

# Improving Comfort About Sex Communication Between Parents and Their Adolescents: Practice-Based Research Within a Teen Sexuality Group

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Unplanned pregnancy and the contraction of sexually transmitted diseases continue to be prevalent problems among adolescents. These problems often result in adverse health, social, and economic consequences for teenagers and their families. Previous research has explored the impact of parent–teen communication on reducing risk-taking sexual behaviors by adolescents. Discomfort with this topic of discussion has been identified as a barrier to effective familial sex communication. Currently, there is little practice-based information concerning interventions designed to improve communication comfort about sexually related issues within families, especially between parents and their adolescents. Therefore, this article describes a time-limited psychoeducational group designed to increase familial comfort in communicating about sex. In four group sessions, six court-ordered adolescents between the ages of 14 and 18 and their parents were provided information on teen sexuality along with skill building in the area of communication and decision making. At the end of this practice-based group, evaluation of the data indicated significant improvements in communication comfort levels among participants. The results are discussed, and the limitations of the intervention are reviewed. Implications for future research and practice with parents and their adolescents are also examined. [*Brief Treatment and Crisis Intervention* 5:379–390 (2005)]

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Adolescents often engage in a wide range of high-risk sexual behaviors that can result in adverse health, social, and economic conse-

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quences for themselves and their families. Although teenage pregnancy is a worldwide problem, adolescent pregnancy in the United States is a particularly problematic situation. In 1990, adolescents aged 15–19 accounted for an estimated 1 million pregnancies, 95% of which were unintended (Centers for Disease Control [CDC], 1993). The United States has a higher rate of adolescent pregnancy than any other

industrialized country (Berger & Thompson, 1994). In this nation, it is estimated that \$29 billion is spent each year caring for families with teenage parents (Henderson, 2000). Many teenagers who become parents may raise their children as single parents, a very difficult situation that frequently places them at higher risk for poverty (Arnold, Smith, Harrison, & Springer, 1999) and depression related to a lack of family support (Rushton, Forcier, & Schectman, 2002).

The contraction of sexually transmitted infections (STIs) also continues to be a major public health problem in the United States with 850,000 to 950,000 people currently suffering from HIV and an additional 40,000 new infections occurring each year. Teenagers between the ages 15–19 have higher rates of gonorrhea and chlamydeous infections than any other age group in the United States (CDC, 2002).

Public concern about the costs and consequences of these problems has led researchers to focus on measures for preventing unplanned pregnancies and sexually transmitted diseases among adolescents. Although there are several factors that contribute to these problems, effective sex communication between parents and their adolescents has been identified as a key strategy for reducing teen risk-taking sexual behaviors (Holtzman & Robinson, 1995). Accurate information regarding sex is more likely to reduce adolescent risk-taking sexual behaviors when combined with effective parent–teen communication about adolescent sexuality issues (Holtzman & Robinson, 1995). Because communication between parents and their teenagers has been linked to responsible adolescent sexuality (Raffaelli, Bogenschneider, & Flood, 1998), it is important to identify factors that increase the effectiveness of parent–teen communication, thereby decreasing the potential for the erosion of family and community supports (Harris & Franklin, 2004).

There appear to be several barriers to effective familial sex communication: (a) Parents are often uncomfortable talking about sex; (b) parents misperceive their adolescents' sexual behaviors; (c) parents may lack accurate information in the area of sex education to share with their adolescents (Raffaelli et al., 1998); (d) information shared during parent–adolescent discussions about sex often fails to include critical topics, such as maturation and sexually transmitted diseases (Pistella & Bonati, 1998); (e) many parents assume that their adolescents are not sexually active, so they may often focus only on discussing abstinence; and (f) parents are more likely to discuss contraceptive methods with their adolescents only after a pregnancy (Pistella & Bonati, 1998).

Research suggests that time-limited sex education programs intended to reduce risk-taking sexual behaviors by teenagers are most effective when contraceptive information, discussions about adolescent sexuality, and skills training (e.g., decision making) are based on social learning techniques, such as modeling, role-play, and the reinforcement of prosocial norms (Franklin & Corcoran, 2000). Unfortunately, many of the programs serving teens and their families do not utilize social learning or other similar approaches to facilitate effective communication about sex between parents and their adolescents. In addition, many programs do not emphasize effective familial communication about adolescent sexuality, specifically the prevention of pregnancy and STIs, and this lack of attention may explain why changes in adolescents' knowledge, attitudes, and skills have not always resulted in corresponding changes in their risk-taking sexual behaviors (Franklin & Corcoran, 2000).

