A Statewide Survey of the Nature and Scope of Sexuality Communication in Indiana

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Abstract:

With schools' emphasis on abstinence-only-until-marriage sexuality education, parents' roles as sexuality educators are becoming increasingly important to ensure positive sexual health outcomes for young People. However, research suggests that most American adults have limited basic sexual health knowledge. This lack of knowledge negatively impacts parents' ability to impart accurate information to their children. This research investigated communication between Indiana parents and their children about sexuality. A representative sample of men (n = 158) and women (n = 340) was surveyed via telephone interviews regarding the frequency of their conversations on specific sexuality-related topics and the reasons that might prevent them from discussing sexuality. Rates of parental communication about certain topics related to sexuality varied greatly. This suggests that certain barriers exist that limit the amount and quality of sexuality education between parents and their children.

Keywords: attitudes | barriers to communication | Family communication | gender | Indiana | school based sexuality education | sex education | sexuality

Article:

For many parents and caregivers educating their children about sexuality-related issues is a difficult task. Trying to explain facts about sexuality and one’s own feelings and values can provoke feelings of embarrassment, fear, and nervousness for parents as well as their children. Even though some parents may be fearful or anxious about discussing sexuality with their children, it is imperative that we prepare children to be responsible sexual adolescents and adults. In survey after survey, young people list parents as the most important source of information about sexuality and values (Bates & Joubert, 1993; Jaccard, Dodge, & Dittus, 2002; Kirby & Miller, 2002; Yarber & Greer, 1986). Unfortunately, many young people are not having quality

conversations with their parents. Many youth reported not even having "one good talk" with their parents about sexuality (Raffaelli, Bogenschneider, & Flood, 1998).

Previous research has demonstrated that communication about sexuality can have a significant positive impact on sexuality-related outcomes for young people (Clawson &Reese-Weber, 2003; Fisher, 1986; Fox & Inazu, 1980; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Mueller & Powers, 1990; Sanders & Mullis, 1988). Parental communication about sexuality has been shown to be related to the following outcomes:

- older age at first coitus (Fox & Inazu, 1980; Kahn, Smith, & Roberts, 1984; Pick & Palos, 1995),
- more effective use of contraception (Fisher, 1986; Fox & Inazu, 1980; Hutchinson, 2002; Hutchinson & Cooney, 1998; Whitaker, & Miller, 2000),
- greater condom use self-efficacy (Hutchinson & Cooney, 1998; Hutchinson et al., 2003),
- fewer reported sexual partners (Darling & Hicks, 1982; Kallen, Stephenson, & Doughty, 1983),
- greater communication between adolescent partners (Hutchinson & Cooney, 1998),
- fewer episodes of unprotected intercourse (Hutchinson et al., 2003), and
- fewer reported pregnancies as a teenager (Leland & Barth, 1993; Pick & Palos, 1995).

Much of the research to date has focused on parental communication about "sexual risk" topics such as unintended pregnancy, sexually transmitted infections, multiple sex partners, and lack of birth control usage. Some parents have discussed the importance of communication with partners, how teens know they are ready to have sex, condoms and other methods of birth control, and STIs and HIV/AIDS (Henry K. Kaiser Family Foundation, 2002) and menstruation, dating and boyfriends, sexual morality, conception, and sexual intercourse (Fox & Inazu, 1980). However, this communication may not seem relevant to young people, especially if the link to sexual health outcomes is not made for them.

Even though talking to young people about sexuality portends better outcomes, there are many reasons why parents may be reluctant to talk to their children about sexuality-related issues. Previous studies have suggested the following:

- parental beliefs regarding their own lack of appropriate knowledge about sexuality-related topics (Brock & Jennings, 1993; Fisher, 1986),
- parental embarrassment with the topic of sexuality (Brock & Jennings, 1993),
- parental worry that talking about sex will imply permission to have sex (Werner-Wilson & Fitzharris, 2001; Yowell, 1997),
- parental perception that a child's "sexual coming of age" is an "anxiety provoking developmental crisis" (Baldwin & Baranoski, 1990), and
- unresolved parental sexuality issues (Simanski, 1998).

