“MOTHERS AND DAUGHTERS: CONVERSATIONS ABOUT SEXUALITY”

“MADRES E HIJAS: CONVERSACIONES DE SEXUALIDAD”

A graduate project submitted in partial fulfillment of the requirements for the degree of Master of Science in Counseling, Marriage and Family Therapy

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Dedications

I lovingly dedicate this project to my fiancé who was supportive of my completion of the master’s program in so many ways. He showed his support in big and little ways such as making delicious snacks and coffee for me while I dove in the creation of this project, giving me words of encouragement, and calling me out on my procrastination at times. He continues to motivate me to keep my head up and continue pursuing my career goals and dreams through his humor and good will. I also dedicate this project to my committee, specifically to Dr. Stone who was an excellent chair during the process. Dr. Stone provided specific clear feedback and expectations while still being patient and kind during the process. She held her belief that I would accomplish my creative goal of designing a powerful intervention to be used in the field. Dr. Rubalcava also served as part of my committee and has been a very influential person in my life. He was my first practicum instructor and one of the few who challenged me enough to truly look at myself and grow through this inner exploration. Without the help and support from these individuals I would not be as successful as I am feeling today. Thank you.
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Abstract

Mothers and Daughters: Conversations about sexuality

Madres e Hijas: Conversaciones de Sexualidad

By

Jennie Zuniga

Masters of Science in Counseling, Emphasis on Marriage and Family Therapy

Researchers have shown that there is a need for increased communication regarding sexuality topics related to contraception, sexually transmitted infections, abortion, teenage pregnancy, etc. in the Latina adolescent population. There is an absence or minimal implementation of comprehensive sexual education in the public school system where young Latinas attend. There is also a lack of clear positive sexuality communication between Latina mothers and their adolescent daughters. Factors such as religion, cultural beliefs, cultural values, and transgenerational patterns may contribute to such lack of communication. The avoidance of sexuality conversations between Latina mothers and their adolescent daughters could result in Latina young women not receiving the accurate information, support, and resources that they need in order to navigate and make healthier informed decisions regarding their sexuality.
Mother-daughter conversations about sexuality can greatly influence adolescent Latinas in making informed decisions regarding their sexuality practices and avoiding negative outcomes such as sexually transmitted infections and unplanned pregnancies. A women’s group psychotherapy curriculum is offered for Latina mothers and their daughters aged 11-17, with the objective of increasing the quality of clear and effective communication between these mothers and their daughters specifically related to sexuality conversations. This intervention will help mothers be more equipped to communicate about and answer sexuality related questions with their adolescent daughters. Additionally, young Latina adolescents will feel equipped and informed regarding their sexuality as they grow and develop throughout their lives as sexual beings.
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CHAPTER ONE: INTRODUCTION

An intervention for parenting on sexuality topics such as: adolescent pregnancy, abortion, and sexually transmitted infections among others, is important within Latino families in the United States. Latino families can greatly benefit from improving and establishing stronger relationships and communication bonds. Stronger relationships and bonds may lead to the increase and enrichment of sexuality conversations between Latina mothers and their adolescent daughters. As an intervention, the proposed psychotherapy group curriculum Mothers and Daughters: Conversations about Sexuality aims to increase healthy and positive sexuality communication between Latina mothers and their adolescent daughters living in the United States.

Background and Significance

The Latino/a population of the United States as of 2011 according to the U.S Census Bureau (2012) was 52 million, making people of Latino origin the nation’s largest ethnic minority. Although the Latino population is categorized as one ethnic group, Latino/a communities in the United States are very diverse since they often include individuals who are Latino/a- American born citizens and legal or illegal immigrants from many diverse Latin countries around the world. This diversification among Latino communities calls for an inclusive intervention that can accommodate multiple Latin cultures and levels of acculturation. Acculturation is often beneficial for Latino families since increased levels of acculturation can lead Latino families to hold positive relationships between parents and their adolescents which helps motivate adolescents to achieve higher education and meet parental expectations among other benefits (Ambert, 2001).
Besides the Latino/a ethnic group being a large component of today’s U.S. population, the adolescent population is also significant. According to Osius and Rosenthal (2009) The National Research Council and Institute of Medicine (NRCIM) found that adolescents aged 10-19 make up approximately 15% (nearly 45 million) of the U.S. population. Additionally, the racial and ethnic diversity of adolescents is growing rapidly, outpacing that of most other age groups in the U.S. (Osius & Rosenthal, 2009). As the U.S. adolescent population becomes larger and more diverse, youth are at an increased risk of being unable to access education, health care, and other social services that help positively influence adolescent health and well-being (Osius & Rosenthal, 2009).

The Latino culture, like any other, carries its own multitude of norms, beliefs, language, customs, traditions, and values that shape and dictate how sexuality communication is to be or not to be carried out within the Latino family. Communicating and parenting regarding sexuality topics (i.e. masturbation, menstruation, sexual intercourse, sexually transmitted infections, abortions, teenage and unplanned pregnancy, etc.) is tied to culture in many intricate ways. One of the most important and influential cultural components from the Latino/a culture is religion, and in the case of Latino/as, the most commonly practiced religion is Catholicism (Funk & Hamar, 2014; Gallup Annual Minority Relations poll, 2005).

The Catholic’s view on human sexuality has sexual morality at its core meaning that sexuality is about expressing God’s love through the body for the sole purpose of procreation within a marriage (West, 2000). It is believed that both husband and wife have the responsibility to procreate and raise their children within their indissoluble
marriage since divorce is not accepted (Paul VI, 1968). Homosexuality is not accepted as part of natural and normal sexuality, and neither is masturbation, prostitution, pornography or any other sexual expression that is not penile-vagina intercourse within a female-male marriage (Paul VI, 1968; West, 2000).

Artificial contraceptive methods (i.e. condoms and oral contraceptives) are something that Catholicism also does not accept even within a marriage (Paul VI, 1968; West, 2000). Catholicism views human life as sacred thus any method and means to prevent or interrupt procreation, whether permanent or temporary, are not accepted as God’s natural way of managing procreation (Paul VI, 1968).

Sex outside marriage is not acceptable within the Catholic faith thus chastity and virginity is valued in women (Camelot, 2003; O’Riordan, 2003; Paul IV, 1968) especially when referring to ‘Latino Catholicism’ (De La Torre, 2009). ‘Latino Catholicism’ is greatly influenced through an idealized image of the Virgin Mary and is presented as the perfect role model for women. Because of this, women in Latino families tend to put their family before their own needs (De La Torre, 2009). These religious views place sexual intercourse for women as only for reproduction as women’s sexual identity (De La Torre, 2009). Such strong and conservative sexuality and social religious views lead Latino families to feel uncomfortable about sexuality conversations and thus avoid sexual communication within the family altogether (Guzman et al., 2013; Hutchinson, 2002; Karasz & McKee, 2006).

Besides holding strong religious views that lead parents to avoid communicating with their children about sexuality, many Latino parents also believe that parenting about sexuality is unnecessary due to the belief that sexual education in the school system is
sufficient (Guzman et al., 2013). This belief is troublesome since many schools do not offer any sexual education (Zinth, 2007), or do not adhere to the comprehensive sexual education curriculum that they say they employ (CDC, 2006; 2012). In contrast, some schools only offer abstinence sexual education (Trenholm et al., 2007). Gaps in sexual education, in the home and school environment, may leave adolescent Latinas without sufficient sexual education and guidance.

According to Satir (1988), adults can only teach their adolescents what they know and thus they continue passing on old attitudes that may or may not fit well with their adolescent’s culture and generation. Offering evidence based practice interventions to Latina mothers and their adolescent daughters on how to improve communication about sexuality topics may positively impact the futures of Latina women through stronger relationships with one another.

**Statement of the Problem**

The research shows that many sexually active Latina adolescents do not practice safe sex and as a result are at risk for teenage pregnancy and other sex related negative outcomes (CDC, 2009). Although Human Papillomavirus (HPV) vaccines have shown to be effective for health and economic reasons, few Latina adolescents have utilized these vaccines leading to an increased risk of contracting HPV during sexual intercourse (CDC, 2013). Additionally, Latina adolescents are also at risk for acquiring other sexuality related infection such as Chlamydia, Gonorrhea, and Human Immunodeficiency Virus (HIV) (CDC, 2013; 2014). Further, in spite of teenage pregnancy statistics showing a reduction in the Latina population (CDC, 2013; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2015) there is still a need for reliable interventions and
preventative measures to target all sexually related risks in the Latino adolescent population.

Sexually active Latinas who avoid using a reliable method of contraception do so for many reasons that points to lack of resources, lack of sex related information, as well as other factors related to drug and alcohol use, and older sexual partners (CDC, 2009; 2012; Kelly & Kalichman, 1995). To help avoid or eliminate many of these predicting factors, higher levels of parent–adolescent communication, family communication, parental involvement, and positive parenting about sex are needed (Malcolm et al., 2013). These positive familial factors have been directly and positively associated with condom use attitudes among adolescents, decrease in adolescents attending to peer norms and peer guidance, and reducing the likelihood of adolescents engaging in sex at an early age (Lamb, 2006; Malcolm et al., 2013; Whitaker, 2000).

One of the many parental responsibilities of parents is to convey sexuality values and provide support to their adolescents about sex and sexuality (Rekers, 1995). However, very few parents educate and guide their adolescents in the area of sexuality (CDC, 2009). Much research points to a gap in sexuality communication between parents and their adolescents and the significant predicting factors that lead to lack of sexuality parenting communication (Bogenschneider, Flood, & Raffaelli, 1998; Charmaraman & McKamey 2011; Elliot, 2010; Lefkowitz, Boone, Kit-fong Aul, & Sigman, 2003; Malcolm et al., 2013). These relevant factors include: parental beliefs about their adolescent's sexual activity, parental beliefs of adolescent's friends as sexually active, parental worries about sexuality, parental feelings of being or not being competent about communicating with their adolescent about sexuality, parental discomfort and
embarrassment about communicating about sexuality, parental beliefs that sexuality is private and not something to openly discuss, and parental beliefs that sexuality conversations do not fall within the parental role. Other factors include: parental ambivalence due to the preference of virginity until marriage, disconnection and unavailability of busy parents in the lives of their adolescents, parents waiting to communicate about sexuality until their adolescent approach them about sexuality, and adolescent’s resistance on speaking and listening to their parents regarding sexuality parenting, (Bogenschneider, Flood, & Raffaelli, 1998; Charmaraman & McKamey 2011; Elliot, 2010). These factors were shown to influence parents on deciding if they would communicate about sexuality, how to communicate, how much to communicate, and what values and messages to send to their adolescents about sexuality.

**Purpose Statement**

The objective of this project is to offer tools to increase effective communication regarding sexuality topics between Latina mothers and their teenage daughters. Keeping the lines of communication open may serve Latinas as a possible source of information regarding sexuality topics. Sexuality topics refer to and include; adolescent development, sexual intercourse, contraceptive methods, pregnancies, abortions, sexually transmitted infections, sexual orientation, sexual relationships, teenage pregnancy, masturbation, sexual identity, sexual morals, sexual beliefs and sexual values.

Alford (2006) suggests that when it comes to adolescent Latina sexuality, culturally appropriate health care services and public information include commitment to family support systems. Since culture is an important factor to consider in designing sexuality health care programs (Alford, 2006) a psychotherapy group was chosen as the
ideal therapeutic modality intervention. As an adequate intervention for Latina women, a psychotherapy women’s group is offered since psychotherapy groups are a great way for women to come together and explore sexuality topics in relation to culture and society (Brody, 1987; Jacobs, 2012; Walen & Wolfe, 2000). Psychotherapy groups are also seen as efficient since they can help several individuals at the same time and are a great way for members to provide mutual support and mutual problem-solving as well as learning opportunities from each other’s feedback (Jacobs, 2012; Liebmann, 1986). Further, psychotherapy groups are beneficial for adolescents (Jacobs, 2012) and Latinos/as (Organista, 2000).

The main theory of this psychotherapy group intervention is Cognitive Behavioral Therapy (CBT) since this theory works well with Latinos/as adolescents, families and psychotherapy groups (Gehart, 2013; Jacobs, 2012; Organista, 2000; Talashek, Norr, & Dancy, 2003). The CBT interventions used encompass several forms of psychoeducation which involves teaching clients about their problems and ways for handling those problems (Gehart, 2013; Jacobs, 2012). Besides following a Cognitive Behavioral Therapy framework a family systemic therapy approach is also embedded in this psychotherapy group curriculum.

As part of the family systemic perspective, intergenerational theory is one that explores family patterns and how these are passed down from generation to generation between families (Banowsky, 2001; Gehart, 2014; McGoldrick, Gerson, & Petry, 2008). Through the use of this intergenerational theory the psychotherapy group utilizes each mother-daughter dyad as a way to assess the family system. Another family system’s theory that is implemented is Emotionally Focused Therapy (EFT) which offers great
communication assessments and interventions for couples and families (Johnson et al., 2005).

The proposed psychotherapy group incorporates a parenting skills component through the implementation of Parent Effectiveness Training (P.E.T) (Gordon, 2000). This parenting model provides effective ways of communicating between parents and their children (Gordon, 2000) which is the goal of this psychotherapy group.

As a final component of this psychotherapy group, Art Therapy is included because creative therapy works well with families, adolescents, and psychotherapy groups including those that are mixed groups with both adults and children (Banowsky, 2001; Buchalter, 2009; Liebmann, 1986). Art therapy can be an avenue of communication and creative expression, the art projects are tangible and can be kept to be examined at a later time, art can also incorporate fantasy and the unconscious (Liebmann, 1986).

All of these therapy models and interventions are incorporated to create one psychotherapy group intervention to increase positive and healthy sexuality communication skills between Latina mothers and their daughters. Having open and effective communication and a positive relationship can help Latina mothers guide and prepare their teenage daughters to deal with their own sexuality as they grow into adulthood (Lamb, 2006; Satir, 1988; Rekers, 1995). Alford (2006) states that high self-esteem and communication skills in Latina adolescents are associated with positive sexual health practices such as using condoms and other contraception. Factors that contribute to high self-esteem among young Latinas include warm and supportive parent-child relationships and close and affectionate family relationships such as closer mother-child relationships, thus it is important to encourage family support within Latino
families rather than developing individualistic self-reliance (Alford, 2006). Due to these benefits of close familial relationships, improving communication skills and providing education about topics of sexuality to Latina mother and their daughters may lead to the narrowing of the communication gap that exists today regarding sexuality topics between Latina mother and their adolescent daughters.

**Definitions: Key Terms and Concepts**

The following key terms and concepts refer to those that are not directly related to the marriage and family therapy field or to key terms and concepts that have various meanings.

**Acculturation:** Acculturation is a dynamic and multidimensional process of adaptation that occurs when distinct cultures come into sustained contact. It involves different degrees and instances of culture learning and maintenance that are contingent upon individual, group, and environmental factors. Acculturation is dynamic because it is a continuous and fluctuating process and it is multidimensional because it transpires across numerous indices of psychosocial functioning and can result in multiple adaptation outcomes (Balls-Organista, Marin, & Chun, 2010).

**Adolescence:** The adolescent stage occurs between the approximate ages of 14-21 and it entails discovering one’s identity, transitioning through puberty, beginning development of sexual identity, beginning development of body image, increase the ability to handle intimate physical and social relationships and handle complex social situations, beginning development of the philosophy of life which includes their moral and spiritual identity (Carter & McGoldrick, 2005). Adolescence is also the fifth psychosocial stage of Erik Erikson’s life cycle stages where industry vs. identity confusion occurs where adolescents...
explore and discover who they are in relation to their society (Erikson, 1982).

**High Risk Sexual Behavior:** Unprotected vaginal, anal, and or oral-genital intercourse without the use of a latex condom from beginning of sexual contact to end of sexual contact (Rathus, Nevid, & Fichner-Rathus, 2005).

**Latina/o Population:** The Latina/o population can hold traditions that include Native American, African, and/or European cultures in a variety of ways such as adhering to Roman Catholicism or other Christian traditions and/or hold West African, Native American, and/or local belief traditions. Latinos may speak Spanish (with strong regional and national differences), a Native American language (such as Mayan), English, Portuguese, or they may speak some combination of these languages (Alford, 2006).

‘**Latino Catholicism**’: Refers to the way that Latinos/as practice Catholicism by incorporating their own cultural traditions (De La Torre, 2009).

**Safe Sexual Practices:** Refer to using highly effective contraceptive methods in avoiding pregnancy such as oral contraceptive pills, patch, vaginal ring, etc, as well as using latex female or male condoms to guard against sexually transmitted infections. Other practices include; having regular and routine medical screenings for sexually transmitted infections, washing genitals before and after sexual intercourse, and remaining sober during sexual intercourse to think clearly about safe sexual practices (Rathus, Nevid, & Fichner-Rathus, 2005).

**Sex:** Can refer to genital-genital contact (female-female, male-female, or male-male), oral-genital, anal-genital, and or anal-oral sex (Rathus, Nevid, & Fichner-Rathus, 2005).

**Sexual Education:** Sexual education in the United States can consist of either abstinence-only education or comprehensive sexual health education and each state has
their own laws pertaining to sex education (Zinth, 2007). Abstinence-only until marriage (AOUM) sexual education teaches the social, psychological, and health gains of abstaining from sexual activity until marriage (Trenholm et al., 2007). Comprehensive sexual health education consists of age-appropriate, medically accurate, and objective information for students of all races, genders, sexual orientations, ethnic and cultural backgrounds and students with disabilities. The sexuality topics include: sexually transmitted infections, methods of preventing pregnancy and sexually transmitted infections, abstinence information, etc, depending on the specific state’s laws on comprehensive sexual health education (California Department of Education, 2013).

**Sexuality:** Refers to the way that each individual experiences and expresses themselves as a sexual being. Sexuality includes sexual orientation which is the direction of one’s sexual interests toward members of the same sex, the other sex, or both. Sexuality also includes gender identity which refers to one’s personal experience of being male or female. Sexuality also refers to the way each person chooses to engage in sexual behavior which refers to physical activities that involve the body in the expression of erotic or affectionate feelings. Sexual behavior can also include masturbation (Rathus, Nevid, & Fichner-Rathus, 2005).

**Sexuality Related Risks:** Refer to risks that can occur as a result of sexual behavior (genital-genital contact, oral-genital, anal-genital, and or anal-oral) such as sexually transmitted infections (STI’s) and pregnancy (Rathus, Nevid, & Fichner-Rathus, 2005).

‘**Sexuality Related Topics’:** These topics refer to abortion, anal sex, contraception, coercive sex, high risk sexual behavior, masturbation, menstruation, oral sex, pornography, prostitution, puberty, rape, safe sex practices, sexuality, sexuality
communication, sexual curiosity, sexual desire, sex education, sexual harassment, sexual intercourse, sexuality related risks, sexual orientation, sexually transmitted infections, and unplanned teenage pregnancy (Rathus, Nevid, & Fichner-Rathus, 2005).

**Sexually Transmitted Infections (STI’s):** Sexually transmitted infections (STI’s) are infections passed through sexual contact such as penile-vaginal intercourse, anal intercourse or oral sex. STI’s include bacterial infections such as; Gonorrhea, Syphilis, and Chlamydia. STI vaginal infections include; Bacterial Vaginosis, Candidiasis (yeast infection), and Trichomoniasis. STI viral diseases include; Oral Herpes (HSV-1), Genital Herpes (HSV-2), Hepatitis A, B, C, and D, Human Immunodeficiency Virus (HIV), and Human Papilloma Virus (HPV). Finally, STI’s that are ectoparasitic infections include; Pediculosis (“crabs”) and Scabies (Rathus, Nevid, & Fichner-Rathus, 2005).
CHAPTER TWO: LITERATURE REVIEW

The extensive research available on the topic of sexuality supports the basis for a psychotherapy group intervention for Latina mothers and their adolescent daughters that can aim to increase their communication on sexuality related topics. Specific research on the Latina population is highlighted to point out the trends that support a need to target sexuality communication for Latina adolescents aged 11-17. In this review of the literature the themes pertaining to the foundation of a needed psychotherapy group curriculum are organized in a way that will portray the overall necessity for an intervention. This research will draw a complete picture taking into consideration the various factors that play a role in the sexuality of Latinas in the United States.

