Let’s talk about sex: A training program for parents of 4th and 5th grade children

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LET’S TALK ABOUT SEX: A TRAINING PROGRAM FOR PARENTS OF 4TH AND 5TH

GRADE CHILDREN

By

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Let’s talk about sex: A training program for parents of 4th and 5th grade children

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The purpose of this study was to construct a training program for parents of 4th and 5th grade children on how to initiate and maintain conversations about safe-sex and sex-related topics by using Beebe, Mottet, and Roach’s (2013) Needs-Centered Training Model. The main topics arising from the needs assessment include experiencing puberty, healthy friendships, and peer pressure/media influence. The need for better communication surrounding sex can be seen from rates of teenage pregnancy in the United States remaining higher than those of other developed countries (Martinez, Copen, & Abma, 2011) as well as adolescents accounting for only a quarter of the sexually active population, but half of the population acquiring new STDs (Martinez, Copen, & Abma, 2011). Although this study does not address pregnancy and STD prevention, it encourages parents to initiate open conversation with their children about sex-related topics and to maintain this conversation so future topics (such as those concerning participating in sex) are more comfortable for both parent and child. Providing parents with information on important and age-appropriate topics for their children, as well as how to best initiate and maintain open and honest communication, can better equip parents to feel prepared for conversations with children that encourage them to act responsibly when it comes to sex-related situations in the future.
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Introduction

As society becomes more sexualized, it becomes increasingly important to communicate with children and adolescents about sex. However, these discussions should not be as limited in scope as they have been in the past. Talking about the birds and the bees can no longer be limited to messages encouraging abstinence or only discussing condom use. Today, with the abundance of new media and technology, the permanence of electronic messages and photos (which may continue to exist online forever, even in cached pages), and the presence of a rape culture, the messages we send to our youth must be much more extensive.

Youth of today are faced with a sexual society that is extremely different than the one in which their parents and educators experienced while growing up. With the introduction of technology, cell phones, and online social network and dating sites, sexual messages and content have become more ubiquitous. Some minors have begun participating in what is commonly referred to as “sexting,” which is the use of text messaging to send sexually explicit photographs (Wastler, 2010). Online chat rooms, such as ChatRoulette, also provide internet users reporting to be 16 years or older (ChatRoulette, n.d.) with an interactive site that includes web-camera video, audio, and text. Kreps (2010) agrees with social media writers like Ingam (2010) that this site is used by exhibitionists, subjecting users of the site to nude images or videos. Kreps (2010) argues that the internet is the “ultimate look-but-don’t-touch medium” that offers “a pornographic emporium in the privacy of our homes…” (p. 207). Sites such as these serve as potential threats to youth as they may be faced with decisions they are not prepared to make. This was the case with Amanda Todd, a Canadian teen who committed suicide after being perpetually bullied. Much of the bullying seemed to stem from an incident in which she was
persuaded to reveal her breasts to an anonymous online chat user who captured her exposure and made the photograph public.

Not only is the changing media a concern that may contribute to child and adolescent sexual behaviors, but the number of pregnancies, STDs, and rapes reveal what may potentially be the outcome of our increasingly sexualized society. Although teenage pregnancies in the U.S. are reported as having fallen to all-time lows, presumably from an increase in messages promoting pregnancy prevention and contraception use (Martin, Hamilton, Ventura, Osterman, Wilson, & Mathews, 2012), the rates still exceed the number of teenage pregnancies in other developed areas of the world (Martinez, Copen, & Abma, 2011), such as Western Europe (Santelli, Sandfort, & Orr, 2008), indicating an area for improvement in our country. For instance, Martinez, Copen, and Abma (2011) report that the teen birth rate in the United States in 2009 was 39.1 births out of 1,000 and compared this to Canada’s 2007 rate of 14, Germany’s 2008 rate of about 10, and Italy’s 2005 rate of about seven (United Nations Statistics Division, 2008). As for contracting STDs, adolescents are at a higher risk than are adults; even though young men and women (ages 15-24) only account for a quarter of the sexually active population, they make up approximately half of the population acquiring new STDs (Martinez, Copen, & Abma, 2011). These numbers are indicative of the dire need to implement better safe-sex messages to the youth of the United States.

It is also evident through statistics surrounding rape and sexual abuse that our country needs better sex education. Statistics from the U.S. Department of Justice’s National Crime Victimization Survey (Truman, 2011) show that in 2010, there were over 188,000 victims of rape and/or sexual assault. However, it is difficult to know if this number is representative of the true number of rapes that occurred, as organizations may use differing definitions of rape and as
sexual violence is often unreported (United States Department of Justice Office on Violence Against Women, 2010). Although there are currently resources to help victims of sexual assault, it is important to address the issue where it begins (Christopher, 2012), which may include informing adolescents of what constitutes rape and the importance of consent.

The purpose of this study is to discover the messages about sex youth receive from their parents, and to identify what messages or information both youth and parents wish would have been included in these messages. This information will be used to develop a guide for parents to inform their children about sex and sexuality. The end goal is to satisfy the need for new educational programs regarding relationships and sex. This need for new programs has been expressed by a number of researchers (e.g. Boynton, 2007, Hirst, 2008, and Koyama, 2009). Findings from this study may help parents feel more confident in talking to their children about sex and may provide content for comprehensive messages regarding sex in general and safe sex in particular. In turn, children will be better equipped with the information and tools needed to navigate sexual situations in a safe and competent manner.

While there are currently other programs that focus on parent-child communication of sex-related topics, this program focuses on a younger demographic and does not discriminate training based on the child’s sex. The existing program most similarly related to this program is done without face to face interaction, encouraging parents to use CDs to guide them through information with their child. Although both the existing program and the current program cover similar topics, this program will allow the trainer to directly interact with the trainees, and possibly more importantly, with other trainees, allowing for them to discuss together the personal experiences they have had and what has or has not worked well while talking to their children.
Chapter One: Literature Review

Communication surrounding sex is not a new phenomenon. Nor should it be, as sex plays a pivotal role in human life, specifically in human reproduction. However, unlike for a number of other species, the motivating force for humans to participate in sex extends beyond creating offspring, and is many times focused on pleasure, which is evident through the prevalence of behaviors such as masturbation, oral sex, anal sex, and the use of contraceptives. Due to the array of reasons to have sex and the consequences of participating in sex (e.g. pregnancy, sexually transmitted infections - formally referred to as sexually transmitted diseases, emotional turmoil, etc.) it is important to discuss sex with pre-teens, as the majority of individuals first experience sexual activity as a teenager (Koyama, Corliss, & Santelli, 2009). The scope of this discussion should not be limited to simply talk about abstinence or the use of contraceptives, but should be all-encompassing, including information falling under the broader term sexual development. This includes information about sexually transmitted infections (STIs), pregnancy, consent, and masturbation, as well as areas outlined by Coleman and Roker (1998): potential impact on one’s reputation, sexual experimentation, and emotional outcomes. After all, views of sexuality are shaped through discourse (Elliott, 2012). If children are not participating in this discourse with their parents, it is likely talk about sex is happening outside the home.

Being such an important and controversial topic, sex has been the focus of research in both communication studies and health fields. These studies range in scope and depth, ranging from the sexual behaviors people practice, to what effects pornography has on viewers, to what sex scripts people typically follow. Specifically applicable to guiding this study is research pertaining to (1) how parents communicate with their children about sex, (2) how sex education is structured in schools, (3) where children get information and advice about sex, and (4) how
effective health messages can be constructed, and (5) what current programs exist for parents looking for guidance on talking to their children about sex.

**Parent-child communication about sex**

Although parents may view teenagers to be highly sexual or promiscuous, many parents insist that their children do not fall into this category, believing instead that their children are asexual (Elliott, 2012). Elliott (2010) explains sex is seen by parents as an “adult activity with adult consequences” (p. 24) and they continue to see their children as non-adults. This may be the primary reason explaining why a number of parents wait to talk about sex with their children until they leave for college, which may be seen by some parents as epitome of the transition into adulthood. Other parents may avoid talking about sex and contraceptives because of their religious beliefs, thinking that discussing contraception, in particular, interferes with the belief of waiting until marriage to engage in sexual activity (Elliott, 2010).

However, it is important to begin discussions about sex before adolescents leave for college, and potentially before they enter high school. Unfortunately, many teenagers become sexually active by the age of 18 (Carver, Joyner, & Udry, 2004, from Zimmer-Gembeck & Helfand, 2008); Eaton, Kann, Kinchen, Shanklin, Flint, Hawkins, Harris, Lowry, McManus, Chyen, Whittle Lim, and Wechsler (2012) surveyed high school students, of which 47.4% reported having had sexual intercourse (specifically, 63.1% of 12th graders) and only 60.2% of which used a condom during their most recent sexual encounter. However, it is not just high school students that are experiencing sexual activity. Mosher, Chandra, and Jones (2005) found that based on data gathered in 2002, 25% of males and 26% of females had vaginal intercourse by the age of 15 and that these statistics jump to 62% and 70%, respectively, by age 18. In low-income families, sexual experiences may begin at even earlier ages. Jordahl and Lohman (2009)
found that by Wave 2 of the *Three City Study* examining low income families, a quarter of the participants had engaged in sexual activity, with the average age of initial intercourse taking place at 12.77 years old. These statistics demonstrate a need for parents to talk to their children about sex and related subjects at an earlier age than they may currently be doing.

Many researchers have investigated the context and demonstrated the importance of parent-child communication about sex. DiIorio, Kelly, and Hockenberry-Eaton (1999) explain that the majority of early adolescents, both male and female, were more likely to have a conversation about sex with their mothers than their fathers. Although these teenagers were less likely to talk to their friends rather than their mothers about sex, they still preferred discussing the issue with friends over their fathers (DiIorio, Kelly, & Hockenberry-Eaton, 1999). An interesting thing to note about these findings is that although mothers were reported as being the preferred communication partner with whom to discuss sex, males reported being more comfortable talking to their fathers about sex, and both males and females indicated they were most comfortable discussing sex with their friends (DiIorio, Kelly, & Hockenberry-Eaton, 1999).

Although researchers support the finding that same-sex parent-child communication about sex is more common (DiIorio et al., 1999, Nolin & Peterson, 1992), researchers also find that cross-sex parent-child communication may be beneficial. Wright, Randall, and Arroyo (2012) studied the effect of parent-daughter communication about sex on recent sexual activity of females who watched the television programs *16 and Pregnant* and/or *Teen Mom*. Although the females’ communication with their mothers did not result in significant findings, communication with fathers about sex was found to affect sexual activity. Females who exposed themselves more often to television programs and had low levels of communication with their fathers were more likely to have engaged in sexual activity than those with high exposure to
programs and high levels of communication with fathers about sex (Wright, Randall, & Arroyo, 2012). Although mothers tend to discuss sex with their children more often than fathers (DiIorio, et al., 2000), it is important that fathers also join the discussion, both for the possible effects it has on daughters, and for increased comfort of discussion with sons.

Regardless of the gender dynamic of the communication, it has been demonstrated in several studies that initial intercourse among adolescents occurs later when they discuss sex and sex-related topics with their parents than that of adolescents who forego discussion (DiIorio, Kelley, & Hockenberry-Eaton, 1999) and the children who discuss sex with their parents also have fewer sexual partners (Holtzman & Rubinson, 1995, Leland & Barth, 1993). Additionally, youth who have discussed sex with their parent(s) have higher condom usage once sexually active (Holtzman & Rubinson, 1995; Miller, Levin, Whitaker, & Xu, 1998). As based on DiIorio, et al.’s (2000) findings, increased confidence in discussing sex, as well as believed positive outcomes of having such discussions, are associated with a mother’s increased likeliness to have discussions with her children about sex and related topics. Therefore, one aim of this study is to gather information for parents so they can learn about what their children would like to know about sex, and how to best share this information with their children.

**Sex education in schools**

Sex education in schools has been a hotly debated issue since its conception. Researchers, parents, politicians, and healthcare professionals have all added their opinions to this conversation and how it should take place (Eisenberg, Madsen, Oliphant, & Resnick, 2012). In recent years, sex education has continued to be a hot topic for debate. This debate has surrounded many aspects of sex education, such as what information should be included in sex education
curriculum, at what age it should be taught, who should teach it and how it should be taught (Koyama, 2009).

Perhaps the biggest controversy surrounding sex education has been the debate on whether comprehensive programs or abstinence-only programs should be introduced into schools. Recently, abstinence-only designed classes have begun to increase (from about 9% in 1995 to over 20% in 2002) while comprehensive education including information about birth control has decreased (from about 84% for females and 65% for males to 65% and 59%, respectively) (Lindberg, Santelli & Singh, 2006). Much of the reason for this switch is because Section 510 of the 1998 Social Security Act provides millions of dollars in grants for such abstinence-only programs (Eisenberg, Madsen, Oliphant, & Resnick, 2012; Trenholm, Fortson, Quay, Wheeler, & Clark, 2007). The Department of Health and Human Services (2008) reveal in their President’s Budget that $191 million was dedicated to abstinence education during that fiscal year alone. The abstinence only versus comprehensive sex education debate was given mass public attention as recently as March of 2011 when new legislation in North Dakota limited sex education to abstinence-only programs. The legislation attempts to limit teachers from discussing contraceptives and focusing instead on abstinence as the only foolproof way to avoid sexually transmitted diseases and unintended pregnancies (Associated Press, 2011). Montana is also currently in a heated discussion about sex education in public schools. A sex education bill has recently been drafted requiring written consent from parents before their children would receive any instruction in sex education, which is a change from the current situation in which parents who prefer that their children get information about sex at home can opt their child out of in-school sex education (Lundquist, 2013). The bill was passed by both the House and Senate but was vetoed by Montana Governor Steve Bullock (Billings Gazette, 2013). Although the bill was
ultimately vetoed by the governor, it is important to recognize the significance of being passed by both the House and Senate, demonstrating that many of the nation’s lawmakers continue to support abstinence-only education.

However, it is unclear whether decisions such as the one made for North Dakota, or opting out of sex education in school like some Montanans, is truly beneficial. Researchers have found that comprehensive sex education programs, or those that are “medically accurate, age-appropriate… education that includes information about abstinence and contraception,” (Koyama, 2009, p. 447) delay students’ participation in sexual activity, increase condom use, and reduce sexually risky behaviors (Kirby, 2002). The impact of abstinence-only education programs has been investigated, but results show no positive outcomes or change in sexually-related behavior, such as age at first sex, number of sexual partners, or abstinence during the past 12 months (Trenholm, Fortson, Quay, Wheeler, & Clark, 2007). Educators have concerns about abstinence-only sex education in schools, partially based on what they believe is, or is not, taking place at home. Eisenberg, et al. (2012) explain that many teachers report being frustrated with parents who denounce comprehensive education and think abstinence-only education is sufficient. One participant explained that:

It’s hard for us when parents are so adamant that they should be the ones teaching their kids about this stuff… but then they don’t… So if you don’t want me teaching it and you don’t teach it, they are going to learn it from someone, and wouldn’t you rather have it be me than that kid in the 3rd floor bathroom?...

(Community sexuality educator, Eisenberg, et al., 2012, p. 322)

Teachers’ frustrations with parents expressing support for abstinence-only programs may be the lack of supportive research on the benefits of such programs. According to Koyama
(2009) the age of initiation, number of partners with whom an individual engaged in sex, and condom or other contraceptive use are not affected by abstinence-only education. Some abstinence-only programs also promote virginity pledges, or making a promise to abstain from sexual activity until marriage (Rosenbaum, 2009). These pledges, however, have proven to be ineffective. Specifically, Rosenbaum (2009) finds that pledgers had similar numbers of sex partners as matched non-pledgers throughout their life, similar STD rates, and reported similar ages for the first time they had sex. However, pledgers were less likely than matched non-pledgers to have used condoms or other birth control during the past year (Rosenbaum, 2009).

Both pledgers and matched non-pledgers reported more conservative sex behavior than that of the general public (Rosenbaum, 2009). Rosenbaum (2009) argues that the pledge itself is unlikely to have made that difference, but may be what accounts for the lack of pledgers using condoms and birth control. Therefore, parents and educators may still want to stress abstinence, but may be of more help to students if a comprehensive-style sex education approach is taken. However, it is important to note that some teachers believe that even if they are able to teach comprehensively, there is not enough time to cover the range of topics they find necessary beyond the typical issues of birth control and sexually transmitted infections (Eisenberg, et al., 2012). In effect, some even believe that the switch to comprehensive sex education alone is not sufficient and only a “cultural shift around sexuality” can truly help (Eisenberg, et al., 2012, p. 325).

One of the challenges that teachers currently face is a lack of funding to both further their own knowledge of sex-related issues and to provide the most current resources to students (Eisenberg, et al., 2012). Sex education is also typically very limited, with health education courses mostly being offered for only a semester in both middle and high school, and even then,
sharing that time with topics such as nutrition and substance abuse (Eisenberg, et al., 2012). As education in schools may be limited in a variety of ways, the aim of the current study is to construct an effective health promotion message for parents unsatisfied with their child’s school-provided education to use in order to communicate a variety of sex-related topics and concerns to adolescents.

