to me and ask if it's ok if they had sex, I would say, it's ok, but use a condom, I don't want to become a grandma.

- Caucasian mother, 15214

I don't know. I have never thought about whether she would talk about it with someone before she actually did it. I would hope that she would come to me, but then she would probably think, "Oh, he's so damn stern!"

- African-American father, 15206

4.2.4 Honesty

Several parents concluded that an open and honest approach was the best way to gain their child's attention. One mother was very proud of her ability to communicate openly with her son:

Tell the truth. Just be honest with your children. I mean, I'm an honest person. I don't respect lying because I don't lie. I mean, being truthful...that's the only way it's gonna be embedded in their head. I mean, if you're honest with your child, they're gonna be honest with you.

- African-American mother, 15147

Another mother forewarned of negative consequence of not talking openly and honestly:

Somehow you've got to open up or you'll regret it later.

- Caucasian mother, 15214

One parent stressed the importance of having a well-balanced relationship with your child:

...I know for a lot of parents who aren't very close to their kid that's got to be difficult. Especially if...you have to have a relationship with them in order to have these types of discussions. Because this is not, "Oh, what color four star folder do you need for school?" This is different; this is a really big, huge thing. And the kids know that too. And so it's all gonna be sort of weird at first. But just like any other thing as a parent, it's work and you have to think about it and you have to know what to say to your child.

- Caucasian father, 15221

Some parents who felt comfortable sharing personal anecdotes with their children said that their child was not comfortable hearing this information from them. However, these same parents were more likely to report that their child had voluntarily come to them with questions about sex and relationships:

I've actually been much more comfortable...with it [talking about sex with kids]...maybe they haven't been more comfortable about it, but...uhhh, I know with my daughter, she's been uncomfortable talking to me about sex...here I am tryin' to do all this work trying to cultivate a relationship with him so that he can feel comfortable talking to me about something like that because this is important; the most important discussion we'll have during his teenage years. And he approached me about it and he felt comfortable enough to say "Hey, Dad, I need to talk to you about this."

- Caucasian father, 15221

4.2.5 Times have changed

Parents were asked if they thought their children knew more about sex than they did when they were their child's age. Most parents stated that they did feel that their children knew more about sex and attributed this to leniency in the media as well as increased access to certain media outlets such as computers and cell phones with wireless internet connection.

One father comments on the lack of censorship in the media:

Oh, you can't get away from it. It's everywhere, on TV and movies. You know, it can say pg-13, but. You can only cover their eyes for so long. Then you have the videos. Our kids

glorify that, they think it's cool. Whether it's the girls gyrating or you know, everyone wants to be a "Ciara" or "Beyoncé".

- African-American father, 15206

One parent revealed that she was motivated to talk to her children about sex because of what she had heard was going on in her children's school:

They would just come home [from school] and you know, the STDs are always a big thing. And herpes is like the word of the week for some reason. Ya know, they just like...they think it's funny and you try to explain it to them and they just don't comprehend it at that level, but ya know... at some point. you have to step in...I mean, when I was young, you never even thought about it [sex] until you were 18, like high school and now it's like...

- Caucasian mother, 15239

Another mother heard disturbing stories about students possibly engaging in sexual activity but seemed unsure of how to address the issue with her child.

...They got such new things coming out, like I found out about the jelly bracelets where every color means something different, like one meant "kiss," another one meant, "blow job", another one meant to have sex..... Ya know, the girls are taking them off the boys. I called the school! I said [to my son] what are you doing wearing that? Take it off now! I told him it was a girl thing.

- Caucasian mother, 15085

After this interview, all subsequent participants were asked if they had ever heard of children or students sharing the aforementioned wristbands. No other parent had ever heard of this being an issue in any of their children's schools. When asked about this incident, one mother replied:

They must be in other areas like Homewood or Wilksburg where it's pretty bad.

- Caucasian mother, 15214

4.2.6 Cultural differences

Only one parent directly commented on cultural differences and how they impact the ways in which she communicates with her children about sexuality. She highlights self-esteem as a critical issue among minority girls, African American in particular:

Self-esteem and confidence and empowerment are extremely important, especially to African-American girls... Because I think a lot of African-American girls come from single parent families, and the parent themselves is a woman and a lot of those kids may come from lower SES backgrounds and depending on where kids are on income level and their social environment, it can have a lot to do with how they feel about themselves, and their surroundings and how they view the role model that they have as a parent, whether they're living with their dad or their mom. So I think those kids are much more vulnerable than say a teen white girl who may be from Upper St. Clair who has always been told by mother and father how important they are and a lot of advantages have been given to them. On the other side you have kids from low SES who sometimes wonder what's wrong with them that they can't have these things they see that other people have that they can't have. It puts them at risk for meeting older people, men that will sometimes take advantage of them.

- African-American mother, 15206

It is notable that in this study, the only two male participants, who were both single fathers of young girls, held very different views toward their daughters' ability to navigate the dating pool.