An exploration of contributing factors stemming from the Latino/a culture will be provided. These cultural factors include the dominant religion of Catholicism, immigration and acculturation, values, beliefs, and language. These cultural components are explored specifically in relation to how they influence and shape female sexuality for Latinas. The intended population is also specific to adolescent females thus a fundamental exploration of the sexual development of adolescents is provided. Following this developmental analysis is the sexuality related trends and statistics that discuss adolescent sexual activity. These trends illustrate the sexuality related risks that can derive from sexually risky behavior in the adolescent population. Overall the research on adolescent sexual activity depicts the gap that exists in sexual education for adolescents.

Sexuality related education in the public educational system is also analyzed to assess what sexual education is provided and how effective this education is in the adolescent population. Following the description of the current sexual education that
most Latina adolescents are receiving in the public school system a presentation of parenting themes are then described. As part of the exploration of the parenting component in adolescent sexuality the family life cycle stage of parenting adolescents is provided as a foundation. As part of the description of parenting adolescents, parenting on sexuality is also explored and includes a detailed analysis of parenting themes between Latina mothers and their adolescent daughters regarding sexuality. The Latina mother-daughter parenting themes are specifically discussed to illustrate the interactions and patterns that occur between Latina mothers and their daughters as well as alluding to their effectiveness and ineffectiveness of what works well while educating adolescent Latinas about sexuality.

The last portion of the literature review is a demonstration of the research regarding the therapeutic interventions that are included in the actual design of the psychotherapy group curriculum. These interventions derive from evidence based theories and practices to provide a scientific explanation of how these interventions will help the issue at hand and the Latina population. Overall the literature review provides a complete analysis of how the complex linkage between culture, school sexual education, and parenting interactions affect and shape adolescent Latina sexuality and how there is a current gap between Latina mothers and their daughters regarding sexual communication topics.

**Latino/a Culture in the United States**

The Latino/a community currently living in the United States is a diverse group that may include individuals who have emigrated legally or illegally from many Latin countries around the world. Here a detailed review is provided about the Latino/a
population with exploration of the most common cultural components of family life such as religion, values, morals, beliefs, and language. These cultural components of the Latino/a population are discussed in reference to how they specifically influence parental/adolescent general communication and relationships.

**Demographics.** The Latino population is the largest and fastest growing minority group in the United States; by 2020 it is estimated that one-quarter of all teens will be Latino (National Campaign to Prevent Teen and Unplanned Pregnancy, 2015). The Latino/a population of the United States as of 2011 according to the U.S Census Bureau (2012) was 52 million, making people of Latino origin the nation’s largest ethnic minority. The Latinos/a minority represent 16.7 % of the nation’s total population. The number of Latino family households in the United States in 2011 was 10.7 million. From these 10.7 million, 61.1% were married couple households that had children younger than 18 present in 2011. In California as of 2011 an estimated 14.4 million individuals were from Latino/a origin meaning Latinos represented more than 50% of the total California population. Further, in Los Angeles County alone, there were 4.7 million Latinos/as in 2010 (United States Census Bureau, 2012).

The Latino population can represent a variety of cultures since it is a highly diverse group that can be of Native American, Asian, European and/or African origin (Alford, 2006). Latinos can hold traditions that include Native American, African, and/or European cultures in a variety of ways such as adhering to Roman Catholicism or other Christian traditions and/or hold West African, Native American, and/or local belief traditions as well. Latinos may speak Spanish (with strong regional and national differences), a Native American language (such as Mayan), English, Portuguese, or they
may speak some combination of these languages (Alford, 2006). Thus since the Latino population in the United States is a very diverse group it requires mental health services that are culturally sensitive.

**Religion in the Latino Population**

Religion is an important part of the Latino/a population and the U.S. Gallup's Annual Minority Relations poll (2005) took a close look at the major religious affiliations of Latino/a Americans. Researchers found that nearly two-thirds of Latinos (63%) self-identified as Catholic, 16% said they were Protestant, 10% claimed other Christian faiths, and 6% stated that they had no religious affiliation. In terms of religious participation, 49% of Latinos/as stated that they attend religious services once a week or almost every week, 17% of Latinos/as stated that they attend at least once a month, and finally 32% of Latinos/as stated that they seldom or never attend church (Gallup, 2005).

The U.S. Pew Research Center also conducted a survey to study religious preference among a sample of 5,103 Latino/a adults (Funk & Hamar, 2014). More than half of Latinos/as (55%) identified themselves as Catholic, while most of the remainder were closely divided between Protestants (22%) and those who stated that they had no religious affiliation (18%) (Funk & Hamar, 2014). Both of the studies found that Catholicism is the dominant religion in the Latino/a population of the U.S. thus it is relevant to explore this dominant religion more thoroughly while still keeping in mind that this religious culture does not apply to all Latinos across the board as stated by Alford (2006).

**Catholicism and Sexuality**

All religions have their own view on human sexuality and the beliefs and values
that come with it. These sexuality values and beliefs dictate expectations on how to or
how not to express oneself as a sexual being. In terms of the Catholic religion, human
sexuality beliefs and values derive from the teachings of the Bible and the church’s
Magisterium (a hierarchy composed of the Pope and bishops) (West, 2000).

**Marriage and Sex.** The Catholic’s view on human sexuality has sexual morality
at its core which means that sexuality is about expressing God’s love through the body
(West, 2000). Sexual intercourse is seen as a participation of life and the love of God by
sharing the sexual connection with a marriage partner (West, 2000). Sex is also seen as a
gift from God where a married man and woman can give themselves to each other until
death separates them. Further, sex is seen as the marital embrace and a consummation of
the marital union and the vows that the couple processed to one another on their wedding
day (West, 2000). Sexual desire is seen as a powerful force that aims to help married
couples sexually engage in the participation of life and human existence by procreating
with one another through the sacrament of marriage (West, 2000). This concept of sex
describes what Catholicism regards as God’s original plan for sex (West, 2000).

Marriage in Catholicism is a very important sacrament since it is seen as an
“intimate, exclusive, indissoluble communion of life and love entered by man and woman
at the design of the Creator for the purposes of their own good and the procreation and
education of children” (West, 2000, p. 46). Within the marriage both husband and wife
have the responsibility to procreate and raise their children according to Catholic faith
(Paul VI, 1968). A Catholic marriage demands exclusivity and fidelity and rejects open
marriages and divorce since an indissoluble union can only be broken through death
regardless of the civil status of that marriage (Paul VI, 1968; West, 2000). A Catholic
Marriage is also only possible between a man and a woman and homosexual marriages (man married to a man and a woman married to a woman) are impossible. Homosexual marriages are believed to be impossible due to the inability to procreate children within that homosexual union (West, 2000).

**Sex Outside Marriage.** Catholicism views AIDS and other sexually transmitted infections, prostitution, pornography, unwed mothers, adultery, divorce and abortion as shameful and not as part of the accepted Catholic beliefs about sexuality (West, 2000). Even though the Catholic religion does not see sex as a dirty, evil, or as a bad act, it can be seen this way if engaged in outside of marriage; since sex is considered a sacred gift from God that is to be cherished and enjoyed only in a legitimate marriage (West, 2000).

Catholicism is against sex outside marriage because Catholics understand it to be a predictor of adultery in marriages, and adultery is understood to be a high predictor for divorce (West, 2000). Further, it is considered that someone who is engaging in sex outside marriage or while they are engaged to be married, to be ill-prepared for marriage since they are not valuing sex and practicing authentic love in the way Catholicism believes it should be done. Premarital sexual activity can also lead to self-indulgence that often hosts lust, pride, selfishness, dishonesty, and distrust (West, 2000).

In terms of rape, Catholicism views committing rape as wrong (West, 2000), and rape is seen as one of the few exceptions to the loss of virginity outside of marriage (in case the person was virgin) since rape was not desired by the victim (Paul VI, 1968). All of these Catholic sexuality values and beliefs refer to the virtue of chastity that dictates how sexuality should be expressed outside and within Catholic holy matrimony (West, 2000).
**Chastity/Virginity.** Chastity refers to virtue that frees sexual thoughts, desires, and behaviors from being self-seeking and instead directs them to real authentic love both outside and within marriage (West, 2000). Virginity is seen as a form of chastity, specifically referred to as genital chastity, which is the state of a person who has not had sexual relations. The term virginity can be used to describe both men and women however it is mostly honored in women as measurement of religious virtue, physical integrity, and spiritual purity (Camelot, 2003; O’Riordan, 2003). Premarital virginity has been and is still expected for Catholic women before marriage however the punishments for the violation of this religious belief have changed throughout the centuries. Some of the punishments that used to be carried out against women who had sexual relations outside of marriage were excommunication, being forced to marry the man who she engaged in sexual relations with, or death (Camelot, 2003). Virginity before marriage is expected mainly because sex outside of marriage can lead to procreation outside the marriage union, which is not acceptable in Catholicism (Camelot, 2003).

Catholicism accepts that humans are by nature sexual beings whom have specific sexual desires or drives (O’Riordan, 2003). It is also understood that sexuality affects the entire individual, social, and religious life of humans (O’Riordan, 2003). Even though sexuality is accepted as natural, social and religious morality dictate that self-moderation and self-regulation be followed when it comes to sexuality in order to live with moral virtue. Therefore, chastity is seen as both a gift of the Holy Spirit and a task of self-discipline (O’Riordan, 2003).

**Masturbation and Pornography.** Certain sexuality expressions such as masturbation and pornography are not allowed nor considered chaste. Catholicism views
masturbation as a disorder that is wrong, even for adolescents (West, 2000). Masturbation is led by immaturity, the force of habit, anxiety and other psychological factors; it symbolizes self-pity, fear of abandoning oneself to another, and isolation. Masturbation is considered a self-seeking, self-gratifying sexual indulgence that is not accepted since according to Catholicism sex is to be shared with another person and only for the purpose of fertility and procreation not for self-pleasure (West, 2000).

Pornography is considered wrong and not a part of chastity outside or within marriage for both men and women due to the underlying lust it inspires (West, 2000). Pornography is considered going against the purpose of sex and true love according to the Catholic faith since it leads people to treat and see each other as sexual objects rather than human beings. Pornography can ruin the sexual relationship within a marriage and the marriage itself (West, 2000).

**Contraception and Abortion.** Catholicism does not accept contraception since marriage is seen as the sacrament that is designed to require procreation through God’s gift of sex (Paul VI, 1968). Thus each and every marital act must retain its intrinsic relationship and responsibility to the procreation of human life (Paul VI, 1968). Catholicism believes that new life is not the result of each and every act of sexual intercourse but rather that God has created laws of nature in which the incidence of fertility sometimes occurs and sometimes does not in a natural way without the need for contraception (Paul VI, 1968).

Catholicism views human life as sacred thus any method and means to prevent or interrupt procreation, whether permanent or temporary, are not accepted as God’s natural way of managing procreation (Paul VI, 1968). Because of these beliefs, abortion and
artificial contraceptive methods are seen as unacceptable in the catholic religion (Paul VI, 1968). The only natural method that Catholicism recognizes as an acceptable way to manage the amount of children or timing of these within a Catholic marriage is that of using the natural cycle of the reproductive system by engaging or avoiding sexual intercourse during the fertile days of that natural menstrual cycle (Paul VI, 1968). This method is recognized as legitimate since it does not interfere with the moral principles of procreation, life, and the sexual relationship within the marriage (Paul IV, 1968).

Another reason why contraception is not accepted by the Catholic religion is because it is believed that a man who becomes accustomed to the use of contraceptive methods may forget the respect and admiration that is due to a woman by disregarding her physically and emotionally and instead reduce her to only being an instrument for the satisfaction of his own sexual desires (Paul IV, 1968). All of these Catholic sexuality beliefs and values shape gender roles and norms within the Latino culture. They dictate many aspects of life that may or may not be related to sexuality directly.

‘Latino/a Catholicism’. ‘Latino/a Catholicism’ refers to the way that Latinos/as practice Catholicism by incorporating their own cultural traditions (De La Torre, 2009). ‘Latino/a Catholicism’ tends to be family-centered where ‘la familia’ (the family) typically becomes the primary place of religious nurture and formation. This is reinforced with the implementation of household religious practices such as table prayer, moral instruction, storytelling, and regulated behavior associated with beliefs and or superstitions. Another religious practice that is common is the placement of religious iconography in Latino/a Catholic households such as the Last Supper, Jesus’ Crucifixion, the Sacred Heart, the Blessed Virgin, etc (De La Torre, 2009).
Religious devotion is also expressed in the family in many ways such as children and young people regularly asking or receiving blessings by older relatives. Language is another way to express Catholic devotion through the use of everyday expressions for example; “Gracias a Dios” (Thanks to God), “Si Dios y la Virgen lo permiten” (If it is the will of God and the Virgin) among many others (De La Torre, 2009). “Latino/a Catholicism’ also tends to have great admiration for and devotion to the Virgin Mary and saints (De La Torre, 2009).

‘Marianismo’. Catholicism has greatly influenced what role women play within society through an idealized image of the Virgin Mary, hence the term ‘marianismo’ (De La Torre, 2009). The Virgin Mary is presented and accepted as the best representation and perfect role model for Latina women. ‘Marianismo’ encompasses female passivity, chastity, purity, being docile and self-sacrificing. Because of this, women in Latino families tend to oversee and improve the well-being of the family and its future prosperity by putting the family before their own needs and concerns at times and by generally mimicking the Virgin Mary who silently accepted her faith and suffering (De La Torre, 2009).

This religious female gender role requires women to hold the sole purpose of supporting their husbands and raising their children by ultimately being the giver of care and pleasure not the receiver of these. Through ‘marianismo’ the value of women and life purpose is placed in being virgins, wives, or mothers. Since ‘marianismo’ sees sex for women as only for reproduction and not for enjoyment, this female gender role deprives Latina women of being independently minded, self-supporting, and without an independent sexual identity (De La Torre, 2009).
Familial Life in the Latino Culture

Besides religion being an important factor and determinant of the many day to day living practices of Latinos/as, there are other cultural components that are not directly associated with religion. These cultural components refer to values of familism and when it comes to immigrant Latino families’ acculturation plays a role in this familial value.

‘La Familia’/Familism. Latino families affiliate by extending the nuclear family through a set of relationships that are maintained across generations and geographic locations (De La Torre, 2009). ‘La familia’ (the family) may be composed of parents, siblings, grandparents, aunts and uncles, cousins, and other relatives within an extended network of genetic kinship (De La Torre, 2009). ‘La familia’ may often also affiliate and include individuals who have significant roles to the family without biological or marital affiliation (i.e. godparents), through the meaningful relationships that they form and hold. ‘La familia is also seen as the primary place of religious nurture and formation (De La Torre, 2009).

Within a Latino family, children do not actively participate in family decision making since their input in matters relating to the household and their own upbringing is rarely sought (De La Torre, 2009). This is different in the case of acculturation because children of immigrant families often become social links between their parents and the North American U.S. society. Children become social links since they possess the capacities for both linguistic and cultural translation which in turn may place these children at the core of the family (De La Torre, 2009).

Acculturation in Latino Families

“Acculturation is a dynamic and multidimensional process of adaptation that
occurs when distinct cultures come into sustained contact. It involves different degrees and instances of culture learning and maintenance that are contingent upon individual, group, and environmental factors. Acculturation is dynamic because it is a continuous and fluctuating process and it is multidimensional because it transpires across numerous indices of psychosocial functioning and can result in multiple adaptation outcomes” (Balls-Organista, Marin, & Chun, 2010, p. 105). There are many factors that influence acculturation including both cognitive and behavioral factors (Martinez, 2014). Cognitive factors can include personal beliefs, perceptions, values, and attitudes one expresses, among many others. Behavioral factors that influence acculturation may include language spoken in the home, following customs and holiday practices, dietary practices, listening and viewing habits for television or radio, and social behavioral practices in which one engages, etc (Martinez, 2014). ‘Heritage Consistency’ is a concept that describes the degree to which one’s lifestyle reflects his or her culture (Martinez, 2014). ‘Heritage Consistency’ believes that since acculturation is continuous and cumulative over time, generational differences influence the level of acculturative practices meaning that with each generation, there is a greater degree of acculturation (Martinez, 2014).

There are four ‘acculturation models’ or ‘acculturative strategies’: ‘assimilation’, ‘separation’, ‘marginalization’, and ‘integration’ (Balls-Organista, Marin, & Chun, 2010). These ‘acculturation models’ are based on two dimensions; one dimension reflects the individual’s positive or negative attitude toward maintenance of the heritage culture and identity. The second dimension classifies the individual, also from a negative to positive continuum, in terms of the preferred level and type of interaction with another group or groups (Balls-Organista, Marin, & Chun, 2010). ‘Assimilation’ refers to when
an individual wishes to decrease the significance of their culture of origin and instead desires to identify and interact primarily with the other culture (typically with the dominant culture if one comes from an ethnic minority group) (Balls-Organista, Marin, & Chun, 2010). ‘Separation’ refers to when an individual wishes to hold on to their original culture and wishes to evade the other culture thus they avoid interacting or learning about the other culture(s). ‘Marginalization’ refers to individuals that show little involvement in maintaining the culture of origin or in learning about the other culture(s). Finally, ‘integration’ refers to when an individual shows an interest in maintaining the original culture and in learning and participating in the other culture(s) as well (Balls-Organista, Marin, & Chun, 2010). Overall, acculturation promotes the development of bicultural individuals where individuals can learn the attitudes, values, behavior, and other cultural aspects of the ethnic groups with whom they interact (Balls-Organista, Marin, & Chun, 2010).

Since many Latino families emigrate to the U.S. from various countries they are faced with difficulties of acculturation. Discrimination is a difficulty that immigrant Latino families may experience and may exacerbate risk factors for immigrant youth since discrimination and racism have a negative impact on a child’s sense of self-esteem, leading to depression and poor mental health as well as involvement in risky behaviors (Martinez, 2014). Adolescents, as part of their developmental stage, become more aware of the disadvantages and oppression Latino/as experience having an immigrant status in the U.S. (Ambert, 2001). Immigration can also influence family relationships for example when adolescents experience discrimination from their peers or in their community, based on their immigrant and minority status, they tend to have more conflict with their parents.
as they take home the stressors from being discriminated against often blaming their parents for their minority status and disadvantages in the U.S. (Ambert, 2001).

Additionally, adolescents may feel resentment towards their parents for bringing them to a foreign country from the one they have known (if they were born and raised in another country previously). These feelings of resentment can hinder and block communication between adolescents and their parents on all levels due to the negative feelings surrounding the relationships (Ambert, 2001).

Another possible factor that may affect the communication between parents and adolescents in immigrant families is disagreement of immediate familial goals (Ambert, 2001). Adolescents are more concerned with peer acceptance during adolescence whereas parents are mostly concerned with their adolescent’s school performance (Ambert, 2001). Amber (2001) explains that immigrant adolescents have an even higher desire for acceptance from their peers than other non-immigrant adolescents due to the intense desire to belong. This desire often influences immigrant parents to feel rejected by their adolescents as their teens strive for acceptance from their peers and often adopt ways of living and thinking that go against or deviate from their familial Latin cultural norms (Ambert, 2001).

It is also important to note that immigrant parents often value family cohesiveness with their children more so than parents born in the U.S. due to immigrants often having no other familial ties in the U.S. other than their children (Ambert, 2001). This emphasis on family cohesiveness can drive Latino/a immigrant parents to cultivate and nourish the parent-adolescent relationship in order to continue the family cohesiveness that is so important to them. In addition, immigrant Latino families emphasize cultural traditions
such as strong family connection and respect which can provide meaning and purpose for children and adolescents and potentially protect them from risky behaviors (Ambert, 2001).

Through acculturation immigrant Latino families can strengthen the parent-adolescent relationships by incorporating certain values and beliefs from the host culture and retain other components from their original Latin culture (Amert, 2001). Acculturation can provide families with a positive outcome since according to Ambert (2001) immigrant families do well when they combine economic and educational adaptation from the U.S. and retain their core family and religious values as well as their ethnic identity from their country of origin. This may be helpful because cultural continuity helps adolescents and their families to have more positive relationships since the adolescents do not reject their parent’s culture. It is also based on the tendency to have more emotional acceptance and support at home towards each other and also the tendency to hold more respect for parental authority. As a result, these positive relationships between adolescents and parents motivate the adolescent to achieve higher education and meet parental expectations (Ambert, 2001).

When it comes to Latina adolescents, even with acculturation many retain allegiance to their Latino familial values (Alford, 2006). These familial values in turn deem important for guiding young Latinas in developing a strong sense of family interdependence along with being socially well-adjusted and having high motivation for higher education (Alford, 2006).

