RURAL PARENTS: THEIR EXPERIENCES AND NEEDS AS SEX EDUCATORS

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ABSTRACT

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Rural areas have a higher teen pregnancy rate when compared to national averages; research indicates that adolescents in rural areas are more likely to have had sex and less likely to use contraception compared to teenagers in metropolitan areas, highlighting a need for better interventions. Although effective school-based programs have been identified, curricula have not been widely disseminated in the United States. There is strong evidence that parents can play an important role to positively impact adolescent outcomes related to sexual health, including reducing teen pregnancy, sexually transmitted infections, and HIV transmission. However, it remains unclear how parents are currently employing this role and how to effectively engage parents in this role. Thus, the proposed study engaged 19 parents of first-born young adolescents (age 11-14) in a semi-structured interview to understand their experience, strengths and needs in their role as sex educators. Findings from this investigation describe parents' desire to be the primary educators in the sex education of their adolescent children and the importance this role plays within the family system. Data show the relevancy of the barriers parents face lacking adequate resources to know when to introduce and discuss developmentally appropriate sex education content. Finally, research findings indicate that parents are unaware of the risk facing rural adolescents in particular, which may contribute to this risk. Recommendations for future research and intervention approaches are discussed.

Dedication: To my family

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CHAPTER 1: INTRODUCTION

Statement of the Problem

The United States continues to have the highest teenage birth rates of all the industrialized countries in the world, estimated at 24.2 births per 1,000 15-19 year old females in 2014 (Kearney & Levine, 2012; Sedgh, Finer, Bankole, Eilers, & Singh, 2015). Importantly, teenagers in rural areas are at higher risk: they are having sex earlier, less likely to use contraception at first intercourse, and more likely to be exposed to human immunodeficiency virus (HIV) and sexually-transmitted infections (STIs) than their peers living in cities (Ng & Kaye, 2012a). In addition, teen births in rural areas occur at a rate 1/3rd higher than the national average (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2014). Regardless of where a teen lives, almost 80% of teen pregnancies are unplanned (Mosher, Jones, & Abma, 2012) often resulting in multiple poor outcomes for the teen parents (Perper, Peterson, & Manlove, 2010) and their offspring (Hoffman & Maynard, 2008). These negative findings make teen pregnancy and responsible sexual behavior critical public health concerns in the United States (US Department of Health & Human Services, 2001).

The Center for Disease Control and Prevention (CDC) identifies the prevention of pregnancy and STIs and other diseases, as priorities in health care and public health missions specifically as they relate to 15-19 year olds. Such risks can be overcome or drastically reduced with quality sex education and resources (CDC, 2010). The country as a whole bears the burden of teen pregnancy at a cost of $9.4 billion dollars in 2010 alone (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2013), in addition to the over $16 billion in costs of treating STIs, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (Owusu-Edusei et al., 2013). There are also less tangible costs of teen

pregnancy and sexually transmitted infections in terms of interrupted education, compromised health, and increases in risk to infants and young mothers.

Unfortunately, due to often bitter political, religious, medical, and economic debates, school-based sex education approaches have largely failed US youth by providing minimal and, at times, inaccurate information about sex, sexuality, reproductive health, and STI prevention (CDC, 2014a; Huber & Firmin, 2014; Kirby, 2007; Raymond et al., 2008). In addition, although family systems theory and empirical data support parental involvement as one approach to promoting sex education for adolescents (Markham et al., 2010; Miller, Benson, & Galbraith, 2001; Romo, Lefkowitz, Sigman, & Au, 2002; Wilson et al, 2010), school-based programs rarely directly involve parents in the lives of young teens (Guttmacher Institute, 2017). This may be because it remains relatively unknown what role parents, particularly rural parents, could play in the sex education of their children. Therefore, the focus of this study is to understand the experience of rural parents in their role as sex educators and to identify what needs parents have and their ideas on the nature of optimal curricula to successfully engage their youth in sex education, specifically during the time of adolescence. Adolescence is defined as the transitional stage of physical and psychological development that occurs from puberty through adulthood, ages 10 through 19 (Adolescence, n.d.; Age limits and adolescents, 2003). This study focused on the ages from 11 to 14 as this window is an opportune time for intervention, as most adolescents have not yet sexually debuted (CDC, 2014b).

National Costs of Poor Sex Education for Adolescents.

Poor outcomes of teen pregnancy. When adolescents become teen parents, their life trajectories face a number of short- and long-term consequences. For example, education outcomes for many teens are negatively impacted when they become teen parents. A third of teen

mothers do not attain a high school diploma or a General Education Development (GED) certificate by the age of 22, and only 10% of teen mothers complete a two-or four-year college program (Perper, Peterson, & Manlove, 2010). Teen fathers are 25-30% less likely to graduate from high school than teenage boys who are not fathers (Fletcher & Wolfe, 2012). Due to these barriers of educational attainment, teen parents are more likely to live in poverty (Ng & Kaye, 2012b).

Children born to teen parents also face a series of risk factors such as increased likelihood of low birth weight, lower levels of emotional support, and higher risk of behavior problems and chronic medical conditions (Hoffman & Maynard, 2008). From a social welfare perspective, children born to teen parents are at an increased risk of becoming involved in the child welfare systems and law enforcement (National Conference of State Legislatures, 2016a). The impacts of teen pregnancy can be long lasting and, unfortunately, adverse for both parent and child. This evidence supports an argument for the development and dissemination of effective sex education programs for youth that target strategies for reducing teen pregnancy.

Costs of Sexually Transmitted Infections (STIs). In the US, there are 110 million active sexually transmitted infections, including, human immunodeficiency virus (HIV). Younger adolescents and young people aged 15-24 have the highest infection rates; representing 50% of the 20 million new cases of STIs identified annually (Satterwhite et al., 2013). Of teenage females who are sexually active, 25% have an STI such as chlamydia or human papilloma virus (HPV) (Forhan et al., 2009). Looking at HIV specifically, youth aged 13-24 accounted for 7% of the estimated over 1.2 million persons in the US living with HIV infection in 2010. Adolescents account for nearly 25% of the 50,000 new HIV diagnoses annually (CDC, 2012a).

Adolescents are very much at risk of pregnancy or sexually-transmitted infections. According to reports of high-risk behaviors among high school students, 47% have had sexual intercourse at least once, 34% consider themselves sexually active, and 41% of those sexually active students are not using condoms regularly (CDC, 2014b). In addition, 15% of high school students have had 4 or more sex partners; 6% had sex before the age of 13. These data continue to support the need for efficacious interventions aimed at preventing teenage pregnancy, STIs, and HIV infections.

Sexual Risk of Adolescents in Rural Contexts

Rural areas cover 72% of the territory in the United States and are home to unique risk factors related to teen pregnancy and STIs (Ng & Kaye, 2015). Adolescents living in rural families are exposed to economic and educational disparities compared to their metropolitan counterparts. Specifically, rural teens are more likely to live in poverty (17.6% vs. 14.0%) and are less likely to attend college (39.3% vs. 46.3%), both factors placing them at risk for teen pregnancy (Ng & Kaye, 2012a). Rural families can also face considerable health care barriers as they have fewer health care facilities and doctors (per 10,000 individuals), fewer publicly funded clinics offering contraceptives, and challenges to access these facilities because of long travel distances (Shoff & Yang, 2012).

The Guttmacher Institute recently published a study that identified a significant decline in adolescents' receipt of formal sex education within the United States between 2006-2013, and those most impacted were adolescents living in rural areas (Lindberg, Maddow-Zimet, & Boonstra, 2016). Rural formal sex education seems to experience this disparity due to rural school districts having fewer resources (e.g., health teachers, funding), and less time often because of the resources allocated to high-stakes testing (Au, 2007).

Specific to sexual activity, rural teens, aged 15-19, are more likely to engage in premature sex compared to their counterparts living in cities (55% vs. 40%) and are less likely to use contraceptives the first time they have sex (71% vs. 81%) (Ng & Kaye, 2012a). Because of the failure to use contraceptives, risk of STI transmission is also higher in rural areas. Research suggests that these areas experience higher than national averages for chlamydia and hepatitis B (Roberts, Johnson, Brems, & Warner, 2007). Clearly, the prevalence of premature sex among rural teens, incidence of STIs in rural contexts, as well as risk factors associated with rural teen sexual activity demonstrate the need for developing and disseminating effective sex education prevention programs in rural communities.

Sex Education in the United States: A Brief Historical Perspective

Although the federal government has played a role in sex education/sexual health since the Civil War, a bitter debate continues to rage regarding the role of the public school in the sexual education of US youth. While the first public sex education class in the US was held over 100 years ago with the introduction of a curriculum referred to as 'sex hygiene' (Moran, 1996; Pardini, 2003), today many youth receive sex programming that is limited or inaccurate. This checkered history may be why the US continues to report the poor outcomes described above.

During World War I, military service members received sex education as the government sought to prevent spread of venereal diseases. These programs influenced similar programs in public schools (Imber, 1984). While the changes in the early 1900's were innovative, greater public attention was not achieved until 40 years later when the American School Health Association launched a nationwide program on "family life education" in 1953 (Huber & Firmin, 2014). Very little formal organization existed around sex education; nonetheless, it was beginning to receive political, educational, and public attention.

The 1960s and 1970s saw an increase in public schools offering sex education as the US entered the Sexual Revolution Era. The Religious Right and other conservatives were quick to oppose the increased support of public school sex education, which was considered teaching of "smut and raw sex" (Marshall, Delamont, & Bank, 2007) and slowed or blocked adoption of the programs in many school districts. In response to the AIDS epidemic in the mid-1980s, the U.S. Surgeon General issued a report supporting comprehensive AIDS and sexual education in public schools (Pardini, 2003). To counter this initiative, conservative movements resisted by steering funding towards promotion of abstinence-only education (Mauro & Joffe, 2007) even though this type of approach lacks evidence that it decreases the likelihood of engaging in vaginal intercourse (Denford et al., 2017; Kohler et al., 2008).

Today, amidst the controversy, efforts to provide teens with sex and reproductive health information in the United States are largely focused on the public school system. As of 2016, all states in the US had some role in public school sex education (National Conference of State Legislatures, 2016b); however, the specific content varies widely by state and district and is politically influenced. For example, only 33 states require students to receive instruction on HIV/AIDS. In fact, fewer than 50% of high schools and fewer than 20% of middle schools teach all of the 16 essential components of sexual health education recommended by the CDC (e.g., communication and negotiation skills, how HIV and other STIs are transmitted, how to obtain condoms).

This historical rift continues to influence current public school efforts because a majority of school-based sex education programs throughout the United States are focused on promoting abstinence-only approaches (National Conference of State Legislatures, 2016b). However, abstinence-only programs have not yielded significant outcomes for adolescents in terms of safe

sex practices (Carr & Packham, 2017). Further, while comprehensive sex education curricula show encouraging outcomes, the intervention is not widely disseminated in the United States classrooms (Guttmacher Institute, 2017). Schools have been urged by the CDC (2015a) to play a more intentional role in providing and delivering appropriate education across all domain categories, especially with regard to pregnancy, STI, and HIV prevention; however, it is clear that most teens are not obtaining the information from these school-based programs needed to effectively navigate concepts of sexuality, sexual behavior, and sexual health. This lack of comprehensive programming contributes to the poor outcomes described above. Importantly, none of these school-based programs engage the family system, even though parent involvement in adolescents' lives leads to a myriad of positive outcomes including reducing risky sex behaviors (Chan, Kelly, Carroll, & Williams, 2017; Kirby, 2008; Sui-Chu & Willms, 1996; Wang & Sheikh-Khalil, 2014).

Sex Education and Parental Involvement

The CDC identifies parent engagement as a core school health function in sex education (2015b), creating resources for schools to increase parental engagement in sexual health issues. However, parental involvement in school sex education is rare even though parent-adolescent communication and family connectedness play important roles in the prevention of STI/HIV transmission and teenage pregnancy (Markham et al., 2010; Miller et al., 2001; Romo et al., 2002). Better understanding of and incorporating the family system (Nichols, Schwartz, & Minuchin, 1984) could prove beneficial. Evidence indicates teens who are able to talk with their parents about sex are more likely to delay sexual initiation and are more likely to use condoms when they do have sex (Markham et al., 2010). Further, teens that have satisfying relationships

with their parents initiate sex at a later age and tend to have fewer partners (Markham et al.). Thus, promoting parent involvement in sex education efforts is of critical importance.

Youth are more likely to do well in school (Sui-Chu & Willms, 1996) and less likely to experience depression and anxiety when parents are involved in their lives (Wang & Sheikh-Khalil, 2014). Studies indicate that, when youth talk about sex with their parents on a consistent basis, adolescents report that they feel closer and more able to communicate with their parents (Martino, Elliott, Corona, Kanouse, & Schuster, 2008). In a sample of rural parents in which over 90 percent talked to their teens about sex, youth reported feeling more likely to discuss topics related to the responsibilities of being a parent, STIs, dating behavior, and waiting until marriage to have sex (Jordan, Price, & Fitzgerald, 2000). In addition, parents prefer for the majority of sex education to be provided at home with complementary support to be provided by external resources, such as schools (Wilson, Dalberth, Koo, & Gard, 2010). Parents are in the position to be instrumental socializers with regards to their children's educational, emotional, and sexual development. This means they pass on information that is socially and culturally accepted to their children, and their children internalize these norms about sex and sexuality.

Other research demonstrates that parents need support if they are to be successful sex educators. The majority of parents report struggling in the role of sex socializers for their children (Jordan et al., 2000). In addition, parents tend to report that, despite their interest in acting as sex socializers for their adolescent children, they experience considerable challenges such as viewing their children as too young for discussions of sex or not knowing how to talk to their children about sex. Based on these challenges, promoting parental engagement in adolescents' sex education interventions constitutes a priority for the CDC. However, it remains

unclear how best to support parents in this role because the field lacks information about parent experiences and needs for their youth.

Purpose/Significance of the Study

The purpose of the proposed study is to better understand the parental role in sex education, particularly for rural parents, because of the higher risk of teenage pregnancy and STIs for rural teens compared to their urban peers (Ng & Kaye, 2012a). The research seeks to identify rural parents' needs for the content and delivery of sex education and examine those in relation to the established standards created by the Sexuality Information and Education Council of the United States (SIECUS, 2004). Importantly, the study seeks to identify the needs rural parents express to successfully deliver such content. These findings will contribute potentially valuable information to the fields of parenting, family studies, and sexual health regarding how parents perceive their role as sex educators, the practices they use to engage their children in discussions of sex, and what sexuality and reproductive health content they find important for their children.

Understanding rural parent's experience in their role as sex educators including their needs for their success in this role is important to develop programming and interventions focused on reducing pregnancy and STIs for teens throughout the rural US because it generates knowledge which builds the infrastructure for intervention work focused on parent support. That is, the findings will likely inform the design of effective parent education materials that align with the needs of rural parents. Specifically, the research will identify the type of information shared from parent to offspring in terms of sexuality and sexual health, and identify where parents feel successful already. In addition, it will ascertain what resources parents may need in their role of sex educator to be successful or comprehensive in this effort.

Previous intervention work has found that effective programs are multidimensional, including schools and families (Jackson et al., 2010). To that end, the findings of this study can inform school-based programs interested in engaging parents in a collaborative effort to educate youth, a recommendation of the CDC (2015c). Very few studies have examined parent involvement in school-based sex education (e.g., Blake et al., 2001; Oliver et al., 1998). In fact, the collective results of these studies indicate that much needs to be learned if we are to engage families effectively in school-based programming. Each of these studies reported low parent participation rates (i.e., 7% in workshops and < 50% in homework involvement). The proposed study seeks to answer questions that may lead to the generation of programs that enhance parent involvement in school-based programming by identifying where and in what ways schools and parents can collaborate. One strength of the study is the use of qualitative research methodology, which permits extracting valuable information from the participants themselves (Braun & Clarke, 2013). That is, the findings are derived from the rural parents' perspective, a valuable and little known viewpoint for informing how rural parents might engage in education.

Multiple stakeholders will likely find the results of the study valuable. The CDC considers the prevention of pregnancy and STIs for teens a "winnable battle" (CDC, 2010) and thus, will be interested in the findings of this research to inform strategies for activating parents in their role as sex educators and, potentially, as partners with school and community programming on pregnancy and STI prevention for youth. Other stakeholders include the parents of young adolescents, particularly those living in rural communities, school administrators, school nurses, and school-based sex educators. They will be interested in the findings because understanding the experiences and needs of rural parents may pinpoint the content schools

should cover in more depth, inform ways to engage parents in school-based programming, and identify where to disseminate specific content supports to parents.

Rural communities have unique characteristics, challenges, and opportunities, which have been considered for the implementation of this study. By understanding and accommodating the contextual complexities associated with rural communities, the findings may contribute new knowledge about rural communities and can be used to inform programming in rural middle schools (Markey, Halseth, & Manson, 2010). The research has intentionally included key community leaders like the school principal and school nurse as integral to the research process (e.g., research aims, recruitment strategies, interview protocol review), establishing a solid partnership with the community. This partnership was used to keep the communities' interests in mind (Isreal, Schulz, Parker, & Becker, 1998), and has the potential to empower the community members involved (Diaz, Johnson, & Arcury, 2015).

Research Questions

The main objective of this investigation is to examine parental perceptions related to the sex education of their children. This includes examining the parents' perceived roles as sex educators for their children, as well as their needs for providing effective sex education to their children. These questions appear to be a first in seeking to understand parents' experience and ideas for educating their children about sex and sexual health. Thus, the questions are best answered utilizing qualitative methodology including semi-structured, individual interviews. In addition, due to the particular risk of adolescents living in rural communities (Ng & Kaye, 2012a) the work targets parents living in rural Michigan. This study is guided by the following research questions:

- What are rural parent's experiences with providing sex education for their children?
- What sex education content do rural parents identify as important?
    - What content are they comfortable or uncomfortable discussing?
- If rural parents see themselves as sex educators for their children, what resources do they need to support these efforts?

Research Design

The research questions generated for this study were guided using a qualitative approach. Qualitative research aims to gain a detailed understanding of the meanings of human behavior, especially where research is limited (Creswell, Hanson, Clark Plano, & Morales, 2007; Marshall & Rossman, 2011; Merriam, 2009) and is intended to be respectful of diverse and unique populations (Nápoles-Springer & Stewart, 2006), making it useful for this study. Semi-structured interviews provided a pathway to collect data as such interviews facilitated an understanding of specific areas while remaining flexible to the participant responses (Cassell & Symon, 2004). Thus, the study engaged parents of 19 rural community middle school students (grades 6, 7, and 8) in a semi-structured interview about their experiences and needs for sex education.

Thematic analysis (Braun & Clark, 2006) was used to analyze the data. This type of analysis provides a method for uncovering themes and narratives in rich text data sets like the data that was gathered from the semi-structured interviews. In an effort to reduce threats to validity and credibility, I worked with an undergraduate research assistant and my dissertation advisor throughout the transcription and coding processes.

To ensure trustworthiness of the data I completed member checking at three different time points during interviews. I checked in with participants by reporting back what I had heard

them say and asked them if I was hearing them correctly. Additionally, I kept an audit trail of my reactions and processes throughout data collection.

Assumptions and Limitations

It was important and appropriate to identify the assumptions and limitations of this research, as this research occurs in the real world and is not without unique challenges (Wargo, 2015). This research assumed that parents have a genuine interest in the lives of their children and that the inclusion criteria used allow for recruiting participants who have had similar experiences but may have divergent ideas. Additionally, the work assumed that participants were interested in participating in the study and provided honest responses to the questions. Given the sensitive nature of the study, there were supports to reduce these limitations by ensuring participants they may stop the study at any time and were provided local contact information should they need a support service (e.g., therapy).

Some of the limitations of the study included variation in where participants were interviewed. Interview location (e.g., public library, their home, a restaurant) was not consistent for all participants. This variable could bias the responses of the participants: however, to try to ensure that participants felt they could speak freely and that their responses were private, they were asked where they would like the interview to take place. This supported participants to provide honest information. The sample size determination was made based on research guidelines for semi-structured interview studies (Fugard & Potts, 2015; Green & Thorogood, 2009), where many qualitative researchers experienced saturation after interviewing 16 to 20 people (Green & Thorogood, 2009). In addition, there were provisions for interviewing each parent in ways that would contribute to their own sex education. This meant there was time after the interview for the parent to ask follow up questions. In addition, parents were sent resources

(i.e., books and paper pamphlets) in the mail that provided additional supports in their role as sex educators.

Researcher Biases for Consideration

My education and clinical background grant a unique perspective to facilitate research with underserved populations. My previous membership in and familiarity with this community has benefits (e.g., facilitated connections with school), but also could manifest in personal bias such as viewing the community in a particular positive or negative light that would skew my ability to code and analyze data objectively. I worked with a research assistant and my dissertation advisor throughout this process to limit such bias. We engaged in an analytical strategy of memoing, which involved sharing of conceptual ideas about that data, and through continuous communication contemplated these ideas over time (Birks, Chapman, & Francis, 2008). My research interest is in parent involvement, yet I am not a parent and do not know this experience personally. To address this I will take on a position of learner, inform my understanding with literature, and look to my participants as experts in this area.

Reflexivity. An explanation of the background of the investigators and coders were provided to the readers. It is important to be transparent in qualitative research as the researchers are part of the research experience and that can affect the way the study is implemented, and also the way in which the data collected is perceived. It was important to note that I, as the principal investigator, am interested primarily in parenting and the relationship between parent and youth, specifically in families who live in rural areas. Additionally, I was born and raised in the targeted community, attended the middle school there from 6th to 8th grade, and family members still live in and near the community.

CHAPTER 2: LITERATURE REVIEW

History of Sex Education

Sex is an integral part of the human experience, yet normalizing its presence and process, validating its impact over the life course, and creating avenues for research and education on human sexuality has been a bitter and ongoing battle in the United States. The need for a response to sexuality concerns and education has been present since the birth of the US. As early as 1778, the government proclaimed expectations for premarital purity in the Journals of the Continental Congress (Blaine, 1778). In addition, this text stated that soldiers were responsible for their own treatment of venereal disease (VD), not the government. While the government took a "hands off" approach to sex education at this time, they inadvertently began the conversation. This conversation remains intensely politicized, influenced by religion, government, culture, and medicine in ways that inhibit access to quality education, particularly for adolescents, and forestall efforts to support public health efforts such as prevention of teen pregnancy, and STI and HIV transmission. Such political gridlock is a scandal for a developed nation in the 21st century and establishes a clear need for continued research and intervention in the area of sex education.

Early social influences. Very little regarding sex education and venereal disease prevention was formally documented prior to 1900 (Pearsall, 2001). However, during the Victorian Era, a distinct picture was painted regarding sexuality that was rigid and secretive. Gender roles were set, and sexuality was identified only with men and lower-class women, such as prostitutes (Degler, 1974). Women of the upper classes were seen as sexless; in the context of marriage, sex was a duty of being a wife. Dr. William Acton published a book, *The Functions and Disorders of the Reproductive Organs*, going on record about women's sexuality claiming,

"…in general, women do not feel *any* great sexual tendencies." (1875, p. 216). This book was the most cited sex advice book during that time (Degler, 1974). Socially speaking, there was no space for women to recognize, experience, and explore their sexuality in a safe way, nor did this time normalize sex as a relational and healthy experience for both men and women.

During this time doctors and researchers in medicine and psychology viewed women as possessing no sexual desire, and when women presented to the contrary, the desires were viewed as a disease to be remediated (Degler, 1974). Additionally, the fields of medicine and psychology considered masturbation a social disease and believed engaging in the behavior was linked to causing insanity and other medical and mental illnesses (Patton, 1986). Graham crackers were touted by their inventor (Rev. Sylvester Graham) as a way to stop masturbation in adolescent males (Money, 1982). Although there was no evidence of such connection, masturbation, a typical behavior of both men and women, became medicalized and seen as a disorder or illness. Although little attention was paid toward education about masturbation or other areas of sexuality, efforts were made to control and suppress such behaviors. Even the first female physician in 1849, Dr. Elizabeth Blackwell, wrote books on the matters of sex, relaying contradictory messages that women may experience satisfaction from sex, but that coitus remained a special act for males (Brecher, 1969). Additionally, Dr. Blackwell demonized masturbation as an abuse of sex and warned against the using of fingers and hands for personal pleasure (Brecher, 1969).

These perspectives and writings may not have been formal sex education, however they set a standard enmeshed within values and morals for a code regarding appropriate sexuality. The Victorian Era was often an oppressive time for people, especially women. Not only was there a complete absence of sex education, the information people received was not always

medically and psychologically factual, and sometimes harmful. Looking at the long road of sex education, the Victorian Era views on sexuality would need eradication before positive changes toward sex education could occur. Echoes of those views persist in the 21st Century.

Early disease transmission prevention. Some of the first approaches to sex education were in response to transmission of STIs. In 1892 near the end of the Victorian Era, the National Education Association (NEA) went on record promoting sexuality education as a necessary component of the national education curriculum (Advocates for Youth, n.d.). Around the same time, the public campaigned for better health care practices in response to the syphilis epidemic. In 1910, the American Federation for Sex Hygiene, a professional association, was founded and focused on fighting sexually transmitted infections (known then as venereal disease, or VD) (Pivar, 1973). Promoting sex education became a priority in the United States during the early 20th century as soldiers serving in World War I received sex education to prevent the spread of VD (Imber, 1984). At this time, the government finally made a concerted effort toward VD prevention, even though they validated its presence over 100 years prior (Blaine, 1778). These efforts by the government and military influenced similar programs in public schools in the 1920s (Imber, 1984).

Early formal sex education. History was made by Ella Flagg Young in 1913; she proposed the first sex education curriculum for public schools. The program included a series of three sex education lectures referred to as 'sex hygiene' which included topics on physical facts, venereal disease, and the importance of abstinence until marriage (Moran, 1996). This program was highly controversial; outraged local religious leaders worked with conservative school board members to dismiss Mrs. Young as Superintendent of the Chicago Public Schools. It was not

until 1919 that the US government officially supported sex education in schools (Crooks & Bauer, 2016).

In 1922, the Surgeon General, in collaboration with the United States Bureau of Education, published a lengthy sex education manual on suggestions for sex education in high school (Gruenberg, 1922). This was the first manual of its kind developed in response to research and feedback from administrators in multiple schools. The manual put major responsibility on the school to support pupils in their sexual development, stating that it is what the school does or fails to do that shapes the leaders of the next generation. The manual pointed out that while the home is an appropriate place for sex education, too few children were receiving sex education at home and the schools need to step in to fill the gap. The manual went beyond prevention of disease, but included the definition of sex education to mean a "comprehensive and progressive process of care, guidance, and examples extending over a long period of years, from infancy to maturity" (Gruenberg, 1922, p. 1). Suggestions for sex education included topics of biology, physiology, and physical education perspectives. Such an inclusive and encompassing definition nearly a century ago shows that high-ranking government officials perceived sex as more than just a series of behaviors, but a process of development over time. Even though this manual had many progressive suggestions for schools, and an understanding that *both* parents and schools had responsibility to provide education for adolescents, its integration into public schools was not compulsory or common.

