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Abstract

The purpose of this quasi-experimental study was to determine the effect of a 4-hour mother/daughter sexuality workshop on the attitudes of mothers toward sexuality and their willingness to communicate sexuality to their adolescent daughters. The researcher sought to determine if there was a difference between mothers attending the mother/daughter workshop and mothers not attending the workshop.

The hypotheses tested in this study were as follows:

1. When mothers who have participated in a 4-hour sexuality workshop are surveyed and the results are compared to a group of mothers not participating, there will be no significant difference in attitudes toward sexuality.

2. When mothers who have participated in a 4-hour sexuality workshop are surveyed and the results are compared to a group of mothers not participating, there will be no significant difference in mothers' willingness to communicate with their daughters regarding sex or in mother/daughter interaction.

Eighteen subjects (E = 7; C = 11) participated in the study. The experimental group attended a 4-hour researcher-developed workshop while the control group did not attend any workshop. All subjects took the Parents' Questionnaire

on Family Communication and Attitude Questionnaire both before and after the workshop.

Pretest scores on the Parents' Questionnaire on Family Communication were subtracted from posttest scores and subjected to the *t* test. The same procedures were followed with the Attitude Questionnaire. The *t* value for the attitude change was significant at the .05 level with the experimental group having a more positive change while the change of the Parents' Questionnaire on Family Communication was not significant at the .05 level. Therefore, the researcher rejected the null hypothesis regarding attitude change and failed to reject the null hypothesis regarding willingness to communicate sexuality. The researcher concluded that participation in a mother/daughter workshop positively affected mothers' attitudes about sexuality.

Table of Contents

List of Tables

Chapter I

The Research Problem

According to Gibson (1986) society is currently and has been in a so-called "sexual revolution" for the past 20 years. Our traditional values of monogamy, chastity before marriage, and a lasting marriage are said to have given way to a "new morality." An almost "any-thing-goes" mentality prevails where sexual activity, whether heterosexual or homosexual, between two consenting people is considered a private matter. "If it feels good, do it" is the credo of this revolution. The phenomenon of human sexuality evokes intense interest and investigation. Society is inundated with the proliferation of sex literature, sex studies, sex clinics, sex hot lines, sex therapists, and pornography. Never before has there been such an openness about sex--an openness and willingness to experiment sexually, to have recreational or casual sex, and to live together in a trial relationship outside of marriage.

Hacker (1984) says that weakening of old norms results in inevitable confusion and thus society is experiencing a transitional period. Two moralities are existing uneasily side by side--one encouraging sexual activity at a younger

and younger age and the old morality of denial discouraging dealing with it (Gibson, 1986).

Much of the proclivity toward sexual permissiveness has been generated by the media including movies and television. It is said that one only has to flip the channels to see homosexuality, adulterous affairs, casual sex, and sex outside of marriage depicted as the accepted way of life. Movies go another step and do what television is restricted from doing by showing sexual intercourse and complete nudity. Printed media at least equally devotes itself to championing sex (Gibson, 1986; Goodman, 1969; Goodman & Goodman, 1976; Gordon & Gordon, 1983; Gordon, Scales, & Everly, 1979; Libby, 1971). Sexual activity among teens has received increasing attention recently because of the enormous social, economic, and personal problems associated with it (Alter, Wilson, & Cook, 1982).

While focusing on problems related to adolescent sexuality one must be considered that in reality adolescents are sexual beings regardless of whether or not they are sexually active (Nackerud, Hacking, Nisbet, Parks, and Pies, 1979). Sexuality is far more than physical sex. It is that important aspect of the human personality that enables each of us to function as male or female (Lyman, 1974). A statement adopted by the American Lutheran Church defines human sexuality in the following way:

> Human sexuality includes all that we are as human beings. Sexuality at the very best is biological psychological, cultural, social and spiritual. It is as much a part of the mind as of the body, of the community as of the person. To be a person is to be a sexual being. (American Lutheran Church, 1980, p. 1)

"Each of us is a sexual person from the moment we are born. How we experience our sexuality and how we behave change as we grow and develop" (Stronck, 1983, p. 4). Adolescents are described as being in a struggle as they try to sort out their feelings, their sexuality, and how they fit into their total lives. The problems of adolescent sexuality are not attributed as much to ignorance of facts as lack of experience in considering benefits and costs of sexual involvement. Adolescents are lacking in decision-making tools and skills in communication necessary to convey personal values or standards. Sex education then for the adolescent should not be "problem-oriented" or aimed at keeping the adolescent "out-of-trouble," as adolescents are turned off to such an approach. Such an approach fails to prepare any young person to be able to deal with the many choices and shifting standards that face them. The adolescent needs correct, up-to-date information regarding his/her body. In addition, so that the adolescent might learn to deal with sexuality from a healthy perspective he/she needs opportunities to develop attitudes (Nackerud et al., 1979).

Adolescents are neither children nor adults, yet have the characteristics of both. They are experiencing a very complex period in the human life-span (Brown et al., 1984; Kerrins, 1983). For many a young person, early adolescence is a time of disequilibrium when the young person begins shedding the dependence of childhood and starts that long, slow process of adaptation to independence and responsibility inherent in adulthood. Puberty ushers in physical changes that are greeted with a somewhat ambivalent mixture of both excitement and suspicion. Intellectual abilities rapidly and dramatically develop causing the adolescent to be temporarily engulfed in endless daydreams. Shifts in status--some abrupt--some gradual--suspend the early adolescent between these two worlds of adulthood and childhood and he/she is equally uncomfortable in either (Steinberg, 1980). His/her world turns sexual overnight. One day there may be random curiosity about sex and little personal concern. The next day perhaps everyone in his/her class may be atingle over something sexual. Such subjects as menstruation, masturbation, erections, kissing, dating, and intercourse can be very stressful to the adolescent when encountering them for the first time (Lewis & Lewis, 1980).

The crises of early adolescence in the past 25 years have come to be seen as normative; no longer viewed as a time of mental disturbance but rather as a time of transition by change that is expected, predictable, and normal.

A moderate amount of stress is considered beneficial as it forces the adolescent to develop valuable coping skills for the future (Steinberg, 1980). Adolescence is also fundamentally a period of time when identity and sexual nature become a central concern for the maturing individual. A comfortable sense of sexual identity and understanding of the implications of human sexuality are crucial tasks of adolescence for a healthy personality (Martinson, 1968).

In the daughter's development agenda of autonomy and separation, there is a pulling toward, yet pushing away from the family contributing toward this separation as she seeks out and turns toward peers. Establishing identity or coming to terms with "who am I" is intensified for young women by a current unsettled nature of sex role prescriptions. A third developmental task--the establishment of appropriate attachments outside the realm of the family is consistent with and often facilitated by the daughter's participation in dating, going steady, falling in love. The final developmental task of adolescence is self-mastery wherein one learns to gain mastery over one's own impulses and develops the ability to anticipate the future consequences of present actions. Demands on the family during this period are great as the adolescent is so preoccupied with her own needs and desires (Fox, 1980).

Thornburg (1981a) indicates that pre- or early adolescence are the years when sex information peaks. Ages

12 and 13 are the peak times when sexual concepts are learned. Of all sexual information 51.4% is learned during this period and more is learned about every sexual topic during this period than any other, with the exception of menstruation and conception which have already been learned. Behavioral areas of petting and sexual intercourse are especially dominant. It is important to note that between ages 9 and 11 many learn about prostitution, petting, and intercourse. Thornburg states that 34.3% have acquired these concepts before even leaving elementary schools. This clearly indicates the need for sex education at the middle school and junior high level.

Societal Influence

Adolescents were expected to be chaste 20-30 years ago. Peer groups and society in general are more acceptable of sexual activity today. Though not all teenagers were virgin then, half are sexually active now (Alter, Wilson, & Cook, 1982).

Society is increasingly more aware of sexually-related social problems that are affecting the young. One documented consequence of adolescent sexual behavior is that by age 17 at least 1 in 10 adolescent females has had one pregnancy (Alter, Baxter, Cook, Kirby, and Wilson, 1982). Hofstein (1972) reports that a serious health problem related to early sexual activity is sexually transmitted disease (STD). For over a decade social and government

agencies, philanthropists, and educators in the United States have searched for ways to either prevent or reduce the enormous problems that have arisen from early adolescent sexual activity (Alter, Wilson, and Cook, 1982). Teenagers are beginning sex at a younger age, and it is estimated that 25% of all adolescents under age 15 have been sexually active. Of the more than 10 million females aged 15 to 19 in the United States in 1979, 50% were sexually experienced (Alter, Baxter, Cook, Kirby, & Wilson, 1982; Gordon & Gordon, 1983; Koblinsky, 1983). A large number of these sexually active females have not obtained birth control for fear their parents will find out (Alter, Baxter, Cook, Kirby, & Wilson, 1982).