The Caucasian father states:

Mostly I think she just wants to roll over top of them emotionally, not physically. I think because she's had a few boyfriends and she's sort of driven them into the ground emotionally and said, "ok, I'm done with you."

- Caucasian father, 15221

The African American father's thoughts were much different:

If her self-esteem is low and she hears "hey this guy likes you", she's gonna be like oh wow...ya know. It's like her world has changed because she realized someone is attracted to her when she has already been feeling that she's not attractive enough...

- African-American father, 15206

4.2.7 Gender differences

Parents were asked if they felt there were any differences in how this topic should be discussed with male versus female gendered children. Men more commonly reported telling their sons different information than their daughters. However, one mother in particular commented on the added responsibilities females endure in terms of pregnancy and childcare:

The difference is that if you end up getting pregnant, the chances of that boy being with you for the rest of your life are pretty low. So you're pretty much stuck with a baby. That's a lifestyle change and that's gonna be your responsibility. Boys typically leave. They rarely stay around and even if they stay around for a little time, eventually they move on because making a lifetime decision is a decision that comes with maturity, and you can't make that kind of decision at that age, because you really don't know that much about life.

- African-American mother, 15206

Another mother felt there should be a difference in the tone and manner in which parents address such issues with boys and girls:

You have to be very sensitive with females, but straight up talking to the boys. Like please be careful because you don't want to get pregnant. But with boys you have to be very stern and say, you can't do this. The tone of voice has to change...her [female child] feelings would get hurt and then she would look at you differently. If you yelled at the girl, that would cause her to go out and do it more. But with a boy, you gotta break it down. Look you can't do this. Because I know. That's what I did.

- Caucasian mother, 15214

Both fathers felt there was a difference in what needed to be discussed with boys versus girls.

Yeah, it's definitely different when you're talking to boys...I can sit down and talk to her about what boys think, what boys may want. What they want may not always be what you want.

- African-American father, 15206

One father discussed having experienced a higher level of anxiety or discomfort when talking with his daughter:

I think I'm more caught up on treating them differently as my son versus my daughter. Just because that's something within me. And I'm probably a little more afraid to talk to her about things because...well, for a lot of reasons. But just uhhh, maybe that's not appropriate for a father to sit and talk about or bring up, with his daughter because it can be misconstrued as being something else. So maybe in that respect...I don't think that it's something I do intentionally...I think it's something that sort of subconsciously is working. I mean they both need the same information. With my daughter it's a little more involved because she has to take the onus on for both. Whereas my son, he can say well, I'm not in charge of the girl using protection. And I'm like, you're not in charge of her physically doing that, but you should be having the conversation.

- Caucasian father, 15221

Parents of female children more commonly reported that they had discussed rules to follow for safety when dating or in other social situations:

Safety. Be careful about situations that you get yourself into. Be aware when you are around crowds and at parties and to be safe.

- African-American mother, 15221

I didn't tell her she could not date; I think you need to be prepared for everything in life. I said you may be out with a friend and he may say, hey why don't we do this and that doesn't mean you have to do it. It doesn't mean you have to go to a place that's isolated. I told her that's off limits. No isolated areas.

- African-American father, 15206

...you should be careful about the things that you do there and the things that you say. And even drinks that somebody hands you in case somebody is attracted to you and

thinks that they want to have sex and that something has gone on with the drink. I said, "Go get your own drink."

- Caucasian father, 15221

4.2.8 Facilitators and barriers to discussion

Several factors were identified as facilitators to discussions including parents' recollection of their own experiences during adolescence:

I decided a long time ago my kids weren't gonna be like me...embarrassed...thinking, "I can't go up to the register with this box of condoms." I just said, you tell me when you're ready to have this conversation and I will get them. I will take the worry right out of your hands.

- Caucasian father, 15221

My mom didn't talk to me about it. I was with a 26 year old man...got pregnant...my mom forced me to give it up for adoption...I was only around my mom and my sister; they never talked to me about it [sex]. My sister had her own life. We were in our own little world. Mom was working. We had to raise ourselves. I'm trying to be better than my mom was.

- Caucasian mother, 15214

See I don't...I never had the talk. My parents never talked to me about it... I think my older brothers, but not really. I don't really know. But my parents never told me about nothing...

- African-American father, 15206

When asked how this affected the way he communicated with his daughter about sex he stated:

I'm not sure...I'm not sure about that. I always thought about having that talk with my daughter since she was young. Ya know it was like, wow! I'm having a girl so I'm gonna have to have that talk with her later down the road. I was like well, when am I gonna talk to her? Is it gonna be early, late, when she's 11 or 12? And you can't say better late than never.

- African-American father, 15206

One mother was unsure of how to appropriately address comments made by her young boys:

They'll just be in the shower and they'll say something like, "I'm gonna masturbate!" ...I haven't really gotten into that conversation with them yet...I don't think they know what it means so I don't know if I should go there or not.