**Media as sexual influence**

Even if parents decide to withhold their children from sex education in schools, youth today are barraged with sexual messages; so many that Powell (2010) declares “these are times of an unprecedented sexualized, sex-crazed and sex-everywhere culture…” (p. 1). From messages they hear on the radio, to those they see on television or in films, sexual messages are everywhere in the media. The sexual messages portrayed through the media surround adolescents ages eight to eighteen, on average, more than seven and a half hours every day, and may be one of the most influential aspects of their lives (Rideout, Foehr, & Roberts, 2010). This time spent by adolescents consuming media has increased throughout the years (Rideout, Foehr, & Roberts, 2010), and with the abundance of media has come changes in the messages these media contain. For example, Hall, West and Hill (2012) explain that sexualization in music lyrics has increased drastically from 1959 to today. This change is especially prevalent in music by non-White artists whose music was more likely to include references to sexual activities such as intercourse or oral sex or the preparation to perform the activity (Hall, West, & Hill, 2012). Hall, West, and Hill (2012) explain that this may be due to the sociocultural norms and expectations that have surrounded non-white populations, referring to Bartky’s (1990, in Hall, West, & Hill, 2012) finding that non-white populations have been thought of as hypersexual and unable to control sexual desires.
The most popular form of media consumption among youth is television, which is viewed by adolescents for about four and a half hours each day (Rideout, Foehr, & Roberts, 2010). Eyal, Kunkel, Biely, and Finnerty (2007) argue that television shows that rated among the most popular in both 2001-2002 and 2004-2005 (such as The Simpsons, Friends, CSI: Crime Scene Investigation, and That 70’s Show, to name a few) contained high levels of what would be considered sexual messages, such as kissing, intimate touching, implied sexual intercourse, depicted sexual intercourse, or talk about sex. They also note that messages about risk and responsibility concerning sex were not often portrayed, with only 4% of shows in 2001-2002 and 5% of shows in 2004-2005 addressing risk and responsibility (Eyal, Kunkel, Biely, & Finnerty, 2007). Examples of risk and responsibility messages may include conversations about STIs and unintended pregnancies¹, which are the presumably the most common risks of engaging in sex. Although Callister, Stern, Coyne, Robinson and Bennion (2011) reveal that the frequency of sexual activities in top-grossing teenage films has not changed a great deal since the 1980s, they also acknowledge that the levels of sexual activity are continuously high and potentially detrimental. For example, 80% of the films analyzed revealed teenagers participating in sexual activities, while at the same time there is a dearth of scenes that include talk or references to safe sex practices such as practicing abstinence, using contraceptives or discussing STDS/AIDS (Callister, Stern, Coyne, Robinson, & Bennion, 2011). Teachers interviewed in Eisenberg, et al.’s (2012) study also recognize media as being a detrimental influence on youth’s sexual practices, explaining:

So what kids are viewing now [on television] is, it is pretty much okay to be sexually active. So you are almost talking to them about something that is pretty

¹ Examples of risk and responsibility messages are not provided by Eyal, Kunkel, Biely, and Finnerty (2007). These are examples of what one might reasonably assume would be defined as messages about risk and responsibility.
alien to them because no matter what you watch, even the commercials you watch, what you see in magazines, everything is geared towards sex. Because sex sells. So it makes it even harder for them to contemplate that you can say no…

(Sixth-grade to eighth-grade health teacher, Eisenberg, et al., 2012, p. 325)

Some researchers have even begun considering the media as a “super peer” because it can be so influential in what adolescents consider to be normal sexual behavior, especially if models of sexuality are not available in their own, real-life peer group, but rarely references potential risks or any need for birth control or responsibility (Strasburger, 2005; Strasburger, 2006. Brown, Halpern, and L’Engle (2005) find that girls who entered puberty at earlier ages than their peers were more interested in media such as books, movies, and magazines that contained sexual content. These girls were also more likely to infer messages from these media as supporting sexual activity among teens. The researchers speculate that this may be due to a lack of such information from peers, who have not reached puberty and have less interest in sex.

Teens have also revealed their positive feelings towards media as a sexual information source, citing that it is less embarrassing than talking to parents and more in-line with what they want to know (Bragg, 2006). Findings such as these are extremely important, since the information adolescents receive during their formative years have the possibility to act as the basis of their sexual beliefs and attitudes that may persuade their future sexual behavior (Eyal, Kunkel, Biely, & Finnerty, 2007) and play a role in their sexual development (American Academy of Pediatrics, 2001).

**Internet as a source if health and sex advice.** Individuals are turning to the internet for education and advice about sex (Boynton, 2007). This is not surprising, especially with teens, as they may find asking parents or doctors for advice to be awkward or uncomfortable. Over half of
teens in grades 7-12 report using the internet to find health information on an issue that either
themselves or an individual they knew was experiencing (Rideout, Foehr, & Roberts, 2010).
Jones and Biddlecom (2011) found specific examples of such situations in their exploratory
study of students using the internet for sex education. One such example displays how a
teenager’s discomfort talking to parents may lead them to find the information online:

   Like, I, this one time I had a question, you know? I didn’t really feel comfortable
   asking like my mom, ‘cause she was the only one around. You know, I was like, I
   went on the Internet and I was like, ―Can a girl get pregnant during her period?‖
   (Jones & Biddlecom, 2011, p. 115)

According to Jones and Biddlecom (2011), teenagers from their study had either been
exposed to or intentionally searched for information online about sexually transmitted diseases,
sexual anatomy, pregnancies, and pornography. However, this trend of gathering information
online is potentially dangerous. According to Boynton and Callaghan (2004), not all advice on
the internet is of high quality. Boynton (2007) argues that advice found on the internet can in fact
be “dangerous” (p. 314). Not only can the internet provide incorrect information, but many
teenagers report being involuntarily exposed to inappropriate, sexually explicit images and
pornography advertisements when looking up sex-related information online (Jones &
Biddlecom, 2011). Although most teenagers do not use the internet as their primary source of
information, but rather as a supplement to information gathered elsewhere (Jones & Biddlecom,
2011), it is important to note that if teens do not have alternative sources of information, they
may turn to online pages (Boynton, 2007). This could especially pose a problem as this is the
sole information for those who have not been exposed to it elsewhere.
The internet also proves to be problematic even when youth are not specifically searching for information on sex. Internet pornography is easily accessible to anyone who desires to see it. It can also be detrimental to youth who choose to watch it. Weber, Quiring and Daschmann (2012) found that adolescents who are exposed to a lot of sexually explicit media tend to believe that sex is more common at earlier ages and that the sexual behaviors they participate in are more diverse than they actually are. Males, specifically, tend to believe that a larger proportion of the general population participate in “pornography-like sexual activity” (p. 423) which included participating in sexual role playing and using a wider variety of positions during intercourse. If adolescents are mistakenly learning what are normative sexual practices, there may be increased potential for these adolescents to enact a certain behavior that their sexual partner is uncomfortable with, leading to possible physical, mental, or emotional harm. It is therefore important to create an effective health message that parents can share with children in order to increase awareness of sexually-related issues and minimize any chance for risk stemming from incorrect or misguided information.

**Effective health communication and promotion messages**

In the past several decades, the importance of health communication and health promotion has become an accepted and promoted concept. The National Cancer Institute and the Centers for Disease Control defines health communication as “the study and use of communication strategies to inform and influence individual and community decisions that enhance health” (National Cancer Institute, www.cancer.gov, p. 3). Health communication was first recognized in 1975 when the International Communication Association created the Health Communication Division (Kreps, Bonaguro, & Query, 1998) and has since been the focus of a plethora of studies. Health communication researchers have investigated the topic on
interpersonal, organizational, and institutional levels, have studied public health campaigns, as well as a number of other topics ranging from health disparities to patient compliance. The current study mostly concerns health communication on the interpersonal and public health campaign levels.

Many health messages surround us on a daily basis, and these messages have a wealth of potential effects, such as increasing knowledge or awareness, influencing beliefs, initiating action, or dispelling misconceptions (Kreps, Bonaguro, & Query, 1998) but not all messages make an impact on the way we live. According to Corcoran (2007), “the effectiveness of [health promotion communication] comes to fruition when the audience has achieved, acted on, or responded to a message” (p. 6). In order for messages to really come to fruition, they must also be constructed with the intended audience in mind in order to truly cater to the target audience’s values, understandings, and needs (Institute of Medicine Staff, 2002).

The effectiveness of health communication is also highly dependent on the use of two-way communication. Previously, communication was only thought necessary for health professionals to share information or findings, which many thought would be enough to change individuals’ behaviors (Bernhardt, 2004). However, it is now known that both the receiver’s access to and understanding of health information (Bernhardt, 2004) and their feedback to the communicator (Corcoran, 2007) is pivotal to health communication.

Although much research on health communication has centered on formal communication, such as mass media campaigns and interaction between patients and providers, Cline (2003) argues for more attention to everyday, informal communication and its effect on health. She argues that health messages are disseminated through our social networks and that these messages are beneficial and informative or detrimental and can reinforce risky behavior. It
is through everyday interpersonal communication and interaction that we construct reality which in turn, determines how we act (Cline, 2003). As everyday, informal interpersonal communication can have such an impact on behavior, it is important to consider how parents can occasionally interact and communicate with their children, even informally, about sex and related issues. It is also important to consider whether youth might be receiving informal communication from other sources that might reinforce risky sexual practices or habits and if so, how this can be combatted.

**Current Programs for Parents**

Fortunately, there are currently programs offered to help parents gain the information and comfort they need to talk to their children about sex-related issues and topics. The array of programs that are available cater to parents with children of different age groups and cover a number of different topics. The age groups that are targeted in these programs range from parents of children in the 4th grade to parents of children who are in high school. Some programs are specifically for parents while others offer training/classes in which both the child and parent are present. Topics are also quite varied, ranging from pregnancy and STD prevention, puberty, and relationships, to topics such as abstinence, risk awareness, and overall parent-child communication. Each program reports positive results in some area, such as increased knowledge about the specific topic, increased parent efficacy in communicating with children, children’s comfort communicating with parents, or at the very least an increase of communication between parent(s) and child(ren). Although these programs may prove to be beneficial to parents, the current study provides a training that differs from many of these programs as it aims to enhance parent communication with a younger population, is face-to –
face, and combines topics that have been deemed important by parents, students, and national standards. Provided below is a description of a number of the programs currently available.

One such program is *Talking Parents, Healthy Teens* that aims to improve parents’ communication with their children and includes information on building the parent-child relationship, particularly “adolescent development and new ways of communicating; listening skills for talking about sensitive topics; getting past roadblocks with talking about sex; helping your child make decisions, assertiveness skills, abstinence, and contraception; coping with conflict; supervising your child and how to stay motivated” (Advocates for Youth, 2008, paragraph 9). This program is specifically for parents of children who are in sixth to tenth grade.

Another program available to mothers is *Keepin’ it R.E.A.L.: Mother-Adolescent HIV Prevention Program*. This program is specifically designed for mothers with children between the ages of 11 and 14 and aimed to increase communication between teenagers and their mothers and delay the initiation of sexual intercourse. Specifically, the program also aims to prevent pregnancies and STDs/HIV. *Keepin’ it R.E.A.L.* is based in Atlanta and mostly serves African American adolescents and mothers. It is unclear whether additional topics (other than pregnancy and STD/HIV prevention) are covered in this training.

*Saving Sex for Later* is another program offered that aims to increase parent-child communication. CDs are provided to families with children in 5th and 6th grade. The CDs cover topics such as peer pressure, relationships, puberty, and delaying sex. Parents and children listen to the CDs together and talk about the topics. The goal of this program is not only to increase parent-child communication, but also to delay the onset of sexual activity. Although *Saving Sex for Later* provides similar topics as the current study’s program, it lacks face-to-face instruction and explanation of the issue that will be included in the proposed training, allowing the trainer to
provide immediate feedback and respond to any questions or concerns that arise surrounding the topics.

The final program available as an external resource (not a part of school-based sexual education programs) for parents is *Parents Matter!* This program is catered to African-American parents with children in the 4th and 5th grade and is also implemented in a number of African countries, such as Kenya. *Parents Matter!* focuses on providing parents with the tools they need to reduce their child’s risk behavior by covering topics such as positive parenting practices, risk awareness, and sexual communication. Although *Parents Matter!* aims to inform the same age group as the current study’s training, the demographic is different in that *Parents Matter!* is constructed for African-American parents while the current training is based on responses from most Caucasian participants. Programs catering to different demographics may have differing emphases. For example, in 2010, the birth rate for white women ages 15-19 was 31.9 while for black women of the same age, it was 51.1 (Martin, Hamilton, Ventura, Osterman, Wilson, & Mathews, 2012). Therefore, it may be more important to focus on the risk of teenage pregnancy when catering to an African-American population than with a majorly Caucasian population.

Although these programs have been tested and have positive outcomes in terms of reducing risky behavior, increasing parent-child communication, or increasing both parent and child knowledge about sexual topics, they do not meet the goals of the current study. Many of these programs are catered to parents of children who have already reached junior high (6th grade or older). The training produced for this study will be for late elementary-aged students, as research has shown the effectiveness of comprehensive sex education (which includes the use of age-appropriate topic education) (Kirby, 2001; Kirby, 2002; Koyama, 2009), and as the Sexual Resource Center for Parents (2013) emphasizes the use of introducing these topics early by
saying, “it’s best to start as soon as children begin getting sexual messages. And they start getting them as soon as they're born” (p. 8). The Sexuality Resource Center for Parents (2013) also explains that talking to children about their sexuality from the start can help the child as well increase the child’s trust in the parent, allowing him or her to approach parents at later ages when they have more questions about sex.
Chapter Two: Methods

In order to further understand the communication about sex that takes place between parents and children, a qualitative approach was used. This qualitative approach served as a needs assessment to determine the scope of the training developed for this project. Prior to administering the survey that acted as the needs assessment, permission to advance with the study was received from the Institutional Review Board (Appendix A). Information was gathered using a written needs assessment distributed to participants of two groups. Although written assessments may not be as engaging and interactive as face-to-face interviews or focus groups, they allow for more reflective responses (Lindlof & Taylor, 2011).

Parent-only and student-only groups consisting of 10 and 12 participants, respectively, participated in the needs assessment. Following their explicit consent to participate in the study (consent form is provided in Appendix B), participants were asked to respond to questions regarding a) the safe sex messages that they have communicated or that have been communicated to them (prompted to include information such as location, age of message receiver, topics covered, etc.), respectively, b) the perceived effectiveness of these messages, and c) what additional information they would have liked to be included in the message. The needs assessment questions can be found in Appendix C. Needs assessments are pivotal in developing training as every aspect of the training process depends on what needs the trainees have (Beebe, Mottet, & Roach, 2013). The needs assessment included open-ended questions with some prompting in order to get the most relevant and richest data possible.

After the needs assessment data were collected and analyzed, the current project followed the steps included in Beebe, Mottet, and Roach’s (2013) Needs-Centered Training Model (NCTM), which include analyzing the training task, developing training objectives, organizing
training content, determining training methods, selecting training resources, and completing the training plan.

The needs assessment was formatted using Adobe FormsCentral, an anonymous, online questionnaire site. Anonymity and online data collection is especially useful in research concerning personal and sensitive information (Coomber, 1997), such as sex. However, the needs assessment asked for basic demographic information to determine any patterns in responses. For example, those who report a religious affiliation may be more prone to include discussion of abstinence and the emotional effects of sex while those with no religious affiliation may be more apt to focus on the physiological aspects of sex. Gender of the parent may also affect what topics are believed to be important or comfortable to discuss, which may prove to be useful in suggesting during training which parent may be more impactful in delivering certain messages.

The qualitative information collected from the needs assessment was then coded using a constant comparison method (Glaser & Strauss, 1967), in which categories and themes were deciphered by comparing participants’ answers to each other until the data were saturated. The themes that emerged directed further research on the top selected sex-related topics reported by participants as being desired in the training session. Responses provided in the needs assessment also guided the choice of informational materials that were included in the training. Training will cover what topics the parent and student groups reported as wanting to include in sex messages as well as ways to introduce the topics and suggestions for the appropriate age to begin talking about each topic. The length of training also depended on the array of topics reported by parents and students as being beneficial in the needs assessment.
Participants

For this small-scale study, participants consisted of 22 individuals, 12 between the ages of 18 to 25 and ten age 26 or older who currently have a child between the ages of 10 and 20. The number of individuals participating in the study was limited due to the qualitative nature of the study. According to Kvale and Brinkmann (2009), interview-based (qualitative) studies typically consist of five to 25 participants. Only participants with a minimum age of 18 were allowed to participate due to the nature of the study.

Students. Of the “student” group of individuals age 18-25, nine participants (75%) were 18-20 years old, one (8.3%) was 21-23 years old and two (16.7%) were 24+ years old. Ethnicity in the student group was slightly more varied. Respondents were still predominantly (66.7%) Caucasian, with two participants (16.7%) identifying as Hispanic, and one participant each identifying as African-American (8.3%) and Arab (8.3%). Five participants (41.7%) reported having no religious affiliation, three (25%) reported being Protestant-Other, one (8.3%) reported being Muslim, two (16.7%) are Catholic, and one (8.3%) participant identified his/herself as Christian.

Parents. Of the parent group of those 26+ years old, one (10%) reported being 31-35 years old, one (10%) reported being 36-40, three (30%) were age 41-45, three (30%) were 46-50 years old, and two (20%) were 50 years of age or older. Half of these parents’ children were age 10-11, with the second most represented age group (20%) being 8-9, with 10% of children falling into each of the 12-13, 14-15, and 16-17 year old age ranges. Parents were predominantly (80%) Caucasian, with 10% of respondents identifying as Asian/Pacific Islander and 10% identifying as Native American. As for religious affiliation, half of participants reported
no religious affiliation, four (40%) identified themselves as Protestant-other, and one (10%) reported being Catholic.

