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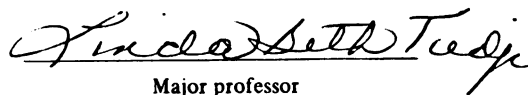


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**FEMALE ADOLESCENT SEXUALITY: AN ANALYSIS OF MOTHER AND
DAUGHTER COMMUNICATION**

By

Ann K. Mack

A THESIS

**Submitted to
Michigan State University
in partial fulfillment of the requirements
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ABSTRACT

FEMALE ADOLESCENT SEXUALITY: AN ANALYSIS OF MOTHER AND DAUGHTER COMMUNICATION

By

Ann K. Mack

According to the literature, sexuality communication between mothers and adolescent daughters has been limited to discussions on reproduction, anatomy and contraceptive use. Few studies have examined interpersonal aspects of sexuality communication such as feelings, emotions and relationships. The purpose of this qualitative study was to gain insight into the content of sex/sexuality communication. Focus groups were used to generate data from which themes were extracted for further use in sexuality communication studies. The content of mother-daughter conversations was examined as well as perceptions and nonverbal messages. Five themes were identified. They were 1) In mother and daughter communication it is difficult to separate sexuality from sex. 2) Mothers perceive that their daughters are uncomfortable discussing subjects of a sexual nature. 3) Mothers perceive that their daughters already had the information regarding sex and sexuality. 4) Daughters identified a lack of trust of their mothers in regards to confidentiality and their mothers perceptions. 5) Methods of communication are a barrier to sexuality communication. The results indicate there is a need to teach sexuality from an early age and the advanced practice nurse has many opportunities to help mothers and teenage daughters open lines of communication and help break the cycle of generations of women not able to openly discuss sexuality issues.

This thesis is dedicated to my loving parents
Ralph and Colleen Patzer
who taught me the value of education and who
smiled down on me from heaven
throughout this challenge

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Chapter 1

INTRODUCTION

Adolescence is a time of physical, social, psychological and emotional growth unlike any experienced before or likely to occur again. This transitional period between childhood and adulthood requires the ability to make decisions in a turbulent and ever-changing world. Although seeking independence, an adolescent looks to significant adults to guide him or her in decision making (Chilman,1990). Sexuality and sex take center stage during the adolescent period. Sexuality is more comprehensive and includes intimacy, emotions, relationships and gender identity (Chilman, 1990; Maddock, 1989). Sex, more commonly refers to the physical aspects of reproduction or reproductive behaviors.

The need for education and guidance from those who can influence sexual health is paramount during this adolescence (Bennett & Dickinson, 1980; Chilman, 1990; Stewart, 1987). The distinction between sex and sexuality is a critical component in communication. Research shows that parents want to be the primary educators of their children in the area of sexuality (Brock& Jennings, 1993; Fox& Inazu, 1980; Green & Sollie, 1989; Hepburn,1983; Newcomer& Udry, 1985; Rozema,1986) and that teens have expressed the need and desire to be able to communicate freely with their parents about sex and related issues (Brock & Jennings,1993; Fox & Inazu, 1980; White & DeBlassie, 1992).

With the desire to communicate in both parents and teens, it is puzzling as to why peers are cited by teens as the major source of sex information (Bennett & Dickinson, 1980; Brock & Jennings,1993; Green & Sollie,1989; Rozema,1986; Spanier,1977) and why the topic of sex and sexuality is ignored in most families. If verbal sexuality education is done at

all, it is done by the mother and most often is between a mother and a female adolescent (Brock & Jennings,1993; Fox & Inazu,1980; Hepburn,1983; Maddock,1989).

There is also widespread discrepancy between actual levels of communication about sex-related topics between parents and kids (Fox & Inazu ,1980; Furstenberg, Herceg-Baron, Gilbert & Bailes,1980; Rozema,1986; Shea & Webb,1984). Parents tend to report higher levels of communication than their teens, and teens do not report retaining or hearing what their parents say they are communicating (Newcomer & Udry,1985).

Where there is teen /parent communication, daughters have shown more responsible patterns of sexual behavior. Those that report lower levels of communication have also reported higher levels of sexual risk taking behaviors(Fox & Inazu, 1980; Jaccard & Dittus, 1991). Sexual behavior is widely reported in teens. Of high school students surveyed, 54 % claim they have had sex with the average age of initiation of coitus being 16-years of age (CDC 1990).

Sexually transmitted diseases are also frequently reported in this age group. One in 5 people under the age of 21 who are sexually active have an STD (CDC 1996). It is estimated that 86% of STDs occur among persons 15-29 years of age (CDC 1990). Sex at a young age can not only result in pregnancy and STD' but may lead to long term problems such as Pelvic Inflammatory Disease , infertility, cervical cancer and emotional ill health (Berti,1994). There are many factors associated with teen pregnancy and STDs such as peer pressure, self-esteem issues, media influences and parent/teen communication. This study will examine one of these influences on teen pregnancy and STDs: the communication between teens and their parents.

An increase in parent/teen communication could potentially change these influences as the teen could be enlightened to the risks involved in sexual activity such as pregnancy and STDs.

Another reason for the need for communication is to communicate the positive aspects of sexuality.

The purpose of this study is to describe the communication between adolescent females and their mothers in a semi-rural community. This communication will be examined for content, perceptions of both mothers, and daughters and nonverbal communication areas. The general research question is: What is the nature of mother-daughter communication regarding sexuality?

Adolescents do not lack formal sex education in school to influence their sexual behaviors as all 50 state educational agencies now either mandate or strongly encourage some form of sex education in school. The majority of sex education in school takes place in the ninth and tenth grades long after the period of puberty has begun (Kirby,1992). Formal education in a majority of the states consists of anatomy and the risk and consequences of pregnancy, values clarification, decision making and communication skills (Kirby, 1992; Lock & Vincent, 1995). While research has shown that talking about sex in school based programs does not promote or encourage sexual activity, sex education programs also do not consistently or measurably reduce or delay intercourse (Kirby,1992).

Today, there is a trend toward more comprehensive sex education that addresses the biological, sociocultural, psychological and spiritual dimensions of the cognitive, affective and behavioral domains (Glazer,1989; Kirby,1992). These new programs look beyond sex to sexuality talking about subjects such as interpersonal relationships, affection, intimacy, body image and gender roles (Glazer,1989; Kirby,1992).

A more comprehensive approach including both home and school gives the teen a more holistic view of healthy sexuality (Chilman,1990; Kirby, 1992).

As we see changes in formal, school-based sex education, focus now needs to be turned toward helping to improve sex education at home. Parents want to be the primary sex educators of children but are either embarrassed, unsure, confused, lack information, or assume the child already has the information (Bennett & Dickinson, 1980; Brock & Jennings, 1993; Jaccard & Dittus, 1991). It is difficult for an adolescent to have open discussions about sexuality in a classroom without drawing attention to themselves. Without open and honest communication at home, the child is then left with unanswered questions and often turns to peers for what is often inaccurate information (Green & Sollie, 1989). It is the combination of home and school sex education that promotes healthy sexuality and informed decision making. Laying the ground work at home with open, honest communication can foster informed group discussions in the classroom with an increased comfort level. Parents input into the establishment and development of sexual attitudes and behaviors can foster healthy sexual development, although this has rarely been tested empirically (Chilman, 1990; Gilbert & Bailes, 1980; Maddock, 1989).

Parents are the earliest and most important influence on sexual health and do so in both positive and negative ways. Parents lay the foundation for sexual health in the first months of life by methods of discipline, control, interaction patterns and affection patterns. All of these parental behaviors influence gender identity, gender appropriate behavior and moral values (Bennett & Dickinson, 1980; Jaccard & Dittus, 1991). We teach our children morals and lessons from our life experiences about drinking and driving, stealing and lying, but not about sex. Many parents find it difficult to discuss the lessons learned from their own experiences with sex. This is often difficult for parents as they are often unsure about what to discuss regarding sexuality. Most parents are also unsure about when to discuss sexual issues.

In both overt and covert ways the activities and relationships within a family transmit messages regarding sexuality, sex roles, sexual feelings and values (Jaccard & Dittus, 1991; Maddock, 1989; White & DeBlassie, 1992). Interpersonal relationship styles, parent relationships, and interaction patterns of everyday life set the stage for sexual health. Sexual health as defined by World Health Organization (WHO) is “the integration of the somatic, mental, and social aspects of sexual beings in ways that are positively enriching and that enhance personality, communication and love” (WHO, 1975). One influence on our sexual health comes from both verbal and nonverbal cues from our parents.

The study reported here is significant for several reasons. There are many factors involved in the increase of STDs, AIDS, and teenage pregnancy in the adolescent population. One factor is the communication process of parents and teens regarding sex. Health care professionals need to examine ways adolescent sexuality is currently being communicated between parents and teens (Maddock, 1989).