Around the same time, grassroots political players targeted change around access to contraceptives. Margaret Sanger opened the first birth control clinic in 1916 in New York, which included education on family planning (Crooks & Bauer, 2016). The actions of Ms. Sanger and her associates were against federal law under the Comstock Act. The Comstock Act forbid the

distribution, publication, or possession of information, medication, or devices of abortion or contraception (Brodie, 1997). Accordingly, Ms. Sanger was arrested for her actions 9 days after the clinic opened. Access to birth control did not fall off the radar, yet it would take 20 years until the American Medical Association went on record recognizing birth control as an integral part of medical education (Kennedy, 1970), even though there was no legal protection for contraceptives at the time. History demonstrates a consistent awareness and need for access to health services and education regarding human sexuality over time; however, the general lack of action to address this pressing issue has also been persistent.

Pioneer in sexuality research. One researcher who did respond to a need for sex education was Alfred Kinsey, an entomologist with a career devoted to the taxonomy of gall wasps. Kinsey was a pioneer in sexuality research in the United States. He asked forward-thinking questions in response to the lack of student knowledge in the marriage and family courses he taught in the late 1930s through the Indiana University Biology Department (Brown & Fee, 2003; Jones, 1997). Class sizes soared in response. Very controversial at the time, he required the support of the university president to persist in his teaching and research (Hegarty, 2013). While still inaccessible to children, adolescents, and the public at large, Kinsey's courses and research efforts brought attention to the need for sex education. He began formal research to examine male and female sexual behavior that continued into the 1950s (Brown & Fee, 2003), publishing those studies in two books, *Sexual behavior of the human male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual behavior of the human female* (Kinsey & Institute for Sex Research, 1953). Kinsey's work has continued to the present day through the researchers at the Kinsey Institute for Research in Sex, Gender, and Reproduction at IU.

Although the research base was growing in the area because of the work of Kinsey and his colleagues, issues related to the accuracy of sex-related information received by the public remained a concern because there was little regulation of the dissemination of sex education information. The American School Health Association launched a nationwide program on "family life education" in 1953 (Huber & Firmin, 2014). The program, which typically was part of the home economics classes that were limited to female students, included lectures on character building, relationships, money management, marriage, and childbearing. Sex, however, was still placed in the biology course, and still feared by parents as a topic that would encourage sexual activities when discussed (Huber & Firmin, 2014). Two years later, the American Medical Association in partnership with the NEA published pamphlets for a sex education series for adolescents. The pamphlets covered subjects such as finding yourself, coming into adulthood, and becoming a parent; none of which were explicitly about sex. Schools began using the resource; however, there was no federal policy or mandate instructing schools on implementation, and no evaluation of concrete outcomes. Even though very little formal organization existed around sex education, and content was limited; sex education in the schools was nonetheless beginning to receive political, educational, and public attention.

Professional organizations in sexuality education. The need for wider dissemination to the public of accurate and complete information about sexual health encouraged Dr. Mary Calderone, the Director of Planned Parenthood in the 1960s to begin speaking with religious congregations about the social problems that resulted from lack of sexuality information and how to collaborate with them to best circulate this content (Cunningham, 1999). Planned Parenthood was synonymous with contraception and abortion, both of which were highly controversial and received major pushback from religious communities (Powderly, 1995). Due to the pushback

associated with Planned Parenthood's link to contraception, Dr. Calderone identified a need to establish human sexuality as a health entity and differentiate it from Planned Parenthood itself. Moving in this direction opened up avenues to sex education that presented fewer barriers. Additionally, legitimizing human sexuality as a health entity was difficult with its controversial connections to contraception.

With five colleagues in 1964, Calderone founded the Sexuality Information and Education Council of the United States (SIECUS) (Cunningham, 1999). SIECUS, from its birth, prioritized the importance of training competent teachers of sex education (Schulz & Williams, 1967) and emphasized this continuously in newsletters reflecting their philosophy that effective sex education programs begin with appropriate teacher preparation (Schulz & Shimmel, 1968). Shortly thereafter (1967), these goals materialized when SIECUS leader Patricia Schiller formed the American Association of Sex Educators and Counselors and Therapists (Engel, 1989). This association offered training and established a set of standards for sex education providers.

These changes were necessary because sex educators in the 1960s did not have a major role in the "family life education" program that existed in schools. Teachers were prohibited from including their personal perspectives or opinions on content and within student-based discussions on sex education (Lamb, 2013). Given that teachers were without proper instruction on teaching about sexuality and were forbidden to be active participants in the education, how educational the programming was for students is unknown.

Government funding for sex education. The government finally legitimized the critical need for sexual health services and education in 1970 when Congress appropriated funding for Title X of the Public Health Services Act. This specifically appropriated funds devoted to family life, sex and population education programs, family planning services, preventative health

services, and funds for research (Napili, 2016). It had become apparent that sex education, family planning services, and research were critical to combatting issues related to poverty. Since its inception, Title X has set a precedent of serving low-income men and women who are largely impacted by limited access to health care, barriers to family planning, and the high costs of parenting. This was the first definitive funding stream for community-based sex education designed for pregnancy prevention in the United States (Huber & Firmin, 2014).

As a result of Title X funding in the 1970s, an increasing number of teens were receiving contraceptive education and services. In addition, specific funding was directed towards sex education for unmarried teens (Scales, 1981). Title X–supported clinics were, and still are, open to all women, regardless of age, marital status, income or health insurance status and offer a wide range of services including blood pressure evaluation, breast examinations, pelvic examinations, Pap tests, and STI and HIV testing (Gold, 2001). By 1973, federally supported family planning programs existed in over 650 US communities and by 1983, programs supported by this funding served almost 5 million people (Dryfoos, 1988). Of the people using these services, 70% were white and about 25% were black. In 1973, the U.S. Supreme Court issued the landmark ruling (Roe v. Wade, 1973), which legalized abortion. The nation could no longer turn a blind eye to this topic as women now had legal protections to pursue vast forms of contraceptive options.

The government also pushed to expand primary health care programs to rural areas during this time. By the late 1970s almost 1,000 rural based health clinics existed across the U.S. existed including comprehensive health centers, group practices, institutional extension practices, free-standing primary care centers, and solo physician practices (Sheps, 1983). These clinics experienced a multitude of issues that ranged from financial instability, long-term sustainability

of programming, and recruiting and retaining clinical staff. Even though multiple efforts were made to bring access to services to rural areas, many barriers impeded their success.

In 1971, 65% of the public approved of sex education in schools (Gallup, 1978), however only 35% of private and public schools provided some form of sex education by the late 1970s. The content and dissemination varied enormously (Scales, 1981). In one snapshot of 540 schools in Massachusetts at the time, half of the schools offered sex education; of those, over 2/3rds covered human reproduction, but less than 40% covered topics related to contraception and abortion (Hottois & Milner, 1975). Content including contraception, homosexuality, abortion, masturbation, decision-making and communication skills, self esteem, and discussion of personal values and emotions were less likely to be included in sex education. It was estimated that only about 10% of students throughout the 1970s were exposed to such a high level of content (Kirby, Alter, & Scales, 1979).

While many schools at the time either provided some or no sex education to students, school-based health clinics were another means of providing health care information and education to at-risk youth (Rienzo & Burton, 1993). This was however perceived as controversial, as school-based health clinics also included services and education related to reproductive care. School-based health clinics were generally supported by the government, health care professionals, parents, and school (Lear, Gleicher, St. Germaine, & Porter, 1991), however there was also great opposition which primarily came from national conservative associations including National Right to Life, Eagle Forum, and the Christian Broadcast Network (Rienzo & Burton, 1993). Due to this opposition it was difficult to establish school-based health clinics in communities (Donovan & Waszak, 1989), and further, actually be in a position to

provide information related to sex, contraception, and abortion to youth (Rienzo & Burton, 1993).

AIDS epidemic and sex education. The next big change in sex education began in the mid-1980s as the AIDS epidemic gained governmental and public attention. The U.S. Surgeon General C. Everett Koop issued a report supporting comprehensive AIDS and sexuality education in public schools in 1986 (Pardini, 2003). Because of the increase in concerns for health risk, teaching about sexual restraint to youth was deemed opportune, and, for the first time, abstinence-only education became a federally funded program (Pear, 1986). Abstinence-only education, according to its definition, teaches the social, psychological, and health gains from abstaining from sexual activity, that abstaining from sexual activity outside of marriage is the expected standard, and the only way to avoid unwanted pregnancy and STIs is to be abstinent (Social Security Act, 1989). Abstinence education continued to receive funding in the 1990s when President Clinton signed the Welfare Reform act into law in 1996 (Klein, 2006). Its intent was to combat child poverty by aiding at-risk and impoverished adolescents to abstain from sex, in hopes of diminishing unwanted pregnancies and breaking the cycle of children born into poverty (Haskins & Bevan, 1997). Beginning in 1998, $5,000,000 a year was set aside for abstinence-only education grants to the states, continuing through 2007. Evaluation reports on abstinence-only sex education over the last two decades show that these programs have not reduced the likelihood of engaging in vaginal intercourse (Denford, Abraham, Campbell, & Busse, 2017; Kohler, Manhart, & Lafferty, 2008), nor have they had a significant impact on HIV/STI prevention (Kirby, 2007). Although data has identified the gross ineffectiveness of abstinence education at multiple points, a majority of sex education programs were abstinence-only through the early 2000's. Abstinence-only education, even with its unsatisfactory outcomes

continued to receive support from religious and conservative communities favored by the Christian and Religious Right based on idealistic, and seemingly unobtainable, values (Shatz, 2007). Major issues persisted during this time as 'best practice' was debated while children and adolescents continued to receive education that was incomplete and ineffective, putting them at risk of pregnancy and/or HIV/STI transmission.

In response to the lack of outcomes, a majority of the funding for abstinence-only sex education was removed (SIECUS, n.d.), and advocacy for comprehensive sex education increased over the years. Beginning in 2008, the Obama administration created significant avenues for change. In 2009, President Obama signed the Consolidated Appropriations Act of 2010 by which major federal funding was specified for comprehensive sex education approaches. These approaches included programs educating on topics related to sexual anatomy, relational skill building, behavior skill building, HIV/STI information and prevention, and contraception information, all of which included developmentally appropriate information depending on age/grade level. These changes have caused an increase in access to condoms in many schools and challenges to the continued abstinence-only curricula, with more schools teaching comprehensive sex education curriculum and districts taking sex education into their own hands by conducting their own research to better meet student and community needs (Edwards, n.d.). In some schools, students became their own advocates with one group of high school students from Arizona recommending that school board enhance their curriculum, create a sex education resource center at their school, provide a pregnancy support group, and offer educational activities during prom week.

Continued controversy in the new millennium. The 21st century has also seen passionate debates about and protests against Planned Parenthood, an organization that provides

vital resources such as contraception and family planning, both nationally and internationally At the heart of the debate and protest are issues of legal access to abortion even in cases of rape and incest, with issues of providing information on sexuality, contraception, and disease prevention always in the background (Aizenman, 2017). The current political climate (2017) may change some of the progress because the new Secretary of Education, Betsy DeVos, has a history of financial contributions to organizations whose work undermines protections for the most at-risk students, e.g. the Foundation for Individual Rights (FIRE), which works to weaken Title IX's protection of students subjected to gender violence. She has also contributed millions of dollars to anti-choice causes, including centers that have been documented to mislead women and provide misinformation about birth control and abortion (National Women's Law Center, 2017).

Even with improved knowledge from research in medical, psychological, human development, and human sexuality fields, effective intervention programming, established professional standards for content and teacher education, and the development of quality curricula, US adolescents do not have universal access to quality, accurate sex education programs. A hundred years after WWI and the pioneering efforts at sex education, the vehement debate inhibits access to effective and comprehensive sex education, marginalizing the most vulnerable populations, perpetuating teen pregnancy and STIs in the wealthiest nation in the world.

Research Examining Sexuality Education in the United States

Today, US public schools have been given the responsibility to provide sex education to children and adolescents. This responsibility has increased over the years due to policy changes, increased funding sources, public support, and an awareness of the preventable impacts brought on by teen pregnancy and STI transmission (CDC, 2010). Program content varies widely given

that each state has the power to decide the direction of sex education, causing variations to exist from school district to school district (National Conference of State Legislature, 2016b) resulting in a great deal of variation in program content, delivery, and evidence for effectiveness.

Even though all states are somehow involved in public school sex education, no minimum standards exist. Only 24 states require public school sex education (21 mandate sex education and HIV education), 33 states require some instruction about HIV/AIDS, and 20 states require that, if sex and/or HIV education is provided, it must be medically and factually accurate (National Conference of State Legislatures, 2016b). Given that a majority of states have no requirements or standards for sex education content, students are at risk for receiving inadequate or biased sex education information, contributing to the already alarming health and social impacts of teenage pregnancy and STI transmission facing this country.

Two avenues have been developed for school-based sexuality education: abstinence-only sexuality education and comprehensive sexuality education. Abstinence-only sexuality education primarily transmits messages emphasizing abstinence from all sexual activity outside of marriage, and tends to omit controversial topics such as adolescent sexuality, contraception, abortion, masturbation, and sexual orientation (Alford, 2001). Sex only after marriage is the expected standard, and priority is placed on the social, physical, and emotional benefits of abstaining from sexual activity until married. Comprehensive sexuality education is defined as education that includes sexual anatomy, reproduction, intercourse, reproductive health, emotional relations and skill building, abstinence, and contraception (Boonstra, 2009). Evaluations of these two approaches have resulted in differing outcomes.

Abstinence-only outcomes. In a very recent review of school-based sex education interventions, abstinence-only interventions were found to be ineffective in promoting positive

outcomes in sexual behaviors such as delay of sexual debut (i.e., first sexual intercourse), decrease in sexual activity, and use of contraceptives (Denford et al., 2017). These evaluations also mirror what has been found in the past two decades, viz., there is no evidence that abstinence-only education decreases the likelihood of engaging in vaginal intercourse (Kohler et al., 2008). Additionally, abstinence-only programs have not typically reported on HIV/STI outcomes, and those that did found no significant impact on HIV/STI infections (Kirby, 2007). Disturbingly, a few have been found to increase the risk of contracting HIV or STIs (Kirby, Laris, & Rolleri, 2007), attributed to the lack of content covering contraceptive use. And while states have mandates for abstinence-only education this has not lowered teen birth rates or abortion rates (Carr & Packham, 2017).

A critical error that takes place in abstinence-only education is the disregard of adolescent sexuality and the profound impact it *could have* on the bio-psycho-social development of youth (Engel, 1980). Puberty is a landmark that is met with rapid physical, emotional, and psychological changes and transition into an adult body and mind. This period of time is vulnerable to psychological, social, and environmental influences (Kar, Choudhury, & Singh, 2015). These years are met with pressures from peers to smoke and drink (Urberg & Shyu, 1990), become popular (Adler & Adler, 1998), and partake in sexual risk taking (Raffaelli & Crockett, 2003). School education could lay a strong foundation for adolescents, normalizing these changes, providing education and support to help students navigate these challenging influences; however, abstinence-only education does not address these areas of development and in fact, tries to suppress behaviors that do not align with abstinence-only beliefs (e.g., adolescent sexuality), limiting the program's reach to diverse populations (e.g., see Need for Diversity in Content below).

Another reason abstinence-only programs may fail is due to the inaccurate or lack of information provided to students. Issues of accuracy of information in abstinence-only programming have come under scrutiny. Some programs convey messages that condoms fail to provide protection against HIV, focusing on the actually low rate of condom failure and leaving out complete, current, and accurate medical data regarding the effectiveness of condoms in preventing unwanted pregnancy, HIV, and STIs (Lin & Santelli, 2008). The availability and use of birth control methods (e.g., pills or implants) for older adolescents is not mentioned. Other programs do not provide medically accurate information, in fact one program entitled *WAIT Training*, students are taught that HIV/AIDS can be transmitted through tears and sweat (U.S. House of Representatives, 2004), even though tears and sweat have never been shown to transmit HIV (CDC, 2016). Some curricula teach other inaccurate information, such as having an abortion is associated with an increase in tubal and cervical pregnancies post abortion along with an increased likelihood of infertility (U.S. House of Representatives, 2004). Essentially, abstinence-only programs tend to offer incomplete and sometimes inaccurate information, and may even present false information as fact.

Based on this extensive body of work reporting ineffective outcomes, researchers have asserted that abstinence, as a sole option for adolescents, is scientifically and ethically problematic (Santelli et al., 2006). In the last decade, some states (e.g., California, Maine, New Jersey, Pennsylvania) have gone as far as to refuse federal funding for abstinence-only programming because of concerns about the lack of medical accuracy and the lack of evidence for the efficacy of these types of programs (Raymond et al., 2008). Instead, this funding has moved away from abstinence-only programming toward supporting comprehensive sex education.

Comprehensive sexuality education (CSE) outcomes. Research has demonstrated that CSE is more effective than abstinence-only education regarding outcomes of delaying first sex, reducing frequency of sex and number of sexual partners, increasing use of condoms and contraceptives, and reducing risky sexual behaviors (Kirby, 2007; Kirby, 2008; Stanger-Hall & Hall, 2011; Williams, 2011). Students who attended CSE programs have a lower risk of pregnancy than compared to their counterparts who receive abstinence-only sex education and are significantly less likely to report teen pregnancy and vaginal intercourse (Kohler et al., 2008). Males and females receiving comprehensive education were more likely to use birth control the first time they had sex (Mueller, Gavin, & Kulkarni, 2008; Lindberg & Maddow-Zimet, 2012). Even a program characterized as "abstinence-plus" education that follows the abstinence-only curriculum primarily but includes contraceptive information was shown to be effective in increasing contraceptive use in 7 out of 10 programs (Bennett & Assefi, 2005).

In regards to HIV/STI prevention, comprehensive sex education shows encouraging outcomes. A recent review of comprehensive programs found that those specifically targeting HIV prevention were found to be effective in improving knowledge and changing behaviors by targeting risky sexual behaviors (Denford et al., 2017). In addition, males were less likely to have been diagnosed with STIs and were more likely to have ever been tested for STIs (Dodge, Reece, & Herbenick, 2009).

Unfortunately, this research has not quieted the disagreements over the two approaches nor necessarily led to widespread changes in school-based education. Extensive data have identified the failure of abstinence-only programming, yet a vast majority of states still subscribe to its use (Guttmacher Institute, 2017). Evidence suggests CSE is on a more promising track even though major changes to our education standards have not been realized. This may be

because, even at the end of 2015, the Federal government had not dedicated any funding for CSE programming but has spent $1.87 billion dollars on abstinence-only programs since 1982.

Effective CSE programming. SIECUS, the professional sexuality education organization, is the most-cited source on *comprehensive* sexuality education and defines the standards for comprehensive information for Kindergarten through 12th grade. SIECUS identifies six key concepts within their guidelines for CSE: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture, and provides developmentally appropriate content for each concept depending on the grade/age level of students (SIECUS, 2004). Topics within each concept are extensive for each grade level, and reflect developmental level. For example, for elementary, middle school, and junior high school students, topics include developmentally appropriate messages on decision-making and assertiveness (personal skills), masturbation and sexuality throughout life (sexual behavior), and contraception, abortion, and STIs (sexual health) (SIECUS, 2004). The emphasis within the guidelines is factual and more, rather than, less information. It covers broad aspects and important details in each concept, and breaks down information that is developmentally appropriate and necessary for children and youth to have the knowledge and skills to make informed decisions as they move from one grade level and challenge to the next.

Critical components in CSE. Content and delivery are two vital components of effective sex education that must be considered as research and program implementation move forward. Concerning content, the above review has clearly articulated how a CSE approach is critical, including content about sexual development in addition to pregnancy and STI prevention. Contraception such as condoms is an effective means to reducing teenage pregnancy and the most common contraceptive method used among teenagers (Martinez & Abma, 2015). The

inclusion of condom education and use, according to the CDC, is one of the most effective strategies in reducing the risk of acquiring or transmitting HIV and or STIs (2015b). In a global analysis of social and health factors contributing to the HIV epidemic, it was found that the contraceptive prevalence rate of the country was a strong predictor of the prevalence of HIV (Mondal & Shitan, 2013). The inclusion of contraceptives and thorough HIV/STI content as a standard for sex education is critical in preventing teenage pregnancy and STI transmission, and the CDC and SIECUS have extensive standards and curriculum content for both.

The delivery of sex education is also critical. The timing of programming, when students are exposed to specific curricula, is important due to the fact that almost half of all high school students have had sexual intercourse at least once, and 6% of students have had sex before the age of 13 (CDC, 2014b). Thus, adolescents, specifically 11-14 year olds, should be receiving sex education prior to engaging in this behavior, but most are not. There is a window of opportunity for adolescents that are missed without early implementation. Delay of sex education content may place adolescents in danger due to lack of preventative knowledge. Who delivers sex education is also an aspect under debate. Multiple players, including parents, have the potential to positively impact sex education outcomes, as parent involvement in adolescent's lives tends to lead to better outcomes.

Typical practice. There are some general themes common to sex education across the United States. Sex education typically occurs during Grades 7 through 9 and is a unit in health or science class ranging from one to 15 classes (Berne & Huberman, 1999). SIECUS (2004) suggests every grade level from Kindergarten through grade 12 receive appropriate and accurate sex education. The single unit exposure that some students receive as their primary sex education is well below these standards. Content in abstinence-only and CSE programs ranges from topics

related to sexual anatomy (e.g., male/female reproductive systems, fertilization), relational skill building (e.g., how to create and sustain healthy and respectful relationships), and behavior skill building (e.g., benefits of being sexually abstinent). Some abstinence-only programs may provide HIV/STI information (e.g., how HIV and other STIs are transmitted), while it is a standard component in CSE programs, along with inclusion of contraception information (i.e., how to obtain and use condoms) (CDC, 2015b).

Variation in sex education implementation. Although extensive standards and quality curricula for comprehensive sex education exist (e.g., Family Life and Sexual Health (F.L.A.S.H.), Sexuality Education Within Comprehensive School Health Education; Klein, 1994), actual implementation of the curricula varies widely across schools because decisions regarding curricula, content, and time of implementation are determined locally and politically. For example, even though more than half of all states require instruction about HIV/AIDS, it is not necessarily disseminated within the context of sex education (National Conference of State Legislature, 2016b). Not even *all* states require students to learn about the health consequences of HIV/AIDS or offer reliable information about prevention or treatment, leaving the school to select whether or not this content is delivered. Certainly, whether the curriculum is abstinence-only or comprehensive is a school district-level decision and will be very much influenced by the political views of the community and families. In fact, unless a state mandates sex and/or HIV education, there may be no or only limited programming for students. This is unfortunate, because adolescents are at risk when they lack adequate education (Kirby et al., 2007), and currently many students are in such a position (Guttmacher, 2017).

Even with mandated content, current programs are not implemented with fidelity, that is, they are not implemented in a way such that the intervention maintains the program model or

protocol originally developed (Mowbray, Holter, Teague, & Bybee, 2003). This means important content or delivery practices may, and often are, left out. As evidence, SIECUS curriculum recommendations are not followed on a consistent basis in many current sex education programs (SIECUS, 2015). Furthermore, an evaluation of secondary school sex education programs throughout the US by the CDC (2015b), found that among Grades 6, 7, and 8 and across 16 recommended HIV, STI, and pregnancy prevention topics, an average of 17.1% (range 3.7-45.6% across states) of schools taught all topics.

Educator preparation. Another way in which programs vary is by instructor's background preparation. SIECUS has prioritized and supported standards and trainings for teachers for almost 50 years, yet currently many are ill prepared to lead sex education classes (Schulz & Shimmel, 1968). More than 50% of college-level teacher preparation programs do not require sexuality education courses (Barr et al., 2014), nor do instructors have access to professional development covering evidenced-based training to effectively implement sex education curricula (Barr et al., 2014). Even when instructors are well prepared, they may face barriers to implementing a truly comprehensive curriculum due to restrictive policies at the school or community level and concern about student, parent, and administrator feedback (Eisenberg, Madsen, Oliphant, & Sieving, 2013). This often results in omitting critical components of the curriculum.

Evidence shows that fidelity to sex education curricula can be increased when teachers are credentialed and have access to continued training opportunities. Compared with those not credentialed, credentialed health education teachers have greater comfort and sense of self-efficacy regarding instruction (LaChausse, Clark, & Chapple, 2014), and trainings are an effective means to supporting teachers and increasing program fidelity (Drake, Firpo-Triplett,

Glassman, Ong, & Unti, 2015). Monitoring fidelity, even across multiple sites and varied curricula, can increase adherence to program components (Cornish, Losch, & Avery, 2016).

Like teachers of other content areas (Datnow & Castellano, 2000), even well trained instructors adapt curriculum. In one sample of sex educators in California, 59% implemented evidence-based curricula, however 95% reported adapting the curriculum and 83% said they needed to add content (Arons, Decker, Yarger, Malvin, & Brindis, 2016). Teachers reported adaptations were necessary to make sure content was accurate and appropriate, to meet time constraints, and to balance state and local requirements. For other curriculum areas, like reading, better outcomes have been found when teachers have some autonomy with the curriculum (Tivnan & Hemphill, 2005; Wilson, Martens, & Poonam, 2005). This may be true for sex education instructors too, though it remains untested. Widespread adaptations to curricula bring up issues of whether original programming is effective and fits the needs and priorities of the community, how much overall flexibility should be granted to meet community needs, and how much this impacts overall fidelity. Specifically for sex education, which has a deeply controversial history and present, concern exists regarding whether adaptations are driven by the need to provide more and accurate information, or by instructor, school, or community values wishing to suppress accurate and comprehensive information.

The variations that exist in sex education implementation are problematic because it becomes very difficult to identify what is the best or necessary curriculum content, method of delivery, instructor approach, and time and length of program exposure. These are all program variations that impact program outcomes, and more importantly, the health and wellbeing of adolescents and youth.

Limitations of school-based sex education. Vast variation exists within program implementation, teacher preparation, and limited coverage of sex education content aligned with SIECUS recommendations. Current school-based methods are failing US youth, and school-based instruction, as a sole practice, is not an effective program. To provide effective sex education for adolescents, other resources need to be identified and activated to better assist in their education and development. Parental involvement in sex education is a critical step towards improving sex education outcomes, such as lowering the rates of teen pregnancy and STI and HIV transmission.

Parental Involvement in Sex Education

Adolescents fair much better in life when their parents are involved. Parental involvement is related to better adolescent outcomes in school performance, attendance, good behavior, and academic success (Perkins et al., 2016; Sui-Chu & Willms, 1996). Adolescents are less likely to use drugs (Chan et al., 2017), drink alcohol (Koning, Maric, MacKinnon, & Vollebergh, 2015), and smoke cigarettes (Smith, Aycock, Hook, Chen, & Rueger, 2017) when they know their parents disapprove. When parents engage an authoritative/democratic parenting style adolescents are likely to have increased self-esteem and adjustment, better peer relationships, and higher levels of intrinsic motivation for learning (Cripps & Zyromski, 2009). In addition, parental involvement has been found to improve adolescent's emotional functioning and serves as a protective factor for mental health issues including anxiety and depression (Wang & Sheikh- Khalil, 2014).