Nearly 30% of the adolescent females who are sexually active become pregnant (Fox & Inazu, 1980; Gordon & Gordon, 1983; Harris, 1985; Kirby, 1984; Marks & Cates, 1986; Nackerud et al., 1979). One in 10 young women aged 15 to 19 become pregnant (Alter, Wilson, & Cook, 1982; Benson, Perlman & Sciarra, 1986; Fox, 1979) accounting for nearly one million pregnancies. Each year another 50,000 pregnancies occur among girls age 14 or younger (Fox, 1979). Pregnancies doubled in number among 10- to 14-year-old girls in the United States between 1957 and 1975. The percentage of all teenage women premaritally pregnant rose from 9% in 1971, to 13% in 1976, and to 16% in 1979 (Zelnik & Kantner, 1980). A disproportionally high percentage of the abortions

performed each year are among adolescents and preadolescents (Koblinsky, 1983). One third of the pregnant 15- to 19-year-olds and almost half the pregnant 10- to 14-year-olds terminate their pregnancies (Alter, Wilson, & Cook, 1982; Harris, 1985; Kirby, 1984; Koblinsky, 1983).

Of those who decide to carry their pregnancy to term 96% keep their babies (Cook, Kirby, Wilson, & Alter, 1984). These teenagers are faced with a greater percentage of complications of pregnancies and their babies have more birth defects (Koblinsky, 1983). These pregnant teenagers and their offsprings are also faced with greater health risks than are their peers, and they are more likely to be and stay on welfare (Alter, Baxter, Cook, Kirby, & Wilson, 1982). Sixty percent of the children who are born to teenage mothers out-of-wedlock and who are not adopted receive welfare. Statistics show that women who had their first baby during their teen years receive more than half the welfare budget (State Department of Public Welfare, 1985). Pregnancy is also cited as the major cause for females dropping out of school and teenage marriages precipitated by pregnancy last on the average less than 5 years with two thirds ending in divorce (Kirby, 1984; Koblinsky, 1983; Alter, Wilson, & Cook, 1982).

Another consequence of adolescent sexual behavior is STDs. Venereal diseases are on the rise among teenagers (Bloch, 1979; Gordon & Gordon, 1983; Gordon et al., 1979;

Hofstein, 1972; Kirby, 1984; Marks & Cates, 1986). In no other age group is the problem of venereal diseases increasing at such a rapid rate (Koblinsky, 1983). Individual responsibility and ignorance have contributed to the spread of these diseases (Adame, 1985; Hofstein, 1972). To prevent problems in the teen years, preteenagers need the facts about the transmission of STDs, the symptoms, and available medical treatment (Hofstein, 1972).

In the late 1970s the federal government recognized sex education as one potentially effective solution to the major problem of unintended pregnancies and STDs. It is now believed by many researchers that educating the children beginning at a young age would be the most effective solution (Brown et al., 1984). Many authorities in the field of sex education, researchers, and parents believe the responsibility of sex education rests with the parents (Alter, Baxter, Cook, Kirby, & Wilson, 1982; Alter, Wilson, & Cook, 1982; Bloch, 1979; Brown et al., 1984; Fox, 1979; Gordon & Gordon, 1983; Harris, 1985; Mace, 1962; Scales & Everly, 1977). According to recent national studies, about 80% of American parents agreed it is the parents' responsibility to educate their children (Brown et al., 1984; Cook et al., 1984). Many teenagers who admit their friends are the main source of information regarding sexual matters, are often ill informed. Yet, peers and companions continue to constitute the main repository of sexual lore for most teenagers

(Goodman, 1969; Goodman & Goodman, 1976; Gordon & Gordon, 1983; Gordon et al., 1979; Kerrins, 1983; Kisker, 1985; Koblinsky, 1983; Libby, 1970; Scales & Everly, 1977).

Most parents have unexamined attitudes, beliefs, or values stemming from childhood into adulthood (Alter, Wilson, & Cook, 1982). Adults have been taught by society that talking about sexuality, including speaking explicitly about sexual parts of the body, is not polite. Consequently, most parents are embarrassed or feel awkward talking about sex to their children (Alter, Wilson, & Cook, 1982; Gordon & Dickman, 1977; Gordon et al., 1979; Kisker, 1985; Lewis & Lewis, 1980; Lyman, 1974; Parcel & Coreil, 1985). However, parents are teaching their children sex through their attitudes (Alter, Baxter, Cook, Kirby, & Wilson, 1982; Gordon & Dickman, 1977; Koblinsky, 1983; Lyman, 1974). Parents need help exploring their own values about sexuality and how to impart those values to their children. Parents need to be clear about what they wish to communicate (Alter, Wilson, & Cook, 1982; Scales & Everly, 1977; Gordon et al., 1979).

The problems associated with teenage pregnancy can be reduced or prevented through education. According to Gordon et al. (1979), sex education decreases both VD and pregnancy. Though some think sex education awakens dormant sexual desires and increases sexual activity (Gordon & Gordon, 1983; Sonenstein & Pittman, 1984), sex education has

been shown to neither increase nor decrease sexual intercourse (Furstenberg, Moore, & Peterson, 1985; Gordon & Dickman, 1980; Gordon & Gordon, 1983; Gordon et al., 1979; Kirby, 1984; Stronck, 1983; Zelnik & Kim, 1982). Studies have shown that children who communicate with their parents about sexuality do, in fact, delay intercourse (Gordon et al., 1979; Gordon & Gordon, 1983; Fox, 1979; Scales & Everly, 1977).

Many parents do not support sex education in the schools (Gordon & Gordon, 1983; Kirby, 1984) while others--parents and educators--do support sex education in the schools (Gordon & Gordon, 1983; Harris, 1985). Less than 10% of all young people in the United States receive compulsory sex education in the schools (Yarber & McCabe, 1984). Youth supposedly prefer sex education from their parents (Martinson, 1968), and adults think open discussion of sexual topics would decrease teenage pregnancy (Harris, 1985). However, parents are not educating their children (Gordon & Gordon, 1983; Harris, 1985; Kisker, 1985; Martinson, 1968). Parents believe that they are lacking in knowledge and communication skills to convey information about sexual matters to their children (Brown et al., 1984; Fox, 1979; Fox & Inazu, 1980; Gordon & Dickman, 1977; Gordon & Dickman, 1980; Nackerud et al., 1979).

The Family Nurse Clinician (FNC) has many opportunities to disseminate sexual information to mothers and their

teenage daughters (Beiser, 1977; Kerrins, 1983). It is within the FNC's scope of practice to develop community programs designed to help the mothers to both clarify and appreciate their own sexual values and provide strategies for communicating these to their children (Fox, 1979). If mothers' attitudes toward sexuality can be changed positively, and if mother/daughter communication can be enhanced through a short-term sexuality education course, the FNC should consider including mother/daughter sexuality education and communication within the realm of her practice. This then could alter the adolescent's sexual behavior and prevent the problems associated with early sexual experience.

This researcher proposed that one solution to the problem of adolescent sexuality is through an educational program about sexuality which incorporates both mothers and daughters. This researcher, a mother and FNC, attended such a program which changed the researcher's own attitudes and generated an interest to try and positively influence other mothers. Therefore, the purpose of this research is to determine the effects of a short-term sexuality education program on the sexual attitudes and communication skills of mothers of adolescents. The question the researcher was seeking to answer was: What effect will an educational program on sexuality have on mothers of adolescent daughters

in terms of attitudes and communicating about sexual matters with their daughters?

Chapter II

Theoretical Basis of Study

The framework of this study about the effect of education on adolescent sexuality is Orem's Self-Care Deficit Model of Nursing. The researcher is applying this concept of self-care to the problems associated with mothers' and daughters' lack of knowledge regarding sex, mothers' attitudes regarding human sexuality, and mother-daughter communication about sex.

Orem describes nursing as a health-care service based specifically on the values of self-help and help to others. Nursing focuses on helping individuals achieve health results through therapeutic self-care. According to Orem the concept of self-care activities is therefore the foundation upon which nursing practice is based (Reihl & Roy, 1980). Self-care is defined by Orem as "the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health and well-being" (Orem, 1980, p. 35). In discussing man's nature, Orem reflects man as both self-reliant and responsible for the self-care and well-being concerning his dependents (Fitzpatrick & Whall, 1983).

According to Orem's theory, the responsibility of educating the daughter about sexual matters rests with the parents. According to society, such responsibility rests with the mother (Fitzpatrick & Whall, 1983).