**Procedures**

Student participants were recruited from a single section of COMM 111A, the Introduction to Public Speaking course, at the University of Montana. These students were offered extra credit for their participation, which was awarded to them upon completion of the needs assessment. As the assessment is anonymous, students were instructed to print off the final page of the questionnaire (a simple page consisting of a message thanking the individual for participating in the study) and turn it in to their instructor with their signature attached. The parent-only group consisted of a network sample of parents whose children attend local elementary, junior high, and high schools, ensuring that individuals have children between the specified ages. Demographics other than age did not influence the selection of participants but rather were gathered in order to provide insight on potential correlations.

All participants were asked to read and sign an informed consent form (Appendix B) before participating in the needs assessment (Appendix C). This consent form followed Lindlof and Taylor’s (2011) guidelines for informed consent and explained the voluntary nature of the study, detailed all of the potential risks of the study, and informed the participants why the study is taking place and what potential benefits the study may provide. This page also included my name and e-mail address and informed the participant when the study is likely to be completed. Participants will be welcomed to contact me at the end of the study if they would like to be informed of findings. The debriefing section included a warning about the type of questions that were asked and provided the participants with contact information of local organizations available to provide help to those who have experienced any sort of sexual trauma, including
sexual aggression or abuse. These organizations include the University of Montana’s Student Assault Resource Center, as well as St. Patrick’s Hospital’s First STEP. The National Sexual Assault Hotline number was also available for those affected participants who prefer to abstain from face-to-face meetings.

At the end of this introduction to the assessment, participants were directed to provide consent before proceeding, which they indicated by checking a box and providing the date. Once the participant consented to the study, they were directed to the needs assessment page, which included a set of instructions and required each question to be answered. For the parents with more than one child falling into the desired age bracket who were completing the assessment, they were instructed to discuss their sex communication experience with the older child. This was because parents with children on the younger end of the bracket may not have discussed any sex-related topics with their child yet, so there is more opportunity for discussion while reflecting on the older child. Upon completion of the assessment, a final page thanked the participant for their time and again reminded them of local resources in case of trauma and outlined the potential benefits of the study. All information collected was stored on the online questionnaire site and protected by a username and password only accessible by the researcher and the researcher’s advisor. Information will be kept until completion of the study and acceptance of the completed professional paper by the graduate school.

Once data determining parents’ and children’s needs were analyzed, this project continued through the remaining steps of the NCTM (See Figure 1). Based on the needs assessment responses, the training task was determined and analyzed. This included defining what topics will be included in the training and what skills parents need to have pertaining to each topic and communicating the topic to the children. Analyzing the training task also helped
determine the information that is essential about the main areas uncovered by the needs assessment, allowing the trainer to focus on what is most important given any time constraints. This step also helped determine the methods to be used to best teach each topic to the designated audience. At this point in the project, additional research was required to gain knowledge on the topics necessary for the training, as it is pivotal to understand the material you are teaching (Beebe, et al., 2013). This research was minimal as it was in order to provide an example of the information that would need to be included, and it is the responsibility of the trainer to conduct further research on each topic. In essence, the training task section of the NCTM acted as a blueprint of the actual training session.

FIGURE 1

Once additional research of sex topics was conducted, training objectives meeting Beebe, et al.’s (2013) four objective-writing criteria (objectives that are observable, attainable, measureable, and specific) were outlined. These objectives were put into place in order both to help guide the training but also as a means of determining the effectiveness of the training once
the session has concluded. Objectives concentrate on what trainees should know about the topics as well as how they can effectively communicate these topics. The training content follows from these objectives. This content is organized in an outline format in order to easily see what will be discussed in each section of the training.

After the training content was organized, training methods determined to be most appropriate for the audience were chosen to convey the information. These methods include lectures, discussions, and experiential activities (Beebe, et al.’s, 2013). A combination of methods are used in order to cater to various types of learners, such as visual, auditory, and kinesthetic learners, as well as field-dependent and field-independent learners. Using a variety of methods is also beneficial as each method has different strengths and weaknesses. This step was combined with selecting training resources, which include visuals such as PowerPoint presentations and short video clips that are to be used during the lecture section of the training. PowerPoint slides will aid the trainees by providing an outline of the information being shared. Brochures and other handouts were chosen in order to provide trainees with additional information and will be provided at the end of the training session with important reminders and tips for parents.

The next step in the NCTM was to complete the training plan. In this case, completing the plan equated to preparing a written plan that includes all the information covered during the training. In addition, the plan details what resources are needed for which topics, what teaching method is used for each topic, and approximately how long the training of that specific topic will take (Beebe, et al., 2013). A description of the training objectives is also be included at the beginning of the plan to help guide content and assure these objectives are being taken into consideration. This plan can be found in Appendix D.
A final assessment was created for the trainer to use post-training to determine the effectiveness of his or her training. This assessment consists of questions that reflect each training objective. The extent to which these objectives have been met will determine the effectiveness of the training. If training proves to be ineffective, future research may investigate whichever aspects of the training resulted in low assessment scores, and new content or new teaching methods may be substituted in order to increase overall effectiveness in these sections. These steps will be described in more detail as plans for the training will be highlighted in the next chapter.
Chapter Three: Results

Both youth and parent questionnaires produced helpful results which guided the direction of the safe-sex conversation training. Participant responses were coded using emergent themes.

Youth Questionnaires

Description of Safe Sex Talk. The youth questionnaire results revealed that 75% of students received some sort of safe-sex talk from their parents. However, those who did receive the talk from their parent(s), reported experiences that differed greatly from those who did not receive any safe-sex talk. For example, those who participated in the safe-sex talk reported differences in aspects such as their age when the talk occurred, what information was included in the message, and how they felt during the talk. The following statistics are based on the ten responses from the participants who participated in a safe-sex discussion with their parents.

For those who experienced a safe-sex talk, the age at the time of talk ranged from approximately eight to 16 years old, with the majority of participants (55.6%) reporting the talk occurring when they were between ages 10 and 13 (figure 2). One-third of the participants indicated that their mothers initiated the discussion, one-third reported their father’s initiation, and one-third indicated both parents were present during the discussion. Two respondents (22.2%) clarified that the same-sex parent facilitated the majority of the discussion.

Slightly fewer than half (44.4%) of respondents described feeling awkward or uncomfortable during conversations about sex and sex-related topics with their parent(s), and 22.2% even indicated interrupting their parent(s), telling them to stop or that they already knew the information. However, 22.2% of the respondents also explicitly indicated feeling comfortable with the conversation, although it is important to note that these two participants also indicated the earliest ages of talk initiation (at 8 and 9 years old). One respondent (11.1%)
also mentioned feeling as though the parents were trusting and open to being approached. Although reporting feeling awkward during the safe-sex conversation, one respondent (11.1%) indicated appreciation that the conversation took place.

**Description of desired safe-sex interaction.** Approximately 66.6% of participants who experienced some sort of safe-sex talk with their parents reported no need to change the way in which the conversation took place. One participant described her feelings as follows:

I think my parents did a good job. They had my mom talk to me and my sister and my dad talk to my brother. When we got embarrassed they stopped, and got us other information that was less embarrassing. Some parents can be too pushy and I think this makes some kids want to have sex just so they can prove their parents wrong or something. My parents respected our privacy, but also made sure we had the information. I would say they did a great job. (Youth Participant 7)

Two out of three (66.6%) participants who did not receive any form of safe-sex talk also reported not being upset at the lack of conversation. One of these respondents clarified that she was not upset because she had already decided to be abstinent and did not have any questions or concerns. However, suggestions for improving safe-sex talk interactions included using mostly same-sex parent-child interactions, including materials to give youth when they get uncomfortable with face-to-face interactions, refraining from being “pushy” (trying to control or dictate what their children may do) and respecting the child’s privacy, being more open and honest, removing the guilt associated with sexual thoughts, initiating the conversation and a younger age, and keeping an open mind that the child may choose to have sex instead of remaining abstinent.
My parents never talk about sex. It is not a subject that gets talked about. If they would of started younger it would of been more comfortable to talk about but I don't believe them communicating about it would have impacted my sex life.

(Youth Participant 12)

**Parents’ knowledge about technology and sex.** Just over 58% of respondents indicated at least one parent as being up-to-date on what youth face with technology and sex, such as sexting an online exposure and one participant (approximately 8%) said parents are only familiar with online exposure. One respondent (approximately 8%) provided no response. Although over half of the participants indicated parent knowledge of technology and sex, only one participant reported the topic being addressed in the safe-sex communication episode with parents.

**Where do youth get most of their information about sex?** Respondents included a variety of sources from which they believe youth get information about sex. The leading response, listed by 66.7% of respondents, is the internet. The second most cited sources, both listed by half (50%) of the participants are friends and media. School, or health education classes, was only listed by 16.7% of respondents, and porn was included by 8.3%. One respondent seemed to misunderstand the question and explained where s/he got information in the past, but the response was consistent with other participants’ answers, including friends, television, and internet as top sources. Interestingly, this participant included that s/he “never learned much in sex-ed class” (Youth Participant 11).

**Where did you first learn about sex, if not from your parents?** A variety of sources first educating participants about sex were listed, including parents (25%), friends (25%), classmates at school (16.7%), sex education class (16.7%), television (8.3%), school-unspecified (8.3%), and sexual abuse as a child (8.3%). Participants were allowed to indicate more than one
source, resulting in the summation of percentages equaling more than 100%. One participant who indicated sex education class as the first source of information regarding sex made note in the response section that it was not completely helpful, saying “I didn’t quite understand the mechanics because everyone was giggling during most of it…” (Youth Participant 4).

At what age do you think youth start having sex? Participants believe that youth start having sex between the ages of 12 and 20 years of age. Age brackets suggested by participants overlap, impeding a clean breakdown of estimated age at first sex. However, 8.3% of participants reported believing youth’s first sex occurred at 12-13 years of age, 8.3% said 13 years of age, 8.3% said 13-14 years of age, and 16.7% said between 14-15 years of age. Therefore, almost half (41.6%) of participants believe youth start having sex before the age of 16. One participant (8.3%) believed youth start having sex between 15-16 years old, 8.3% reported at 16 years old, and 25% said between 16 and 18 years old. The remaining participants indicated first sex occurs at 18 years old (8.3%) and between 18 and 20 years old (8.3%). Two respondents acknowledged media in their answer. One respondent explained, “I think a lot of people think that most teens are having sex really young at the age of like 15, but I believe that those [are the] teens that you see on T.V. and in your school who are pregnant are the few teens who made a bad choice when they were young…” (Youth Participant 7). Another respondent wrote, “I would say most youth these days start having sex at around the age of 14 or 15 because the media portrays it as so scandalous and such an adult thing to do that they feel the need to do that to be viewed as older and more mature” (Youth Participant 5).

Do you know anyone who didn’t talk to their parents about sex? If so, why do you believe that they did not talk with their parents? Although not all participants reported knowing an individual who did not talk to their parents about sex, reasons provided as for why
youth might not discuss sex with their parents included, discomfort (“I didn't. My parents didn't bring it up and I felt odd bringing it up. I was fine with what I learned in Health Ed.” (Youth Participant 2)), religious beliefs (“Yes, and I believe that it was because of their religious beliefs” (Youth Participant 5)), culture (“Yes I know [someone who hasn’t talked to their parents], because in some culture its (sic) really not respectful to talk about this topic with the parents or to be more specific, with the mother” (Youth Participant 3)), seeing your child as responsible, and assumed knowledge from other sources such as friends or health education classes. These last two themes were seen in the following responses:

I don't (sic) really ask people if they talked to their parents about sex, but I would guess almost all of my friends had at least limited talk about sex. What I've (sic) noticed is that the friends I know that have religious parents, they tend not to talk about sex with the children as much. Parents who come to the realization that kids will have sex are more likely to talk to their kids about it. I think even if parents aren't (sic) okay with their kids having sex as a teenager, they should accept that they might and teach them how to be safe about it. (Youth Participant 10)

I did not. Because my parents are older and I am a responsible guy they let me do what I want and you kinda just grow up learning from sex from your friends and it would just be awkward if they tried to talk about sex. (Youth Participant 12)

Do you know people who have misconceptions about any sex-related topics? If so, why do you think they have these misconceptions? The majority of participants responded saying they did not know anyone with misconceptions about sex-related topics. This is very surprising as (insert some research here). However, a couple respondents acknowledged that
although they do not personally know anyone with misconceptions, they are very aware that these misconceptions exist. Respondents who recognized this existence of misconceptions seemed to attribute them to lack of education. For example, one participant explained, “Yes, and I believe they have those misconceptions because they are not educated on sex and topics surrounding it” (Youth Participate 5). Another respondent said “… I’m usually floored that such ignorance exists. If they were never taught [these topics] then education can be the only effective tool to combat their ignorance.” (Youth Participant 11).

However, one participant seemed to believe that misconceptions are not necessarily the result of lack of education, but rather people’s desire to see things as they would like them to be in reality. This participate states, “A lot of times misconceptions are about crazy stuff or things they would like to believe is (sic) true. They are willing to believe anything as long as it aligns with what they want to hear.” (Youth Participant 12). Another participant explained that kids might be participating in sex at younger ages because of the misconception that their friends are doing it and they simply want to fit in (Youth Participant 7). Birth control was another area defined as containing misperceptions, particularly because of rumors of how different birth control work (Youth Participant 4). Overall, it was clear that although many participants did not know anyone with misconceptions, these misconceptions do exist among the general public.

**How might your parents have benefitted from a training course of additional material teaching them what topics their children need/want to hear and how to approach them?** Overall, participants defined a number of ways in which parents might have benefitted from training. Benefits included being more knowledgeable, particularly pertaining to the relevant and needed information, being up-to-date with topics and concepts, decreasing discomfort or nervousness, and knowing what to say and how to approach the topic with kids.
For example, Youth Participant 2 stated, “It would be good benefit. Because they will know more about different topics that might their children need to know about it by the right way. Also, they will be up to date with every topic that their children might want to know about it.” Some participants even remarked that had their parents gone through a training, they might have approached certain topics at earlier ages or changed the way they approached the topic, stating, “They might have brought up the sex topic earlier. I believe there gets to a point where it is just too late to have the sex talk…” (Youth Participant 12). One participant misinterpreted the question, replying that their parents would not benefit because they do not have young kids anymore, and another participant believe their parents would not benefit because they would feel hesitant to participate in the training because of their discomfort communicating about these topics with strangers.

**What would you want to see included in a course or written material for parents of 4th and 5th grade students?** Youth participants responded with many things that they would wish to see in a course or written material for parents of 4th and 5th graders. Of the comprehensive list provided for participants to choose from, only abstinence received fewer than half the participants’ votes to be included in material. One participant added the additional topic of “maintaining open and honest communication.” The topic most chosen by participants was experiencing puberty (91.7%), followed by healthy friendships (83.3%). Peer pressure and media influence, technology, sex and emotions, pregnancy prevention, initiating conversations, and materials were all desired by 66.7% of participants, while information on sexually transmitted infections was desired by 58.3% and masturbation, healthy relationships, and consent were desired by 50% of participants.
What would you like to see included in a course or written material for yourself?

When given a comprehensive list from which to choose topics they would like to see in a course or written material for themselves, the leading responses were healthy romantic relationships (83.3%), pregnancy prevention and information on sexually transmitted infections (75% each). Additionally, 66.7% included consent, 58.3% included sex and emotions and peer pressure and media influence, 50% included healthy friendships. Fewer than half of participants included masturbation and technology (41.7%), abstinence and experiencing puberty (25% each), and maintaining open and honest communication (8.3%). Two participants (16.7%) did not respond to this question.

How might a technological approach (such as creating an interactive website or game, such as the SIMS) help youth learn about sex? Of the 12 youth participants, 33.3% replied that a technological approach would not be helpful or did not include a response. Other respondents described a technological approach as being helpful by being appealing to younger kids (8.3%), making [learning about sex topics] more fun (16.7%), decreasing embarrassment (8.3%), and providing quicker/more accessible learning (8.3%). One participant said that a technological approach was not needed to the extent of making an interactive game, but that it would be nice to have a simple website to share with kids. Another participant (8.3%) explained that a technological approach might be specifically effective in educating youth about STDs. Overall, respondents seemed to support the idea of a technological approach, which can be seen in comments such as “Youth today often learn more quickly with proper electronic integration of the course material. I think it would be a great facet to their sexual education” (Youth Participant 11).
Parent Questionnaires

When did/will you have any sort of “sex talk” with your child? The majority of parents responding to the needs assessment have communicated with their child about sex in some form. One participant (10%) had enrolled her children in a church-sponsored sexual education class but has not yet talked to them quite yet, although she states she plans on doing this with her husband before her children enter middle school. Two respondents (20%) enrolled their child in the same program and followed up with children by helping them with the homework and readings that went along with the class. Sixty percent of participants replied that they had some sort of talk about sex at home. Examples of topics covered by these parents included body changes (20%), what sex is and what leads up to it (10%), and how babies are made (10%). Twenty percent of participants specifically responded that topics should vary depending on the age of the child. One participant described this in depth, as follows:

“At pre-school age, we spoke about differences between boys and girls and keeping bodies private. In late elementary (10 or 11 years old), we talked about puberty and body changes plus the "boyfriend-girlfriend", [in] late middle school we spoke frankly about sex, including what it means exactly, pregnancy risk, STD risk, condoms, birth control, emotional consequences, pretty much the works. None of the conversations were intentionally planned, they just sort of evolved out of a conversation.” (Parent Participant 9)

Only one participant (10%) responded as having not communicated with the child (who is 8-9 years old) at all about sex, but is trying to encourage him to ask questions by providing prompts that would allow a segue into a conversation about sex. Half of the participants said first talking about these topics took place around the age of 9 (or 4th
grade), one (10%) reported the child being seven years old, one (10%) reported the child being in preschool, and one (10%) clarified that it would happen whenever the child began asking, regardless of age. Twenty percent did not mention the child’s age during the interaction.