A number of studies have examined the *content* of familial sex communication focusing on the importance of providing accurate sexual information between parents and their teenagers (Holtzman & Robinson, 1995;

King & Lorusso, 1997; Kotchick, Dorsey, Miller, & Forehand, 1999; Raffaelli et al., 1998). Surprisingly, however, there has been little investigation of the *process* through which familial communication takes place, even though the nature of the communication process is significant in reducing risk-taking adolescent sexual behavior (Kotchick et al., 1999).

Furthermore, parents need accurate information and support to feel more comfortable and confident that they possess the necessary communication skills to be effective in discussing risk-taking sexual behaviors with their adolescents. Although effective familial sex communication can lead to decreased adolescent risk-taking sexual behaviors (Holtzman & Robinson, 1995), discomfort experienced by parents and their adolescents in speaking about adolescent sexuality can prevent effective sex education from occurring (King & Lorusso, 1997).

This study explored communication comfort levels between parents and teenagers during psychoeducational group sessions that focused on adolescent sexuality. Group intervention strategies were used to provide parents and their teenagers accurate and comprehensive sex education information and to identify and reduce barriers to communication.

## Literature Review

Although increasing communications between parents and their teenagers about sex is helpful in reducing adolescent risk-taking sexual behaviors and practices (King & Lorusso, 1997), few studies have specifically examined the relationship between familial group interventions and communication comfort levels during parent-teen sex communication.

Jaccard, Dittus, and Gordon (1998) compared the congruency of reports of adolescent sexual behavior and communication between parents

and their adolescents. Seven hundred and forty-five African American adolescents aged 14–17 and their mothers participated in the study. Self-administered questionnaires were used to identify (a) adolescent sexual behaviors (e.g., sexual intercourse, intimacy, or abstinence), (b) adolescent perceptions of peer sexual activity, (c) contraceptive methods utilized, (d) parent and teen perceptions of sexual behaviors and attitudes, and (e) parent-teen relationship satisfaction.

The results indicated that mothers significantly underestimated the sexual activity of their teenagers, particularly of their sons. Factors that appeared to contribute to the mothers' miscalculation of their adolescents' sexual activity were the perception of their teenagers as religious and too young to engage in such behavior. Mothers were more likely to underestimate their teenagers' sexual behavior if the mothers (a) were older, (b) strongly disapproved of teenage sexual intercourse, (c) communicated less with their teens, and (d) were more satisfied with the parent-teen relationship. In general, the findings indicated that the mothers' underestimation of the sexual behaviors of their adolescents was based on erroneous assumptions made by the mothers. An interesting finding was that positive parental perceptions of the parent-teen relationship *increased* the underestimation by the parents of their teenagers' sexual behaviors.

Furthermore, Jaccard et al. (1998) looked at the reports given by parents and their teens and found several inconsistent results. For example, mothers (72%) were more likely than their teenagers (45%) to report that they had familial discussion about sex, and parental satisfaction with the parent-teen relationship was not predictive of teen satisfaction. Some teens underestimated the actual reported level of maternal disapproval of sexual intercourse. Factors predictive of whether the teenagers would underestimate maternal disapproval of

sexual intercourse occurred (a) when peers were perceived as accepting of premarital sex, (b) when the teenager was male, (c) when mothers were less religious, and (d) when teens reported little parental communication about sex. In this study, a relationship was found between a teenager's *perceptions* of his or her mother's disapproval of premarital sex and lowered levels of adolescent sexual behaviors. It was also found that a lack of parent-teen sex communication increased adolescent sexual behaviors. Given the findings of Jaccard et al., parents opposing premarital sex should clearly state their position to their teenagers, and in turn, this may reduce risk-taking sexual behaviors by the adolescent. Furthermore, by having parents and their teenagers discuss adolescent sexuality in a supportive and facilitated setting, it is hoped the barriers to familial sex communication can be effectively reduced.