Parental involvement in sex education has also contributed to positive outcomes in adolescent development. High parent-child connectedness has aided in the reduction of adolescent pregnancy, number of sexual partners, and has increased contraception use among

adolescents and teens (Markham et al., 2010; Miller et al., 2001). Parental-child communication on sex related topics plays a role in sex education outcomes as adolescents and teens were more likely to be sexually abstinent, or postpone sexual activities (Romo et al., 2002).

Importantly, some evidence supports that parents actually prefer to be their child's primary sex educator with school acting as complementary (Wilson et al., 2010). Ninety-three percent (93%) of parents support teaching sex education in high school and 84% in middle school (Landry, Darroch, Singh, & Higgins, 2007). Even when controlling for how parents identify politically (e.g., Republican, Democrat), a large majority of parents support including sex education that includes topics on STIs and contraception for middle school (78%) and high school (89%) (Kantor & Levitz, 2017).

Even though evidence indicates that parents want to be involved and parental involvement is beneficial, parents experience barriers related to a lack of confidence and skills in their role as sex educators (Asekun-Olarinmoye, Dairo, Asekun-Olarinmoye, & Adebimpe, 2014; Guilamo-Ramos, Jaccard, Dittus, & Collins, 2008). Bridging this gap by better responding to parent needs through intervention supports may be an effective direction in sex education programming. It is important for all families to have access to education and resources that benefit them.

Rural parental involvement in sex education. Limited existing research has investigated rural parents behaviors and beliefs about sex education, providing some guidance and also leaving many gaps in this area of the literature. What we do know about rural parents specifically is derived from parent survey research on parents' attitude towards inclusion and expansion of sexuality education of the school curriculum, as well as, parents' perceptions of themselves as sex educators (Jordan et al., 2000; Welshimer & Harris, 1994). Survey data was

collected from a district composed of two small rural towns with an estimated population of 7,000 community members who all identified their ethnicity as white. The community experienced an increase in teen pregnancy for teens 15-17 years of age. Rural parents of current high school students were surveyed. Of the rural parents in this study, 87% (n = 224) approved of sexuality education for high school students. A majority of these rural parents (63%) were also in favor of expanding sexuality education to grades K-8 (Welshimer & Harris, 1994). Just over 50% of these parents had identified as providing adequate sex education to their children, yet only 15% of parents indicated that they thought parents knew how to engage as a sex educator and provide their children what they need.

In a rural Midwest area composed of four districts researchers inquired parent perspectives on topics including communication about sexual issues, their comfort level addressing certain topics, parents' support for sexuality education, and desired assistance regarding sexuality education (Jordan et al., 2000). A total of 374 rural parents were surveyed; a majority were White (92%), female (87%) and identified religion (73%) as "important" or "very important". A majority of parents (94%) reported they had talked with their teen about sex, and two-thirds (65%) reported being comfortable talking with their teen about sexual issues. A large majority of parents (87%) identified that they should be the primary provider of sex education, with school acting as a secondary source.

Around 64% of these parents believed that sexuality education should begin before students reach seventh grade, and that sexuality education should include information related to STIs (91%) and birth control, including condoms (92%). Additionally, parents were most interested in receiving a newsletter from the school regarding sexuality education and resources to integrate into their own practices (Jordan et al., 2000). This research indicates that rural

parents are engaging their role as sex educators with adolescents and they are interested in receiving supports.

What continues to be unknown is what communication or discussions looked like for these parents in both studies (Jordan et al., 2000; Welshimer & Harris, 1994), that is, when discussions about sex began, what content was covered, what was challenging, and what factors supported parents to be comfortable talking with their children about sex. This qualitative context is lacking due to the survey methodology used in both studies. Additionally, while the surveyed parents supported public school sex education and reported wanting to be involved in some way (Welshimer & Harris, 1994), these studies did not ask what "involvement" might look like from the parents' perspective, leaving a critical gap in our understanding. Research must specifically identify the current practices and needs of parents living in rural areas in terms of sex education if we are to understand rural parents' role in sex education.

While the focus of the present study is on rural parental involvement in sex education, no study was found that qualitatively investigated the rural parent experience in their roles as sex educators as an aid to guide participant selection (Jordan et al., 2000; Welshimer & Harris, 1994). Previous research on sex education with parental involvement did not differentiate between mothers or fathers, or explicitly target either parent group (i.e., Abel & Greco, 2008; Blake et al., 2001; Grossman et al., 2013; Grossman et al., 2014; Oliver et al., 1998; Tortolero et al., 2010). Some studies conducted over the last few decades have shown that parents are more likely to seek out their same-sex child to initiate conversation about sexual topics (DiIorio, Kelley, & Hockenberry-Eaton, 1999; DiIorio, Pluhar, Belcher, 2003; Nolin & Peterson, 1992; Wyckoff et al., 2008). However, other work has identified mothers to be more likely than fathers to talk to sons and daughters about sexual topics (Nolin & Peterson, 1992; DiIorio et al., 1999;

DiIorio et al., 2003; Byers, Sears, & Weaver, 2008). A gap exists within the literature capturing both the rural parental perspective of mothers and fathers in their roles as sex educators.

Theoretical Framework

Family systems theory. Theoretically, family involvement may be one way to enhance the effectiveness of sex education, particularly for young adolescents. Family systems theory is an extension of Bertalanffy's general systems theory (Bertalanffy, 1969) which has been informed by multiple theorists, researchers, and psychiatrists as they made decisions to include a larger family framework in their treatment approach and study family stress, conflict, and pathology from a systems level perspective rather than focusing on a single individual (Foley, 1974).

Among others, in the 1970s theorists Nathan Ackerman, Virginia Satir, and Murray Bowen were dignified as pioneers of and major contributors to family systems theory in their work in family therapy settings (Foley, 1974). Ackerman (1938) articulated the importance of seeing the family unit as dynamic and changing due to internal and external pressures and understanding these interchanges were essential to understanding how a person functions. Satir (1972) emphasized the importance of good communication within families, and family member's abilities to self-express and share emotions within the family system. Bowen (1966) highlighted a family system's process and how they engage and manage anxiety, as well as, the transgenerational impact these issues can have on families over time. In the 1980s theorists Salvador Minuchin and Ivan Boszormenyi-Nagy become influential in the field as well (Nichols, Schwartz, & Minuchin, 1984). Minuchin (1974) contributed to family systems theory by raising the importance of boundaries within a family system, focusing on the level of interconnection within families and their overall functioning. Boszormenyi-Nagy (1987) identified the relevance

of loyalty, trust, and relational ethics that exist within families both in their present form, and the legacies before them that continue to influenced them.

Family systems theory has multiple contributors and takes the position of looking at the many complexities that are involved with the family system. This theory highlights the interaction of parts, or individual family members, within a living system, or family. Family systems theory helped to form the rationale for this study by providing an argument that understanding the parent perspective and identifying parental needs in sex education are necessary steps in an effort to engage the family system with a goal of decreasing teenage pregnancy, transmission of STIs, and premature or risky sexual behaviors.

Families are organized to maintain structure and establish boundaries between themselves and their immediate environments (Minuchin, 1974). Boundaries define the limits of the system, and the family maintains these boundaries by filtering out external elements that appear hostile to the goals and policies of the family while at the same time incorporating elements that are seen as beneficial (Ingoldsby, Smith, & Miller, 2004). Feedback from the environment is used to regulate a family's functioning, and families may break down or adapt depending on their overall health as a system (Becvar & Becvar, 2013; Broderick & Smith, 1979). One characteristic that is particularly important when considering families and children is interconnectedness. Individual family members do not act in isolation, but on the contrary, influence one another (White & Klein, 2008). When family systems theory is applied to sex education, adolescents' behaviors are considered within the context of their families. Thus, the prevention of high rates of teen pregnancy and STI transmission are no longer responsible of the adolescent alone, but now engage the family as a whole.

Depending on a family's boundary system and willingness to incorporate sex education, parents may be particularly primed to be involved in the sex education of their adolescent. A majority of teenagers want to look to their parents as sources of information about sex (National Campaign to Prevent Teen Pregnancy, 2002). In fact, 69% of teenagers said that if they had consistent opportunities to have open conversation about sex with their parents, it would make it easier to postpone sexual activity. Additionally, depending on how interconnected parents are with their children, they may be particularly invested to take part in this transaction. Families have a vested interest in sharing and continuing beliefs, values, choices, and behaviors held in common, this is true in general and for sexual health and behaviors. However, if families do not have sufficient skills and information, they may not be able to provide education that is factual and effective, even if this is something they desire to do.

Theoretically, parent involvement in sex education has the potential to influence adolescent outcomes. However, to design a program that successfully involves parents, there is a need for understanding how parents can or want to be involved in adolescent sex education. Sex education is a broad topic that includes: what they want adolescents to know, what they identify as their role and experience, which content they feel they can disseminate successfully, which content they may struggle to disseminate or discuss, and how parents would like to receive resources to aid in the education of their child.

Understanding family dynamics and how they organize is important. The inclusion of sex education in family communication has been studied by researchers with promising results, and is promoted for inclusion in sex education (Grossman et al., 2014; Tortolero et al., 2010). Best practices for parental involvement are not yet known, as it has not been rigorously studied. Involving parents in sex education asks/permits families to cross parent-child boundaries that

may not be something they would do naturally. How new information is presented and how a family responds to new information is an important aspect when learning a skill or information that challenges an original way of thinking. This can be done effectively by respecting the fact that the parents are in charge of their family system, creating resources that speak the family's language and blend in with their communication styles, and affirm the strengths they already possess (Minuchin, 1974).

Family communication is a critical part of how the family system can share and integrate sex education. The way in which children learn from their parents is through communication; messages about sex are sent, received, and incorporated by adolescents based on the parents' conscious and unconscious beliefs, values, and fears. Family systems therapist Salvador Minuchin (1974) explained the core of family systems by explaining that people are not individuals but part of overall patterns, and these interaction patterns take precedence. Duncan and Rock went on to assert that communication is central to understanding family patterns. When two or more persons form a relational system "the most important feature of such a relationship is communication. Relationships are established, maintained, and changed by communicated interaction among members" (1993, p. 48). Adolescents who live in a home environment where there is open communication and satisfying interactions with their family are more likely to receive sex education from their parents (Baldwin & Baranoski, 1990). These interactions in some homes are already happening, and with additional and specific prompts these conversations could occur in even more homes.

Outcomes for adolescents will continue as they are as long as sex education programs continue to disseminate information only through school officials, focusing on the consequences of sex behavior (e.g., pregnancy, STI). To view sex strictly from a behavioral or biological

perspective brings the risks of missing critical relational and emotional factors involved in the beginning and continued development of sex education. However, including parent support in this process may open doors to discussing sexuality beyond the mechanics of sex behaviors and provide a more comprehensive and effective curriculum. Parents have an opportunity to broaden this conversation by bringing in both sex communication as well as sex education, allowing for the co-creation of meaning about sexual beliefs, attitudes, values, and behaviors between persons, and permitting the transfer of information and content on topics of sexuality (i.e. reproduction, puberty, birth control, etc.) (Socha & Stamp, 1995). Parents are a valuable asset in a family system that has been underutilized for generations. Evidence supports changing the traditional approach to sex education to one that includes the critical figures for children and adolescents, their parents.

Intervention Studies of School-based Sex Education with Parental Involvement

Parental involvement is not a formal component of school based sex education; however, it is highly recommended by the CDC (2012b). Research indicates that comprehensive sex education with parental involvement can be effective in delaying sex for middle school students (Grossman et al., 2014; Kirby & Miller, 2002; Kirby, Peterson, & Brown, 1982). A limited number of studies offer some direction for including parents in sex education programming, but the also leave unfortunate gaps in the fields' understanding of parent involvement in sex education.

Limited intervention work in this area has identified useful components moving forward. Of the programs evaluated since 1995, a total of only 6 studies met criteria specifically related to public middle school sex education with inclusion of a parental component (i.e., Abel & Greco, 2008; Blake, Simkin, Ledsky, Perkins, & Calabrese, 2001; Grossman, Frye, Charmaraman, &

Erkut, 2013; Grossman et al., 2014; Oliver, Leeming, & Dwyer, 1998; Tortolero et al., 2010). The attempts at including parents in a formal way has lead to some findings, but has created more questions than answers as to how best to include parents in sex education.

Abstinence-only sex education involving parents. Three studies involving parents implemented abstinence-only sexuality education programs (Abel & Greco, 2008; Blake et al., 2001; Oliver et al., 1998). The primary goal of the programs was to promote the message that abstinence until marriage is the expected standard, and researchers hypothesized that incorporating parents would increase communication between parent and child, strengthen student beliefs supporting abstinence, and increase the students' sense of self-efficacy and intentions to remain abstinent. The parental component included parent workshops (Abel & Greco, 2008; Oliver et al., 1998) and/or sexuality education homework supplements (Blake et al., 2001; Oliver et al., 1998) designed to enhance the curriculum as well as promote parent-child discussions on relationships, sex, and sexuality. Regrettably, only one study gathered and discussed parent outcomes (Oliver et al., 1998), and two of the studies were limited to student-reported outcomes (Abel & Greco, 2008; Blake et al., 2001). Thus, the results of these studies provide very little understanding of how families were engaged in the process, and if any interaction outcomes were present.

Parent workshops were implemented in two studies (Abel & Greco, 2008; Oliver et al., 1998). One 2-hour parent workshop was very poorly attended (Oliver et al., 1998). Of the 274 children in the experimental group, only 18 parents attended (<7% of those eligible). All 18 parents rated the program at least "somewhat valuable. No information was provided as to how researchers advertised the program, when it was offered, or what would have facilitated more parental participation. Perhaps, implementers failed to fully understand the needs, goals, and

resources (e.g., time) of families, critical if families are to be key partners in sex education programming. The second study, which included a parent workshop, (Abel & Greco, 2008) did utilize a parent communication measure. Unfortunately, no discussion or analyses of these data were included in the report, further limiting our understanding of parental involvement within this context.

Homework supplements were implemented in two studies (Blake et al., 2001; Oliver et al., 1998). Blake and colleagues included five homework assignments involving parental participation. Thirty percent of students completed one or two homework assignments, 51% completed three or more, and 19% completed no assignments with their parents. Each assignment had 3 to 5 activities, but students and parents could choose which they did, so not all were completed. Student reports indicated those who completed any of the homework supplements had significantly lower intentions to become sexually active, greater self-efficacy to refuse substances and sexual intercourse, and a greater overall frequency of parent-child communication about sex. Unfortunately, no parent data were gathered; thus, it remains unknown how the parents experienced the homework supplements, what was helpful to them, or what could be changed to better serve the parent-child conversations on sex education. Oliver and colleagues (1998) did include parent reports about the homework supplement. Around 77% of parents agreed assignments were useful in promoting communication with their children, and 67% of parents agreed that homework assignments encouraged children to talk about topics not previously discussed.

Even though parents were supportive of the homework supplement (Oliver et al., 1998), no information was provided on what the supplements included, what could assist parents in better incorporating the supplements, or if there were different resources that could have been

more useful. In both studies, students were required to initiate the homework with their parent, putting the responsibility on the student rather than their parent. Depending on their comfort level, this could be challenging for students and set a standard that adolescents have to be the ones to initiate the conversation. While these data provide positive evidence for family involvement in sex education, moving forward, programs need to inquire about best methods of parental involvement from parents specifically, rather than assume what is best for parent support and inclusion effort. Diverse samples were included (Abel & Greco, 2008; Oliver et al., 1998) including families from diverse ethnic backgrounds (i.e., African American, Hispanic) and targeted areas with high rates of teenage pregnancy. Black and Hispanic adolescent students were less likely to complete the homework assignments than non-Hispanic white students (Blake et al., 2001). This finding raises issue that the program may not meet the needs of all participants. There could be cultural differences at play within diverse communities that require unique variations to better meet the needs of students and their parents.

One study employed a randomized control trial (RCT) methodology (Blake et al, 2001). The others used a time-limited pretest posttest design, weakening the ability of the investigators to draw causal inferences (Abel & Greco, 2008; Oliver et al., 1998). Due to weak methodological designs issues of reliability are of concern and results need to be considered with caution.

Important issues regarding these interventions include the lack of evidence that they reduced the risk of teen pregnancy or STI/HIV infection over time, or dealt effectively with diverse samples. In fact, of the two studies that targeted counties with high incidences of teen pregnancy (Abel & Greco, 2008; Oliver et al., 1998), neither reported outcome data on teen pregnancy. Of the three abstinence-based programs, none of the curricula addressed topics

related to the prevention of HIV and AIDS, nor did they address the spectrum of sexuality beyond heterosexuality. It may be that comprehensive sex education engages families more successfully.

Comprehensive sex education involving parents. Three studies reported the results of comprehensive sex education programs involving parents (i.e., Grossman et al., 2013; Grossman et al., 2014; Tortolero et al., 2010). The primary goal of the interventions was to provide sexuality education with inclusion of topics of HIV/AIDS, STI, and pregnancy prevention. The overall intention of the inclusion of a parent component was to facilitate dialogue between parent and child on topics related to dating, healthy versus unhealthy relationships, sexual behavior, reasons to abstain from sex, and topics regarding HIV and STIs. For the studies using CSE the parental component was joint homework assignments.

Tortolero and colleagues (2010) implemented six parent-child homework supplements with 7th and 8th grade students and their families (12 activities total); each was designed to facilitate communication on friendship qualities, dating, and sexual behavior. The participants included 907 diverse students (43% African American, 44% Hispanic, 13% other). Student outcome data reported that 1/3rd of students in the control group initiated sex by 9th grade compared to 25% in the treatment group. Adolescents in the control group were at 1.76 times greater risk of initiating oral sex and 2.67 times at greater risk of initiating anal sex by 9th grade than the treatment group. The homework supplement appears to have a significant impact on adolescent behavior. Unfortunately, no measures were collected on homework completion, student or parent experience of the homework supplements, or what kind of impact the component had on the results. While it appears as though the intervention had an effect on student outcomes, specifics about the homework supplement usefulness remains unknown.

Homework supplements were incorporated into another diverse population's curriculum (Grossman et al., 2013). A predominantly African American and Hispanic school district implemented a 3-year program (Grades 6, 7, and 8) implementing homework supplements at each grade level. Student reports at Grade 8 indicated that 51% of students completed at least 4 of the 8 homework supplements, and 25% of students completed none of them. Reports indicated that 16% fewer boys and 15% fewer girls had had sex compared to students who received sex education as normally taught in their schools (Grossman et al., 2014). Student reports also indicated reasons for non-completion: personal reasons (55%) (e.g., felt awkward/embarrassed/afraid of parent's reaction), curriculum-based reasons (24%) (e.g., disliked assignments), and family reasons (21%) (e.g., parent too busy, parent uncomfortable with assignments). Overwhelmingly, the issues of comfort, confidence, and skill around talking about sex were challenges for both child and parent and a large deterrent to completing assignments.

Even though there were significant outcomes for adolescent behaviors, the data regarding parent involvement was not included in main-effects analyses or as moderators of the effect. Thus, it remains unclear how this involvement influenced the outcomes. Even more, no parent measures were included in analyses. Researchers nod to the importance of parental involvement, yet the gap in the literature remains as to how the student and parent engagement component influences adolescent outcomes, how this component is meeting the needs of students and parents, and how to improve upon these efforts.

Research designs for the CSE studies were stronger, implementing a RCT (Tortolero et al., 2010), and a longitudinal RCT (Grossman et al., 2013; Grossman et al., 2014), populations in the three studies were diverse, and curriculum content included theory-based HIV, STI, and

pregnancy prevention programming. Some limitations included how intercourse was defined (i.e., penile-vaginal), and the overall lack of data regarding whether the intervention and/or homework supplements played a role in reducing initiation of non-vaginal intercourse, or how parents managed conversations on HIV, STIs, and pregnancy.

In summary, these few studies provide a window into school-based sex education with a parental component and highlight the potential benefits of such a program. However, they failed to capture the parental component experience and impact, both from student and parent perspectives. This missing data makes it difficult to identify what about parent involvement makes a contribution to sex education though theoretically there are benefits to family involvement in sex education.

The Rural Context

According to the National Center for Health Statistics (NCHS), a rural area is defined as a "micropolitan" area (counties with a population of 10,000 to 49,999) and "noncore" areas (counties that do not meet the criteria of a metropolitan or micropolitan areas and have a population of less than 10,000) (Ingram & Franco, 2014). Micropolitan and noncore areas constitute 72% of the land in the United States (Ratcliffe, Burd, Holder, & Fields, 2016). In 2010, almost 30% of Americans were living in an unincorporated area or in a city of between 2,500 and 50,000 residents (Ellis, 2013). Approximately 23% of all women aged 18 and older live in rural areas. Of all rural households, about 26% were near poverty or worse, and of the children living in poverty, 35% were in rural areas. Female and male life expectancies declined in rural counties over the past 10 years, reflecting reports stating that rural residents smoke more, exercise less, have less nutritious diets, and are more likely to be obese than their suburban or urban counterparts (Morgan, 2002).

Rural America is often considered to be small town and lower-income, yet its places and the people offer many complexities to the US. Rural areas are very diverse; however, they share some common threads related to strengths and barriers (Bender, 1985). People living in a rural area are more likely to work multiple jobs (Gringeri, 2001), reflecting limited employment opportunities and greater rates of poverty. People living in a rural area are more likely to work in areas of agriculture, factories, and mining than their urban counterparts (Ng & Kaye, 2015). Such communities are known for their strong work ethic, ability to get by with fewer resources, cohesive communities, and overall resiliencies against hardships (e.g., financial, weather) (Lyson & Falk, 1993).

Risk Factors for Rural Adolescents and Families

Living in a rural area for an adolescent means higher risk of premature sex, less likely to use contraception at first intercourse, more likely to be exposed to HIV and STIs, and at higher risk of becoming a teen parent (Ng & Kaye, 2015). Researchers have taken a systemic look into what is causing the rates of STIs and pregnancies to be higher in rural areas among teens than other areas (i.e, urban, suburban), and linked these higher rates to more limited economic and educational prospects, health services, and recreational activities (Ng & Kaye, 2015).

Economic and educational prospects. Rural communities face the obstacles of limited resources and high and persistent poverty (Weber, Jensen, Miller, Mosley, & Fisher, 2005). Rural teens and families are more likely to live in poverty, and they are much less likely to attend college than their metropolitan counterparts (Ng & Kaye, 2015), thus limiting their educational and occupational prospects. This fact is important, as poverty is a predictor of teen pregnancy (Young, Turner, Denny, & Young, 2004). One of the biggest issues facing rural families is financial stress, as job opportunities that offer adequate pay and benefits may not be plentiful or

may require advanced education that rural communities are less likely to offer and individuals living there are less likely to obtain.

Looking at rural communities in general, an estimated 21% of adults have not completed high school, 35% have completed only high school 20% have attended some college, and 24% earned a college degree (Ellis, 2013). Access to education can be a barrier as they may have to travel long distances to college or may not be able to afford the costs of tuition and living expenses (Ng & Kaye, 2015). Rural areas are more likely to struggle with chronic and intergenerational poverty.

Health services. Health care disparities exist on multiple levels in rural areas. There is evidence of issues related to accessing medical services (Shoff, & Yang, 2012) and an insufficient supply of mental health professionals in these areas (President's New Freedom Commission on Mental Health, 2003). As individuals leave rural areas to attend college or graduate school, they do not always return to provide the resources they possess. Fewer knowledgeable health care providers means this resource for at-risk teens is in low supply. Additionally, rural employment is less likely to offer private coverage insurance, and roughly 20% of people living in rural areas are without health insurance, higher when compared to suburban (15.1%) and metropolitan areas (17.6%) (Blumenthal & Kagen, 2002; Meit et al., 2014).

Publicly funded clinics may be a resource to youth and families; however; there are fewer of them and, reflecting the lower population density and greater area, tend to be less accessible (Ng & Kaye, 2015when access is not an issue, privacy and confidentiality can become a problem in a small community (Crooks & Bauer, 2016). Community members are more likely to know one another and have dual relationships (Gonyea, Wright, & Earl-Kulkosky, 2014), limiting trust

in confidentiality (Daley & Doughty, 2006). This can impede on access to adequate and quality care for fear of having other people know and share one's personal information outside of a professional setting. This can be particularly important for teenagers who may feel fear, embarrassment, or shame obtaining contraception or treatment for STIs or pregnancy.

Recreation and risk. A rural area may be associated with the statement, "there's nothing to do there". One factor contributing to higher rates of teen pregnancy in rural areas is a lack in positive recreational outlets (i.e., after school programming, active sports programs, community centers, etc.) for youth to engage with on a regular basis (Ng & Kaye, 2015). When communities have more activities to keep youth engaged and monitored, they are less likely to engage in risky behaviors (Ng & Kaye, 2015). These behaviors include, but are not exclusive to, sexual behaviors.

Youth in rural communities are at higher risk for substance abuse than their urban youth counterparts (Pruitt, 2009). Rural youth are more likely to use alcohol, tobacco, hard drugs such as cocaine and methamphetamine, and are also more likely to start using substances at a significantly earlier age than urban youth. The recent opioid "crisis" has been seen as concentrated in rural areas and small towns. Adolescents who have higher levels of family support and monitoring are less likely to use substances and engage in risky behaviors (Sullivan, Kung, & Farrell, 2004). Participation in afterschool programming also serves as a protective factor for adolescents (Tebes et al., 2007). Risky behaviors increase when young people do not have safe options for diversion and lack sufficient supervision.

Support for Providing Sex Education Early

Research and theory provide evidence for a need to target sex education to early adolescents because of several risk factors facing modern adolescents. First, in order for sex

education to be informative it should occur before their sexual debut, which can be before high school. Second, developmentally, this is a time of identity development, including sexual identity. Third, today's adolescents have access to more information than previous generations about sex via the internet and social media, including sexually explicit information which may or may not be accurate. Each of these risks must be addressed for the development of a useful program.

Evidence for early sex education. The CDC reports that many teens receive sex education after they have already become sexually active (CDC, 2014a), a clear and dangerous disconnect between sex education and sexual debut. From a global perspective, 11% percent of girls and 6% of boys, age 15–19, reported having sex before turning 15 (UNICEF, 2011), and from a national perspective, 6% of boys and girls have had sex before the age of 13 (CDC, 2014b). By the time students complete high school, almost half of students have already had sex, and over a third of them consider themselves sexually active (CDC, 2014b). If the goal of sex education is to provide students with information to promote healthy sexual behavior and reduce risk factors, providing sex education opportunities for adolescents ages 11-14 *before* they enter high school and *before* they sexually debut is critical, yet this does not happen.