Parental reluctance to discuss sexuality is compounded by many young people's unwillingness to initiate discussions with their parents about sexuality out of concern about their parents' reactions. Many teens worry that if they bring up the subject their parents will suspect that they are having sex or planning to have sex (Henry J. Kaiser Family Foundation, 2002). Teens also

say that they fear their parents might "panic" and cut back on their privileges (Fitzharris & Werner-Wilson, 2004). In addition, slightly more than 75% of teens report that they feel embarrassed and/or don't know how to bring the subject of sexuality up to their parents (Henry J. Kaiser Family Foundation, 2002). In another study, 45% of female teenagers reported that they were "very" or "somewhat" uncomfortable discussing sexuality with their parents. Many of these same teens (33%) perceived that their parents were "very" or "somewhat" uncomfortable discussing sex also (Hutchinson & Cooney, 1998).

The current study further investigates three issues: (1) the frequency with which Indiana parents discuss a broad range of sexuality-related topics with their children, (2) parental perceptions of the most appropriate time to begin sexuality-related discussions with their children, and (3) possible barriers to communication about sexuality-related issues.

METHOD

Participants

Participants were 518 Indiana residents age 18 to 89. There were 340 female and 158 male (n = 498) respondents. An additional 20 respondents' gender could not be clearly identified by voice. The sample was ethnically representative of the state of Indiana with the majority (83%) of respondents identifying as Caucasian. (See Table 1.)

Table 1a. PPIN* survey data comparison with U.S. Census Bureau data for Indiana

Ethnicity	*PPIN Survey*	*2000 Census*
African America/Black	9.0%	8.4%
American Indian/Alaskan Native	1.0%	0.3%
Asian/Pacific Islander	1.0%	1.0%
Biracial	2.0%	1.2%
Caucasian/White	83.0%	87.5%
Hispanic/Latino	1.0%	3.5%
Level of Education		
Less than a High School Diploma	11.2%**	
Diploma or Higher	88.7%**	82.1%***
B.A. Degree or Higher	26.7%**	19.4%***
Household Income		
Median Income	$40,000-$50,000	$41,467

*PPIN–Planned Parenthood of Indiana; **18+ years old; ***25+ years old; ****$0-$10,000

Table 1b. PPIN survey data–PPIN respondents only

Age Range	*Range*	*Average*
Total Sample	18-89	45.79
Men	18-85	42.66
Women	18-89	46.99

Political Affiliation	*Total*	*Men*	*Women*
Democrat	27%	25%	29%
Republican	31%	34%	32%
Independent	10%	13%	9%
No Party Affiliation	21%	23%	22%
Other	1%	1%	2%

The sample was also geographically representative of Indiana. Twenty-one percent identified as living in a large city/metropolitan area, 30% identified as being from a medium-sized city, 31% identified as being from a small town, and 18% identified as being from a rural area.

More than half (54%) of all respondents had some vocational/technical college or 4-year university experience. (See Table 2.) The household income of respondents was normally distributed. The median income fell between $40,000 and $50,000 per year. Twenty-five percent of respondents had an annual household income above $60,000 per year. Two percent reported an annual household income below $10,000 per year.

Table 2. Highest level of education completed

Level of Educational Attainment	*Percentage*
Professional/Graduate degree	8%
4-year college graduate	19%
Associates/Technical degree	5%
Some college	22%
High school diploma/GED	35%
Did not complete high school	11%
Total percentage that had at least a high school diploma/GED	89%
Total percentage that had at least some college experience	54%
Total percentage that had at least a 4-year degree	27%

The sample was also representative of the state of Indiana politically. Thirty-one percent of respondents identified as "Republican," 27% identified as "Democrat," and 10% identified as "Independent." (See Table 2 for 2000 U.S. Census data which confirms the representativeness of the current sample.)

Eighty-five percent of respondents indicated that they were "very" or "somewhat" religious and 64% percent indicated that they "always" or "frequently" use their religious beliefs to help them make decisions in their lives.