- Caucasian mother, 15239

Other parents thought that books and/or classes served as great resources and motivators to discussion:

There are two really good books on the market that I listen to about teens and sex. So I often tell them about what I'm reading and what it says. So I do pass some of those anecdotes onto them.

- African-American mother, 15206

*I am certain that she had a conversation about that [condoms and birth control] in *Girl Talk Because of the stuff that she brings home; the different info. the books and the pamphlets and materials.*

- African-American father, 15206

*Girl Talk is a support group for African American girls.

Another mother noted that the fact that her child was mentally challenged motivated her to discuss certain topics:

Well, because my child has some developmental delay and he's 14, but he operates more like a ten year old, but his body is still operating at that of a child that is 14. Because of that, I am more selective with my choice of words and I also try to do a lot of prevention by warning him about who he approaches and how he engages them. So that was my main focus and also, there is a time and place for everything. As far as wanting a girl and how he perceives her too. For instance, he might perceive a cousin and a friend the same way because he's not understanding...so that was important for me to get across to him too.

- African-American mother, 15147

Parents rarely counted themselves as being the source of any inaccuracies. Further questioning revealed that this may serve as a barrier to discussing sex and related issues with children. Although parents were adamant that their child be informed of the risks, it seemed that they themselves could potentially convey incorrect information. One parent recalled a conversation with her 13 year old son about ways the AIDS virus is transmitted:

I told him that it's mostly in saliva. I said that if a person coughs on you, you can't get it. I said it's not transmitted by hand touching...it mostly affects the immune system where it will bring your immune system down real low. He got kind of very scared. He was like, "Oh yeah mom, if I ever do that, I will use a condom." I'm like that's good because you never know what's out there.

- Caucasian mother, 15214

Parents' inability to overcome their child's resistance to the discussion was also identified as a potential barrier:

That's sort of the hard thing is that you're trying to cover all this info and it's difficult to get kids to sit down and listen. I think as parents, we just have to push ahead, regardless of whether they're sitting there, rolling their eyes and slumping in their chair asking, "How long is this gonna take?" You don't want to find yourself asking "What if?"

- African-American mother, 15206

One father reported that his view of how and when to talk to his son about sex differed from that of his child's mother:

She knows a conversation took place, but she has no idea of the content. Yeah, if she knew that I gave my son condoms...Oh my God! (Me: laughs). She'd have me arrested. Oh, if she knew what I told him, she'd be...

- Caucasian father, 15221

Parents with different opinions on how and when to have the sex talk with their children could potentially serve as a barrier as the conversation may be delayed as a result of the parents'

inability to come to an agreement. Children may also be more reluctant to discuss these issues openly with their parents if they feel their inquiries will be met with disapproval.

5.0 DISCUSSION

The themes outlined above reflect the four main topics identified in the analysis. This section presents a discussion of each theme and compares the findings of this research to what has been cited in the literature.

5.1 WHAT SHOULD BE DISCUSSED?

The desire of these parents to keep their children safe from disease and pregnancy is similar to what other researchers have found (Wilson, Dalberth, & Koo, 2010; Wilson, 2010; Pistella & Bonati, 199;). As found by Wilson et al. (2000), what was implied when parents reported they had talked to their children about sex varied. Some parents felt that talking about sex meant teaching their children to remain abstinent, while others went in to detail about the biological aspects of sexual intercourse and discussed methods of prevention for pregnancy, HIV/AIDS and other STIs.

Previous studies have found talks about contraception to be positively associated with talks about family planning services (Pistella & Bonati, 1998). Most parents in this study report discussing only condoms or birth control pills with their children. Those who discussed birth control pills did not discuss other forms of birth control (other than condoms). Furthermore, they

never told their children about family planning services or other places they might obtain such products. Reasons given were that they felt the children were too young, the topic never came up or they thought their child had learned about that in school.

In this study, parents were less likely to be concerned with protecting their child from the emotional consequences associated with early sexual initiation, such as heartbreak or neglect. Only parents who felt their children were not yet sexually active focused on values such as how men are supposed to treat women, deciding when was the best time to have sex and the appropriate ways to express interest in a potential partner. This is consistent with findings by Beckett et al. (2010), who state that parents are more likely to discuss parental values when they think their child is not sexually active. Robert and Sonenstein (2010) stress the importance of discussing sexuality with children well before they become sexually active. While this point was recognized by some parents, others felt it more appropriate to wait until the child entered their pubescent years. As noted by Rosenberger et al. (2010), parents who held conflicting views about when and how to discuss sexuality with their child often gave inconsistent messages.

Other parents who discussed issues that were indirectly related to sexuality, such as self-esteem were African American parents of African American girls. Doswell et al. (2002) discuss how girls of minority status often struggle with issues of low self-esteem and self-efficacy. This fact is largely attributed to the lack of positive role models with whom they can identify (Doswell & Baxter, 2002).