The mentioned components of the Latino culture often influence the way that Latino parents choose to educate, discipline, and communicate about sexuality with their
children. An extensive review of the parenting communication patterns that show how Latino culture influences sexuality conversations between Latino parents and their adolescents is given in another section of this literature review. Before further exploring parenting factors and interactions, adolescent sexuality is explored to understand how adolescents develop their sexuality.

**Adolescent Sexual Development**

Human sexuality is the way in which humans experience and express themselves as sexual beings (Rathus, Nevid, & Fichner-Rathus, 2005). Gender, gender identity, sexual orientation, and sexual values are all a part of human sexuality and influence sexuality in many ways. Sex refers to the biological features related to male or female body parts whereas gender identity refers to one’s personal experience and the social construction of being male or female (Rathus, Nevid, & Fichner-Rathus, 2005). Sexual orientation refers to the direction of one’s sexual interests, either toward members of the same sex, the opposite sex, or both. Sexual values are qualities in life that are deemed important, unimportant, right, or wrong, by family, culture and society, etc. and these may dictate our sexual thoughts and actions (Rathus, Nevid, & Fichner-Rathus, 2005).

**Puberty.** Puberty is a period of rapid physical changes in early adolescence during which the reproductive organs mature (Crooks & Baur, 2005). Puberty starts at the beginning of the appearance of secondary sex characteristics (i.e. breasts, wider hips and larger buttocks in women and muscle mass and deepening of the voice in males) as the body prepares for reproduction (Rathus, Nevid, & Fichner-Rathus, 2005). The main marker of puberty for females is menarche, (the first menstruation). Girls typically experience menarche between the age of 10-18. During puberty, females’ pituitary gland
increases the production of estrogen which stimulates growth of breast tissue, growth of the uterus, thickening of the vaginal lining, and growth of fatty and supportive tissue in the hips and buttocks (Rathus, Nevid, & Fichner-Rathus, 2005). Along with estrogen, androgen production increases which stimulates development of pubic and underarm hair for females. Internal female organs develop such as the ovaries which begin to release mature eggs capable of being fertilized that can lead to pregnancy.

During puberty, males’ pituitary gland increases the production of testosterone which stimulates the growth of the testes, scrotum, and penis (Rathus, Nevid, & Fichner-Rathus, 2005). Testosterone also promotes growth of facial, body and pubic hair, and the deepening of the voice. By age 13 or 14 erections become frequent, semen production begins, and the first ejaculatory experience typically occurs by this age (Rathus, Nevid, & Fichner-Rathus, 2005).

**Sexuality Development.** Adolescence is a period of exploration when both self-stimulation and partner-shared stimulation generally increases (Crooks & Baur, 2005). Sexual orientation as part of sexuality is also developing during this stage and many adolescents come to identify themselves as gay, lesbian, bisexual, or heterosexual (Crooks & Baur, 2005). Many homosexual adolescents do not act on their sexual feelings until adulthood, and some adolescents experiment with their sexual orientation and have one or more early homosexual experiences but do not generally identify themselves as homosexual (Crooks & Baur, 2005). Homosexuals can frequently encounter adverse societal reactions to their sexual orientation such as verbal or physical assault, family or peer emotional rejection; all of these reactions may make it difficult for homosexual adolescents to feel comfortable with their developing sexuality (Crooks & Baur, 2005).
Masturbation refers to self-stimulation of the genitals for purposes such as relieving sexual tension and obtaining sexual pleasure (Rathus, Nevid, & Fichner-Rathus, 2005). Masturbation is also an excellent way to learn about one’s own body and its sexual potential; furthermore, adolescents can increase their self-knowledge which can be helpful during sexual interactions with a partner (Crooks & Baur, 2005). Kingsley and his colleagues (as cited in Rathus, Nevid, & Fichner-Rathus, 2005) found that masturbation is the primary means of achieving orgasm during preadolescence for both boys and girls; 45% of males and 15% of females masturbated by age 13. Pinkerton (as cited in Rathus, Nevid, & Fichner-Rathus, 2005) found that the frequency of masturbation in adolescent males and females was connected with social norms that appear to hold that masturbation is more acceptable or normal for males than females.

During adolescence males and females may engage in noncoital sexual expression to express affection, satisfy their sexual curiosities, heighten their sexual arousal, and or reach orgasm while avoiding pregnancy and maintaining virginity (Rathus, Nevid, & Fichner-Rathus, 2005). Noncoital sexual expression may include kissing, holding, hugging, touching, manual stimulation, or oral-genital stimulation (Crooks & Baur, 2005).

**Adolescent Sexuality.** Many factors may motivate adolescents to engage in sexual intercourse such as sex hormones (especially testosterone), increase in sexual desire, sexual curiosity, and a sense of sexual readiness (Crooks & Baur, 2005). Adolescents whose secondary sex characteristics developed early may begin dating earlier which may lead to engaging in sexual intercourse earlier (Rathus, Nevid, & Fichner-Rathus, 2005). Adolescents may not perceive sex the same way as adults do
Adolescents often believe sex can be justified as a new experience, a sign of maturity, a form of peer-group conformity, a challenge to parents or society, and or as an escape from the pressures of life (Sharpe, 2003). Further, what adults often call promiscuity, adolescents may see as normal sexual exploration (Sharpe, 2003). What adults term as risky sexual behavior (i.e. not using condoms during sexual penetration) adolescents may view these behaviors as a sign of a trusting, loving relationship (Sharpe, 2003).

Adolescents are mostly concrete thinkers who lack the ability to think abstractly about the future, this concrete thinking may result in poor decision making especially regarding sex (Sharpe, 2003). Sexually active adolescents may be concerned more about what a partner thinks of them and what is going on in the sexual moment rather than about the long-term outcomes and consequences of their behavior (Sharpe, 2003). Sexual knowledge and critical thinking skills are valuable in allowing adolescents to make informed sexual decisions. Increased sexual knowledge may perhaps help adolescents make up for the cognitive development they still lack at this life stage. Other skills may also help adolescents in leading a healthier sexual lifestyle, for example, Davis and Niebes- Davis (2010) found that adolescents who can envision positive futures for themselves are more likely to maintain healthier sexual behaviors and to avoid or reduce sexual risk-taking.

**Sexual Activity among Adolescents**

Some adolescents start engaging in sexual activity during their years of adolescence. The CDC (2012) found in a self-report survey that about 47% of high school students reported ever having had sexual intercourse (vaginal or anal). About 33% of 9th-
grade students reported ever having had sexual intercourse, compared with 44% of 10th-
grade students, 53% of 11th-grade students, and 63% of 12th-grade students (CDC, 2012). The proportion of students who reported ever having had sexual intercourse declined from 1991 (54%) to 2001 (46%) and remained relatively stable from 2001 to 2011.

Female Adolescents. In 2002, 30% of female adolescents aged 15–17 years reported ever having had sex (penile- vaginal intercourse), compared with 70.6% of those aged 18–19 years old (CDC, 2009). Among these same female teenagers aged 15–19 years, 13.1% of females reported having had sex before they were 15 years of age (CDC, 2009). In terms of coercive sex, 9.6% of females aged 18–24 years who had sex by age 20 reported that their first sexual intercourse was non-voluntary (CDC, 2009). Forced sexual intercourse was reported by 14.3% of females aged 18–19 years (CDC, 2009).

Considering ethnicity, trends among female adolescents 15–19 years old, 40.4% of Latina females reported ever having had sex, compared with 46.4% of white females and 57.0% of black females (CDC, 2009). Approximately 22.9% of black adolescent females aged 15–19 years, compared with 11.6% of white females reported engaging in sexual intercourse before the age of 15 (CDC, 2009). Among adolescent females aged 15–19 years, Latinas were more likely (35.2%) than whites (19.6%) and blacks (19.0%) to report having had sex for the first time with a partner who was substantially older (1-4 years older) (CDC, 2009).

Male Adolescents. For adolescent males aged 15–17 years, 31.6% reported ever having had sex, compared with 64.7% of those aged 18–19 year (CDC, 2009). Among these same male teenagers aged 15–19 years, 14.8% of males reported having had sex
before they were 15 years of age (CDC, 2009).

**Contraceptive Use among Adolescents**

The CDC (2009) studied the usage of contraception among teenagers and found that among never-married adolescents aged 15–19 years who were sexually active, 75.2% of females and 82.3% of males reported using a method of contraception during their first intercourse. In 2012 the CDC found that about 18% of students who had sexual intercourse in the past three months, reported that they or their partner had used birth control pills before their last sexual intercourse, and 60% reported condom use.

According to the CDC (2009) condom use during first intercourse was reported by 67.5% of females and 70.7% of males ages 15-19. Condom use increased from 46% in 1991 to 63% in 2003, then remained relatively stable through 2011 (CDC, 2012). Considering ethnicity among these same adolescent females aged 15–19 years (who reported being sexually active), 40.8% of Latinas reported using no method of contraception at last intercourse, compared with 25.2% of blacks and 10.3% of whites (CDC, 2009).

Kelly and Kalichman (1995) discuss the various factors that contribute to lack of condom use in adolescent sexual relationships such as coercive sex, which involves power differentials in heterosexual relationships where women feel that they cannot voice their desire to practice safe sex with their partners. Alcohol and drug use is also another factor that may influence a female to not practice safe sexual interactions due to the lower inhibitions that alcohol causes, decrease in judgment, etc. Mood states such as loneliness, depression, and elation can also influence safe sex practices (Kelly & Kalichman, 1995).

**Latinas and contraceptive use.** The CDC (2012) gathered data of self-reported contraceptive methods used by Latinas ages 15-19 resulting in an unintended pregnancy
in the United States. Twenty point four percent used highly effective contraceptive methods (i.e. oral contraceptive pills, patch, vaginal ring), 26.3% used moderately effective methods (i.e. male condom), 4.0% used less effective methods (i.e. withdrawal method and the rhythm method), and 49.3% used no method (CDC, 2012).

The CDC (2012) also gathered data of self-reported reasons Latinas ages 15-19 did not use contraceptives across the United States. Forty-two percent reported; “I thought I could not get pregnant at the time”, 24.5% reported; “my partner did not want to use contraception”, 24.4% reported; “I did not mind if I got pregnant”, 10.7% reported; “I had trouble getting birth control”, 4.2% reported; “I did not use contraception due to the side effects from contraception”, and finally 7.6% reported; “I thought my partner or I was sterile” (CDC, 2012). These self-reported reasons shed light into the way that adolescent Latinas may be viewing contraceptive methods and how and why they choose or not choose to use these methods in preventing teenage pregnancy. Overall these statistics show a need for increase safe sexual practices in the Latina population.

**Adolescent Sexuality and Technology**

A recently new area of adolescent sexuality has been introduced with the spread of internet connection and technological advances. Although there are different types of ‘sexting’ (consensual, nonconsensual) (Gillespie, 2013), the type of ‘sexting’ referenced here is consensual. Consensual ‘sexting’ refers to self-generated material that a person sends via text messages such as pictures of themselves where they present as either nude, semi-nude or of a sexual act (Gillespie, 2013). Some see ‘sexting’ as a combination of sexual expression and modern communication technologies while others see it as a form of exploitation and child pornography (Gillespie, 2013).
‘Sexting’ can shape teenagers’ sexuality in many ways; some may be negative and others positive. According to Gillespie (2013) adolescents are engaging in ‘sexting’ to avoid sexual intercourse because of the risks associated with sexual intercourse such as sexually transmitted infections. Another explanation that Gillespie (2013) describes is that ‘sexting’ is part of the dating process for adolescents and that it may relate to the over sexualized culture that adolescents are exposed to. One of the negative effects of ‘sexting’ is the possible widespread dissemination of the explicit images by the recipient of these. This widespread dissemination can occur by sending explicit images which can be rapidly shared through the vast communication systems that exist in today’s technological world. The public dissemination of these images can lead to potential distress and psychological harm of the adolescent in the image, and these widespread images can lead to bullying and harassment (Gillespie, 2013).

Mitchell, Finkelhor, Jones, and Wolak (2012) researched adolescents’ exposure to sexually explicit images sent by technological devices or internet commonly known as ‘sexting’. A national telephone survey of 1,560 minors aged 10-17 revealed that roughly 7.1% had received “nude or nearly nude” pictures or videos (Mitchell et al., 2012). About 2% of the adolescents surveyed had appeared in or created such images, while 5.9% reported receiving sexually explicit images such as naked breasts, genitals, or buttocks. Females were more likely to create or appear in such images. Over half of such images were generated between senders and recipients as part of a romantic relationship. Twenty-one percent of respondents who created or appeared in images reported feeling very or extremely upset, embarrassed, or afraid as a result of ‘sexting’ (Mitchell et al., 2012).
The importance of integrating the education regarding this form of sexual expression may increase as adolescents increasingly practice ‘sexting’ as part of their sexuality development. It may be crucial for adolescents to become more fully aware of the possible risks of engaging in ‘sexting’ since it can lead to many dire effects that can impair their quality of life. As the culture of adolescent sexuality evolves, preventative education needs to develop simultaneously to provide adequate sexual education that meets the sexual educational needs of each adolescent in the U.S.

**Risks Related to Adolescent Sexual Behavior**

During adolescence both males and females face opportunities or pressure from others to engage in sexual activities during their adolescent years. These sexual activities, if unsafe, can lead to a number of negative consequences such as sexually transmitted infections (STI’s). Sexually transmitted infections are infections passed through sexual contact such as vaginal intercourse, anal intercourse or oral intercourse (Rathus, Nevid, & Fichner-Rathus, 2005). STI’s include bacterial infections such as; Gonorrhea, Syphilis, and Chlamydia. STI vaginal infections include; Bacterial Vaginosis, Candidiasis (yeast infection), and Trichomoniasis (Rathus, Nevid, & Fichner-Rathus, 2005). STI viral diseases include; Oral Herpes (HSV-1), Genital Herpes (HSV-2), Hepatitis A, B, C, and D, Human Immunodeficiency Virus (HIV), and Human Papilloma Virus (HPV). Finally, STI’s that are ectoparasitic infections include; Pediculosis (“crabs”) and Scabies (Rathus, Nevid, & Fichner-Rathus, 2005). Some of these STI’s can also be contracted by other means other than vaginal, anal or oral intercourse (Rathus, Nevid, & Fichner-Rathus, 2005). The Centers for Disease Control (CDC, 2013) point out that young people aged 15-24 account for 50% of all new sexually transmitted infections.
**HPV.** The Human Papillomavirus (otherwise known as HPV) is the most common sexually transmitted infection in the U.S. and the most common in people in their late teens and early twenties (CDC, 2013). HPV unfortunately may cause detrimental effects such as genital warts, cancer of the vulva, vaginal cancer, penis cancer, cancer in the anus and or oropharyngeal cancer (throat cancer) (CDC, 2013).

In recent years, two vaccines to protect against four different strains of HPV (6, 11, 16, and 18) were approved by the U.S. Food and Drug Administration in June 2006 for females and males between the ages of nine and twenty-six (Markowitz et al., 2013). Before the HPV vaccine introduction, the prevention and treatment of HPV-related diseases imposed an estimated of $8 billion or more in direct costs in the United States each year (CDC, 2014). Studies have shown that the HPV vaccines are cost-effective especially when young females receive the vaccine around the age of 12 (CDC, 2014). The Advisory Committee on Immunization Practices recommends routine vaccination (3-dose series) of females ages 11 to 12, and catch-up vaccination for females ages 13 to 26 who have not been previously vaccinated to avoid the transmission of the HPV virus (Markowitz et al., 2013). Since this vaccine was introduced in 2006 it has decreased the prevalence of HPV by 56% among female adolescents aged 14-19 in the U.S. (Markowitz et al., 2013). For males, it is advised by the Advisory Committee on Immunization Practices, routine vaccination (3-dose series) at age 11 or 12 years and through age 21 if not vaccinated previously to avoid the transmission of HPV (CDC, 2014).

Even though this HPV vaccine has shown to be effective, only one third of teenage adolescents ages 13-17 have utilized this vaccine (Markowitz et al., 2013).
Considering ethnicity trends, the CDC (2013) found that the estimated HPV vaccination coverage (3 dose series completion) among female adolescents aged 13–17 in the year 2012 was 71.8% of white female adolescents, 63.7% of black adolescents, and 59.3% of Latina adolescents. For adolescent males aged 13-17 the estimated HPV vaccination coverage in 2012 was 45.2% among whites, 27.8% among blacks, and 27.8% among Latinos (CDC, 2013).

**Other STI’s.** Other STI’s with detrimental effects are Chlamydia and Gonorrhea; both serious sexually transmitted infections that can impact a woman’s ability to have children (CDC, 2012). If left untreated, Chlamydia and Gonorrhea can cause severe permanent damage to the woman's reproductive organs (CDC, 2013). Chlamydia is most common among young people and it is estimated that one in 15 sexually active females aged 14-19 has Chlamydia (CDC, 2013). Gonorrhea was the second most commonly reported STI in 2006 (CDC, 2009). Among adolescents aged 15–19, the highest rates of Chlamydia and Gonorrhea occurred among black females (CDC, 2009).

**Latinas and other STI’s.** Latinas ages 10-14 in 2012 accounted for 1,400 new reported Chlamydia infections CDC (2014). In the same year of 2012 Latinas ages 15-19 accounted for 41, 389 new reported Chlamydia. Latinas ages 10- 14 accounted for 156 new reported Gonorrhea for Latina females ages 15-19 in 2012 (CDC, 2014). There were no new reported Syphilis infections for Latina females ages 10-14 in 2012 however there were 28 new reported Syphilis infections for Latina females ages 15-19 in 2012 (CDC, 2014). These data statistics shed light into the necessity of prevention methods to ensure that no Latina receives a diagnosis that can cause fertility issues, cancer or other detrimental effects in their quality of life.
HIV. The Human Immunodeficiency Virus (HIV) is a serious and possibly deadly STI for which there is no cure. In 2006, a total of 2,194 persons (668 females and 1,526 males) in the United States aged 10–24 years received a diagnosis of HIV (CDC, 2014). According to the CDC (2014) youth aged 13 to 24 accounted for an estimated 26% of all new HIV infections in the United States in 2010. Most new HIV infections among youth occurred among gay and bisexual males; with a 22% increase in estimated new infections in this group from 2008 to 2010 (CDC, 2014). Among youths aged 10–14 years, more diagnoses were received by females (44%) than by males (30%) (CDC, 2009).

When considering ethnicity, in 2010 black youth accounted for an estimated 57% of all new HIV infections among youth in the United States, Latino/a 20%, and white youth 20% (CDC, 2014). By the end of 2010, an estimated 11,731 youth with an AIDS diagnosis had died in the United States (CDC, 2014). Among adolescents and young adults who reported being sexually active, black females aged 20–24 years were more likely (62.4%) to have ever been tested for HIV, STIs, or both compared with 47.9% of Latina females and 45.4% of white females (CDC, 2009).

According to the CDC (2014) there are many risk factors that contribute to the contagion of HIV in the adolescent population. One of these challenges is the low perception of risk, in which many adolescents and adult youth (ages 18-24) are not concerned with contracting HIV, and thus avoid preventative measures such as proper condom use. Low rates of condom use are an important factor; for example in a 2011 survey 40% of the 34% of high school students reporting sexual intercourse in the previous 3 months did not use a condom (CDC, 2014). High rates of STI’s also contribute to an increased chance of contracting HIV in the adolescent and adult youth since the
presence of an STI greatly increases a person’s likelihood of acquiring or transmitting HIV (CDC, 2014).

Another challenge pertains to low rates of testing; for example in a 2010 survey only 35% of adults aged 18 to 24 had been tested for HIV (CDC, 2014). Substance use has also been linked to HIV infection because substance users are more likely to engage in high-risk behaviors (such as sex without a condom) when they are under the influence of drugs or alcohol as well as the use of contaminated needles (CDC, 2014). Homelessness in adolescence and youth can play a role since many of these homeless teens become dependent on drugs and thus exchange sex for drugs, money, or shelter (CDC, 2014). Feelings of isolation is also a risk factor that can affect all adolescents and adult youth however gay and bisexual high school students may engage in risky sexual behaviors and substance abuse because they may feel highly isolated and with lack support from family because of their homosexual orientation (CDC, 2014). Finally inadequate HIV prevention education is a challenge since young people are not always given effective HIV interventions or prevention education. This may be especially absent in young gay and bisexual youth since some sex education programs exclude information about sexual orientation (CDC, 2014).