Most participants did not provide much detail about their sex talk beyond when it took place and what information was included, however, a number of participants did mention how the conversation was spurred and how the child reacted to the event. Thirty percent of participants reported having the conversation after a child asked about a sexual topic. One participant (10%) explained that a sexual incident that happened at a neighbor’s house required the participant to address the topic, and one participant (10%) said they “just evolved out of the conversation” (Parent Participant 9). In some cases, parents explained that the child showed discomfort (10%) or disgust (10%) with the topic. The parent mentioning the child’s discomfort explained that this discomfort seemed to decrease when the child (a boy) talked to his father (Parent Participant 5). Another parent explained that the child seemed to be less shy about sexual topics at a young age (9-10 years old) compared to now (12 years old) (Parent Participant 10).

**Do you think abstinence-only education or more comprehensive programs are more beneficial to youth?** All of the parent participants responding to the needs assessment described comprehensive sex programs as being more beneficial to youth and provided a variety of reasons for believing this. A number of parents who reported comprehensive sex education as being better than abstinence-only seemed to choose this because of the belief that teenagers will inevitably have sex. This can been seen in remarks such as “Abstinence only is a recipe for disaster” (Parent Participant 8) and “teenagers are going to have sex, they may as well be
educated about protection and emotional consequences” (Parent Participant 8). Sex being inevitable is also seen in the response from Parent Participant 2:

Absolutely a comprehensive program is more beneficial. Adults need to understand that the more accurate information the child receives will give him/her a broader base of knowledge to make smarter decisions for themselves. Most kids will not be able to resist the desires their hormone produce as they get older.

Abstinence rarely works -- as evidenced by scandals with priests in the Catholic church.

In their responses as to why comprehensive sex education is more beneficial, parents reflected the idea that the more one knows, the safer s/he can be. This can be seen in Parent Participant 2’s response above, but also from Parent Participant 3’s comment that “education is always better than ignorance when it comes to our bodies.” One parent also showed concern that his/her child may be teased by other children if s/he is not informed on the important topics (Parent Participant 4).

At what age do you believe youth should start receiving sex education? Many parent participants seemed to believe that starting sex education at an early age is beneficial. Twenty percent of participants indicated that sex education can start at any age with age-appropriate topics (another 10% clarified that these age-appropriate topics should start in preschool), and 20% of participants indicated that sex education should start as soon as children start inquiring about the topic. Thirty percent of participants indicated that sex education should start earlier at home than it does at school (10% indicated it should be present throughout childhood, 10% indicated it should start around age 7-8 years, and 10% did not clarify a specific age). The latest age indicated by parents was age nine, showing that parents believe children should start learning
about sex related topics at an early age. This sentiment was apparent in responses to other questions in the needs assessment, as well, such as Parent Participant 10 stating,

We have been talking about sex since my daughter was very young. Age appropriate answers to questions started very early... Specifics about sexuality and puberty were initiated by my daughter off handedly so I jumped on the opportunity to talk to her when she did. She was much less shy about it at 9 and 10 than now at 12.

Where do you think most youth get their information about sex? Although the parent participants clearly supported talking to their children about sex, only 20% reported believing that this is where most youth got their information about sex. Seventy percent indicated that youth probably get their information from peers or friends, 30% indicated they got information from each school, internet, or other media, and only one participant (10%) believe information was received from classes or books. Parent Participant 8 demonstrated a mix between wishful thinking and reality when s/he replied, “hopefully parents and school, but friends and TV/internet are probably taking that role more and more.”

Describe what you would think would be the most effective setting for a safe sex conversation. Parents provided an array of themes for what would make an effective setting for a safe sex conversation. One of the more prominent themes was parents’ belief that the conversation should be initiated by the child or should flow naturally from a situation, seen by the responses below:

I think the most effective setting is when it is a natural conversation and not forced or planned ahead. If kids are comfortable enough with their parents or
another adult that they trust, the conversations would be more natural and comfortable and props can be added if questions arise. (Parent Participant 9)

I think you can never start too early. Age appropriate conversations can happen any chance there is an opportunity. When kids ask (sic) questions or bring things up or your (sic) watching a movie with sexual or romantic content, all can be times to have a conversation about sex. (Parent Participant 10)

Some parents indicated that the most effective setting would be with parents, others indicated it should be a “trusted adult” (Parent Participant 8), while others thought that a formal program would be preferred, specifically if it were mixed gender, like-aged youth, led by someone “young”. Topics that parents would like to be covered include protection, STDS, oral sex, human biology, puberty, feelings, and birth control. While a number of parents indicated a desire to keep information age appropriate, one parent said that questions should be addressed regardless of the age of the child or the topic. Parent Participants 5 and 9 also indicated the use of additional items, such as props, books, or other resources may also add to the effectiveness of a sex-related talk setting.

**How might a training course for parents that identified specific sex education topics and ways to introduce them would be beneficial to you as a parent?** One respondent did not answer how a training course would benefit the parent and one respondent replied that a training course was not necessary. However, other parents seemed open and supportive of training, offering potential benefits such as knowing how to introduce or approach topics, decreasing awkwardness, keeping up to date on issues, and filling in the gaps. One specific response demonstrated these benefits well:
It is always helpful to have training sessions to give us tools we may not think of for anything we do. Training sessions for sex topics are uncomfortable sometimes and learning ways to talk about it and answer questions that take some of the awkwardness out of it would be helpful. Also, to keep up on what is going on with education, sexual practices by age demographics so we can be prepared and understand what is going on sexually these days vs when we were kids. (Parent Participant 10)

Another parent commented that a training course would be beneficial by providing parents with necessary support (Parent Participant 5). However, Parent Participant 2 responded that a training course, personally, was too time consuming but resources such as a short online training video or pamphlets about how to discuss topics with children would be more beneficial.

**What would you like to see included in a course like this?** All ten participants indicated they would like to see the topics of puberty, healthy friendships, and peer pressure/media influence in a training course. Ninety percent of participants also indicated they desire the inclusion of the topics of healthy relationships, sex and emotion, masturbation, how to initiate conversations, and would like materials to provide to youth. Information on STDs, pregnancy prevention, and consent were only desired by 80% of participants, followed by information on abstinence and sex and technology desired by 70% and information on the financial cost of children being desired by 10% of participants.

**How might a technological approach (such as creating an interactive website or game, like the SIMS) help youth learn about sex?** Out of the eight responses received for this question, 87.5% believed it would be helpful in some way and 12.5% were unsure about how it
would be beneficial. Those who provided insight into how it may help youth included that it could be more comfortable and therefore increase learning of information (Parent Participant 1), would allowing kids to access information on their mobile devices in a comfortable location, away from parents (Parent Participant 2), could act as a conversation starter (Parent Participant 4), is already a way in which kids are accustomed to learning (Parent Participant 6) and getting information (Parent Participant 10), and it could make it more accessible, less intimidating (Parent Participant 10), and more interesting (Parent Participant 7). A number of parents implied that face to face conversation with parents is still the optimal choice (Parent Participants 4 & 6) but that a technological aspect would be a nice addition or the second best substitute. For example, Parent Participant 6 stated, “It would be useful as our kids are so accustomed to learning things in this fashion, but it would be helpful to followup (sic) with face to face conversation about it.” One participant showed enthusiasm and provided the additional idea of creating an app in her response, “… PLEASE do this. Make it an app too so kids can play/watch on their mobile devices instead of at their parent’s computer in the living room. Also, don’t discount young adult novels that are already available” (Parent Participant 2).
Chapter Four: Training Plan

Develop objectives

Based on the responses to the needs assessment questionnaires distributed to parents and students, three topic areas appeared to be prominently desired for inclusion in a training program for parents of 4th and 5th graders. These topics were puberty, healthy friendships, and peer pressure/media influence. Once these topics were chosen, objectives were developed to specify what behavior trainees should be able to display or perform after training completion. The objectives constructed include:

General
1. Parents will experience an increase of at least one point of self-reported confidence (measured on a 1 to 5 Likert-type scale, shown in Appendix E, before Session I and after Session III) in their knowledge of important sex-related information relevant to their 4th and 5th grade child(ren).
2. Parents will experience an increase of self-reported confidence (measured on a 1 to 5 Likert-type scale, before Session I and after Session III) in their ability to share the aforementioned important sex-related information with their 4th and 5th grade child(ren).

Puberty
3. Parents will be able to accurately list and describe three out of five major changes discussed that girls experience during puberty.
4. Parents will be able to describe a potential scenario of when to initiate conversations about puberty that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).
5. Parents will be able to accurately describe four out of five major changes that boys experience during puberty.

*Healthy Friendships*

6. Parents will be able to describe a potential scenario of when to initiate conversations about healthy friendships that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).

7. Parents will be able to list and describe four out of five characteristics of healthy friendships.

*Peer Pressure/Media Influence*

8. Parents will be able to and describe four out of five ways in which children are influenced by peers and media.

9. Parents will be able to describe a potential scenario of when to initiate conversations about peer pressure/media influence that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).

**Assessing objectives.** Beebe, Mottet, and Roach (2013) emphasize the need for objectives to be attainable, observable, measurable, and specific. The above session-based objectives meet these criteria in a number of ways. By expecting approximately an 80% retention rate of information, objectives are attainable. It cannot be expected for trainees to recall 100% of the material covered during a training session, yet only being able to recall slightly more than half of the information presented simply cannot be deemed an indicator of a successful training.
Objectives are also measurable when they provide a minimum percentage of information expected to be presented correctly as trainers can review answers and determine whether the 80% minimum was achieved. Prompting trainees to partake in a particular behavior (such as listing and describing) makes objectives specific, making it clear to trainees what they are expected to do to meet each objective. Lastly, as these objectives are to be met in writing, they are all observable. It is easy to determine by reviewing answers whether or not trainees have understood the material presented.

The general objectives also meet Beebe, Mottet, and Roach’s (2013) criteria for objectives, although in different ways. Beebe, Mottet, and Roach (2013) suggest that objectives specify observable behavior, since emotional states are difficult to assess. However, there are times in which the desired change for trainees is attitudinal. For this reason, trainees will be asked specifically how they would rate their confidence in (a) their knowledge on topical content and (b) in their ability to share this information with their children. Although the trainer is unable to infallibly assess trainee confidence through observation, trainees are able to determine and report their level of confidence to trainers, who can then compare pre-session confidence levels to post-session confidence levels, making the objectives observable. Using a Likert-type scale and stating trainees will be able to report at least a one-point increase in self-reported confidence also makes these objectives measurable. A one-point increase is also quite specific and attainable, as increased knowledge in subject areas typically makes individuals more comfortable talking about that subject. For example, King and Smith (2000) found that after attending a training program on suicide prevention and intervention, trainee’s perceived knowledge was positively associated with their perceived efficacy in performing tasks related to prevention and intervention. As the popular adage states, “knowledge is power.” Sharing stories and
recommendations with parents who also have children in the same age bracket may also help parents feel more comfortable with talking to their children.

**Organize training content**

Content to be delivered during the training is based on what parents will need to know in order to accomplish the above objectives. Topics do not need to be discussed in any particular order as they are separate and knowledge of one particular topic is not necessarily needed in order to understand other topics. However, peer pressure/media influence and healthy friendships will be discussed consecutively since both directly relate to relationships with peers. It may be beneficial to introduce the topic of puberty last, as it is likely the most uncomfortable topic of the three. Structuring the training in this way allows parents to become comfortable and confident conversing with their children with important topics before introducing topics that may increase discomfort.

Each section (healthy friendships, peer pressure/media influence, and puberty) will contain a short section including essential information on the topic. For example, the section on puberty will include specific changes (physical and psychological) that youth go through. However, the majority of each session will focus on how to initiate and maintain the conversations parents have with children to discuss and explain this information. Initiating and maintaining conversations will be given more attention than informing about facts as parents typically report a high level of discomfort talking about sex-related topics with their children. In a study by Mcneely, Shew, Beuhring, Sieving, Miller, and Blum (2002), 80-90% of mothers agreed or strongly agreed that they were uncomfortable talking to their child about sex (32.8% and 51.1% strongly agreed or agreed, respectively, concerning talking to their son while 42.9% and 46.1% strongly agreed or agreed, respectively, concerning talking to their daughter).
This section of the training will include the opportunity for trainees to learn how to approach topics, decrease the discomfort of talking about topics, and receive support from other parents/trainees. Parents responding to the needs assessment questionnaire stated these things as what may be enhanced by a training program.

Determining training methods

While determining the methods to be used for training, it was necessary to keep in mind the demographics of trainees. Most importantly, the training is intended for parents of children who are currently, or who soon will be, in 4th or 5th grade. In most cases, parents will be at least 30 years of age, making for an audience of adult learners. As trainees will all be adults, andragogy was one of the main concepts used to guide the choice of training methods used. According to Merriam (2001), there are five assumptions essential to andragogy. She explains that an adult learning is an individual who

(1) has an independent self-concept and who can direct his or her own learning,
(2) has accumulated a reservoir of life experiences that is a rich resource for learning, (3) has learning needs closely related to changing social roles, (4) is problem-centered and interested in immediate application of knowledge, and (5) is motivated to learn by internal rather than external factors. (p. 5)

Beebe, Mottet, and Roach (2013) believe these assumptions may help trainers construct a training with the learner’s perspective in mind. These assumptions can be applied to the current training in a number of ways. Adults are able to direct their own learning because they know what deficiencies they have and what needs to be done to combat the deficiency, making them less reliant on instructors (Beebe, Mottet, & Roach, 2013). Since parents attending the training do so because they are aware of their discomfort or lack of knowledge on sexually-related topics
and see it as a problem, the trainer does not have to discuss too in depth explaining why these
topics are uncomfortable yet important, although minimal time may be dedicated to this
discussion in order for trainees to know they are not alone in their discomfort.

Since adult learners have much life experience, they bring skills that younger individuals
may not have. This allows the trainer to begin at a more advanced level (Beebe, Mottet, &
Roach, 2013). It can prove beneficial for a trainer to draw upon this life experience to increase
comprehension or empathy. For example, during the session on puberty, trainees may be asked
to recall some of their own experiences, or experiences of peers, when they themselves were
going through puberty. Then the trainer may also challenge the trainees to think how their
children’s experiences may be similar to their own, but also how changes in society may
differentiate their children’s pubertal experiences.

The third assumption Merriam (1991) includes the adults’ needs being related to a change
in social roles. Beebe, Mottet, and Roach (2013) phrase this assumption differently, suggesting
the training be “meaningful and directly related to the trainees’ lives and the problems they
experience on a daily basis” (p. 33). Either way, the information being shared needs to be related
and meaningful to the trainees’ needs. In this training, parents already realize the meaningfulness
of the material as they have opted to attend the training (versus being required to attend, as many
adults are for occupational reasons).

Considering the fourth assumption, parents may be interested in training because they see
their child’s lack of sexual education as a problem and wish to immediately apply what they
learn in training (how to talk to their children and some important information to include) to
remedy the problem. The fifth assumption is also relevant to this specific training, as it is likely
that most parents are motivated to attend the training session due to their desire to connect with their child(ren) and be able to comfortably discuss sexual topics with the child(ren).

These assumptions are essential to the structuring of a training program, but are not the sole aspects of adult learners on which one must focus. Glass (1994) argues that older learners have unique needs that require modification of training programs. Although the research emphasizing meeting these needs by focusing on factors such as structure, motivation, organization, familiarity, and time seem to be based on teaching adults upwards of 60 years of age, Callahan, Kiker, and Cross (2003) argue these factors may be important for learners of any age. Indeed, one of the criticisms of andragogy poses consideration of whether the assumptions made of adult learners are actually characteristics of only adult learners (Merriam, 1991). Houle (1996) suggests that the significance of andragogy is the focus on encouraging educators to “involve learners in as many aspects of their education as possible and in the creation of a climate in which they can most fruitfully learn” (p. 30).

Regardless of age, then, it is important to continue to take the factors of structure, motivation, organization, familiarity, and time into consideration. In this training, content is arranged to graduate from more comfortable to more uncomfortable topics to allow for structure in which parents can build new methods of introducing and communicating topics in addition to previous methods. This also relates to organization, as the material is logically arranged. Beebe, Mottet, and Roach (2013) provide this sort of arrangement of information as one method of teaching trainees, stating that sometimes it is necessary to teach simpler skills or concepts before the more complex information can be shared. Organization is also demonstrated through the use of an introduction (including a preview), a body, and a conclusion which reviews training highlights.
Information is inherently motivational as it is relevant to all parents attending, as they have at least one child experiencing the challenges covered throughout the training sessions. However, to motivate trainees to learn, the training plan will also incorporate set inductions (Beebe, Mottet, & Roach, 2013). Beebe, Mottet, and Roach (2013) provide a host of set induction techniques, including demonstrations, analogies, quotations, and statistics, but this training will use a few other techniques they mention, such as stories and rhetorical questions. Stories will clearly demonstrate what types of problems or situations their children face, while rhetorical questions will provoke them to recall their own experiences and/or put themselves into their child(ren)’s shoes. These set inductions will be used throughout the training in order to keep attention from fading (Beebe, Mottet, & Roach, 2013). Variation of stimuli will also be used to maintain trainee interest. This variation will take place through changing training methods (such as moving from a lecture to a discussion) as well as using movement and vocal variation (Beebe, Mottet, & Roach, 2013).