It seemed that many parents thought their child received adequate information regarding sexual health and reproduction from their schools, and none was in opposition to the schools' involvement in their child's sexual health education. Some parents who admitted they were less comfortable discussing these issues with their children felt that school classes were especially helpful because they explained the biology of sexual reproduction and prompted children to ask their parents questions. However, there seemed to be a lack of communication between the school system and parents. When asked specifically about their child's sexual health curriculum, most parents knew it existed in their child's school but could not give a description of the curriculum. Furthermore, only one parent recalled being notified beforehand that her child would be receiving sexual health education at school.

Markham et al. (2009) found 'school connectedness' to be a protective factor against early sex initiation among adolescents. They define this term as the level of involvement in school activities. Parents in this study did not identify their child's participation in school activities as having any influence on their child's sexually activity or lack thereof. One parent did comment that he felt his child was more prepared to handle pressures to become sexually active based on her participation in a support group for young African-American girls.

As seen in the literature, the issue of safety or protection is the main focus of most parent-child conversations regarding sex, whether it be from disease, pregnancy or both (Wilson, Dalberth, & Koo, 2010; Wilson, 2010; Miller, 2009). Several studies noted that male and female adolescents were more likely to learn about sexual health information from their same-gender parent (Kapungu et al., 2010; Miller et al., 2009). That was not the case in this study. Most were parents of opposite gender children. One mother reported that her husband had primarily spoken to her sons about sexuality while she had taken the responsibility of talking to

her daughter. However, she also stated that she had spoken to her sons as well, particularly about how to treat females when courting or dating.

5.2 MATURITY

When gauging “maturity,” parents often considered the age of the child as well as certain social cues such as whether the child had expressed interest in dating or if the child appeared to be more interested in attending co-ed events. Parents would also be prompted to initiate conversations about sex if they noticed their child was already having conversations about sex with their friends. Miller et al. (2007) describes this as responsiveness. They found that children whose parents were more responsive, especially during conversations about sex, were most likely to delay sexual intercourse. This appears to be true for parents in this study, who report that having open conversations about sex prompted their child to delay sexual intercourse and also to consult them before they actually made the decision to engage in sexual relations. However, this is not always the case, as found by Becket et al. (2009).

Overall, parents reported child’s level of maturity and comprehension, awkwardness, and child’s inattentiveness during such conversations as reasons for delaying “The Big Talk” or subsequent follow-up discussion. Consistent with the findings of Wilson et al. (2007), parents in this study recognized that their child may be exposed to information he or she is not mature enough to appropriately discern as fact or fiction. Therefore, it is the parent’s responsibility to be involved in the child’s social life to the extent that he or she might be able to correct any

misinformation that may occur (Woodhead et al., 2009; Rosenberger et al., 2010). As found in the literature (Doswell & Baxter, 2002; Wilson et al. 2007), participants in this study were fully aware that media plays an undeniable role in the sexual education of children today. Similar to other studies (Doswell et al., 2002), participants in this one raised the issue of the objectification of women; they think the airwaves are becoming devoid of positive female role models for young girls. Despite the perceived effect of media, more youth report that their parents are the most influential source of information about sex-related issues (Robert et al., 2010; Rosenberger et al., 2010). This point was attributed to the fact that young children depend on their families to provide support and guidance (Rosenberger, 2010).

5.2.1 Child's autonomy

An interesting concept that was rarely mentioned in the literature was parents' recognition of a child's autonomy or free will to make his or her own decisions about sexuality. Parents in this study felt that discussing sex and related issues with their child could potentially serve as a deterrent, but ultimately they acknowledged their children as individuals. They also recognized that the desire to engage in sexual intercourse is a natural part of human development and understood that they were, in a sense, competing with this and other influences for their child's innocence.

One study (Campero et al., 2010), which tested an intervention to teach parents how to initiate conversations about sexual health issues, describes the importance of parents' willingness to acknowledge their children as individuals who are responsible for their own sexual behavior.

In this study parents were encouraged to provide their children with adequate resources so that they might make informed decisions about their sexual activity. They were also made aware that withholding information from their children was not an effective method of control (Campero, Walker, Rouvier, & Atienzo, 2010).

5.2.2 Honesty

What parents have reported about honesty in this study is consistent with what has been found in the literature (Kapungu, 2010; Wilson, 2010; Martino et al., 2008). As found by Wilson et al. (2010), honesty was highly promoted and valued among these parents. Although they thought it was difficult to be honest with their children about sex-related issues, they felt it created the best foundation for trust between themselves and their children. They also thought that being honest during initial conversations made it easier to talk about sex and related issues in future discussions. Parents in this study felt that talking to their child openly and honestly about some of their personal experiences would allow the child to feel more comfortable to come to them if they had a problem or a question. This is consistent with findings by Martino et al. (2008). Also consistent with findings from Wilson et al. (2010), parents admitted that they did not want to have the “Big Talk” with their child, but they understood that it was better for their child to be informed by the parent than by a peer or other less reliable source.