The study by King and Lorusso (1997) compared the recollections of parents and their children regarding sexual discussions within the home. The respondents were 530 undergraduate students enrolled in a human sexuality course and their parents. The parents and their adult children completed a questionnaire that asked about the nature of "meaningful" discussions regarding sex, their ages when discussions occurred, and whether it was a single or an ongoing discussion. Additional questions for the parents included the following: (a) Did they have meaningful sexual discussion with their parents?, (b) did they take sex education in school?, (c) would they have approved of their child's current enrollment in a sex education course?, and (d) should such courses be offered in high school or junior high?

Within the families studied, mothers were identified as the primary providers of sexual information to their children. Topics that generated the most controversy were sexually transmitted diseases, intercourse, reproduc-

tion, birth control, homosexuality, and sexual abuse. Parents gave the following reasons for not talking about sex with their children: (a) it was the responsibility of the other parent, (b) feelings of embarrassment, and (c) unacceptability of the subject. Furthermore, a general discrepancy existed between recollections of parents and children about the occurrence of meaningful sex communication and the specific topics covered. Parents reported both a higher frequency of discussions about adolescent sexuality and more topics being covered than did their adult children. Discrepancies about participation in a significant sexual discussion often occurred when parents talked to their children indirectly about sex. These findings suggest a tendency for parents to avoid direct discussions with their children about teenage sexuality due to their discomfort and their lack of accurate information.

Findings from the study of King and Lorusso (1997) showed a familial trend reflective of meaningful discussions regarding sex within subsequent generations of parents and their teenagers. Of the few parents who completed a sex education course, most remained uncomfortable discussing this subject with their own children. Ninety-five percent of parents indicated that the course should occur in college, 91% said it should occur in high school, and 71% said that the course should occur in junior high.

In 1995, Pick and Palos investigated the sex lives of adolescents in Mexico City. Their study examined three related issues: (a) contraceptive practices of 12- to 19-year-old girls, (b) the differences between adolescent males who had got their partners pregnant and those who had not, and (c) perceived levels of sexual communication within families. Sexual behaviors and contraceptive practices of subjects were identified through the use of a questionnaire given to 1,257 adolescents. The findings indicated that maternal-teen communication

and the history of pregnancy among close relatives were predictors of decreased adolescent sexual activity, fewer pregnancies, and more contraceptive use. Specifically, adolescent girls were least likely to initiate sexual relations if they frequently talked to their mothers about sex, did not have a pregnant sibling during their teen years, and if their mother had married prior to pregnancy. The highest levels of mother–daughter communication occurred when mothers were viewed as positive role models and were married before pregnancy. This study highlights the importance of mother–daughter sex communication and the important influence of role modeling in terms of adolescent sexual behavior.

When Pick and Palos (1995) examined the differences between 338 adolescent males who had impregnated their partners and those who had not, their findings revealed that those with better parental communication showed lower rates of pregnancy. In addition, when interviewing 725 adolescents and their parents regarding the issue of familial perceptions of sex communication, mothers were found to communicate more with their adolescent children about sex than fathers. Furthermore, there was greater discrepancy about perceived levels of sex communication and discomfort between fathers and their adolescents, as it appeared that fathers underrated their adolescents' levels of sex communication discomfort. Both fathers and adolescents showed higher levels of discomfort in talking about adolescent sexuality than did mothers. It is important to note, however, that in this study women traditionally led group communication about adolescent sexuality. The findings of Pick and Palos document the importance of parent–teen communication and parent modeling in reducing adolescent risk-taking sexual behaviors.

Overall, there is a sincere effort for practice strategy to include brief evidence-based interventions (Corcoran & Vandiver, 2004; Roberts

& Yeager, 2004). Previous research in this area clearly documents the need to include parents in sex education programs that are designed to provide accurate information while raising comfort levels when parents and their teens communicate. To accomplish this, a psychoeducational group to increase comfort during sexually related communication between parents and their teenagers was offered.

## **Intervention Methodology**

### ***Subjects***

The psychoeducational teen sexuality group involved six adolescents aged 14–18 and six of their parents. All participants were court ordered to attend the group due to the adolescents' involvement with the Department of Juvenile Justice. All participants had completed from 8 to 12 years of high school and resided in Central Florida. Four of the adolescents were male and two were female; five were White and one was Hispanic. Half of the adolescents reported being in what they considered a "serious sexually active relationship." The parents' ages ranged from 36 to 54; two parents were male and four were female. Five of the parents had completed high school, and one parent had graduated from college. One parent was single, two were married, and three were divorced.