Female adolescent health has long been a neglected issue in health care (Adesso, Reddy & Fleming, 1994; Chilman, 1990). Improving family and community health including adolescent health is a major health care goal in this country. Health promotion is thought to be the means to achieve this goal (Stoto, Behrens & Rosemont, 1990). Sexuality communication either explicit or implicit, starts at an early age. Childhood offers an opportunity to set healthy life long behavior patterns and establish the foundation for positive sexual health (Stoto et al., 1990).

Past and present day studies look at parent/adolescent sexuality communication from a view point of birth control, intercourse and reproduction. Few studies have investigated the content of the parent/adolescent sexuality communication, both verbal and nonverbal.

Few studies have examined how sexuality communication is conveyed from an interpersonal aspect between parent and adolescent, and few studies have examined how sexual messages, both verbal and nonverbal are perceived by the adolescent (Bennett & Dickinson, 1980; Fox & Inazu, 1980; Furstenberg et al., 1984; Jaccard & Dittus, 1991; Newcomer & Udry, 1985).

Chapter 2

Review of Literature

Review of the literature as far back as 1915 indicates that parents are seldom the first source for sex education (Rozema,1986). Adolescent sexuality and parent communication is a well researched subject but usually an avoided subject. There are numerous studies examining communication between mothers and daughters. The influence of mother-daughter communication on contraceptive use appears in the literature. Studies that examine exactly what is communicated are lacking (Bennett & Dickinson, 1980; Furstenberg et al.,1984; Moore, Peterson & Furstenberg, 1986). Studies examining parent-teen communication as a deterrent to sexual activity are numerous but the focus is on anatomy, reproduction and contraceptive use. Studies of parent-teen communication lack comprehensive focus on interpersonal aspects of communication such as feelings, emotions and relationships (Brock & Jennings, 1993; Fox & Inazu,1980; Furstenberg et al., 1984; Hepburn,1983).

This review of the literature will identify several links between mother-daughter communication and the sexuality of adolescent females. This review will examine: 1) the style of communication, both verbal and nonverbal; 2) deterrents to communication; 3) sex verses sexuality, content of communication; 4) timing of communication; 5) influences of communication on sexual behavior; and 6) adolescent growth and development.

Style of Communication

In a majority of studies done on mother/daughter communication what the mother intended to say or thought she had said was not always what the daughter heard or perceived (Fox & Inazu, 1980; Furstenberg et al, 1984; Hepburn, 1983; Newcomer & Udry, 1985; Moore et al., 1986).

Menstruation, dating, birth control, intercourse and reproduction were identified as the most discussed issues in mother daughter communication. Interpersonal issues such as relationships, feelings, intimacy and emotions were the least discussed (Brock & Jennings, 1993; Fox & Inazu, 1980; Furstenberg et al., 1984; Green & Sollie, 1989; Hepburn, 1983; Moore et al., 1986).

The transmission of messages or the style of communication differs from family to family. General family discussions of social issues and comments on other people's behavior indirectly convey values. These abstract discussions prevent direct connections to be made between the parent and the issue of sexuality. Families convey messages about their sexuality beliefs in indirect messages such as their reaction and responses to photos, commercials and questions asked by their children. How menstruation equipment is purchased and stored in the home can convey either a message that sexuality and sex are a natural part of the human process or 'dirty' and bad. The communication may also be vague and limited such as a statement like, "fooling around can get you into trouble." Such vague statements because they are either misinterpreted or too general, may have no impact at all on the adolescent (Newcomer & Udry, 1985).

Parent child communication concerning sexuality issues can be a vital component in the sexual health of the adolescent (Chilman, 1990; Calderone, 1985; Maddock, 1989). The content of the communication and the way it is conveyed may be the most influential aspect which contributes to sexual health (Calderone, 1985; Gilbert & Bailes, 1980; Newcomer & Udry, 1985). Using proper terminology to describe body parts or sexual activities is an example of how healthy sexuality can be conveyed.

Deterrents to Communication

Themes identified in the literature were that both mothers and adolescent daughters want open lines of communication (Bennett & Dickinson, 1980; Brock & Jennings, 1993; Fox & Inazu, 1980; Green & Sollie, 1989). Teens want to talk about sensitive sexual issues and mothers want to be the primary source of sexuality education for their daughters (Brock & Jennings, 1993; Fox & Inazu, 1980; Green & Sollie, 1989). Problems identified were that mothers did not always know what to discuss or when to discuss sex, were embarrassed by their own lack of information, and were uncertain about their own sexuality, beliefs and values (Brock & Jennings, 1993; Fox & Inazu, 1980; Furstenberg et al., 1984; Green & Sollie, 1989; Rozema, 1986). Several studies identified the inability to accept the sexuality of children as an added deterrent for mother-daughter communication (Fox & Inazu, 1980; Newcomer & Udry, 1985; Rozema, 1986). Daughters identified deterrents such as the need for privacy and the fear that bringing up the subject may make them appear to be sexually active (Fox & Inazu, 1980).

Early onset of puberty may also leave the mother unprepared to discuss sexual issues, as she may not recognize her daughter is a sexual being at such an early age. Over the past 50 years the age of puberty has declined (Berti, 1994; Chilman, 1990). This decline has been attributed to better health practices and better nutrition. With the decline of the age of puberty we are now seeing sexual behaviors in adolescents who are not biologically, cognitively or emotionally mature to handle the consequences (White & DeBlassie, 1992). Communication can be hindered due to lack of preparation in both the mother and teen on issues that have in the past been reserved for older teens.

Sex verses Sexuality

The terms sex and sexuality have been interchangeably used throughout the literature in the context of intercourse, birth control, reproduction and menstruation with only a few studies that differentiate between the two (Eisen & Zellman, 1986; Fox & Inazu, 1980; Green & Sollie, 1989; Maddock, 1989). The cited studies examine sexuality from the emotional and psychological aspects and not merely from the biological aspects of sex.

The literature on sexuality, although well researched from the aspect of biologic consequences like STDs, is lacking in addressing more comprehensive sexuality communication between mothers and daughters. The effect more comprehensive sexuality communication has on sexual health is sparse. Both a distinction between sex and sexuality and the outcome of such sex verses sexuality communication is lacking in the literature. Most studies focus only on assessing direct communication regarding biologic and physical sex and do not assess sexuality education about values and attitudes.

Timing of Communication

Timing is another issue influencing parent and adolescent sexual communication and positive outcomes. While there are discrepancies in the research findings as to the benefits of parent/ child communication regarding sexuality issues, most studies identify the need to establish communication at an early age and provide comprehensive sexuality education rather than a one time talk about sex (Bennett & Dickinson, 1980; Fox & Inazu, 1980; Kirby, 1992; Moore et al., 1986; Silverstone, 1992). By the age of puberty many beliefs and values have already been established, so most authorities agree the groundwork must be laid early and be continuous to have a positive influence on positive sexual health in the adolescent (Fox & Inazu, 1980; Green & Sollie).

Influences of Communication on Sexual Behavior

The literature has identified influences on the sexual behavior of adolescents such as peers, family structure, socioeconomics, demographics, puberty timing and parent child communication (Berti, 1994; Irwin, 1990; Lock & Vincent, 1995; Luster & Small, 1994; White & DeBlassie, 1992). Lower levels of parent-child communication have been associated with many demographic factors such as race, age, religion, economic and education. Those with less education and income, those from minorities, and members of conservative church groups report lower levels of communication within the family structure regarding sex and sexuality communication. (Berti, 1994; Chilman, 1990; Fox and Inazu, 1980; Lock & Vincent, 1995; White & Deblassie, 1992).

Timing of puberty has also been identified as a factor in poor communication and increased sexual risk taking among female adolescents (Berti, 1994). Teens who have friends engaging in sexual activities are more likely to engage in sexual activities themselves (Luster & Small, 1994).

The literature on family structure as it contributes to adolescent sexual behavior is mixed. Single parent households with the mother as head of the household have been identified in some studies as a positive factor in sexuality related communication as the mother and daughter may share more of a common ground or role similarity (Fox & Inazu 1980).

Other studies report single parent households increase the risk taking of female adolescents as they may lack the necessary communication due to family struggles and distance in their relationship (Berti, 1994; Fox & Inazu, 1980; Irwin, 1990; Lock & Vincent, 1995; White & DeBlassie, 1992). These same studies have linked overall communication and outcome sexual behaviors to the frequency of communication, timing of the communication, who initiates the communication and the comfort levels of the parent and teen.

Parent/ adolescent studies concerning sex/sexuality communication have shown a variety of discrepancies in the results. While a number of studies argue that parent and adolescent communication has been shown to delay or reduce teenage sexual intercourse or teenage pregnancy (Bennett & Dickinson, 1980; Fox & Inazu, 1980; Green & Sollie 1989; Moore et al., 1986; Silverstone, 1992), others have concluded that communication does not have enough influence to justify a correlation between communication regarding sex and positive outcomes such as lower rates of teen pregnancy (Eisen & Zellman, 1986; Furstenberg et al., 1984; Lock & Vincent, 1995; Newcomer & Udry, 1985).