5.2.3 Times have changed

Similar to what has been found in the literature, parents in this study acknowledged the advances of current technology and media that have a significant influence on what their children know about sexuality (Miller, 2009; Martino et al., 2008). They struggle to shield their children from messages about sex and relationships which they feel their children are not yet mature enough to process. The fact that children are exposed to such messages has been a motivator for some parents in that they felt the need to talk to their children about what they are viewing on television or other forms of media. Also, exposure to highly sexualized media may explain why some children have engaged in or at least entertained the idea of participating in sexual activities (Collins, et al., 2004).

5.2.4 Cultural differences

Although this study was designed in part to explore how race affects having “The Big Talk,” participants did not address this, with the exception of one. An African-American mother discussed a need to build self-esteem in her daughters because she felt that as young African-American females, they needed to know their own self-worth and value so that they would not feel the need to have a boy or man validate them. This point was also mentioned by an African-American father; however, he did not relate this issue as one of race or culture. The view of self-esteem which parents in this study have discussed as an important factor when having talks about sexuality with young African-American girls has been recognized in the literature as a factor

confounding the spread of disease and pregnancy, particularly among African-American girls (Doswell & Baxter, 2002; Shambley-Ebron, 2008).

5.2.5 Gender differences

In general, participants in this study were the parent of a child of the opposite gender. Although several studies report that children usually receive information about sexuality from their same-gender parent, most parents in this study state they did not have any issue with talking to their child about sex or related issues. Also consistent with what has been found in the literature, fathers of adolescent females reported having greater discomfort when talking to their daughters compared to their sons. Participants in this study stated they discussed the same topics with both male and female children. This differs from what has been found in other studies, where mothers talked more about dating, pressures to have sex, and when to start having sex (Kapungu, 2010; Miller, 2009) and fathers were more likely to talk about reproduction and birth control (Miller, 2009).

Rebert and Sonenstein (2009) found that females were more likely to talk with parents about birth control method than were males. Parents in this study rarely reported speaking to their sons or daughters about birth control methods other than condoms. Discussions about condom such as where to purchase them and how to use them were reported most often by parents of male adolescents. Despite this, all parents in this study thought it was of equal importance to teach both male and female children about birth control methods namely condoms and birth control pills.

5.2.6 Facilitators and barriers to discussion

Parents in this study felt that books and support groups that focused on sexual health related issues were useful as conversation starters. They also thought it was an effective way to overcome barriers such as resistance (from their children) to conversations about these topics and also their own lack of knowledge of sexual health information. This is consistent with findings from previous studies that have used tools such as books or safer sex kits and support groups as interventions with parents who have had difficulty discussing sexual health information with their children (Campero et al., 2010; Shambley-Ebron, 2008).

The fact that parents never received “the talk” was identified in the analysis as both a facilitator and a barrier, in that it motivated them to initiate such conversations with their children and also made them unsure of how to approach their own children. Miller et al. (2009) found the lack of information and discomfort experienced by parents when discussing sexuality with their children to be a barrier as parents would often avoid such conversations. These same results were found by Wilson et al. (2010). As reported by participants in Miller’s study (2009), responsiveness was viewed as a facilitator among parents who report being more open and responsive during sex-related conversations.

6.0 CONCLUSIONS

Adolescents are engaging in sexual activity at early ages, which places them at risk for HIV/AIDS, sexually transmitted infections and unwanted pregnancy (CDC, 2009). Rates of HIV/AIDS and STIs are highest among adolescents and young adults (CDC, 2009). In some ways it seems the U.S. has failed to effectively educate children in sexual health so that they might act more responsibly.

Parents play an important role in their child's sexual health education as they are a primary source of information. As young people are becoming sexually active at younger ages and stages of development, it is becoming necessary to have discussions about sexuality and related issues such as STIs and pregnancy earlier in life. Despite external influences, children ultimately look to their parents to provide accurate information about the complexities of life.

Many children learn the functional aspects of sexual reproduction in school; however, there are other topics such as HIV/AIDS and other STIs that are typically not thoroughly discussed in such classes. Additionally, children need not only to be informed of the health risks that are involved in sexual activity, but they should also be informed of ways to protect themselves. As such, it is imperative to children's health and well-being that parents are prepared to have on-going discussions with their children as they mature through adolescence.

Parents who have discussed sex or sex-related issues with their children have considered such factors as 1) what should be discussed, 2) the maturity of the child, 3) their child's autonomy and 4) the importance of being honest. These factors help them to determine when they start talking to their children about sex and the specifics of the content that will be discussed.

Parents agree that it is important to talk to their children about sex. They feel that children should specifically learn about STIs and how to protect themselves from such diseases. Parents also want their children to know how to prevent pregnancy. They discuss birth control but do not explain to their children that there are several methods nor do they tell them where to obtain it. Many parents admit they are not sure how to initiate these conversations. Most parents rely on their own parents' methods as a guide. In some cases where parents themselves were never taught about sexuality and relationships, it was necessary to refer to outside sources such as self-help books and support groups. Many parents are aware that these resources exist, but they do not use them because they either do not know where to go to get them, or choose not to participate because they do not feel comfortable talking about such issues in group settings.