Orem (1980) views man as an integrated whole, who functions symbolically, socially, and biologically. Societal influence is considered a determinant of man's behavior, and man's interaction with his environment reflects society's influence (Fitzpatrick & Whall, 1983). How the attitudes of mothers are influenced by environment and how the mothers behave as reflected by attitudes and communication influence their daughters about sex. Since the responsibility of health is said to belong to society (Fitzpatrick & Whall, 1983), then nursing as a part of society can be influential in altering sexual attitudes/behaviors of mothers and daughters by assisting them to "overcome those circumstances which interfere with self-care and which cause self-care limitations and deficits" (Brunner & Suddarth, 1980, p. 5).

According to Orem (1980), nursing is responsible for helping individuals overcome these circumstances. Orem identifies three systems of nursing activities. These systems were designed to meet the self-care requirements of the individual according to whatever extent the self-care is disrupted. These systems are: (a) the wholly compensatory system which is utilized when the individual is not able to

take an active part in his care and it becomes necessary for the nurse to assist by acting for and doing for him; (b) the partly compensatory system wherein both the nurse and the individual accomplish the therapeutic self-care actions. Either may assume major responsibility in performing these actions. This would depend on the individual's physical or medically prescribed limitations, knowledge, and skills. Important also would be the psychological readiness of the individual to accomplish such activities, and (c) the supportive-educative system identified by Orem can be "utilized when the individual is capable of performing, or learning to perform, those measures which are necessary to accomplish in the form of support, guidance and teaching" (Brunner & Suddarth, 1980, p. 5).

Because mothers are taught by society that talking explicitly about sexuality is impolite, they are very embarrassed or awkward in talking about sex to their daughters. Thus, mothers' unexamined attitudes, beliefs, and values stemming from their childhood are carried over into adulthood. Mothers also feel they lack knowledge and communication skills to convey matters of a sexual nature to their children. As a result mothers are teaching sex to their children not through communication but through these attitudes. A mere 10% of young people receive compulsory sex education in the schools. Most still rely on their peers as their main source of information.

If the mother does not teach her daughter about sexuality and neither the daughter nor mother is communicating about sexuality, there exists a self-care deficit. A result of this deficit leads to a lack of knowledge and many societal problems such as pregnancy and VD. The Family Nurse Clinician (FNC) by applying the supportive-educative system of Orem's self-care model can assist both mothers and daughters through imparting knowledge and identification of attitudes, values, and beliefs, to hopefully reduce or prevent many of the problems that exist as a consequence of the "so-called sexual revolution."

Chapter III

Hypotheses

Theoretical Hypotheses

1. When mothers who have participated in a 4-hour sexuality workshop are surveyed and the results are compared to a group of mothers not participating, there will be no significant difference in attitudes toward sexuality.

2. When mothers who have participated in a 4-hour sexuality workshop are surveyed and the results are compared to a group of mothers not participating, there will be no significant difference in mother's willingness to communicate with their daughters regarding sex or in mother/daughter interaction.

Definitions

1. Mothers: Any woman with a daughter age 11 to 14 years who agrees to participate in the study.

2. Participated: Attended a 4-hour researcher-designed and presented course on sexuality.

3. Sexuality workshop: A 4-hour mother/daughter workshop utilizing discussion, films, and group participation.

4. Surveyed: Administered the Attitude Questionnaire and the Parents' Questionnaire on Family Communication pre and post workshop.

5. Results: difference in pretest and posttest scores.

6. Compared: Using the t test.

7. Significant difference: Determined by the .05 level of significance.

8. Attitudes toward sexuality: As determined by the score on the Attitude Questionnaire.

9. Willingness to communicate and mother-daughter interaction: As determined by scores on the Parents' Questionnaire on Family Communication.

Operational Hypotheses

1. When mothers with daughters between the ages of 11 and 14 years attend a 4-hour researcher-designed and researcher-led course in sexuality and are administered the Attitude Questionnaire pre and post workshop and the difference in pretest and posttest scores are compared utilizing the t test to the difference in scores of mothers not participating, there will be no significant difference at the .05 level.

2. When mothers with daughters between the ages of 11 and 14 years attend a 4-hour researcher-designed and researcher-led course in sexuality and the mothers are administered the Parents' Questionnaire on Family

Communication pre and post workshop and the difference in pretest and posttest scores are compared utilizing the *t* test to the difference in scores of mothers not participating, there will be no significant difference at the .05 level in the mothers' willingness to talk to their daughters or in mother/daughter interaction.

Chapter IV

Review of the Literature

The review of the literature addresses the dilemma involving mother-daughter communication and interaction about sexual activity and adolescent sexual behavior. This examination reveals that communication regarding matters of a sexual nature is very lacking between mothers and daughters (Fox, 1980). Sex education has been suggested as a way to improve this communication. Little research has been published about the impact of improved communication between mothers and daughters on sexual beliefs and attitudes. Because of this fact the review of the literature also examines communication as a way that parents can effectively change behavior. According to Lewis and Lewis (1980), talking with the child about sex helps him/her to become more responsible in his/her sexual behavior and helps the young person to develop a healthier attitude toward sex.

Most children do not learn sexuality at home, but consequently seek their information from peers (Gordon & Gordon, 1983; Goodman, 1969; Libby, 1971; Scales & Everly, 1977; Wagner, 1980). The adolescent's direct "sexual" experience and the processing of that experience generally occurs with peers, and the sex education received from

friends seems to be associated with more permissive sexual behavior (Gordon et al., 1979).

In 1979, Mathtech was awarded a contract to help improve and then evaluate 10 of the promising sexuality programs. As a result of the work and research done by Mathtech many interesting facts about parent/child communication regarding sexuality were compiled. For example, 80% of American parents agree the responsibility of providing sexuality education to their children is the parents' responsibility. One hundred fifty-two teenagers surveyed reported receiving most information about sex first from peers and secondly from the literature. The mothers were most likely to provide information on menstruation and conception, but very little on other sexual matters such as homosexuality, ejaculation, masturbation, contraception, prostitution, petting, venereal disease, or seminal emissions. Fathers are said to provide 4.3% or less of the child's first sex information on any topic (Cook et al., 1984).

Mathtech also interviewed 1,400 Cleveland parents and provided information on how often they discussed sexuality topics with their 3- to 11-year-old children. Of the fathers, 96% rarely discussed any aspect of sex with their children. As much as 40% of 9- to 11-year-old girls had never discussed menstruation with either their mother or father. Erotic behavior was never mentioned by 85-90% of

parents. Nudity was discussed by 40%; wet dreams less than 2%. One hundred twenty-four mothers of 11- to 14-year-old daughters revealed the following: 20% had never discussed menstruation; an additional 16% had discussed only issues of hygiene; a mere 4% had provided detailed information about the physiology of menstruation and how it relates to pregnancy. The man's role in reproduction had been discussed by 50%, while 11.7% had discussed that there are ways to prevent pregnancy (Cook et al., 1984).

Improved family communication about sexuality may result in reduced irresponsible sexual behavior and in turn decrease unwanted pregnancy. A survey by Mathtech of 419 college students revealed that those who received sexual information primarily from parents instead of peers or media reported less premarital sexual activity, fewer sexual partners, and delayed first intercourse. Another survey about college students revealed of the 1,177 sampled that those who indicated mothers as playing a prominent role in their sex education had less sexual experience. Even limited instruction by parents was significant in increasing the chance daughters would correctly use contraception. Those young women who successfully used contraceptives more often reported mothers as their primary source of information as compared to those women failing to use contraception successfully and who sought abortion (Cook et al., 1984).

From these surveys conducted by Mathtech, it was concluded that family members have definite feelings about discussing sexuality with each other. Two of three parents experience great difficulty discussing death, sex, drugs, and other matters of a sensitive nature with their children of any age. Adolescents are said to desire more open communication about sensitive topics, and most parents perceive they had need for assistance in their role as sex educators--80% feel they need additional training--30% asked for structured courses (Cook et al., 1984).

Scales (cited in Gordon et al., 1979) conducted a study in which 14 "treatment" and 13 "control" families were included. Mothers who had taken part in a parent sex education program were compared to those who had not taken part in the sex education course. Mothers who had participated in the sex education course reported significant increases in several variables of communication including frequency in initiating conversations with children regarding sexuality and comfort in talking about sex. In similar research reports by the Institute for Family Research and Education in 1977 of video-taped conversations between parents and children, it was revealed that those families who had participated were more likely rated "facilitative" than "inhibitive" during communication.

Parental involvement has been reported as the most important component for increasing the quality and level of

parent-child communication about sexuality. A study by Parcel and Coreil (1985) was conducted by the interview method using a structured questionnaire in which parents evaluated their child's participation in a school-based sex education course. Information from this study was intended, among other things, to document the influence of the course on parent-child interactions. One hundred fifty-eight students met 50 minutes a day for 6 weeks. The program, designed for adolescents aged 13-14 years, was comprehensive and included areas typically considered controversial. The course was also evaluated with a pre-post delayed treatment/ control group design in order to determine the impact, if any, on attitudes and knowledge relating to sexuality. The project, a pilot program, conducted among three major ethnic groups of White, Black and Hispanic in Galveston, Texas (population 65,000) was funded to develop and field-test the sex education program. The course was an elective and required parental permission.