Latinos/as and HIV. In 2011 there were an estimated 7,266 new HIV diagnoses in Latinos (adult and adolescents) from male-to-male sexual contact, there were an estimated 707 HIV diagnoses from injection drug use in Latinos, and an estimated 979 HIV diagnoses for Latinos from heterosexual contact (CDC, 2013). In Latinas (female adults and adolescent) there were an estimated 252 HIV diagnoses from injection drug use, and 1,522 new HIV diagnoses from heterosexual contact in 2011 (CDC, 2013).
There were 290 new reported HIV infections of Latina females ages 13-24 in 2010 (CDC, 2014). Estimated HIV diagnoses of Latino/a children 13 years or younger were 34 in 2008, 35 in 2009, 42 in 2010, and 25 in 2011 (CDC, 2013). An estimated 3,001 Latinos/as (both men and women of all ages) diagnosed with HIV died in 2008, 2,975 in 2009, and an estimated 2,846 in 2010 (CDC, 2013).

Kelly and Kalichman (1995) state that in efforts to deal with and decrease the HIV epidemic, high-risk sexual behavior needs to be targeted first. This preventative topic is important since many adolescents are not receiving and have not received adequate and accurate information for their sexuality needs. The effects are as mentioned, sexually transmitted diseases that can hinder the quality of life of a person or cut it short.

**Teen Pregnancy.** Another effect of high-risk adolescent sexual behavior is that of teenage pregnancy. Pregnancies among adolescents are very likely to be unintended (unwanted or mistimed) at conception (CDC, 2009). In 2002, 88% of births from females aged 15-17 years during the preceding 5 years were the result of unintended pregnancies (CDC, 2009). In 2006, a total of 435,436 births occurred to adolescent mothers aged 15–19 years (CDC, 2011). In 2009 approximately 4% of females aged 15-19 gave birth (CDC, 2011). According to the Child Trends Data Bank (2014), during 1990–2009, pregnancy rates for U.S. females aged 10–17 years declined among all age groups. The CDC (2011) states that despite recent declines in teen pregnancy, birth rates to teens in the U.S. remain as much as eight times higher than in other developed countries.

There are many risk factors that may lead to teenage pregnancy. According to the CDC (2010) both female and male adolescents whose mothers’ had their first birth as a teenager, and those who did not live with both parents at age 14, were more likely to be
sexually active than those whose mothers had their first birth at age 20 or older, and those who lived with both parents at age 14. Young females are also twice as likely to have a birth in their adolescent years if their mother had a birth when she was a teenager (CDC, 2010). East (1998) found that younger sisters of teenage girls who are teenage mothers find themselves to be more susceptible to becoming teen mothers themselves. This relational context tells us that family life deeply influences the sexuality of teenage girls as well as the effects that come with poor choices regarding sexual behaviors.

Teenage pregnancy can lead to negative health consequences in the newborn infant. Mothers under 15 years old were more likely than adolescent females aged 15–19 years or young women aged 20–24 years to receive late or no prenatal care, to have a preterm infant, and to have a low birth weight infant (CDC, 2009). Also, adolescents aged 15–17 years were three times more likely to smoke during pregnancy than pregnant youth 10–14 years old (CDC, 2009).

Being a young single mother is considered a disadvantage in today’s society since teenage pregnancy reduces the likelihood of completing high school (Forste & Tienda, 1992). This could be due to the economic difficulties of raising a child as well as other societal factors that come along with teenage pregnancy (Forste & Tienda, 1992). When looking at healthcare costs related to teenage pregnancy, childbearing among adolescent girls in the U.S. cost taxpayers an estimated $9.1 billion dollars in 2004 (Mummert, Nagamine, & Myer, 2007). Medicaid was billed for the majority (73.8%) of childbirth-related hospitalizations among adolescent girls in 2004 and private insurance was billed for 21.1 percent of the charges (Mummert, Nagamine, & Myer, 2007). These economic costs affect not only the lives of the young adolescent parent and their families, but the
entire societal economic structure as well.

**Latina teen pregnancy.** Birth rates for Latinas ages 15-19 in the United States have dropped about 40% from 10.46% in 1991 to 7.53% in 2007 (CDC, 2013). Rates also dropped about 30% from 2007 (7.53%) to 2011 (4.94%) (CDC, 2013). In 2004, the highest pregnancy rates for adolescents aged 15–19 years were reported among Latinas and Black adolescents compared with White adolescents (CDC, 2009). In the year 2012 there were a total of 89,548 births from unmarried Latinas between the ages of 15-19 years old in the United States (CDC, 2013).

Latinas adolescents are also exposed to negative newborn health risks. Of the 89,548 births mentioned from the year 2012, 1,380 births were from Latinas below the age of fifteen in which 101 births occurred before 34 weeks of gestation and 33 infants were born under weight (less than 1,500 grams). There were 4,415 births from 15 year old Latinas in which 256 births occurred before 34 weeks of gestation and 90 infants were born under weight (less than 1,500 grams). There were 10,306 births from 16 year old Latinas in which 491 births occurred before 34 weeks of gestation and 140 infants were born under weight (less than 1,500 grams). There were 17, 079 births from 17 year old Latinas in which 735 births occurred before 34 weeks of gestation and 245 infants were born under weight (less than 1,500 grams). Finally 24,887 births were from 18 year old Latinas in which 1,028 births occurred before 34 weeks of gestation and 371 infants were born under weight (less than 1,500 grams) (CDC, 2013).

According to the National Campaign to Prevent Teen and Unplanned Pregnancy (2015) ongoing declines in both the pregnancy and birth rates for Latina teens suggest an optimistic outlook. Since 1990 the pregnancy rate among Latina teens decreased 49% by
2010 and most births to Latina teens were first births. In 2013, 80% of births to Latina teens age 15-19 were first births, 17% were second births, and the remainders were births to Latinas who had two or more previous births (National Campaign to Prevent Teen and Unplanned Pregnancy, 2015).

Abortion. Adolescent abortion is a realistic issue that may derive from lack of sexual information and poor decision-making regarding sexual activity among adolescents. According to the Child Trends Data Bank (2014) about a quarter of all teenage pregnancies in the U.S. end in abortion. Specifically 4 in 5 (82%) teenage pregnancies are unintended and 2 out of every 5 (37%) unintended teen pregnancies end in abortion (Child Trends Data Bank, 2014). In 2004 adolescents aged 15–19 years had 57% of pregnancies that ended in a live birth, 27% of pregnancies ended in induced abortion, and 16% of pregnancies were fetal losses (CDC, 2009). Fortunately Child Trends Data Bank (2014) states that there have been declines in teenage pregnancy rates and these are reflected in reductions in both births and abortions. The abortion rate for adolescents under 15 years of age dropped from 1.5% in 1990 to .6% in 2009. The rate for adolescents aged 15–17 years dropped from 26.6% in 1990 to 9.6% in 2009 (Child Trends Data Bank, 2014). Finally, the birth rate for teenagers aged 15-19 dropped 6% from 2011 to 2012 (CDC, 2013). According to Child Trends Data Bank (2014) abortion rates are currently much higher for African-American teens than for white and Latina teens. Abortion rates among African-American adolescents however, have fallen more than rates for the other ethnic groups, narrowing the gap over time (Child Trends Data Bank, 2014).

Latina abortion. Abortion rates for Latina females under age 15 decreased from
1.1% in 1990 to .6% in 2009 and for Latina females ages 15-17 abortions decreased from 24.3% in 1990 to 10% in 2009 (Child Trends Data Bank, 2014). According to the CDC (2013) claimed abortions in 2010 from adolescent Latinas in certain reporting areas of the United States were; 395 abortions from Latinas below the age of 15, 728 abortions from 15 year old Latinas, 1,305 abortions from 16 year old Latinas, 2,040 abortions from 17 year old Latinas, and 3,410 abortions from 18 year old Latinas. Even though teenage pregnancy rates have decreased over time for Latina females, there is still a need to create interventions and preventative measures to avoid teenage pregnancies altogether in the Latina population.

This overview of various sexuality related statistics from the teenage population provides a description of the many gaps that exists in today’s youth regarding safe sex practices to ensure the prevention of teenage pregnancies, sexually transmitted infections and abortions. Not every adolescent that is sexually active is engaging in safe contraception use. Specifically the Latina population depicts a dire need for preventative measures that will help these make more informed decisions regarding their sexuality. These statistics provide a strong foundation of knowledge for which to develop a method of educating adolescent Latinas about sexuality in the United States.

**Sexual Education in the School System**

Sexual education in the United States can consist of either abstinence- only education or comprehensive sexual health education. The U.S. does not have specific laws regarding sexual education across the board; rather laws concerning sex education vary significantly in their scope and type across the states. Most states currently have their own laws pertaining to sex education (Zinth, 2007). For example, as stated by Zinth
(2007), Alabama, Illinois, Louisiana, Missouri, Ohio, Mississippi and Oregon are currently the only states that include education regarding financial responsibility and financial difficulties that the student and his or her parents are likely to face when an adolescent gives birth to a child (Zinth, 2007). Eight states (Illinois, Michigan, Missouri, South Carolina, Vermont, Wisconsin, and Virginia) have provisions meant to inform students about adoption (Zinth, 2007). California is one of the three states (along with Illinois and Michigan) that have provisions informing students about laws concerning legal and safe methods for surrendering infants (Zinth, 2007).

Abstinence-only until marriage (AOUM) sexual education as part of Title V, Section 510 (b) of the Social Security Act (P.L. 104-193) holds the exclusive purpose of teaching the social, psychological, and health gains of abstaining from sexual activity until marriage (Trenholm et al., 2007). AOUM highlights abstinence from sexual activity outside marriage as the expected standard. AOUM also teaches that abstention from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted infections, and other associated health problems that may come from sexually transmitted infections. Abstinence-only sexual education also purports that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity and that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects (Trenholm et al., 2007). AOUM sexual education teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child’s parents, and society. AOUM also teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances. Lastly AOUM sexual education teaches students of the
importance of attaining self-sufficiency before engaging in sexual activity (Trenholm et al., 2007).

According to Block (as cited in Walters & Hayes, 2007) abstinence-only programs have been implemented by many schools due to increased federal financial funds that are given to the implementation of abstinence-only programs. The enactment of Title V, Section 510 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 significantly increased the funding of abstinence education as an approach to promote sexual abstinence and healthy teen behavior (Trenholm et al., 2007). Since the year 1998, the Title V, Section 510 program has allocated 50 million dollars annually in federal funding for programs that teach only abstinence from sexual activity outside of marriage as the expected standard (Trenholm et al., 2007).

**Trends across the U.S.** School Health Profiles surveys have been conducted biennially since 1996 to assess school health practices in the United States (CDC, 2012). Those participating schools across states are from junior high and high schools grades 6–12 (CDC, 2012). In 2010, compared with 2008, the percentage of public secondary schools in 45 states teaching specific HIV, other sexually transmitted infections, and pregnancy prevention topics in required courses generally did not increase (CDC, 2012).

Another School Health Profiles survey showed a low statistic that 0.6% of middle schools and 4.5% of high schools made condoms available to students according to the CDC (2006). This raises concerns regarding the availability of condoms to teenagers for use in order to practice safe sex. The other options that teenagers have in obtaining condoms would be from parents, peers, or by purchasing them themselves. Once a teenager has access to condoms it is important for them to have the knowledge of how to
use them properly in order to maximize their efficiency; however, the percentage of high schools in which teachers taught students how to correctly use a condom in at least one required course decreased from 49.5% in 2000 to 38.5% in 2006 (CDC, 2006). Fortunately, the percentage of states that required districts or schools to provide sexually transmitted infection prevention services such as abstinence and condom efficacy, in one-on-one or small-group sessions increased from 17.6% in 2000 to 32.0% in 2006 (CDC, 2006). One-on-one or small-group interactions could perhaps provide more of an intimate environment for teenagers to discuss sexual education which could help them feel more comfortable to learn and speak about sexuality related topics in school.

Besides analyzing the legal requirements of sexual education and the trends across the U.S., it is of importance to look into those professionals that are educating students about sexuality in the public school system. There are professional and academic sexuality organizations that serve as resources for health and sexuality teachers such as The American Association of Sex Educators, Counselors, and Therapists (AASECT) and the Sexuality Information and Education Council of the United States (SIECUS) (Walters & Hayes, 2007).

Using an Internet-Based questionnaire Tanner, Reece, Legocki, and Murray (2007) collected data from 399 Indiana public middle and high school teachers, nurses, and counselors. Seventy-three percent of teachers, 65.9% of nurses, and 51.9% of counselors reported feeling comfortable to address the sexuality-related questions that students asked of them. Additionally, over 80%, reported they had both the knowledge and skills required to answer students’ sexuality-related questions (Tanner et al., 2007). In that same study Tanner et al. (2007) investigated the sexuality related topics that
students were interested in across the ages of middle school and high school. Students at the middle school level tended to ask questions regarding sexual behavior (23.5%), general health (18.7%), and relationship, gender, and identity topics (13.3%) (Tanner et al., 2007). At both the middle and high school levels, personnel were most likely to receive questions about pregnancy (25.9%) and contraception (32.7%). High school students tended to ask questions regarding relationships, gender, and identity (25.3%), HIV and other STI’s (16.1%), and sexual behavior (14.3%) (Tanner et al., 2007). It appears that the categories of sexual related questions evolve across an adolescent’s life. Assessing patterns such as these could aid in designing sexual education criteria to address important topics adolescents are interested in learning throughout their development.

According to Barr (2014) many parents want age-appropriate school-based sexual education starting at the elementary school level such as communication skills, human anatomy/ reproductive information, abstinence information, information on Human Immunodeficiency Virus (HIV) and other sexually transmitted infections, and information regarding gender/ sexual orientation issues. This is in accordance with the public service organizations such as the National HIV/ AIDS Strategy for the United States and the Community Preventive Services Task Force (CPSTF) which recommends educating young people about HIV before they begin engaging in behaviors that place them at risk for HIV infection (CDC, 2012). Prevention education in grades 6–8 is particularly important because most students in those grades are not yet sexually active (CDC, 2012). In terms of parent involvement, the Kaiser Family Foundation (as cited in Walters & Hayes, 2007) found that collaborations between school-based sexuality
programs and parents have been shown to facilitate parent-child conversations about sexuality. This possible connection is of importance for the underlying concept of the proposed psychotherapy group curriculum. If parents in fact can collaborate and influence the sexual education of their children then it is key to help them engage in the necessary everyday sexuality related conversations with their children and adolescents.

California. California like other states has educational codes and curriculum in place across the school districts for sexual education. According to the California education code 51933, school districts are not required to provide comprehensive sexual health education; however, if they choose to do so they must comply with all the legal requirements and criteria (California Department of Education, 2013). The criteria for those school districts that choose to provide sexual education is very detailed and specific about what content should be covered according to California law.

California’s education code 51930 through code 51939 describes Authorized Comprehensive Sexual Health Education as all instruction (from kindergarten through twelfth grade) and accompanying materials to be age-appropriate, medically accurate, and objective. This education has to be appropriate for the age group, for students of all races, genders, sexual orientations, ethnic and cultural backgrounds, and for students with disabilities. Instruction and materials must encourage the students to communicate with their parents or guardians about human sexuality. Further, instruction and materials must teach respect for marriage and committed relationships (California Department of Education, 2013).

Commencing in the seventh grade, all instructions and materials must teach that abstinence from sexual intercourse is the only certain way to prevent unintended
pregnancy or sexually transmitted infections and provide information about the value of abstinence while also providing medically accurate information on other methods of preventing pregnancy and sexually transmitted infections. Instructions must also provide information about how sexually transmitted infections are and are not transmitted and information on local resources for testing and medical care of these, contraceptive methods in preventing pregnancy, and information on the law on surrendering physical custody of a minor child 72 hours or younger. Overall, instruction must provide students with skills for making and implementing responsible decisions about sexuality (California Department of Education, 2013).

The required HIV/ AIDS prevention education in California (as part of the comprehensive sexual education) states that students are required to receive this instruction at least once in middle school and high school. HIV/ AIDS prevention education must comply with certain aspects of CAL. EDUC. CODE 51933 and accurately reflect the latest information and recommendations from the U.S. Surgeon General, the federal Centers for Disease Control and Prevention, and the National Academy of Sciences. Instruction must include information on the nature of HIV/ AIDS and its effects on the human body, how HIV is and is not transmitted, methods to reduce the risk of HIV infection, and information on local resources for HIV testing and medical care. Discussions must include public health issues associated with HIV/ AIDS including stereotypes, myths, and societal views on HIV/ AIDS. Further, refusal skills to assist students in overcoming peer pressure and using effective decision making skills to avoid high-risk sexual activities must be a part of discussion (California Department of Education, 2013). Finally, all instruction and materials related to sex education may not
teach or promote religious doctrine or promote bias against any person according to the California Educational Code 220 (Zinth, 2007).

The previously described educational requirements are clear and detailed, however they are not always implemented accurately. The percentage of public secondary schools (grades 6-8) in California that taught the differences between HIV and AIDS decreased from 85.2% in 2008 to 81.1% in 2010 (CDC, 2012). These same public secondary schools decreased in educating how HIV and other STI’s are transmitted from 86.1% in 2008 to 81.6% in 2010. The same declining trend was found regarding educating on how HIV and other STI’s are diagnosed and treated from 80.6% in 2008 to 72.4% in 2010 (CDC, 2012). Educating on the health consequences of HIV, other STI’s, and pregnancy also decreased from 84.6% in 2008 to 79.3% in 2010. Similarly educating on how to prevent HIV, other STI’s, and pregnancy decreased from 85% in 2008 to 76% in 2010. Education of the benefits of being abstinent also decreased from 81.6% in 2008 to 78.9 in 2010 (CDC, 2012). Information of how to access valid and reliable health information, products, and services also decreased from 72.5% in 2008 to 67.2% in 2010 (CDC, 2012). Regarding other topics (such as influences of media, family, and social and cultural norms) on sexual behavior decreased from 73.9% in 2008 to 67% in 2010 (CDC, 2012). Finally, education regarding communication and negotiation of sexual themes decreased from 70.1% in 2008 to 64% in 2010 such as goal-setting of sexual behaviors and decision-making skills related to sexual themes (CDC, 2012).

The percentage of public high schools (grades 9-12) in California that taught the efficacy of condoms virtually held constant from 89.3 in 2008 to 89.2% in 2010 (CDC, 2012); however, an increase occurred regarding the education of the importance of using
condoms consistently and correctly from 82.9% in 2008 to 85.8% in 2010. Even though there is a clear criteria set in place for those school districts that choose to implement comprehensive sexual education in California, many school are not complying and adhering to these.

In terms of permission to receive sex education from and in the public school environment, school districts are required to notify parents or guardians about planned instruction regarding sexuality for the school year (Zinth, 2007). California’s Education code 51939 allows parents or guardians to remove their children (from all or certain parts) of that sexual-health education (Zinth, 2007). The right for parents to choose sexual education for their children is important; however, it is critical that those parents offer sexual education at home or in other ways. Children who grow up without intentional or formal sexual education may be misinformed about sex and their sexuality.

**Parenting Adolescents**

An overview of the family life cycle stage is described in this section with the descriptions that characterize the stage of the family life cycle of parenting adolescents. In this section there is no specific ethnic population discussed, rather the general description of the stage is given to provide a general overview of the family with adolescents. This stage like all the other stages of the family life cycle, bring changes to the structure and organization of the family (Walsh, 2003).

**Pubescent Stage.** While discussing any stage of the family life cycle one must not neglect the individual life cycle that co-occurs with the family life cycle at every point, at times causing conflict of needs among family members (Carter, & McGoldrick, 2005). The two stages of the individual life cycle that encompass the overall stage of the family
life cycle stage of parenting adolescents are; the pubescence stage and the adolescent stage. The pubescent stage is categorized as the ages of 11-14 and is described as the beginning development of authenticity for an individual. During this stage the pubescent child copes with dramatic bodily changes of puberty, the ability to assert oneself, develops awareness of own and others’ sexuality, begins the control of sexual impulses, increases capacity for moral understanding, increases understanding of self in terms of gender, race, culture, sexual orientation and self in relation to peers, family and community, and increases ability to handle social relationships and complex social situations (Carter, & McGoldrick, 2005). These are a few among many other developmental milestones of the pubescent years.