Overall, parents feel they are the best sources of information for their child, but they welcome the assistance of friends, family members, and even more formal social networks such as teachers and members of their churches so long as they share their same values. They feel that it is acceptable for their children to participate in group discussions about these issues, but find it difficult to get them to do so. While parents are aware that some children may be more responsive to abstinence-only messages, they feel that these are mostly ineffective. Parents who have a strong religious background also agree. They think that teaching their child about all

methods of contraception will better prepare them for “real world” situations and make them more likely to practice sexual responsibility.

These parents understand that children will ultimately exercise their own autonomy which will either result in sexual intercourse or choosing to remain abstinent. Parents are aware that this is not their choice to make and thus feel it is best to take a more comprehensive approach to sexual education. As such, they agree that both girls and boys should be taught about the importance of using methods of contraception to avoid unwanted pregnancy and disease. Parents feel the only difference in how one approaches these discussions with boys and girls may be in the manner in which you approach the topic. Parents feel that boys are more responsive to language that is more direct while girls are most responsive to language that is more subtle. The content and the messages that are conveyed should be the same.

6.1 LIMITATIONS

The relatively small sample size of study is a limitation in that the results are not generalizable to the population. The recruitment strategy resulted in a sample of parents who volunteered to participate and therefore, respondents to this study most likely included only parents who were willing to discuss sexuality and sexual health with their children. Furthermore, results may have been affected by the participants’ desire to be accepted into the study. The P.I. could not verify by any means other than self-disclosure that the participant met the eligibility requirements of the study. Also, we have no way of knowing whether participants were being honest in describing

the content of the conversations they had with their children since the children were not interviewed.

6.2 RECOMMENDATIONS

While this study was relatively small, it has important implications for public health practice. Interventions targeting parents should encourage them to talk to their children on an on-going basis and should also highlight certain behaviors such as genital touching and the use of sexually explicit language as cues for responsiveness. Parents should be thoroughly educated in the modes of transmission of HIV and other STIs. Parents who are not comfortable in their knowledge of sexual health issues should be made aware of resources that are available to them such as books and credible websites which can be used for further information. They should also be encouraged to seek advice from physicians or public health nurses working in community health centers or private offices.

It is also recommended that future interventions which aim to encourage parents to talk with their children about sexual health issues employ the use of theoretical models such as the Social Ecological Model (Glanz, Rimer, & Viswanath, 2008), which can be used to illustrate the influence that parents, peers, teachers and others have on a child's sexual health education and highlight points of intervention. Also, the Health Belief Model (Glanz, Rimer, & Viswanath, 2008) would be applicable as its constructs can be used to promote self-efficacy among parents who are unsure of how to address such issues with their children.

Two strengths of this study are that most of the participants were parents of males and also that the two male participants were single fathers of females. Often, studies similar to this focus on mother-daughter or father-son relationships. Future research should consider focusing on how fathers discuss these issues with their daughters and on how mothers talk to their sons about sexuality. Additional research should further explore the cultural differences that were identified in this study.

Parent-child communication about sexuality has been shown to have a positive influence on a child's decision-making in regards to sexual activity. In order to encourage parents to have such discussions with their children researchers and public health professionals should first gain a better understanding of the facilitators and barriers to this sort of conversation. This research adds to the current literature on parent-child communication about sexuality and as such would be useful for health educators and other health professionals who wish to develop interventions with this purpose.

APPENDIX A

INTERVIEW SCRIPT AND GUIDE

Introductory Script: Hi, how are you? Thank you for meeting with me today. As you read on the flyer, my name is Brittany Littlejohn and I am a student at the University of Pittsburgh in the Graduate School of Public Health. I am working on a research project that aims to explore parents' attitudes, ideals, and approaches towards discussing HIV/AIDS and related issues with their children. The questions that you'll be asked during this interview will help us to get a better understanding of how you handle these issues with your own child/children. Hopefully we can use the information you provide to help future researchers to develop interventions that could help parents who find it difficult to talk to their children about these topics. Our conversation will be audio recorded, however all information that you provide will be anonymous. The interview will last between 30 minutes and one hour. Once the interview is complete, you will be given a gift card in the amount of \$20. This research is voluntary. If at any point you feel uncomfortable and think that you may want to skip a question or withdraw from this research study, please let me know and we will either move on to the next question or stop the interview. You cannot withdraw from the study once we have separated as I will have no way of distinguishing your interview from that of another participant. I ask that you answer the questions honestly and to the best of your ability. Feel free to ask me to clarify myself if you're not sure what I am asking. As a parent, you are the expert and my goal is to get the best advice you have to offer. If you have any questions about the interview or the study please feel free to contact myself, Brittany Littlejohn at bl117@pitt.edu or my research advisor, Dr. Martha Terry at materry@pitt.edu.