Early adolescence is a developmentally appropriate time for sex education, as young people are experiencing puberty, sexual attraction to others, and, with exceptions, have not initiated sex yet (CDC, 2014b). Theoretically, Erikson (1968) labeled adolescence as the stage of identity formation: a crucial time for adolescents to discover and learn about themselves. He also stressed that this is a stressful time in which cues from the environment (education, peers, friends, and family) hold much weight for a developing adolescent. Sexuality and gender identity typically begin to emerge during this time as well (Igras, Macieira, Murphy, & Lundgren, 2014).

Younger adolescents may be curious and experiment with adult sexual behaviors, but, due to their stage of cognitive development and lack of information, are not able to assess risks and consequences (Dixon-Mueller, 2011). Researchers agree that investing in early adolescents has strong potential to facilitate healthy transitions through sexuality development and into adulthood (Blum, Bastos, Kabiru, & Le, 2012; Sawyer et al., 2012). Early adolescence is an opportune period for education and support.

Attention to diversity issues in sex education programs. Early adolescence is a time when sexual identity is under formation and quite malleable (Erikson, 1968). As such, it is important to consider the diversity of content covered in sex education courses in regard to culture, religion, definitions of sex, and socioeconomic status, because of how typical approaches may impact or marginalize adolescents who do not identify with a "mainstream" group or its values. Researchers suggest that, while youth are relatively free of sexual and reproductive health problems and gender role biases, they are in need of education that covers diverse topics to assist with healthy identity formation (Igras et al., 2014).

Religious values. The social purity and social hygiene movements of the 18th and 19th Centuries laid the foundation for religious and conservative values to prosper within sex education (Pivar, 1973). Even though there is currently a separation between sex education and religious teachings, sex education is not without threads of religious influence (e.g., abstinence-only education). A majority of families are religiously affiliated (Smith, Marsden, Hout, & Kim, 2013) and this part of their culture can have an impact on how they develop attitudes about sex, birth control, and viewing sex relationally and/or physically (Hooley, 2017). These attitudes can continue to persist into adulthood as well. In a large sample of ethnically diverse, college-aged adults, those that identified as highly religious had more conservative sexual attitudes regarding

homosexuality, traditional gender roles, and extramarital sex (Ahrold & Meston, 2010). Rural cultures often are characterized by more conservative religious and political values (Harowski, Turner, LeVine, Schank, & Leichter, 2006), and if interventions are to meet the needs of rural communities, this is an important factor to consider.

Economic disparities. The literature demonstrates that youth living in poverty are more likely to become sexually active early, and to have elevated risk of STIs, unintended pregnancies, and non-marital births (Duncan, Ziol- Guest, & Kalil, 2010). For youth in poverty who become teen parents, the impacts can have long-term consequences. A 10 and 20-year follow up of a large cohort of teen mothers and fathers found that teenage mothers were more likely to be unemployed, live in poverty, and depend on welfare. Additionally teen mothers were less likely to have gone to college, and teen fathers were more likely to be without employment (Assini-Meytin & Green, 2015). An effective intervention considers the systemic issues that families face. An intervention must be sensitive to these issues and remove potential barriers. These require attention to accessibility of programs, ease of use, and must be of little to no cost to parents.

Racial disparities. Even though teen pregnancy rates have decreased over the last two decades, African American and Hispanic youth teen pregnancy rates remain twice those of their white counterparts (CDC, 2015d). Researchers examined racial/ethnic differences in sex and contraceptive education of men aged 15-24 years using data from the 2006–2010 National Survey of Family Growth. Black men were less likely to have received formal contraceptive education than their white counterparts; however, black and Hispanic men were more likely to have had parental sex discussions than their white counterparts (Farkas, Vanderberg, Sucato, Miller, Akers, & Borrero, 2015). This evidence suggests that diverse communities may have

certain challenges and possess particular strengths that need programming tailored to their unique needs.

Sexual orientation. The inclusivity or exclusivity of how education defines sex has critical impacts for youth. This is especially true for youth who do not identify with heteronormative orientations or expressions. The mean age of first awareness of same-sex attraction for one sample of youth in the United States was 11 (Maguen, Floyd, Bakeman, & Armistead, 2002). There is a critical window, possibly earlier than expected, where adolescents need education and support for their developing sexual identity. Historically, sex education teaching has been centered on heterosexual relationships, where sex is defined as intercourse between a man and a woman. This definition is exclusionary and has negatively impacted persons identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ), as well as providing a limited view of sexual behavior (Elia & Tokunaga, 2015). Sex behaviors outside of penile/vaginal intercourse including masturbation, oral sex, anal sex, and others, are typically not mentioned (Guttmacher Institute, 2017). Unfortunately, only 13 states require a discussion of sexual orientation in sex education courses; however, four of these require providing negative information about sexual orientation, in contrast to the nine that require that the content be inclusive (Guttmacher Institute, 2017). For example, Arizona teachers of sex education cannot promote a homosexual lifestyle or portray diverse sexual orientations in a positive manner (Guttmacher Institute, 2017). Oklahoma, while it does include homosexual activity in its curriculum, also teaches that homosexual behaviors are responsible for contact with and spread of the AIDS virus (Guttmacher Institute, 2017). However inclusive these states are trying to be, the additional negative information regarding sexual orientation is harmful to students of all sexual orientations.

Youth who identify as LGBTQ are at greater risk for suicidal ideation and suicide attempts (U.S. Public Health Service, 2001), and show greater risk for depression than their heterosexual counterparts (Fergusson, Horwood, & Beautrais, 1999). The school environment plays a significant role in this outcome because LBGTQ youth have higher rates of school victimization strongly linked to adult mental health issues later, a higher risk of STI/HIV, and elevated rates of depression and suicidal ideation (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Providing sex education that includes diverse sexual identities and contexts has the potential to normalize the diversity of sexual identity and expression, facilitate positive sexual identity development for LBGTQ youth, and promote safer sex behaviors. In addition, such discussions may reduce negative ideas about sexual minorities held by heterosexual adolescents.

Adaptations for inclusive curriculum. In general, sex education curricula lack appropriate cultural adaptations. Communities require programs that are sensitive to community needs, cultural traditions, and beliefs. That is, we know other interventions, such as parenting interventions, adapted to cultural expectations and beliefs of Latino/a immigrants have improved parenting practices and children's behaviors (Parra-Cardona et al., 2017), and relationship education interventions specific for male same-sex couples have improved couple constructive communication patterns, perceived stress, and relationship satisfaction (Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016). These programs mentioned above have responded to specific community needs, and thus, are more relevant than the original programs (based on white and/or heterosexual populations) due to their cultural adaptations.

Even though a strength of sex education programming is its attention to dissemination of 'evidenced-based' practices, large bodies of research are not treated as essential evidence and integrated into standard sex education practices in content areas such as LGBTQ, gender, racial

disparities, economic inequalities, and health disparities (Schalet et al., 2014). Therefore, it is critical to gather information from families, whose adolescents are at increased risk of teen pregnancy and STI and HIV transmission, about their specific needs and resources to generate meaningful, effective, and inclusive curriculum.

Technology challenges for young adolescents. Today's generation of adolescents is at the frontier of a new digital era where information is available via a handheld device. Adolescents have access to the Internet, social media, and information about sex. Such online information can be accurate, inaccurate, and/or sexually explicit. Contemporary adolescents have a unique experience as they navigate puberty and develop sexual identities in a highly advanced technological world.

Internet activities and social media have become commonplace for most adolescents in today's society (Mesch & Talmud, 2010). A large majority (74%) of adolescents and teens (ages 12-17) report they access the Internet on cell phones, tablets, and other mobile devices (Madden, Lenhart, Duggan, Cortesi, & Gasser, 2013), sometimes spending up to 8 hours a day, 7 days a week (Rideout, Foehr, & Roberts, 2010). More than 80% of teens and young adults have at least one online social media account (e.g., Facebook, Twitter) (Madden, 2012). In a sense, adolescents are connected to information and one another in ways that their parents never were.

Dating behaviors have changed due to technology as well. Communication occurs via text messaging and through social media accounts. Text messaging also provides a means for sending/receiving sexually explicit texts and images via a cell phone, commonly referred to as sexting. Fifteen percent of adolescents with cell phones reported sexting, and, if their peers were sexting, they were more likely to also sext (Rice et al., 2012). Importantly, sexting in adolescents is associated with a higher likelihood of engaging in oral and vaginal sex (Houck et al., 2014).

Adolescents are also sexually curious. Not only are they seeking sexually-related information and images for sensation or pleasure-seeking purposes, adolescents use the Internet to receive education about sex. In a qualitative study of adolescents, a majority of participants reported having a positive experience using the Internet, describing it as a safe and easy means of accessing sexual information specific to their concerns in the absence of other sources (Smith, 2011). While they reported seeking sexually explicit material, adolescents also reported seeking out information related to sexual anatomy, STIs, and contraception. The Internet opens access to potentially developmentally-inappropriate, sexually-related materials for adolescents; however, it can also serve as a means to answer their concerns and questions in a confidential way.

Parents have the potential to have a fairly influential role regarding adolescent use of technology. Over 50% of teens report that their parents have the biggest influence on what they believe is appropriate or inappropriate behavior when engaging with a cell phone or online content (Lenhart, Purcell, Smith, & Zickuhr, 2010). However, depending on an adolescent's perception of their parents' knowledge, they may place more or less value on the advice offered by their parents and rely on peers or the Internet instead (Lenhart et al.). This does raise issues as research examining the parent experience reports that parents lack understanding, technical skills, and participation with their children's online lives and this may lead to a disconnection between parents, children, and the supervision of online activities (Solecki, 2016).

Many parents are making efforts to supervise and monitor their adolescent's activities online. Parents who monitor their children in general are more likely to see their adolescents engage less in instant messaging (IM) and social networking site use (Vaala & Bleakley, 2015). A national survey of 511 adolescents (12 to 17-year-olds) and 906 parents on parental regulation practices of children's and teenagers' online activities found that parents implement multiple

strategies in an effort to monitor their child's use of the internet (Livingstone & Helsper, 2008). Parents tend to favor co-use (viewing a device at the same time) or discussing rules rather than using restriction filters or monitoring software. Unfortunately, these methods do not necessarily result in effective risk reduction (Livingstone & Helsper, 2008). Qualitative findings of parents' experience with monitoring suggest that the protective factor of a positive parent-child relationship surpasses the need to use blocks and filters (Solecki, 2016). This evidence suggests that the parent-child relationship has potential to impact adolescents and teens online experiences, and there is room for improvement in how parents execute these practices. Their role as parents has a large influence on children and can be fostered to better support and protect adolescents as they navigate the online world.

Summary

Parent engagement, particularly rural parent engagement, in adolescent sex education has the potential to critically impact adolescent health outcomes in teen pregnancy and STI and HIV transmission. Understanding the parent experience and their needs in their roles as sex educator will likely support the development of a more effective sex education curriculum. Evidence-based approaches for the inclusion of parents in sex education are a new frontier of research. Importantly, timing, diverse content, and technology may play an important role in understanding parents' experience and needs within a culturally sensitive lens.

CHAPTER 3: METHODS

Research Design

Overview of approach. This investigation had multiple research objectives. Qualitative research methodology and analysis was used to gain a better understanding of the life experiences of parents in a rural community. The focus was on their parenting roles in the sex education of their adolescent children. First, the study explored parent's experiences in their role as sex educators. Secondly, the study examined parent's perspectives on sex education content. Finally, it explored the needs and resources that parents identified as critical to increasing success in their role as a sex educator with their adolescents.

This investigation used an exploratory qualitative research design governed by the rules and tenets of Thematic Analysis (TA; Braun & Clarke, 2006). Qualitative data were collected through individual interviews with 19 parents living in a rural community whose oldest child was an adolescent in 6th, 7th, or 8th grade attending a public middle school. Data were analyzed according to the circular process of semantic analysis followed by latent thematic coding (Braun & Clark, 2006; Clarke & Braun, 2013).

Justification for the use of qualitative methods. Rural communities are diverse in their cultural and contextual qualities (Ellis, 2013) and require a research approach that is responsive to those aspects. A qualitative approach was selected for this study for its ability to explore detailed understandings of the meanings of human behavior where research is limited (Creswell, 2007; Marshall & Rossman, 2011; Merriam, 2009). In addition, it is a useful approach when conducting research with diverse populations, as the results are reflective of a specific population (Nápoles-Springer & Stewart, 2006).

The topic of parenting roles and practices specific to sex education of adolescents may be a sensitive topic for parents, and thus utilizing a methodology that may permit the development of trust will elicit the most accurate and meaningful data. Qualitative research can be accomplished as a personal method of analysis, which helps to promote trust between the researcher and participants, as participants may feel their voices are important and valued (Umaña-Taylor & Bámaca, 2004). In addition, this approach is important for communities that have little exposure to research and may be hesitant to engage in the process, like my target community (M. McCollum, personal communication, November 6, 2015). Rural parents in this area may not have engaged in research before, understand its purpose, or see its value. The principal of the middle school, who served as a liaison, explained that engaging in research is new territory for the community and was unable to state how the community might respond. Thus, there were unknown variables that existed and could impact the research process and results.

This qualitative study utilized semi-structured qualitative interview methodology to gather data because it highlights and emphasizes the voice of participants within their own context (Carter & Little, 2007). This method of qualitative inquiry combines pre-determined questions with the additional opportunity for the researcher to respond to themes or patterns that emerge as the data collection process happens over time (Cohen & Crabtree, 2006). In qualitative research, the semi-structured interview format is the most commonly used interview technique (DiCicco-Bloom & Crabtree, 2006), and works well as it is a flexible technique for small-scale research (Drever, 1999). An advantage of the semi-structured interview is that it has been successful in enabling reciprocity between the interviewer and participant (Galletta, 2012), picking up the nuances of meaning in the give and take of social interactions. This can also help

to create comfort in what may feel like a formal setting, and open avenues of discovery depending on where the interview leads.

While the interview remains the most common form of data gathering (Cassell & Symon, 2004), it is also the preferred method for answering the research questions posed in this study for several reasons. First, interviews are the best-suited methodology to use for exploration of new topics when little is known (Gill, Stewart, Treasure, & Chadwick, 2008). Currently, there is very little qualitative or quantitative data on rural parents and their experiences as sex educators with their adolescent children. This lack of understanding results in an incomplete framework or conceptualization of what this experience looks like making it difficult to generate meaningful formal research questions. Therefore, beginning this line of research with interviews enabled questions to be considered in an open way (i.e., using open-ended questions) and reduced constraints created by researcher-generated parameters (e.g., items on a survey) (Coughlan, Cronin, & Ryan, 2009).

Second, interviews are especially useful for the proposed work as they serve as a means to gain a deeper understanding of a person's lived experience or social phenomena that would not be gained from other research efforts such as written surveys or questionnaires (Gill et al., 2008; Kvale, 1983). In addition, interviews provide space for an individual to reflect and offer her/his own lived experience. This is critically valuable for the research questions in this study.

Finally, individual interviews are appropriate for exploring sensitive topics and in cases where participants may be vulnerable (Wolgemuth et al., 2015). This is particularly important for this study, as interviewees were asked about their experience and position on issues related to sexuality and sex education, which are highly controversial topics (Kirby, 2007). Responses differed based on parents' religion, beliefs, and values (Patton, 1986), and thus, considerations

were made to allow participants to speak freely without concern that they had to suppress or alter responses in the presence of a group (Wolgemuth et al., 2015). This is particularly important for rural communities, as participants may not have anonymity within a group, and the individual interview may have yielded more accurate data as it eliminated public judgement from responses. Options were explained to participants that they can skip or go back to questions that may be difficult or triggering, as well as, pause or stop the interview depending on their comfort level.

Thematic analysis. Thematic analysis is a method for identifying, analyzing, and reporting the extracted patterns and themes that are found in the data. Interview methodology, like that used in this study, yields data appropriate for thematic analysis (Braun & Clarke, 2006). Thematic analysis (Braun & Clarke, 2006) was selected and used because it focuses on identifying themes and patterns of people's lives around a central experience. Components of ideas or experiences are often unclear when viewed in isolation; however, when brought together, themes begin to emerge (Leininger, 1985), enabling a more comprehensive and collective experience to become tangible.

Thematic analysis is a widely used approach when analyzing qualitative data (Braun & Clarke, 2006) and an excellent way to identify critical themes. At a minimum, it organizes and describes data in detail, and often goes further as a means to interpret various aspects of the topic under investigation (Boyatzis, 1998). Researchers argue that the process of thematic analysis must be flexible to the data and research questions (Patton, 1990), and the process may not be linear, but develop over time (Ely, 1997). This means that throughout data collection, when themes or patterns began to emerge, inquiring in that area further was important and necessary. Space was provided for this in the semi-structured interview.

Participants

Site description. The target site for this study was a small rural city in a Midwestern state. As of the 2010 census, there were 4,568 people living in this city (US Census Bureau, 2010). Racially/ethnically it was quite homogeneous with 96.6% of its residents identifying as white. The county's population was around 67,700 and was similar in population to at least 50 other counties in the United States, which constitute smaller town/rural locations rather than urban areas. As of 2015, over 16,400 cities in the United States had a population of 10,000 people or less (US Census Bureau, n.d.). Approximately 31% of households in this area have children under the age of 18 living with them (US Census Bureau, 2010). The median household income in 2015 for residents of this county was $45,409 and the poverty rate was 17% (DATAUSA, 2015).

During the 2017-2018 school year, the middle school was the only middle school in the city, housing grade levels 5 through 8. Each grade level had roughly 115 students. The average middle school in Michigan had 513 students, and in the United States the average was 578 (U.S. Department of Education, 2010). This school was below both the state and national averages.

The middle school's current practice in sex education was described as reproductive health education. There was a curriculum for 6th and 7th grade that occurs over a two-week time frame and was taught by two health teachers and a school nurse. Sixth grade focused on puberty, anatomy, relationships, responsible decision-making, and abstinence. Seventh grade focused on the reproductive systems, STIs, and HIV. Parents were informed of the reproductive health information classes, were required to provide consent for their child to attend, but were not formally involved in the educational process (M. McCollum, personal communication, November 6, 2015).

Recruitment. Procedures for recruitment were discussed with and approved by community collaborators. For recruitment I utilized purposive sampling. Purposive sampling is a method that relies on selecting participants that are uniquely knowledgeable or experienced regarding a particular phenomenon of interest (Creswell & Clark Plano, 2017), and a technique widely used when the goal is to select information-rich cases that are effective in situations where there are limited resources (Patton, 2002). It is also important to include individuals who are willing to participate and able to communicate their experiences and opinions (Spradley, 2016).

Multiple recruiting efforts were made employing purposive sampling. An easily understood, descriptive, and attractive invitational flier including a description of the study and contact information for the researcher (i.e., phone and email; See Appendix B) was packaged in envelopes and distributed by school administrators to students in 6^{th}, 7^{th}, and 8^{th} grade. Students were instructed to deliver the letters to their parents. An invitational postcard (See Appendix C) was also mailed directly to parent homes. Additionally, a Facebook advertisement was published on Facebook regarding the study and shared among parents.

The principal investigator supervised all recruitment activities in order to ensure recruitment goals were met. During the recruitment phase, 26 parents expressed an interest in participating in the study and contacted the researcher via e-mail, telephone, or Facebook message. If parents emailed or messaged the researcher they were asked to telephone the researcher or provide a contact number so the researcher could contact them. Several attempts were made to reach parents throughout this process. Once conversations occurred with participants over the phone, a discussion of eligibility requirements and scheduling took place. Four parents had first-born children that were either in high school or older, one parent was not a

resident of the area, and two parents did not return follow up e-mails or phone calls. Eligibility requirements were checked again once the interviews took place. A digital log was kept of recruitment communications and activity using an excel spreadsheet.

Inclusion and exclusion criteria. Parents were eligible to participate if they met the following criteria: (1) identified themselves as living in a rural area for at least 10 years, (2) identified their oldest child as being in 6th, 7th, or 8th grade at the middle school, (3) currently living in the same home as the child at least 50% of the time, (4) 18 years of age or older, (5) are English speaking, (6) expressed an interest to participate in an interview, and (7) provided written consent. Parents were excluded from the study if they did meet one or more of the eligibility requirements.

Sample size. According to thematic analysis guidelines, sample size is not definite and depends on the expected prevalence of the least frequent theme in the population, the number of desired instances of that theme, and the power of the study (Fugard & Potts, 2015). Sandelowski states that while a quantifiable number may not be tangible, the sample size can be small enough to manage the material and large enough to provide 'a new and richly textured understanding of experience' (1995, p. 183). The sample must be sufficient to reach theoretical saturation (Glaser & Strauss, 1967), meaning no further coding is recommended or the same data content is appearing over and over again without yielding supplementary data.

There is a broad range of suggestions of the numbers of participants needed for qualitative interviews. Some researchers recommend that, for small-scale qualitative research, around 3-16 participants are necessary for individual participants to have a locatable voice within a study and for intensive analysis of each case to be possible (Smith, Flowers, & Larkin, 2009). Fugard and Potts suggest that with an 80% chance (power of study) of observing between 10 and

20 themes, somewhere between 14 and 27 interviews are required (2015). Green and Thorogood state that many qualitative researchers experience approximately little 'new' information after interviewing 20 people (2009).

This study utilized a sample of 19 participants. Saturation of a majority of major themes was indicated after the 7th interview. Saturation of more details emerged within the data over the course of data collection. The main categories and themes were identified by the final interview with no new information contributed.

Participant characteristics. Participants of the study were parents and primary care givers of students from a rural middle school's 6th, 7th, and 8th grade classes. Because of the exploratory nature of the study, the lack of knowledge on the perspectives of rural mothers and fathers within the context of sex education, the study was open to interviewing both mothers and fathers, and ultimately determined by the parent. A screening strategy was used to interview the parent most likely involved in the sex education of the target child (between the ages of 11-14), and this could be both. When a parent called initially to sign up for the project they were asked, "Are you interested in participating in this research?" In addition, were asked, "Is there another parent who would have a role in these discussions?", and "Are they available to participate in a separate interview?" (See Appendix A for the recruitment interview protocol). This occurred initially with six participants towards the beginning of recruitment. The parent that called typically identified as either the primary person to talk to their child about sex and/or offered it would only be them being interviewed. It became clear that the parent calling was self-selecting to be in the interview, and not the other parent. However, I did enroll two parents from the same family on one occasion, and they had both planned to participate in the interview prior to asking screening questions.

The majority of parents who participated in this study self-identified as female (89%). Participants ranged in age from 33 to 50 years old. The majority of participants identified as White (84%), the remaining participants self-identified identified as American Indian/Alaskan Native (11%) or Asian (5%). Over half of participants were employed full time (53%) at the time of the study and 95% of participants had a monthly family income of $2,000 or higher.

Most participants reported having had attended some college, with a majority earning an associate's degree (21%), a bachelor's degree (32%), or a graduate degree (15%). The majority of participants identified as Christian (79%) with variations in denomination. Detailed participant demographic information is reported in Table 3.1.

Table 3.1 Demographic characteristics of parents/primary caregivers

Demographic Characteristic	n	%
Gender		
Male	2	11%
Female	17	89%
Age		
33-36	6	32%
37-43	10	53%
44-50	3	15%
Ethnicity		
Asian	1	5%
American Indian/Alaskan Native	2	11%
White	16	84%
Education		
High School Graduate	2	11%
Some college, no degree	4	21%
Associate's Degree	4	21%
Bachelor's Degree	6	32%
Graduate or Professional Degree	3	15%
Children's Ages		
11	7	29%
12	10	42%
13	4	17%
14	3	12%
Children's Sex		
Male	9	37%
Female	15	63%
Employment Status		

Table 3.1 (cont'd)

Yes, full time employment, in my interest area	10	53%
Yes, full time employment, not in my interest area	0	0%
Yes, part time employment, in one position	5	26%
Yes, part time employment, in multiple positions	1	5%
No, I am currently unemployed	2	11%
Other	1	5%
Household Income (monthly)		
$249 or less	1	5%
$2000 - $2499	5	26%
$2500 - $4999	7	37%
$5000 or more	6	32%
Religious Affiliation		
No affiliation	4	21%
Christianity (no denomination identified)	3	15%
Christianity: Lutheran	6	32%
Christianity: Catholic	3	15%
Christianity: Lutheran and Catholic	2	11%
Christianity & Buddhism	1	5%

Procedures

Data collection. For interested participants who contacted the researcher, the researcher described the purpose and procedures of the study. To ensure participant comfort and confidentiality, interviews took place at participant homes, the public library in a semi-private room, or at a local restaurant. Participants were provided with topic areas of what they would be asked about. When participants identified that they were willing to meet in a public space, this was further addressed to ensure they were comfortable. Each interview began with rapport building, small conversation, and thanking them for their contribution and participation in the study. Building rapport is crucial for completing successful in-depth interviews (Legard, Keegan, &Ward, 2003). Following that, participants received an informed consent document (see Appendix D), which was reviewed with the researcher, and participants were provided the opportunity to ask questions prior to signing the document. This form contained information about the study, staff responsible for the investigation, procedures to ensure confidentiality, and

contact information of the researchers and the MSU IRB office. Participant consent was required in order to participate, meaning they were required to sign the consent to continue with the interview process. After obtaining informed consent but prior to conducting the interview, participants completed a demographic survey (see Appendix E). Once the paperwork was completed, the interview began. Interviews ranged from 33 minutes to 79 minutes, with an average of 53 minutes. To thank participants for their time, participants received a $40 Amazon gift card for compensation.

Interview format. The interviews were conducted by myself. The semi-structured interview guide (see Appendix F) used in this study included broad, open-ended questions and inquiries on specific content related to parent's experiences talking about sex with their children, their perspectives on sex education content, as well as, their needs as a parent sex educator. Interviews began with structured open-ended questions, and follow-up questions with specific probes were asked if I needed to elicit more detail. I used specific prompts to capture the rural aspect of parent's role in sex education, as well as present-day challenges (e.g., social media, Internet/access to information). To make sure participant responses were accurately captured I engaged in a member checking process throughout the interview. At the end of each phase of the interview I repeated back to participants what I heard them report. I then asked participants, "Am I hearing you correctly?" or "Am I capturing what you intended to say?" Engaging in this process was critical as it served as an effective way to validate participant's responses, and improve accuracy and credibility of the data that was collected (Creswell & Miller, 2000).

Data preparation. Each interview was audio recorded and later transcribed verbatim by myself, one research assistant, and a confidential online transcription service. Data was saved in digital audio records and then transcribed. For interviews where transcription was completed by

the research assistant or online service, the principal investigator read these transcripts thoroughly. These steps were necessary to capture accurate responses from participants and present the participant's voice. Additional field notes were taken during the interviews, highlighting points of interest (Morrow, 2005). Primary data capturing occurred by the audio recordings. This allowed me to focus on moving the participant through the interview protocol and remain present during the interview. A separate note taker was not used due to efforts to increase participant comfort in discussing a potentially sensitive topic (Ryan, Coughlan, & Cronin, 2009).