In summary, communication about sex between parent and child as well as the timing, its frequency, and the comfort levels correlate most with positive sexual health.

Development

According to developmental theories, resolution of each stage of development is necessary in sexuality as well as emotional and cognitive development in order to advance to the next stage (Chilman, 1990; Howe, 1986; Stevens-Simon, 1993). One cannot move onto the next stage of development and remain healthy if the prior stage has not been fully resolved. Emotional and cognitive development may not keep pace with physical development which may potentially create discord and lead to poor sexual health (Berti, 1994).

“ It is a widely held belief that it is a combination of all aspects of adolescent development that helps an adolescent understand that sexuality is not a thing apart but an integral aspect of their total lives.” (Chilman, 1990; p.124).

Critique of the literature

The majority of the studies on parent/child communication about sexuality were conducted in the 1970s and 1980s in urban areas with the general focus on black families and lower socioeconomic groups. Most studies examined parent/child communication in general

rather than mother/daughter or father/child communication. Most studies looked at communication outcomes from the perspective of use of contraceptives and clinic visits (Bennett & Dickinson, 1980; Furstenberg et al., 1984; Newcomer & Udry, 1985; Silverstone, 1992). Most studies used instruments or interviews that measured frequency and timing of sexual communication requiring participants to recall past conversations (Brock & Jennings, 1993; Fox & Inazu, 1980; Furstenberg et al., 1984; Gilbert & Bailis, 1980; Hepburn, 1983; Newcomer & Udry, 1985; Rozema, 1986). Most studies queried only mothers or daughters, not both.

The study reported here queried both mothers and daughters to assess differing perceptions. Asking teens at the time the sex education is occurring helps decrease forgotten or selective reporting.

Examining the mental and emotional sexuality health of female adolescents can offer guidance to the Advanced Practice Nurse in educating parents and teens. Examining the interpersonal sexuality communication between female adolescents and their mothers in this study attempted to fill the gaps in the literature by investigating and describing what is communicated both verbally and nonverbally and what is perceived by both parties.

The reported study also focused particularly on mother/daughter versus father/daughter communication as mothers are the primary sex educators (Brock & Jennings, 1993; Fox & Inazu, 1980; Hepburn, 1983; Maddock, 1989). Once mother/daughter sex education is better described comprehensively (nonverbals as well as verbals, attitudes as well as the biology/physical side), we can then better link mother/daughter sex education with outcomes.

Chapter 3

Conceptual Model

An extensive review of the literature brought to light three commonly used theories used as a framework for studies of adolescent and parent sexual communication. The socialization theory which focused on sexual socialization did not discuss the methods and perceptions of the communication process (Hepburn, 1983; Fox & Inazu, 1980). The learning theory was also used in a number of studies in combination with the socialization theory but again did not take the interpersonal aspects of communication into account (Fox & Inazu, 1980; Furstenberg et al., 1984; Hepburn, 1983). The third model identified in a number of studies was that of the Health Belief Model and/or the Health Promotion Model. Studies using Health Belief frameworks to interpret parent/child sexual communication were mostly limited to the topics of birth control and reproduction (Eisen & Zellman, 1986; Lock & Vincent, 1995).

A more comprehensive framework was sought which employed the basic concepts of the communication process and also included the interpersonal aspects of sexuality such as feelings, emotions, relationships, and intimacy. Relational communication fulfills these criteria and will be the model used for this study.

Relational Communication

Communication in the general sense of the word is the exchange of information either verbally or nonverbally. The Shannon-Weaver model of communication is a simple model that depicts descriptions of communication. The model was an early influence on other more current models of communication (Bormann 1980). Messages are sent from the sender through various channels and are received, decoded or interpreted by the receiver as illustrated in

Figure 1. The interaction between two or more people is influenced by many factors such as assumptions and expectations (Bormann, 1980).

Interpersonal communication, more specifically relational communication is the framework used to guide this research on mother daughter sexuality communication.

During the 1950s a research group called The Palo Alto Group had a major impact on the study of interpersonal communication. Through their work they developed many theories of communication that have a direct relationship to relational development (Littlejohn, 1989).

Relational communication offers an understanding of the implied sharing of meanings between two individuals through the use of both verbal and nonverbal symbols. The message or the informational component is directed by syntactics which is concerned with how accurately the message is conveyed (Broderick, 1993). This is reflected by the channels used to convey the message. (See figure 1)

Meaning of the Communication

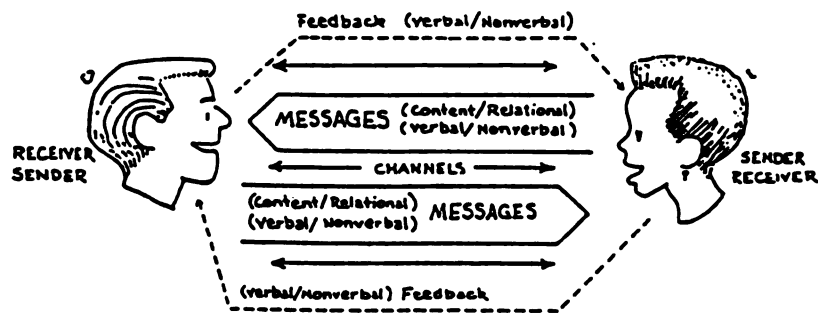
A second consideration when applying the communication process is the semantics or what is really meant by the message (Broderick, 1993). In sexuality communication this can be qualified by what the mother intends to accomplish with communication. For example, does she wish to educate, listen, or just prevent sexual activity? This is reflected in figure 1 by the content of the message which include expectations as part of the message.

Impact of Communication

A final consideration is the impact of the communication on behavior (Broderick, 1993). Sexuality communication is not thought to be effective if it does not influence behavior

Figure 1: Interpersonal Relational Communication Model

Perceptions, Assumptions
and Expectations



Adapted from: Watson & Barker (1990)

in some manner (Green & Sollie, 1989; Jaccard & Dittus, 1991; Spanier, 1977). The impact may be on influencing self-esteem, the ability to communicate effectively to partners, and resisting pressure from peers.

Sexuality communication is often a difficult and cumbersome task for both a mother and an adolescent female. “No matter how one may try, one cannot *not* communicate”(Watzlawick, Beavin & Jackson, 1967 p.51). A formal verbal exchange of knowledge and understanding does not necessarily occur but the message may be conveyed by nonverbals which may lead to miscommunication. Verbal communication may also be misinterpreted if nonverbals do not coincide with the spoken word. When communicating about sexuality, mothers and daughters may verbalize to each other the socially acceptable messages but in doing so may use terms or gestures that can be interpreted in an opposite manner than intended. Nonverbals such as facial expressions, tone of voice and phrasing of words can be misinterpreted. Figure 2 illustrates how nonverbals and verbal communication can contribute to miscommunication.

Mother’s verbal message to her daughter “sex is wonderful” may be spoken in a nervous tone of voice. The mother may be unable to make eye contact with her daughter during the discussion. The daughter then, may perceive her mother is uncomfortable with the message.

Channels of Communication

The means by which a message is communicated or the channel of communication is also an important factor in effective communication. If a mother communicates to her daughter through written materials the message may either be perceived as unimportant or unspeakable.(See figure 3) On the other hand, books and written materials can be an important

first step, especially if this is the only means of sexual communication the child ever receives. If the message is channeled in such a way that the receiver interprets it as important enough to take the time to discuss, the message will then be held in higher regard by the receiver (Littlejohn, 1990).