### ***Psychoeducational Group Format***

Unlike most traditional sex education programs, parents and teenagers were expected to participate equally in the group. The goal of this time-limited intervention was to allow parents to be active participants in a sex education process that was intended to have their adolescents delay or reduce their sexual activity. This psychoeducational group used

traditional social-learning techniques to teach participants sex education and skill-building strategies. Participants were taught decision-making and communication skills, and they engaged in role-playing in response to selected adolescent sexual situations. All activities and discussions emphasized the prevention and reduction of adolescent risk-taking sexual behaviors by suggesting alternatives such as the use of contraceptives and delaying intercourse. Like many programs based on social-learning theory, this psychoeducational group made use of role-plays and modeling to teach communication and negotiation skills as well as to reinforce prosocial values that discourage premature sexual activity and unprotected sex. Furthermore, it was anticipated that the parent-adolescent interaction during the group sessions would help reduce barriers associated with discomfort in talking about sex while providing participants with accurate information about adolescent sexuality, particularly ways to reduce pregnancies and STIs. The group leaders were especially interested in knowing whether differences occurred between male and female parents in addressing issues related to teenage sexuality. It was hypothesized that familial sex education in the psychoeducational group sessions would increase the comfort levels of parent-teen communication about adolescent sexuality.

In summary, each of the group sessions focused on providing information on sex education and included skill-building exercises that assisted participants in learning about effective decision making and assertiveness. Emphasis was placed on facilitating communication between parents and their teenagers. Topics covered included the following: abstinence, contraceptive use, the effects of sexually transmitted diseases, sexual intercourse, levels of risk-taking sexual behavior, pregnancy, and masturbation. The discussions focused on participants' formulating future

goals and placed emphasis on how sexual risk-taking behaviors and practices by adolescents could interfere with and perhaps stop goal acquisition. Parents and teens had opportunities for open discussion as well as opportunities to engage in role-played scenarios identified by the group facilitators. Generally, both parents and teens received the information as a group, but at times group sessions were divided into parent and teen subgroups.

### **Instrumentation**

A pretest/posttest design that involved the use of a survey was specifically developed for this study by the authors in order to measure communication comfort levels. To ensure face validity of the survey, it was piloted with four adolescents and their parents; some minor changes were then made in the wording of the survey before it was used.

The survey collected demographic information on respondents, such as respondents' gender, age, race, and highest level of education completed. Adolescents were asked if they were in a current serious relationship; parents were asked if they were married, separated, single, divorced, or widowed. Respondents were asked to respond to several statements related to communicating about adolescent sex using a Likert scale that ranged from 1 to 5 (1 = *never agree*, 2 = *rarely agree*, 3 = *sometimes agree*, 4 = *often agree*, 5 = *always agree*). Parents and adolescents completed similar surveys; however, the wording of some statements was slightly different on the two versions. For example, the question "talking to my *teenager* about birth control would be embarrassing" on the parent survey was changed to "talking to my *parents* about birth control would be embarrassing" on the adolescent survey.

Examples of survey statements included: (a) I feel comfortable talking to my teen about sexual issues; (b) my opinions are important to my

teen; (c) there are things I could never talk to my teen about; (d) to avoid conflict, I do not talk to my teen about things; (e) I have talked to my teen about sex; (f) if I had a concern, I would talk to my teen about it; (g) when I talk to my teen, they do not hear what I am trying to say; (h) I can talk to my teen about sexually transmitted diseases; (i) my teen never listens to me; (j) talking about birth control with my teen would be embarrassing; (k) my teen understands what it is like to be a parent; (l) talking about serious problems with my teen leaves me feeling frustrated; (m) when talking to me about sexuality, my teen's comments make sense; (n) talking about sexual issues may positively effect my teen's future choices; and (o) I have talked to my teen about sexually transmitted diseases.

### Procedures

The teen sexuality and decision-making psychoeducational group was held for 2 hr, twice a week, for two consecutive weeks. The group had two facilitators and focused on delaying or reducing the sexual activity of adolescents. At the beginning of the first group session, pretests were given; at the last group session, posttests were administered.