Parents play a great role in the pubescent stage since parental support is essential for helping children deal with peer pressure and helping the child distinguish their own values from their peers (Carter, & McGoldrick, 2005). Typically at this stage the child starts to differentiate what is expected of them within the family and outside of the family. This is also the last stage for parents to affirm their support of their children’s competence before the struggles from adolescence begin (Carter, & McGoldrick, 2005). Pubescent girls often confuse identity with intimacy by defining themselves through relationships with others (Carter, & McGoldrick, 2005).

Adolescent stage. The adolescent stage occurs between the approximate ages of 14-21 and is described generally as the stage of discovering one’s identity (Carter, & McGoldrick, 2005). During this individual life cycle stage the adolescent continues to experience rapid bodily changes as well as develop their personal views about their body image (Carter, & McGoldrick, 2005). The adolescent’s views about their body image are
highly influenced by the cultural ideals of body image relevant to their culture. The
development of sexual identity is also co-occurring during this adolescent stage. The
adolescent’s awareness and ability to deal with their own and other’s sexuality is
increased as well as their ability to handle intimate physical and social relationships and
handle complex social situations (Carter, & McGoldrick, 2005). Adolescent socialization
growth includes increased self-understanding in relation to peers, family, and community;
during this stage adolescents also begin to develop a philosophy of life which includes
their moral and spiritual identity (Carter, & McGoldrick, 2005).

As Klimek (1988) states, the primary task of adolescence is for the individual to
separate from their parents and to come fully into their own with all the uniqueness and
diversity implied in becoming one's own person. Some overly compliant teenagers
become exactly what their parents want them to be. This may leave the adolescent
seriously disturbed as he or she has had to renounce the real and authentic self in order to
become a clone of the parents' desires and needs, because of this they often enter
adulthood with a seriously defective sense of self (Klimek, 1988). Adolescence is
partially precipitated by biological changes which render the individual a sexual creature
for the first time in his or her life. During this time the adolescent is biologically drawn
away from the parents for gratification of the deeper level human needs such as love,
support, recognition, attention, and affirmation (Klimek, 1988). As a result, most parents
feel a combination of anxiety, fear, and even panic over the realization that their teenager
is being pulled away from the family and is becoming a sexual being (Klimek, 1988).

According to Klimek (1988) approximately 70-75% of adolescents navigate this
life phase fairly well, while the remaining 25-30% experience turmoil ranging from
delinquency, acting out, drug dependence, self-destructive behaviors, school failure, sexual involvement, parental conflicts and anger, to depression, etc. There appears to be a tendency among late junior and senior high school aged boys to act out with direct expression of anger and aggression, while the girls at this age tend to be driven by powerful mood swings, depression, and wavering self-esteem. Interestingly, these gender patterns that come in the commencement of adolescence are repeated fairly consistently throughout adulthood specifically pinpointing that women suffer more from deeper and longer periods of depression than men, while men act out their emotions in a variety of ways (Klimek, 1988).

Parenting adolescents. The family life cycle stage of parenting adolescents affects parents in various ways. Sixty-one point seven percent of mothers and 64% of fathers experience the period of raising their adolescents (ages 14-18) as the most difficult and stressful due to issues of; independence, issues with lack of control, parental fears for the teen (i.e. teenage pregnancy), parental aggravation and annoyance with the adolescent, and social relations such as disagreement about their choice of friends (Pasley, 1984). The parents that saw the stage of parenting teens as the best parenting stage admired increased independence and maturity from the teenager and less responsibility for the parents (Pasley, 1984). The economic effects on parents when raising adolescents can be a very expensive one for parents due to consumer demands of adolescents derived from media advertisements (Ambert, 2001). The economic effect on parents may be more severe in single parent households among young mothers and in situations of separation and divorce (Ambert, 2001). Based on the changes that occur during the family life cycle stage of families raising adolescents, the couple or the marital
relationship within the family tends to have the lowest marital satisfaction of all the family life cycle stages (Walsh, 2003).

It is important to note that the more unresolved and conflicted one or both parents are in terms of sensitivity to separation, loss, abandonment, and the more conflicted each parent is with his or her sexuality, the greater will be the conflict between the parent and his or her teenager; parents here face their own sexuality, attachment, etc. (Klimek, 1988). Parents must face their own sexuality and attachment to more effectively deal with their adolescents. Most parents feel a combination of anxiety, fear, and even panic over the realization that their teenager is being pulled away from the family and is becoming sexual (Klimek, 1988). Effects of teen delinquency on parents may present itself as preoccupation and obsession about their adolescent, lowered performance at work, low appetite or high appetite, depression, poor sleep habits, social isolation, stress, and or shame (Ambert, 2001).

In the case of separated or divorced families it can be additionally difficult when there are step-parents and step-siblings creating a relational change for the entire family. Adolescents may resent the addition of authority figures in their lives in a time when they are seeking autonomy in their family and wanting to step away from authority figures (Ambert, 2001).

Although this family life cycle stage is difficult for all members of the family, it is an inevitable part of the changing system that the family will navigate. In the words of Virginia Satir “in this period of tremendous change, everyone becomes new to each other and people have to get to know one another all over again” (Satir, 1988, p. 312). Due to all the changes that arrive during this family stage of raising adolescents "negotiating the
adolescent stage is neither quick nor easy" (Satir, 1988, p. 312).

**Parenting and Sexuality**

Lamb (2006) believes that it's the parent's right and responsibility to convey their values and provide support to their adolescents around sex and sexuality to establish and provide a foundation. Similarly, Rekers (1995) states that "parents ought to be the sex educators of their children" and that a "healthy sex life is hardly attainable without education in sexual knowledge, attitudes, and values" (p. 32.). Yet according to the CDC (2009) only 49.8% of females and 31.1% of male adolescents had talked with a parent before reaching the age of 18 about contraceptive methods. "Sexuality is an important dimension of our humanity,... sex education is a lifelong process during which information is taken in, processed, and manifested in diverse behavioral patterns" (Rekers, 1995, p. 31).

Language is a form in which information could be given through communicative processes; further, language can have many meanings and be on different levels of communication such as the content level and relationship level (Watzlawick, Weakland, & Fisch, 1974). Lack of language in itself is a form of meta-communication (Watzlawick, Weakland, & Fisch, 1974); in the case of sexuality communication it can mean various things to not communicate about sexuality. Denial of sexual communication is a problem since according to Watzlawick, Weakland, and Fisch (1974), denial is a form of mishandling a problem where the existence of a problem is avoided and unrecognized.

**Parent-Adolescent Sexuality Communication**

Bogenschneider, Flood, and Raffaelli (1998) studied parent-teen communication
about sexuality topics of 666 mother-teen and 510 father-teen dyads. The adolescents were in the 8th-12th grade and all participants were from the Midwest region. The majority of the parent participants were White (97% mothers and 94.5% fathers), and 79% of mothers and 74% of fathers stated that they had continued their education beyond high school. The sexuality topics that were studied included whether teen sex is okay, sexually transmitted infections, and birth control (Bogenschneider, Flood, & Raffaelli, 1998). The findings showed that daughters reported more parental sexual discussions than sons, and that adolescents of older mothers were less likely to say they had discussed birth control with their mothers. Bogenschneider, Flood, and Raffaelli (1998) also found that mother's belief about her own adolescent's sexual activity predicted discussions of birth control, and the belief that her child's friends were sexually active predicted conversations about whether teen sex is okay. Maternal worries about sexuality were significantly associated with discussions of the dangers of STI’s. Mother's feelings of having competence about communicating with her adolescent about sexuality predicted higher reports of conversations about birth control by the adolescent sons and daughters (Bogenschneider, Flood, & Raffaelli, 1998).

Adolescent reports of personal talk with their fathers and father's reports of frequency of sexual discussions were both predictors of all three sexuality discussion topics (Bogenschneider, Flood, & Raffaelli, 1998). Father's belief that other adolescents are sexually active predicted conversations about the dangers of STI's and birth control; further, fathers who were more accepting of adolescent sexuality were more likely to have their adolescent son or daughter report discussions of the dangers of STI’s with their fathers (Bogenschneider, Flood, & Raffaelli, 1998).
Elliot (2010) used qualitative interviews to gather how 40 mothers communicated with their adolescent sons and daughters about sexuality, and the barriers and difficulties that they experienced during these conversations. Many mothers stated that their communication on sexuality was passive since they would wait for cues, questions or wait until their adolescent explicitly asked to talk about sex before they initiated a conversation about sex (Elliot, 2010). Resistance was one of the barriers that made sexuality communication difficult for these mothers; mothers stated that they encountered a great deal of resistance when they tried to talk to their teenagers about sex and sexuality. This resistance was shown by adolescents ignoring, dismissing, and or arguing that they already knew what their mothers were speaking about (Elliot, 2010). Most mothers viewed the resistance as a part of normal adolescent development in which adolescents normally withdraw from their parents and want to avoid the complex emotions that may stem from sexuality topics. Another barrier to sexual conversations, were the difficult emotions that the mothers experienced themselves such as discomfort and embarrassment (Elliot, 2010). These difficult feelings of discomfort and embarrassment tended to stem from the mother’s beliefs and attitudes toward sexuality. Some of these beliefs were that sexuality is private and not something to openly discuss, that sexuality conversations do not fall within their mother role (especially if the communication is with a son more so than a daughter), and that a virtuous mother is to not know or openly show that she knows about sex topics (Elliot, 2010).

One sexuality topic that most mothers were able to easily discuss was that of negative consequences and risks of sexual behavior (Elliot, 2010). In spite of the difficult feelings mentioned, most of the mothers pushed through their discomfort in order to hold
sexuality conversations with their adolescents due to believing that the risks were too high if the sexuality conversations did not occur. The risks that these mothers referred to were STI’s such as HIV, AIDS, and HPV, teenage pregnancy and the negative social and economic outcomes of this (Elliot, 2010). Sexual desire, sexual pleasure and masturbation were the most difficult sexuality topics to discuss with the mothers of this study. Very few mothers reported speaking to their adolescents about masturbation and if they did it was mainly to their sons as related to privacy spaces in which the behavior was appropriate, only one mother reported speaking to her daughter about masturbation (Elliot, 2010). The discomfort of communicating about sexual desire and pleasure was also tied to the idea that these conversations would automatically place mothers in the role that they too experience sexual desire and pleasure and thus be seen as sexual individuals themselves by their children (Elliot, 2010). Mother’s ambivalence about speaking about sexuality was also connected to the mother’s preference of virginity until marriage versus the reality (in some cases) of premarital sexual intercourse; some of these mothers would only promote abstinence- until-marriage during sexuality conversations with their adolescents (Elliot, 2010).

Charmaraman and McKamey (2011) also found, through qualitative research, that the adolescent participants’ (23 sixth graders participating in a comprehensive sex education impact evaluation) stories about talking with family members regarding sexual issues most often addressed the topic of delaying sex. These adolescents stated that their parents and caregivers often used a variety of strategies to talk about delaying sex such as scare tactics and unrealistic age expectation of sexual initiation such as until age 51 (as one adolescent shared) (Charmaraman & McKamey, 2011). The adolescent participants
in Charmaraman and McKamey’ study (2011) also described how they were often ambivalent about approaching their parents and or welcoming their parent’s efforts to communicate about sexuality. The main reason that was described for this adolescent ambivalence was the overwhelming disconnection and unavailability of busy parents that did not have the time to connect and communicate on a consistent basis with their adolescents due to long work hours among other reasons (Charmaraman & McKamey, 2011). Other sexuality topics that these adolescent participants stated to have had spoken about with parents and caregivers were puberty related changes such as menstruation and how these changes could lead to pregnancy (Charmaraman & McKamey, 2011).

Malcolm et al. (2013) studied the effect of family functioning on condom use intentions and behaviors of 171 eighth graders (mostly male, 73.1%) Latinos/as that were living in Florida and that identified as sexually active and struggling with a behavioral issue such as conduct disorder, socialized aggression, or attention problems. Family functioning was assessed by: parent-adolescent communication, family communication, parental involvement, and positive parenting. Malcolm et al. (2013) found that family functioning was indirectly related to condom use through communication about sex and condom use attitudes. Higher levels of family functioning were directly associated with higher levels of parent-adolescent communication about sex. Higher levels of parent-adolescent communication about sex were directly and positively associated with condom use attitudes. The researchers suggest that preventive interventions seeking to improve family processes may promote condom use attitudes and consequently increase condom use intentions and behavior in adolescents (Malcolm et al., 2013).

Lefkowitz, Boone, Kit-fong Au1, and Sigman (2003) also studied how 50 mothers
and their adolescent daughters and sons discussed abstinence and safer sex as related to HIV/AIDS conversations, and how these discussions differed between gender and religious affiliation (36% of the mothers were Protestant, 26% Catholic, 18% Jewish, 6% reported other religions, 12% reported no religion and 2% did not answer the question).

Each mother participated in a dyad with either their adolescent son (25 sons) or daughters (25 daughters) who were aged from 11 to 15 in the qualitative recorded interviews where only the mother-adolescent dyad was present. Lefkowitz et al. (2003) found that both genders of adolescents equally discussed abstinence and safer sex with their mothers. In terms of age, younger adolescents were more likely to discuss abstinence with their mothers and older adolescents were more likely to discuss safer sex with their mothers. Adolescents who were less religious also discussed safer sex with their mothers more so than those adolescents who were more religious.

Lefkowitz et al. (2003) also found that when mothers and adolescents were directly asked to talk about HIV/AIDS and sexuality for 7 min most dyads did not talk about abstinence nor safer sex; only 42% of mothers mentioned safer sex and only 36% mentioned abstinence. Instead, when discussing HIV/AIDS, dyads brought up topics such as people they knew personally who were HIV positive, HIV positive celebrities, and whether HIV can be transmitted through behaviors such as drug use, giving blood, blood transfusions and casual contact. Other topics (other than abstinence and safer sex) that were discussed during the conversations were about dating and sexuality including types of sexual activity (i.e. kissing, petting, ‘making out’), puberty and physical development, sexual orientation, dating, romance, relationships, and love. Mothers with higher socioeconomic status were more likely to discuss abstinence and safer sex with
their children than mothers of lower socioeconomic status; on average mothers who discussed safer sex with their adolescent had 1.5 more years of education than those who did not (Lefkowitz., 2003).

**Sexuality Communication between Latina Mothers and Adolescent Daughters**

Research on the communication and interaction patterns between Latina mothers and their daughters show a gap in sexuality related conversations between these. The research also sheds light into what parenting skills are helpful and which ones are not and how parental sexual education is provided, or not, in the home of Latina adolescents living in the U.S. This mother-daughter interaction analysis is important since females tend to receive more sexual information from their mothers than their fathers and males tend to receive more sex information from their fathers than their mothers (Anagurthi, 2011; Lamb, 2006).

Romo, Bravo, Cruz, Rios, and Kouyoumdjian (2010), used qualitative interviews from 59 Latina mothers and their non-sexually active daughters around the age of 12 living in the U.S to study the prevalence of messages related to four sexual values (abstinence, delay sex until older, sex is “normal”, sex is “improper”) as well as concerns about pregnancy and STI transmission. The mother-daughter dyads were asked to discuss dating and sexuality in a video recorded session. Each mother and daughter also separately filled out demographic questionnaires and an adolescent and maternal self-reported open communication questionnaire to assess the extent to which the adolescents and their mothers feel that they can openly communicate with each other (Romo et al., 2010). The researchers examined whether the duration of time spent conversing about these messages was associated with participant characteristics, general communication
openness, and the amount of time the dyads spent discussing contraceptive use. Twenty-nine percent of dyads discussed that sex is normal, 22% discussed that sex is improper, 17% discussed abstinence, 49% spoke about delaying sex until an older age, 46% discussed the warnings about pregnancy and STI’s, and 20% discussed contraception use practices (Romo et al., 2010). Mothers with less perceived openness in general about sexuality and less sexual communication as reported by both the mothers and the daughters were associated with increased time discussing that sex is improper (Romo et al., 2010). Mothers with fewer years of education spent more time warning about pregnancy and STI transmission and more time on messages that their daughters should delay sex until they were older. Mothers from lower income backgrounds engaged in longer discussions about contraceptive use than did mothers from higher income levels. Finally, mothers and daughters who engaged in more discussions that sexual behavior is normal spent longer periods of time discussing contraceptive use practices (Romo et al., 2010).

In another study that looked at communication interactions about sexuality between Latina mother- daughters dyads with two daughter age groups 6-9 and 10-13, O’Sullivan, Meyer-Bahlburg, and Watkins (2001) found that mothers typically sought information about their daughters’ sexual experiences through parenting interactions in efforts to prohibit sexual experimentation by their daughters. Due to this the daughters typically withheld personal information from their mothers, thus they avoided conversations about sex when disclosure was expected (O’Sullivan et al., 2001).

Other reasons why mothers avoid speaking to their daughters about sexuality are depicted by Karasz and McKee (2006) who found that many mothers are reluctant to
discuss sexual health with their teenage daughters because of embarrassment. Karasz and McKee (2006) used qualitative interviews with 10 Latina mothers (mostly from Puerto Rican, and Dominican Republic background) and their daughters living in the New York. All interviews were conducted separately and were recorded. Both mothers and daughters were asked to describe mothers’ concerns about raising adolescent daughters, the value of communication about sex, and about barriers to communicating about sex. Karasz and McKee (2006) describe from their findings that both mothers and daughters from low-conflict dyads reported using a number of strategies to soften the effects of potentially upsetting conversations such as a friendly and egalitarian nature in their relationships. In contrast daughters from high-conflict dyads reported that when mothers did not use the egalitarian and friendly strategies the daughters reacted with anger, mistrust, and avoidance when discussing sexuality (Karasz & McKee, 2006).

This study showed that mothers and daughters both viewed open, honest communication as necessary to build and maintain a close relationship (Karasz & McKee, 2006). Many mothers were embarrassed or reluctant to discuss sexual health, and mothers and daughters indicated that daughters were not always receptive to messages about sexual health. Mothers believed that through communication they could help their daughters avoid the negative consequences of sexual activity. Matyastik and Wampler (2008) also state that mothers avoid communicating about sexuality with their daughters if they feel that their daughters lack interest in talking about the subject.

Delaying sex and fear of teenage pregnancy was viewed by the mothers as absolutely necessary for education and future success (Karasz & McKee, 2006). Most mothers in the sample had experienced unwanted pregnancies or early childbearing,
poverty, and broken or violent relationships themselves, they hoped that their daughters would avoid the mistakes they themselves had made (Karasz & McKee, 2006). Daughters also believed that communication was crucial to avoiding bad outcomes and were aware of their mothers’ aspirations for them (Karasz & McKee, 2006). Mothers and daughters agreed that talking openly about sex was important and when both desired a close relationship, open communication was a marker of a close relationship. Daughters were resentful when they felt they could not communicate openly with their mothers about sexuality.

Most mothers shared that they grew up in an environment of traditional and religious conservatism about sexuality and most felt that their own traditional upbringing had not prepared them for the sexuality related risks (Karasz & McKee, 2006). A few mothers acknowledged the concern that providing specific information about how to manage the threats associated with sexuality would send the message to have sex to their daughters. Further, some mothers felt it would be dangerous to speak too openly, forcefully, or frequently about sex since it could be experienced as an assault. Daughters who felt that conversations about sex were painful or risky avoided these conversations by telling their mothers that they were either too old or too young for the sexuality conversations (Karasz & McKee, 2006).

Guzman et al. (2013) found that even thought Latino/a parents and their teenagers did not engage in many conversations about sex, dating and parenthood; when they did the key messages given by parents and heard by the teenagers (ages 15-17) were to wait to become parents, wait for sex until marriage, to use protection, to be aware and prepared to face the consequences on their own, and that expectations and dangers are
different for females and males. To these parents waiting to become parents meant that they explained to their teenagers to first finish their education, be financially responsible and mature enough to be able to parent a child. The teenagers in the study agreed on waiting to become parents until after their teenage years. However, Guzman et al. (2013) also found that when Latina mothers would strongly tell their female teenagers to not have sex and to wait until marriage the teenagers felt accused and they felt this made it difficult to approach their mothers about sexuality and be open about their sexual lives. The messages sent to male and female teens where different since the males were more encouraged mostly by their fathers to engage in sexual activities and the females were encouraged to guard their “honor” and avoid sex (Guzman et al., 2013).