A 37-item questionnaire was used to evaluate parental assessment of the course. Most of the questions used a fixed response option with open-ended questions used to expand on some of the questions. A trained interviewer conducted interviews with parents. Parents of 58 (38%) of students enrolled were interviewed. Since mothers were more willing to participate, the final sample included females (69%) and males (31%). Fifty-three percent were parents of

boys and 47% parents of girls who participated in the course (Parcel & Coreil, 1985).

The findings of this study were that most parents are involved in some sex education activities. One half of the parents sometimes encourage their child to learn about sex. One third often teach about sex, 42% do sometimes, and 28% rarely or never do. Fifty percent rarely or never set sexual rules for the child while one fourth often do. Most parents (75%) never encourage their child to be less or more active sexually. A great percentage (44%) reported talking a lot about dating than sexuality (37%). A majority (56%) talked infrequently with their child about dating and 61% about sexuality (Parcel & Coreil, 1985).

The decision for the student to take the sex education course was almost evenly distributed; the parents and child decided together (24%), the child decided (23%), both parents decided (24%), and mother decided (23%). Seventy-nine percent of the parents felt the course made discussing sexual matters with their child easier. According to the parents, a reduction in tension supposedly made it easier for the child to discuss sexual matters (Parcel & Coreil, 1985).

Furstenberg (1976) conducted a study in which communication between mothers and daughters concerning contraception was reported. The study sample was predominantly black and consisted of 404 pregnant teens and their mothers

in Baltimore. Forty percent of the families had females as the household head. Almost 60% of the mothers reported to have frequently attempted to discuss sex with their daughters and 92% had discussed sex occasionally with their daughters. Sixty-one percent of mothers reported discussing birth control while 45% of the daughters reported discussing birth control. In those families discussing birth control, 52% of the daughters reported having used contraception at some time as compared to 23% where birth control had not been discussed. The researcher concluded that even limited instruction was found to have an impact on the daughter's use of contraception.

Mother-daughter communication has been found to have similar effects on behavior. For example, Miller (1976) compared a group of women seeking abortion to a group of successful contraceptors. The sample included two matched groups of single women who were sexually active. Each group consisted of 26 women. All the women were Caucasian, never married, and none previously pregnant. Ages varied from 17 to 26 years with a mean age of 20.6 years. Ages and socio-economic status of both groups were matched.

The successful contraceptor group was recruited from a group of women who used contraception regularly--mostly oral contraception. The therapeutic abortion group came from the same geographical area. All were being followed by an obstetric-gynecologic physician either in private or clinic

practice. The therapeutic abortion subjects were chosen after their abortion had been approved and scheduled. All subjects answered questionnaires and took part in a series of interviews. Most of the therapeutic abortion group were interviewed at least a week or longer after the procedure. The interviews were unstructured and focused on sexuality and contraception from early adolescence to the time of the study. All these young women reported entering adolescence with internalized prohibitions against premarital intercourse for women (Miller, 1976).

All subjects reported their mothers had played some role, though not a large role, in their acquiring knowledge about their sexuality, and especially small regarding prevention of pregnancy. Of the 52 subjects, 23 indicated mothers as the first important source of information regarding menstruation; 14 subjects indicated mothers as the first important source of information regarding sexual intercourse; and 5 reported mothers as the first source of information regarding birth control. Miller found that in respect to information about sexual intercourse that the two groups differed significantly. "Approximately 40% of the successful contraceptor group indicated their mothers as the first important source of information on this subject, whereas only 12% of the therapeutic abortion group indicated their mothers" (Miller, 1976, p. 429).

Few studies have been conducted that specifically deal with mother-daughter relationships and with sexual socialization within those relationships. Bloch (1979) reports a study in which the sex education practices of a random sample of 124 mothers of seventh grade girls in two California communities were investigated. The modal age of the girls was 12; 35% had passed menarche. Bloch questioned mothers in detail regarding what had been said to their daughters about menstruation, about birth control, and the male role in reproduction. Even when a liberal scoring system was used which would bias the mothers' results toward greater communication it was found that as many as 20% had never discussed anything about menstruation, 50% had never discussed the father's role in reproduction, and 68% had never talked to their daughters about fertility regulation or birth control. When rating the adequacy of what those mothers had said to their daughters in terms of the level of sex education which might be reasonable, it became more distressing as the percentages dropped even more. Bloch concluded that the data from the study seemed to support findings from prior studies which have consistently indicated children get little sex education in the home (Bloch, 1979).

Fox and Inazu (1980) conducted a study of mother-daughter communication patterns about sexuality. Two questions in particular were addressed: (a) what topics

mothers and daughters discussed and how their descriptions of these discussions differed and (b) what factors characterized those mothers who were actively involved in the sexual socialization of their daughters from those who were not. The study involved selection of teenagers from school registration lists of seven schools to avoid biases inherent in samplings from family planning clinics or other therapeutic populations. Criteria for selection for the schools were based on the general socioeconomic status level and racial composition of the student body. These school registration lists were stratified by date of birth, sex, and race. Mothers and daughters were asked about their discussions of several topics related to sexuality. The sampling included 449 mothers and their daughters aged 14-16 years of age. Proportional sampling within the race was done (Fox & Inazu, 1980).

Mothers and daughters were interviewed in separate rooms simultaneously by interviewers who had been matched by race and age. Mothers and daughters were asked about their discussions of several topics related to sexuality. Nearly all mothers and daughters had discussed all these topics at some time in the girl's lifetime. Most often discussed were menstruation, boyfriends, and dating. Sexual intercourse and birth control were least often discussed. A high degree of consistency existed in the mothers' and daughters' reporting, with mothers reporting that a topic had been

discussed slightly more often than the daughters. Greatest discrepancy was in the area of sexual morality with 92% of mothers reporting ever discussing this whereas the daughters reporting was 78%.

Daughters reported initiating conversations about menstruation, dating, and boyfriends. Mothers initiated conversations about birth control, sexual intercourse, and sexual morality. Mothers reported being very comfortable discussing all topics with sexual intercourse as the one mothers felt least comfortable with. The daughters had more difficulty discussing sexual intercourse and morality. Not even half felt "very comfortable" discussing any of the topics with their mothers. The extent of sexual communication was also found to vary according to social and family structural characteristics. A conclusion of this study is that sexual information and guidance from parents is critical in the daughters' development of responsible sexual norms and results in less risky sexual behavior. Thus, facilitating communication between mother and daughter would be the vital key in prevention of unwanted teenage pregnancies (Fox & Inazu, 1980).

A very comprehensive study in which sex education practices of parents with their young children were examined was conducted by Roberts, Kline, and Gagnon (1978). A representative sampling of parents of children ages 3 to 11 years old were interviewed regarding their attitudes and

sexual behaviors in sex education. It was found that parents share little information with their children. Fifty percent of the fathers and 75% of the mothers had previously discussed pregnancy with their children. Only 8% of fathers and 15% of mothers had provided any information regarding sexual intercourse and even fewer parents had ever broached the subjects of venereal disease or contraception.

Further information regarding parents' involvement in their children's sex education has been provided through studies of adolescents. Elias (1978) conducted a study of high school students. Two thirds of high school girls had discussed sexuality with their mothers with the conversation focused on the "negative" aspects of premarital relations and menstruation. A small 2% of high school girls had ever discussed issues of a sexual nature with their fathers. Thirty-three percent reported neither parent had talked with them. According to this study parents have a tendency to ignore the sex education of their sons. One quarter of the boys had received any sexual information from their fathers. Two thirds reported they had never discussed any sexuality with either parent. For females the mother was indicated as the first source of information regarding menstruation, pregnancy, conceptions, and menopause. In such areas as male erection, sexual intercourse, prostitution, homosexuality, and masturbation, peers provided the first source of information. The researcher concluded that the only

significant discussions concerning sexual issues occurred between mothers and daughters.

A study to determine sources from which adolescents received their sex information and its implications for sex education was conducted by Thornburg (1981b) in a midwestern town with a population over 250,000. Sampling included the entire population of a large high school. Socioeconomic characteristics ranged from lower middle class to upper middle class.

Students completed a questionnaire which asked at what age and from whom they first learned the following concepts: conception, contraception, abortion, ejaculation, intercourse, homosexuality, masturbation, prostitution, petting, menstruation, venereal disease, and seminal emissions. The questionnaire restricted the following categories as sources: father, mother, peers, schools, literature, minister, physician, experience, and don't know. Lastly, subjects were asked to write a definition of each sexual term they indicated they knew (Thornburg, 1981b).