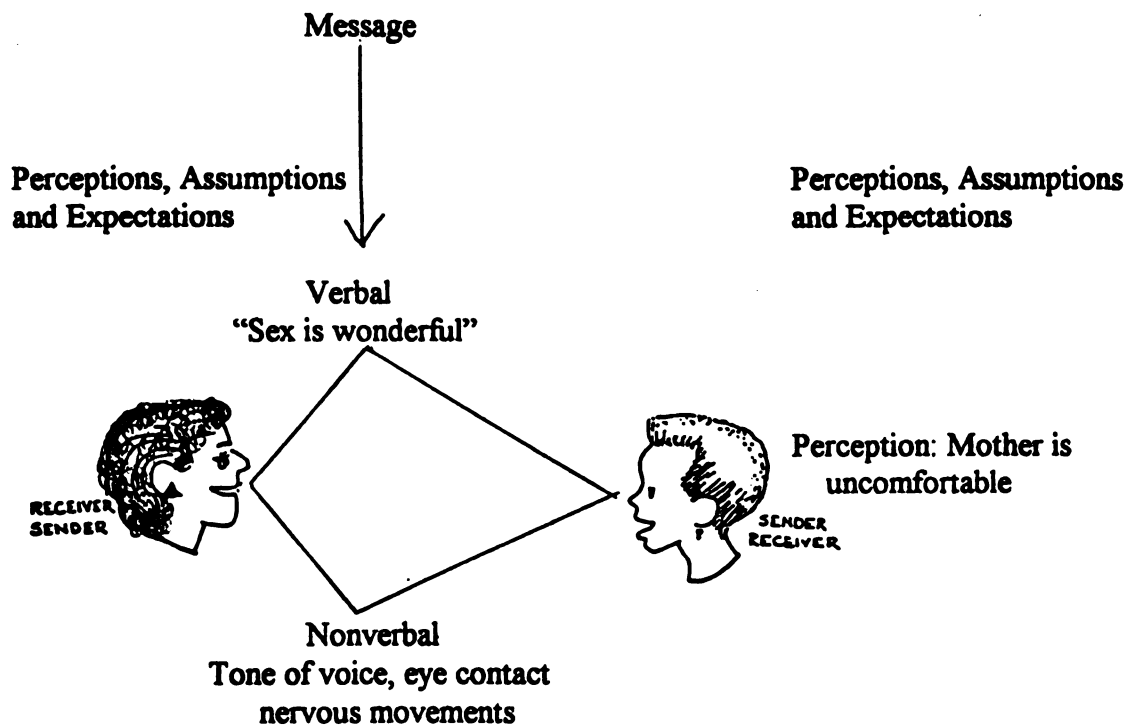
Perceptions in Communication

What is meant by the message can also affect effective communication. A daughter asking her mother what she would do if she told her she was pregnant may not necessarily mean she is pregnant or even sexually active but may rather be a hypothetical question. The meaning of the message can be misinterpreted. Depending on the reaction of the mother, the daughter's hypothetical question may create a communication breakdown. (See Figure 2) Clarification is an important role of the parent as sex educator(Hepburn, 1983).

A theory in relational communication is that one's communicative behavior is largely shaped by one's perception of the relationship with the other communicator(Littlejohn, 1990; Watson & Baker, 1990). In the mother daughter dyad , especially during the adolescent period, relationships are often strained and sexuality communication can be affected . Knowledge about this sexuality developmental process further intensifies the need for sexuality communication, which begins early in life and continues throughout life.

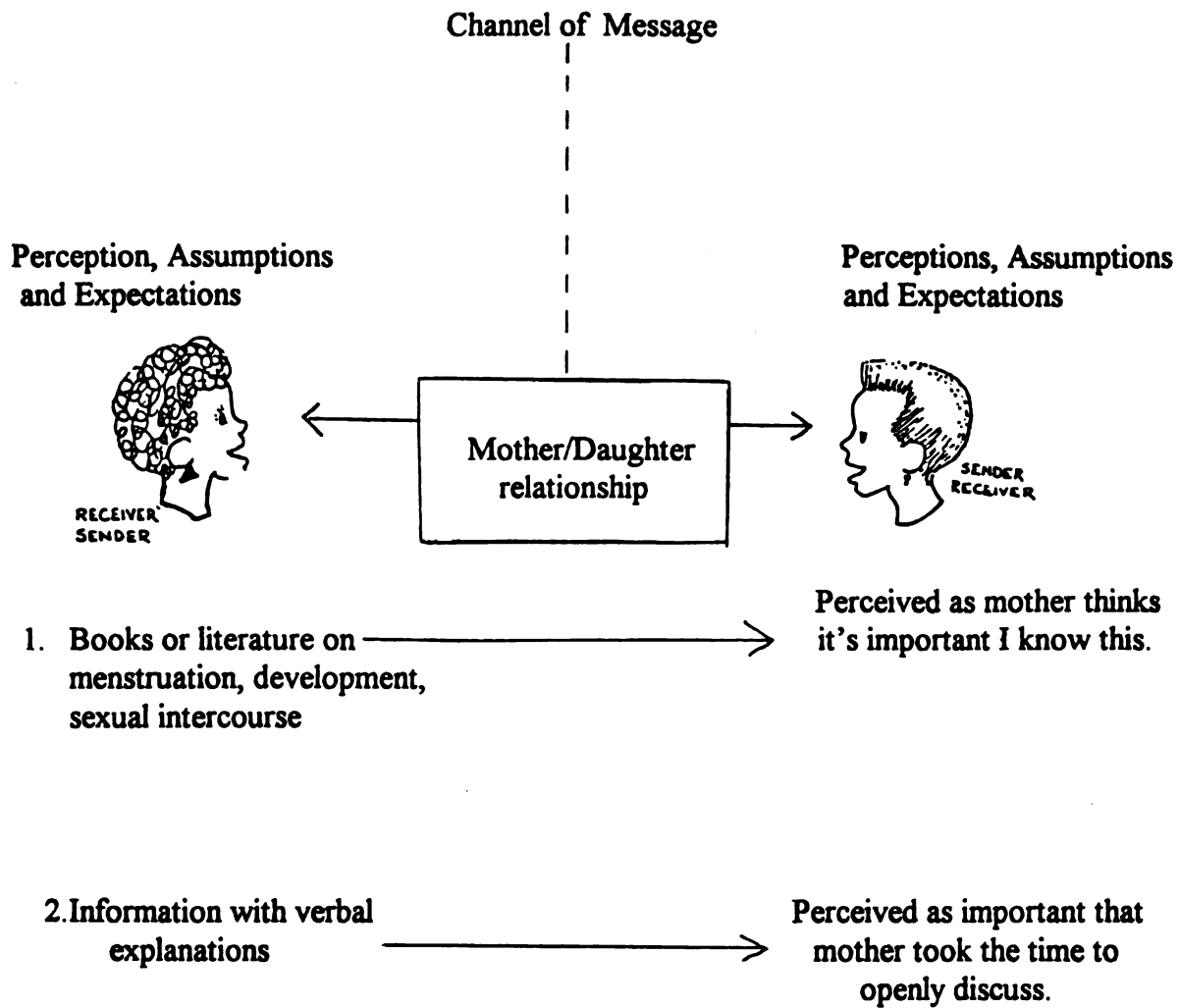
For the purpose of this study, this researcher will focus on what is communicated between mothers and daughters and how it is perceived in both verbal and nonverbal communication. Aspects of biological/physical sex education as well as values/beliefs sexuality education will be explored. Outcomes of the communication process in terms of sexual behavior will not be explored.

Figure 2: Sexuality Communication: Nonverbal ¹⁹



Adapted from: Watson & Barker(1990)

Figure 3: Sexuality Communication



Adapted from: Watson & Barker (1990)

Conceptual Definitions

Listed below are the specific definitions for the research variables.

1. Sex: The act of physical interaction by means of fondling, kissing or coitus for pleasure.
(Chilman,1990)
2. Sexuality: The values, behaviors, beliefs and attitudes about self as a sexual being .
Sexuality encompasses personal views, emotions, relationships and all interpersonal aspects of the person.(Chilman,1990)
3. Communication: The process of interacting and exchanging feelings, ideas, beliefs, and expectations. (Littlejohn, 1989)
 - a. Verbal communication: What is said in the spoken or written word.
 - b. Nonverbal communication: What is implied by gestures and expressions.
4. Sexual Health: “The integration of the somatic mental and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.”
(WHO 1975)
5. Adolescence: The period of interpersonal, emotional and psychological growth from the early adolescent period (ages 11-14), through middle adolescence (age 14-17) to the late period(ages 17-21).(Stevens-Simon, 1993)
6. Sexuality Communication Content:
 - a. Biological: Focus of communication on anatomy, reproduction and contraceptives.(Chilman, 1990)
 - b. Interpersonal: Focus of communication on relationships, morals, values, experiences, expectations and beliefs.(Chilman, 1990)

Chapter 4

METHODS

Design and Operational Definitions

This descriptive exploratory study was conducted using the focus group method of qualitative research to generate constructs for further use in sexuality communication studies. This borrowed method of research uses the experiences and everyday life occurrences of individuals and their perception of their world (Folch-Lyon & Trost, 1981; Krueger, 1988; McDaniel & Bach, 1994). The blending of group process and qualitative research allows the nurse researcher to explore a wide variety of phenomena (Dilorio, Hockenberry-Eaton, Maibach & Rivero, 1994; Folch-Lyon & Trost, 1981 Kingry, Tiedje & Friedman, 1990; McDaniel & Bach, 1994). The focus group process is used to elicit use of the group interaction to produce data, insights, feelings and perceptions in a permissive and non threatening way. Focus group sessions are helpful as a source of knowledge about determinants of behavior and can answer questions of how and why people behave as they do (Folch-Lyon, 1981, Krueger, 1988).