The majority (82%) reported being parents and said that their children were in the following grades: 17% currently in kindergarten or younger, 13% in elementary school grades, 11% in middle school grades, 11% in high school grades, and 7% in college. Forty-one percent of the parents had adult children (22+ years old). The majority of parents (65%) reported that their children attend(ed) public schools.

Procedure

Planned Parenthood of Indiana initially contacted the Social Science Research Center (SSRC) at Ball State University in February 2003 to solicit their assistance in conducting a statewide telephone survey of Indiana residents. Interviewers were hired and trained by the Social Science Research Center, and a survey instrument was developed by a Planned Parenthood staff member in conjunction with research staff at the Social Science Research Center. The Institutional Review Board (IRB) at Ball State University approved the survey instrument and research protocol.

In March 2003, the Social Science Research Center purchased 3,506 randomly generated telephone numbers from Marketing Systems Group: Genesys Sampling Systems from Fort Washington, Pennsylvania. Using the 3,506 phone numbers, a total of 5,751 telephone calls were made including call-backs to busy numbers, answering machines, and respondent instructions to try again later. There were a total of 547 unusable numbers (i.e., disconnected service, business/government numbers, computer tones) bringing the total of available numbers to 2,959. Using the dispositions of "Initial Refusal" and "Blocked Call," a total of 830 potential participants were unwilling to participate. This translates to a refusal rate of 28.1%.

Beginning in mid-April 2003, respondents were contacted via random-digit telephone number dialing by one of 15 interviewers (13 females and 2 males, between the ages of 18 and 30). Staff from the Social Science Research Center supervised the interviewers to ensure compliance with the protocol and to maintain quality control. None of the interviewers were terminated due to inability to follow protocol and none removed themselves due to discomfort with the subject material.

All data were directly managed using Win Query's Computer-Aided Telephone Interviewing software that allowed for the automation and recording of all responses. Data were then transferred into SPSS for Windows format for statistical analyses.

Materials

Respondents were asked a series of demographic questions to assess age, ethnicity, size of home city, household income, highest level of education completed, level of religiosity, importance of religion in decision-making, grade level of any children the respondent may have, choice of school enrollment for any children the respondent may have had, and political party affiliation. Most questions were multiple-choice format with the exception of gender; respondents could offer alternatives if they desired to do so. Per SSRC protocol, respondents' gender was determined by the interviewer based on voice-analysis and recorded as male or female. Collecting demographic information was considered essential as it was expected that these factors would be related to parents' attitudes and behaviors about sexuality communication.

Following the demographics, respondents were asked 40 questions related to parental communication about human sexuality. They were asked to give their opinion about when parents should begin discussing sexuality-related issues with their children and what grade level was most appropriate to begin sexuality education at school. Both items were open-response format and respondents could offer any answer they believed was appropriate. Additionally, respondents were asked to indicate the extent to which they agreed that statements such as "I get embarrassed" and "I feel like I lack accurate knowledge about sexuality" stopped them from discussing sexuality issues. Level of agreement was coded on a 4-point Likert-type scale with *1 = Strongly Agree* and *4 = Strongly Disagree.*

Respondents were then asked how frequently they had discussed 21 sexuality-related topics such as abstinence, how to make good decisions about being sexually active, messages young people receive from popular media about sexuality, and peer pressure to have sex. The frequency of conversations coded on a 4-point Likert-type scale were *1 = Frequently* to *4 = Never*. All other

responses were coded as "no response." These response items were generated utilizing the SIECUS Guidelines 2nd edition Key Concepts and Topics as a starting point (National Guidelines Task Force, 2nd edition, 1996). From this list, we chose content areas that we expected had the greatest likelihood of being a part of a family-based discussion about sexuality. Topics not specifically mentioned by SIECUS such as condoms and their correct use, peer pressure, and peer messages about sex were added and other topics suggested by SIECUS such as raising children and sexuality and the arts were omitted.

To conclude the interview, respondents were asked, "To what extent do you think images of sexuality on TV and in magazines influence the way young people view sex and sexuality" and "To what extent do you believe parents influence a child's attitude toward sex?" Both items had 4-item Likert-type response choices from *1 = The most influential factor* to *4 = Not at all influential*. All other answers were recorded as "Don't know/no response."