Results confirmed previous studies that peers (37%) are most often the source of sex information, followed in descending frequency by literature, mothers, and schools as sources of information. Experience ranked fifth as the most common source of information, even above fathers, ministers, and physicians combined--a trend that has held constant in five of Thornburg's studies. In areas involving actual

sexual behavior such as petting, sexual intercourse, and homosexuality peers ranked highly, contributing more than 50% of the total information. The concepts of abortion and seminal emissions were learned primarily from the media. Mothers contributed information on menstruation and conception, which accounted for nearly half the total information provided by mothers. Mothers were also cited for the first time as providing information about intercourse, a fact that is considered a positive sign for early adolescents. The schools provide about one sixth of information on these sexual concepts (Thornburg, 1981b).

Results of this study indicated that females were more dependent on mothers for information, as they obtained three times more information from mothers than subjects' male counterparts. Males were more dependent upon their peers, gaining 15% more information from peers than did females. Females depended more on literature than males (Thornburg, 1981b).

Sex information was learned by 3.6% of the subjects before the age of 9 years. Between the ages of 9 to 11, 30.7% of all initial sexual information was learned. Seminal emissions and venereal disease were learned by fewer adolescents than any other concepts. It is significant that many learned about petting, sexual intercourse, and prostitution between 9 and 11 years and 34.3% of all 12 concepts are learned before the students leave elementary school.

Half (51.4%) of all sexual information is learned between the ages of 12 and 13 years. Of the sex information learned, 8.3% is learned at age 14; 5% at age 15; and beyond age 15 only 1% is learned. In defining early adolescence as 10 to 15 it is important to note that 99% of all sex information is learned during the early adolescent years (Thornburg, 1981b).

The researcher further found that although accuracy about sexual matters is increasing contraception in particular seems highly inaccurate compared to other areas. This may be a contributing factor to the increase in teenage pregnancies. It is the researcher's opinion that adolescents have learned only partial concepts and stand in need of more complete information regarding human sexual behavior. Many are considered quite naive, a risk far too high for responsible adults to ignore (Thornburg, 1981).

Conclusion

Few studies adequately address how and when parents discuss sexual topics with their children, the differentiation between uninvolved and involved parents, or the impact the involvement in sexual socialization has on sexual knowledge, behavior, and attitudes of their children (Fox & Inazu, 1980). Parents do, however, agree that they should be the principal sex educators of their children. Communication between mothers and daughters in particular seems to be the vital key in preventing unwanted pregnancies.

Therefore, parental involvement in the sex education of their children should become a concern of Family Nurse Clinicians and family researchers. As yet, little is know about sex education plans or practices by parents for children.

Chapter V

Research Design and Methodology

Research Design

The design employed in this study was quasi-experimental. Leedy (1980) describes quasi-experimental research as that research using an experimental and control group wherein there are certain variables that are not under the researcher's control. Since the researcher is working with human subjects, there are several intervening variables that the researcher cannot control.

The pretest-posttest control group design was used. In this design the experimental group is carefully chosen through randomization. The control group is similarly selected. The experimental group is first evaluated, then subjected to the experimental variable, and then reevaluated. The control group is isolated from any experimental variable influences and merely evaluated at both the beginning and end of the experiment (Leedy, 1980).

In this study, the experimental group was subjected to a researcher-designed sexuality program and pretest and posttest scores were compared. The control group had the option of attending the course after posttesting.

Variables

The independent variable in the study was the mother-daughter workshop on sexuality. Dependent variables included mothers' attitudes toward sexuality and communication with their daughters regarding sexual matters. Attitudes and communication were measured using the Attitude Questionnaire and the Parents' Questionnaire on Family Communication. Controlled variables were age of the adolescent, place of residence, and daughters' educational levels. The intervening variables may have been religious and political beliefs, cultural factors, participants' past experiences regarding sexuality, honesty in responding to the questions, and subjects' physical and mental states at the time of testing.

Setting, Population, and Sample

The setting for this study was a small rural town in Northeast Mississippi. Estimated population is approximately 6,500. There is no sex education included in the school curriculum. At present there are no sex education courses offered by any organization in the region. Area churches include several Protestant and one Catholic church. Agriculture is the economic base. Industry, primarily furniture production, also plays a significant role in the economy. Racial distribution is mostly white with approximately 38% of the population black (Mississippi Statistical Abstract, 1980). The number of adolescents enrolled in

local schools grades 6-9 is 298. According to J. Lee, Director of Family Planning, Bureau of Health Services, Mississippi State Department of Health, Jackson, Mississippi (personal communication, February 10, 1987), the teenage pregnancy rate for the county in which the study will take place is 35.83%. The VD rate for the county (per 100,000 cases) is: primary syphilis, 217.7% with 5 cases reported; tertiary/secondary syphilis, 8.7% with 2 cases reported; and gonorrhea, 130.2% with 30 cases reported.

The population was restricted to mothers of adolescent daughters ranging in ages 11 to 14 years living in a 50-mile radius of the town. The sample consisted of all mothers responding to an advertised workshop by filling out a registration blank. The researcher planned to assign subjects to either the experimental or the control group by putting all the forms in a box and putting every other one in the control group; however, the researcher had to accept those subjects willing to come for the workshop in the experimental group. The control group was contacted to come in for testing with the experimental group; however, this was not possible so separate questionnaires for pretesting and posttesting were delivered to each subject in the control group with a 4-hour lapse. As a reward this group was offered the sexuality workshop free. The experimental group had 7 subjects, and the control group had 11 subjects.

Data-Gathering Process

The District Director of the State Health Department was contacted to use the audiovisuals and course outline of the mother/daughter workshop offered by the department (see Appendix A). Two weeks prior to the data-gathering sessions, announcements were posted on bulletin boards at the hospital and welfare department and in store windows, advertisements were published in the local newspaper, and radio spots were broadcasted on a local radio station. Permission was obtained to send announcements home with daughters in grades 6-9 enrolled in the public schools. These announcements included the following: nature of the workshop, time, place, and instructor.

Participants were requested to return a completed registration form prior to the date of the workshop. The registration forms were then to be placed in a box. Every other one was to be chosen for the control group. This procedure had to be changed as noted in the previous section. Prior to the workshop the study was completely explained, and all mothers who chose to participate signed the consent form (see Appendix B). After the consent forms were signed, both groups of mothers were to be administered the pretest. However, since subjects in the control group did not want to come in for testing, the researcher delivered the tests to their homes. The experimental group then participated in the mother/daughter workshop which

consisted of discussions, films, and activities related to puberty, sexual development, and communication skills. See Appendix C for a more complete outline. Following the workshop the posttest was administered to the mothers of the experimental group. The control group was offered the opportunity to participate in the workshop after testing.

Instrumentation

The Parents' Questionnaire on Family Communication and the Attitude Questionnaire used in this study were developed by Mathtech for the U.S. Department of Health and Human Services. There has been no established reliability and validity, but the researcher assumes the questionnaires have face reliability and validity for this study since they have been used in previous studies.

The Parents' Questionnaire on Family Communication Questionnaire (see Appendix D) was developed to assess change in communication behavior. It asks questions about communication frequency and the mothers' general communication habits with five possible responses: never (1), sometimes (2), half the time (3), usually (4), and always (5). The questionnaire also asks participants to agree to disagree with statements about family communication using a 5-point Likert scale from strongly disagree (1) to strongly agree (5). Also, included are additional questions about the child's communication behavior. The more positive the score, with a maximum of 120, the more positive the

communication between mother and daughter. The questionnaire with a total of 24 questions is divided into four parts. Part I measures mothers' comfort in communicating with their adolescent daughter and consists of four questions on a Likert scale of 1 to 5, with 5 indicating the most comfortable, a total of 20 points is possible on this part. Part II measures mothers' behavior during communication with the daughter and consists of six questions on a Likert scale with a maximum positive score of 30. Part III measures child behavior in response to communication by parent and consists of six questions on a Likert scale with a maximum score of 30. Part IV measures how mothers discuss sexuality and is composed of eight questions on a Likert scale with a maximum score of 40. Therefore, the total possible score for communication is 120.

The Attitude Questionnaire (see Appendix E) assesses the attitudes of the mothers toward sexuality. The questionnaire consists of two sets of Likert format items. The first set attempts to ascertain how clearly participants are about their personal values regarding these five topics: acceptable behavior at different ages, personal sexuality, gender roles, contraception, and abortion.

The second set of attitude items addresses basic values--values which are believed to be necessary for parents to be effective sexuality educators of their children. The questionnaire poses statements which are to

be rated on a scale of 1 to 5: strongly disagree (1) to strongly agree (5). The more positive the score the more positive attitudes are toward sexuality.