All participant information was de-identified to protect the privacy of the participants. Data (audio files, transcripts) were saved in a password-protected laptop computer and in a password-protected USB drive. All transcriptions were created according to MSU IRB regulations in order to ensure the safety of the data and the participants' confidentiality (e.g., names were removed). The data will be stored for a minimum of 3 years after the project's completion. Only Dr. Hope Gerde, the IRB trained research assistant, representatives of the MSU IRB, and I had access to the stored data.

NVivo software was used to facilitate data analysis (Bazeley & Richards, 2000). Transcribed interviews were uploaded into the NVivo program. NVivo is designed to help find insights in unstructured data such as interviews. Once the transcripts were uploaded into the program, I organized data into clusters based on specific codes and categories. This software is specifically useful for organizing and analyzing rich text-based data sets, like the one created in this study.

Data Analysis

Data analysis followed a sequential process that used semantic and latent data analysis. With a semantic approach, themes were identified within their explicit or surface level meanings, making no inferences beyond that about the data (Vaismoradi, Turunen, & Bondas, 2013). This occurred through the use of Nvivo, through the creation and grouping of codes and patterns that emerged within the data set. Data were coded over time based on the three research questions. This is important as it provided context to the language. This was followed by latent analysis, where data were examined to identify underlying ideas, assumptions, and specific conceptualizations (Braun & Clarke, 2006). This was an iterative process that occurred through repeated rounds of writing, analysis, and discussion with my dissertation advisor. This was intended to increase researcher knowledge of the rural parent experience in their role as sex educators of their children.

Phases of thematic analysis. Thematic analysis involved a recursive step-by-step process that involved six phases (Braun & Clarke, 2006). The phases included: (1) familiarizing with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing a final report.

In order to *familiarize myself with the data*, I collected data, read, and re-read the transcriptions, noting initial ideas. *Generating initial codes* took place in a systematic fashion across the entire data set to collate statements relevant to codes. As data was collected and organized, I *searched for themes* by collating codes. The recording/highlighting of parent statements to illustrate themes was used as evidence of themes. Once the initial search was completed, a *review of themes* took place with my primary advisor and was discussed in length. This analysis continued as data was *defined and themes were named* as specifics of each theme

were generated and an overall story was extracted from the data. Analysis was an iterative process through discussion and refining of the major themes. Illustrative quotes and context were examined as evidence for themes, and consensus was reached for any disagreements during the review and discussion with my dissertation advisor. Once this process was complete I *produced a final report.* For a more detailed description of thematic analysis and the coding procedures, see Appendix G.

Role of the researcher. The "self-of-the researcher" plays a critical role in qualitative research, especially as it relates to working with sensitive material and vulnerable populations. Researchers have experienced issues related to lack of training, confidentiality, role conflict, costs to the participants, the desire for reciprocity, and feelings of isolation (Johnson & Clarke, 2003). It is important that I identify my personal strengths, my connection and concern for the well-being of this rural community, and the challenges I may face as a researcher in this context.

I am a clinical social worker and a couple and family therapist. My education, specialized training, and experience have given me a unique set of skills to be able to build rapport, connect, and facilitate genuine interactions with individuals and families. I hold a level of privilege that has come from my education; yet, I have a familiarity with this community that aided in my entry into working with this community.

As I conducted this work, it was important that I considered the bias my education has brought me and to remember that I may not know what is best for this community. Additionally, I am not a parent of an adolescent, which limits my experience and understanding of this population.

Trustworthiness of the Data

Trustworthiness in qualitative data refers to the essential demonstration that the research findings are the conclusion of implementing methodological procedures that are rigorous that produce findings that are accurate descriptions of participants experiences (Morrow, 2005; Shenton, 2004). Trustworthiness includes four criteria: a) credibility, b) transferability, c) dependability, and d) confirmability (Lincoln & Guba, 1985; Morrow, 2005).

Credibility. Credibility refers to the extent to which findings are accurate representation of the experience of study participants (Merriam, 2009). I engaged in member checking to ensure I was capturing what participants intended to say (Lincoln & Guba, 1985). During the interview process I reported back to participants at three different times what I heard them report and checked in with them to confirm my understandings of their answers were accurate. My dissertation advisor reviewed 50% of the coded transcripts and provided feedback regarding coding discrepancies. In addition, my dissertation advisor and I discussed coding results and reviewed the thematic codes that emerged within the data until agreement was reached. There were no disagreements about the specific codes; however a few codes were combined to better reflect the meaning of the data. For example, originally there was a separate category for "Parents drew from their sex education experience", after peer debriefing it was included as one code within the category of "Parents support of young adolescents."

Confirmability and dependability. Both confirmability and dependability are concepts that are interrelated that refer to ensuring that the findings from a study are actually the result of adequate methodology that was implemented (Lincoln & Guba, 1985; Merriam, 2009). To ensure dependability and confirmability, I kept an audit trail and journal to document decisions throughout the research process (Morrow, 2005), and I engaged in continuous conversations with

my dissertation advisor informing her of research decisions and requested feedback during the process. In addition, my dissertation advisor and I discussed coding results, specifically where the data was complex, had multiple meanings, and addressed any discrepancies.

Transferability. Transferability refers to the extent to which research findings are generalizable to alternative populations (Morrow, 2005). The sample size in this study was 19, and in typical qualitative studies, assertions of generalizability are not typically valid. Qualitative data does contribute to a gain in knowledge as researchers provide detailed information about their study and allow those reading to decide if study findings are applicable in their or other situations (Merriam, 2009). To try to ensure transferability, this study documented and provided information about research methods, study context, project investigators, and participants (Lincoln & Guba, 1985; Morrow, 2005).

CHAPTER 4: RESULTS

Parents provided detailed narratives associated with their experiences in their roles as sex educators for their first-born adolescent children. Parents described their experiences providing sex education to their children and what is was like to have these conversations for the first time. Additionally, parents discussed the important topics within sex education they wanted their children to know. Finally, parents identified what they needed to be more successful in their roles as sex educators and suggestions for potential parent-based resources and interventions.

Parent Experiences Providing Sex Education

Adolescence is a challenging time; the majority of parents interviewed described it this way. Parents noted their children were like "rollercoasters", displaying a range of emotional ups and downs. One parent (participant #2) expressed, "Emotionally, the rollercoaster. One day she'll be depressed and then a couple hours later she'll be happy and then she'll go down again and up again." Another mother (participant #15) expressed about her son, "Oh good Lord, sometimes it's rough. He's got so much anger. The biggest challenge is just teaching him how to deal with that in a healthy way." While adolescence and puberty is a challenging time for parents, when asked how they support their kids through this time, parents reported several strategies to tackle this.

Parents support of young adolescents.

Open communication: "Anything you've got going on, anything you want to know, come to me." Overwhelmingly 18 out of 19 parents reported using some form of open communication, affirming in a multitude of ways that they want to be there for their children. One parent (participant #12) expressed, "If there's anything you ever need or want to know, it could even be in the middle of the day, it could be in the middle of the night, it don't matter, just

come and ask." Another parent (participant #14) conveyed a similar sentiment stating what she expressed to her child:

> I want you to be able to come talk to one of us. And if you can't talk to us, write it down. Write it in a letter or do whatever you feel like you have to do to be able to because I don't want you to feel like you're going through it alone.

Decrease awkwardness: "Don't be embarrassed. Every girl goes through it [menstruation]." Parents were mindful about the difficulties experienced by their children during this time and almost 66% of parents made attempts to decrease awkwardness for their adolescent. One parent (participant #4) noted:

> I've kind of tried to bring it up to them in a joking matter because I kind of feel like that kind of opens the door for them to talk about how they feel about things. We all get a little bit embarrassed and we giggle, y'know, it's kind of awkward for us all, but the more we kind of talk about it the less we giggle and the more it's discussed.

Another parent (participant #15) expressed this in a very matter-of-fact way, "I've made it not taboo. It's just never been an awkward subject because I never made it an awkward subject."

Personal experience: "I'm open to her about my experiences." A few other parents pulled from their own personal experiences as a way to support their children. One parent (participant #13) shared, "I went through puberty, so one of the biggest positives is she has me to talk with." Another parent (participant #9) expressed, "Having been an adolescent myself, having had multiple boyfriends, going to college, I feel like we kind of know what goes on. Growing up is tough."

Parents drew from their sex education experience. As parents talked about having conversations with their children about sex, 15 of the 19 parents that were interviewed brought up their own histories on sex education with their parents. This theme surfaced without elicitation. Thirteen parents either described their own parents as completely absent in their sex education or had negative experiences with their parents and sex education when they were

adolescents. One parent (participant #6) said, “My parents certainly didn’t breathe a word about anything like that [sex] to me. My mom found I started my period from the laundry.” Another parent (participant #7) described her experience, “I wasn’t embarrassed to ask my parents, I was flat out afraid to ask my parents any of the questions I’ve already been asked by my kids.” Another parent (participant #13) reported:

> My first sexual experience was with a guy that I loved. We lost our virginity together. We can joke about it now but we talked about how we thought we were going to hell after that. We were raised really hardcore Catholic…the huge Catholic cloud of doom and gloom over us that made us feel horrible. When I started to develop my mom didn’t make me feel good about my period. She wouldn’t talk to me, and she made me feel bad about it. I felt embarrassed. I remember crying.

A couple of parents had a positive experience with their parents and sex education. One parent (participant #15) said, “My mom was always super open with me so she never made it a big deal. All my friends would come to her. I would come to her and I guess that’s just kind of what I wanted with my kid too.”

Almost 50% of parents identified wanting their children to have a better sex education experience with them than what they had with their own parents. One parent (participant #2) said:

> I really didn’t have anybody to talk to when I was growing up. I want my kids to be able to talk to me. The biggest thing to me is communication. I think communication is the key to a lot of things working.

Another parent (participant #8) expressed, “I didn’t really have anybody there for me. My mom wasn’t comfortable talking to me about it. I felt awkward, really strange, and inhuman. I just don’t want her to feel any of those feelings that I felt.” And another parent (participant #13) sharing a similar sentiment said, “I grew up feeling really ashamed of my body and sex. I think that affected my choices early on in life. I don’t want that for her.”

Are parents talking with their kids about sex? Overwhelmingly, 74% of parents reported that they have initiated conversations with their child age 11-13 about sex. One parent (participant #8) said, "We are actually really open about the dialogue that we have in our house as far as sex goes." Another parent (participant #15) recalled conversations happening when her children were very young, saying:

> We've been open with sex talks since he's been first questioning about it. I've never hid anything from them if they ask. I try to give age-appropriate answers. It's never been a weird subject for us to talk about, so it's probably been since they were four or five when they first started asking questions.

And another parent (participant #3) persisted through her child's embarrassment to have the conversation, she said:

> I've made it a point to sit down and talk with her, or try to. As she always says, 'Mom, it's okay, I've heard it at school.' And I'm like, 'No! I want to talk about this. We're gonna talk about this. Tell me what you learned.'"

For a few parents who have not initiated conversations about sex with their children, there were a range of reasons why they made their decision. Some parents saw their children as too young or not ready. One parent (participant #10) said, "I just didn't think he needed to have those conversations yet. He is 11, but socially he seems more immature than some of his friends. He just wasn't quite there, and he didn't need that yet." Another parent (participant #11) was waiting for an external indicator to start the conversation, "I hate to say it like this, but almost like, when is school gonna start talking about it, then I will." And lastly, another parent (participant #19) expressed fears associated with having conversations about sex with their child, sharing:

> I think it's too early at that age because I feel like if you talk about it, it gives them ideas about sex or gives them ideas that, 'Oh, I guess it's okay to do this or talk about it.' I think when you talk about it, it encourages them to do it or reminds them that at this age you can do these kinds of stuff."

Responding to child readiness. As parents discussed their experiences initiating, having, or thinking about having conversations with their children about sex there were many issues influencing parents' experiences. Both parents who have and have not had these conversations identified responding to their own child's readiness for making this decision. For example, one parent (participant #7) reported, "My 12 year old, I don't think that she's actually ready for the facts of it yet. The giggling part indicates to me that she's not really listening. She's just more embarrassed about it." Another parent (participant #5) discussed having a conversation about reproduction and making a decision about providing the right amount of information:

> Our most recent [conversation] was a couple of months ago. We were talking about babies, I think. And he said 'how does that work?' and I said, 'Well, dads have sperm and moms have eggs and when those two things come together, the egg multiplies, and then cells multiply, and then a young baby grows'. He never asked how the sperm gets to the egg. I'm not sure what I would have said. Then he said, 'Where are your eggs at?' and I said, 'They're in our ovaries and whatever we're born with is what we're born with.' And he said, 'So, you're like a chicken?' And the conversation was over at that point.

Parents noted multiple cues from their children regarding readiness including emotional and maturity level, physical changes, their social skills, and whether or not their kids are initiating conversations about sex with them. Some parents experienced a clash between wanting to protect their child's innocence and also educate them properly. One parent (participant #10) expressed:

> It's like their youth is taken away from them too soon. They still believe in Santa Clause, like why would you want to talk about sex with them? It just blows my mind that someone could still believe in Santa Clause and have their period at the same time.

Responding to child's embarrassment. Parents noted that navigating their children's embarrassment around this topic was common. One parent (participant #10) said, "When the stuff came home last spring [sex education materials from school] I read the topic and asked him if he wanted to talk about any of those things. He said, 'no', and tried to hide under a blanket." Another parent (participant #2) expressed, "The fact that they're embarrassed. It's hard. They're

shy about it because it's sex. Even a tampon commercial will come on the TV and the kids are kind of shy about it."

I don't know what to say. Parents also identified that not knowing what they might say was a reason for not having initiated conversations with their children. One parent (participant #1) said, "I wouldn't know how to approach it [intercourse] with her. That is where I guess I am clueless." Another parent (participant #2) sharing a similar sentiment on the same topic, shared:

> Like actual sex and how to do that, well, she understands like the egg and the sperm. She gets that part but she's not there yet with [intercourse]. I haven't approached that yet. I'm not quite sure what I would say about that.

Issues related to gender. One parent (participant #4) compared her perspective on providing sex education to her son and to her daughter. When asked if she had any conversations with her daughter she replied:

> We haven't, other than what's been discussed with her older brother (age 14). I don't know. I guess I feel that it's more of a male thing to do as opposed to a female thing to do. I guess it's just something that is socially accepted amongst males, but not always amongst females.

What prompts parents to initiate conversations about sex?

School sex education programming. One of the main events that prompted parents to initiate conversations with their young adolescent was a notification from school that they would be engaging in sex education. One parent (participant #18) said:

> I guess one way that made it easier for me to break the ice was the fact that he brought the piece of paper [sex education consent form] home. So it was already established that he was going to this class. So it made it much easier for me, because the ice had already been broken by the school.

Another parent (participant #2) shared that experience, "A pamphlet came home that talked about that they were going to be starting sex education. So I did talk a little bit about it with her." And a similar sentiment by another parent (participant #1) expressed, "They're talking about it in

school, my oldest is really learning about the birds and the bees. It's opening up the doors of communication a bit more." This last quote indicates that the school is not only a cue for parents, but for children to initiate conversations.

Child initiated. Another event that may initiate conversations is when their own child initiates conversation. Parents shared that a common theme among child-initiated conversations was their children sharing about other students or friends about sex. One parent (participant #1) said:

> She told me that one of the girls in their grade is already having sex. Inside I was like, 'oh my gosh are you serious?' So now that encouraged me to say I guess we need to start talking about it more than we were even before, because this stuff is really happening.

Another parent (participant #7), also experiencing some shock in what her child was asking said, "My 14 year old asked what a blow job was because a girl at school did that. I was floored."

One parent (participant #19) discussed that she waits for her son to talk about it, "I only talk about the topic when he starts mentioning it. For me to open up, I don't usually start a conversation unless he asks about it."

Children maturing. Parents noticed their children maturing physically and engaging in different behaviors as reasons to initiate conversations with them. One parent (participant #10) expressed, "My nine year old daughter has a lot of armpit hair and she's starting to sprout her breasts." Another parent (participant #4) reflected on why they discussed masturbation with their son, saying, "He didn't want me washing his clothes. He only wanted dad to wash them. He shut his door to the bedroom a lot more, too." Other conversations were prompted from their kids or their kid's friends showing romantic interest in others. One parent (participant #15) expressed:

> He asked me because all of his friends are starting this whole dating and kissing. He's like, 'I don't really have the need for that right now. Am I different?' I told him you'll know when you're ready to date and kiss and gradually move on to other things, but right now it's just not important to you.

Technology. Many parents cite technology as a reason for prompting conversations about sex, including watching TV, movies, and commercials. One parent (participant #16) expressed, "She'll hear something or see something and ask, 'What's this?' Like on TV. TV's not PG like it used to be anymore. She'll see things and say, 'What's that? What are they doing?' That's how it comes out usually." One parent (participant #11) who has not initiated conversations about sex yet is planning on using television or movies as an aide for these conversations to happen. They said, "I'm trying to wait like if we're watching a film or something, if he asks me or kind of hints, then let's talk about this."

Parent preparation methods. Almost one-third of parents reported that they had not prepared to have conversations about sex. One parent (participant #8) expressed, "I guess we have not really prepared necessarily. I guess we just kind of wing it." And another parent (participant #14) providing reason as to why she had not, "I think as parents sometimes you just put blinders on and just kind of hope that it'll remedy itself and it's something that we won't have to talk about."

Of the two-thirds that had prepared, parents reported a range of strategies for preparing for the conversations about sex. The most common theme among parents that had prepared was talking with their partner, family, or a peer to prepare for these conversations. One parent (participant #12) commented, "I've talked with my mom about questions, I've talked with my husband, and my husband's parents." And a similar report from another parent (participant #16) said, "Talking with my friend, and talking with my husband." Another parent (participant #15) reflected on her own experience as preparation, she reported, "I think the biggest thing is my family experience. My mom was very open with me and she taught me a lot probably before I was ready for everything." Other parents utilized different resources for preparation. One parent

(participant #13) said, “I listen to a lot of books on psychology.” One parent (participant #18) simply said, “I usually just refer to the Bible.” Individual parents identified using the internet or google, counseling, and TV as ways they had prepared to engage different topics around sex.

Parent identified barriers and challenges in conversations about sex. Parents reported the major barrier to having conversations about sex was not knowing what to say and when to say it. One parent (participant #14) expressed:

> I think it goes back to the whole knowledge thing and what exactly I should be talking to them about. I don’t know. Do I walk up to them and just sit down and say, ‘Okay, well, we’re going to talk about sex today’. Which part do you talk to them about first? What part is more important? What are the different parts that should be talked about? It’s overwhelming to me.

Another parent (participant #11) also experienced this difficulty:

> If I start talking about it, do I get too over the top with it? Am I like, almost, not like scarring them but is there a different way that kind of like, baby steps lead up to it? I didn’t want to overstep my boundary and kind of freak him out or something.

Parents reported this was exacerbated by the fact that this was the first time parents were having this conversation, that they identified feeling awkwardness or embarrassment, and that they perceived that their child would be embarrassed. For example, one parent (participant #1) reported “This is my first rodeo. I feel like your oldest kid is kind of like your guinea pig. You try and do your best, and I’m trying, but am I doing it the right way?” Another parent (participant #18) said, “It is awkward as a parent, obviously. It’s awkward talking to you (the interviewer) about it. It’d be awkward talking to anybody about it.” And lastly, a parent (participant #18) talked about their child’s embarrassment referencing a previous conversation he said, “We talked about, I said, ‘You’re going to be going through changes at this point in your life. You’re becoming a man. You’re going to have feelings towards girls.’ And he started blushing and said, ‘Shut up.’”

Some parents fear that if they say the wrong thing at the wrong time this might lead to "being shut out" or the communication being closed from their child. One parent (participant #2) expressed, "I kind of have to tip toe around, just because otherwise I don't want them to shut me out. You've got to know when to push and when to not push. It's kind of like a dance." In addition, another main theme felt among parents was not knowing what the school is doing and finding this very challenging. One parent (participant #17) said, "What they're being taught in school is not always sent home. I feel it would be really helpful to have that relayed. Like what type of things are being taught and how we can talk about those things." Another parent (participant #11) shared a similar feeling, they said, "I never heard nothing in the school as far as that [sex education] goes. I saw a pamphlet but I never heard anything more, no follow up or anything, so I don't know what they even learned yet."

Multiple parents reported technology as a barrier for them and for their child. For example, parents reported wanting to seek information from the internet, but their searches resulted in what they identified as inappropriate content. One parent (participant #17) expressed:

> The comfort level I have of Googling sex ed is kind of uncomfortable. I don't really want to search that, because you don't know what you're going to get. I think that's kind of a limitation. Like, while they have a lot of articles on the internet, I don't want to come up with the pornographic articles or the one that might not be reliable.

Also, they reported frustration with the fact that kids could access information on the internet when they would rather the child talk with them about it. One parent (participant #16) shared:

> She heard things at school and asks, 'Mom, what's this?' And so, we'd tell her, 'This is what a blow job is', because these are words she's hearing in school. I'd rather her come to me and ask me than Google it and find something on YouTube that would be inappropriate.

Two parents reported a cultural difference between themselves and their community, which made it difficult to know what to share with their children. One parent (participant #13)

said, “There are people in our family that are homophobic. I have to teach her that some people are limited in their capacity for love and some people are just flat out wrong.” These conversations were grounded in parent’s value systems and parents wanting to instill their values through these conversations. The same parent (participant #13) reported, “I want her to be whoever she wants to be when she grows up, but like, at the core, the value system, you have to model that. I think that’s a pretty serious job.”

Parent identified strengths and skills in conversations about sex. Parents reported a range of strengths that they bring to their conversations with their children about sex. A desire to support their children was a theme shared among some parents. One parent (participant #10) expressed:

> I guess a strength is that I want to be there for my children and I want to help them through this awkward stage as best I can. The right tools and the right information and stuff I don’t necessarily have, but I have the want and the desire, so I think that’s a strength.

Another parent (participant #13) said:

> I feel like I have a really big job on my shoulders, but I feel like I’m up for the task because being able to ask questions and educating her is really, really important to her being emotionally and sexually healthy in the future.

Individual parents reported strengths from the support of their friends, they are persistent with their kids, and tried to relate to them as well.

Some parents identified educational strengths, identifying their careers or jobs as helping them in this area. One parent (participant #15) expressed:

> I work in the medical field. I’ve worked in the medical field my whole life. I’ve seen teen pregnancy. I’ve seen abortions. I’ve seen STDs. I’ve seen a lot. I guess it makes me more open. It makes me more comfortable talking about it. I guess having the knowledge and the skills to answer those questions and just having the faith in my kids that what I say to them will help them get through any period of their time. I just try.

Another parent (participant #16), who is a nurse, said, “I understand the trials and such that she is going through. I know how to answer her questions more than someone who has no clue. Having that medical field behind me really helped me in guiding her through it.” And a similar sentiment made by a parent (participant #) who was a teacher, said, “I have an educational background on that platform of adolescence. So I think that helps me to put it into words that he would understand, I think more than anything.”

Other parents who don’t have any formalized education in this area are taking it upon themselves to seek information and get educated. One parent (participant #4) exemplified this by saying:

> You can Google anything. We Google a lot in my house. Just to understand and just to kind of educate ourselves. I mean, how am I supposed to help them through some things if I don’t necessarily understand it myself? I’ve given birth three times, but at the same time, sometimes a medical term will come up and I will be like, ‘Wait, what is that?’.

The theme of honesty and open communication was reiterated as parents talked about their strengths. One parent (participant #5) shared:

> I’m super open in general and honest with him. The idea of Santa Clause came up a couple years ago and he said, ‘Would you just be honest with me?’ And I said, “Yeah”, so we killed Santa Clause, the tooth fairy, and the Easter bunny all in one sitting (laughs). I have no reason to lie to him or to sugar coat much of anything. I think that honesty would be the biggest strength when talking to him about sex and sex education.

Another parent (participant #16) offered, “We’re so open, setting the precedence since the time she was young to know that she can talk to us about anything really helped.” And another parent (participant #8) described what open communication meant to her, she said:

> A lot of empathy. I think the biggest thing is being really compassionate, really understanding, and reassuring. Letting her know that, you know, I know you feel uncomfortable, I know this feels strange, I know that this is not something that’s great to talk about, but it is normal.

Humor is a tactic some parents use to have some of these conversations. One parent (participant #18) referencing a conversation he had said:

> When I saw his eyeballs rolling, once I see that, I maybe make a small joke to laugh and let him laugh. It releases some of that tension. Sometimes I have that ability I guess in conversations with difficult subjects.

Another parent (participant #13) offered, "I can put a comedic spin on it, which always helps. It takes them out of feeling vulnerable and it takes the spotlight off them."

Parents reported using personal experience as their strength. One parent (participant #6) said, "I don't know if I have skills or strengths. I just have the experience of what I've gone through in my 37 years of being here." Another parent, (participant #18) related to his child by being the same-sex parent, said, "Well, being male myself, that would be the advantage I would say, that I'm a man, and I went thought the same experiences that he's going through."

A few parents reported no strengths. One parent (participant #2) said, "Y'know, I don't really know if I've got any skills as far as communication with sex." For some this was distressing. One parent (participant #14) expressed, "Probably not a whole lot. I don't know. It feels horrible as a mom to not."

Parent's Role in Sex Education

Parents hold primary role: "It starts with the parents." A majority of parents viewed themselves as the primary sex educator for their child. One parent (participant #18) said, "I believe it is totally my role and solely my role to provide the education to my son." Another parent (participant #13) commented on this, "I think I'm the number one person to give her sex education, so I'd better do my best to get it right." And a similar feeling shared by another parent (participant #7), "I think initially that sex education should start with the parents."

The descriptions parents provided in what these roles looked like varied, but overwhelmingly parents wanted to be there for their children in ways that were positive and supportive. One parent (participant #10) said, "My role is to be a role model and provide guidance and understanding, and help to find the answers to questions that might come up." Another parent (participant #15) prioritized the importance of emotional support, offered, "To be someone to listen, someone they can express their fears and their anxiety. Emotional support. Just being a loving person who has their back." Creating a safe space for conversation was also important. One parent (participant #2) expressed this by saying, "I'm a safe place, they know they can talk to me. I won't ever shut them off. I won't ever say that's wrong or you shouldn't think that." One parent (participant #14) created this safe place by tailoring one-on-one conversations offering guidance, she expressed, "With a personal one-on-one [you can gage] what you think your child can handle, what you feel they need to know, what questions they have, and where their maturity level is."

Parent's beliefs systems were also very important as they discussed their role as a sex educator with their child. Thirteen parents indicated that in this role they attempt to instill values in a variety of ways. One parent (participant #18) said:

> We're teaching values to our children and everybody has different values that they teach. This is one of those topics of things that I believe as a parent I need to talk to or instill what my values are with my child.