In measuring the effectiveness of the intervention in a pretest/posttest format, two versions of the survey were utilized. One version of the survey was given to the adolescents and another was given to their parents. Each respondent was asked to complete the demographic section and the 15 questions on the survey. The survey questions were designed to gather information about the dynamics of participants' comfort levels in learning and communicating about adolescent sexuality.

To ensure confidentiality within the intervention setting, respondents were informed that their identities would remain confidential in the evaluation analysis. This was of particular importance because participation in the

group was court ordered. If respondents felt uncomfortable answering any of the questions, they were told that they could leave those questions blank or withdraw their participation in the group at any time without penalty. More important, respondents agreed to participate after being assured that their participation or nonparticipation in completing the evaluation measures would not have an impact on the services that they would receive.

### Results

A dependent (paired) samples *t* test indicated significant differences between the pretest and posttest scores ( $t = -3.25$ ;  $df = 11$ ;  $p = .008$ ). The results of the *t* test were further supported when utilizing a nonparametric test known as the Wilcoxon Signed Ranks Test ( $z$  score =  $-2.8$ ,  $p = .005$ ). Furthermore, it appeared that group participants with higher pretest scores also had higher posttest scores ( $r = .66$ ,  $p = .02$ ). Participants with the 25% highest pretest scores showed a lesser degree of improvement on the posttest overall than the remainder of the participants. When averaging degrees of improvement by gender, fathers' scores improved three times more than mothers did (fathers 15.5, mothers 5).

### Discussion

In this practice-based sample, analysis of the data supported the hypothesis that familial participation in a psychoeducational teen sex group increased comfort levels of sexually related communication between parents and their teens. Communication discomfort has been identified as a barrier to effective familial sex communication and, according to Pick and Palos (1995), a positive relationship between communication comfort and sharing of information can benefit all involved. Additionally,

efforts to improve communication can support the creation of an inverse relationship between familial sex communication and adolescent sex behaviors. In other words, increases in comfort with sex communication would result in a reduction in adolescent sex behaviors. Although, this study cannot claim that adolescent sex behaviors will indeed decrease, evidence-based practice efforts such as this were indicative of significant differences in comfort levels between the pretest and posttest measures. Although not covered in this group, future groups should include discussion of topics such as maturation, reproduction, same-sex relationships, and sexual abuse (Franklin & Corcoran, 2000). In retrospect, it is believed that inclusion of these topics would have made the content more comprehensive.

Furthermore, it is interesting to note that participants who scored higher on the pretest also scored higher on the posttest; yet these participants showed the least improvement overall. Although all participants showed some improvement, it seemed that family members with lower pretest communication comfort levels benefited more from the group sessions than those with higher pretest scores. A contributing factor may have been that all adolescents were involved with the Department of Juvenile Justice and were court ordered to participate in the group. These families with an adolescent classified as delinquent may have had higher levels of ineffective family communication patterns than families without a delinquent teen. Because respondents with lower pretest scores showed the highest degree of improvement on posttest scores, preexisting communication problems may have improved on the basis of the support and structure of the group facilitators. Because it is unclear whether the fact that these individuals were court ordered may have influenced score results, exploring the impact that mandated group participation has

**TABLE 1.** Pretest and Posttest Scores on Familial Comfort Levels About Sex Communication Survey for Participants in the Psychoeducational Teen Sexuality Group

Group (Frequency)	Pretest		Posttest		Degree of Change
	Mean	(SD)	Mean	(SD)	
Total respondents (12)	48.6	9.44	56.0	9.75	7.4
Fathers (2)	45.0		60.5		15.5
Mothers (4)	53.2		58.2		5.0
Adolescent males (4)	45.5		52.2		6.7
Adolescent females (2)	49.5		55.0		5.5

on familial sex communication remains an area for further investigation.

Previous research has identified mothers as the main disseminators of sex communication within families (King & Lorusso, 1997); also, mothers were more comfortable with familial sex communication than fathers (Pick & Palos, 1995). Again, the data from this study was consistent with that of earlier research. Fathers scored lower on the pretest than other respondent groups (see Table 1). However, in terms of improvement, the fathers' scores increased three times more than the scores of mothers on posttests. These results seem to suggest that facilitated familial sex communication is beneficial, most notably for fathers, in reducing communication discomfort.