Familiarity will be incorporated into training by again having parents reflect on their own experience of puberty, sex conversations with their parents, and any experience they have had thus far talking to their own child(ren). This will take place both through the use of rhetorical questions and discussion. Lastly, time will be well-organized to give trainees an adequate period to discuss, analyze, and practice methods of sharing information and getting feedback from other trainees. Lectures will be kept short, at approximately fifteen minutes. Discussions will be longer, at approximately 25-30 minutes, so trainees may each have the opportunity to share their own opinion and to respond to others’ opinions. This leaves a generous 15 minutes for the introduction and conclusion sections, in case there are any questions or concerns the trainer must address, and also to allow for time for trainees to complete the training evaluations.
Beebe, Mottet, and Roach (2013) offer three main training methods: lectures, experiential activities, and discussions. Although the current training aims to incorporate all methods, the primary methods used are lectures and discussions. The desire to use all types of training methods has much to do with catering to different learning styles. Beebe, Mottet, and Roach (2013) outline three perceptual learning differences that may be apparent between individual learners. The perceptual learning modalities are visual, aural, and kinesthetic.

Visual learners are those who process information best when they read or view it (Beebe, Mottet, & Roach, 2013). To aid these types of learners present at the training, materials such as PowerPoint and flipcharts will be used. PowerPoint will be introduced mostly during lecture sections, where information is already carefully chosen and constructed, while a flipchart will be used to write down ideas and suggestions during discussion. Alternatively, aural learners intake information best when they are able to hear other’s explanations and articulate concepts in their own words (Beebe, Mottet, & Roach, 2013). For these learners, opportunities for discussion will be provided and information on PowerPoints will also be presented orally.

Lastly, kinesthetic learners do best when given the opportunity to take a “hands-on approach” (p. 42). These learners will be given the choice on participating in role playing scenarios in which they interact with another trainee, alternating between the parent and child role, to help prepare for the real-life scenarios they may experience while attempting to talk with their child(ren) about puberty, healthy friendships, and peer pressure/media influence. Trainees may also take time to practice using the worksheets provided to parents to complete with their children so they feel prepared when it is time to complete these worksheets with them. Experiential learning is very important and gives trainees a chance to practice the skills they
need to actually perform, yet still receive feedback from the trainer (Beebe, Mottet, & Roach, 2013).

**Selecting training resources**

As trainees will likely have differing learning styles, and as these different learning styles call for differing resources, this training requires a number of materials. One major resource or material that will be needed for the training is PowerPoint or a similar presentational aid such as Prezi. This will be needed in order to present the basic information being discussed orally for those who are visual learners. Presentational aids should be constructed carefully, with attention to how much information is being included on each slide, image symmetry, the use of animation and sound effects, color choice, design theme and layout uniformity, and slide/image versus allotted time (Beebe, Mottet, & Roach, 2013). An example of an appropriate PowerPoint slide can be found in Appendix F. This slide should not use, or should limit the use of, animation and sound effects as too much of these types of additions may prove to be obnoxious (Beebe, Mottet, & Roach, 2013). Rotondo and Rotondo (n.d., in Beebe, Mottet, & Roach, 2013) suggest that trainees do not use more than two slides per minute to prevent an overwhelming use of slides which ultimately makes comprehension suffer.

Trainers using the PowerPoint or Prezi aid must consider not only the construction of the aid, but also the incorporation of it during the training. All presentational material should be tested prior to training, trainers should be sure that lighting is conducive to the presentation, and should be aware of concealing presentation information when it is not needed (Beebe, Mottet, & Roach, 2013). Beebe, Mottet, and Roach (2013) stress that trainers should be prepared with a backup plan in the case that the needed technology is not functioning correctly.
A flipchart, or if preferred a dry erase board, along with multiple writing utensils (in case one malfunctions) is also needed for this training. This chart or board may also be used as a backup if there are technological difficulties with PowerPoint or Prezi, but will mainly be used to keep track of trainee input during discussion and brainstorming. Trainers should test markers for function and readability (is the color dark enough for participants to see?) prior to training.

**Participation Guide.** A participation guide will be passed out to trainees as the beginning of the training session. This guide will include an agenda for the training as well as the notes and materials trainees need for the series of training sessions. A copy of the PowerPoint slides will be provided with additional space for trainees to take supplemental notes regarding information on the session’s topic. Handouts for parents to use by themselves, with their child, or to provide to their child for his/her sole use, are included, as well (see Appendix G, H, and I for example handouts).

The handout for parent-child interviews is meant to help open up general conversation between parents and children and make them more comfortable with each other. One respondent expressed in her response in the needs assessment that “having an open dialogue with your child on ANY subject matter is healthy” (Parent Participant 4). The interview handout would help parents initiate open dialogue about things other than sex and things loosely related to sex, which may help children feel comfortable with talking to their parents about other things that are more sex-related as well. Also, ongoing dialogue may be beneficial as it “closeness between parents and children, and decreases the risk of problems such as unhealthy relationships, unintended pregnancy, and sexually transmitted infections” (Sexual Resource Center for Parents, 2013, p. 6).
As for the analogy handout, it provides a way for parents to talk about puberty in a new way. Just as the trainer should use multiple methods to cater to differing training styles, so too should parents use a variety of methods in teaching their children about sex-related topics. Comparing a new concept to an old concept may also help youth understand the new information, since they had a preexisting structure or idea (Joyce & Weil, 1986) in which to build upon.

The list of tips for talking with children will be provided as a reminder of suggested ways to have discussions with children. Providing this handout allows parents to refer back to information covered during the session they may have forgotten about over time.

**Completing training plan**

During this step of the training development process, trainers are encouraged to create a comprehensive, written plan of the training. This will include how the training will be organized and presented, detailing what the objectives are, what methods will be used for each section of the training, what content will be included, what (and when) resources will be needed, and the amount of time that will be dedicated to each section of the training. An example of what this training plan will look like is provided in Appendix I.

**Elements of a training plan.** Training plans may come in a variety of formats (descriptive, outline, and multicolumn, according to Beebe, Mottet, and Roach (2013)). The most structured formats will contain a number of elements, including time, content, method, and materials (Beebe, Mottet, & Roach, 2013). Time refers to how long the training session will take, total, but also how much time will be spent on each aspect or lesson within the training. Content refers to the information that will be shared in each section of the plan, and although it does not need to be written verbatim, should contain a decent amount of detail. The method aspect of the
training plan describes how trainers will be sharing information with the trainees (lecture, discussion, role plays, etc). Finally, materials identifies what is needed during each specific section of the training. This is the portion of the plan that will inform the trainer when items such as PowerPoint (and specific slides), flipcharts, or handouts will be needed.

**Topics.** The topics covered in this training will include healthy friendships, peer pressure and media influence, and experiencing puberty. These topics were chosen based on their prominence in the list of desired topics, reported by both adult and youth participants responding to the needs assessment, for training provided to parents of 4th and 5th graders. The National Sexual Education Standards also reflect these topics as important for children between the 3rd and 5th grades. This choice, especially with puberty, is also seen as corresponding well with how Parent Participant 9, who takes an age-appropriate approach, talked to his/her child: “At preschool age, we spoke about differences between boys and girls and keeping bodies private. In late elementary (10 or 11 years old), we talked about puberty and body changes plus the "boyfriend-girlfriend", In late middle school we spoke frankly about sex, including what it means exactly, pregnancy risk, STD risk, condoms, birth control, emotional consequences, pretty much the works. None of the conversations were intentionally planned, they just sort of evolved out of a conversation.” It is also apparent through Parent Participant 5’s description of what prompted the sex talk with her child why it is important to talk about peer pressure:

We were all a friends place for a BBQ and there were 6 kids. Two of the kids were visiting [from] Cali who had just recently moved to Portland. We met them that evening, ages 7 and 12 1/2. The 12 1/2 yr old had a girlfriend that he had just said goodbye to in Cali a few months back. He was very verbal about it and open to all. He really missed her and was quite open about it to all of us adults. We
found it to be sweet. The kids went down to the basement and played for a bit.

While there, an 8 yr old girl and 11 yr old girl were also there (it was their house).

The 12 1/2 yr old from Cali told our son to get atop the 8 yr old and move his bottom up and down.

This is probably something that the 8-year-old would not have done unless persuaded by the other child. Therefore it may be helpful to discuss with children what peer pressure is and how they can resist it.

The training for each of these topics will begin with a 15-minute lecture updating the trainees on important and relevant information pertaining to the topic and will be followed by a 30-minute discussion of how to best initiate and maintain conversation about these topics with children. Appendix J includes a sample training plan that covers the introduction of the training, the section pertaining to puberty, and the conclusion of the training.
Chapter Five: Summary

Interestingly, when participants were asked what topics they would most like to see in a training course for parents with 4\textsuperscript{th} and 5\textsuperscript{th} grade children, both parents’ and students’ top three topic choices were experiencing puberty, healthy friendships, and peer pressure/media influence. What is more interesting yet is how these top topic choices resemble suggested topic areas for 3\textsuperscript{rd} to 5\textsuperscript{th} graders in the National Sexuality Education Standards (NSES). It is suggested by these standards suggest that students falling within this age range should be able to understand issues regarding puberty, such as the changes (physical, social, and emotional) that occur, how it is normal for these changes may take place at different times for different people, and that puberty is the process that prepares the body for reproduction. The NSES also outline that these children should be able to describe how social networks, media, and culture may impact how they feel about their bodies. Healthy relationships is also a topic area that the NSES includes for 3\textsuperscript{rd}-5\textsuperscript{th} graders, which includes the ability to describe what healthy relationships look like as well as being able to describe how friends and other peers can either positively or negatively impact relationships. Although the NSES are not limited to these three areas, it is telling that the topics chosen by parents and students are of high importance.

Although this training program is specifically geared toward parents of 4\textsuperscript{th} and 5\textsuperscript{th} graders, it is not meant to imply that parents should wait until this age to talk to their children, nor should they end the conversation after talking about the topics included in the training. Youth Participant 1 mentioned how s/he did not recall much of what his/her parents talked about. This does not necessarily mean what was said was unimportant, but rather may be a testament to how this knowledge may fade if it is not a continually introduced topic.
It is also interesting to note that youth seemed mostly appreciative of their parents talking to them, despite any awkwardness they felt. Youth Participant 12 said, “… my mother approached me in the kitchen and just said “Be careful and use protection if you have sex with [your girlfriend]” that was it. It was pretty awkward but at least she said something” (emphasis added). Another participant who seemed to appreciate parent involvement in conversation was Youth Participant 10 who said, “… my dad knew I would be having sex so he would tell me to be safe and responsible about it which I thought was good” (emphasis added). Even those who did not experience any sort of sex-related talk with their parents showed they would have liked it to happen, such as when Youth Participant 11 explains, “I wish they had been more open and honest about it. Removing the guilt passed down for generations on both sides.”

Limitations and future research

Although this training may prove to be beneficial to a multitude of parents, it is important to note that it is based on the responses of a limited sample. Respondents were predominantly Caucasian with either no religious affiliation or a non-Lutheran protestant affiliation. As can be seen from a few participant responses, ethnicity (or rather, culture) and religion may impact both parent and child views on whether and/or how sex-related topics should be discussed. Although numerous studies have shown that comprehensive sex education results in lower reports of teen pregnancy and vaginal intercourse (Kohler, Manhart, & Lafferty, 2008), delay of sexual intercourse, and increased use of contraceptives and condoms (Kirby, 2001), while abstinence-only or no sex education has not produced such results. Some scholars have gone as far as to say abstinence-only education “censor lifesaving information about prevention of pregnancy, HIV and other STIs, and provide incomplete or misleading misinformation about contraception,” (Santelli, Ott, Lyon, Rogers, Summers, & Schleifer, 2006). Even with this information,
individuals from specific cultures and religions may still be hesitant or unwilling to discuss sex or find it inappropriate. Future opportunities are available for researchers to investigate whether there are opportunities for parents to educate their children about these issues in less direct and possibly more culturally or religiously appropriate manners.

This study also indicates that talking to youth about sex and technology may be an important choice to make. Although this topic was not rated as highly as puberty, healthy friendships, and peer pressure/media influence for topics desired for training, a couple youth responses to the question about whether their parents were up-to-date on issues such as sexting indicate an area of improvement. Youth Participant 10 said, “I don’t (sic) think my parents were as aware as they should be about [sex and technology]. They never talked to me about sexting and online exposure, im (sic) not sure if it is because they were unaware of it being something that goes on at the high school and middle school age or if it was because they didnt (sic) see it as being a big deal.”

That said, this training is valuable because it provides parents with knowledge on important sex-related topics and how to start conversations with their children. Even if the demographic that provided the information the training is based upon are not at the highest risk of teenage pregnancies or other sex-related risks, it is still evidenced that our nation, as a whole, is needing improved sex education, and many parents express that this education should not be limited to schools. With increased comfort of communication between parents and children, children may be more likely to go to parents with questions or concerns about sex or even for relationship advice. Of course, if children are seeking information or advice from parents, parents must be knowledgeable on the topics at hand, again demonstrating the importance of a training program such as the current study provides.
References


Wright, P. J., Randall, A. K., & Arroyo, A. (2012). Father-daughter communication about sex moderates the association between exposure to MTV’s 16 and Pregnant/Teen Mom and

Appendix A

THE UNIVERSITY OF MONTANA-MISSOULA
Institutional Review Board (IRB)
for the Protection of Human Subjects in Research
CHECKLIST / APPLICATION

At The University of Montana (UM), the Institutional Review Board (IRB) is the institutional review body responsible for oversight of all research activities involving human subjects outlined in the U.S. Department of Health and Human Services’ Office of Human Research Protection and the National Institutes of Health, Inclusion of Children Policy Implementation.

Instructions: A separate application form must be submitted for each project. IRB proposals are approved for no longer than one year and must be continued annually (unless Exempt). Faculty and students may email the completed form as a Word document to IRB@umontana.edu or submit a hardcopy to the Office of the Vice President for Research & Development, University Hall 116. Student applications must be accompanied by email authorization by the supervising faculty member or a signed hard copy. All fields must be completed. If an item does not apply to this project, write in: n/a.

1. Administrative Information

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Parent-Child Communication: Effective Health Messages for Managing Safe Sex</th>
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</thead>
<tbody>
<tr>
<td>Principal Investigator:</td>
<td>Elizabeth Eickhoff</td>
</tr>
<tr>
<td>UM Position:</td>
<td>Graduate Student</td>
</tr>
<tr>
<td>Department:</td>
<td>Communication Studies</td>
</tr>
<tr>
<td>Office location:</td>
<td>LA 339</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>406-243-6604</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>952-913-2646</td>
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</table>

2. Human Subjects Protection Training (All researchers, including faculty supervisors for student projects, must have completed a self-study course on protection of human research subjects within the last three years (http://www.umt.edu/research/complianceinfo/IRB/) and be able to supply the “Certificate(s) of Completion” upon request. If you need to add rows for more people, contact the IRB office for assistance.

<table>
<thead>
<tr>
<th>All Research Team Members (list yourself first)</th>
<th>PI</th>
<th>CO-PI</th>
<th>Faculty Supervisor</th>
<th>Research Assistant</th>
<th>DATE COMPLETED</th>
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<tbody>
<tr>
<td>Name: Elizabeth Eickhoff</td>
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<tr>
<td>Email: <a href="mailto:Elizabeth.Eickhoff@umontana.edu">Elizabeth.Eickhoff@umontana.edu</a></td>
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<tr>
<td>Name: Dr. Betsy Bach</td>
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<tr>
<td>Email: <a href="mailto:Betsy.Bach@umontana.edu">Betsy.Bach@umontana.edu</a></td>
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3. Project Funding (If federally funded, you must submit a copy of the abstract.)

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<thead>
<tr>
<th>Is grant application currently under review at a grant funding agency?</th>
<th>Yes (If yes, cite sponsor on ICF if applicable)</th>
<th>Has grant proposal received approval and funding?</th>
<th>Yes (If yes, cite sponsor on ICF if applicable)</th>
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</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Grant No.</td>
<td>Start Date</td>
<td>End Date</td>
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</table>

**Note to PI:** Study is approved for one year only. Use any attached IRB-approved forms (signed/dated) as “masters” when preparing copies. If continuing beyond the expiration date, a continuation report must be submitted. Notify the IRB if any significant changes or unanticipated events occur. When the study is completed, a closure report must be submitted. Failure to follow these directions constitutes non-compliance with UM policy and will have consequences.

IRB Determination:

- Not Human Subjects Research
- Approved Exempt from Review, Exemption # ___ (see memo)
- Approved by Expedited Review, Category # ___ (see *Note to PI*)
- Full IRB Determination

For UM-IRB Use Only
_____ Approved (see *Note to PI)

_____ Conditional Approval (see memo) - IRB Chair Signature/Date: ________________________________

_____ Conditions Met (see *Note to PI)

_____ Resubmit Proposal (see memo) Risk Level: ___________________________

_____ Disapproved (see memo)

Final Approval by IRB Chair/Coordinator: ______________________ Date: ______________ Expires: __________
4. Purpose of the Research Project (not to exceed 500 words): Briefly summarize the overall intent of the study. Your target audience is a non-researcher. Include in your description a statement of the objectives and the potential benefit to the study subjects and/or the advancement of your field. Generally included are literature related to the problem, hypotheses, and discussion of the problem’s importance. Expand box as needed.

Youth of today are faced with a sexual society that is extremely different than the one in which their parents and educators experienced while growing up. With the introduction of technology, cell phones, and online social network and dating sites, sexual messages and content have become more ubiquitous. Some minors have begun participating in what is commonly referred to as “sexting,” which is text messaging to send sexually explicit photographs (Wastler, 2010). Online chat rooms, such as ChatRoulette, also provide internet users reporting to be 16 years or older (ChatRoulette, nd) to an interactive site that includes web-camera video, audio, and text. Kreps (2010) agrees with social media writers like Ingam (2010) that this site is used by exhibitionists, subjecting users of the site to nude images or videos. Kreps (2010) argues that the internet is the “ultimate look-but-don’t-touch medium” that offers “a pornographic emporium in the privacy of our homes…” (p. 207). Sites such as these serve as potential threats to youth as they may be faced with decisions they are not prepared to make.