Another parent (participant #3) discussed how this looks with school sex education in mind, "I feel like my job is to take the good science type stuff they get at school and then mold it into our belief system in our house." And lastly, one parent (participant #19) mentioned the significance of the role of religion by saying, "I want him to know that sex is sacred."

And one parent (participant #1) reported their role was to just not fail them. She said, "I'm worried about failing them. I want them to be able to talk to me before they make the wrong decisions or bad decisions that could impact their lives."

Parents and the school: A team effort. While parents identify as being the primary sex educator for their children, they also identify that the school has an important role and should be a secondary support system. A majority of parents are not interested in tackling this responsibility solely on their own but see themselves and the school as a team. One parent (participant #16) used an illustrative analogy to describe this, saying, "It's kind of like an iceberg. The school is more the tip of the iceberg, but it's up to the parents to go through the whole iceberg." Another parent (participant #14) expressed a similar sentiment:

> I think that the scientific, the factual part of it, is a big part of their [the school's] job. But I think the emotional part and the feelings part is something that I think we as parents have a little more input and a little bit more of a job to show our kids and teach our kids. It's coming from us at a more personal level than the school.

On a similar note, another parent (participant #2) expressed, "I think with both the school and the parent teaming up, hopefully it's enough to get these kids prepared for the world, because it's a crazy world."

Parents provide something unique. Parents reflected on what they provide their children regarding sex education that the school cannot. Parents described in different ways how their relationship is a means for how these conversations happen. Many parents reported that they provided a comfortable environment for their children to discuss sensitive topics. One parent (participant #6) provided an example by saying:

> If she has more in-depth questions, it's not necessarily that the school couldn't provide it, or wouldn't, but I don't think she would ask. I think that would be more of a parent thing, because it would be a more personal level. I don't think she would ask at school because I don't think she would want to look stupid.

Another parent (participant #1) discussed the importance of the parent-child bond:

> I'm hoping that she feels more comfortable that we have that relationship, that bond. I'm pretty sure she knows I love her no matter what and I wouldn't judge her or punish her for something that she came to talk to me about. I want to have that low key 'I'm mom, let's hug it out and talk about it', whereas at school, it's more 'sit across the table kind of talk'.

A similar experience shared by another parent (participant #15) said:

> Trust. Trust is a huge one. Just being there to listen and give your life experiences, and give advice, and let them know that you will love them regardless of what happens. I think that's the biggest emotional support you can give. Just having that bond, which the schools can't have.

When discussing the school's role, the theme of values recurred among a few parents. One parent (participant #9) shared:

> Faith-based morals and values. I don't think the school is going to, or shouldn't be their moral compass, you know. That's what their parents are for and it's kind of sad that in this day and age, there's not a ton of it. I kind of consider myself a little bit old fashioned in what I think and feel, but it's just kind of how we are as a family.

Parents Preferences and Perspectives on Sex Education Content

Parents were asked what sex education topics and information were important for their kids to know at this time, what topics would be comfortable to talk about with their kids, and what topics would be uncomfortable to talk about with their kids. Table 4.1 provides the topics identified as important by parents, Table 4.2 provides the topics identified as comfortable to talk about, and Table 4.3 provides the topics identified as uncomfortable to talk about.

Content identified as important. The most common topic, identified by both the number of participants who said it and how many times it was referenced, centered on establishing boundaries. One parent (participant #8) said, "Make sure that she knows that it is her body and that it's her decision when the time is right for her to explore herself." Another parent (participant #4) put it simply, "That your body is your body. You have the right to say no." And

another parent (participant #1) expressed, “I’ve kind of taught my girls, like, ‘modest is hottest.’ I guess that’s where the basics started.”

Table 4.1 Sex education content identified as important by parents

Content identified as Important	**Parents**
Establish Boundaries	6
Contraception	6
Sexually Transmitted Diseases	5
Abstinence	5
Changing Bodies	5
Relationships and Love	5
Pregnancy	4
Dating	2
Menstruation	2
Sex is Normal/Natural	2
Drinking	1
Intercourse	1
Self Esteem	1
Sexual Assault	1
Sexual Health	1
Sexual Orientation	1

Contraception and birth control was the second most cited topic important to parents. One parent (participant #4) said, “It’s not a choice, you must practice safe sex if you are choosing to have a random partner.” Another parent (participant #14) expressed, “Protection. That if you are going to engage in it and you’re going to have a sexual relationship, we want you to talk with us because we want you to use condoms or want you to have birth control.”

Multiple parents also discussed the risk of sexually transmitted diseases. One parent (participant #15) said, “Educate them on everything. STDs are huge. That’s the biggest thing. My son’s not even 13 yet, and he knows every single STD.” Another parent (participant #13) expressed, “I want her to know that sex comes with responsibility. There are side effects to sex like pregnancy and diseases.”

Content identified as comfortable. Parents varied widely in the topics they were comfortable in discussing with their children at this time. Almost half of parents identified changing bodies (e.g., puberty, maturation, menstruation) as a comfortable topic. One parent (participant #4) said, "Just their changing bodies, so their bodies smell, they bleed, there's all kinds of situations that they're trying to muddle their way through." Another parent (participant #17) expressed, "I feel comfortable talking about the changes that he's gone through physically and emotionally, like the nightly secretions and why's that happening to him." And another parent (participant #15) went beyond bodies changing and said, "Puberty, sex, emotional attachments, the changes his body is going through, and masturbation."

Table 4.2 Sex education content identified as comfortable by parents

Content identified as Comfortable	**Parents**
Changing Bodies	9
Dating	5
Reproduction	5
Intercourse	3
Sexual Orientation	3
Contraception	2
Menstruation	2
Sexually Transmitted Diseases	2
Masturbation	1
Abstinence	1
Foreplay	1
Oral Sex	1
Pornography	1
Sexual Assault	1

Dating was a common theme among parents; however they didn't go into much detail describing this topic. One parent said, "I guess just dating, what that means, and having relationships." Other parents, who also included it, typically included it as they listed other topics.

Parents identified reproduction as a comfortable topic. One parent (participant #1) said, "Just like how it actually works, the sperm and the egg, the reproduction process." Another parent (participant #11) simply said, "How babies are born." And another parent (participant #7) commented, "What happens with the egg and sperm and all of that, talking about how a baby is formed."

Reasons topics were comfortable.

Personal experience. After parents identified and discussed topics they thought were comfortable talking about, they were asked what made these topics comfortable for them to talk about. The most common theme among parents was personal experience and parents described this in different ways. One parent (participant #2) said, "Experience! I've talked to a lot of counselors, because I've been through so much." Another parent (participant #15) said:

> My mom was always super open with me, so she never made it a big deal. All my friends would come to her. I would come to her, and I guess that's just kind of what I wanted with my kid too.

And another parent (participant #8) with fewer supports growing up commented:

> I think it's just going through my own experiences and I didn't really have anybody there for me. My mom really wasn't comfortable talking to me about it. I didn't ever really feel secure enough with anybody to be open about it so that's one thing. When I found out I was [pregnant], I had her a lot younger than I wanted to and I definitely always want to make sure that they know they have me to go to. They'll never have a question in their mind, like is this normal, is it okay to talk about this? It was really important for me to know that they know that I'm here.

Factual information. Another popular reason identified by parents was that these topics were simply factual information. One parent (participant #5) said, "It's just part of everyday life that he's going to be exposed to." Another parent (participant #3) commented, "Because they're just so factual. It's like teaching social studies."

Parent-child relationship. Some parents identified the relationship they have with their children as what makes it comfortable. One parent said, "Because we are close and he will ask good questions. I think it's just our relationship that we have." One parent (participant #7) described this in detail:

> I didn't think I'd be emotional about this. It's just the fact that they come to me about it. You can get answers about anything you want, all without having communication or a relationship, just by Googling it. We keep the communication and the conversations happening within the house. I don't cry when I'm talking to my kids about it, but I guess having to be asked why are you comfortable about it? I think it's not necessarily the comfort in having to address the issues as much as it is the connection with my daughter.

Content identified as uncomfortable. Parents also identified a range of topics that were uncomfortable. It is important to note the overlap in the topics reported as comfortable and uncomfortable, identifying differences and similarities across parents. Almost 70% of parents identified intercourse as an uncomfortable topic. One parent (participant #6) said:

> Anything that has to do with the penis and vagina to be specific. I don't feel that she would be anywhere near [ready]. I think about how I was in 7th grade. I wasn't even close to thinking about anything like that, at all. I feel like I got a couple of years before I have to approach that subject and I would like to wait.

Table 4.3 Sex education content identified as uncomfortable by parents

Content identified as Uncomfortable	**Parents**
Intercourse	13
Contraception	3
Oral Sex	3
Foreplay	2
Menstruation	2
Pleasure	1
Pregnancy	1
Sexual Assault	1

Another parent (participant #4) commented, "If I found out they were sexually active I think that I would have a hard time talking to them about it." And another parent (#19) expressed, "When he mentioned talking about sleeping with girls and stuff or having sex, I'm

uncomfortable about it. If the subject comes up, I'd just tell him that I don't believe in premarital sex."

A few parents identified contraception or birth control as an uncomfortable topic. One parent (participant #4) said, "If my 8th grader came to me and was talking about wanting to be on birth control I would need a minute to gather my thoughts because I think that she is way too young at 13 to be dealing with this." Additionally, a small group of parents identified oral sex as an uncomfortable topic. One parent (participant #9) in reference to oral sex expressed, "As far as really getting into these things, I still feel they're too young."

Reasons topics were uncomfortable.

Children not ready. There were multiple reasons why parents identified these topics as uncomfortable. The most common theme among parents was feeling as though their children were not ready for the information. One parent (participant #10) said, "Maybe I'm naïve to the way the world works, but I feel like 11 is just a little bit too young to be having conversations about sex, but I could be wrong." Another parent (participant #9) referenced intercourse, oral sex, contraceptive use, rape, and abortion and expressed, "As far as really getting into these things, I still feel they're too young." And another parent (participant #5) gave their reasoning for seeing their child as too young, explaining, "I think that it would open too many doors for his brain to developmentally absorb."

Parent's discomfort. Another common theme among parents was their own identified discomfort and lack of experience in having these conversations. One parent (participant #1) said, "I wasn't ready for it yet. I tried not to seem uncomfortable, but inside I was like, "I'm not sure how to handle these questions yet.'" Another parent (participant #18) made reference to intercourse and expressed, "I think for most people it would be uncomfortable to talk to their

children about sexual positions, the how-to's of the penis and the vagina, and how they connect." And another parent (participant #8) talked about when her daughter asked her about oral sex, she commented, "One time she had asked me what a blow job was, and I was like well how do I explain this, because describing this to her would be really embarrassing."

Child's discomfort. A few parents commented on the perceived discomfort in their children. One parent (participant #12) said, "I wouldn't want her to be completely disgusted by the fact that adults still have sex after they're done having babies. I'd have to find a way [to tell her] so she wouldn't be completed disgusted with everything." Another parent (participant #3) expressed:

> I think it would be hard just because she would be embarrassed about it. It's not something that's talked about a lot with a parent and a kid. I don't see a lot of that happening so it would be a new awkward thing for us to talk about.

Child's innocence. A few other parents mentioned their child's innocence as a reason for these topics being uncomfortable. One parent (participant #9) said, "Maybe just my need to keep them little…their innocence. Once you have these conversations they can't unknow that."

Parents Perspective on the Needs of Rural Areas and Sex Education

Parents discussed rural areas in contrast to urban areas in their needs as related to sex education. Multiple parents commented on the differences they perceive of kids raised in the city compared to kids raised in rural areas. One parent (participant #14) expressed:

> I think there's a huge difference between city life and rural life. I think that sometimes these kids that grow up rural don't realize what happens in the cities and it can be shocking and I think sex kind of plays a factor in that. I could be way wrong. This is just my opinion, but I think life in the city is way more fast-paced.

Another parent (participant #3) shared a similar perspective:

> I think in cities, my perception because I haven't lived there, but my perception is that the kids grow up really fast. They know a lot more about sexual behaviors because they see it and experience it quicker than maybe a rural kid does.

And another parent (participant #4) expressed:

> Do I think that our teens are on the same level as kids in downtown Chicago? Absolutely not. I think that kids in bigger cities are definitely required to grow up faster. I don't feel that the 6th, 7th, and 8th graders are as sexually active in our small town as they would be in a larger area.

Some parents described feeling as though due to living in a rural area, parents have a pulse on what is happening with their kids and in their communities. One parent (participant #9) commented on this:

> I feel like we have a benefit that we are small. I feel like our finger is more on the pulse. Like when that big sexting thing happened between the school districts, I felt like people were on it more. Less people, more adult eyes on things. I feel like it's to our benefit to be smaller in that things that are happening in urban areas in eighth grade aren't happening here.

Another parent (participant #4) said:

> If your kid is doing something wrong everybody's going to hear about it. So, if our kids are getting drunk and having sex at a party, you bet your ass that somebody's gonna call us. And I would do the same thing for one of my friends' kids.

Within this small-town sentiment is the feeling that rural kids are easier to reach. One parent (participant #1) said, "We have more of an advantage of reaching them as opposed to a more populated area. We know each other. There's a community based feeling, a more welcoming feeling all around." Another parent (participant #18) expressed:

> I think in a small community and a small school where you [referring to adolescents] know people, there's more of an ability to say if you have questions, or to approach somebody. I think you have a better chance of getting that attention than you would, say in a big place where you just get lost in the shuffle.

And again, another parent (participant #6) shared this sentiment, "I think we actually have a benefit being rural, because we're smaller so our kids don't just get farmed through and pushed through. I think they get a lot more one-on-one attention."

Some parents noted that the conservative values held in the community could hinder certain aspects around sex education, as well as, the lack in diversity within the community. One parent (participant #12) commented:

> Religious factors take hold and a lot of children don't see the information they may necessarily need. In a rural area you're in a smaller population and I think you don't get as much uniqueness as you would in a bigger area. Rural areas tend to be man-woman couples with their children in a small environment. If you go somewhere bigger, closer to Detroit or Chicago, you would see a lot of different ethnicities together, same-sex couples, whatever it may be. I feel like we don't get as much of that here, because of the stigma around it and it's an unfortunate stigma. We're kind of delayed in what goes on in the world. We're kind of back a few steps from everybody else. I feel that since we're in a small community and a safe community that we don't cover as much as we possibly could [in sex education], because of the backlash from the community due to religious factors and closed mindedness.

Another parent (participant #16) shared her perspective:

> I grew up in a really small town over on the West and you didn't have the gays and such, you didn't know about them. I think in a rural area it's less discussed in a sense, less advertised. Where in metropolitans, they see it more. They see at the grocery store, guys holding hands, guys in dresses or drag, whatever. Where up here, you really don't see that. I think it's exposure. I think the school educators aren't comfortable with it, so it's harder for them to teach it. I do think there is a little special need in rural areas than in metropolitans. I think the kids out of a rural area would be less educated. I don't want to say they're dumber, but just because it's not a norm in everyday life that when they start talking about it, it's more of a giggle giggle instead of a serious topic.

Even though parents identified rural areas as different and unique from urban areas, multiple parents also thought that rural areas have the same needs regarding sex education as urban areas. One parent (participant #15) said, "I think kids are kids no matter where they grow up. They're kids. They're growing up. They're going to have questions. Their bodies are all going through the same changes. Yeah, I think the same education is needed." Another parent (participant #4) shared a similar sentiment:

> I think it's needed everywhere. It doesn't matter what kind of community you grow up in. I mean, sex is everywhere. It's not just in small towns or big cities. I think it's just as important to educate them as it would be anybody else.

And another parent (participant #8) brought up the relevance of technology:

> I don't necessarily think that it's any different. I think it's the same everywhere, I mean, kids everywhere are going through the same things, but it's just, it seems that in a smaller area it's a little bit slower. But at the same time not really because we have technology, they have access to the world at their fingertips, so if they're not being taught something at home they're gonna find it out one way or another, so I guess I don't think that there's really much of a difference honestly.

Parent Identified Needs and Resources in their Roles as Sex Educators

Parents: Do they feel supported? Parents were asked if they felt supported in their role as a sex educator. Parents were asked to consider this from multiple angles which included: as a parent, as a person in the community, from the community, from the school, and in society. Almost half of parents identified with feeling supported in their role as a sex educator. The way in which parents viewed this support varied. One parent (participant #4) felt supported in many ways, she expressed:

> Absolutely, and I think that it's only growing. People are more apt to discuss things nowadays than they were in the past. I feel like things are front and center. Like, a transgender student isn't as odd as it would have been for us in high school. I think that the support of the community is there. I think that the support of the school is there. I think that the support of other parents is there as well.

Another parent (participant #7) also identified supports, saying, "I feel supported mainly by my spouse, because we've discussed how we want to parent our children. I think it comes with that first, and then the comfort of being supported by the nice, useful source of Google." Another parent (participant #14) identified multiple resources both within and outside the community. They commented:

> I absolutely feel supported, and there's resources, and information wherever, if you're willing to look for it and find it. I think that kind of support is everywhere. I would say if I really had certain questions, I feel like I could go to the school and say, 'Okay, well, what's been talked about with the kids? Is there things that we can do to help them?' I think that we, up here, have a fantastic community and a fabulous school. I also think that the information on the internet is beyond anything that you could really want to be able to

> research. It's fine to have a question or a concern. It would be easy enough to find [an answer] and I think that's huge.

Parents weren't divided rigidly identifying as either supported or unsupported. Of the parents who did identify as feeling supported, over half of those parents also reported on themes where they did not feel supported as well. One parent (participant #12) expressed, "I feel supported with my family, but socially, and like community wise, I kind of feel like we're lacking." Another parent (participant #5) described this experience by saying, "I think the school part of it, I think that's huge. The community? Yes. Myself? Yes, I feel supported." Yet, when that same parent (participant #5) considered the greater societal influences, her sentiment changed:

> They're exposed to so much. There's conversations happening whether right, wrong, or indifferent that are a lot faster than I think they need to be. Something as silly as Deadpool. He's huge into Marvel. He said, 'Can I see it?' and I said, 'Yes! I'll buy it for you when you're 18, but you're not going to watch it before then.' It's tough because it's a comic book character, y'know?

A few parents did not feel supported in their roles and overwhelmingly the number one reason was a disconnection between themselves and the school. Parents illustrated this disconnection in many ways. Parents described feeling in the dark when it comes to what is happening in the sex education classes at school. One parent (participant #2) said:

> All we get is a thing that says, 'We're starting sex education.' We don't get anything else. Maybe it would be helpful to provide a little info about what parents should try and talk to our children about. We're pretty much blind here. It's hard for kids to talk about [sex]. So a lot of times you're just sitting in the dark where that's concerned.

Another theme is that parents feel like they have to depend on their children to tell them what is happening at school. One parent (participant #4) commented:

> Parents don't even realize that these conversations are even happening at school because they're leaving it up to the children to bring home a paper that says what they're learning at school. Do you honestly think that 50% of those papers made it home to those parents? There's no way.

Some parents expanded on this idea and identified wanting to know what the school is doing when it comes to sex education as a way that they would feel more supported. One parent (participant #2) said, "I wish I knew more as far as what they're actually talking about in the class. That would change things." Another parent (participant #17) expressed:

> I don't really know what's being taught in those courses. So I guess it's not really a support to me. It's a support to my child, I get that, but at the same time I don't feel like we're working together.

One parent (participant #16) expressed wanting far more understanding about the content in sex education, she reported:

> Parents know nothing until the kids come home. I feel the parent should be made aware of exactly what is going to be going on, what is going to be told to the children, and videos they are going to show these kids, whether it's a PowerPoint, or an actual video. I feel parents should have the right to view them prior.

What do parents need to be more successful in their role as sex educator? Parents discussed what they need to be successful in their role as sex educators. Around 50% of participants reported more or better communication from the school, specifically about when exactly these classes happen and what happens in them. One parent (participant #6) said, "A little bit more communication and information from the school kind of outlining, 'Hey this is what we're doing'." Another parent (participant #16) expressed, "I do feel it is a gap of communication. When they had the sex ed classes, the parents should've known what was going to be gone over in these classes." And another parent (participant #2) sharing a similar sentiment commented, "Maybe if they [the school] sent something home or maybe just a little more communication."

Over 50% of parents identified needing a guide to better ensure their success. This guide should include what sex education topics to address with their children, and when the appropriate time is to discuss these topics. One parent (participant #8) described this by saying:

> If there was an 'answer all', like the proper way, like the exact way on how to explain things and to go over things with our kids where nobody is going to be awkward or uncomfortable. Where everything's going to be the correct information on how it's supposed to be.

Another parent (participant #7) defined this as well:

> A guideline of what is appropriate at different ages to discuss. I wait for my kids to ask me so I know what's appropriate for them, but it doesn't mean in general that it should have been answered earlier or behind, so more age appropriate things that they're discussing in school so that we know what to lead up into. Those kinds of things would be helpful. I don't have a clue.

And another parent (participant #12) went into detail describing the purpose of a guide, how it could be useful to parents, and what it could include. She commented:

> Send home a packet with your kids at school saying, 'This is what we're doing. This is… everything we will cover.' Not just sexual reproduction, because there's still a lot of adults that don't get what happens, I swear. A packet for the kid and a packet for the parent, maybe that you can do together and kinda come together as a family to go over. I'm not saying that you have to do it, but it would it would give somebody an avenue or an openness to do it. To be like 'Okay, on my sheet it says discuss what you think sex is. As a child, what do you think sex is?' Because if they don't know what it is or have a skewed idea about what it is, they're gonna be lost. The adult can say, 'Well, this is what I know it to be and this is the factual information I have about it.' But I think a 'do together' work packet, y'know, information for the children and information for the adult about what's being covered in school.

Parents also described a need for expert advice in the area of sex education. How parents characterized this varied. One parent (participant #9) expressed:

> Maybe some sort of a therapist or child psychologist or someone that knows kids psyche more than me and can tell me, 'This is appropriate, this is not, they're ready for this, they're way too old for that" you know what I mean? Just keeping me in the loop on this is what's out there, this is prevalent, and this is necessary. I don't know someone to guide me.

Another parent (participant #12) had another description of an expert that could be helpful. She said, “A sex educator, whether it be a parent, a nurse, a doctor, somebody that can get on the level of an 11, 12, 13 year old kid and explain it to you [the parent] in layman’s terms.” Also, one parent (participant #16) thought an expert should be available to their children. She commented:

> A counselor who is available to the kids, especially in today’s day of technology, be able to email somebody or call somebody and say, ‘This is what I'm feeling.’ There are a lot of students who don't have parents who will talk about it. They'll push it under the rug. If the parents are pushing it under the rug and the schools are pushing it under the rug, the kid’s getting nowhere. I just think having faculty that would be available to talk about these kinds of things with the students would really help.

A couple of parents identified not needing any additional supports or resources outside their family to assist them in their role. One parent (participant #18) expressed:

> I would rather the school, the government, stay out of our lives in that way. I wouldn’t ask them for any help in this matter or in a whole lot of other matters. As far as like getting some kind of support myself, my wife is that support. Other than my own family, my wife, my church, or my faith, I don’t need support from anywhere else. I feel that I’m going to be able to take care of it in the way that I believe is right for myself.

A similar feeling was shared by a parent (participant #19) commented, “I’m more willing to talk to him [son] about sex education when my husband is with me.” When asked if there was anything else she might need, she responded, “No.”

Of the parents that had identified needs and discussed different resources, many parents expressed an enthusiasm in receiving information (e.g., a guidebook) directly from the school. On parent (participant #1) commented, “A pamphlet that comes home, ‘Talking to your kids for dummies’. Sex ed for dummies, that’s probably the perfect book that would be good for me right now.” And another parent (participant #11) described this in more detail:

> If they’d come home with a pamphlet [consent form] saying ‘sign right here’ that your son is allowed [to attend sex education], but I never heard nothing back [from the school]. I’m not putting on the school that they’re wrong, but here’s your information to

> follow up with. Here's some questions that kinda work, triggers or whatever, and then also, here's some questions to ask him prior to. So if they came home with something, here's what to ask beforehand, and here's some questions to ask after.

How do parents want to receive supports/resources? Multiple parents expressed a need for information to come from a trusted source, and the school was that for them. One parent (participant #19) expressed, "If it came through the school I would feel that it was more research based and more trusted I guess, rather than something I found or just showed up in the mail." Alternatively, another parent reported not wanting information from school, but identified another trusted source as, "My Church" (participant #18).

Of parents identifying the need for supports and resources, the most common theme among parents was to receive information in a pamphlet or a book. One parent (participant #5) said, "I would want it in a book through the mail or sent home from school. I think our lives exist so much on electronics now. I would like to sit down with a cup of coffee and flip through it." Another parent (participant #8) commented, "Reading a book, maybe not even necessarily a book, like a pamphlet."

The second most common way parents want to receive information is either online or via e-mail. One parent (participant #17) expressed:

> I feel if we had something that was online and an educational class that parents could take if they wanted to. Just different methods on conversations to have with your kids, how to have these conversations and what to expect. Some parents might not even know what to expect. If I'm a single mom, I might not know what to expect or how to explain those conversations to my male son. So I think, providing those resources would be really helpful.

Another parent (participant #4) simply said, "I would love an email. That's how everybody communicates."

A few parents identified an interest in different types of groups for parents or a means in which parents can talk to one another or an expert. One parent (participant #13) mentioned, “A hotline might be cool” for parents. Another parent (participant #15) commented:

> I want to keep the kids' sex education class, but why not open up a question and answer session for adults? Have a set time at the school where all the parents can get there and just realize, oh wow, we're all going through this. We're all answering these questions and like I said, just question and answer. ‘My son asked me about this, how have some of you explained this?’ Just really get the conversation started.

Other parents suggested a school-based parenting class or a face-to-face resource in parent-teacher conferences. Another parent (participant #2) said:

> Maybe during the time of year that they’re getting sex education, we could go to these teacher’s conferences. If I knew I could bring that up, and talk to them about that and see, y’know, what did you cover, what do you think as a parent I need to do? I’ve never really talked to a teacher about that and maybe that would be good.

CHAPTER 5: DISCUSSION

This study expands on the literature in four important ways. First, it describes the experiences of rural parents providing sex education to their first-born children in 6th, 7th, or 8th grade indicating parents have a vested interest in being the primary sex educator for their adolescents yet do not know what sex education content to address with their adolescents and when to engage specific topics. Second, it articulates the narrow focus parents have on the content they identify as important and their comfort in addressing this content. Third, it describes how parents perceive their rural community as safer or more sheltered from the risks and problems (e.g., teen pregnancy, STI transmission) that occur in cities, contrary to what is known in the field. Fourth, it identifies parents' wish to partner with schools, in many cases, and the resources they perceive as beneficial in enhancing their role as primary sex educator for their young adolescents.