A group situation may encourage participants to be more open and divulge attitudes and perceptions that they may otherwise not reveal on a questionnaire or in an individual interview situation. This in part is due to the participants feeling more comfortable and secure talking with those whose share similar opinions, attitudes and behaviors (Folch-Lyon, 1981). The focus group process allows the researcher to capture a large amount of data in a short period of time.

Focus group techniques have been used in other studies such as gerontology (Gray-Vickrey, 1993), adolescent research on contraceptive use (Kisker, 1985), and in generating

questions about prenatal behavior (Kingry, Tiedje & Friedman, 1990). This technique is particularly suited for this study as teens are more inclined to open up in a group of their peers and feel more comfortable discussing sensitive subjects with those they feel will not be judgmental (Krueger, 1988).

The purpose of this study is to describe the content, perceptions, and nonverbal sexuality communication between adolescent females and their mothers.

Sample

This study used a non-probability convenience sampling method. The population sampled were females adolescents ages 14-16 and the mothers of these adolescents living in a small mid-western school system with a population of 33,000 in a semi-rural county. This age group was chosen due to the developmental stage. Developmentally, the mid adolescent period is characterized by the completion of the physical processes of puberty for most adolescent girls and because it is beyond early adolescence (age 11-14), which is a time of self-consciousness and adjustments to body changes (Chilman, 1990; Howe, 1986; Stevens-Simon, 1993). When girls are 14-16 years of age they begin dating and experimenting with heterosexual behaviors (Chilman, 1990). They are comfortable with and rely on their peers for social support which makes focus group sessions an ideal situation for generating discussion.

Recruitment of Sample

Recruitment of the sample was done by first contacting the local middle school and high school principals and obtaining permission to recruit and conduct this study using female students within this school system.

Letters were sent to 432 local teens and their mothers. A computer generated list of those who were eligible was processed by the school system. Those eligible were those female students whose birthdays fell between August 30, 1980, and September 1, 1982. A letter (appendix A)

was mailed to all females that fell into the above dates of birth. Willingness to participate was obtained by phone calls made to this researcher by mother/daughter pairs. Reminder notes were sent one week prior to the session to those who expressed a willingness to participate. One week after the requested response date only 5 teen/parent groups had responded. This researcher then contacted acquaintances that fit the proposed demographics asking for participation. A total of four focus groups were conducted, two with adolescents and two with the mothers of those same adolescents. Focus group one had six participant dyads and group two had nine participant dyads.

The inclusion criteria was, both parties of the mother daughter dyad had to be willing to participate and speak English. All adolescents were included including girls who were and were not sexually active. Pregnant and non pregnant adolescents who had given birth were also included although none participated in this study.

Procedures for Data Collection

The method of data collection involved conducting 4 focus group sessions with 30 participants.(N=30) Separate sessions were conducted for the adolescents and their mothers. Due to the nature of the subject matter, recruitment of subjects was difficult. As anticipated, only a small number of volunteers responded but enough to conduct two mother/daughter focus groups. A total of eighteen mother/daughter groups responded with three groups failing to show up at the agreed upon time.

Conducting the Focus Groups

This researcher conducted the focus groups with the assistance of Dr. Mary Killean Ph.D. who has experience conducting focus groups. Due to the sensitive matter of the subject, it was felt that the moderator should be of the same sex as the participants (Folch-Lyon, 1981; Krueger, 1988).

The student researcher was the moderator. The moderator guided the discussions without entering into the discussion, facilitated the sessions and directed the conversations to meet the goals of the research (Dilorio et al., 1994; Fox, 1993; Kingry et al., 1990; Krueger, 1988).

Focus group sessions took place after school in a reserved room at the local high school for convenience and accessibility for the adolescents. A separate meeting time took place for the mothers at a community room in the local library in the evening. Same day sessions were conducted to prevent sharing of discussions between mother and daughter that could influence responses.

The setting was a comfortable room with a round table large enough to seat ten people. Using a round table allowed participants to establish eye contact and facilitated group discussion (Dilorio et al., 1994; Grey-Vickrey, 1993; McDaniel & Bach, 1994).

After a brief introduction, ground rules were established keeping in mind the 90 minute time limit and the purpose of the research. Focus group questions were formulated from literature review and suggestions within those reviews that needed further study. The sessions were recorded both with audio recorder and note taking. On the days that the focus groups took place, field notes were generated by the moderator/researcher and a summary of the discussions and the personal impressions of the moderator were noted.

The data were then transcribed by a trained medical transcriptionist. Data analysis was conducted using content analysis and extraction of themes. This overall perspective may be viewed as a combination of other paradigms historically used for qualitative analysis.

At the beginning of each focus group session, clarification of the terms sex and sexuality were made by the moderator.

Focus Group Questions

1. Have there been discussions between you and your mother/daughter regarding sex or sexuality? If so, when did these discussions take place? Where were you when the discussions occurred? Were other siblings included?
2. Name one topic that parents are responsible for when talking to their adolescents about sexuality.
3. In the balancing of shared responsibility of sexuality communication, what is the daughters responsibility to share with her mother if any, her experiences and feelings as a sexual being?
4. How are sexuality experiences shared in your family? i.e.: What do you currently tell your children/mother, if anything, about your own sexual activities both past and present? Do mothers/daughters talk about their own experiences, feelings, relationships and dating?
5. How were nonverbals perceived? i.e.: did you avoid looking at each other, did you notice sighs or nervous movements, blushing or looking out the window? Can anyone think of other examples?
6. It is common for families to send mixed messages due to the sensitive nature of sexuality, can you think of any examples when this has occurred in your family?
7. It is normal for daughters to sometimes perceive things differently from what the mother intended, can you think of examples when this may have happened in your family?

Operational Definitions

1. **Sex:** Sex will be operationally defined by use of the words intercourse, slang terms, reproduction, birth control, doing it, and descriptions of physical contact.
2. **Sexuality:** This will be defined by use of words such as relationships, emotions, feelings, body image, love, self-esteem.
3. **Communication:** This concept will be defined by use of written materials, planned and spontaneous discussions about sex and sexuality related subjects, settings of discussion, frequency of discussions, mutual interactive communication, perceptions, comfort levels, implied intent and meaning. Nonverbals will be descriptions of gestures, tone of voice, expressions, reactions and timing of discussions.
4. **Adolescence:** This concept will be defined by the use of terms such as emotional, social, cognitive, spiritual and psychological growth and related terms. For purposes of this study the age group of adolescents are 14-16 year old females.
5. **Sexuality Communication Content:** This concept will be defined by use of terms such as anatomy, reproduction and intercourse. The interpersonal aspects of communication will be defined by use of terms such as relationships, attitudes, beliefs, shared experiences, expectations, morals ,values, love and commitment.

Protection of Human Subjects

To ensure the protection of human subjects, approval was secured from the University Committee on Research Involving Human Subjects at Michigan State University.(#97-051)

The researcher assured the participants that participation was entirely voluntary and they had a right not to participate in any discussions they were not comfortable with. Each parent was asked to sign a consent to participate form (appendix B) prior to the session. Both mothers and adolescent daughters were assured that each session was confidential and that information would not be shared with the other group. The names of participants were not recorded. Each group was informed in advance that the session would be audio recorded and used only for this research project. Audio tapes were destroyed once transcribed and transcriptions stored in locked file cabinets.

Data Analysis

Once audio tapes were transcribed verbatim, accuracy was confirmed by the researcher by comparing audiotapes with the transcribed material. The raw data were then coded for recurring regularities, clusters or patterns and results then collaborated with a second person, a Ph.D. prepared nurse seasoned in qualitative analysis. This nurse was also present at two focus group sessions and recorded field notes. All group session transcripts were read several times. From each transcript significant statements and phrases that directly pertained to the research question were extracted. Meanings were then formulated from these significant statements and phrases and were then organized into clusters of themes. Themes were then extracted from the coded categories with collaboration from the Ph.D. prepared nurse. Data were then reconstructed and synthesized by extracting meanings and significant statements from the descriptive summary.

The credibility and validation of the data was verified by two participants of each focus group to assure accuracy. Numerous quotes from both mother and daughter groups provided thick, rich slices of data. Confirmability was established with an audit trail and confirmed by an independent judge, a Ph.D. prepared nurse.

Chapter 5

RESULTS

Results

The average age of the adolescents was 15 years of age with the ages ranging from 14 to 16 years. The mothers average age was 39 years of age with ages ranging from 33 to 49 years of age. All participants were Caucasian and 60% were of the Catholic faith. The mothers were all high school graduates with 11 out of the 15 having some post high school education. All the mothers were married at the time with only 3 of the 15 not married to the teens biological fathers. Three of the teens live with stepfathers and one teen lived with a step mother who participated in the study.