RESULTS

Most parents (83.5%) had participated in at least one discussion with their children about sexuality-related issues (see Table 3). Regardless of age level of the children, only a small percentage of parents (26%) indicated that they "frequently" discussed sexuality-related issues with their children. The majority of respondents indicated they only discussed sexuality issues "sometimes." There was a trend toward increased communication about sexuality-related issues as children got older (i.e., 13% of parents "frequently" had discussions with their kindergarten-aged or younger children versus 51% of parents who "frequently" had conversations with their high-school aged children). (See Table 3.)

Table 3. Self-reported frequency of parental discussions with their children about sexuality

	Frequently	*Sometimes*	*Rarely*	*Once*	*Never*	*No Response*
ALL PARENTS	33%	36%	13%	1.5%	6%	1.5%
< = Kindergarten (n = 84)	12%	18%	10%	1%	52%	7%
Elementary Age (n = 67)	28%	28%	17%	3%	22%	2%
Middle School Age (n = 58)	32%	46%	17%	2%	2%	2%
High School Age (n = 58)	52%	38%	8%	2%	0%	0%
College Age (n = 39)	46%	39%	10%	0%	5%	0%
Adult Children (n = 219)	40%	44%	13%	1%	2%	0%

Table 4. Suggested age and grade level for beginning discussions

Age Range of Child	*Average*	*Mode*
Kindergarten and Younger		
Age for Parental Discussion	10.10 years	10 years
Grade Level for School	7th grade	7th grade
Elementary Aged Children		
Age for Parental Discussion	9.48 years	12 years
Grade Level for School	6th grade	7th grade
Middle School Aged Children		
Age for Parental Discussion	9.68 years	12 years
Grade Level for School	6th grade	7th grade
High School Aged Children		
Age for Parental Discussion	8.96 years	10 years
Grade Level for School	6th grade	5th grade

When asked to give an appropriate age when parents should begin discussing sexuality-related issues, the average age given was age 9 or 10 (x = 9.68, mode = 10 years of age) which equates to late-elementary age. On average, parents suggested that sexuality education in schools should begin in about 6th or 7th grade (x = 6.76, mode = 7th grade). (See Table 4.)

Because we anticipated that demographic factors would predict respondents' attitudes about when parents should begin discussing sexuality with their children, we wanted to control for their effects. We were most interested in understanding whether one's status as a parent and political affiliation were predictive of attitudes about appropriate timing of sexuality discussions. To understand this question, a set of hierarchical regression analyses were performed. In Step One, ethnicity, gender, age, level of education, household income, city size, respondents' level of religiosity, and respondents' reliance on religion were entered. In Step Two, respondents' parental status and political party affiliation were entered.

In regards to the issue of when parents should begin discussing sexuality in the home, results indicated that the overall model was statistically significant at the final step [F (21,272) = 3.69, p < .001] and accounted for 22% of the variance. Three factors stood out as being statistically significant factors in the final regression equation: age [b = –0.04, p < .001], level of educational attainment [b = –0.39, p < .001], and gender [b = –1.33, p < .001]. Older age of the respondent and a higher level of education resulted in a younger suggested age for beginning sexuality discussions. Likewise, women were more likely than men to suggest a younger age for beginning sexuality discussions in the home.

Regarding the question of the most appropriate grade level in which to begin sexuality discussions, results indicated that the final overall model was statistically significant [F (21, 284) = 1.89, p < .01] and explained 10% of the variance. Results from the hierarchical regression yielded three factors that were statistically significant: respondent's gender (b = –0.751, p < .03), identification as a "very religious" person (b = –2.10, p < .04), and political party affiliation as a Democrat (b = –0.92, p < .01). Two other variables, household income and residing in a large city/metropolitan area, approached significance. Identification as a female and a Democrat resulted in suggesting an earlier grade level for sexuality education at school. Alternatively, identification as a "very religious" person resulted in suggesting that sexuality education begin in later grades.