Some of the barriers that impede parents to communicate with their adolescent girls (and vice versa) about sexuality tend to be parents who are strict and overprotective, parents who hold conflicting cultural norms about sexuality, parents who think conversations can wait regarding sexuality and parents who think their teenagers are getting sexuality information elsewhere (Guzman et al., 2013). With strict and overprotective parents teenagers may feel that the conversations about sexuality are not allowed and thus avoid these conversations with their parents. When cultural norms are conflicting especially regarding sexuality many parents are conflicted about how and if to address the subject since they have not resolved the cultural conflict for themselves. Guzman et al. (2013) found that parents often held views that sexuality related conversations where shameful and inappropriate and explained that in their Latin countries of origin they did not speak about sexuality with their parents thus they were conflicted about changing their parenting methods from those that they experienced as
children. Some parents expressed the denial that their teenagers needed to obtain education about sexuality because they were not being sexually active thus they dismissed any conversations with their teenagers about sexuality. Further, some parents viewed it unnecessary to speak to their adolescents about sexuality because they believed it was the school’s responsibility to provide sexual health education because parents often did not have enough time to do so (Guzman et al., 2013).

Hutchinson (2002) studied the parent-adolescent relationships and sexual communication of 244 young women aged 19-21. Of these participants, 65 were Latinas, 78 were African-Americans, and 91 were White young women. Hutchinson (2002) also studied if there was a relationship between the timing parent-adolescent sexual communication and certain sexual risks behaviors (initiating sexual intercourse, consistent condom use, and self-reported STI’s). Self-reports were used to gather data from all 244 young women's reports of parent-adolescent sexual communication and sexual risk behavior. Overall young Latina women reported less parent-adolescent sexual risk communication with both parents than Black and White young women. Nearly 78% of African American young women reported their parents discussed sexual topics with them before they became sexually active, compared to 53% of Latinas and 50% of Whites (Hutchinson, 2002).

Hutchinson (2002) found that the young women who discussed sex with their parents before becoming sexually active were less likely to initiate sexual intercourse than those who did not discuss sex with their parents. Further, those who reported better general communication with their fathers were less likely to initiate sexual intercourse although sexual communication with fathers was lower than with mothers (Hutchinson,
General communication with the mother, communication with the mother about condoms, and sexual communication prior to sexual initiation were significant predictors of consistent adolescent condom use (Hutchinson, 2002). Young women who reported that their parents talked to them about sex before they became sexually active were nearly seven times more likely to report consistent condom use during adolescence. Young women who reported more communication with their mothers about condoms and those who reported good general communication with mothers were more than 60% more likely to report consistent condom use compared to other young women (Hutchinson, 2002). There was no direct effect found from early parent-adolescent sexual communication on the chances of contracting sexually transmitted infections, however later age of sexual initiation and consistent condom use were associated with a low chances of contracting STI’s (Hutchinson, 2002).

Factors that make communication easier about sexuality include trust between parents and adolescents and openness on sexuality related conversations by avoiding the taboo that comes along from their cultural beliefs that the parents grew up in (Guzman et al., 2013). Romo (2010) found that Latina adolescent’s reports of satisfaction with their family functioning were positively associated with the amount of time they and their mothers had sexually related conversations.

**Benefits of Sexuality Communication.** Many benefits can occur as a result of parental communication of sexuality themes with their adolescent children. According to Whitaker (2000), parental discussions about sex were associated with less risky sexual behavior from the teens, less conformity to peer norms, and a greater belief that parents provide the most useful information about sex. Whitaker (2000) also states that teens who
do not discuss sexual issues with a parent attend more to peer norms and peer guidance. When adolescents become desperate for information to help them make sense of the immense changes they are experiencing they usually turn to peers who are usually equally uninformed (Rekers, 1995). When sex communication is frequent, parents exhibit positive styles of communication, both about sex and in general. When sex communication is infrequent, parents are more likely to engage in negative styles of communication (Rosenthal, 2001). Lamb (2006) states that when a child has warm, supportive, and communicative parents the child is less likely to engage in early sex.

**Suggestions on Sexuality Communication.** Some parents wait to initiate discussions about these matters until they believe their child is ready (Rosenthal, 2001). Rekers (1995) point out that parents are often uncomfortable with the subject of sex when it comes to communicating about it with their children. This parental anxiety regarding the discussion of sex topics can be exacerbated if these discussions have not begun early in the child's life. Instead, Rekers (1995) suggests that parents not engage in the poor sex education and communicating practices that they learned from their parents and instead start educating their children about sexuality since at an early age, in an age appropriate and positive way. It is best if parents do not wait until their children start asking sex related questions, as some never will, but rather start these conversations early offering short and simple explanations to then use sophisticated and detailed explanations as children transition into adolescence (Rekers, 1995).

Rekers (1995) suggests that while educating children and adolescents about sexuality correct anatomical terms, descriptions, and functions should be used instead of slang terminology. This serves the goal of providing scientific factual information to
provide the individual with accurate information about the normal changes associated with puberty (Rekers, 1995). Since adolescents will be exposed to these sexually related slang terms and descriptions, it is helpful for them to discuss and know them, while still being aware that they are not the best way of communicating about sexuality (Rekers, 1995).

When it comes to self-exploration, Rekers (1995) states that although not all children and adolescents will be inclined to masturbate, they can be taught to feel that it is not guilty or shame ridden activity since there are no scientific negative consequences related to it. Rekers (1995) suggests that the only boundary regarding masturbation is to engage in this in private. Overall parental sexual communication is more effective when parents understand that "sexuality education will be more effective when expressed positively and less effective when expressed negatively" (Rekers, 1995, p. 40).

**Evidenced Based Practices and Interventions**

The following interventions are beneficial for the intended population of Latina mothers and Latina adolescents. These interventions may be helpful in raising awareness and providing information about the need to increase communication and information about sexuality topics for future generations. These interventions are also important in working towards the goal of increasing open and fluid communication between mothers and daughters in a psychotherapy group setting while employing evidenced based intervention practices from the psychotherapy field. Through these interventions the process of change can hopefully be set in motion towards healthier family reparation. Family reparation is important to keep families together throughout the family life cycle since according to Banowsky (2001) a family’s ability to repair things when they go
wrong is an important contributing factor to healthy cohesive families. As part of the family reparation process, communication and cognition must re-adapt to allow for safety, fairness, normalization, hope, acceptance, forgiveness and a new family perspective (Banowsky, 2001).

**Psychotherapy Groups**

According to Liebmann (1986) psychotherapy groups can be very beneficial since most social learning is done in groups. Group members can provide mutual support and mutual problem-solving, can learn from each other’s feedback, and can be a great alternative for those that find individual psychotherapy too intense. Groups can also be very democratic in the sense of sharing power and responsibility. Finally groups are an economical way of providing therapy and helping several individuals at the same time. Other reasons for using a group approach according to Jacobs (2012) include the feeling of commonality, the experience of belonging, the chance to practice new behaviors, the opportunity for vicarious learning by listening and observing others, the approximation to real-life encounters, and the pressure to uphold commitments.

Psychotherapy groups are beneficial for adolescents and can help with issues of identity, self-esteem, sexual concerns, issues with friends, parents, and school (Jacobs, 2012). Groups for pregnant teenagers, teenage fatherhood and teenage motherhood, drug and or alcohol use, parents’ divorce or remarriage, school dropouts, assertiveness, sex education, dating, gay and lesbian issues, runaways, etc. can be extremely helpful in the adolescent population and are a few example of the various adolescent groups that could be offered (Jacobs, 2012).

**Dyads in psychotherapy groups.** According to Jacobs (2012) there are many
benefits to incorporating dyads in psychotherapy groups. Group members can benefit from dyad discussions by giving the dyad the opportunity to share reactions, ideas, concerns or questions with each other while saving the group time. Dyads can also be used to provide a change from sitting in the group by incorporating a different way to relate to group members. Some of the reasons why a group therapist might utilize dyads in order to give certain members a chance to interact with one another are if the therapist believes that certain members do not feel comfortable with each other, have differing views on an issue, or have something in common and would benefit from the dyad interaction (Jacobs, 2012).

**Latino/a and psychotherapy groups.** The literature tells us that group therapy is beneficial for the Latino population (Organista, 2000). Since the Latino population tends to be driven and embedded for the most part in collectivism and interdependence, a psychotherapy group can provide a small community where Latinos/as can express themselves and learn from one another in the same way that they relate to the world outside of therapy (Organista, 2000).

Additionally, according to Jacobs (2012) awareness of multicultural issues is very important in psychotherapy groups since most groups are made up of group members from diverse cultural backgrounds. The group therapist needs to understand the different cultures of the group members and how each member’s culture affects their participation in the group (Jacobs, 2012). As mentioned before, even if a group is solely offered and composed of members whom identify as Latinas, the members can still hold a wide array of diverse cultures from many Latin countries around the world; thus even in an all Latina women’s group there is much multicultural diversity.
**Women and psychotherapy groups.** There are many benefits to holding all women’s groups. According to Brody (1987) therapy groups for women eliminate the unconscious sexism that gender mixed groups (male and female) hold. Groups that are solely for women provide a supportive environment in which women can discover and experience the commonalities of being a woman. Brody (1987) states that in women’s only groups, participants are more able and willing to accept the expression, self-disclosure, and exploration of deep feelings, such as anger, more openly. This could be connected to the intense feelings of closeness since the expression and exploration of deep intense feelings tends to lead to intense feelings of closeness and trust between the female members of the group (Brody, 1987).

According to Brody (1987) research also highlights that topics that are considered taboo in gender mixed groups, such as sexuality and body image, are more openly discussed in women’s groups. "The all-women’s sexuality group provides a place where a woman can come and,... enter a supportive and protective place where she can discuss learn and practice an entirely different set of attitudes about herself and her sexuality" (Walen & Wolfe, 2000, p. 306). It is important however, to keep in mind that each female member of the group will be at different comfort levels of speaking about sexuality (Jacobs, 2012).

Walen and Wolfe (2000) describe that women's sexuality therapy groups have often resulted in reduced sexual anxiety, sexual inhibitions, and increased self acceptance, body acceptance, confidence in the ability to feel pleasurable feelings and increased desire for sex. Although Walen and Wolfe (2000) are referring to sexuality groups that aim to increase sexual enhancement, perhaps some of these benefits could result as a
consequence of providing a women's sexuality group that intertwines with adolescent parenting. There are many therapeutic factors that contribute to the benefits that Walen and Wolfe (2000) describe. One therapeutic factor is that there is a relief of self-blame and anxiety that comes from the group member’s shared suffering and the acceptance by others despite one's flaws. Another therapeutic factor is the powerful corrective emotional experience that women need to feel in order to create lasting changes in themselves. The final therapeutic factor is that of a facilitative learning environment (Walen & Wolfe, 2000), which can be experienced in many ways such as with the use of psychoeducational handouts and discussions, communication exercises, art activities, among others.

**Group and exercise discussions.** According to Jacobs (2012) exercises can be great for initiating discussion by triggering thoughts and feelings. Understanding the process of exercises is essential because the group processing of the exercise is ultimately the most important phase of any exercise. Processing a group exercise means spending time discussing thoughts, feelings, and ideas that were triggered by the exercise. In general group discussions can help stimulate members to delve deeper into their thoughts and feelings as well as facilitate group dynamics and group process that may be influenced by the group exercises.

When it comes to group discussion with specific topics, Jacobs (2012) supports the exploration and discussion of religion as beneficial either as a group or with dyad discussions. Some of the possible religious avenues for exploration can be the early parental religious messages that were received, religious history of members, personal benefits of religion, personal religious restrictions, religion as a personal choice, effects
of religion on guilt, sexual issues, marriage, divorce, abortion, and birth control among many other topics (Jacobs, 2012).

Jacobs (2012) also supports the exploration and discussion of the topic of sex with either group or dyad discussions. These discussions can include explorations of how members learned about sex, guilt related to sex, difficulties and inhibitions regarding sex, sex without love, sex and religious beliefs and early messages about sex, orgasm and pleasure, masturbation and fantasy, homosexuality, and more (Jacobs, 2012).

**Cognitive Behavioral Therapy (CBT)**

Cognitive Behavioral Therapy (CBT) is a theory focused on changing thoughts, behaviors and feelings by targeting dysfunctional beliefs that are caused by dysfunctional thinking (Gehart, 2013) since thoughts cause feelings (Jacobs, 2012). CBT can be implemented with individuals, couple’s, family and group psychotherapy (Gehart, 2013). Jacobs (2012) agrees that CBT is helpful for children, adolescents, and adults in psychotherapy groups because it helps them feel they are in control by learning that their feelings are caused by their thoughts.

**CBT and adolescents.** Talashek, Norr, and Dancy (2003) studied 30 intervention studies that addressed the issues surrounding adolescent pregnancy and adolescent sexual activity. Those that used a combination of cognitive-behavioral approaches showed the most effective results (Talashek, Norr, & Dancy, 2003). Cognitive-behavioral approaches are effective with sexuality themes because they incorporate improvement of problem-solving and decision-making skills by teaching assertiveness and communication, partner negotiation, personal responsibility, and understanding of feelings and emotions. Behavioral change is thus achieved by targeting self-efficacy and attitudes about
sexuality related risks (Talashek, Norr, & Dancy, 2003).

**CBT and Latinos/as.** According to Organista (2000) the literature supports Cognitive Behavioral Therapy as a theory that works well with the Latino population. One of the ways CBT is beneficial for the Latino population is that it focuses on actions and not just verbal expression; this is important to the Latino population since many tend to desire immediate symptom relief (Organista, 2000). Further, CBT offers less abstract explanations of problems than other more philosophically complex theories (Organista, 2000).

**CBT interventions.** As an important component of CBT, psychoeducation involves teaching clients about their problems and ways of how to handle these (Gehart, 2013). One of the ways that psychoeducation is provided is by giving information about the problem at hand to motivate clients to take action and change (Gehart, 2013). According to Jacobs (2012) giving information is a part of psychotherapy groups and it enables members to learn from the leader and from the discussion that follows. Jacobs (2012) suggests that when giving information, the information should be interesting, short (usually no more than 5–8 minutes), relevant, energizing, include considerations of cultural and gender differences, and the information needs to be current, correct, and objective.

This psychoeducational information can be statistical data to help illustrate trends and issues such as current sexuality statistics in the Latina adolescent population (i.e. sexuality transmitted infections, adolescent pregnancy, abortion), and information about family transgenerational patterns through the use of Genograms (McGoldrick & Gerson, 2008). Finally, according to Yalom (2005) imparting information about communication is...
helpful for the group members to understand some of the basics of communication patterns, thus psychoeducation on communication is a helpful intervention strategy.

**Family Systems Therapy**

Family systems therapy theories view the family as a system that runs on specific interactional patterns that govern family relationships (Gehart, 2014). This systemic way of viewing families means that no single person orchestrates the interactional patterns. Rather, all family members participate in these interactional patterns through the influence of feedback and correction that aims to always return the family to its usual state of normalcy (Gehart, 2014). Since these interactions dictate all methods of communication (verbal and non-verbal levels), personal characteristics and behavior make sense in the context of how the family system interacts and the messages they communicate on all levels. There are many theories that have been influenced by this family systems perspective, Murray Bowen’s intergenerational theory is one of these (Gehart, 2014).

Intergenerational therapy theory believes that families pass down myths, patterns and rules from generation to generation called the multigenerational transmission process through repetitive interactions that are connected to differentiation, boundaries and or the lack of these interpersonal and intrapersonal skills (Gehart, 2014; Kramer, 1985; McGoldrick, Gerson, & Petry, 2008). Differentiation refers to an individual’s ability to separate their intellectual and emotional functioning by separating thoughts from feelings in order to respond rather than react (Kramer, 1985). Differentiation also includes understanding where the self ends and the other individual begins without any loss of self (Kramer, 1985). Low differentiation can interfere with healthy family relationships and
boundaries by causing dysfunctional family relationships and interactions such as emotional reactivity, triangulation, and disconnections (Banowsky, 2001; Gehart, 2014). Intergenerational family systems therapy can help family members differentiate and halt the repetition of dysfunctional multigenerational (physical, psychological, and behavioral) patterns in families with the use of Genograms and other interventions (Banowsky, 2001).

**Genograms.** Genograms are a central assessment and intervention from intergenerational family therapy (Gehart, 2014; McGoldrick, Gerson, & Petry, 2008). A Genogram is a detailed visual tree map of three or more generations that show family structure, family relationships, and family multigenerational patterns (Banowsky, 2001). Genograms are helpful for therapists since they are aid in mapping out a family’s patterns in a systematic way to understand client’s and family’s problems in context. Genograms are not only useful in the field of family therapy, these are utilized as assessment tools in the field of family medicine because there is much value in family history (McGoldrick, Gerson, & Petry, 2008).

According to McGoldrick, Gerson, and Petry (2008) a Genogram is the most efficient framework for assessing sexual history. Sexual Genograms can help in understanding the function of fears and sexual relationship problems. Further, these sexual Genograms can be used to identify themes in families such as avoiding discussions of sex (McGoldrick, Gerson, & Petry, 2008). A Genogram is a valuable visual assessment tool that can help families track sexuality related patterns such as adolescent pregnancy in families, teenage abortion, sexually transmitted infections, etc. This intervention and assessment tool can hopefully also highlight communication patterns to
improve and restructure a healthier new way of communicating within families specifically in relation to communicating about sexuality related topics.

**Effective Communication Strategies**

**Emotionally Focused Theory (EFT).** Interaction cycles are an assessment tool that is reframed as the “enemy” to shift the focus away from the person (Johnson et al., 2005). This assessment strategy is one of the central concepts of Emotionally Focused Theory (EFT). EFT is a theory that combines attachment theory, humanistic, experiential and systemic approaches to be utilized mainly in couple’s therapy but also with families (Johnson et al., 2005). EFT is a short-term systematic evidenced based practice that helps in reducing distress in love relationships and creates more secure attachment bonds through the utilization of existing emotions from the relationship (Johnson et al., 2005). EFT can be incorporated in family therapy through Emotionally Focused Family Therapy (EFFT) which focuses on nurturance and connections between family members to create and maintain secure bonds (Johnson et al., 2005).

A strong secure attachment is viewed as having confidence that a family member will provide support, comfort, and protection and will remain emotionally responsive and accessible. EFFT is great for families with children or adolescents with symptomatic or behavior problems, parenting problems, interactional difficulties to prevent family breakdowns, and isolation within families and instead create flexible and open-systems (Johnson et al., 2005). By tracking and highlighting the negative communication interaction cycle that the family engages in, the family can gain a metaperspective on their underlying emotions that conduct the negative way they relate within their family relationships. A new healthy interactive cycle is necessary to promote attachment security.
within the relationship (Johnson et al., 2005).

**Parent Effectiveness Training (P.E.T).** As part of striving to help Latina mothers and their adolescent daughters restructure and improve their communication interactions; “Language of acceptance” is necessary for helping mother-daughter relationships (Gordon, 2000). This language helps kids be able to share their feelings and problems with their parents when they feel accepted by them. Parent Effectiveness Training (P.E.T) has many valuable interventions and interactive communicative teachings and techniques that work. Parent effectiveness Training (P.E.T) incorporates language of acceptance when helping parents learn to communicate differently and more effectively with their children (Gordon, 2000). Language of acceptance includes ‘You-messages’ and ‘I-messages’ which are helpful and efficient in many ways. These messages guide parents to own their problems, feelings, thoughts and behaviors through communication and as a result children learn to communicate in these positive ways by also owning their problems, thoughts, feelings and behaviors (Gordon, 2000).

A healthier and more effective way of communicating helps parents avoid ordering, directing, commanding, warning, threatening, preaching, and moralizing to their adolescents (Gordon, 2000). Gordon (2000) points out that ‘I-Messages’ can help children learn to assume responsibility for their own behavior. Further, it sends the message to the child that the parent is leaving the responsibility with them, trusting the child to handle the situation constructively, and giving the child the chance to behave constructively. Interventions on communication skills may give an alternative effective communication approach to Latina mothers and their daughters especially regarding the sensitive topic of sexuality.
**Art Therapy**

Art therapy uses art as personal expression to communicate feelings and is something that everyone can do regardless of creative and artistic abilities (Liebmann, 1986). Art therapy can be utilized in all psychotherapy groups including mixed groups of adults and children, and women’s groups (Liebmann, 1986). Liebmann (1986) suggests that psychotherapy groups that incorporate art consist of six to twelve members to ensure that members can maintain visual and verbal contact with all other members, group cohesiveness can be achieved, each member has adequate time during group discussions, and that there are enough members to allow for enough interaction and movement of ideas. Art therapy and family therapy can also be effectively combined to create family art therapy which Banowsky (2001) states to be a great intervention and therapeutic method for families. Through family art therapy, culture, experiences, family interactions, and needs in family relationships can be explored (Banowsky, 2001).