The Attitude Questionnaire is composed of Likert responses on a scale of 1 to 5. In scoring the responses to questions 1-5, 7-11, 13, 15, 20-22, 25-26, 28, the higher the score the more positive the attitude toward sexuality. Questions 6, 12, 14, 16-19, 23-24, 27, and 29 are scored inversely, the lower the score the more positive the attitude. There is a possible maximum score of 145.

The Demographic Information Sheet is composed of 10 questions. Demographic information includes race, age, marital status, financial income, education, religion, and living arrangements. Each questionnaire was coded with a number for subject identification.

Statistical Analysis

The *t* test was used for analysis. This test is the test of choice to examine group means for two samples with less than 30 subjects (Brase & Brase, 1978).

Assumptions

1. Participants will respond truthfully.
2. Sexuality is an important component of one's life.
3. Mothers have attitudes toward sexuality and those attitudes can be measured.

4. Mothers and daughters communicate in a manner that can be measured.

Limitations

1. Limiting the study to mothers with daughters 11 to 14 years prevents generalization to mothers with daughters either younger or older.

2. Limiting the study to mothers with daughters prevents generalization to mothers with sons or fathers with daughters.

3. Limiting the study to a southern town prevents generalization to other parts of the country.

4. Lack of randomization between control and experimental groups may have affected the findings.

Chapter VI

Analysis of Data

The purpose of this study was to determine if a 4-hour mother/daughter sexuality workshop with emphasis on communication could affect a change in mothers' attitudes about sexuality and mothers' willingness to communicate about sexuality to adolescent daughters. The experimental and control groups were administered the Attitude Questionnaire and the Parents' Questionnaire on Family Communication. The experimental group was tested both before and after attending the mother/daughter workshop. The control group was tested in their homes with an approximate 4-hour interval between the pretest and posttest.

There were 18 subjects with 7 in the experimental group and 11 in the control group. All subjects were female and mothers of adolescent daughters who were between the ages of 11 and 14 years. The ages of all subjects ranged from 28 to 58 years with a mean age of 36.5 years. Ages of the experimental group ranged from 28-36 years with a mean age of 33.7 years and in the control group ages ranged from 38-50 years with a mean age of 38.3 years. There was one black subject in the experimental group. The remaining subjects in both

groups were white. Education of the subjects in number of years ranged from 10-17 years with a mean age of 14 years. Income for the experimental group ranged from $5,000-$10,000 to over $45,000 per year with a mean income of slightly less than $30,000. The income level for the control group ranged from $30,001 to $35,000 and slightly under $25,001 a year.

Pretest scores on the Parents' Questionnaire on Family Communication for the experimental group ranged from 76 to 90 with a mean of 84.1, and posttest scores ranged from 72 to 95 with a mean of 85.6. Pretest scores for the control group ranged from 75 to 95 with a mean of 84, while posttest scores ranged from 74 to 95 with a mean of 83.6.

For the experimental group, pretest scores on the Attitude Questionnaire ranged from 114 to 140 with a mean of 124.7. Posttest scores for the experimental group ranged from 121 to 142 with a mean of 131.7. Pretest scores on the Attitude Questionnaire for the control group ranged from 123 to 143 with a mean of 131. Posttest scores ranged from 117 to 143 with a mean of 130. These data are found in Table 1.

Table 1

Raw Subject Data Including Age, Income, Education, Number of Children Ages 10-14, Number of Children Per Family, Church Attendance and Scores

Subject	Age	Family Income ($000)	Years of Education	Children Ages 10-14	Total Number of Children	Church Attendance	Communication Scores		Attitude Scores	
							Pretest	Posttest	Pretest	Posttest
E_1	36	25-30	14	1	1	Few x year	85	82	114	121
E_2	33	> 45	14	1	2	Once a week	76	72	116	130
E_3	35	30-35	14	1	1	2-3 x month	89	91	127	131
E_4	34	15-20	10	1	3	2-3 x month	81	80	121	132
E_5	34	25-30	16	1	3	> once a week	89	95	136	142
E_6	36	> 45	17	2	2	> once a week	90	88	140	141
E_7	28	15-20	12	1	2	> once a week	79	91	119	125
C_1	31	20-25	12	1	3	Few x year	92	87	128	134
C_2	33	5-10	14	1	2	Once a week	80	84	123	124
C_3	41	40-45	16	1	3	> once a week	81	85	136	136
C_4	39	35-40	16	1	2	> once a week	83	83	133	133
C_5	38	20-25	14	1	1	> once a week	77	77	131	131
C_6	37	40-45	14	1	3	Few x year	95	95	143	143
C_7	50	15-20	14	1	3	> once a week	75	74	130	126
C_8	44	40-45	14	1	4	> once a week	83	82	134	125
C_9	36	10-15	12	1	2	> once a week	81	75	123	128
C_{10}	38	20-25	16	1	2	Once a week	85	90	126	117
C_{11}	35	25-30	14	2	3	> once a week	92	88	135	135

Hypothesis One

The researcher hypothesized there would be no significant difference in mothers' attitudes towards sexuality after attending a 4-hour sexuality workshop when compared to the attitudes of a group of mothers not attending the workshop. Pretest scores were subtracted from posttest scores for both groups and the difference was subjected to the *t* test. The *t* value was 3.53 ($p = .003$) and thus significant at the .05 level. The researcher therefore rejected the null hypothesis. The experimental group had a higher mean score indicating a more positive attitude change. These data can be found in Table 2.

Table 2

Comparison of Difference in Pretest and Posttest Scores on the Attitude Questionnaire

Group	*n*	$\bar{M}$	*SD*	*t*
Experimental	7	7.00	4.32	3.53*
Control	11	- .90	4.80	

*$p \geq .05$.

Hypothesis Two

The researcher hypothesized that there would be no significant difference in the willingness of mothers to communicate sexuality with their daughters or in the mother/daughter interaction after attending a 4-hour sexuality

workshop as compared to a group of mothers not participating in the workshop. Again, pretest scores on the Parents' Questionnaire on Family Communication were subtracted from posttest scores and the difference was subjected to the *t* test at the .05 level of significance. The obtained *t* value was .81 (*p* = .429).

Since the *t* value was not significant at the .05 level, the researcher failed to reject the null hypothesis. The obtained *t* value was .81 (*p* = .429). These data can be found in Table 3.

Table 3

Comparative Scores in Mothers' Willingness to Communicate Sexuality on the Parents' Questionnaire on Family Communication

Group	*n*	$\bar{M}$	*SD*	*t*
Experimental	7	1.42	5.76	.81
Control	11	-.36	3.66	

Additional Findings

The experimental group was observed as being somewhat reluctant in the beginning but became more responsive as the workshop progressed. Very open and positive communication between mothers and daughters was observed during the scheduled times of activity and communication. Once the

workshop was completed there were exceedingly positive and enthusiastic comments expressed regarding the workshop. All participants expressed satisfaction at having attended and expressed wishes that they had encouraged other friends to come. All mothers believed it would be easier for them to communicate sexuality to their daughters as a result of the workshop. Due to sampling problems there were only 7 in the experimental group. The researcher tried every tactic to elicit subjects but failed to do so. This points out a distinct lack of interest by mothers about this subject.

Chapter VII

Summary, Conclusions, Implications, and Recommendations

Summary

The purpose of this quasi-experimental study was to determine the effect of a 4-hour mother/daughter sexuality workshop on the attitudes of mothers toward sexuality and their willingness to communicate sexuality to their adolescent daughters. The researcher sought to determine if there was a difference between mothers attending the mother/daughter workshop and mothers not attending the workshop.

The hypotheses tested in this study were as follows:

1. When mothers who have participated in a 4-hour sexuality workshop are surveyed and the results are compared to a group of mothers not participating, there will be no significant difference in attitudes toward sexuality.

2. When mothers who have participated in a 4-hour sexuality workshop are surveyed and the results are compared to a group of mothers not participating, there will be no significant difference in mothers' willingness to communicate with their daughters regarding sex or in mother/daughter interaction.

Eighteen subjects (E = 7; C = 11) participated in the study. The experimental group attended a 4-hour researcher-developed workshop while the control group did not attend any workshop. All subjects took the Parents' Questionnaire on Family Communication and Attitude Questionnaire both before and after the workshop.

Pretest scores on the Parents' Questionnaire on Family Communication were subtracted from posttest scores and subjected to the *t* test. The same procedures were followed with the Attitude Questionnaire. The *t* value for the attitude change was significant at the .05 level with the experimental group having a more positive change while the change of the Parents' Questionnaire on Family Communication was not significant at the .05 level. Therefore, the researcher rejected the null hypothesis regarding attitude change and failed to reject the null hypothesis regarding willingness to communicate sexuality. The researcher concluded that participation in a mother/daughter workshop positively affected mothers' attitudes about sexuality.

Conclusions and Implications

The findings of this study suggest that a 4-hour workshop can alter the attitudes of mothers about sexuality in a positive manner. This conclusion implies that the Family Nurse Clinician in clinical practice could enhance attitudes of mothers toward sexuality through formal teaching.