In an exhaustive analysis of the data, themes were extracted in an attempt to answer the research question: What is the nature of mother/daughter communication regarding sexuality? The themes that emerged included:

1. In mother/teen communication it is difficult to separate sexuality from sex.
2. Mothers perceive that their daughters are uncomfortable discussing subjects of a sexual nature.
3. Mothers perceive that their daughters already have information regarding sex and sexuality.
4. Daughters identify a lack of trust of their mothers in regards to confidentiality and perceptions.
5. Methods of communication are a barrier to sexuality communication.

Theme 1: In mother/teen communication it is difficult to separate sexuality from sex.

At the start of each focus group session, this researcher defined sex and sexuality to each group. This was done to attempt to keep the focus of the answers on sexuality

communication. A general consensus of understanding was confirmed from each group prior to beginning.

The discussion was aimed at focusing around interpersonal relationships rather than physical sex. However, throughout the focus groups with the adolescents, members inevitably reverted back to physical aspects of the word sex. When asked how sexuality is discussed in their family, the general response was, *"it is not discussed in our family"* or *"I don't think I would want it to be discussed.."* General references are made throughout the study to IT when referring to the word sex. Terms used to indicate sexuality such as emotions, relationships and intimacy were used in the focus groups only on rare occasions.

Mothers in the group had less difficulty with the concept of sexuality as it relates to the person as a whole and separating sex from sexuality. They, too, often reverted back to physical sex issues rather than relationships when discussing sexuality. Mothers spoke of self-esteem and being yourself in general discussions that might influence sexuality: *"I stress to my daughter she should be who she is and not worry about what other people think, she should strive to be the best."* Another stated, *"I think it's a mother's responsibility to teach them about taking pride in themselves."*

Some included the discussions of life-style choices and biological choices of bisexuals as lessons in sexuality. Included in their discussions were their own beliefs and feelings on sexual orientation. Another example of a general sexuality discussion was several mothers stated they have used women in adult magazines and in "Girlie Clubs" to demonstrate their beliefs of female sexuality to their daughters.

Although sexuality was not directly communicated by the mothers, they discussed sexuality communication more often than daughters in the focus groups.

Theme 2: Mothers perceived that their daughters are uncomfortable discussing subjects of a sexual nature with them and that they already have the information regarding sex and sexuality.

Mothers perceive that the reason daughters do not want to talk to them about sex or sexuality issues is that the daughters are nervous, embarrassed or uncomfortable about the subject matter. *"My daughters are very uncomfortable talking about that stuff,"* one mother said. Another stated, *"she is very embarrassed to talk about it"* and *"I am nervous to talk to my daughter because it makes her nervous."* Although none mentioned discussing the nervousness or embarrassment with their daughters, many of the mothers were sure this was the reason for their daughters hesitation in discussing the subject: *"I take my cues from my kids. My daughter is not at all comfortable talking about it."* The majority felt their daughters were more comfortable talking to a sibling or friend before they discussed it with their mother.

Mothers spoke of the influence that the lack of discussions from their own mothers had on how they deal with their own daughters today. Many expressed they felt the need to be more open and give more information, attempting to be the opposite of their mothers. When attempting to give the information, mothers felt they encountered barriers: *"It's so invading that private territory"* one mother said. Another felt, *"you try to keep this door open and they keep trying to shut it on you."*

Theme 3: Many assumed daughters already had the information from just what the daughters implied. *"I know my daughter has the information, I know it intuitively."* Some mothers just assumed that if the daughter had any questions she would ask. *"I said, do you have any questions and she said 'No'. I told her if she did have any questions she could come to me."* It was also assumed that if their child had read the books given to them by the parent and if they had any questions, they would ask if they didn't understand. Several mothers stated they addressed questions as they came up but never had a sit down discussion with their daughter

on human anatomy, reproduction or sexuality. *"I never had a specific talk, it was if she asked questions we would address that question,"* said one. It was inferred that only subjects that the daughters had questions about were addressed.

Six of the 15 mothers that disclosed that they were not told of their daughters first period assumed that it was because the daughters were too embarrassed or uncomfortable telling them. Most said their other daughters or friends helped out. It was never asked or implied where the other siblings/friends got their information or if the information was correct. Theme 4: Daughters identified a lack of trust of their mothers in regards to confidentiality and the mothers perceptions.

Perceptions of the daughters of what they felt their mothers were saying or implying was identified as the reoccurring theme of trust. It was re-emphasized over and over by the daughters that they were, *"not comfortable telling their mothers anything."* It was verbalized by a majority that, *"I would rather tell my friend or my sister before I told my mom."* Even the occurrence of their first period, the preference was to talk to a friend before mom even knew about it.

Distrust in the mothers was extracted as the reason for the daughters lack of comfort. This trust issue can be broken down into two entities. First, the adolescents expressed difficulty talking to their mothers about sex and sexuality because of the underlying fear that the information would be shared with others such as with the fathers or friends of the mother: *"They always go along with their women friends and tell it all."* A number felt if they were to go to their mother with an important issue, they *"would be more comfortable telling something if I knew that you were not going to tell."*

Several of the teens responded to questions about trust issues by describing situations where they had asked or implied to their mother that they did not wish for the information to be

shared only to have their trust betrayed. *"My mom will always tell my dad,"* said one. Another commented, *"I'll tell my mom something and say like, mom don't tell dad, and I will hear her whispering to him."* Again, most implied that they would feel more confident telling a best friend or sibling before they told mom due to the fear that their mother would tell someone else.

Another issue concerning trust developed from the discussions of shared experiences. It is difficult for many of the adolescents to believe that their mothers abstained from sexual intercourse prior to marriage. *"She says she never had sex before she got married but I don't believe her."* They perceive the stories they have been told by their mothers were slightly exaggerated to express a point. Many interpreted this as a mixed message. *"How do they expect us to be honest with them if they aren't honest with us?"* Although the teens did not expect to be told exact details, they did feel honest communication would be more of a learning tool than fabricated stories. Many are just looking to see the human side of their mothers: *"I think it would make me more comfortable if she would share experiences like the guys she liked."* Another stated, *"I like it when she tells me her stories about her boyfriends and stuff."*

The sharing of experiences has also been misinterpreted by many of the teens as a form of lecturing: *"It always turns into a lecture or an argument."* Another said, *"It will turn into a four-hour dinner discussion."* Many expressed their hesitation to talk with their mother because they are not sure of the reaction they may encounter. One teen stated, *"I'll try to tell her and be real open and she just comes down and says like, 'you should never do it,' even if I was just curious. I'm more open with my sister."*

When asked about the responsibilities of the daughter in the balancing of sexuality communication, daughters did not feel they could be as honest as they might wish to be because of the perceived reaction from their mothers: *"I don't think I could share that stuff with my mom because the whole thing would revolve around the whole sex thing,"* said one.

Many expressed that they just didn't trust that the mother wouldn't take it the wrong way. They expressed fear that their mothers would misinterpret what they were communicating and think they were having physical sex with boys.

Many also perceived these lectures as criticism of a personal nature: *"I think they have expectations of what they think you're supposed to be."* Another stated, *"My mom has even asked, 'what did you do to him' when I've had a fight with my boyfriend. She always thinks it's my fault."*

The majority assumed a direct relationship between the mother not wanting the teen to have intercourse and the mother misinterpreting what the daughter has said. Perceptions and misinterpretations appear to be the central focus in the trust issue of sexuality communication.

Theme 5: Methods of communication are a barrier to sexuality communication.

Content of sexuality communication includes more than what is said, but also how it is communicated, why it is being communicated and when and where it is communicated.

While both groups did discuss, in limited amounts, the subject of menstruation, dating and anatomy, these subjects were most often discussed while riding in the car. It is not known if this is a consciously chosen place because it is without major distractions such as the phone, or if it is chosen because it requires limited eye contact and this makes it easier to hide embarrassment or reactions.

Content such as discussions that come up while watching television have been cited by the mothers as an opportunity to educate their daughters. The teens stated they learn from these incidental discussions as long as they do not turn into, *"two hour lectures."* One teen stated, *"Examples help a lot and have more influence on me instead of saying 'Don't do it this way.'"*

The method in which a subject is brought up can also influence a daughter's reaction to the subject matter: *"They can't just say, 'don't have sex' because you would just think, it's not your decision. You can tell me things and warn me but just saying 'NO' isn't going to help me one bit."*

Many expressed the desire to have life-long discussions about sex and sexuality instead of the "the talk" mothers have with girls when they reach the age of menstruation. When asked why they did not feel comfortable talking with mom about certain subjects regarding sexuality, the general consensus was, *"It's not something you can just go to her and bring up, like out of the blue,"* and *"it's embarrassing if you have never talked about it with your mom when you were younger."*

Some also said *"It's like when it's never talked about, you don't feel comfortable just walking up to your mom and talking about it. It's never been done before so it doesn't feel right."*

While mothers sought to give accurate information to their daughters, some teens found the conversations to be *"too blunt"* and therefore a deterrent to future conversations. One mother described her own conversation with her mother when she was a teen, *"When I asked my mother to explain about how babies were made, her comment to me was, 'what do you want a blueprint?'"* This answer prevented this person from initiating further conversations in the area of sex and sexuality. Another said, *"It's like answering a question with a three word answer and that is the end of the discussion."* This sends the teen a mixed message that either the question was not important, that it was *"dumb"*, or mom was not sure how to answer so she dismissed the teen. Whatever the perceived message, it could potentially turn the teen away with unanswered questions and confusion: *"I don't know why that would cause me to*

grow up so shy about the subject, but because of that I don't ever want to talk about the subject."