When looking at parents' level of communication, the five most common reasons for not engaging their children in discussions about sexuality-related issues were:

- difficulty bringing up the subject of sexuality,
- worry about saying the wrong thing,
- worry about saying "too much,"
- belief that children were too young, or
- feeling embarrassed by the subject matter. (See Table 5.)

While not one of the top five reasons, one item displayed a statistically significant gender difference. Men were more likely than women to agree with the statement that "their spouse/partner talked to the kids" about sexuality-related issues [F (1, 230) = 24.17, p < .001].

Indiana parents also responded to questions about the frequency of communication that occurs in the home on 21 sexuality-related topics (see Table 6). Results indicated several topics in which more than 25% of the responses were "rarely" or "never" including:

- communicating with a boy/girlfriend,
- condoms,
- birth control,
- how to make good decisions about becoming sexually active,
- masturbation,
- media images about sexuality,
- religious messages about sexuality,
- peer pressure to have sex,
- puberty,
- sexual assault/rape,
- sexual health checkups,
- sexual orientation, and
- sexually transmitted infections.

Table 5. Potential barriers to sexuality-related discussions reasons for not discussing sexuality

	All Parents	*Women*	*Men*
I didn't know how to bring it up	20%	20%	12%
I was worried about saying the wrong thing	19%	20%	17%
I worried about saying "too much"	18%	19%	16%
I thought the kids were too young	18%	17%	21%
I was embarrassed	18%	18%	16%
Kids didn't bring it up so I didn't either	16%	14%	19%
I feel like I lack accurate knowledge	13%	13%	13%
My spouse/partner talked to the kids*	8%	4%	18%
I was afraid	6%	7%	4%
I was ashamed	6%	5%	8%
Another family member talked to the kids	3%	2%	5%
My cultural beliefs prevented discussion	3%	3%	3%
My religious beliefs prevent discussions	2%	2%	1%

*statistically different gender difference

For most topics, only about one-third of respondents indicated that they had "frequent" discussions with their children (see Table 7). Focusing just on the responses for those parents with middle school and high school aged children, the topics for which more than 25% of the responses were "rarely" or "never" included:

- communicating with a boy/girlfriend,
- condoms,
- birth control,
- masturbation,
- religious messages about sexuality,
- sexual assault/rape,

- sexually transmitted infections, and
- making good decisions about sexuality (middle school age children only).

Lastly, 73% percent of parents generally believed they were "the most influential" or "a strong" factor in determining their children's understanding of sexuality. A large majority of parents (86%) believed that the media was "the most influential" or "a strong factor" in shaping young people's attitudes about sexuality (see Table 8).

Table 6. Frequency of discussions on specific sexuality-related topics

Topic	*Frequently*	*Sometimes*	*Rarely*	*Never*	*Don't Know*
Abstinence	29%	25%	6%	14%	2%
Correct names	30%	24%	10%	10%	3%
Body image	36%	22%	6	12%	2%
Communication	27%	21%	7%	19%	3%
Condom	15%	15%	13%	32%	2%
Birth control	19%	20%	9%	27%	3%
Making decisions	32%	17%	7%	19%	3%
Gender roles	26%	26%	6%	15%	4%
Love	53%	14%	2%	6%	2%
Masturbation	3%	14%	15%	42%	4%
Media images	24%	24%	9%	17%	3%
Religious messages	17%	25%	10%	22%	4%
Peers' opinions	30%	22%	6%	15%	3%
Peer pressure	29%	17%	7%	21%	2%
Pregnancy	29%	22%	8%	15%	2%
Puberty	21%	27%	10%	16%	2%
Sexual assault	18%	23%	12%	21%	2%
Sexual health	30%	19%	8%	17%	2%
Sexual orientation	13%	23%	16%	21%	3%
STIs	25%	22%	9%	19%	2%
Values about sex	34%	23%	4%	13%	3%

TABLE 7 MAY BE FOUND AT THE END OF THIS FORMATTED DOCUMENT.