There was no significant difference in mother's willingness to communicate about sexuality after attending the workshop. This conclusion is inconsistent with the literature that parental involvement in sex education is the most important component for increasing the quality and level of parent-child communication about sexuality (Cook et al., 1984; Fox & Inazu, 1980; Miller, 1976; Parcel & Coreil, 1985; Scales & Everly, 1977). This may have been because all socioeconomic groups were not represented and the results could be biased. The inconsistency of the findings about change in communication after teaching could have also occurred due to the short period of data collection and/or the small sample size.

The researcher noted that mothers and daughters became more enthusiastic and involved as the workshop progressed. Given a longer period of data collection then it might be easier to obtain subjects once those that participated shared the experience with others. This would suggest that the research should be replicated over a longer period of time.

Recommendations

Based upon the data obtained in this study, the following recommendations are made:

1. Further study should be conducted over a longer period dividing the workshop into more than one session and allowing for more communication and material to be covered.

Allowing more time would determine if more and shorter sessions over a period of time would have an even more positive effect on attitudes about sexuality or improved communication between mothers and adolescent daughters.

2. Additional studies should be conducted including both younger daughters and older daughters.

3. Additional studies should be conducted for father and son groups.

4. The study should be replicated in which subjects of a more diversified nature would be included, i.e., to represent other races and other socioeconomic groups.

5. The study should be replicated with a larger sample.

6. The study should be replicated in an urban area.

7. The Family Nurse Clinician in her practice should conduct formal teaching of sexuality with mothers and daughters.

APPENDICES

Appendix A

Dear _____:

I am a registered nurse and presently a student at Mississippi University for Women. As part of my graduate studies I am doing my thesis work in the area of sexuality education.

Several years ago I assisted with a program, sponsored by the Health Department, especially designed for mothers and daughters. I was very much impressed with this new approach to sexuality education and as a result have chosen this subject for my research study.

It is my intention to present this same mother/daughter workshop for the purpose of conducting a study in which I will be collecting data regarding mothers' attitudes toward sex education and their abilities to communicate sex with their daughters. I would like to utilize the materials from the mother/daughter workshop.

The purpose of this letter is to confirm our telephone conversation in which you granted permission for me to use the materials from the mother/daughter workshop. I will be contacting your office in the near future concerning this.

Thanking you in advance, I am

Sincerely,

Esther Dunlap, RN, BSN

Appendix B

Parent Consent Form

My name is Esther Dunlap. I am a registered nurse and a graduate student at Mississippi University for Women. Today you will be exposed through this mother/daughter workshop to areas of human sexuality that are specifically pertinent to you and your daughter. This program has been especially designed for mothers and adolescent girls.

This workshop is being used as part of a research study that I, as a student, am conducting regarding sexuality education. You will be asked to fill out a questionnaire both before and after the workshop. All information will be confidential and the data will be used for research purposes only.

You may refuse to participate in the study and have the right to withdraw for both yourself and your daughter from this workshop or study at any time. Should you have any questions, please ask.

Parent Consent

I agree to participate in the research study being conducted by Esther Dunlap. I understand the explanation given to me and that the information obtained will be confidential.

_____ _____

Date Participant

_____

Researcher

Appendix C

Course in Human Sexuality

Overall Objective

To increase participants' knowledge of puberty and sexual development and enhance mother-child communication.

Session One - First Saturday - 9:00 a.m. - 1:00 p.m.

Content	Media and Methods	Objectives
1. Introduction (10 min.)	Didactic	1.1. Welcome
		1.2. To identify expectations for the course--to increase participants' knowledge of puberty and sexual development and to open the door to parent-child communication.
		1.3. Description of packets, which are distributed at reception table.
		1.4. Explanation of Question Box--to be used for submitting private written questions which will be answered toward the end of the program.
		1.5. Explain study, questionnaires and have consent forms signed.

2. Pretesting for mothers with Attitude Questionnaire and Parents' Questionnaire on Family Communication for Experimental and Control Groups (20 min.)		2. To obtain data for evaluation of treatment.
3. Parent/Child Relationships (20 min.)	Discussion followed by Group Exercise: "Do You Know Your Family?"	3.1. Icebreaker. 3.2 To increase participants' knowledge of themselves and their own families.
4. Male/Female/ Individual Differences (25 min.)	Film Presentation: "Then One Year." Covers the male and female reproductive systems. Emphasizes wide variation in normal growth and maturation rates. Present factual information about puberty and reproduction in a manner teens can understand. (ethically mixed)	4. Increase participants' knowledge regarding male and female reproductive system.
5. Mother/Daughter Exercise (35 min.)	Exercise: "The Body Clock" followed by discussion	5. To enable mothers and daughters to be more aware of the sequence of physical changes during puberty.

Break (10 min.) Explain Question Box

6. Female Anatomy (20 min.)	Use of Pelvic Model followed by discussion	6. To increase knowledge and facilitate communication about female anatomy and physiology.

7. Issues that concerns young adolescent girls (30 min.)	Film Presentation: "DEAR DIARY"-- Humorous film about how three friends explore their feelings about boys, female roles, breast development, menstruation and growing up (racially mixed cast). Followed by discussion and answering questions.	7. To increase knowledge and to help participants explore their feelings about concerns of adolescence.
8. Preparing for adolescence (15 min.)	Small group activities with parents and separated. Puberty puzzles	8. To correct myths and misinformation about puberty. Reinforce what already discussed.
9. Sexually Transmitted Diseases (35 min.)	Film Presentation: "V.D.--What is it?" Simple, factual and informative. Help students understand the prevalence of the diseases, the symptoms and the complications of untreated syphilis and gonorrhea. Followed by 10-min. discussion	9. To increase knowledge of STD--through presentation/ discussion medical facts, myths of and attitudes.
10. Posttesting for mothers with Attitude Questionnaire and Parents' Questionnaire on Family Communication for Experimental Group (20 min.)	Administer tests to mothers	10. To obtain data for evaluation of treatment.

Session Two - Saturday - 1:00 p.m. - 5:00 p.m.

Content	Media and Methods	Objectives
1. Introduction	Didactic	1.1. Welcome
		1.2. To identify expectations for the course--to increase participants' knowledge of puberty and sexual development and to open the door to parent-child communication.
		1.3. Description of packets, which are distributed at reception table.
		1.4. Explanation of Question Box--to be used for submitting private written questions which will be answered toward the end of the program.
		1.5. Explain study, questionnaires and have consent forms signed.
2. Posttesting for mothers with Attitude Questionnaire and Parents' Questionnaire on Family Communication for Control Group (20 min.)		2. To obtain data for evaluation of group without treatment.
3. Parent/Child Relationships (20 min.)	Discussion followed by Group Exercise: "Do You Know Your Family?"	3.1. Icebreaker.
		3.2 To increase participants' knowledge of themselves and their own families.

4. Male/Female/ Individual Differences (25 min.)	Film Presentation: "Then One Year." Covers the male and female reproductive systems. Emphasizes wide variation in normal growth and maturation rates. Present factual information about puberty and reproduction in a manner teens can understand. (ethically mixed)	4. Increase participants' knowledge regarding male and female reproductive system.
5. Mother/Daughter Exercise (35 min.)	Exercise: "The Body Clock" followed by discussion	5. To enable mothers and daughters to be more aware of the sequence of physical changes during puberty.
Break (10 min.)	Explain Question Box	
6. Female Anatomy (20 min.)	Use of Pelvic Model followed by discussion	6. To increase knowledge and facilitate communication about female anatomy and physiology.
7. Issues that concerns young adolescent girls (30 min.	Film Presentation: "DEAR DIARY"-- Humorous film about how three friends explore their feelings about boys, female roles, breast development, menstruation and growing up (racially mixed cast). Followed by discussion and answering questions.	7. To increase knowledge and to help participants explore their feelings about concerns of adolescence.
8. Preparing for adolescence (15 min.)	Small group activities with parents and separated. Puberty puzzles	8. To correct myths and misinformation about puberty. Reinforce what already discussed.

9. Sexually Transmitted Diseases (35 min.)	Film Presentation: "V.D.--What is it?" Simple, factual and informative. Help students understand the prevalence of the diseases, the symptoms and the complications of untreated syphilis and gonorrhea. Followed by 10-min. discussion	9. To increase knowledge of STD--through presentation/ discussion medical facts, myths of and attitudes.

Appendix D

Demographic Information

Directions: Please answer a few questions about yourself.