The key themes of this study are; 1) Mothers were more likely than their daughters to discuss relationships and emotional aspects of sexuality. 2) Mothers perceive that their daughters are uncomfortable discussing subjects of a sexual nature. 3) Mothers perceive that their daughters have the necessary information regarding sex and sexuality. 4) Daughters lack the trust in their mothers in regards to confidentiality, misperceptions and the reactions of the mothers. 5) Methods of communication are a barrier to sexuality communication.

These themes clearly indicate that sex/sexuality is not discussed frequently between mothers and daughters but there is a great need for exploration in this area for both mothers and daughters alike.

The themes extracted attempted to answer the research question: What is the nature of mother/daughter communication regarding sexuality? Themes 1 and 5 adequately respond to this question. There is a lack of intentional sexuality communication although the responses do identify covert methods of communication. The themes also suggest that information is a barrier to sexuality communication by the continuous reverting to physical sex when discussing sexuality. Theme 5, methods of communication are a barrier to sexuality communication, reveals that it is often how the questions are answered or topics that are never brought that can be a means of nonverbal communication.

Communication as identified by the themes is more covert and general in nature. The focus tends to be on the physical aspects more than the interpersonal aspects in the mother and daughter sexuality communication. The perceptions of what, how, when and why communication is occurring are all factors that affect sexuality communication.

Theme 2 identifies how mothers perceive the comfort levels of their daughters and knowledge of sex and sexuality in regards to their own sexuality comfort. It is often difficult to ascertain if the lack of comfort is real or a projection of the mothers discomfort and if so, were the mothers making excuses for not discussing sex/sexuality with their daughters on the pretense that they already had the information.

Theme 4 identifies there is a lack of trust that daughters have of their mothers regarding confidentiality, honesty and fear of their mothers reactions to subjects discussed.

The final theme, methods of communication as a barrier to sexuality communication attempts to answer the research question by examining what is being observed and the perceptions each have when looking at the same issue. Each person's reaction will be different depending on their perception of what is being communicated and why.

In the communication model adapted for this study, perceptions and assumptions are interrelated and are dependent on the relationship the sender and receiver have. If the relationship is that of mistrust, perceptions may become distorted. This may explain the differing themes that emerged between the two groups although the same questions were ask of each of the groups. It is also important to look at the developmental stage of the adolescent and their cognitive development when assessing the differing themes. Teens continue to think concretely and may not yet be able to look at emotions and relationships in a abstract way that an adult would.

Chapter 6

DISCUSSION OF FINDINGS

The findings in this study clearly indicate that mothers and daughters may wish to communicate about sex and sexuality but few actually do. Mothers want to share their experiences and knowledge to keep their daughters safe and to be able to make correct decisions. Daughters would also like input from their mothers. It may very well be the perceptions of both parties that interfere with healthy sexuality communication.

Assumptions

The assumptions of this study were:

1. That all participants were truthful in their responses.
2. That their responses were a true indicator of perceptions of life as they see it.
3. That mothers did not prepare their daughters to give already discussed answers.
4. That teens did not share with mother the content of discussions before the mother group met.
5. That teen or mothers from the first focus group did not share the content of the discussions with the next focus group prior to meeting. There was a 3 day time difference between the two groups.
6. That participants did not answer in compliance with peer pressure.

Limitations

With the completion of the data collection and analysis, limitations of the study were noted. The difficulty recruiting subjects became a major limitation in this study. With only enough volunteers to conduct two mother/daughter focus groups, the point of saturation was never obtained. The second limitation was that the study was conducted in a semi-rural area

and all the participants were white, middle class. This did not offer the richness of a more diverse population. A more diverse group from the inner city and of different races and cultures may have yielded different responses and perceptions. Also included in this diverse group could be single parents and more girls that are already sexually active or who have experienced pregnancy.

The third limitation of this study was the wording or phrasing of the focus group questions. Although not asked in ways to illicit yes and no responses, the questions often yielded yes and no responses. The topic and the discomfort of being in an unfamiliar group may have added to the reluctance to disclose more information at times. In addition to this, using the terms sex and sexuality in the same overall question may have added to the general difficulty in differentiating between the two terms.

Another limitation to the study was the wording of the recruitment letter. When pooled about why they thought the responses were limited, most teens responded that the letter led them to believe they would be talking about their own sexual experiences and not sexual communication with their mothers. They felt this was a deterrent. More teens may have been willing to participate if they were more familiar with the researcher. This could be accomplished by recruiting personally by attending classes or extracurricular activities and the personal introduction of the researcher to the teens.

Support of Previous Literature

Many other themes were identified in this study that support the literature. Parents reported higher levels of communication than did their teens. When asked if there had been discussions in their family about sex and sexuality, teens reported sex, periods and boyfriends were discussed in limited amounts.

Many said, *“she brings it up once in awhile”* but report overall they have been more comfortable discussing sex/sexuality with siblings or friends. The majority stated, *“she will probably say we talk about it all the time, but we don’t.”*

Mothers reported having given daughters information on menstruation prior to beginning their first period, stating *“I made sure she had the information,”* whereas the daughters recalled obtaining the information from school or siblings or friends. This supports the literature that states that parents are usually not the first source of information.

Mothers report decreased self comfort levels and blame this on the lack of communication they received from their own mothers as they were growing up. *“Their mothers didn’t tell them so they didn’t tell us,”* was a common statement from the teens.

Shared experiences are also identified in the literature as barriers to sexuality communication. Abstract discussions that don’t associate mothers with the situation are often used including statements such as, *“My mom never wants to tell me about the stuff she did, she tells about the stuff my aunts did. She never wants me to think she was bad as a child.”* Vague messages can also be misinterpreted or ignored. Many girls were being told, *“don’t do it”* without the benefit of elaboration on the statement.

The basic understanding of the terms sex and sexuality can be considered the major issue in sexuality communication. Mothers need to separate their rules about abstaining from sex and instead teach their daughters that healthy sexuality is a vehicle for enhancing self-esteem. Their daughters could then make good decisions about sexual behavior. Knowing who you are, where you come from, and what you want to be as an individual is what healthy sexuality is about. Mothers do attempt to teach their daughters this in covert ways. In today’s sexually confusing climate, perhaps openly discussing sexuality and actually calling it by name could influence teens to make more informed decisions.

Mothers unfortunately are products of their mothers and may not have the comfort level they desire when talking with daughters about sex and sexuality. In an attempt to do the right thing, mothers may become over zealous. Lectures and misperceptions may occur. Mothers may also use their daughter's discomfort as an excuse to cover their own discomforts.

Daughters, on the other hand, want to be able to be close to their mothers and open up to them but because of their current maturity levels cannot see past the misperceptions. Many trust and perception issues may stem from the teens just misunderstanding what is being said. Both parties need to openly express their meaning and intent to the other party. Asking for clarification is also an important part of the process. The barriers of mistrust and misperception need to be openly discussed as the other party may never know this is occurring. When only a part of the meaning or intent is implied, miscommunication takes place.

It is important for both mothers and daughters to look at why a person desires communication, be it for advice or to vent frustrations. As one mother eloquently put it, *"The hardest thing I found to learn was when a child brings things to you, they really just want you to listen. Instinctively, we feel like we should comment or give advice. I think kids just want to vent sometimes and they don't want you to judge it."*

Implications for the Family Nurse Practitioner

As assessors of present or potential health problems, the Family Nurse Practitioner or FNP is in an ideal position to examine family communication styles, and more specifically, the sexuality communication styles of mothers and daughters. Health promotion and health education are the back-bone of a practitioner's role and by assessing the communication process between mothers and daughters early on, the FNP can begin implementing a plan to assist the family to promote self care. Assessment could be done starting at an early age by observing mother-daughter interactions and discussing these

observations with the mother. Offering suggestions of methods that are known to assist in communication could then be done. Recording this interaction at each visit is important to insure continuity. When examining and collecting both subjective and objective data, the FNP can at each visit determine both individual and family needs by taking into consideration the family developmental stage and other family theories such as system theory.