### ***Limitations and Need for Future Research***

Several limitations should be noted when interpreting this type of practice-based small group research. First, the participants were court ordered, and their participation in this group was not optional. It therefore remains unclear whether this may affect the results. Although not intended, the data are based on a primarily White sample. Whether this lack

of diversity is due to a small sample size, the location of the study, or both, remains uncertain. Nevertheless, the lack of ethnic diversity within the sample prevents generalizability to ethnically diverse populations even though previous research has indicated that ethnicity plays a role in adolescent risk-taking sexual behaviors. In 1990, pregnancy rates for African American adolescents aged 15–19 were two to three times higher than the rates for White and Hispanic adolescents (CDC, 1993). Ethnicity contributes to risk-taking sexual behaviors by adolescents and also to the dynamics of parent–teen sex communication. For example, research indicates that the maternal sex behaviors of Hispanic women have a greater impact on their adolescents' behavior than that of adolescents from other ethnic groups (Kotchick et al., 1999). Further study is needed to address the needs of ethnic minority adolescents and their families as related to familial sex communication and preventative sex education services.

Finally, in interpreting the data, it is important to note that several of the scores of individual questions within the survey were not consistent. For some participants, individual scores decreased, even though scores increased overall. For example, an adolescent who *always agreed* with “my parents have talked to me about sex” on the pretest survey, rated *sometimes agree* on the posttest. Although the reason for this can never be fully identified, it is possible that the change in score could be interpreted as the by-product of a successful intervention, rather than a decrease in sex communication discomfort. By participating in the psychoeducational group, the adolescent may have gained a better understanding of what should be included in parent–teen sex talks, and thus, after receiving this education, may have decided that the communication was less than originally indicated. Therefore, although the overall increase in respondents'

posttest scores indicates improvement in familial comfort levels in discussing sex, the nature of the individual responses warrants further study.

It has been suggested that parent and teen participation in a psychoeducational group is more effective in reducing adolescent sex behaviors than teen participation alone (Franklin & Corcoran, 2000). However, when this finding is applied to practice in groups such as this, attention to prescreening participants for groups cannot be underestimated. For example, if parents are not good role models or if they exhibit values that promote adolescent sexual risk-taking behaviors, it might be better to exclude them from the group. This is especially important in court-ordered cases when the adolescents have been victims of parental incest and the perpetrating parent attends. Good screening practices and information gained through further intervention research may help clarify specific factors in parent–teen relationships that would make participation in a familial sex communication group ineffective or detrimental to the participants.

## Conclusion

Even though parents and teenagers are often uncomfortable talking about sexuality, parent–teen communication about sex appears to be linked to responsible sexual behavior among adolescents (Raffaelli et al., 1998). Despite support for increased parental communication with their adolescents about sex, many parents remain uncomfortable approaching this subject. The findings from this practice-based study remain consistent with those of earlier investigations supporting the importance of familial participation in sex education toward increasing communication comfort levels between parents and their

teens. This observation has implications for professional social work practice, especially if practitioners are to design interventions at a variety of levels that address the complex problems of unplanned pregnancy and STIs among adolescents.

First, previous research has suggested that mothers underestimate the sexual activity of their teenagers because they make erroneous assumptions about adolescent sexuality. A positive parental perception of the parent–teen relationship even *increases* the underestimation of teen sexual behaviors by parents (Jaccard et al., 1998). A good parent–child relationship will not necessarily prevent an adolescent from experimenting with sex. However, the relationships that professional helpers form with parents can be critical in providing them with the sex education information needed to dispel myths about adolescent sexuality and to improve parent–teen sex communication.

The purpose of practice and intervention should not be to merely improve the quality of the relationship between adolescents and parents (Ballou, 2002). Intervention needs to address erroneous parental assumptions and to help parents provide information related to teen sexuality. Social work practitioners in schools, clinics, and other community-based programs frequently function in the role of teachers and supportive professionals with adolescents (Hall & Torres, 2002; Mellin & Beamish, 2002). As frontline providers of accurate information to parents, social workers can better serve the adolescents, families, and communities in which they work.