Table 8. Percentage of Responses to Media and Parental Influence

Source of Influence	*Most*	*Strong*	*Slight*	*No Influence*
Media	14%	72%	9%	1%
Parents	15%	58%	20%	2%

DISCUSSION

It is encouraging that many parents report being supportive of sexuality-related family communication and see such discussions as appropriate and necessary for the sexual development of their children. Parents in this study were supportive of beginning sexuality-related discussions with their children at home at age 9 or 10 and of school-based sexuality education starting in sixth or seventh grade. However, it is unfortunate that many parents seem to have difficulty discussing topics that are vital to a young person's sexual health such as birth control, condom use, making good decisions, and communicating with a partner.

This lack of communication is a critical issue. Young people have made their desire to have a more comprehensive sexuality education known on multiple occasions. Previous research has indicated that young people ages 14-20 want to know about STI/HIV prevention, testing, and treatment, parenting skills, birth control, abstinence, sexual abuse, sexism, drug use during pregnancy, sexual identity, sexual development, abortion, rape, adolescent sexual behavior, sexual orientation, extramarital sex, premarital sex, incest, masturbation, pornography, what constitutes appropriate sexual conduct, gender issues, and prostitution (Cairns, Collins, & Hiebert, 1994; Davis & Harris, 1982; Inman, 1974; Lawlor & Purcell, 1988). Additionally, it has been noted that young people want sexuality education that has a "positive emphasis" on sexuality topics such as "commitment and emotional factors associated with sex" (Maslach & Kerr, 1983).

Clearly, young people have an understanding about what kind of information they would find to be most helpful. Adolescents seem to be asking for medically accurate, factual information about sexual health issues as well as accurate information about the current socio-cultural milieu, so they can frame their understanding of what behaviors are and are not acceptable. From this study, it is apparent that teens are not getting critical information they need from home.

Results from the regression analyses regarding the most appropriate age for at-home and at-school discussions about sexuality were interesting and suggest some possible changes to the way we provide sexuality education. As the respondents' age increased, the reported age at which parents should begin discussing sexuality-related issues with their children decreased. This suggests that with age and life experience, individuals see the value of early sexual health education for children to help avoid them potentially negative outcomes associated with being sexually active. Perhaps this suggests calling upon other caring older adults such as one's friends, family members, or other community resources to assist in providing sexuality education as opposed to limiting efforts to parents alone. Likewise, we found that increases in educational attainment equated to lower suggested age and grade level for sexuality discussions. There seem to be opportunities here to encourage college-educated individuals to volunteer to be sexuality educators in their communities, serve on their local school boards, organize parent-teacher meetings to address the issue of sexuality education, become involved as political activists, and offer financial support to fund programs that would otherwise go unfunded.

In regards to the appropriate timing of sexuality education in public schools, it was important to learn those respondents who identified as being Democrats were more likely to suggest that school-based instruction should begin at an earlier grade level. For educators and activists working to promote sexuality education on the local, state, and national level, the results suggest that a coalition of Democratic supporters exists and should be tapped into and leveraged for political change. Not surprisingly, those who identified as "very religious" were more likely to suggest a higher grade level for school-based instruction. These findings may serve to identify those most opposed to timely sexuality education in the public schools and allow us to work with them to increase awareness and rationale for the need for early (and often) sexuality education in the school system. It should also be pointed out that, while individuals who consider themselves "very religious" may not be supportive, not all religiously affiliated organizations or places of worship are opposed to comprehensive sexuality education. Such organizations would be good partners in the effort to ensure that comprehensive sexuality education is available in a variety of

venues and can provide young people with important messages about sexuality in the context of their spiritual beliefs.

In the current study, gender was also a significant predictor of responses to both attitudinal questions as well as one of the potential barriers to parental communication. Women were more likely than men to suggest that sexuality discussions begin at an earlier age at home and at a lower grade level in school. The data may be reflective of the fact that many women feel responsible for sexuality-related decisions regarding birth control, pregnancy, safety against sexual assault and rape, and other issues. Due to physiology, women are more susceptible to sexually transmitted infections. Perhaps because of these concerns, women, more so than men, may see the need for earlier instruction on sexuality to prepare other young women for the realities of our society. A gender difference may also suggest a female gender role preference or a male aversion toward sexuality communication with their children. Either way, it serves to diminish the ability of fathers to have a positive impact on their child's sexual development. This is important as one study has shown that a gender difference within certain households as to which parent (male or female) is providing information to which child (son or daughter) can lead to inconsistency in the content of discussions and values transmission (Mueller & Powers, 1990), and may reinforce the sexual double standard that promotes "male experimentation and female protection" (Downie & Coates, 1999). The data confirms the importance of educating mothers about their children's sexual health needs, but more notably highlights the fact that we have not done a good job engaging fathers in these discussions and need to work harder and smarter on this issue.