The beneficial aspects of art therapy are that it provides an alternative avenue of communication and creative expression, as well as the art projects being tangible offering the ability be kept by clients to be examined at a later time. Art can also incorporate fantasy and the unconscious, and finally art can be enjoyable which can lead the group to a shared pleasurable experience (Liebmann, 1986). Buchalter (2009) also supports art therapy as a vehicle to unconscious and conscious issues and beliefs. Art images also serve as vehicles to facilitate communication, growth and insight through the discussion of the artwork, which is important since it allows the group members to observe, analyze and relate to the representations and figures illustrated (Buchalter, 2009).

Liebmann (1986) states that working in pairs using art therapy is a way that art
therapy can be implemented during psychotherapy group sessions. Working in pairs is a great way to explore the dyad relationship by completing a joint art project such as a collage (Liebmann, 1986). Collages allow for free expression by using a variety of resources such as magazine pictures, which can help individuals to participate in an art activity since magazine pictures are easily accessible (Buchalter, 2009). There is no correct or incorrect way to create a collage since the photos just need to be torn or cut out and placed on a paper in any way desired (Buchalter, 2009). Collages can incorporate any directive such as using photos and or symbols that represent feelings, family members, and or incorporating likes and dislikes. Further, collages can specifically express social relationships describing how these communicate with each other, as well as relationships and boundary issues (Buchalter, 2009).

Art therapy can also incorporate other creative methods such as writing (Buchalter, 2009). Writing a letter can be an effective intervention exercise in which the group member writes a letter to someone they love or admire and illustrate the envelope using art to convey the contents of the letter. DeSalvo (1999) supports that writing can be therapeutic in the sense that it can provide an avenue for self-exploration and reconnection to life experiences. Writing can provide healing and an opportunity to gain new perspectives of past stories, experiences, emotions, and traumatic events. The experience of writing in combination with art therapy can be cathartic and help in the exploration of relationships and communication dynamics within families (Buchalter, 2009).

**Sex Therapy and Adolescents.**

Sex may be difficult to talk about in therapy with minors since it can often bring
up mixed feelings in clients and therapists; therapists often worry that they are contributing to the overstimulation of sexuality in the child’s world if they speak about sexuality with underage clients (Lamb, 2006). In spite of these discomforts, it is the therapist’s responsibility to slow down children and adolescents to help them reflect on what they understand about the sexual world around them and how these perceptions may influence them and the adults they might become (Lamb, 2006). After all, the understanding of oneself as a sexual being is part of psychological health (Lamb, 2006).

Lamb (2006) states that one of the therapy goals, when it comes to helping adolescent girls deal with issues of sex and sexuality, is to help them discover their own desire among the conflicting messages of the culture telling them for example, to be sexy while insisting they remain pure. Sex therapy can involve exploring how the adolescent’s sexuality may represent the need for attention, the need to be noticed, the need to have someone think they are special, the need to look tough, and the need to belong (Lamb, 2006). Some adolescent girls need help in avoiding acting out their feelings of worthlessness, depression, or anxiety in dangerous sexual ways (i.e. unprotected sex). By allowing and encouraging them to bring these feelings in therapy adolescent girls can talk about their developing sexuality and learn to make better choices out in the world (Lamb, 2006).

One of therapist’s main worries regarding discussions of sexuality topics with children and adolescents in therapy is that parents do not or will not give permission and or might try to legally sue the therapist if they find out that sexuality related conversations are taking place in therapy sessions with their children (Lamb, 2006). Additionally, therapists often worry that adolescents will not get the adult help they need
to acquire accurate information or see the long-term consequences of their sexual behaviors (Lamb, 2006). When it comes to sexual abuse, therapists are trained to be on alert for signals of this form of abuse especially when children bring up sexual material in session, considering that children that have been sexually abused tend to bring up sexual material in sessions (Lamb, 2006). However children and teenagers also have healthy and positive sexual lives and thus therapists can help in supporting them in understanding their sexual selves in ways appropriate to their developmental age. Lamb (2006) states that some children who have not been sexually abused can present as over preoccupied with sex due to overstimulation from the culture, thus it is important to note that not all sexuality discussions are related to child sexual abuse.

So far the literature supports the idea that there is a gap in communication when it comes to sexuality topics between Latina mothers and their adolescent daughters. This communicative gap tends to lead to misinformation of sexual knowledge for young Latinas. Lack of sexual knowledge places Latinas at risk for various serious sexuality related risks such as unplanned adolescent pregnancy, abortion, and sexually transmitted infections. The literature also depicts a sexual education gap across the public school system. As a result, young Latinas are left without much accurate and reliable sexual education, sexuality life skills, and overall with a lack of sexuality guidance needed to navigate their sexuality development.

Through the use of evidenced based interventions such as the ones mentioned, preventative interventions can be utilized to narrow the sexuality communication gap over time in families. These psychotherapy interventions can help in developing and strengthening mother-daughter relationships. Stronger mother-daughter relationships
can lead to the increase of open lines of communication between these and thus provide young Latinas with a stronger support system from which they can receive information and guidance related to their sexuality development. As an intervention Mothers and Daughters: Conversations about Sexuality group curriculum is designed to help Latino families. The following chapter describes how Mothers and Daughters: Conversations about Sexuality group curriculum was designed and how it is to be implemented.
CHAPTER THREE: METHODS AND PROCEDURES

Introduction

The purpose of this project is to create an intervention that will help Latina mothers and their adolescent daughters improve communication regarding sexuality topics. Sexuality topics include but are not limited to: contraception, sexually transmitted infections, adolescent pregnancy, abortion, coercive relationships, masturbation, etc. This psychotherapy group curriculum named “Mothers and Daughters: Conversations about Sexuality”/ “Madres e Hijas: Conversaciones Sobre la Sexualidad” is designed to be culturally sensitive for the Latina population. Researchers have noted that psychotherapy groups for the Spanish speaker population related to communication and sexuality are lacking. This psychotherapy group integrates a systemic approach and also combines cognitive behavioral therapy (CBT) interventions, Art therapy interventions, effective communication practices from Emotionally Focused Therapy (EFT), and Parent Effectiveness Training (P.E.T). The group curriculum also incorporates extensive group process in both verbal and written expression.

Additionally, this group accommodates group members that may have difficulty bringing up topics by the usage of an “Anonymous Box”. The overall design of this women’s psychotherapy group is to raise awareness of the need for increased effective communication between Latina mothers and their adolescent daughters, specifically as it relates to sexuality. An additional purpose of the group is to and to provide information regarding the negative effects that can arise from the lack of open communication in families about sexuality. The goal of the group is to strengthen the quality of attachment between Latina mothers and their daughter(s), to improve relationships, and to facilitate
effective and clear communication. This group will also provide parenting and communication skills guidance to improve on the previously mentioned areas.

Development of Project

During my adolescence I struggled with lack of open and clear sexuality related communication with my mother; many other Latina friends also had this issue with their mothers. I have always been inclined to learn about human sexuality (I received a minor in Human Sexuality during undergraduate studies) as well as interested in learning about parenting and adolescence. I hoped to create an intervention tool that could combine all of these topics of interest and solve a realistic and current problem in today’s Latina community. I explored the idea with my thesis chair and delved in the current research on the subject.

The CDC (2006; 2012) suggests a current gap in the comprehensive sexual education thatLatinas are exposed to. There is also a need for sexuality related mother-daughter psychotherapy groups since most sexuality related groups are for adult women on marital sexual satisfaction topics. Specifically groups conducted in Spanish on the sexuality topic are almost non-existent. Researchers have shown the negative effects of high risk sexual behaviors such as pregnancy, sexually transmitted infections, and abortions as presently affecting the Latina population. This psychotherapy group is a preventative effort to equip adolescent Latinas with the necessary accurate information to make the best sexuality related choices for themselves through close relationships with their mothers. In this role, mothers can serve as sources of support, knowledge and resources.
This psychotherapy group is a combination of a support group, self-growth group, training group, and education group. It aims to support mothers who may feel that they are alone and hopeless in their struggle of raising an adolescent daughter. The training part of the group aims to train mothers and their daughters on effective and clear communication techniques. The education piece of the group is designed to inform, through the use of psycho-education about sexuality related risks and benefits of open clear sexuality communication. This group is also a self-growth group since it incorporates time to process all the information given and gain insight on the intricate factors that are connected to sexuality through the use of extensive journaling.

The group is to meet every week for a two hour session during 11 consecutive weeks. It is considered a brief psychotherapy group since it lasts less than six months (Yalom 2005). The ideal group size is between 8 members (4 mothers / 4 daughters) to 10 members (5 mothers/ 5 daughters). This group size will help foster an intimate environment for the group culture and thus encourage open honest discussion among all group members. This psychotherapy group is a closed group in order to avoid disruptions from incoming members who would also be missing important information from previous sessions. This closed group policy would also help to avoid disruption in the relationship building process between the group members.

**Intended Audience**

Although it is important for all mothers to have open and clear communication with their daughters, this psychotherapy group is designed specifically for Spanish and or English speaking Latina mothers and their adolescent daughters aged 11-17. It is important to exclude anyone below the age of eleven since they are not yet considered
adolescents and to also avoid having an age group that is too far apart among the Latina adolescent daughter members. Further, while it is beneficial to start sexuality conversations early and to initiate open communication between mothers and daughters starting from an early age, this group is designed to target adolescent female Latinas and their respective mothers. This group is specifically designed to help facilitate sexuality conversations before Latinas transition into adulthood.

Even though this group implements a parenting skills component, and Latino fathers are sometimes active participants in the communication of sexuality related topics with their adolescent daughters, this group is solely designed for mothers and their daughters. This is important since this group is an all-women’s group that aims to provide a safe space for women to come together and discuss mostly women related sexuality topics. In the case that an adolescent Latina does not have her biological mother available; a female guardian who is responsible for her parenting can take her mother’s role in the group.

**Qualifications**

This psychotherapy group can be facilitated by one or two therapists (no more than two) whom identify as Latinas themselves. Being a culturally competent Latina therapist may help aid the group members in feeling more understood and welcomed. The therapist(s) must be female since this group is an all-women’s group. This is important because the all-women group mandates a female since this reinforces the important concept that women are the best authorities on their sexuality (Walens & Wolfe, 2000). This gender requirement is important to help the female group members feel the most comfortable to discuss sensitive topics such as sexuality. Besides helping facilitate
sexuality topics, Broody (1987) states that female therapists are more sensitive to women's issues and can provide a positive identification model for the group members; thus it is beneficial for women groups to be led by female therapists. In order to conduct each session in both English and Spanish, the therapist(s) needs to be bilingual in order to meet the linguistic needs of all group participants. Finally, each group therapist should be a Marriage and Family Therapy trainee, intern, or licensed therapist due to this group integrating a systemic approach.

Environment and Equipment

This psychotherapy group can take place in a government funded mental health agency, resource center, cultural center, private practice, non-profit agency, etc. in the Latina community. A private room is necessary with enough space to accommodate about 12 individuals (group members and therapists) with a white or chalk board available in the room. All consent forms and legal documents required by the center must be collected and kept following proper confidentiality protocol. Journals for each member are necessary and these are to be confidentially kept and secured by the therapist(s) after each session. The provided session handouts must be printed at the start of each corresponding session in both the Spanish and English languages. These handouts are to be collected and placed in the same file/cabinet where the individual journals are safely kept. The Genograms and collages are to also be safely kept alongside the journals and session handout until the end of the final group session when all group members take home their completed group work and all other documents.

To complete the Genogams, collages and all activities, the following materials and tools are necessary; pens, pencils, markers/crayons, rulers, glue, scissors, magazines,
12 x 12 and 28 x 22 poster boards. A box for anonymous questions and comments named “Anonymous Box” is also required. This box is designed in case group members do not want to ask something or comment on something in front of the group. Group members can place an anonymous note in the box which would then be discussed during the sessions and still keep anonymity of the person who wrote it.

**Project Outline**

I. Introduction: A Note for the Clinician(s)
   a. Materials and Necessities
   b. Psychoeducational Handouts
   c. Tone of Group
   d. Clinician Requirements
   e. Group Member Requirements
   f. Final Session
   g. Group Rules

II. 11-Session Curriculum: “Mothers and Daughters; Conversations about Sexuality”
   / “Madres e Hijas; Conversaciones Sobre la Sexualidad”


   Goal: To introduce group members to each other, to sexuality topics, and to group process in order to begin establishing group cohesion and sexuality discussions.
   a. Silence Breaker
b. Handout 1: “Sexuality Statistics in the Adolescent Latina Community”
   / “Estatísticas de Sexualidad en la Comunidad de Latinas Adolescentes”

c. Group Process
d. Journal Process

2nd Session: Introduction of family system dynamics: transgenerational Genogram
   mother-daughter dyad activity.
   
   Goal: To create a Genogram by each mother-daughter dyad with at least
   three generations to begin to explore and learn each member’s family
   history and transgenerational patterns.
   
a. Silence Breaker

b. Dyad Genograms
c. Journal Process

3rd Session: Detailed analysis of familial patterns: identification of patterns,
   mother-daughter dyad goal setting, and group sharing.
   
   Goal: To highlight transgenerational patterns from Genogram to begin to
   explore these patterns and to further connect with group members.
   
a. Silence Breaker

b. Handout 2: “Trangenerational Patterns”/ “Patrones
   Trasgeneracionales”
c. Group Process
d. Journal Process

4th Session: Continued detailed analysis of familial patterns: identification of
   patterns, mother-daughter dyad goal setting, and group sharing.
Goal: To highlight transgenerational patterns from Genogram to begin to explore these patterns and to further connect with group members.

a. Silence Breaker

b. Handout 2: “Tragenerational Patterns”/“Patrones Trageneracionales”

c. Group Process

d. Journal Process

5th Session: Introduction of communication interaction topics: Psychoeducation of effective clear communication practices and the benefits and effects of this.

Goal: To educate group members about the basics of communicational interactions and to introduce the group process to communication topics.

a. Silence Breaker

b. Handout 3: “Thoughts and the Basics of Sexuality Communication” / “Pensamientos y lo Basico de la Comunicacion Sexual”.

c. Group Process

d. Journal Process

6th Session: Continued discussions of communication practices: analysis of mother-daughter dyad communication interactions.

Goal: To help guide group dyads in learning about their specific communicational interactions with each other.

a. Silence Breaker

b. Group Process

c. Handout 4: “Communication Interaction Cycle” / “Circulo de
7th Session: Communication intervention: increasing differentiation by communicating without reacting, blaming, and generalizing

Goal: To provide a communication intervention so that mother-daughter dyads can begin to speak to each other more effectively and positively.

a. Silence Breaker
b. Group Process
c. Handout 5: “You and I messages” / “Mensajes de Tu y Yo”
d. Group Process
e. Journal Process

8th Session: Extensive Group Process: Exploring the interconnection of cultural, sexuality, and familial topics.

Goal: To guide group members in exploring how their beliefs and attitudes about their sexuality have or are being shaped.

a. Silence Breaker
b. Extensive Group Process
c. Provide Homework Assignment to Daughters
d. Journal Process

9th Session: Continued extensive group process and continued daughter to mother letters.

Goal: To allow daughters to voice to their mothers what they desire from
their mother-daughter relationship and allow group process of these needs.

a. Silence Breaker
b. Group process
c. Daughter to Mother Letter
d. Journal Process

10th Session: Final dyad activity: Dyad Collage with the directive of creating a vision that shows what the dyad desires in terms of communication (especially regarding sexuality), and relationship dynamics.

Goal: To allow both daughters and mothers to visualize what they want their relationship to look like through a shared art activity.

a. Silence Breaker
b. Mother-Daughter Collage
c. Journal Process

11th Session: Final session: Presentation of Collages, and final group process.

Goal: To allow both daughters and mothers to present their visualizations of what they want their relationship to look like as they navigate through life.

a. Silence Breaker
b. Collage Presentations
c. Final Group Process
d. Final Journal Process
e. Presentation of all work and documents kept (all handouts, Genograms, Journals, Psychoeducational handouts, and Collages) for
each group member to take home.

f. Provide Community Resources

g. Possible/Optional Group Celebration (i.e. pot-luck) depending on agency protocol
CHAPTER FOUR: CONCLUSION

Second-Order change is when a system creates a new Homeostasis with new rules that regulate the new system as result of Positive Feedback (Watzlawick, Weakland, & Fisch, 1974). In comparison, First-Order change occurs when a system returns back to its previous homeostasis as a result of Positive Feedback (Watzlawick, Weakland, & Fisch, 1974). Positive Feedback refers to new information that is given to the system to alter it and create change (Gehart, 2014). In contrast, Negative Feedback refers to equivalent and redundant information that is given to the system leading to no change (Watzlawick, Weakland, & Fisch, 1974). Homeostasis refers to a state of balanced and stable normalcy (Watzlawick, Weakland, & Fisch, 1974). Second-Order change is the level of change that this psychotherapy group curriculum strives to achieve.

Mothers and Daughters: Conversations about Sexuality is a psychotherapy group curriculum intervention that aims to establish Second-Order change within Latino families. Since Second-Order change requires new rules and new interactions to ultimately form a new family system, this psychotherapy group curriculum needs to be able to provide enough Positive Feedback to enact change. Positive Feedback is given through the use of evidenced based psychotherapy interventions to create change and ultimately a new homeostasis between Latina mothers and their adolescent daughters.

Summary of Project

Mothers and Daughters: Conversations about Sexuality psychotherapy curriculum offers Latina mothers insight about the importance of speaking to their daughters about sexuality topics such as contraception and adolescent pregnancy. Information and increased awareness about sexuality related risks is also given through the use of
interventions such as psychoeducational handouts. Increased insight about the reasons why Latina mothers avoid sexuality related conversations is also addressed through the use of trangenerational Genograms and group process. Education about positive and effective communication skills is provided through the use of psychoeducational and worksheet handouts as well as through role-plays. Finally a new goal and vision for a new mother-daughter relationship is established through the use of writing, collages, and group process. These various interventions are designed to provide Positive Feedback for the mother-daughter relationship in order to create a new homeostasis.

The group leader will strive to create a supportive environment where mothers can relate to their daughter(s) on a deeper level and also relate to other women in the group. The ultimate goal of this project is for Latina mothers and their adolescent daughters to create positive, fluid, open lines of communication to allow for increased conversations about sexuality topics so that young women can diminish sexuality related risks such as sexually transmitted infections among others. It is my belief that increasing positive and more effective communication skills between mothers and daughters will lead to stronger and healthier relationship bonds. Further, stronger relationships bonds and the use of positive communication regarding sexuality may lead young Latinas to increase their sense of agency in sexual situations so that they can make the best decisions that fit their desired quality of life.

**Recommendations for Implementation**

Although this psychotherapy group is designed for mother-daughter dyads, a Latina adolescent can have another female guardian as representation of the mother role. This relationship may not have the same characteristic as a mother-daughter relationship
thus it is preferred that all group dyads be composed of mothers and their daughters if possible. Since there is implementation of much process and mother-daughter activities it is best that each Latina mother attend this group with one adolescent daughter. The maximum amount of adolescent daughters present to each mother is two, however this can compromise the amount of time a mother can dedicate to her daughter during group therapy sessions. Further, this can also compromise the overall group time planning.

Lastly, this psychotherapy group curriculum could perhaps be implemented in a school setting and or mental health agency. These settings can perhaps help reach Latinas who may not be familiar or involved with psychotherapy. These settings can also perhaps offer this mental health resource as economically reachable to Latino families who may not otherwise afford mental health.

**Recommendations for Future Research**

It was difficult to find research on pre-existing psychotherapy groups that included familial dyads such as mothers and their daughters, this could be due to lack of psychotherapy groups who consist of dyads such as these. Research on women’s groups specifically composed of Latina women was also difficult to find. An exploration of women’s psychotherapy groups in the Latina population can serve as useful to help determine if these are effective.

Much research and information is available when it comes to psychotherapy groups that focus on sexuality themes mainly as it pertains to sexuality related disorders among adult women. However, research is lacking when it comes to psychotherapy groups that combine sexuality topics and parenting skills. Research in this area can be helpful in determining if a psychotherapy group modality is in fact effective as a
parenting intervention when it comes to sexuality parenting. Lastly, research on psychotherapy groups that are facilitated in both the English and Spanish languages is missing. This research could help determine if a bi-cultural and bi-lingual psychotherapy group can be efficient and helpful in spite of the possible language and cultural barriers that may arise.