Parents Want to be Primary Sex Educator

Parents overwhelmingly reported that they identified as the primary provider of sex education for their children. This finding echoed previous research that parents want to be the primary sex educator for their children (Wilson et al., 2010) and expands the work by identifying that even rural parents aspire to this role. Additionally, parents see their role as an opportunity to instill their family values as it relates to sex, something they feel other sex educators (e.g., the school) cannot do. This finding corresponds with the research that parents engage their role not only to educate, but also to communicate their sexual beliefs, attitudes, and values on topics of sexuality (Socha & Stamp, 1995). Parents recognize themselves as a valuable part of the family system and take seriously the importance of their role for the passage of information that aligns with the goals and values of the family from generation to generation (Bowen, 1966; Ingoldsby,

Smith, & Miller, 2004). There is something unique about sex education within the family system unlike education on other topics in schools (i.e., mathematics). As reported by parents, sex education is a transmitter of family values. It makes sense that the family system plays an integral part in the passage of such information.

Parents identified multiple strengths and skills that assisted them in their role as sex educator. These strengths included having the desire to support their adolescents, having support persons to assist them (i.e., family member, spouse), and using persistence and humor with their adolescents to engage these topics. These findings are important as it highlights personal resources that parents currently employ to facilitate these conversations with no formal support systems in place. Other parents identify their professional education (i.e. nursing, teaching) as a strength that specifically aided them in being able to have conversations about sex with their adolescents. The CDC emphasizes the need to utilize parents and better integrate them into adolescent sex education (2012b); however very few programs exist that include parents (e.g., Abel & Greco, 2008). Necessary steps need to be taken to better facilitate the integration of parents in formal sex education, as they are already taking on this role and they vary widely in the personal resources and education they bring to this endeavor leaving some at risk (Luster & Small, 1994). Findings from this study articulate important strengths that could be leveraged, as programs are developed to include parents in sex education.

Rural communities in particular could benefit from the inclusion of parents in formal sex education as they are already lacking resources that make effective sex education accessible to adolescents (Lindberg et al., 2016). Researchers could invest in parents as a means to providing more thorough and accessible sex education. Results indicate that the family system is fine-tuned to transmit sex education information based on evidence that parents want to do this and children

want to receive sex education from their parents (National Campaign to Prevent Teen Pregnancy, 2002; Wilson et al., 2010). Parents are an incredibly untapped and underutilized resource available within rural areas. It may be that future research is best employed by working to better activate the resources already available in rural areas, rather than reintroducing or creating resources, when certain resources (i.e., parents) are already in a position to intervene.

Parents Employ Open Communication to Promote Sex Education

Parents almost exclusively identified that the primary strategy they used or intend to use in their role as sex educator was communicating about sex, specifically, engaging open communication to have conversations with their children about these topics. Only a few parents mentioned using a book or the internet to aid in these conversations, but primarily discussed the use of parent-child verbal communication as the means by which to educate their child. Parents are not consulting sex education books, enrolling children in a class, or asking an expert (e.g., doctor or nurse) to disseminate this information to their child. They are relying on themselves and their communication skills to make this happen. Families who typically practice open communication in the home are more likely to discuss sex education with their adolescents (Baldwin & Baranoski, 1990), which is positive considering parent-child communication on sex related topics is related to postponement of sexual activities for teenagers (Romo et al., 2002).

Parents leveraged their connectedness with their child to facilitate open communication about sex. Parents identified that they provided space for the sensitive or relational aspects of sex and relationships to be discussed (e.g., dating, relationships, and emotional aspects of sex). This is meaningful because it allows for discussions of sexual beliefs, attitudes, values and behaviors (Socha & Stamp, 1995) much of which is not covered in school curricula (Michigan Department of Education, 2009). Parents identified using their relationship, or the bond they have with their

child, as a means to engage these topics and provide a supportive space for children to ask questions. This finding is critical as it may explain why previous research has found that children that experience a high level of connectedness with their parents are less likely to become pregnant, have fewer sexual partners, and are more likely to use contraception when having sex (Markham et al., 2010; Miller et al., 2001). While this is useful for parents and children who experience connectedness or a strong bond, this could also be problematic for parents and children who lack strong relationships with one another. These may be families who are not talking about sex at all or suspend conversations about sex, much like the families these parents talked about growing up in. In fact, previous work found 39.5% of parents did not discuss sex education with their children (Asekun-Olarinmoye, Dairo, Asekun-Olarinmoye, & Adebimpe, 2014). Although this study included families who had not yet talked to their child about sex, the parents in this study all reported that they would use open communication when they did. This unanimous use of open communication may be because parents self-selected into the study, a study which required them to talk about sex. I recognize, there may be a group of parents who do not have the same values and experiences that the participants from this group reflected in this study, and thus their strategies for providing sex education with their child may look very different.

In addition, parents used their open communication to create sex-positive educational experiences. The majority of parents reported that the main ways they support their adolescent was by providing a space of open communication, decreasing awkwardness or embarrassment for their children, and also sharing their own personal experiences. A sex-positive approach includes being open, communicative, and accepting of a person's uniqueness regarding sexuality, and it is not about engaging in frequent sexual activity or condoning sex (Williams, Prior, &

Wegner, 2013). A sex-positive approach is also in line with the World Health Organization's (2004) definition and position on sex, which describes sexuality as shaped by interactions of biological, psychological, cultural, social, economic, political, legal, ethical, historical, and religious and spiritual factors. Even though parents from this study were not speaking to the inclusion of all these categories, they were being intentional about creating an experience that was open and accepting, which for many parents was vastly different than their own experience.

Many of the parents experienced either no sex education from their own parents or received a sex-negative experience. This includes exposure to messages about sex that are shaming (e.g., masturbation is a sin) or are rigid (e.g., align with heteronormative values and definitions exclusively). The parents in this study reported wanting to create a different experience for their children that was more open and positive. Even parents who identified with a more structured value system (e.g., no premarital sex) wanted their children to talk to them rather than seek another resource. Even though these parents may not be as inclusive with a diverse range of content, they emphasized communication within the family system about sex. These findings highlight the fact that parents are making progressive changes with very little formal supports in place, even while their experiences and history were somewhat deficient in these areas. Results indicated the importance of understanding family systems boundaries, openness to new information, and how families change over time. Even though some parents received a sex-negative experience they were invested in providing a sex-positive experience, indicating these family systems were open to new information, adept to changing, and intentional about a change within the family system context that they identified as deficient in their own upbringing (Nichols et al., 1984).

Child and Parent Factors Influence Sex Conversations

Multiple factors influenced parent's engagement in these conversations. Certain factors were child-centered; parents used their knowledge of their child's emotional and physical development to make decisions about when to have conversations and what information their children were ready to hear. It was clear parents were intentionally filtering information to be sure it aligned with their child's capacity and the families' values for that child in the moment (Ingoldsby et al., 2004). In addition, parents responded to children's reaction to information/discussions including the questions they asked and their level of embarrassment to determine how to proceed during conversations, recognizing the influence parent and child had on one another (White & Klein, 2008). These findings are positive indicators that parents are in tune to their child's development and, at least to some extent, use this information when preparing and engaging in conversations about sex, reflecting a healthy family system (Becvar & Becvar, 2013). However, parents reported difficulty with these conversations when they identified a juxtaposition between content about sex and a child's maturity; parents felt the need to protect their children from external stimuli that was potentially hazardous (i.e., information about sex) to the values of the family (i.e., the child's innocence; Ingoldsby et al., 2004). Similar to these findings, previous qualitative research on parent's experiences providing sex education has found that parents tended to be selective on the information shared with their children and what they considered to be appropriate for their age (Walker, 2004). Additionally, when children were considered too young their questions were not always answered (Walker, 2004) and parents have feared destroying their child's innocence (Jerman & Constantine, 2010). Parents made these decisions based on their own experiences of sex education and their understanding of current social norms of young children's and adolescents' sexual development (Walker, 2004). There is

evidence that parents are using what they have and what they know to make the most informed decisions for their adolescents however may need additional information and education to assist them in this process. For example, as parents identify their child as too young they may not address a critical topic, potentially placing their child at risk.

There were also parent-centered factors that influenced conversations about sex. Parents reported lack of content knowledge. For example, they reported not knowing what to say about some topics (e.g., intercourse), how to respond to some questions on sex, and the time at which to engage these conversations. These findings reinforce previous research which has indicated that parents often wait to initiate conversations about critical topics (e.g., sex behaviors, contraception) until after their adolescents have already sexually debuted (Lindberg, Ku & Sonenstein, 2000; Somers & Paulson, 2000) missing a critical window of opportunity and the potential to prevent or delay risky sexual behaviors. In addition, parents reported experiencing their own discomfort and embarrassment when confronted with this topic. Specifically, for parents who were the opposite sex of their child (i.e., mother/son) they identified increased challenge due to not knowing the unique experiences their child may be going through and not having sufficient information about the opposite sex.

While parents are somewhat skilled at identifying physical and emotional development in their child to use as cues for beginning conversations about sex, parents are not adequately prepared to know what to say and when to discuss certain topics. Previous research indicated that parents identified with lacking effective communication skills and lacking the necessary knowledge about sexuality to engage these conversations, both of which were present among parents regardless of a range of demographics (i.e., race, gender, education, religious attendance (Jerman & Constantine, 2010). The current study adds to this evidence, further identifying that

parents in rural areas also experience a gap between their desire to be effective in their role as a sex educator and the knowledge they have of evidence-based resources to engage this role effectively. Thus, if parents had more age appropriate ways to talk to children about sex or skills in how to use their observations to inform their discussion, this could alleviate the concerns they have about taking away their child's innocence, reduce the embarrassment experienced by both parent and child, and aid in the delivery of effective sex education.

Sex Talks v. The Sex Talk

Findings indicate that parents are communicating with their adolescents about sex, and that these conversations are happening over time and even a few parents indicated some conversations are occurring during childhood as well. For this group of parents there was an emphasis on having multiple conversations and a creation of dialogue between parent and child. These findings align with prior reports of parents talking with their adolescents about sex (Jordan, Price, & Fitzgerald, 2000; Martino et al., 2008) however, the creation of dialogue around this topic is the opposite of conventional wisdom, which often refers to having the 'Birds and the Bees' one-time talk.

Evidence and outcomes of developmental parent-child sex education conversations over time has not been captured in the literature as most studies examine parent-child communication specifically during a short duration (i.e., one year) during adolescence (Beckett et al., 2010; Martino et al., 2008). The limited rural parent data that does exist also lacks longitudinal data on the outcomes of parent-child sex education conversations over time (Jordan, Price, & Fitzgerald, 2000). One unique contribution of the present study is the finding that parents from this study are engaging in conversations over time as a few expressed having conversations with their children when they were young and in elementary school. This approach aligns with research and

standards that identify that the most effective sex education is an ongoing, developmental process that occurs through many conversations covering a spectrum of topics at multiple developmental levels (SIECUS, 2004). These findings highlight the need to capture the impact of parental involvement in sex education outcomes across the span of development for children, adolescents, and teens. There may be a window of opportunity to engage parents earlier in this process and the need to identify how best to meet parents needs at this stage. It may also be beneficial to identify early childhood initiators or prompts as some parents are already engaging these topics at early ages.

Prompting conversations about sex. Parents reported a few stimuli that initiated their multiple conversations about sex. Most prominently, a flier sent home about the commencement of a school sex education course was the main prompt for parents to engage in these conversations. This reflects an instance in which parents break down the barrier to an environmental stimulus to the family system, and in this case, incorporate elements that seem beneficial (Ingoldsby et al., 2004). This marks an incredible opportunity for the school and as such, they must reflect on their timeliness and the content they provide. Potentially, the school has an opportunity to create multiple openings for parents to talk to their children about sexual health by providing age-appropriate content every year. However, it may be that this particular flier was so effective at eliciting sex conversations because it was timely, arriving as parents were noticing changes in their child's physical and emotional development. As such, fliers sent at other times may be ignored, but may be more helpful if additional information was provided. For example, parents could be provided with content and ways to discuss specific content with their children in early elementary school. Referring to SIECUS guidelines, topics like 'Sexuality throughout Life' include content on: *most children are curious about their bodies* and *bodies can*

feel good when touched. Additionally, for upper elementary, parents could be provided with content related to: *people become more curious about their sexuality as they become older* (2004). Parents are already making decisions about what to talk about with their children, however if they had more appropriate information and trusted that it was credible, they may be more likely to engage topics earlier than they had initially, or ever, planned. A small group of parents that were interviewed regarding talking about sex with their elementary-aged children specifically requested similar resources; they desired a booklet provided by the school with age appropriate information on sexuality topics covering age appropriate sexuality knowledge, as well as, techniques to use when communicating about these topics (Reichel, 2014). We must not negate other systems beyond the family system that influence families, and consider how to incorporate them in ways that are useful and educative to parents. In fact, school was the number one prompt for parents, identifying a system outside the family system that parents willingly incorporate.

Other parents were prompted to communicate about sex education in response to their children initiating conversations demonstrating that family members, including children and their parents, influence one another (White & Klein, 2008). Children may have initiated due to the open communication created by their parents, increasing the likelihood for these interactions to occur (Baldwin & Baranoski, 1990). These conversations typically involved adolescents relaying stories about what they heard about their peers at school. Some of these conversations included elicit topics, including intercourse and oral sex, neither of which are covered in the sex education classes offered at this school (Michigan Department of Education, 2009) or are typical content covered in middle school sex education classes (NCSL, 2016b). This finding is critical as it emphasizes the disparity between the formal education that adolescents receive and the

information they are exposed to and inquiring about. Without guidance, context, or an opportunity to process appropriately adolescents may form misconceptions about realistic sexual behaviors, may not have all the information to make informed decisions regarding their own sexual behaviors, and may be more permissive to engaging in premarital or casual sex (Chia, 2003).

A few parents utilized various means of technology (i.e., television shows and commercials, access to information on mobile devices) to initiate conversations with their adolescents about sex. This finding is important because it showcases that parents are eager for openings and opportunities to discuss sex education with their children. However, these television shows that depict examples of relationships or sex may not be developmentally appropriate or effective for education. Many television programs portray alcohol use and engaging in sexual behaviors concurrently, which adolescents then see and are more likely to accept as normal (Bleakley et al., 2017). Additionally, popular movies like *Fifty Shades of Grey* romanticize intimate partner relationships that involve manipulative, controlling, emotionally abusive behavior, and anger during sexual interactions, of which can be confusing for young people navigating relationships (Bonomi, Nichols, Carotta, Kiuchi, & Perry, 2016). It is not uncommon for parents to turn to media, particularly television to promote the education of their youth. For example, for younger children, television programming focusing on school readiness education has been exceedingly successful and widely used by families for decades (e.g., Sesame Street, Public Broadcasting System). Parents might welcome a television show for youth that illustrates characters talking about different aspects and issues of sex in a variety of developmentally appropriate ways. Additionally, they may respond well to programming for a young adolescent audience with appropriate sexual health content that depicts actual

relationships and issues pertaining to sexuality that do not glamorize promiscuous and risky behavior or normalize abusive relationships. These programs could initiate parent-child communication about these topics in a family setting with which they may already be engaged.

Narrow Content Focus

Previous work has identified within different settings the type of curriculum parents want schools to teach (i.e., suburban community: 58% abstinence based themes, 42% comprehensive sex education; Asekun-Olarinmoye, Dairo, Asekun-Olarinmoye, & Adebimpe, 2014). Regardless of how people politically identified, 78% of parents supported the inclusion of content on STIs and contraception for middle school, and 89% supported inclusion of those topics in high school (Kantor & Levitz, 2017). While previous work has made progress trying to identify parent's perspective on sex education curriculum and content, the picture is incomplete. The findings of this study move forward the field by identifying specifically which content parents identified as important for young adolescents. Parents differed on the sex education content they identified to be important, as well as content they perceived as either comfortable or uncomfortable to discuss. Parents identified establishing boundaries (i.e., respect yourself, your body is your body and you can say no, abstinence first), contraception, STIs, abstinence, changing bodies, relationships, and pregnancy as the most important content. Changing bodies, dating, and reproduction were the most cited topics identified as comfortable for parents, all of which reflect changes experienced during puberty. Intercourse, contraception, oral sex, and foreplay were the most frequently mentioned topics identified as uncomfortable, all of which reflect sex behaviors.

All parents identified topics with which they were comfortable and uncomfortable discussing, suggesting that they feel prepared to contribute to sex education in some ways and less adept at discussing other topics. Interestingly, these lists were not mutually exclusive; topics

that were comfortable for one parent were identified as uncomfortable for others. For example, topics such as contraception, intercourse, menstruation, foreplay, and sexual assault appeared on both the comfortable and uncomfortable lists, but were contributed by different parents. Parents did have a few areas of consensus. In general, changing bodies and reproductive health topics (i.e., boys have penises, girls have vaginas, sperm and egg create a baby) were considered comfortable to address, however; sex behaviors, specifically intercourse (i.e., how the sperm gets to the egg, pleasure), were identified by a majority of parents as uncomfortable to discuss with their children. Recognizing that parents are comfortable with some topics is valuable for intervention programming as developers can leverage this content from parents. While these results provide some answers here (i.e., parents are more comfortable leading discussions of sexual health topics and less comfortable discussing sexual behaviors) in general, this content differs widely by parent.

Importantly, the content identified by parents across these three categories reflected a fraction of the necessary sex education content identified for this age group by SIECUS (2004). These standards are in place to guide sex education such that children and adolescents have developmentally appropriate and adequate information and knowledge to make informed decisions regarding their sexual health. Previous research indicates that the content discussed between parent and child has an impact on how vulnerable adolescents will be to peer influences (Whitaker & Miller, 2000). The more parents specifically addressed discussions of sex and contraception, the more likely adolescents were prepared and able to handle peer pressures related to these topics. Findings from this study indicated that while parents identified important content included in the SIECUS standards, parents only identified a very small portion of critical content areas. There may be two reasons for this. First, parents may be unaware of the extensive

content important for promoting sexual health for adolescents suggesting that while parents view themselves as the primary support system for their children in sex education, they are unequipped to deliver content identified as crucial for comprehensive sex education, and what may be necessary to prepare their children to make decisions in contexts that may be stressful. This is likely as it aligns with work demonstrating that a majority of parents prefer schools to utilize a curriculum that includes abstinence based themes, though it does not cover all necessary content for developing sexually healthy youth (Asekun-Olarinmoye, et al., 2014). Research has identified that a comprehensive approach to sex education for youth, specifically Comprehensive Sex Education (CSE) results in delaying first sex, reducing frequency of sex and number of sexual partners, increasing use of condoms and contraceptives, and reducing risky sexual behaviors (Kirby, 2007; Kirby, 2008; Stanger-Hall & Hall, 2011; Williams, 2011). Under this approach, a disconnection for parents exists between wanting to be 'first in line' to educate their children about sex and being underprepared.

This is corroborated by the findings that some parents were conflicted on what topics were appropriate depending on the age or gender of their child. Many parents reported that their child was just too young for particular content as noted by their lack of interest or embarrassment when the topic was broached. However, not engaging in these discussions in a timely manner can result in increased risk for children (Carr & Packham, 2017; Kirby, 2007; Mosher et al., 2012). In addition, some parents seemed to provide evidence of a double standard that males are privy to information and content that females may not need or for which they were not ready. This is consistent with a pervasive double standard in our culture that sex and sexuality are considered appropriate and acceptable topics for men whereas for females, discussions of sex are considered shameful (Sprecher, McKinney & Orbuch, 1987). The double standard that exists

within society hinders the delivery of evidenced-based sex education to all adolescents, both males and females.

An alternative idea is that the way in which the data were gathered resulted in this narrow focus on content. In the present study, parents were required to generate topics based on their own knowledge of sexual health and were not provided with a list of topics from which to select. While this was an important approach to use for the first study in this line of research because the open-ended nature of the question did not persuade the participants toward any specific content, thus minimizing the researcher bias and researcher-generated parameters in the data (Coughlan et al., 2009), it may have artificially limited parent responses. Parents may have identified other topics as important, comfortable, or uncomfortable had they been provided with guidance on this topic, perhaps from the SIECUS standards, outlining content and topic areas as identified for adolescents aged 11 through 14. While some narrowing may have occurred as a result of the open-ended question, it seems like the first idea that parents are unaware of the vast content for sex education, remains true as well based on the consistent responses from parents indicating that they just do not know how to handle multiple topics of sexual health education. Nevertheless, to deepen our understanding of parent's knowledge of content, future research needs to expand on this initial study in which parents generated their own list of important content by asking parents to respond to a survey listing a wide spectrum of sex education content guided by previous research on evidence-based content for this age group (SIECUS, 2004).

Rural Risk Unidentified by Parents

Another important contribution to the literature provided by this study is the focus on rural parents' experiences in their role of sex educator. Rural parents identified that living in a rural area provides security and protection to their children as they go through adolescence and

puberty. They reported that, due to their rural community, they had a pulse on what their children were doing and that parents within the community look out for each other's children, reducing their exposure to risky sexual behaviors. Parents indicated that kids growing up in cities are exposed to more (e.g., diversity in sexual orientation) and are engaging in sexual behaviors earlier than their children who grow up in a rural area. This finding is counter to the research identifying rural teens to be at higher risk than urban teens. In fact, teenagers in rural areas are having sex earlier, less likely to use contraception, and more likely to be exposed to HIV and STIs than their urban counterparts (Ng & Kaye, 2012a). Additionally, teen births in rural areas are 1/3rd higher than the national average (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2014). These data indicate a dangerous disconnection between how rural parents perceive what happens in their communities and what is actually happening in their communities which may be perpetuating the appalling outcomes for rural teens.

Even though parents identified that rural areas have the same sex education needs as urban areas, research indicates that in the last 10 years rural adolescents are receiving less formal sex education than before (Lindberg et al., 2016). These findings are critical as they identify rural adolescents as the most at-risk population and the least likely to receive formal sex education. Further, parent perceptions that their children are safer than urban adolescents and that their children are lagging in their sexual development and behaviors could influence their decision to delay conversations about sexual health and risky behaviors so critical for preventing risky sexual behaviors and negative outcomes. The data show that parents need education regarding the specific and heightened risk for rural adolescents as one way to support their role as sex educator and schools may have a role in disseminating this important message.

Parents Want to Partner with School

Although parents identified themselves as the primary sex educator, they also reported wanting to partner with the school in this process. Multiple parents reported that they initiated conversations about sex *only* after the school initiated sex education (e.g., fliers, class, children asking question from school), and wanted to receive more communication from the school about what is occurring within the sex education classes, reflecting the parent's need to set limits by filtering information entering the family system (Ingoldsby et al., 2004). Although a few parents identified the school as an environmental stimuli that was hostile to the goals and policies of the family, the vast majority of parents viewed the school sex education program as beneficial and thus, were willing to incorporate the information from the school into their family system and begin their own conversations about sex (Ingoldsby et al., 2004). This provides evidence that the school plays a critical role in the onset of parent-child conversations and that parents are looking to the school for assistance in this area. The school acts as a type of gatekeeper for parents and could potentially benefit parents by initiating earlier to better communicate with parents what and when sex education happens at school and offer specifics about class content so that developmentally appropriate conversations about sex and sexual health begin with the parent, and occur from the beginning of school including the elementary years as well. Initiating earlier would align with the National Sexuality Education Standards, Core Content and Skills, K–12 (NSES) that provide clear, consistent, and straightforward guidance on age-appropriate content that begin in kindergarten (Future of Sex Education Initiative, 2012). Some parents of school-aged children are asking for this (Reichel, 2014), and some parents may benefit from this by understanding their child is not too young for discussions about sex that are developmentally appropriate.

The school has a very important role as initiator, as parents looked to the school to see when to commence conversations about sex. The school could be harnessed in multiple ways to better assist parents as they navigate their role. For example, they could offer parent workshops focused on how to engage children in conversations about sex. Previous work has found that parents who attended workshops found them to be useful (Oliver et al., 1998). Although parents in this study welcomed attendance at a school-led workshop on sex education, the few studies which have attempted to engage parents in workshops (Abel & Greco, 2008; Oliver et al., 1998) reported very poor attendance. This may be because these studies did not enact practices known to successfully engage parents such as ascertaining what parents identify as their role and the school's role in a workshop, what parents would like to receive from a workshop (i.e., identifying resources in the community, bringing in an expert, lecture and/or discussion based), or effective logistics for parents (i.e., appropriate times for differing work schedules, available child care). Given that parents identified themselves as the primary sex educator, they may not be as eager to attend a workshop where the school is instructing them or telling them how to engage their role. Considerations need to be made to understand the dynamic that parents see themselves as leaders, however look to the school as a trusted partner in this process.

Engaging families with parent-child homework supplements has previously been found to increase sex education conversations with their children. This may be one particularly meaningful way to engage families because open communication is their strategy of choice and the homework supplements simply provide more content to stimulate these conversations (Grossman et al., 2014). Unfortunately, in recent studies utilizing homework supplements, the responsibility of initiating the homework supplements was on the adolescent (Grossman et al., 2013), rather than the parent, which does not align with the findings of this study that parents

want to be in the leadership role with their adolescents or with family systems theory that parents are in charge of their family system (Minuchin, 1974). This research on parental inclusion in sex education did not prioritize or understand the parent perspective on how best to include parents in this process. It may be that providing the homework supplement or other resources to parents rather than to the adolescents may provide enhanced engagement by providing parents with content and allowing them to lead discussions. Moving forward, efforts need to be made to continue to capture the parent perspective when creating interventions and curricula that specifically engage parents.

The importance of a trusted source. Parents were willing to engage in workshops or receive information from the school because they identified it as a trusted source. In fact, they wanted to know more about what the school sex education curriculum covered and when their children would receive it. Alternatively, some parents did not want a partnership with school but, identified alternative trusted sources, such as their church, from which they would like to receive information. This theme of receiving information from a "trusted source" permeated the interviews across parents, and highlights an important consideration for developing resources that would speak to parents. It is important to note that while school is one trusted source for some parents, others prefer alternative trusted sources. Connecting with all of these trusted sources (e.g., church, temple, religious community, etc.) could create a multifaceted approach to supporting sex education, initiating conversations and providing parents with accurate content for supporting their conversations about sexual health. It is important for interventionists and researchers to consider the multiple trusted sources that could be a delivery system for sex education content to reach the widest, most vulnerable audience and communities.

Parents are Preparing but Need Resources

Parent preparation methods. The results of this study highlight the clear need and want of parents for resources to promote sex education for adolescents. First, many parents did not prepare to engage their adolescents in conversations on sex education at all. This finding emphasizes the fact that while some parents are taking an active role as sex educators with their children, they have not prepared to execute this role effectively. Results indicated that 2/3rd of parents in this study had done some preparing to engage their adolescent on sex education; however, the main way in which parents had done this was either talking with their partner or spouse, asking their own parents or family members, or asking other peer parents also going through this stage with their own children. Curiously, a majority of families indicated that they did not receive sex education from their parents, or had a negative experience, yet sought out these same individuals for guidance. Inaccurate ideas and information may be circulating from generation to generation due to the lack of evidence-based education for parents, having a transgenerational impact within the family system (Bowen, 1966). Findings indicate that parents making attempts to prepare for these conversations with their children, turn to sources that may very well be ill-equipped to effectively prepare or help them. Additionally, findings from this study identify that parents are looking to resources outside themselves and may benefit from evidenced-based materials suited just for them. Previous research on school teacher preparation has found that teachers who were trained had greater comfort and sense of self-efficacy regarding sex education instruction (LaChausse et al., 2014), and were more likely to teach the intended content (Drake et al., 2015). These findings highlight the issue that parents lack sufficient resources to prepare them for a role they want to pursue, yet existing research highlights that when sex educators have the appropriate supports and resources, they are more

successful in their role. An urgent need exists to identify avenues in which parents can receive evidenced-based resources, from a trusted source, to enhance their education and better prepare them to engage their role as sex educators.