1. What is your zip code?

2. How old is your child?

3. Have you ever talked to your child about HIV/AIDS?

{Probes: How old was your child when you discussed HIV/AIDS with him/her?; Is there a particular age at which it is appropriate to discuss HIV/AIDS with your child?; Did you feel comfortable?; How do you think your child felt about that conversation? What was his/her response? Did it seem that he/she was already aware of the most important points?; If so, where do you think he/she may have obtained some of this information?; What do you think was the most important thing for your child to know about HIV/AIDS?}

4. Have you ever discussed sex (sexual intercourse, sexual behavior) with your child?

{Probes: How old was your child when you first discussed sex with your child?; Is there a particular age where it is appropriate to discuss sex with your child?; Did you feel comfortable?; How do you think your child felt about what that conversation?; Did it seem that he/she was already aware of some of the most important points? If so, where do you think she/he may have obtained this information?; What was the most important thing for your child to know about sex?; Should the approach be different with boys vs. girls?}

5. Do you think it's appropriate for someone other than yourself to discuss HIV/AIDS and/or sex with your child?

{Probes: why/why not?; Who (if anyone at all) would be most fit to talk about these issues with your child and why?; Would you say it is more helpful or harmful for someone other than yourself to talk about these issues with your child and why?}

6. Do you think that most kids who are your son/daughters age are well informed about sex and all the risks that are involved?

{Probes: What might be missing?; What do you think has most influenced your child's knowledge of sexual health or lack thereof?}

7. As a parent/guardian of a teenage girl/boy, what do you think is the best approach to discussing these issues with young kids?

{Probes: Do you think there should be more help from schools or community organizations? (sex ed. Programs/Curriculum); Do you think parents should have more training or support in this area? (support groups, reading materials)}

Additional Questions:

- (a) What was the most important thing you wanted your child to know about sex?
- (b) Have you discussed condom-use and /or methods of birth control with your child?
- (c) How does religion, if at all, influence the way in which you discuss sex and related issues with your child?
- (d) Should parents approach discussions about sex and related issues differently for male and female children?

Conclusion:

I would like to thank you for your time. I really appreciate the information you provided. Again, if you have any questions about the study or what was discussed, feel free to contact either myself (Brittany Littlejohn; bl117@pitt.edu) or my research advisor, Dr. Martha Terry (materry@pitt.edu).

*I would like to share the results of my research with you and all my other participants. Once everything is complete, I will contact Cheryl Walker at Manchester Youth Development Center (MYDC) to make arrangements for me to present my findings to the community. Again, thank you for your time. Enjoy the rest of your day/evening!

*This portion of the script is for MYDC patrons/staff

APPENDIX B

LETTER OF SUPPORT FROM MYDC

BIBLIOGRAPHY

- Allegheny County Health Department [ACHD]. (2009). *Allegheny County Health Department STD/HIV Program: 2008 Annual STD Summary*. Pittsburgh: Allegheny County Health Department.
- Allegheny County Health Department. (2000). *2000 Census Data*. Retrieved from http://www.achd.net/biostats/pubs/pdf/commprofiles/Allegheny_County.pdf
- Beckett, M., Elliot, M., Martino, S., Kanouse, D., Corona, R., Klein, D., et al. (2010). Timing of Parent and Child Communication About Sexuality Relative to Children's Sexual Behaviors. *American Academy of Pediatrics, 125*, 34-42.
- Campero, L., Walker, D., Rouvier, M., & Atienzo, E. (2010). First Steps Toward Communication About Sexual Health Between Adolescents and Parents in Mexico. *Qualitative Health Research, 20*(8), 1142-1154.
- Centers for Disease Control and Prevention [CDC]. (2010, September 9). *HIV Among African Americans*. Retrieved October 13, 2010, from Centers for Disease Control and Prevention: <http://www.cdc.gov/hiv/topics/aa/>
- Centers for Disease Control [CDC]. (2009). *Sexual and Reproductive Health of Persons Aged 10-24 Years-United States, 2002-2007*. Atlanta: Centers for Disease Control [CDC].
- Centers for Disease Control and Prevention [CDC]. (2010, January 25). *National; Notifiable Disease Surveillance System*. Retrieved October 13, 2010, from CDC: <http://www.cdc.gov/ncphi/diss/nndss/nndsshis.htm>
- Collins, R., Elliot, M., Berry, S., Kanouse, D., Kunkel, D., Hunter, S., et al. (2004). Watching Sex on Television Predicts Adolescent Initiation of Sexual Behavior. *American Journal of Pediatrics, 114*(3), e280-e289.
- Corcoran, J. (1998). Consequences of Adolescent Pregnancy/Parenting: A Review of the Literature. *Social Work in Health Care, 27*(2), 49-67.
- Darroch, J. E., Singh, S., Frost, J. J., & Team, S. (2001). Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use. *Family Planning Perspectives, 33*(6), 244-250.