The current study has implications for sexuality educators and what needs to be done to promote and encourage parental participation in the education of their children. Additionally, it points to groups of individuals who may be more or less supportive of comprehensive sexuality education at home and in schools. Results of the current study suggest that parents are supportive of sexuality education in schools. A comprehensive sexuality education program in the schools helps to ensure that the majority of young people will receive basic information to make more informed decisions about sexuality and will give them an opportunity to clarify their values about sexuality-related issues.

While the current study provides instructive detail in terms of parental communication about sexuality and related issues, the study is not without limitations. Although this study used a representative sampling of Indiana residents, it is possible that residents from other states or geographic locations may have responded differently to the items presented in the research. Due to the fact that the majority of the respondents were Caucasian and female, it is possible that the results of the survey would have been different if more non-Caucasian and male respondents participated. It is also important to note that the methodology only included residential phone numbers. This is noteworthy as there is an increasing reliance on the use of cellular phones, and it is possible that different results may have been obtained if such numbers were included. Lastly, it is possible that the gender of some respondents was misattributed by the interviewer creating a discrepancy in the accuracy of the gender count.

In addition to demographic issues, there are some limitations within the survey itself. While parents were asked how often they were having conversations with their children, the survey did

not ask details about the *specific content* of those discussions. It could be that a particular parent might have responded that they "frequently" discussed birth control with their child because they regularly tell their daughter that she "better not get pregnant" and their son that he had "better use protection." While one might interpret both of these statements as a request to use birth control to prevent pregnancy, neither of the statements are very helpful to a young person who might be trying to figure out what exactly "protection" is and how to access and use it correctly to avoid an unintended pregnancy. A more in-depth, qualitative study would be useful in getting a better understanding of the actual content of the communication that occurs between parents and children.

One additional limitation of the current project is that parents were not asked to provide detailed information about their communication patterns with their children based on the child's gender. The results from such research would be very illustrative in highlighting gender differences that may exist in parental communication. Data such as this would be very useful in helping drive future education efforts and future research should investigate such a difference.

While the current project does have limitations, it is important to remember that Indiana parents are supportive of sexuality education at home and in the schools. Additionally, while many parents are having regular discussions about sexuality with their children, many others are inhibited in their discussions and are not having regular conversations about very important topics. Because of this, it is necessary to encourage parents to increase their role as the primary sexuality educators. It is equally important to encourage policymakers to promote the provision of comprehensive sexuality education in public schools, and community-based, faith-based, and health care settings to ensure that children are receiving quality sexuality education from a multitude of reliable sources.

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Table 7. Discussion about sexuality-related topics by grade level of child