The purpose of this study is to discover the messages about sex adolescents receive from their parents, and to identify what messages or information that both youth and parents wish would have been included in these messages. This information will be used to develop a guide for parents and educators, to inform their children and students about sex and sexuality. The end goal is to satisfy the need for new educational programs regarding relationships and sex. This need for new programs has been expressed by a number of researchers (e.g. Boynton, 2007, Hirst, 2008, and Koyama, 2009). Findings from this study may help parents feel more confident in talking to their children about sex and may provide content for comprehensive messages regarding sex in general and safe sex in particular. In turn, children will be better equipped with the information and tools needed to navigate sexual situations in a safe and competent manner.

4.1 What do you plan to do with the results? If not discussed above, include considerations such as whether this is a class project, a project to improve a program/school system, and/or if the results will be generalized to a larger population, contribute to the general field of knowledge, and/or be published/presented in any capacity.

The data collected from the needs assessment constructed for this project will be used to guide research about sex topics and how and when these topics are most effectively discussed by parents with their children. The end result of the study will be a training plan that can be used to instruct parents what information should be shared with their children, when this information should be shared, and how it is best to approach these specific topics. This training will hopefully occur in order to provide parents with a better idea of how to talk to their children about sex in a way that is effective.

Is this part of a thesis or dissertation? ☑ No ☑ Yes If yes and other than the PI’s, then whose?

5. IRB Oversight

Is oversight required by other IRB(s) [e.g., tribal, hospital, other university] for this project? ☑ Yes ☑ No If yes, please identify IRB(s):

6. Subject Information:

6.1 Human Subjects (identify, include age/gender):

Both male and female subjects ages 18 and older. Subjects will consist of students from the University of Montana and parents of children at local elementary schools. Demographics such as ethnicity, socioeconomic status, and marital status will not influence participation.

6.2 How many subjects will be included in the study? 20

6.3 Are minors included (under age 18, per Montana law)? ☑ Yes ☑ No

If yes, specify age range: to
6.4 Are members of a physically, psychologically, or socially vulnerable population being specifically targeted?  
☐ Yes ☒ No
If yes, please explain why the subjects might be physically, psychologically or socially vulnerable:

6.5 Are there other special considerations regarding this population?  ☐ Yes  ☒ No
If yes, please explain:

6.6 Do subjects reside in a foreign country?  ☐ Yes Specify country:  ☒ No
If yes, please fill out and attach Form RA-112, Foreign Site Study Appendix (http://www.umt.edu/research/complianceinfo/IRB/Docs/foreign.doc).

6.7 How are subjects selected or recruited? Include a bulleted list of inclusion/exclusion criteria.  (Attach copies of all flyers, advertisements, etc., that will be used in the recruitment process as these require UM-IRB approval)

Student participants will be recruited from a single section of COMM 111A, the Introduction to Public Speaking course, at the University of Montana. As many 100-level courses enroll mostly freshman and sophomores, this sample pool would be most likely to consist of participants falling into the younger age bracket to make up the “child” focus groups. These students will be offered extra credit for their participation, which will be awarded to them upon completion of the needs assessment. As the assessment is anonymous, students will be instructed to print off the final page of the questionnaire (a simple page consisting of a message thanking the individual for participating in the study) and turn it in to their respective instructor with their signature attached. The parent-only group will consist of a network sample of parents whose children attend a local elementary school, ensuring that individuals have children between the specified ages. Demographics other than age will not influence the selection of participants. Parents will not be compensated in any form, but will be informed of the potential benefits of the study and will be able to contact the researcher upon the completion of the project to ask about the final findings.

6.8 How will subjects be identified in your personal notes, work papers, or publications: (may check more than one)

☐ Identified by name and/or address or other
(Secure written [e.g., ICF] or verbal permission to identify; if risk exists, create a confidentiality plan.)

☐ Confidentiality Plan
(Identity of subjects linked to research, but not specific data [e.g., individuals identified in ICF but not included in publications]; identification key kept separate from data; or, data collected by third party [e.g., Select Survey, SurveyMonkey, etc.] and identifiers not received with data.)

☒ Never know participant’s identity
(An ICF may be unnecessary [e.g., anonymous survey, paper or online] unless project is sensitive or involves a vulnerable population.)

6.9 Describe the means by which the human subject’s personal privacy is to be protected, and the confidentiality of information maintained. If you are using a Confidentiality Plan (as checked above), include in your description a plan for the destruction of materials that could allow identification of individual subjects or the justification for preserving identifiers.

Participants will never be asked for their name or any identifying information during this study. An online questionnaire site, such as Survey Monkey, will be used to gather information. Only the researcher and faculty advisor will have access to the survey, which will be protected by a username and password. Responses will be deleted within one year of the study’s completion.

6.9a Will subject(s) receive an explanation of the research – separate from the informed consent form (if applicable) – before and/or after the project?  ☐ Yes (attach copy and explain when given)  ☒ No
7. Information to be Compiled

7.1 Explain where the study will take place (physical location not geographic. If permission will be required to use any facilities, indicate those arrangements and attach copies of written permission):

Since subjects will be completing an online survey, they will be able to do so from the privacy of their own home or from a location of their choice. No specific facility will be requested for use by the researcher.

7.2 Will you be working with infectious materials, ionizing radiation, or hazardous materials? Please specify.

No.

7.3 Subject matter or kind(s) of information to be compiled from/about subjects:

Subjects will be asked to respond to questions regarding a) the safe sex messages that they have communicated or that have been communicated to them, respectively, and b) the perceived effectiveness of these messages, and c) what additional information they would have liked to be included in the message. Additional information collected will include age and gender.

7.4 Activities the subjects will perform and how the subjects will be used. Describe the instrumentation and procedures to be used and kinds of data or information to be gathered. Provide enough detail so the IRB will be able to evaluate the intrusion from the subject’s perspective (expand box as needed):

Subjects will complete an anonymous, online questionnaire using a site such as Survey Monkey. They will be asked approximately ten questions concerning discussions about sex that they have had with their parent or child. Answers will be qualitative and will be later coded using an emergent coding scheme.

Instructions: Please answer the following questions to the best of your ability. All answers are anonymous. If you have more than one child between the ages of 9 and 11, please choose the older child for this questionnaire. For your reference, abstinence only sex education is when an individual is taught only to abstain from sex, while comprehensive sex education is “medically accurate, age-appropriate… education that includes information about abstinence and contraception,”(Koyama, 2009, p. 447) that includes a variety of topics such as abstinence, contraception and condoms, pregnancy/reproduction, sexuality, STD prevention, relationships, puberty/sexual development, social pressures, refusal skills, and psychosocial risk.

Your age:
- 25-30
- 31-35
- 36-40
- 41-45
- 46-50
- 50+

Current age of child:
- 9
- 11

Ethnicity:
- Caucasian
- Hispanic
- African-American
- Asian/Pacific Islander
- Native American
- Other: ___________

Religious Affiliation:
- Catholic
1. When did/will you have any sort of “sex talk” with your child? (Please describe, in detail, the experience, including who brought it up, how old your child was, how the conversation began, and what was covered, but additional information is appreciated and beneficial.)

2. Do you think abstinence-only education or more comprehensive programs are more beneficial to youth? (Please explain. Refer to the definitions above for more information.)

3. At what age do you believe youth should start receiving sex education?

4. Where do you think youth get most of their information about sex?

5. Describe what you would think would be the most effective setting for a safe sex conversation (who is there? How old is the youth? What is talked about? Are there “props” or other items to help you explain things?)

6. How might a training course for parents that identified specific sex education topics and ways to introduce them would be beneficial to you as a parent?
   a. What would you like to see included in a course like this? Please mark any of the following you would like to be included in a safe-sex message targeted toward 4th and 5th graders.

   - Abstinence
   - Experiencing Puberty
   - Healthy Friendships
   - Healthy Romantic Relationships
   - Sexually Transmitted Diseases
   - Sex and Emotions
   - Sex and Technology (sexting, use of webcams, pornographic sites)
   - Pregnancy prevention
   - Sexual Consent
   - Peer Pressure and Media Influence
   - Masturbation
   - How to initiate sex conversations
   - Materials to provide to children
   - Other: ______________________

7. How might a technological approach (such as creating an interactive website or game, like the SIMS) would help youth learn about sex?

Youth “Needs Assessment” Questionnaire

Instructions: Please answer the following questions to the best of your ability. All answers are anonymous. For your reference, abstinence only sex education is when an individual is taught only to abstain from sex, while comprehensive sex education is “medically accurate, age-appropriate… education that includes information about abstinence and contraception,”(Koyama, 2009, p. 447) that includes a variety of topics such as contraception, sexuality, STD prevention, relationships, puberty, etc.

Your current age:
   - 18-20
   - 21-23
   - 24+

Your approximate age when sex talk occurred:
   - Younger than 8
   - 8-10
   - 11-13
14-16  
17-19  
Other: ________________

Age of your parent when sex talk took place:
- Younger than 25  
- 26-30  
- 31-35  
- 36-40  
- 41-45  
- 46-50  
- Other: ___________

Ethnicity:
- Caucasian  
- Hispanic  
- African-American  
- Asian/Pacific Islander  
- Native American  
- Other: ___________

Religious Affiliation:
- Catholic  
- Jewish  
- Protestant – Lutheran  
- Protestant – Other: ___________  
- Baptist  
- LDS  
- Buddhist  
- Muslim  
- No religious affiliation  
- Other: ___________

1. What was it like having the “sex talk” with your parents? (Please provide a detailed description including how old you were, who was there, who initiated the conversation, what was mentioned, and how comfortable you were during the conversation.)
2. How do you wish your parents had talked with you about sex? (Please compare/contrast your desired safe-sex conversation with your answer above.)
3. Are your parents are up-to-date on what youth face these days, such as sexting and online exposure? Please explain.
4. Where do you think most youth get their information about sex?
5. If your parents did not talk with you about sex, where did you first learn about it?
6. At what age do you think most youth start having sex? Explain.
7. Do you know anyone who didn’t talk to their parents about sex? If so, why do you believe that they did not talk with their parents?
8. Do you know people who have misconceptions about any sex-related topics? If so, why do you think that they have these misconceptions?
9. How might your parents have benefitted from a training course or additional material teaching them what topics their children need/want to hear and how to approach them?
10. What would you want to see included in a course or written material for parents of 4th and 5th grade students? Please check all that apply.
   - Abstinence
   - Experiencing Puberty
   - Healthy Friendships
   - Healthy Romantic Relationships
Sexually Transmitted Diseases
Sex and Emotions
Other: ________________________
Sex and Technology (sexting, use of webcams, pornographic sites)
Pregnancy prevention
Sexual Consent
Peer Pressure and Media Influence
Masturbation
How to initiate sex conversations
Materials to provide to children

11. What would you like to see included in a course or written material for yourself?

Abstinence
Experiencing Puberty
Healthy Friendships
Healthy Romantic Relationships
Sexually Transmitted Diseases
Sex and Emotions
Sex and Technology (sexting, use of webcams, pornographic sites)
Pregnancy prevention
Sexual Consent
Peer Pressure and Media Influence
Masturbation
Other: ________________________

12. How might a technological approach (such as creating an interactive website or game, like the SIMS) would help youth learn about sex?

7.5 Is information on any of the following included? (check all that apply):

- Sexual behavior
- Drug use/abuse
- Alcohol use/abuse
- Illegal conduct
- Information about the subject that, if it became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject’s financial standing or employability.

7.6 Means of obtaining the information (check all that apply). Attach questionnaire or survey instrument, if used:

- Field/Laboratory observation
- Blood/Tissue/Urine/Feces/Semen/Saliva Sampling (IBC Application must be submitted)
- Medical records (require HIPAA form)
- Measurement of motions/actions
- In-person interviews/survey
- Telephone interviews/survey
- On-site survey
- Mail survey
- Online survey (attach Statement of Confidentiality)
- Use of standard educational tests, etc.
- Examine public documents, records, data, etc.
- Examine private documents, records, data, etc.
- Other means (specify):

7.7 Will subjects be (check all that apply):

- Videotaped
- Audio-taped
- Photographed
- N/A

(secure an additional signature is recommended on consent/assent/permission forms)

Explain how above media will be used, who will transcribe, and how/when destroyed:
7.8 Discuss the benefits (does not include payment for participation) of the research, if any, to the human subjects and to scientific knowledge (if the subjects will not benefit from their participation, so state):

The purpose of this study is to discover the messages about sex adolescents receive from their parents, and to identify what messages or information that both youth and parents wish would have been included in these messages. This information will be used to develop a guide for parents and educators, to inform their children and students about sex and sexuality. The end goal is to satisfy the need for new educational programs regarding relationships and sex. This need for new programs has been expressed by a number of researchers (e.g. Boynton, 2007, Hirst, 2008, and Koyama, 2009). Findings from this study may help parents feel more confident in talking to their children about sex and may provide content for comprehensive messages regarding sex in general and safe sex in particular. In turn, children will be better equipped with the information and tools needed to navigate sexual situations in a safe and competent manner.

7.9 Cite any payment for participation (payment is not considered a benefit):

N/A

7.9a Outline, in detail, the risks and discomforts, if any, to which the human subjects will be exposed (Such deleterious effects may be physical, psychological, professional, financial, legal, spiritual, or cultural. As a result, one can never guarantee that there are no risks – use “minimal.” Some research involves violations of normal expectations, rather than risks or discomforts; such violations, if any, should be specified):

There is minimal risk related to this study. The types of questions asked in this study may prompt subjects to think of sexual activity. A potential risk that is presented any time a sexual topic is at hand is the possibility of discomfort, due to a general discomfort with the topic to a discomfort stemming from previously experienced sexual aggression or abuse. The questions, although related to sex, do not specifically ask about sexual behavior or experiences, but rather the discussion that takes place with parents and surrounds sex topics like pregnancies and STDs.

7.9b Describe, in detail, the means taken to minimize each such deleterious effect or violation:

All participants will be asked to read and sign an informed consent form before participating in the needs assessment. This consent form will follow Lindlof and Taylor’s (2011) guidelines for informed consent and will explain the voluntary nature of the study and detail all potential risks of the study and inform the participants why the study is taking place and what potential benefits the study may provide. The debriefing section will include a warning about the type of questions that will be asked and will provide the participants with contact information of local organizations available to provide help to those who have experienced any sort of sexual trauma, including sexual aggression or abuse. These organizations will include the University of Montana’s Student Assault Resource Center, as well as St. Patrick’s Hospital’s First STEP. The National Sexual Assault Hotline number will also be available for those affected participants who prefer not to abstain from face-to-face meetings.

8. Informed Consent

An informed consent form (ICF) is usually required, unless subjects remain anonymous or a waiver is otherwise justified below. (Templates and examples of Informed Consent, Parental Permission, and Child’s Assent Forms are available at http://www.umt.edu/research/complianceinfo/irb/forms.aspx).

- A signed copy of the consent/assent/permission form must be offered to all subjects, including parents/guardians of subjects less than 18 years of age (minors).
- Use of minors
  - All minor subjects (under the age of 18) must have written parental or custodial permission (45 CFR 46.116(b)).
  - All minors from 10 to 18 years of age are required to give written assent (45 CFR 46.408(a)).
  - Assent by minor subjects: All minor subjects are to be given a clear and complete picture of the research they are being asked to engage in, together with its attendant risks and benefits, as their developmental status and competence will allow them to understand.
  - Minors less than 10 years of age and all individuals, regardless of age, with delayed cognitive functioning (or with communication skills that make expressive responses unreliable) will be denied involvement in any research that does not provide a benefit/risk advantage.
- Good faith efforts must be made to assess the actual level of competence of minor subjects where there is doubt.
- The Minor Assent Form must be written at a level that can be understood by the minor, and/or read to them at an age-appropriate level in order to secure verbal assent.

- Is a written informed consent form being used? ☒ Yes (attach copy) ☐ No (justify below)
  To waive the requirement for written informed consent (45 CFR 46.117), describe your justification:

- Is a written parental permission form being used? ☐ Yes (attach copy) ☒ No
  (If yes, will likely require minor assent form)

- Is a written minor assent form being used? ☐ Yes (attach copy) ☒ No
  (If yes, will likely require parental permission form)

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**Principal Investigator’s Statement**

By signing below, the Principal Investigator agrees to comply with all requirements of The University of Montana-Missoula IRB, the U.S. Department of Health and Human Services Office of Human Research Protection Guidelines, and NIH Guidelines. The PI agrees to ensure all members of his/her team are familiar with the requirements and risks of this project, and will complete the Human Subject Protection Course available at http://www.umt.edu/research/complianceinfo/irb.