- DiIorio, C. R. (2000). Social cognitive factors associated with mother-adolescent communication about sex. *Journal of Health Communication, 5*(1), 41-51.
- Doswell, W. M., & Baxter, B. (2002). Risk-taking behaviors in early adolescent minority women: Implications for research and practice. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 31*(4), 454-461.
- Duberstein, L., Lindberg, J. S., & Singh, S. (2006). Changes in Formal Sex Education. *Perspectives on Sexual and Reproductive Health, 38*(4), 182-189.
- Foster, H. W. (1997). The national campaign to prevent teen pregnancy. *Journal of Pediatric Nursing, 12*(2), 120-121.
- Geronimus, A. T. (2003). Damned if you do: culture, identity, privilege, and teenage childbearing in the United States. *Social Science and Medicine, 57*, 881-893.
- Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco: Jossey-Bass.
- Glaser, B. G. (1992). Open Coding. In B. G. Glaser, *Basics of Grounded Theory Analysis* (pp. 38-48). Mill Valley: Sociology Press.
- Glenn, B. D. (2008). Father and adolescent son variables related to son's HIV prevention. *Western Journal of Nursing Research, 30*(1), 73-89.
- Guttmacher Institute. (2010). *National Reproductive Health Profile*. Retrieved October 13, 2010, from Guttmacher Institute: <http://www.guttmacher.org/datacenter/profiles/US.jsp>
- Henshaw, S. K. (2000). Teenage abortion and pregnancy statistics by state, 1996. *Family Planning Perspectives, 32*(6), 272-280.
- Hoyt, H. H., & Broom, B. L. (2002). School-Based Teen Pregnancy Prevention Programs: A Review of the Literature. *The Journal of School Nursing, 18*(1), 11-17.
- Hunte, H., Bangs, R., & Thompson, K. (2002). *Sexually Transmitted Diseases Among African Americans in Allegheny County: A Black Paper for The Urban League of Pittsburgh*. Pittsburgh: The Urban League of Pittsburgh.
- Jones, E., Forrest, J., Goldman, N., Henshaw, S., Lincoln, R., Rosoff, J., et al. (1985). Teen Pregnancy in Developed Countries: Determinants and Policy Implications. *Family Planning Perspectives, 17*, 53-63.
- Kapungu, C. B.-B. (2010). Beyond the "birds and the bees": Gender Differences in sex-related communication among urban African-American adolescents. *Family Process, 49*(2), 251-264.

- Markham, C. L. (2010). Connectedness as a predictor of sexual and reproductive health outcomes for youth. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 46(3 Suppl), S23-41.
- Martino, S., Elliot, M., Corona, R., Kanouse, D., & Schuster, M. (2008). Beyond the "big talk": The roles of breadth and repetition in parent-adolescent communication about sexual topics. *Pediatrics*, e612-8.
- Miller, K. F. (2009). Barriers and facilitators to maternal communication with preadolescents about age-relevant sexual topics. *AIDS and Behavior*, 13(2), 365-374.
- Morgan, E. M., Thorne, A., & Zurbriggen, E. L. (2010). A Longitudinal Study of Conversations With Parents About Sex and Dating During College. *Developmental Psychology*, 46(1), 139-150.
- Navarro, C., Jolly, A., Nair, R., & Chen, Y. (2002). Risk Factors for genital chlamydial infection. *Canadian Journal of Infectious Diseases*, 13(3), 195-207.
- Nicoletti, A. (2004). Teen pregnancy prevention issues. *Journal of Pediatric and Adolescent Gynecology*, 17(2), 155-156.
- Pistella, C. L., & Bonati, F. A. (1998). Communication About Sexual Behavior Among Adolescent Women, Their Family, and Peers. *Families in Society: The Journal of Contemporary Human Services*, 206-211.
- Resnick, M., Bearman, P., Blum, R., Bauman, K., Harris, K., Jones, J., et al. (1997). Protecting Adolescents From Harm. *Journal of the American Medical Association*, 278(10), 823-832.
- Robert, A. C., & Sonenstein, F. L. (2009). Adolescents' Reports of Communication With Their Parents About Sexually Transmitted Diseases and Birth Control: 1988, 1995, 2002. *Journal of Adolescent Health*, 46(2010), 532-537.
- Rosenberger, J. B. (2010). Condoms and developmental contexts in younger adolescent boys. *Sexually Transmitted Infections*.
- Shambley-Ebron, D. Z. (2008). My Sister, Myself: A Culture- and Gender-Based Approach to HIV/AIDS Prevention. *Journal of Transcultural Nursing*, 20(1), 28-36.
- Wilson, E. D. (2010). Parents' perspectives on talking to preteenage children about sex. *Perspectives on Sexual and Reproductive Health*, 42(1), 56-63.
- Wilson, E.K., Dalberth, B., & Koo, H. (2010). "We're the Heroes!": Fathers' Perspectives on Their Role In Protecting Their PreTeenage Children from Sexual Risk. *Perspectives in Sexual and Reproductive Health*, 42(2), 117-124.

Woodhead, N. C. (2009). Protective and risk factors for sexually transmitted infections in middle school students. *Sexually Transmitted Diseases*, 36(5), 280-283.