Topic	*K-under*	*Elementary*	*Middle School*	*High School*
Abstinence				
Frequently	20%	38%	60%	47%
Sometimes	5%	21%	24%	40%
Rarely	0%	7%	8%	7%
Never	65%	31%	4%	6%
No Response	10%	3%	4%	0%
Correct names for sex organs				
Frequently	50%	59%	60%	60%
Sometimes	25%	34%	36%	40%
Rarely	10%	7%	4%	0%
Never	5%	0%	0%	0%
No Response	10%	0%	0%	0%
Body image				
Frequently	50%	72%	72%	67%
Sometimes	25%	24%	20%	27%
Rarely	0%	0%	4%	6%
Never	15%	4%	4%	0%
No Response	10%	0%	0%	0%
Communication with boy/girlfriend				
Frequently	30%	31%	28%	40%
Sometimes	10%	21%	24%	20%
Rarely	10%	17%	28%	20%
Never	40%	28%	12%	13%
No Response	10%	3%	8%	7%
Condoms				
Frequently	7%	10%	22%	36%
Sometimes	7%	10%	33%	31%
Rarely	6%	16%	15%	17%
Never	71%	55%	30%	16%
No Response	10%	9%	0%	0%
Birth control				
Frequently	20%	17%	40%	40%
Sometimes	5%	10%	24%	33%
Rarely	10%	24%	16%	20%
Never	55%	49%	20%	7%
No Response	10%	0%	0%	0%
Making good decisions about sex				
Frequently	30%	28%	48%	47%
Sometimes	10%	17%	28%	40%
Rarely	5%	24%	8%	6%
Never	45%	31%	16%	7%
No Response	10%	0%	0%	0%
Gender roles				
Frequently	35%	31%	44%	60%
Sometimes	35%	59%	48%	40%
Rarely	5%	10%	8%	40%
Never	15%	0%	0%	0%
No Response	10%	0%	0%	0%
Love				
Frequently	70%	66%	56%	60%
Sometimes	5%	28%	40%	33%
Rarely	5%	3%	4%	7%
Never	10%	3%	0%	0%
No Response	10%	0%	0%	0%
Masturbation				
Frequently	5%	7%	8%	6%
Sometimes	0%	21%	28%	27%
Rarely	15%	14%	20%	20%
Never	70%	58%	44%	47%
No Response	10%	0%	0%	0%
Media images about sexuality				
Frequently	20%	38%	56%	60%
Sometimes	15%	38%	32%	30%
Rarely	25%	14%	12%	7%
Never	30%	10%	10%	0%
No Response	10%	0%	0%	0%
Religious messages about sexuality				
Frequently	5%	7%	16%	20%
Sometimes	10%	41%	56%	40%
Rarely	15%	17%	16%	20%
Never	60%	35%	12%	20%
No Response	10%	0%	0%	0%
Peer evaluation of sexuality				
Frequently	20%	38%	56%	53%
Sometimes	10%	27%	36%	40%
Rarely	20%	21%	8%	7%
Never	40%	14%	0%	0%
No Response	10%	0%	0%	0%
Peer pressure to have sex				
Frequently	25%	41%	64%	53%
Sometimes	15%	17%	28%	33%
Rarely	10%	4%	4%	7%
Never	40%	38%	4%	7%
No Response	10%	0%	0%	0%
Pregnancy				
Frequently	25%	38%	56%	53%
Sometimes	15%	38%	28%	27%
Rarely	10%	10%	12%	7%
Never	40%	14%	4%	13%
No Response	10%	0%	0%	0%
Puberty				
Frequently	25%	42%	64%	47%
Sometimes	20%	41%	32%	47%
Rarely	10%	10%	4%	6%
Never	35%	7%	0%	0%
No Response	10%	0%	0%	0%
Sexual assault/rape				
Frequently	10%	35%	32%	13%
Sometimes	20%	28%	28%	40%
Rarely	20%	20%	36%	34%
Never	40%	17%	4%	13%
No Response	10%	0%	0%	0%
Sexual health and getting checkups				
Frequently	15%	31%	36%	33%
Sometimes	20%	31%	44%	60%
Rarely	5%	14%	12%	0%
Never	50%	24%	8%	7%
No Response	10%	0%	0%	0%
Sexual orientation				
Frequently	15%	17%	20%	7%
Sometimes	20%	52%	60%	73%
Rarely	5%	7%	12%	7%
Never	45%	21%	4%	13%
No Response	15%	3%	4%	0%
Sexually transmitted infections				
Frequently	15%	24%	40%	40%
Sometimes	5%	14%	28%	33%
Rarely	10%	28%	20%	20%
Never	55%	31%	8%	7%
No Response	15%	3%	4%	0%
Values about sexuality				
Frequently	85%	76%	68%	67%
Sometimes	10%	17%	24%	27%
Rarely	0%	0%	0%	0%
Never	0%	0%	0%	0%
No Response	5%	7%	8%	6%