Parent identified resources. Overwhelmingly parents wanted resources and made multiple suggestions for what would make them feel more prepared and more successful in their role. Parents identified that a guide outlining what to say and when to say it would be helpful. Some parents identified that this guide should also include how to engage certain topics (i.e., questions to prompt conversation) and provide age ranges for when to have these conversations with their children. This finding is interesting because there are a plethora of current resources specific for parents to meet this need. There are books like *It's Perfectly Normal: Changing Bodies, Growing Up, Sex, and Sexual Health* (Harris, 2014), for kids aged 10 and up, as well as, *Amazing you: Getting smart about your private parts* (Saltz & Avril, 2005), targeted for younger children aged four to eight. Online resources exist as well. SIECUS provides a newsletter, *Parents Are Talking*, including a range of content (i.e., puberty, abstinence, sexual orientation) that centers on how to talk to children about these topics (Kreinin, Rodriguez, Edwards, & Levine, 2001). During interviews, parents either did not know these resources existed, or explicitly stated that they did not. While there are resources that exist for parents, clearly there are barriers to awareness of and engaging with these sources. It may be that these resources are difficult for parents to find in libraries, bookstores, or online or they may not be seen as a trusted resource by parents. Future work should investigate further about why these available resources are not accessed by parents.

Parents differed in the modality in which they wanted to receive this information, suggesting that a multi-modality approach may reach the most parents. The majority of parents

identified wanting to receive information, or a guide, in paper form, such as a pamphlet or a book. Some parents identified wanting to receive information online, via a website or an e-mail. Other parents wanted to receive information in person or via a one-on-one conversation with a trusted source. This finding is important as it highlights the importance of utilizing a range of delivery methods and the need to respond to different parent learning styles.

It is important that rural parents continue to embrace their role as primary sex educator for their adolescent children. Unfortunately, there is a major deficit in parent's awareness of resources that are currently available, as well as, access to trusted evidence-based supports to help them engage their role successfully. This study provides evidence that communities hold a seriously underutilized resource for promoting sexual health: parents. This is especially critical for rural communities that are less likely to receive funding for programming, resources, and additional positions (i.e., health care provider, school nurse) and need to utilize what is already present in the community the most feasible way possible. Research needs to better work with parents to identify and create resources, possibly a guide that has age-paced information, content, and conversation starters, that could support parents in their role. Interventionists should broaden their view to identify a range of sources of intervention, as parents are looking to trusted sources to receive this information and this could mean from many different places, the school being just one.

Study Limitations and Strengths

Study findings should be considered in light of several limitations. The findings described here are not intended to be generalizable to a wide population. Due to the limited geographic area, the diversity of ideas and saturation within the group could be limited and not reflect all ideas and perspectives of all parents living in a rural area. It is expected that if other

scholars conduct similar research in similar settings they may find comparable results, as well as, new ideas or themes. Rural areas are diverse and encompass many contextual variables (Bender et al, 1985). These results should be identified within the context they were discovered which were based on the experiences of 19 parents in a rural area in the Midwestern United States. The study sample consisted of a majority of Caucasian parents, identifying similarly in religious backgrounds, and majority held full time employment. Using broader sampling frames within different rural areas would strengthen the transferability of results.

Although saturation of ideas was met, the parents that self-selected into the study volunteered to talk about sex education with a stranger. It may be that the parents who participated in the study already practice and rely on open communication as a strategy in their parenting styles and would subscribe to open communication in their life in a more general way. It may be that the parent perspectives of families who are less open with their children would not self-select into this kind of study, which is not surprising as nearly 40% of families do not engage in sex education with their children (Asekun-Olarinmoye, Dairo, Asekun-Olarinmoye, & Adebimpe, 2014). One parent (participant #18) commented on this and expressed, "I would suspect though it's not a representative sample, just those parents who are willing to give you their perspective. Many people believe we're wrong even though we believe we're right. I always like giving my opinion."

Finally, the parent content knowledge is narrow, and may be due to the way in which the data was collected, relying on parent's ability and knowledge of sex education content. Study findings indicated that parents do not know *what* to say to their children (i.e., content) and *when* to say it (i.e., timing). This indicates that the way in which the question was asked (i.e., qualitative inquiry) may not have been the most effective way to gather data related to content

preferences and future work employing a survey to gather more in-depth parent data would be useful.

Parental engagement has been identified as one core school health function within formal sex education by the CDC (2015b). This study expands existing literature regarding the importance of including parents in the sex education of their children and is responsive to the stakeholdership parents have in the delivery of sex education in their own homes. Additionally, data from this study can contribute to the tennets of Comprehensive Sex Education which emphasize the importance of including parents in the process (SIECUS, 2004).

This study also offers important contributions to the literature and addresses a gap of emperical knowledge for understanding the rural parental experience in sex education. Additionally, data was sought out to better understand how parents would like to be supported in their role, as well as, included in school-based sex education programming. This knowledge is useful to inform parent-based interentions moving forward. It is especially important as it pertains to rural areas that experience increased risk regarding teen pregnancy and STI transmission (Ng & Kaye, 2015), and may require culturally informed interventions that address the unique challenges within these specific areas.

Implications for Research

The results of this study provide multiple implications for future research. While this study provides an initial, albeit descriptive, examination of rural parents' experiences, perspectives, and needs for providing sex education to their children, future work should sample from different rural areas—recognizing the diversity in rural regions (CITE)—to provide a broader understanding of rural parents' experiences. Specifically targeting parents who are not, or are less likely to, engage their children on sex education, or look to the school for support

could provide valuable data to expand the efforts to reach parents in ways that they would trust and welcome.

Rural areas are currently experiencing a lack in necessary resources (i.e., funding, CSE curriculum) to deliver evidenced-based sex education to adolescents (Lindberg et al., 2016). Fortunately, parents are a ready and available, but underutilized resource that exists within these areas who could be leveraged to provide sex education to their children. This line of research suggests that targeting parents as a means of delivering sex education to adolescents could be a welcomed and effective approach. Additionally, parents are already making shifts towards creating sex-positive sex education for their children, suggesting parents may be open to sex education curricula that align with CSE.

Although parents were engaging their children in sex education (e.g., engaging in open conversations, seeking out resources such as Google and their peers), this was in light of the misconception that rural adolescents and teenagers are at lower risk than their urban counterparts for risky sex behaviors and STIs/HIV, a belief which is in direct opposition to the current data. Providing specific information about this risk seems an important step in heightening the risk awareness of this group and further activating parents.

It was clear, from this research, that parents wanted guidance on sex education, specifically a guide explaining what to say and when to say it. They welcomed this information in a range of formats including a book, a pamphlet, an e-mail, or a parent workshop, but require that it come from a trusted source. Some parents identified that the school qualified as a trusted source, however for others it did not, and preferred a source such as their church.

Implications for Family Therapy

Considerations from this study can be drawn for family therapy practice, specifically for clinicians working with rural parents who have young children and adolescents. Research has indicated that some rural parents identified with engaging their children in sex education at home (Jordan et al., 2000; Welshimer & Harris, 1994), however findings from this study showed that parents indicated a narrow knowledge of sex education content and identified with wanting to know *what* to say and *when* to say it to their children. For clinicians, this indicates a need that could be met with a psychoeducation approach using adequate resources that involve discussion of necessary sex education topics and the delivery of resources such as trusted books, pamphlets, and online sources.

Findings from this study indicate that clinicians should consider the sensitivity of this topic as it pertains to parents own sex education history within their family. A majority of parents indicated that their own sex education was either absent, insufficient, or shaming at home, yet parents also indicated wanting to provide an experience for their children that was better than what they experienced. Therapists should be prepared that engaging in sex education conversations could trigger clients depending on their history, both as it pertains to the sex education they received and the sexual experiences they have had. In addition, this finding indicates a unique resilience and developmental process within parents without any formal intervention provided. By being responsive to parent's experiences and needs, a clinician could assist parents in their role as sex educator, which they may be already engaging. Therapists should also consider whether or not a client system identifies them as a trusted source prior to engaging these topics. Findings from this study indicated that parents look to trusted sources for receiving information and support regarding sex education.

Rural areas face increased challenges as they have higher rates of teen pregnancy and STI transmission (Ng & Kaye, 2015). Parents from this study, however, indicated a perception of safety within rural areas that their adolescents were sexually behind their urban counterparts. Parents' perception of safety is in conflict with evidence identifying heightened risk in rural areas. Family therapists and school social workers in rural areas could benefit families, parents, and adolescents by engaging interventions and treatment approaches that include these considerations. Critical topics of sex education that address rural area risk factors, the need for adequate evidenced-based sex education, and the provision of resources for rural parents are a few ways that family therapists can seek to assist rural families and parents in meaningful ways.

Conclusion

This study set out to capture and understand the experiences and perspectives of rural parents as they navigate their roles as sex educators with their adolescents. Using a qualitative research approach resulted in findings that begin to identify rural parent's experiences, preferences, and needs as the primary sex educators of their children. The findings of this study suggest recommendations for informing and creating evidenced-based programs for parents, guidance for parent-school partnerships, and direction for future research to improve the delivery of effective sex education for adolescents, specifically those most at risk. Parents are a vital resource in families and communities. In the words of one mother from this study (participant #9):

> I just feel like if parents just played a bigger role in their kids' development, and were more in tune with their children, and had better knowledge of what they do, and what they're into, and who their friends are, and just paid more attention to their kids in general, it'd probably solve a lot of problems.

APPENDICES

Appendix A: Recruitment Interview Protocol

Hello, my name is Teresa Barabe. I am a doctoral student at Michigan State University in the Human Development & Family Studies department. I am working with Negaunee Middle School to develop a more effective program for educating youth about sexual health. We believe that parents are critical to strong youth development and so I want to understand parents' perspectives and experiences in their role in educating their own child about sex. I am inviting you to participate because you are a parent of a 6^{th}, 7^{th}, or 8^{th} grade student at Negaunee Middle School.

To participate in this research, you will be interviewed about your experiences talking with your child about sex as well as your goals and needs to more successfully talk to your child about sex. The interview will take approximately 60 minutes. For your time you will receive a $40 gift card.

Which parent is likely to talk to your child about sex? Are you interested in participating in this research?
Is there another parent who would have a role in these discussions? Are they available to participate in a separate interview?

Proceed to schedule interview(s).

If you have any questions, I can be reached at barabete@gmail.com.

Appendix B: Invitational Flier

ADVERTISEMENT FOR RESEARCH STUDY

Parents: Let's talk about "the Birds & the Bees"

Your voice matters! We want to hear from you! Parents play a really important role in their children's lives and your experience and story is what we want to hear!

If you are a parent and your oldest child is in 6th, 7th, or 8th grade at Negaunee Middle School you can help improve the understanding of parents' perspectives and experiences in their role in educating their own child about sex. Your story will support the development of effective programming for educating youth about sexual health.

Parents participating in the study will be asked to partake in a 60-90 minute interview. These interviews will be conducted in a safe, confidential location at the Negaunee Public Library or at the parents' home, whichever location is more convenient. All participants will receive a $40 Amazon Gift Card.

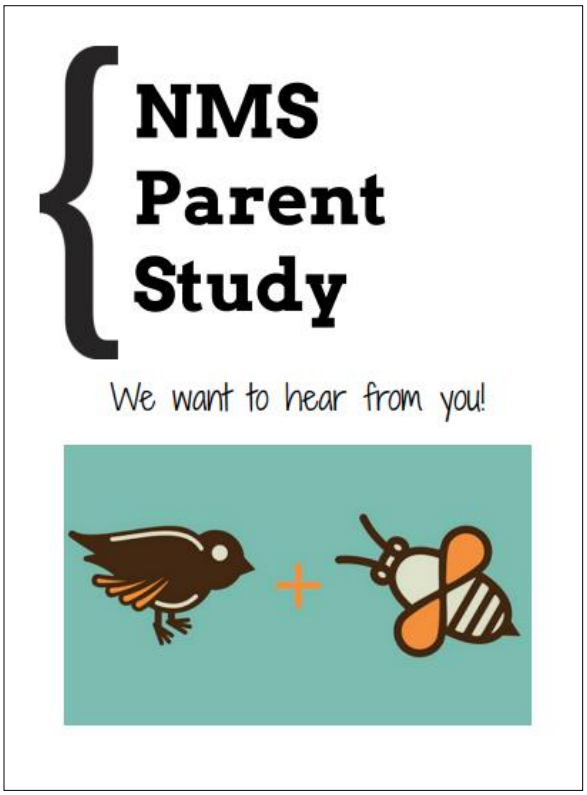
If you or someone you know would be interested in participating in this study please contact Teresa Barabe for more information.

By email: barabete@msu.edu

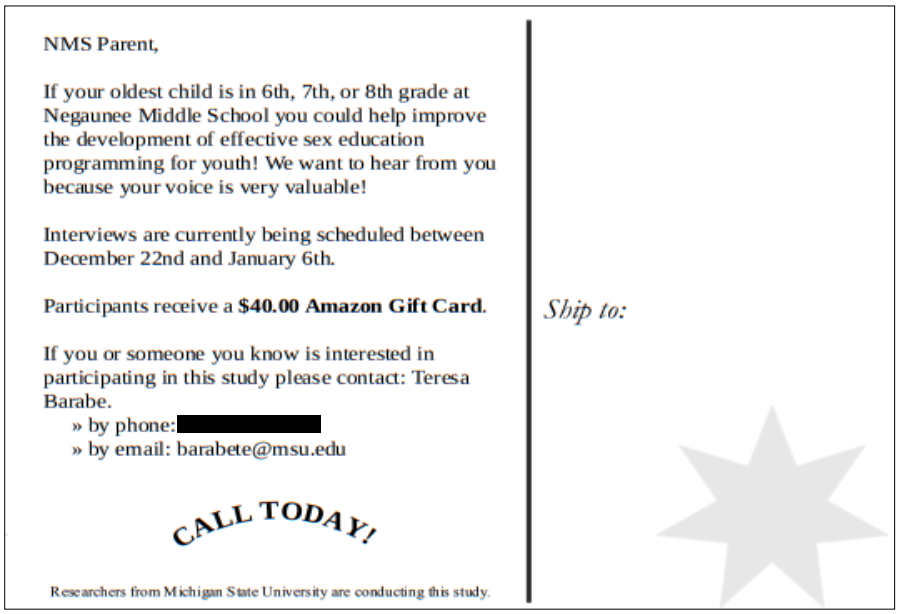
Researchers from Michigan State University are conducting this study.

Appendix C: Invitational Postcard

Postcard front:



Postcard back:



Appendix D: Qualitative Study Consent Form

Investigation of Rural Parental Experiences and Needs in their Roles as Sex Educators

Michigan State University
Department of Human Development and Family Studies
Consent Form – Interview Participants

You are being asked to participate in a research project. Researchers must provide a consent form to inform you about the study. It must let you know that participation is voluntary, explain risks and benefits of participation, and to empower you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Study Title: Investigation of Rural Parental Experiences and Needs in their Roles as Sex Educators

Researcher and Title: Hope K. Gerde, PhD, Associate Professor
Department and Institution: Human Development & Family Studies, Michigan State University
Address and Contact Information: 552 W. Circle Drive, East Lansing, MI, 48824; telephone, 517-355-0365; e-mail, hgerde@msu.edu

1. PURPOSE OF THE RESEARCH

I am conducting a preliminary study, Investigation of Rural Parental Experiences and Needs in their Roles as Sex Educators, to learn more about parents who have a child in 6th 7th or 8th grade and their experiences in their roles providing sex education to their children and their needs in this role. The first step in the study is to conduct interviews with parents to understand your experiences, areas where you feel comfortable or uncomfortable, and what resources you need to assist in this role.

2. WHAT YOU WILL DO

If you agree to participate in this study, you will participate in an interview that will take place in person. I expect the conversations to be approximately 60-90 minutes in length. Participation in this project is completely voluntary. Participants may discontinue the study at any time and/or refuse to answer any questions they do not want to answer. Refusal to participate in the study will not affect you or your child attending middle school in any way.

If you choose to participate, a sixth-year Graduate Student, from Michigan State University, will conduct the interview protocol. Each interview will be audiotaped, unless this is not an

acceptable option to you. If you agree to be audiotaped, please circle your response and initial in the box below.

I agree to allow audiotaping of the interview. Yes No Initials_____

3. POTENTIAL BENEFITS

The potential benefits in taking part in this study are the opportunity to discuss your experiences in providing sex education to your child. In addition, your participation in this study will contribute to our understanding of rural parents' goals and needs for providing sex education and may contribute to the development of future parent-based sex education programs for families like yours.

4. POTENTIAL RISKS

The study includes minimal risk. Potential risks of participating in this study may include any distress and/or discomfort regarding discussions of topics related to sex. Any study participant experiencing distress or discomfort is invited to contact Catholic Social Services. The phone number is: (906) 227-9119.

5. PRIVACY AND CONFIDENTIALITY

The data for this project, including the responses you provide to all questions, will be kept confidential to the maximum extent allowable by law. Any responses you offer during the interviews will be combined with others in all reports of these data; reports will never refer to data about an individual. Identifying information will not be attached to any of your individual responses when reporting results from the interviews. All data will be stored in locked file cabinets or on password-protected computers in locked offices on the Michigan State University campus. No one in your child's middle school will have access to your data. Only the principal investigator, her advisor, research assistants with IRB training, and the University Research Protection staff will have access to that data. The results of this study may be published or presented at professional meetings, but identities of all research participants will remain anonymous. The data will be retained for at least three years after the project ends.

6. YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW

Participation in this research project is completely voluntary. You have the right to say no. You may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time without penalty to your child's access to quality education at their middle school.

7. COSTS AND COMPENSATION FOR BEING IN THE STUDY

There are no costs associated with participation in the study beyond the time of the participant. Participants will receive one $40 gift card after completion of the interview.

8. CONTACT INFORMATION FOR QUESTIONS AND CONCERNS

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact:

- Dr. Hope Gerde, Michigan State University, Human Ecology, East Lansing, MI 48823, 517-355-0365, hgerde@msu.edu

- Teresa Barabe, Doctoral Candidate, Michigan State University, Human Ecology, East Lansing, MI 48823, barabete@msu.edu

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or regular mail at 4000 Collins Rd, Suite 122, Lansing, MI 48910.

Your signature below indicates your willingness to participate in this study. Thank you for your time. I look forward to talking with you about your experiences.

☐ ***Yes, I voluntarily AGREE to participate in the study***
☐ ***No, I DO NOT AGREE to participate in the study***

_____ _____

Your Signature Today's Date

_____

Please Print Your Name

You will be given a copy of this consent form to keep.

Appendix E: Qualitative Study Demographic Questionnaire

Participant #: _____
Date: _____

Directions: Please fill in the blank or circle the response that best describes you.

1. What year were you born?: _____
2. What is your gender?: _____
3. What is your race? (circle all that apply)
    a. American Indian/Alaskan Native
    b. Asian
    c. Black, African American
    d. Native Hawaiian/Pacific Islander
    e. White
    f. Other: _____
4. Are you of Latino/Hispanic origin? _____
5. What is your highest level of education? (please circle)
    a. Less than 9th grade
    b. Less than 12th grade, no diploma
    c. High School Graduate
    d. Some college, no degree
    e. Associate's Degree
    f. Bachelor's Degree
    g. Graduate or Professional Degree

<u>Household Dependents</u>

6. Number of individuals residing in the home: _____
7. Number of children 18 years of age and younger: _____
8. List your children's age and sex:

_____ _____

_____ _____

Continue to next page…

Employment Status

9. Are you currently working? (please circle)

    a. Yes, full time employment, in my interest area
    b. Yes, full time employment, not in my interest area
    c. Yes, part time employment, in one position
    d. Yes, part time employment, in multiple positions
    e. No, I am currently unemployed
    f. Other, please specify: _____

Current Financial Information

The following questions address your **present financial circumstances today**. Currently, what is your families:

10. Approximate monthly gross income before taxes (please circle)

    a. $ 249 or less
    b. $ 250 - $ 499
    c. $500 - $ 749
    d. $750 - $ 999
    e. $ 1,000 - $1,499
    f. $ 1, 500 - $ 1,999
    g. $ 2,000 - $ 2,499
    h. $ 2,500 - $ 4,999
    i. $5,000 or more

Religious Affiliation

11. What is your religious affiliation? (Optional: write in denomination on line)

    a. No affiliation
    b. Christianity:_____
    c. Judaism: _____
    d. Hinduism: _____
    e. Buddhism: _____
    f. Islam: _____

Appendix F: Qualitative Study Interview Question Protocol

INTRODUCTION TO THE STUDY

As mothers, we want our children to be as risk-free as possible when it comes to their sexual health. You were invited to participate in this interview because you are interested in talking about your experience and role as a sex educator for your child. The goal of my study is to understand parent's experience with this topic and use this information to develop resources to effectively support parents in their roles as sex educators.

We know that schools vary widely in the sex education they provide. As such, not all students obtain the sex education they need or desire. Some research shows that youth want to hear from their parents about sexuality and sex, and so I want to hear from you as the parent of a youth. I want to hear about your experience as a parent, your successes and challenges, and get your feedback about what would be most helpful to you.

We define youth as young people ages 11, 12, and 13. When answering these questions think about your oldest child who is of this age.

Interview Guide

RQ1: What are parent's experiences with providing sex education for their children?

As we begin this interview I first want to say that there is no expectation of what you should or shouldn't be doing or what you should or shouldn't say as a parent when it comes to sex education. I really just want to understand your experience in providing sex education to your child.

1. What is it like being a parent of a child going through puberty?
    a. Prompt: positives, challenges
2. Have you initiated any conversations about *sex* with your child?
    a. If yes:
        i. Can you explain how this happened?
            1. Prompt: conversation, texting, pamphlets, social media
        ii. What prompted you to initiate conversations about sex with your adolescent?
            1. Prompt: Adolescent changes, Adolescent initiated, Social media
    b. If no:
        i. Can you explain why this has not occurred?
        ii. When do you plan to have these conversations?

3. As a parent, how do you support or help your adolescent through this time?

    a. Prompt: sex, puberty, bodies, relationships
4. What strengths or skills do you use in talking to your adolescent about sex?
    a. Prompt: rural, technology
5. What barriers do you experience in talking to your adolescent about sex?
    a. Prompt: rural, technology

RQ2: What do rural parents consider should be the main characteristics of their preferred sex education for their children?

We've discussed a bit about your experiences providing sex education and now I'd like to transition to discussing different topics in sex educatino that you may be comfortable talking about and less comfortable talking about.

1. How would you describe your part, or your role, regarding sex education with your child
2. What are some of the important things you want your child to know about sex at this time?
    a. What should schools do in providing this information?
    (Again there is no expectation or right answer, and I'm just interested in your perspective as a parent.)
    b. What should you do, or parents do, in providing this information?

    (Sex education can include a large range of topics for developing children, adolescents, and youth. I would like to get an understanding of some different topics in sex education that you find might be easier or more difficult to discuss with your child.)
3. What topics or things do you feel comfortable to talk about with your adolescent?
    a. What makes that more comfortable to talk about?
4. What means, if any, have you used to prepare yourself to engage this topic/these topics?
    a. Prompt: technology, peers
5. What topics or things do you feel uncomfortable to talk about with your adolescent?
    a. What makes that uncomfortable to talk about?
6. Is there anything that you, the parent, can provide your adolescent in terms of sex education that the school cannot?

    (Now I'm going to ask about living in a rural area. When different issues come up some people say that rural areas have the same needs as urban areas, or cities, whereas others may rural areas have unique needs that are different than urban areas.)
7. Do you think there are specific needs for rural areas regarding sex education?

RQ3: If parents see themselves as sex educators for their children, what resources do they need to support these efforts?

1. Do you feel supported in providing education about sex to your child?
    a. Prompt: bodies, puberty, relationships to your child?
    b. Describe these supports.
    c. If not, how would you feel supported?
2. What would you need to feel you could discuss these topics successfully?
3. In what format would you like to receive information about providing sex education to your child?
4. What else would you like to say about parent-child sex education? Do you have any other thoughts?

Appendix G: Stages of Thematic Analysis

PHASES OF THEMATIC ANALYSIS (Adapted from Braun & Clarke, 2006)	
1	***Familiarization with data:*** • *Data Collection:* All semi-structured individual interviews will be conducted by the first author. During this early process, basic ideas and inquiries will be developed. • *Field notes:* During the interview process, notes will be taken about important aspects reported by participants. • *Transcribing:* Transcription will be completed by the first author along with a research assistant. • *Reading, and re-reading, noting down initial ideas:* This early exploration will be conducted by reading the digital copies of the transcripts and inserting comments along the transcripts from the Word program.
2	***Generating initial codes:*** • Transcripts will be printed and coding features of interest will be done by hand. This systematic process will be implemented across the data set, categorizing the entire data in the appropriate code(s). • At this stage, the semantic level of analysis will happen on the right side of the transcript margin and a latent (interpretative) level of analysis will be conducted on the left side of the margin. • Themes will be identified and later condensed and reorganized. • Illustrative quotes will be identified to support themes.
3	***Searching for themes:*** • NVivo 9 software program will be utilized for the task of searching themes. • After uploading the transcripts, a second round of coding will occur using the software for creating nodes and tree-nodes. • The codes (nodes) will be categorized into prospective themes and grouped together the data related to each prospective theme. At this point, the nodes will be reorganized and re-categorized. • At this stage, the evolving-prospective themes in regards to their category and name will be refined. • A thematic map of the themes will be drafted by hand and digitally, using NVivo.
4	***Reviewing themes:*** • Congruence of each theme with each of the coded extracts and all the data set will be reviewed. • Initial field notes will be revisited. The notes will help to support the analysis process. • Continuation of refining the thematic map of the TA by classifying and re-classifying themes that are similar or that are not related to the research questions. • Finally, major themes and sub-themes will be identified.
5	***Defining and naming themes:*** • At this phase, the analysis will continue in order to attain an increased refinement of each particular theme, as well as the general narrative that the data are perceived to be transmitting. • More distinctive concepts and names for each of the themes will be reached.
6	***Producing the report:*** • The process of writing the research report will allow an additional chance for reviewing the data analysis as the narrative of the results section is told. • For illustration purposes, a careful selection of persuasive and powerful extracts will be selected. This will be a challenging process due to the inclination to honor the voices of all participants. • Then, the chosen extracts will be revised and analyzed, making connections between analysis and research questions.

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