Taking into consideration both the maturity levels and outside influences and using the knowledge of the family process, the FNP can collaborate with the client in developing healthy sexuality communication skills. The FNP may suggest books or articles that begin to develop this from early on. Books such as "Bellybuttons are Navels" (Schoen 1990) is a method that helps parents accept a child's natural curiosity about body parts and name them. There are many such books written by authors Sol and Judith Gordon that deal with topics of sexuality and expand on the information as the child matures. Other literature is available from organizations such as Planned Parenthood, the American College of Obstetricians and Gynecologists and American Academy of Pediatrics that can be offer suggestions to parents and teens on sexuality communication. Having these available in the primary care setting can be catalyst to opening communication.

As a change agent, the FNP is skilled at examining the current communication process and by using a deliberate approach, can coordinate activities that bring about positive alterations in the communication process. This can be accomplished by assisting the family in identifying ways to incorporate sexuality into health practices from an early age. This can be done by suggesting to parents different ways of communicating the messages of sexuality such as reminding them that the simple act of hugging and cuddling teaches the child that they are loved. The choice of clothing (pink versus blue) or toys (dolls versus trucks) for the child can establish male or female roles or expectations from an early age. Suggesting that parents read

non-sexist literature to the child and expand the child's viewpoint of role expectations can help develop high levels of self-esteem.

There is also the need to assist the family that has no established sexuality communication in developing a comfortable process for all concerned. This can also be accomplished by offering reading materials previously suggested and role playing with the mother. The FNP may also suggest to the mothers to begin at an early age to answer questions as they arise. Anticipating common questions, clarifying and answering them is an important process to talk about and rehearse with parents. Questions such as "How does the baby come out?" requires open honest answers and sets the stage for trust and a willingness to respond.

By educating the family to incorporate sexuality education into health practices, the FNP can act as a catalyst in heading off potentials for sexually transmitted diseases, infertility, teenage pregnancy and mental health problems associated with early sexual activity and poor sexual health. As previously mentioned, developing higher levels of self-esteem and giving honest answers to questions helps teens make more informed choices and feel good about themselves when doing so.

The issue of trust identified in this study can be a central focus for the FNP when managing adolescent health. By helping the adolescent look at their own trust issues and perceptions the FNP may help identify misconceptions that may have lead to the mistrust. Active listening to the teen involves getting input as to their suggestions to assist in developing a more trusting relationship. This allows the teen to feel they are a part of the solution and may detract from the sense that they are being lectured to. The FNP can also then help expand communication by allowing both mother and daughter to look at the misconceptions in their relationship that may have lead to mistrust. Also developing a trusting relationship between teen and the practitioner can demonstrate to the teen that adults can be trusted.

The knowledge gained from this research suggests that sexuality communication is an ongoing life-long process and the Nurse Practitioner can assist parents in establishing this communication from an early age. As an educator, the FNP can help facilitate identification of healthy methods of enhancing healthy sexuality.

The Sex Information and Education Council of the U.S. (SIECUS), recommends a variety of reading material for parents of children of all ages. Included in these are: "Where Do Babies Come From?" (Royston 1996) and "Where Did I Come From?" (Mayle 1973) for preschool ages. Literature for school age kids include: "How Babies Are Made," (Andry & Schepp 1968). Books for the preteen include: "Facts About Sex for Today's Youth," (Gordon 1992), and "What's Happening to Me?" (Mayle 1996). The sharing of this literature with children followed by discussion helps foster an atmosphere of trust.

As a researcher, the FNP can continue to collect data about human sexuality and communication and apply it to specific areas of nursing. Following the focus group sessions, many mothers commented that they had enjoyed talking with other mothers about this sensitive issue and suggested that future discussions be scheduled to expand on what was already discussed. Continued focus groups could be scheduled and facilitated by the FNP to assist both mothers and daughters in developing methods of enhancing their sexuality communication. Focus group sessions could also be expanded to include both the mothers and daughters in groups together develop communication skills. Reimbursement for such services could be obtained through proposals made to insurance companies in the way of health promotion.

Implications for Further Research

There are still many unanswered questions regarding the issue of female adolescent sexuality communication. Why do mothers hesitate to share sex/sexuality information? Do

mothers hesitate to share their own experiences because they are not sure how their daughters will react? Is there a hesitation for mothers to allow their daughters to see their human, vulnerable side? Do mothers generally lack skills and information because of the lack of a role model? Do mothers think sharing information will encourage sexual activity, for example, if they don't talk about it maybe it won't happen? Further research in the area of why mothers hesitate to share is needed.

Research shows that parents want to be the primary sexuality educators of their children but they continue to assume that their daughters have the knowledge. Further research is needed to ascertain from mothers how they assume their daughters have gotten the information and how they determine if the information is correct. Also, if indeed the mothers really want their daughters to have the information and how they control this.

The trust issue revealed in this study (of not trusting mother with confidential issues, on fearing that mother will overreact or that the teen suspects that the mother has not been honest about her own sexuality issues) indicates that further study is needed in this area. Is this trust issue about sex and sexuality at the forefront now because trust is an issue for most adolescents or is it an issue that could also be identified with females at later ages? Do the perceptions of trust change over time?

Another area for further research is generalizability. Are the feelings and perceptions of the mothers and daughters in this study isolated to this small rural area or do mothers and daughters in the suburbs and cities look at sexuality communication in the same manner? Is it a universal problem that people have difficulty communicating about sex and sexuality? What can we as health care providers do to educate our clients and communities? How can we help families develop healthy sexuality communication?

In summary, the Family Nurse Practitioner possesses the expert knowledge and skills to assist families in developing and maintaining healthy sexuality communication. This study sought to examine the content of sexuality communication between adolescent females and their mothers. Areas that are lacking were identified and implications for advanced practice nursing and clients' overall health care were discussed. Including sex/sexuality education into the health care of all individuals from an early age can be the corner stone of reducing teen pregnancy, STDs, and other health related issues associated with poor sexual health.

APPENDICES

APPENDIX A

APPENDIX A

Ann Mack
1818 Oak Grove Rd.
Howell, Mi. 48843
(517) 546-6369

Dear Parent or Guardian:

I am a graduate student from the College of Nursing at Michigan State University and I am conducting a study of sexuality communication between female adolescents and their mothers. This study will be conducted using separate focus group sessions for teenage girls between the ages of 14 and 16 and their mothers. Teens will be in one group and mothers in a separate focus group. Participation in the study will consist of group discussions about how mothers and daughters communicate with each other in the area of sexuality.

Information obtained will be used to further our knowledge on how and what we communicate. Participation in this study is strictly voluntary and responses will be held in strict confidence only to be used by this researcher. Please note that no one at any time will be asked to divulge information about sexual practices.

Focus group sessions will be conducted in a private setting by the investigator who is a registered nurse. Groups of 7-10 participants will be gathered with sessions lasting approximately 1 1/2 hours. Group discussion will focus on what, why, how and when we communicate about sexuality and related issues with our mother or daughter.

If you and your daughter would like to participate in this informative and important study please call me at 517-546-6369 after 5pm. Responses before February 25th would be appreciated.

Focus group sessions will be conducted during the month of February and March 1997. General results of this study will be made available to you, if desired, after April 1997.

Please be reminded that participation is confidential and voluntary.

Thank you for your time and I look forward to hearing from you if you are interested in participating. Feel free to call me any time with questions and concerns about this study.

Sincerely,
Ann Mack R.N.
Nurse Practitioner Student
Michigan State University

APPENDIX B

APPENDIX B

I consent to participate in the focus group study on sexuality communication conducted by Ann Mack RN Nurse Practitioner Student from Michigan State University. I understand that participation is voluntary in this two hour session and that am under no obligation to participate in any discussions that I are not comfortable with.

I understand that the group process will be audio recorded and that the information obtained will be used only in this research project and that all information will be treated with strict confidence. I understand that tapes will be destroyed once transcribed and transcriptions will be stored in a locked file cabinet. I understand the subjects will remain anonymous in any report of research findings and that names will not be used and responses will not be identifiable.

I understand that I can contact Ann Mack @ 517-546-6369 if I have any concerns or questions regarding this study.

MotherName (print) _____
Signature _____
Date _____

APPENDIX C

MICHIGAN STATE
UNIVERSITY APPENDIX C

February 18, 1997

TO: Linda Beth Tiedje
A-230 Life Sciences Building

RE: IRB#: 97-051
TITLE: FEMALE ADOLESCENT SEXUALITY: AN ANALYSIS OF
MOTHER AND DAUGHTER COMMUNICATION
REVISION REQUESTED: N/A
CATEGORY: 1-C
APPROVAL DATE: 02/18/97

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

PROBLEMS/
CHANGES:

Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517) 355-2180 or FAX (517) 432-1171.

Sincerely,

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Ann K. Mack



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University Committee on
Research Involving
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Michigan State University
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48824-1046

517/355-2180
FAX 517/432-1171

APPENDIX D

APPENDIX D

DEMOGRAPHICS

1. What is your current age? _____
2. What is your religious preference? _____
3. Who do you currently live with? _____
4. Are you currently married? _____
5. What is your educational status? _____

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