I certify that the statements made in this application are accurate and complete. I also agree to the following:

- I will not begin work on the procedures described in this protocol, including any subject recruitment or data collection, until I receive final notice of approval from the IRB.
- I agree to inform the IRB in writing of any adverse or unanticipated problems using the appropriate form. I further agree not to proceed with the project until the problems have been resolved.
- I will not make any changes to the protocol written herein without first submitting a written Amendment Request to the IRB using form RA-110, and I will not undertake such changes until the IRB has reviewed and approved them.
- It is my responsibility to ensure that every person working with the human subjects is appropriately trained.
- All consent forms and recruitment flyers must be approved and date-stamped by the IRB before they can be used. The forms will be provided back to the PI in PDF format with the IRB approval email. Copies must be made from the date-stamped version. All consent forms given to subjects must display the IRB approval date-stamp.
- I understand that it is my responsibility to file a Continuation Report before the project expiration date (does not apply to exempt projects). This is not the responsibility of the IRB office. Tip: Set a reminder on your calendar as soon as you receive the date. A project that has expired is no longer in compliance with UM or federal policy.
- I understand that I must file a Closure Report (RA-109) when the project is completed, abandoned, or otherwise qualifies for closure from continuing IRB review (does not apply to exempt projects).
- I will keep a copy of this protocol (including all consent forms, questionnaires, and recruitment flyers) and all subsequent correspondence with the IRB.
- I understand that failure to comply with UM and federal policy, including failure to promptly respond to IRB requests, constitutes non-compliance and may have serious consequences impacting my project and my standing at The University of Montana.

**Signature of Principal Investigator:** Elizabeth K. Eickhoff  
**Date:** 3/10/2013

*(Type for electronic submission; sign for hard copy)*

**NOTE:** I AM AWARE that electronic submission of this form from my University email account constitutes my signature.
**Students and Faculty Advisors:** Student applications must be accompanied by either an email authorization from the supervising faculty member or by a signed hard copy (below).

Faculty Supervisor: **Betsy Bach**

My signature confirms:

1) I have read the IRB Application and attachments.
2) I agree that it accurately represents the planned research.
3) I will supervise this research project.

Faculty Advisor Signature: **Betsy Bach**  
Date: 3/10/2013

(Type for electronic submission; sign for hard copy)

Department: **Communication Studies**  
Phone: 406-243-6119
Appendix B

CONSENT FORM

You are invited to participate in a research study investigating the communication surrounding sex that takes place between parents and children. In order to participate in the study as a “student” responder, you must be between the ages of 18 and 25 years old. To participate in the study as a “parent” responder, you must have a child between the ages of 9 and 11. Please read the following information in its entirety. If you agree to be a part of this study, please mark the box indicating your informed consent of participation.

Background Information:
This study is being conducted in order to fulfill a graduation requirement for the Communication Studies Master’s Program at the University of Montana. The purpose of this study is to determine how parents communicate with their children about sex and what sex topics parents typically address. This information will be used in order to determine any disparities in performed communication and needed communication. As a final portion of this project, a training session teaching parents how and what to communicate to their children during these messages will be constructed.

Procedures:
Upon agreement to participate in this study, participants will complete an online questionnaire consisting of a combination of 10-15 open- and closed-ended questions regarding their parent-child communication about sex. This questionnaire may take between 10 and 45 minutes, depending on the depth and breadth of participant responses. Identifying information such as name and address will not be collected and all participants will remain anonymous.

Risks and Benefits of Being in the Study:
This study involves little to no risk to participants. If a participant feels uncomfortable with answering questions at any point of this questionnaire, he or she may withdraw without completing the remaining questions. If a participant is uncomfortable with a single question, he or she may choose to leave it unanswered and continue on to the following question. As questions concern communication about sexual content, there is a slight risk of prompting recollections of sexual experiences that may have been uncomfortable. As participation is voluntary, if any discomfort is experienced, please discontinue the questionnaire and refer to the list of resources available below to help ease any unpleasant recollections.

Benefits to you as the participant: This study may provide insight into what messages need to be included in parent-child communication about sex. It may also aid parents in knowing and being comfortable with how to discuss sex with their children, potentially impacting children’s sexual responsibility.

Benefits to the researcher, academia and society: Information gathered from this survey will be used to construct a training session for parents on how to communicate to their children about sex and what to include in these messages. If effective, this training session may benefit society by decreasing adolescent’s risky sexual behavior, including the spread of sexually transmitted infections and unplanned teenage pregnancies.
Anonymity:
Your participation in this research will remain anonymous. Names and other identifying information will not be collected and any demographic information will be used solely as a means of determining if or how these demographics impact the parent-child communication about sex.

Voluntary Nature of the Study:
It is the participant’s complete decision whether he or she would like to participate in this study. Your decision whether or not to participate will not affect your current or future relations with the University of Montana-Missoula. If you decide to participate, you are free to withdraw at any time by exiting the questionnaire window.

Contacts and Questions:
The principle investigator conducting this study is Elizabeth Eickhoff, a graduate student in the Communication Studies department at that University of Montana. If there are any questions or concerns regarding the study, she may be reached at elizabeth.eickhoff@umontana.edu or by phone at (406)243-6604. If contacting by phone, please explicitly ask to speak to Elizabeth Eickhoff, as the telephone number is for the Communication Studies graduate office.

Resources:
If at any point in this study you experience discomfort and would like to talk to a professional about your experiences, please feel free to contact one of the following resources:

Student Assault Resource Center (SARC)
www.umt.edu/curry/sarc.
Walk-in support, M-F, 9am-5pm, Curry Health Center, Room 108 (use East entrance)
24-hour hotline: 406.243.6559

First Step Resource Center in St. Patrick’s Hospital
24-hour line: 406-329-5776
500 W. Broadway, use emergency center entrance

National Sexual Assault Hotline
1.800.656.HOPE (4673)

Please print or save an electronic copy of this page for your records.

☐ I have read the above information and agree to participate in this research project.
   (Check box to enter questionnaire)
Appendix C

Adult Qualitative “Needs Assessment” Questionnaire

Instructions: Please answer the following questions to the best of your ability. All answers are anonymous. If you have more than one child between the ages of 9 and 11, please choose the older child for this questionnaire. For your reference, abstinence only sex education is when an individual is taught only to abstain from sex, while comprehensive sex education is “medically accurate, age-appropriate… education that includes information about abstinence and contraception,”(Koyama, 2009, p. 447) that includes a variety of topics such as abstinence, contraception and condoms, pregnancy/reproduction, sexuality, STD prevention, relationships, puberty/sexual development, social pressures, refusal skills, and psychosocial risk.

Your age:

☐ 25-30
☐ 31-35
☐ 36-40
☐ 41-45
☐ 46-50
☐ 50+

Current age of child:

☐ 9
☐ 10
☐ 11

Ethnicity:

☐ Caucasian
☐ Hispanic
☐ African-American
☐ Asian/Pacific Islander
☐ Native American
☐ Other: __________

Religious Affiliation:

☐ Catholic
☐ Jewish
☐ Protestant – Lutheran
☐ Protestant – Other: __________
☐ Baptist
☐ LDS
☐ Buddhist
☐ Muslim
☐ No religious affiliation
☐ Other: __________
1. When did/will you have any sort of “sex talk” with your child? (Please describe, in detail, the experience, including who brought it up, how old your child was, how the conversation began, and what was covered, but additional information is appreciated and beneficial.)

2. Do you think abstinence-only education or more comprehensive programs are more beneficial to youth? (Please explain. Refer to the definitions above for more information.)

3. At what age do you believe youth should start receiving sex education?

4. Where do you think youth get most of their information about sex?

5. Describe what you would think would be the most effective setting for a safe sex conversation (who is there? How old is the youth? What is talked about? Are there “props” or other items to help you explain things?)

6. How might a training course for parents that identified specific sex education topics and ways to introduce them would be beneficial to you as a parent?
   a. What would you like to see included in a course like this? Please mark any of the following you would like to be included in a safe-sex message targeted toward 4th and 5th graders.

   - Abstinence
   - Experiencing Puberty
   - Healthy Friendships
   - Healthy Romantic Relationships
   - Sexually Transmitted Diseases
   - Sex and Emotions
   - Sex and Technology (sexting, use of webcams, pornographic sites)
   - Pregnancy prevention
   - Sexual Consent
   - Peer Pressure and Media Influence
   - Masturbation
   - How to initiate sex conversations
   - Materials to provide to children
   - Other: _______________________

7. How might a technological approach (such as creating an interactive website or game, like the SIMS) would help youth learn about sex?
Youth “Needs Assessment” Questionnaire

Instructions: Please answer the following questions to the best of your ability. All answers are anonymous. For your reference, abstinence only sex education is when an individual is taught only to abstain from sex, while comprehensive sex education is “medically accurate, age-appropriate… education that includes information about abstinence and contraception,” (Koyama, 2009, p. 447) that includes a variety of topics such as contraception, sexuality, STD prevention, relationships, puberty, etc.

Your current age:

☐ 18-20
☐ 21-23
☐ 24+

Your approximate age when sex talk occurred:

☐ Younger than 8
☐ 8-10
☐ 11-13
☐ 14-16
☐ 17-19
☐ Other: ______________________

Age of your parent when sex talk took place:

☐ Younger than 25
☐ 26-30
☐ 31-35
☐ 36-40
☐ 41-45
☐ 46-50
☐ Other: __________

Ethnicity:

☐ Caucasian
☐ Hispanic
☐ African-American
☐ Asian/Pacific Islander
☐ Native American
☐ Other: __________

Religious Affiliation:

☐ Catholic
☐ Jewish
☐ Protestant – Lutheran
☐ Protestant – Other: __________
☐ Baptist
☐ LDS
☐ Buddhist
☐ Muslim
☐ No religious affiliation
☐ Other: __________
1. What was it like having the “sex talk” with your parents? (Please provide a detailed description including how old you were, who was there, who initiated the conversation, what was mentioned, and how comfortable you were during the conversation.)

2. How do you wish your parents had talked with you about sex? (Please compare/contrast your desired safe-sex conversation with your answer above.)

3. Are your parents are up-to-date on what youth face these days, such as sexting and online exposure? Please explain.

4. Where do you think most youth get their information about sex?

5. If your parents did not talk with you about sex, where did you first learn about it?

6. At what age do you think most youth start having sex? Explain.

7. Do you know anyone who didn’t talk to their parents about sex? If so, why do you believe that they did not talk with their parents?

8. Do you know people who have misconceptions about any sex-related topics? If so, why do you think that they have these misconceptions?

9. How might your parents have benefitted from a training course or additional material teaching them what topics their children need/want to hear and how to approach them?

10. What would you want to see included in a course or written material for parents of 4th and 5th grade students? Please check all that apply.

- Abstinence
- Experiencing Puberty
- Healthy Friendships
- Healthy Romantic Relationships
- Sexually Transmitted Diseases
- Sex and Emotions
- Sex and Technology (sexting, use of webcams, pornographic sites)
- Pregnancy prevention
- Sexual Consent
- Peer Pressure and Media Influence
- Masturbation
- How to initiate sex conversations
- Materials to provide to children

- Other: ________________________

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11. What would you like to see included in a course or written material for yourself?
☐ Abstinence
☐ Experiencing Puberty
☐ Healthy Friendships
☐ Healthy Romantic Relationships
☐ Sexually Transmitted Diseases
☐ Sex and Emotions
☐ Sex and Technology (sexting, use of webcams, pornographic sites)
☐ Pregnancy prevention
☐ Sexual Consent
☐ Peer Pressure and Media Influence
☐ Masturbation
☐ Other: ________________________

12. How might a technological approach (such as creating an interactive website or game, like the SIMS) would help youth learn about sex?
Appendix D

Let’s Talk About Sex: Parent-Child Safe-Sex Communication Training Program

Goal: To provide parents with up-to-date and relevant sex-related information and instruction on how to share this information with their 4th-5th grade child(ren).

General Objectives
1. Parents will experience an increase of self-reported confidence (measured before Session I and after Session III) in their knowledge of important sex-related information relevant to their 4th and 5th grade child(ren).
2. Parents will experience an increase of self-reported confidence (measured before Session I and after Session III) in their ability to share the aforementioned important sex-related information with their 4th and 5th grade child(ren).

How objectives will be measured
1. Objectives #1 and #2 will be measured by comparing pre- and post-training assessments that include questions for parents about their current comfort/confidence level when it comes to their knowledge of what topics are important to 4th and 5th grade students and how to share important and relevant information concerning sex to this age group.

Topics to be discussed
1. Healthy friendships (based on needs assessment and National Sexuality Education Standards)
2. Peer pressure and Media Influence (based on needs assessment and National Sexuality Education Standards)
3. Puberty (based on needs assessment and National Sexuality Education Standards)

Materials Needed
Paper
Pencils
Computer
Projector
Screen
YouTube videos
Pamphlets
**Session 1: Healthy Friendships**

**Objective A:** Parents will be able to describe a potential scenario of when to initiate conversations about healthy friendships that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).

**Objective B:** Parents will be able to list and describe four out of five characteristics of healthy friendships.

**Total Time:** 1 Hour

**Materials needed:** Computer, PowerPoint, Projector, Whiteboard or Flipchart and writing utensil

**Introduction:**

- **Time:** 5 minutes
  
  [Pre-training: make sure to greet trainees and ask them about their children, e.g. age, gender, etc. Use information to further tailor messages to parents].

Introduce yourself and explain the agenda for the training. Point out restrooms and indicate when there will be a break. Pass out pre-assessment and ask trainees to indicate their confidence in their knowledge and ability to talk to their children about the topics to be covered.

**Set Induction:** [Rhetorical questions, ask for a show of hands] How many of you have already started talking to your children about sex? How many of you have felt uncomfortable, or could tell your child was uncomfortable, with talking about sex? How many of you know that about a quarter of youth have sex by the time they are 15? (Mosher, Chandra, and Jones (2005))

**Welcome/Rationale for Training:** You are all here because you have a child that is currently in or approaching 4th or 5th grade and because you are concerned about your child. The mere fact you are attending this training shows your dedication to your child, so pat yourselves on the back for being a concerned parent! Based on research that was done before constructing this training, students are more comfortable talking about sex-related topics at younger ages. Students whose parents talked to them once they hit their teenage years reported feel more awkward during conversation than did those whose parents talked to them when they were eight or nine. A number of other research studies show that good sex education really does start early—even before youth have reached puberty (Advort.Org). It’s also important to create an open relationship with your child, since studies have shown that youth who feel comfortable having discussions about sexual health with parents delay participating in sex (Advocates for Youth). So the overall goal today is to start getting you informed on what is important to share with your child and how to discuss it with them in a way that is comfortable for both of you.

This session is the first in a series of three. The topics we are covering were chosen by parents when they were given an exhaustive list of sex-related topics and asked what are most important for 4th and 5th grade children to know about. These topics are also listed in the National Sexuality Education Standards for this age group, and were even chosen by young adults as being essential for 4th and 5th graders to know. Even though these topics are suggested by the National Sexuality Education Standards, it is important to note that many schools choose abstinence-only sex education, and even for schools that take a more comprehensive approach, time allocated to sexuality education is limited. Today, we will start by covering healthy friendships. Next week in
training we will discuss peer pressure and media influence, and we will end the following week with the topic of puberty.

[From here, go into the lecture about healthy friendships and follow with how to talk to the child about healthy friendships. Below is an example of how to set up the body of the training, focusing on the third session about experiencing puberty.]

**Session III, Module I: Experiencing Puberty**

**Objective A:** Parents will be able to accurately list and describe four out of five major changes discussed that girls experience during puberty.

**Objective B:** Parents will be able to accurately describe four out of five major changes that boys experience during puberty.

**Objective C:** Parents will be able to describe a potential scenario of when to initiate conversations about puberty that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).

**Time:** 15 minutes

**Set induction:** Story of a typical girl during puberty

**Method:** Lecture

**Materials:** Computer, Projector, PowerPoint, Flipchart and utensil, Handouts

**Introduction:**

Last week we talked about peer pressure and media influence in your child’s life. Today, we are wrapping everything up with our third and final training about experiencing puberty. We saved this topic for last because it is one of the more “awkward” topics to bring up to children, so you can consider the past two weeks practice for having conversations with them!

**Changes in girls**

**Stimulus:** [Tell story about typical pubescent girl. After story, have trainees contribute to a list of changes that girls experience during puberty. After list is complete, discuss each aspect, sharing more in-depth facts]

- Start at about age 9 (webmd)
- **Height:** About 17% of a girl’s final height is gained during puberty (webmd). During this spurt, limbs are the first to grow, followed by the trunk. Girls can grow up to 4 inches in a year
- **Weight:** Weight gain is a commonly recognized part of puberty, and girls mostly gain more body fat in areas like thighs, and upper arms and hips become wider (webmd)

**Changes in boys**

**Stimulus:** “So how does puberty for boys differ from puberty for girls?”

- (Again include basic information so parents know/are reminded what is occurring to the male body during puberty)

**Media/Peer influence and Body dissatisfaction**
**Stimulus:** “How many of you remember how uncomfortable puberty was? Do any brave souls want to share stories about how they were uncomfortable with themselves or allowed peers to influence them in some way?” [If nobody volunteers story, share a story from your past or find examples online]

- Girls and boys can experience low self-esteem and become less satisfied with their bodies if they experience changes much earlier or later than their friends.

**How to initiate the conversation**

**Time:** 20 minutes

**Set induction:** Rhetorical questions about their own talks with their parents.

**Method:** Lecturette + Discussion

**Materials:** Computer, Projector, PowerPoint, Flipchart, Writing utensil

**Stimulus:** “How many of you remember back to when your parents talked to you about sex? Or did the conversation never take place? If it did, how did you feel during the conversation? Was it easy for you to talk about such a personal topic with your parents?”

**Age**

- Professionals have said that it is important for parents to start talking to their children at an early age.
- They say these messages should take place with a lot of age-appropriate small talks and not just one big talk. (Debora Pollack, MD, Webmd.com)

**Approach**

- Other sources also recommend that these talks should not be put off until kids ask questions, but instead can be prompted by “teachable moments” that occur daily and could initiate different conversations.
- This was also reflected in responses I received during the needs assessments. A number of parents discussed how they were successful in using naturally occurring moments as a segue into conversations about sexual topics in non-awkward ways.