1. What is your sex?
   _____ Male
   _____ Female

2. In what age group are you?
   _____ 25-35
   _____ 36-45
   _____ 46-55
   _____ Over 55

3. What is your racial background?
   _____ White
   _____ Black
   _____ Other

4. What is your marital status?
   _____ Single (never married)
   _____ Married
   _____ Separated, divorced, or widowed

5. What is your living situation? (Check all that apply)
   _____ Living alone
   _____ Living with my own children of current marriage
   _____ Living with my own children from previous marriage
   _____ Living with children other than own
   _____ Living with the father or mother of the children
   _____ Living with partner who is not the father or mother of the children
   _____ Living with my own parents or in-laws
   _____ Living with others (please specify): _____

6. What was your total family income last year?

_____ Less than $5,000	_____ $25,001 - $30,000
_____ $ 5,001 - $10,000	_____ $30,001 - $35,000
_____ $10,001 - $15,000	_____ $35,001 - $40,000
_____ $15,001 - $20,000	_____ $40,001 - $45,000
_____ $20,001 - $25,000	_____ Over $45,000

7. How many grades of school did you finish?
   _____ Less than high school graduation (less than 12th grade)
   _____ High school graduation (12th grade)
   _____ Some college
   _____ College graduation
   _____ Some graduate school
   _____ Graduate school degree (M.A., M.S.W., Ph.D., M.D., etc.)

8. What are the sexes and ages of your children?_____
   _____

9. How often do you attend services at a church or synagogue?
   _____ More than once a week
   _____ Once a week
   _____ Two or three times a month
   _____ Once a month
   _____ A few times a year
   _____ Once a year or less
   _____ Do not attend services

10. What is your religious affiliation?
    _____ Catholic
    _____ Jewish
    _____ Protestant
    _____ Other (please specify):_____
    _____ None

Parents' Questionnaire on Family Communication

Part I

Directions: For each question, please check the answer that describes you best.

1. How much do you discuss human sexuality with your child(ren)?

_____ Not at all
_____ A small amount
_____ A medium amount
_____ A large amount
_____ A great deal

2. How comfortable are you discussing human sexuality with your children?

_____ Very uncomfortable
_____ Uncomfortable
_____ Neutral
_____ Comfortable
_____ Very comfortable

3. How comfortable do you think your children are discussing human sexuality with you?

_____ Very uncomfortable
_____ Uncomfortable
_____ Neutral
_____ Comfortable
_____ Very comfortable

4. Are you satisfied with the number of conversations about human sexuality you have with your children?

_____ Very dissatisfied
_____ Dissatisfied
_____ Neutral
_____ Satisfied
_____ Very satisfied

Part II

Directions: Answer the questions in this section by circling one of the five possible responses. Circle 1 for Never, 2 for Sometimes, 3 for Half the time, 4 for Usually, and 5 for Always.

		Never	Sometimes	Half the Time	Usually	Always
1.	When your children want to talk with you, how often are you able to clear your mind and really listen to what they have to say?	1	2	3	4	5
2.	When your children are talking with you, how often do you look at them, nod your head, and say "yes" or "I see" so they will keep on talking?	1	2	3	4	5
3.	When your children are talking with you, how often do you ask questions if you don't understand what they are trying to say?	1	2	3	4	5
4.	When your children are talking with you, how often do you respond to what they've said?	1	2	3	4	5
5.	When you talk with your children, how often do you ask for their reaction to what you've said?	1	2	3	4	5
6.	When you talk with your children, how often do you include statements like "My feelings are. . ." and "The way I see it. . ."?	1	2	3	4	5

Part III

Directions: Again, please answer these questions about your children by circling one of the five possible responses.

		Never	Sometimes	Half the Time	Usually	Always
1.	When you want to talk with your children, how often do you think they are able to clear their minds and really listen to what you have to say?	1	2	3	4	5
2.	When you are talking with your children, how often do they look at you, nod their heads, and say "yes" or "I see" so you will keep on talking?	1	2	3	4	5
3.	When you are talking with your children, how often do they ask questions if they don't understand what you are trying to say?	1	2	3	4	5
4.	When you are talking with your children, how often do they respond to what you've said?	1	2	3	4	5
5.	When your children talk with you, how often do they ask for your reaction to what they've said?	1	2	3	4	5
6.	When your children talk with you, how often do they include statements like "My feelings are . . ." and "The way I see it . . . "?	1	2	3	4	5

Part IV

Directions: Please read each statement and think carefully about whether it describes you. Then circle the appropriate number across from the statement. Circle 1 if you Strongly disagree, 2 if you Disagree, 3 if you are Neutral, 4 if you Agree, and 5 if you Strongly agree.

		Strongly Disagree	Disagree Somewhat	Neutral	Agree Somewhat	Strongly Agree
1.	I use everyday occurrences, such as TV shows, to begin conversations with my children about sexuality.	1	2	3	4	5
2.	I find opportune times, such as when I am taking my children on a 15-minute ride, to discuss sexuality.	1	2	3	4	5
3.	If I don't know the answer to my child's question about sex, I find the answer to give to him/her.	1	2	3	4	5
4.	Even if my children's questions about sex embarrass me, I do my best to answer them.	1	2	3	4	5
5.	I often seem to be too busy to answer when my children ask me a question about sex.	1	2	3	4	5
6.	If my children try to avoid discussions about sex, I encourage them to listen.	1	2	3	4	5
7.	When my children tell me their feelings about a sexual issue, I try to tell them my feelings too (such as my opinion about premarital intercourse).	1	2	3	4	5
8.	My spouse (or partner) and I talk with each other about our children's sexual development.	1	2	3	4	5

Appendix E

Attitude Questionnaire

Directions: Please read each statement carefully and think about whether you agree or disagree with it. Then circle the number which best describes your opinion about the statement. Circle the 1 if you strongly disagree, 2 if you disagree somewhat, 3 if you are neutral, 4 if you agree somewhat, and 5 if you strongly agree.

	Strongly Disagree	Disagree Somewhat	Neutral	Agree Somewhat	Strongly Agree
1. When parents feel real love toward their children, they show it.	1	2	3	4	5
2. Parents have the right to say what they believe about sexual intercourse between unmarried people, even if they know their children disagree.	1	2	3	4	5
3. I feel it is important for my children to develop their own opinions.	1	2	3	4	5
4. Parents should encourage their children to talk about sex when it's on their minds.	1	2	3	4	5
5. Parents have a right to close their bedroom door if they want privacy.	1	2	3	4	5
6. Children should be stopped from asking questions about sexual activity.	1	2	3	4	5

		Strongly Disagree	Disagree Somewhat	Neutral	Agree Somewhat	Strongly Agree
7.	When parents feel angry toward their children, they should show it.	1	2	3	4	5
8.	Parents should tell their teenagers what they feel is acceptable sexual behavior.	1	2	3	4	5
9.	Complete and accurate knowledge about sex is better than the bits and pieces children normally pick up.	1	2	3	4	5
10.	What parents do in the privacy of their bedroom is not their children's business.	1	2	3	4	5
11.	Children have a right to know how their parents feel about sexual issues.	1	2	3	4	5
12.	If parents aren't sure of their values on sexual issues, they shouldn't talk about them with their children.	1	2	3	4	5
13.	It is important for parents to listen to a child's questions about sex, even if the parents don't know the right answers.	1	2	3	4	5
14.	Even if my children are curious about sex, I don't want them to know the facts of life.	1	2	3	4	5

		Strongly Disagree	Disagree Somewhat	Neutral	Agree Somewhat	Strongly Agree
15.	If possible, both parents should be responsible for the sexuality education of their children.	1	2	3	4	5
16.	Only mothers should be responsible for the sexuality education of their children.	1	2	3	4	5
17.	When my teenagers and I discuss marriage and divorce, I make sure that they believe the same as I do.	1	2	3	4	5
18.	I think a young boy should be punished if he has a wet dream.	1	2	3	4	5
19.	It is unnatural for children to talk about their sexual feelings.	1	2	3	4	5
20.	Parents should not read a child's diaries and letters unless the child gives permission.	1	2	3	4	5
21.	Parents should not punish children for having sexual feelings.	1	2	3	4	5
22.	If my children said they wanted to be left alone, I usually would do so.	1	2	3	4	5
23.	Only parents who spend most of the day with their children should try to educate them about sexuality.	1	2	3	4	5

		Strongly Disagree	Disagree Somewhat	Neutral	Agree Somewhat	Strongly Agree
24.	Knowing all the right answers guarantees that a parent will be a good sexuality educator for the children.	1	2	3	4	5
25.	When parents believe their children's sexual behavior is too advanced for their age, they should let them know.	1	2	3	4	5
26.	Children have the right to be curious about sex.	1	2	3	4	5
27.	All members of the family must agree on all issues.	1	2	3	4	5
28.	If my child has a question about sexuality, I would make sure the question is answered as fully as possible.	1	2	3	4	5
29.	If my children's questions about sex were very specific, I would cut off the discussion as soon as I could.	1	2	3	4	5

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