Second, in terms of communication an emphasis on comfort needs to be given to helping parents increase communication skills while strengthening relationships. Adolescents who are sexually active are more likely to report poor communication with their parents (Craig, 1996). Sex education that provides skills

training based on social-learning principles can be an important type of practice-based educational approach (Franklin & Corcoran, 2000). Social-learning theory suggests that the norms and behavior of the people around teenagers, particularly parents, influence their behavior. Most sex education programs communicate that it is desirable to postpone sexual intercourse and that unprotected sex should be avoided. These programs may take place in school or community settings such as hospitals. They usually combine information on human sexuality with specific, concrete skills-building sessions on how to resist influences encouraging sexual activity. Some of these programs also work to increase parent–child communication on sexuality and sexual choices. Although evaluations of these programs have not provided conclusive evidence, they do appear to be effective in postponing sexual activity among virgins. It is important to note that while they do not appear to influence the level of sexual activity of those already sexually active, these programs may help these teens use contraceptives more effectively (Barth, Leland, Kirby, & Fetro, 1992; Howard & McCabe, 1992). Teens not only need information about their sexuality, but they also need to know how to apply this information in daily life. For most people, including adolescents, there is usually a gap between what people know and what they do. Therefore, sex education programs need to place emphasis on teaching decision-making skills, life skills, and life planning.

Last, to date, even though public polls show that increasing numbers of adults favor sex education within the schools (Raffaelli et al., 1998), more evidence is needed to establish the effect that sex education can have in terms of preventing teen pregnancy (Franklin & Corcoran, 2000). Limited evaluation has been done on many of these programs, but they do not appear effective in increasing students' knowledge and have little effect on students'

attitudes or sexual activity (Ooms & Herendeen, 1990). A program that only provides information about teen sex or that just distributes contraception information will not be effective in dealing with problems where so much of the solution depends on personal and social attitudes and behaviors. Given the discouraging results of some sex education programs, it is clear from the consistent research findings that parental involvement is critical to the success of preventing pregnancy and STIs among adolescents. In addition, studies document that unwanted pregnancy in teenagers is related to risk-taking behaviors such as drug use and needle sharing (Downs, Moore, McFadden, & Costin, 2000). This indicates that programs intended to prevent unplanned adolescent pregnancy and STIs should not be operated in isolation from other prevention efforts.

Social workers and other helping professionals need to take leadership roles in designing, implementing, directing, and evaluating comprehensive and effective practice interventions in all areas of practice, including those that involve familial sex education approaches and programs (Dziegielewski & Roberts, 2004). However, practitioners must first recognize and then acknowledge that parents have a vital role to play in prevention efforts. Preventative sex education efforts of most programs still largely exclude parents as agents of change in agency-based interventions intended to reduce adolescent risk-taking sexual behaviors. Research indicates that a majority of parents are not opposed to sex education curricula for their children (Pick & Palos, 1995). Sex education information has been shown to be more effective when combined with familial sex communication (Franklin & Corcoran, 2000). It seems reasonable to believe that parental involvement could be successfully incorporated into existing sex education programs. Doing so may result in both reduced risk-taking sexual behaviors by adolescents and in-

creased levels of comfort during familial sex communication.

## References

- Arnold, E. M., Smith, T. E., Harrison, D. F., & Springer, D. W. (1999). The effects of abstinence-based sex education program on middle school students' knowledge and beliefs. *Research on Social Work Practice, 9*(1), 10–24.
- Ballou, R. A. (2002). Adlerian-based responses for the mental health counselor to challenging behaviors of teens. *Journal of Mental Health Counseling, 24*(2), 154–165.
- Barth, R. P., Leland, N., Kirby, D., & Fetro, J. V. (1992). Enhancing social and cognitive skills. In B. C. Miller, J. J. Card, R. L. Paikoff, & J. L. Peterson (Eds.), *Preventing adolescent pregnancy: Model programs and evaluations* (pp. 53–82). Newbury Park, CA: Sage.
- Berger, K. S., & Thompson, R. A. (1994). *The developing person through the life span*. New York: Worth.
- Centers for Disease Control. (1993). Surveillance for pregnancy and birth rates among teenagers, by state—United States, 1980 and 1990. *Morbidity and Mortality Weekly Report, 42*, 1–27.
- Centers for Disease Control. (2002). Sexually transmitted diseases. *Morbidity and Mortality Weekly Report, 51*, 853–856.
- Corcoran, K., & Vandiver, V. L. (2004). Implementing best practice and expert consensus procedures. In A. R. Roberts & K. R. Yeager (Eds.), *Evidence-based practice manual: Research and outcome measures in the health and human services* (pp. 15–19). New York: Oxford.
- Craig, G. J. (1996). *Human development*. Upper Saddle River, NJ: Prentice Hall.
- Downs, S. W., Moore, E., McFadden, E. J., & Costin, L. B. (2000). *Child welfare and family services: Policies and practices*. Boston: Allyn and Bacon.
- Dziegielewski, S. F., & Roberts, A. R. (2004). Health care evidence-based practice: A product