**Discussion:**

- Can you think of any moments in television shows that might provide an opportunity to talk about puberty?
- Where do you think would be the most comfortable location for your child to talk about puberty?
- How might you use, or abstain from, making eye contact to make your child more comfortable?
- What other factors might impact your child’s comfort level or willingness to converse?

**Conclusion**

**Time:** 10 minutes (5 for review, 5 for assessment)

To wrap things up for today, let’s do a quick review.
Girls typically start puberty around age 9 and experience many changes, such as changes in weight, height, bust, self-esteem, acne, mood swings, etc. Boys go through some similar changes, also with changes in weight, height, and self-esteem. Both boys and girls can experience dissatisfaction if they don’t feel like they are changing at the same rate as their peers. This is an uncomfortable time for the, but they need to be reassured that everything they are going through is normal. Try to take daily opportunities to have small talks about this transition with your child, and feel free to use the handout on puberty and analogies to help your child understand some of the changes they experience.

Before you go, I would love if you could help me determine how training went by filling out a short assessment. This will just be used to help me know whether or not the training was structured effectively and whether or not I need to make changes in the future. Thank you all so much for your time and I hope you found the training very valuable!
Appendix E

Please rate your level of confidence *with your knowledge* of the following topics:

**Puberty**

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Please rate your level of confidence *with talking to your child about* the following topics:

**Puberty**

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EXPERIENCING PUBERTY

Girls Versus Boys

- Start around age 9
- Weight gain in thighs, upper arms, hips

- Starts around age 10 (earlier than assumed)
- Testicle growth (age 11/12) and penis growth (age 13)

Information from WebMD, April 2013
Appendix G

Analogy Game (adapted from www.srcp.org)

Take a look at this list with your child:

Eyeglasses
Xbox
ATM (cash machine)
New car
Bird
Bowling ball
Salad bar
Soft drink
Crossword puzzle
Bicycle
Cell phone
Bowl of cherries
Being stuck in a traffic jam
Peanut butter and jelly sandwich

You're probably wondering why all of these different items are on the same list. Well, it's pretty obvious, isn't it? They all tell us something about puberty. For example, why is puberty like a new car? Because when you get a new car, it has that new car smell. And when you go through puberty, your body odor changes and you have a new smell too. Right?

Take a few minutes to figure out how these other things may be like puberty. Your answers can be funny, serious, or both.

When you're all done, ask yourself if you learned anything new about puberty. What other analogies can you or your child think of?
Appendix H

Parent-Child Interviews
(Adapted from www.SRCP.org)

Take turns asking each other the questions listed below. The questions do not have to be asked in order. Afterward, talk about the interview process…

*Was it easier to ask questions or answer them?*
*Did you learn anything new?*
*Did anything surprise you?*
*How can you use what you learned in the future?*

**QUESTIONS FOR PARENTS TO ASK THEIR CHILDREN**

1. Who is your best friend? Why?

2. What do I do around your friends that embarrasses you or makes you uncomfortable?

3. What is it about me or the things I do that makes you proud in front of your friends?

4. Do you like your name? Why or why not? Is there a name you would have preferred? What is it?

5. What three things do you like best about your looks?

6. Is there anything you don't like about your looks? If so, what?

7. What do you think are the advantages of being a girl? Of being a boy?

8. Do you feel as if you are popular? Does it matter to you?

9. Who are your favorite adults? What do you like about each one?

10. Who do you talk with when you are scared or upset? Why?

11. What, if anything, do you feel is exciting about growing up?

12. What, if anything, do you feel is scary about growing up?

13. Describe a day in your life five years from now, as you hope it will be.

14. Describe three things you would enjoy doing with a group of friends – both boys and girls.
15. Do you think you will want to live by yourself when you're an adult? If not, what kind of family do you imagine having?

QUESTIONS FOR CHILDREN TO ASK THEIR PARENTS

1. Do you think you were popular when you were my age? Did it matter to you?
2. Did you have crushes when you were my age? Tell me about one of them – how you felt and acted.
3. What do you think are some of the good things and bad things about being a female? A male?
4. What three things do you like best about your body and your looks?
5. Is there anything you don't like about your looks? If so, what?
6. What do you think is the best thing about growing up?
7. What do you think is the hardest part of growing up?
8. When did you get your first period or wet dream? What do you remember about it? How did it feel?
10. Who do you talk with when you are scared or upset? Why?
11. How do you know when somebody likes you?
12. When did you start to feel grown up?
13. Describe a day in your life five years from now, as you hope it will be.
14. What is it about me or the things I do that makes you proud in front of your friends?
15. What wishes or dreams do you have for me?
Appendix I

Tips for Talking with Your Child about Sexuality
(For Parents of Children with Typical Development)
Compiled and adapted by Sexuality Resource Center for Parents

Want to make your conversations about sexuality more productive? Then we suggest you take the following tips to heart:

1. **It's never too late to start.** Although it may be easier to talk with younger children, research has shown that older children listen to their parents. It is always beneficial, no matter what their age, to talk with your child about sexuality.

2. **Choose the right time and place.** Discussions go better in private and when everyone involved is in a relaxed, attentive mood. If your child asks a question at a bad time, tell them that you'll answer it later. And make sure you do.

3. **You may have to initiate the conversation.** Don’t consider yourself lucky if your child has no questions. Many children will never bring the subject up, but that doesn’t mean that they don’t have questions or concerns. Children need to know that their parent(s) are interested in talking with them about sexuality. Even if your child is not a talker, they need and want to know your values about the many aspects of sexuality.

4. **Be sure to listen more than you talk.** We often “talk at” children rather than talk with them. Listening provides the opportunity to have a conversation together. Listening also helps us hear what our children’s concerns and questions are and decreases the assumptions that we often make about our children.

5. **Forget the "big talk."** Sexuality is a huge topic and you can’t cover it all in one sitting. And besides, perceptions change as children get older, and the explanation that worked when your child was five will no longer work when your child is twelve.

6. **Look for everyday opportunities.** The best way to start a discussion is to take advantage of "teachable moments," those everyday events that provide a perfect opening. If you know someone who is pregnant, talk with your child about it. If you’re watching a television show or listening to music together, figure out if the contents might spark a conversation about sexuality. Avoid the direct, head-on approach – if you ask your child if they want to talk about sexuality, they’ll probably say, "NO!"

Here’s an example of a teachable moment that way too many parents let slip away: You’re watching a TV show with your young child when a couple begins to kiss. Without saying a word, you either turn off the TV or you switch to another channel.

We’re not saying that you should let your child watch the kissing – that decision’s up to you. What we are saying is that you should tell your child why you didn’t want them to see the kissing. Otherwise, you may be creating all sorts of confusion in your child’s mind. They may think that kissing is bad, but then they may wonder why mommy and daddy like to kiss. By giving your reasons and asking your child for their opinion, you’re creating the potential for a great conversation. That’s the beauty of a teachable moment.

We do think that your older child should be allowed to watch such programs, but only if you’re willing to use them as teachable moments. Otherwise, your child will be receiving all sorts of messages about love and relationships that may or may not coincide with the messages you want them to receive.
7. Let your child "overhear" adult conversations. Your child may be too embarrassed to discuss sexuality, but they may not mind hearing two adults discussing it. Choose a topic based on the day's news or a television show and discuss it at the dinner table with your partner or another adult.

8. There's nothing wrong with being embarrassed, and there's nothing wrong with telling your child that you're embarrassed. Acknowledging your embarrassment and then proceeding with the conversation is much better than letting your embarrassment silence you. Moreover, you're making it clear that the embarrassment belongs to you and not to your child or the topic.

9. A book can be a great resource. This is a way to learn about sexuality that can be very useful especially when you are worried about embarrassing moments. By letting a book say the embarrassing stuff, you and your child are a team, confronting and reacting to all of the embarrassing things being said in the book. Another great resource if your child won't talk with you: Tell your child it's okay to talk with a neighborhood parent whom you both know and trust.

10. You don't need to know the answer to every question. If you don't know an answer, you and your child can hunt for it together. Make use of resources such as websites, libraries, doctors, nurses, etc.

11. If you're thrown by a question, you have the right to answer it later. Sometimes children pose questions that we'd like to answer, but we may be so taken aback that we don't know quite how to respond. It's perfectly okay to say, "I'd like to answer that question, but first I need to think about what I want to say." Just make sure you answer the question later.

12. You have the right to pass on personal questions. Your child needs to know your privacy standards so that they can develop standards of their own.

13. Simplify your responses. When answering children's questions, less is better than more. Begin with the simplest explanation and move to a more complicated one if your child continues to be interested or ask questions. You can't tell your child "too much" – what they don't understand will just go over their heads.

14. Practice pays off. Each time you respond in a way that helps your child learn concretely and positively, it will get easier. Try imagining the hardest question your child could throw your way and practice answering it.

15. Be aware of your body language. Children notice when our words and body language are not giving consistent messages.

16. Be patient. Expect your child to ask the same questions again and again. That's the way they learn.

17. Don't forget your sense of humor. In fact, use it to your advantage. Tell your child about all of the misconceptions you had about sex when you were their age. They'll feel much better about themselves!

18. Ask your child for their opinion. Their self-respect begins with the consideration they receive from others.

19. Share your values. Your child needs to know what your values are about body image, friendships, bullying, dating, relationships, respect for others, and respect for oneself. Your values will be the foundation they rely on and, as they get older, the barometer for assessing the values they want to hold.

20. Teach your child that there is more to sexuality than having sex. Tell them about affection, trust, respect, responsibility, and intimacy, and practice the behaviors you would like them to adopt. Remember, giving information is not giving permission – it is ignorance that leads to bad decisions.
## Appendix J

### Training Plan for Parents of 4th and 5th Grade Children RE: Sex-Related Topics

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To provide parents with up-to-date and relevant sex-related information and instruction on how to share this information with their 4th and 5th grade child(ren).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Assessment</td>
<td>Pre-training questionnaire distributed online to ensure anonymity.</td>
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</table>
| **Training goals and objectives** | **General**  
1) Parents will experience an increase of at least one point of self-reported confidence (measured on a 1 to 5 Likert-type scale, shown in Appendix E, before Session I and after Session III) in their knowledge of important sex-related information relevant to their 4th and 5th grade child(ren)  
2) Parents will experience an increase of self-reported confidence (measured on a 1 to 5 Likert-type scale, before Session I and after Session III) in their ability to share the aforementioned important sex-related information with their 4th and 5th grade child(ren).  
**Puberty**  
3) Parents will be able to accurately list and describe four out of five major changes discussed that girls experience during puberty.  
4) Parents will be able to accurately describe four out of five major changes that boys experience during puberty.  
5) Parents will be able to describe a potential scenario of when to initiate conversations about puberty that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).  
**Healthy Friendships**  
6) Parents will be able to describe a potential scenario of when to initiate conversations about healthy friendships that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation).  
7) Parents will be able to list and describe four out of five characteristics of healthy friendships.  
**Peer Pressure/Media Influence**  
8) Parents will be able to and describe four out of five ways in which children are influenced by peers and media.  
9) Parents will be able to describe a potential scenario of when to initiate conversations about peer pressure/media influence that reflect at least four out of five comfortable conversation initiation suggestions from the training (such as “teachable moments,” having multiple small talks instead of one big talk, or letting children initiate conversation). |
<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
<th>Methods</th>
<th>Resources</th>
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</thead>
<tbody>
<tr>
<td>Introduction &amp; Preview (5 min)</td>
<td>1. Introduce trainers</td>
<td>Set induction</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>2. Provide rationale for and goals of training</td>
<td>- Rhetorical questions</td>
<td></td>
</tr>
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<td></td>
<td>3. Preview training agenda and topics</td>
<td>- Fact about youth's sexual activity</td>
<td></td>
</tr>
<tr>
<td>Session I, Mod I: Healthy Friendship Characteristics (10 min)</td>
<td>1. Characteristics of healthy friendships</td>
<td>Set induction</td>
<td>1. PowerPoint Slides 1-3</td>
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<td></td>
<td>3. Girl-boy friendships</td>
<td>- Quick discussion of video and children’s actions</td>
<td></td>
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<td></td>
<td>4. Boy-boy friendships</td>
<td>Lecture</td>
<td></td>
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<tr>
<td>Session I, Mod 2: Initiating Communication (30 min)</td>
<td>[Open discussion of how to approach topic and discuss with children. If discussion ends with time remaining, move to role play in which one parent acts as child and another parent approaches topic]</td>
<td>Discussion</td>
<td>1. Participant Guide p. 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- When/where might you approach this topic? (Why?)</td>
<td>2. Flipchart</td>
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<td>- What moments can you anticipate that may help initiate conversation?</td>
<td>3. Marker</td>
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<td></td>
<td></td>
<td>- What are possible reactions of children?</td>
<td>4. Chairs for role play</td>
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<td></td>
<td></td>
<td>- How can you overcome negative reactions?</td>
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<td></td>
<td></td>
<td>Role Play</td>
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<td></td>
<td></td>
<td>- “Parent” talks to “Child” who rolls eyes and insists s/he knows the difference between a healthy and unhealthy friendship</td>
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<tr>
<td>Session I, Mod III: At-home Activities (10 minutes)</td>
<td>Explanation of Parent-Child Interview Sheet</td>
<td>Set Induction</td>
<td>1. PowerPoint Slides 4-5</td>
</tr>
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<td></td>
<td>Rationale for use</td>
<td>- Ask parents a few questions about their child from the sheet, see if they know answers</td>
<td>2. Participant Guide p. 4-5 (Interview Sheets, see Appendix H)</td>
</tr>
<tr>
<td></td>
<td>Benefits of open communication</td>
<td>Lecture</td>
<td></td>
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<tr>
<td>Conclusion (5 minutes)</td>
<td>Short review of material</td>
<td>Debriefing</td>
<td>1. PowerPoint Slides 6-7</td>
</tr>
<tr>
<td></td>
<td>Post-training assessment</td>
<td>Assessment/Questionnaire</td>
<td>2. Participant Guide p. 6 (Post-training assessment)</td>
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<tr>
<td>Section</td>
<td>Content</td>
<td>Methods</td>
<td>Resources</td>
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</tbody>
</table>
| **Introduction & Preview (5 min)** | 1. Provide rationale for and goals of training  
2. Preview training agenda and topics | **Set induction**  
- Rhetorical questions  
- Peer pressure examples  
- Media influence examples | None |
| **Session II, Mod I: Experiencing Peer Pressure & Media Influence (15 minutes)** | 1. Types of peer pressure  
2. Examples of peer pressure  
3. Research on media influence  
4. Examples of media influence | **Set induction**  
- Stories of peer pressure  
**Lecture** | 1. PowerPoint Slides 1-5  
2. Participant guide p. 7-9 |
| **Session II, Mod II: Initiating Conversation and Empowerment (30 minutes)** | [Open discussion of how to approach topic and discuss with children. Also cover ways that parents may be able to empower children to say no. If discussion ends with time remaining, move to role play in which one parent acts as child and another parent approaches topic] | **Discussion**  
- When/where might you approach this topic? (Why?)  
- What moments can you anticipate that may help initiate conversation?  
- How can you empower your child to say no?  
- What are possible reactions of children?  
- How can you overcome negative reactions?  
**Role Play**  
- “Parent” talks to “child” about peer pressure and what it looks like/how to say no  
- “Peer” pressures “child” and “child” finds ways to say no | 1. Participant guide p. 10  
2. Flipchart  
3. Marker  
4. Chairs for role play |
| **Conclusion (5-10 minutes)** | Short review of material  
Post-training assessment | **Debriefing**  
**Assessment/Questionnaire** | 1. PowerPoint Slides 10-11  
2. Participant Guide p. 12 (Post-training assessment) |
<table>
<thead>
<tr>
<th>Section</th>
<th>Content</th>
<th>Methods</th>
<th>Resources</th>
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</thead>
</table>
| **Introduction & Preview (5 min)**          | 1. Provide rationale for and goals of training  
2. Preview training agenda and topics                                                      | **Set induction**  
- Story about girl/boy going through puberty  
- Have trainees contribute to a list of changes youth experience in puberty | None                                                                                       |
| **Session III, Mod I: Experiencing Puberty (15 minutes)** | 1. Girls experiencing puberty  
   a. Physical  
   b. Psychological  
  2. Boys experiencing puberty  
   a. Physical  
   b. Psychological | **Set induction**  
- Elicit puberty stories from trainees or share own/ones found online | 1. PowerPoint Slides 12-15  
| **Session III, Mod II: Initiating Conversation (25 minutes)** | [Open discussion of how to approach topic and discuss with children. If discussion ends with time remaining, move to role play in which one parent acts as child and another parent approaches topic] | **Discussion**  
- When/where might you approach this topic? (Why?)  
- What moments can you anticipate that may help initiate conversation?  
- What are possible reactions of children?  
- How can you overcome negative reactions?  
**Role Play**  
- “Parent” talks to “child” who is embarrassed by topic  
- “Parent” talks to “child” who insists they know all the information | 1. Participant Guide p. 16  
2. Flipchart  
3. Marker  
4. Chairs for role play |
| **Session III, Mod III: At-home Activities (5 minutes)** | Point out and discuss take-home activities (puberty analogy sheet and interview activity)  
Include rational behind activities | **Debriefing**  
**Assessment/Questionnaire** | 1. Participant Guide p. 17-23 |
| **Conclusion (10 minutes)**                 | Short review of material  
Post-training assessment  
Thank trainees for their time and attendance |                                                                                           | 1. PowerPoint Slides 16-17  