- of political and cultural times. In A. R. Roberts & K. R. Yeager (Eds.), *Evidence-based practice manual: Research and outcome measures in the health and human services* (pp. 200–204). New York: Oxford.
- Franklin, C., & Corcoran, J. (2000). Preventing adolescent pregnancy: A review of programs and practices. *Social Work, 45*(1), 40–52.
- Hall, A. S., & Torres, I. (2002). Partnerships in preventing adolescent stress: Increasing self-esteem, coping, and support through effective counseling. *Journal of Mental Health Counseling, 24*(2), 97–109.
- Harris, M. B., & Franklin, C. (2004). Evidence-based life skills interventions for pregnant adolescents in school settings. In A. R. Roberts & K. R. Yeager (Eds.), *Evidence-based practice manual: Research and outcome measures in the health and human services* (pp. 312–323). New York: Oxford.
- Henderson, C. W. (2000, April 3). Sex education program educates on the impact of adolescent sexual activity. *Hepatitis Weekly*, p. 28.
- Holtzman, L., & Robinson, M. (1995). Parent and peer communication effects on AIDS-related behavior among U.S. high school students. *Family Planning Perspectives, 27*, 235–268.
- Howard, M., & McCabe, J. A. (1992). An information and skills approach for younger teens: Postponing sexual involvement program. In B. C. Miller, J. J. Card, R. L. Paikoff & J. L. Peterson (Eds.), *Preventing adolescent pregnancy* (pp. 83–109). Newbury Park, CA: Sage.
- Jaccard, J., Dittus, P., & Gordon, V. (1998). Parent-adolescent congruency in reports of adolescent sexual behavior and in communications about sexual behavior. *Child Development, 69*, 247–261.
- King, B., & Lorusso, J. (1997). Discussions in the home about sex: Different recollections by parents and children. *Journal of Sex & Marital Therapy, 23*, 52–60.
- Kotchick, M., Dorsey, L., Miller, M., & Forehand, J. (1999). Adolescent sexual risk-taking behavior in single-parent ethnic minority families. *Journal of Family Psychology, 13*, 93–102.
- Mellin, E. A., & Beamish, P. M. (2002). Interpersonal therapy and adolescents with depression: Clinical update. *Journal of Mental Health Counseling, 24*(2), 110–125.
- Ooms, T., & Herendeen, L. (1990). *Teenage pregnancy programs: What have we learned? Background briefing report and meeting highlights: Family impact seminar*. Washington, DC: American Association for Marriage and the Family.
- Pick, S., & Palos, P. (1995). Impact of the family on the sex lives of adolescents. *Adolescence, 30*, 667–674.
- Pistella, C., & Bonati, F. (1998). Communication about sexual behavior among adolescent women, their family, and peers. *Families in Society: The Journal of Contemporary Human Services, 79*, 206–211.
- Raffaelli, M., Bogenschneider, K., & Flood, F. (1998). Parent-teen communication about sexual topics. *Journal of Family Issues, 19*, 315–333.
- Roberts, A. R., & Yeager, K. (2004). Systematic reviews of evidence-based studies and practice-based research: How to search for, develop, and use them. In A. R. Roberts & K. R. Yeager (Eds.), *Evidence-based practice manual: Research and outcome measures in the health and human services* (pp. 3–14). New York: Oxford.
- Rushton, J. L., Forcier, M., & Schectman, R. M. (2002). Epidemiology of depressive symptoms in the national longitudinal study of adolescent health. *Journal of American Academy of Child and Adolescent Psychiatry, 41*(2) 199–206.