Limitations

As mentioned, this psychotherapy group curriculum is designed for group members who either speak English or Spanish. This could lead to the loss of certain cultural and linguistic concepts during the translation process. This translation process could also slow down the group process and momentum of the sessions. The bi-lingual component is incorporated to accommodate Latina mothers who have not mastered the English language and who may struggle to communicate with their daughters because of a possible language barrier.

Another limitation is that this psychotherapy group curriculum is specifically designed for mothers of Latina adolescents leaving out the fathers of the Latino family. This is done in part because female children in Latino families tend to receive more sexual information from their mothers than their fathers (Anagurthi, 2011). In the future this psychotherapy group curriculum can be modified to include fathers of Latino families since they also belong to the family system. Through this paternal inclusion the psychotherapy group can continue to expand the horizons of Second-Order change regarding sexuality communication and education throughout the family system.

This psychotherapy curriculum is designed specifically for adolescent Latinas however it can be modified to target parent sexuality communication towards Latino
adolescent males. Adolescent males also face sexuality related risks such as sexually transmitted infections thus adolescent males can also benefit from stronger communication relationships with their parents regarding sexuality. A group for Latino male adolescents could include only their fathers, only their mothers, or perhaps both parents.

The Latino population is not the only ethnic group that can benefit from open and fluent communication regarding sexuality topics. Other ethnic groups also face sexuality related risks of adolescent unplanned pregnancy, adolescent abortions, and sexually transmitted infections. Thus this psychotherapy group can also be modified to target other ethnic populations. The cultural component of that ethnic group would have to be included since sexuality and culture are intertwined.

**Possible Risks**

Some of the risks associated with Mothers and Daughters: Conversations about Sexuality psychotherapy group are that Latina mothers may feel their cultural norms and views regarding sexuality are not acceptable or must be replaced. In order to manage this risk, Latina mothers who participate in the group, must feel understood and respected. To facilitate understanding and respect, open dialogue is needed between the group leader(s) and among group members about the best ways to honor the Latino culture while increasing their understanding of the sexual educational needs of their adolescent daughters. Latina mothers sometimes need help and support in understanding that their adolescent daughters are developing and maturing in a culture different from their own. Through mutual respects of the culture in which the Latina mothers grew up in and the culture that their daughters are experiencing as they grow, a common ground can be
established that incorporates all participating cultures while still maintaining open lines of communication and strong mother-daughter relationship bonds.

Conclusion

There are many reasons why Latina mothers fail to effectively and positively communicate with their adolescent daughters about sexuality. As a possible consequence Latina adolescents fail to receive reliable and accurate sexuality information in their home environment. Latinas often also do not receive adequate, reliable, and accurate sexual education in the school environment. These gaps of sexual education and parental guidance lead Latina adolescents to be misinformed regarding sexuality topics. This misinformation often leads adolescent Latinas to increase their risks of acquiring sexually transmitted infections, teenage pregnancy, adolescent parenthood, and or experience adolescent abortion as a way out of their situation. These sexually related risks can lead to economic difficulties, familial and societal shame and rejection, difficulties in educational advancement, as well as an overall undesired quality of life that can lead to mental health issues.

To intervene in the gap of maternal communication regarding sexuality topics between Latina mothers and their adolescent daughters, a psychotherapy group curriculum is offered. The group curriculum is carefully designed since it pulls interventions from various theories to design a specific intervention for Latina women and families. Mothers and Daughters: Conversations about Sexuality group curriculum will effectively lead to Second-Order change and a new homeostasis where Latina mothers and their adolescent daughters will engage in increased sexuality communication. This new homeostasis will result in Latina mothers being open and
willing to communicate and educate their daughters about sexuality and the risks associated. This new homeostasis will also result in Latina adolescent daughters to feel more willing and open to ask sexuality related questions and communicate about these topics with their mothers. Ultimately, Mothers and Daughters: Conversations about Sexuality group curriculum is designed to celebrate and strengthen the special mother-daughter relationship within Latino families.
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Mothers and Daughters: Conversations about Sexuality

(Madres e Hijas: Conversaciones Sobre la Sexualidad)

Jennie Zuniga
# Group Outline

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Overview

This group curriculum is designed for a 12 week process. Each session should be two hours long with a break of fifteen minutes. It encompasses various interventions from various theories to create a collaborative, eclectic and effective group intervention modality. The general clinical goal of this group curriculum is to help Latina mothers feel more confident and comfortable in communicating with their teenage daughters in general but specifically regarding sexuality topics. There are many negative effects that occur when there is lack of or inadequate education and communication regarding sexuality with teenage girls. Sexually transmitted infections (STIs), teenage pregnancy, and teenage abortions are a few of the negative consequences that could decrease the quality of life for a woman in terms of economic status, physical and mental health.

By educating and encouraging mothers and their adolescent daughters to communicate about sexuality topics we can make an impact on the futures of young Latina women. Even though many Latina mothers wish to retain and instill their cultural and religious beliefs from their country of origin, many others also wish to reach a more balanced level of acculturation in regards to their parenting practices in order to maintain generational familial cohesiveness.

The purpose of this group curriculum is to offer tools to increase effective communication regarding sexuality topics between Latina mothers and their teenage daughters. Increased effective communication can help Latina mothers better relate to their daughters in all areas of their lives and improve their overall relationship. Having open and effective communication and a positive relationship can help Latina mothers guide their teenage daughters in being prepared with dealing with their own sexuality as they grew into adulthood.
Materials and Necessities

• White board/ or a large piece of paper and tape in order to write down feelings for every group member to see.

• Journals for each member are necessary so they may document their experiences about the therapy group during the last 10-15 minutes of each group session. The group participants may keep the journals confidential or chose to share their contents with the group. These journals are to be kept safe and private by the group leader at the end of each session. Group members are to not take any journals home until the end of the last group session.

• Each mother-daughter dyad needs a document folder/drawer where handouts, worksheets, art projects and process journals can be safely kept to be accessed when necessary. These documents are not to be given to take home by the dyad until the end of the last group session.

• A box for anonymous questions and concerns named “Anonymous Box” is needed. This box is to be used for group members who may not want to ask something or comment on something in front of the group. Group members can place an anonymous note in the box to be discussed during sessions while keeping anonymity of the person who wrote. Although the outline has designated certain sessions to reading these notes you can read these as time permits during any session.

• Other materials needed are: pencils, pens, markers, rulers, scissors, glue, poster boards (1 for each dyad) (Around 28 x 22 size or larger if needed for large families) for Genograms, name tags, the handouts for each session, 12 x 12 size paper (1 for each dyad) and magazines for Collages.

• A private room with enough space to fit at least 12 group members. Since the topic is very personal, privacy is essential.
Psychoeducational Handouts

The first psychoeducational handout which gives sexuality related statistics in the adolescent Latina population of the United States is based on the most updated national statistics. This psychoeducational handout should be updated so that the statistics offered include the most available data. The second psychoeducational handout does not need to be updated since it is based on communication information.

Tone of Group

It is important for each group member to feel safe thus the tone of the group needs to incorporate empathy, compassion, respect, genuine curiosity, and genuine presence. Appropriate humor is also an important component that can help the tone be less threatening and less serious which will facilitate the nature of the topics and discussions. The tone of the group needs to be professional yet friendly to decrease anxiety regarding the sexuality topics discussed.

At the start of each group session, a warm up exercise called “silence breaker” will be utilized. For each session, a silence breaker is provided, however these could be replaced with any that you have in mind for that specific session. These silence breakers are meant to be fun and engaging. Silence breakers can be linked to the session topic and in some sessions they already are. These silence breakers are also meant to do just what they are named; to break the silence in the group and hopefully between mothers and their daughters regarding sexuality topics.

Clinician Requirements

Since this group curriculum is specifically designed for Latina women the therapist or therapists (no more than 2) will need to be Latina women themselves. The female therapist needs to be a bilingual speaker able to fluently speak and conduct therapy in both English and Spanish. The group facilitator should be a Marriage and Family Therapy trainee, intern, or licensed therapist since this group integrates a systemic approach.
Group Member Requirements

This group curriculum is specifically designed for the Latina population thus the group members need to identify themselves as mainly Latinas. This group curriculum accommodates monolingual Spanish speakers as well as monolingual English speakers. The Latina mothers can be of any age however each daughter participant needs to be between the ages of 12-17. Mothers could have more than one daughter present if they meet the age criteria but should be kept to a maximum of two daughters per mother to ensure enough time and emotional availability between mothers and their daughters.

Final Session

For the final session all group members are to receive all the work they have completed while participating in the group (including their process journals). The anonymous box should be empty and all notes should have been discussed by the final session without leaving any un-processed and or un-answered. Since group process and activities can often take longer than expected there could be a final 12th session to allow ample time to finish all planned activities. The Latino culture tends to embrace reunions and celebrations around food. If your agency (or location in which the psychotherapy group takes place) permits, the final session could incorporate a “pot-luck”. This would be an opportunity for the mother-daughter dyads to prepare a cultural dish together and for all group members to gather in celebration of their collective therapeutic journey while sharing their individual diverse Latino cuisine.
GROUP RULES

- All members are to keep confidentiality of what is shared in group sessions.
- All members are to show respect and be respectful for all group members.
- All members are to respect and be mindful of the limited amount of time when they share to allow others to have time to speak.
- All members are to arrive on time so that the group sessions can begin on time to allow enough time to complete all activities.
- All members are to respect the amount of time given for break time (10-15 minutes) to allow enough time to complete all activities.
- All members are to attend all group sessions. If there is an understandable reason for missing group, those members should notify the therapist(s) before the session and should catch up with the group by completing the missed handouts, etc. on their own time to ensure that they do not miss important material.
- All members are to respect when one person is speaking to the group and avoid side conversations to be respectful of the person speaking/sharing.
- All members are to leave their worksheets, Genograms, handouts, process journals, and vision boards in the care of the group therapist(s) who will secure these in a designated document folder for each dyad. This will allow the documents to be accessed when needed during sessions and to be received to take home at the end of the last group session.
GOAL: TO INTRODUCE GROUP MEMBERS TO EACH OTHER, TO SEXUALITY TOPICS, AND TO GROUP PROCESS IN ORDER TO BEGIN ESTABLISHING GROUP COHESION AND SEXUALITY DISCUSSIONS.

MATERIALS:

CONSENT FORMS AND OTHER NEEDED LEGAL DOCUMENTS SHOULD BE COLLECTED BY THIS POINT

NAME TAGS

WRITING BOARD & MARKER

BLANK JOURNALS (ONE FOR EACH MEMBER THAT WILL BE KEPT LOCKED UP TO BE USED AT END OF EACH GROUP MEETING) & PENS

HANDOUT #1: PSYCHOEDUCATION “SEXUALITY STATISTICS IN THE ADOLESCENT LATINA COMMUNITY”/ “ESTATISTICAS DE SEXUALIDAD EN LA COMUNIDAD DE ADOLESCENTES LATINAS”

- MOTHERS AND THEIR DAUGHTERS SIT NEXT TO EACH OTHER (FOR ALL SESSIONS).
- EACH MEMBER WEARS THEIR NAME TAG AND INTRODUCES THEMSELVES IN THE LANGUAGE THEY PREFER.
- SILENCE BREAKER: PLAY “TWO TRUTHS AND A LIE” WHERE EACH MEMBER SHARES THREE THINGS ABOUT THE AND ONE OF THOSE IS A LIE. THE GROUP TRIES TO GUESS WHICH IS THE LIE.
- PSYCHOEDUCATIONAL HANDOUT #1 IS PASSED OUT IN LANGUAGE EACH PREFERS. ALLOW AND ENCOURAGE DISCUSSIONS.
- FOCUS ON AND ENCOURAGE EXPRESSION OF FEELINGS THAT ARE COMING UP WITH THE DISCUSSION WITH QUESTIONS/ PROMPTS SUCH AS: WHAT ARE YOUR REACTIONS TO THESE STATS?, WHAT FEELINGS ARE COMING UP FOR YOU?
- WRITE DOWN THOSE FEELINGS IN LIST FORM ON WHITE BOARD.
- PASS OUT JOURNALS. ALLOW 10-15 MINUTES FOR MEMBERS TO WRITE DOWN FEELINGS, THOUGHTS, IDEAS, QUESTIONS, ETC. COLLECT JOURNALS AND LOCK THEM. EXPLAIN TO MEMBERS THAT THEIR JOURNALS ARE NOT READ AND ARE TO REMAIN LOCKED UP AND NOT TAKEN HOME UNTIL THE FINAL SESSION.

FIRST SESSION

**Give 10-15 min Break when you deem appropriate**
Sexuality Statistics in the Adolescent Latina Community

Contraception Use

Self reported reasons for not using contraceptives resulting in an unintended pregnancy for Latinas ages 15-19 (CDC, 2012). (4)

- 42% reported “Thought I could not get pregnant at the time”
- 24.5% reported “Partner did not want to use contraception”
- 24.4% reported “Did not mind if I got pregnant”
- 10.7% reported “Had trouble getting birth control”
- 4.2% reported “Side effects from contraception”
- 7.6% reported “Thought partner or I was sterile”

Self reported contraceptive methods used resulting in an unintended pregnancy for Latinas ages 15-19 (CDC, 2012). (4)

- 20.4% used highly effective methods (i.e. oral pills, patch, vaginal ring, etc)
- 26.3% used moderately effective methods (male condoms)
- 4.0% used less effective methods (i.e. withdrawal, rhythm)
- 49.3% used no method

Abortions

Claimed abortions in 2010 from adolescent Latinas in certain reporting areas of the United States (CDC, 2013). (2)

- 395 abortions from Latinas below the age of 15
- 728 abortions from 15 year old Latinas
- 1,305 abortions from 16 year old Latinas
- 2,040 abortions from 17 year old Latinas
- 3,410 abortions from 18 year old Latinas

Pregnancy


- 1991: 10.46%
- 2007: 7.53%
- 2011: 4.94%
Births in 2012 for unmarried adolescent Latinas in the United States (CDC, 2013). (3)

- 1,380 births from Latinas below the age of 15;
  - Of these births 101 occurred before 34 weeks of gestation (7.26%)
  - Of these births 33 (2.37%) were born under weight (less than 1,500 grams)
- 4,415 births from 15 year old Latinas;
  - Of these births 256 occurred before 34 weeks of gestation (5.74%)
  - Of these births 90 (2.01%) were born under weight (less than 1,500 grams)
- 10,306 births from 16 year old Latinas;
  - Of these births 491 occurred before 34 weeks of gestation (4.55%)
  - Of these births 140 (1.30%) were born under weight (less than 1,500 grams)
- 17,079 births from 17 year old Latinas;
  - Of these births 735 occurred before 34 weeks of gestation (3.98%)
  - Of these births 245 (1.33%) were born under weight (less than 1,500 grams)
- 24,887 births from 18 year old Latinas;
  - Of these births 1,028 occurred before 34 weeks of gestation (3.61%)
  - Of these births 371 (1.30%) were born under weight (less than 1,500 grams)

A total of 89,548 births from unmarried Latinas between the ages of 15-19 years old

Sexually Transmitted Infections

New reported HIV infections for Latina females ages 13-24 in 2010 (CDC, 2014) (1): 290

New reported STI infections of Latina females in 2012 (CDC, 2014) (5)

- Chlamydia in ages 10-14: 1,400
- Chlamydia in ages 15-19: 41,389
- Gonorrhea in ages 10-14: 156
- Gonorrhea in ages 15-19: 3,795
- Syphilis in ages 10-14: 0
- Syphilis in ages 15-19: 28

### Uso de Anticonceptivos

Informe de embarazos no deseado con mujeres Latinas entre los 15-19 años y las razones por lo cual no usaron anticonceptivos (CDC, 2012) (4)

- 42% reportaron “Pensé que no podría quedar embarazada en el momento”
- 24.5% reportaron “Mi pareja no quería usar anticonceptivos”
- 24.4% reportaron “No me molestaba poder quedar embarazada”
- 10.7% reportaron “Tuvimos problemas en conseguir anticonceptivos”
- 4.2% reportaron “por los efectos secundarios de los anticonceptivos”
- 7.6% reportaron “Pense que yo o mi pareja era estéril”

Informe de métodos anticonceptivos utilizados y que resultaron en un embarazo involuntario de Latinas entre las edades 15-19 (CDC, 2012) (4)

- 20.4% utilizaron métodos altamente eficaces (ejemplos; píldoras anticonceptivas, parche anticonceptivo, anillo vaginal)
- 26.3% utilizaron métodos moderadamente eficaces utilizados (ejemplo; condon masculino)
- 4.0% utilizaron métodos menos eficaces (ejemplo; método del ritmo, eyaculación externa)
- 49.3% no utilizaron algún método

### Abortos

Abortos reclamados en el 2010 de las adolescentes Latinas en ciertas áreas de información de los Estados Unidos (CDC, 2013) (2)

- 395 abortos de Latinas menores de 15 años
- 728 abortos de Latinas de 15 años
- 1,305 abortos de Latinas de 16 años
- 2,040 abortos de Latinas de 17 años
- 3,410 abortos de Latinas de 18 años

### Embarazos


- 1991: 10.46%
- 2007: 7.53%
- 2011: 4.94%
Nacimientos en 2012 de Latinas solteras adolescentes en los Estados Unidos (CDC, 2013) (3)

- 1,380 nacimientos de Latinas menores de 15 años;
  - De estos nacimientos 101 ocurrieron antes de las 34 semanas de gestación (7.26%)
  - De estos nacimientos (2.37%) nacieron bajo peso (menos de 1,500 gramos)
- 4,415 nacimientos de Latinas de 15 años;
  - De estos nacimientos 256 ocurrieron antes de las 34 semanas de gestación (5.74%)
  - De estos nacimientos 90 (2.01%) nacieron bajo peso (menos de 1,500 gramos)
- 10,306 nacimientos de Latinas de 16 años;
  - De estos nacimientos 491 ocurrieron antes de las 34 semanas de gestación (4.55%)
  - De estos nacimientos 140 (1.30%) nacieron bajo peso (menos de 1,500 gramos)
- 17,079 nacimientos de Latinas de 17 años;
  - De estos nacimientos 735 ocurrieron antes de las 34 semanas de gestación (3.98%)
  - De estos nacimientos 245 (1.33%) nacieron bajo peso (menos de 1,500 gramos)
- 24,887 nacimientos de Latinas de 18 años;
  - De estos nacimientos 1,028 ocurrieron antes de las 34 semanas de gestación (3.61%)
  - De estos nacimientos 371 (1.33%) nacieron bajo peso (menos de 1,500 gramos)

Un total de 89,548 nacimientos de Latinas no casadas entre las edades de 15 a 19 años de edad.

Infecciones de Transmisión Sexual


Nuevos informes de infecciones en mujeres Latinas en el 2012 (CDC, 2014) (5)

- Chlamydia en edades 10-14: 1,400
- Chlamydia en edades 15-19: 41,389
- Gonorrrea en edades 10-14: 156
- Gonorrrea en edades 15-19: 3,795
- Sífilis en edades 10-14: 0
- Sífilis en edades 15-19: 28

SECOND SESSION

GOAL: TO CREATE A GENOGRAM BY EACH MOTHER-DAUGHTER DYAD WITH AT LEAST THREE GENERATIONS TO BEGIN TO EXPLORE AND LEARN EACH MEMBER’S FAMILY HISTORY AND TRANSGENERATIONAL PATTERNS.

MATERIALS:

POSTER BOARDS (1 FOR EACH DYAD) (AROUND 28 X 22 SIZE OR LARGER IF NEEDED FOR LARGE FAMILIES)
PENCILS, ERASERS, COLOR MARKERS, RULERS
EXAMPLES OF STRUCTURE AND BASICS FOR GENOGRAM DESIGN ON BOARD OR WALL OR HANDOUT, ETC (TO GIVE BASIC SPECIFIC GENOGRAM SYMBOLS)
GROUP MEMBER JOURNALS

**Give 10-15 min Break when you deem appropriate**

- SILENCE BREAKER: MIME/ MIRROR GAME WHERE MOMS AND THEIR DAUGHTERS MIRROR EACH OTHER’S FACES AND MOVEMENT. (EXERCISE FOR MODELED LEARNING).

- DISCUSS AND BRIEFLY EXPLAIN WHAT A GENOGRAM IS, HOW IT IS HELPFUL AND THE BASICS OF DESIGNING THESE. COULD CONNECT TO THE ICE BREAKER EXERCISE! (USE EXAMPLES OF GENOGRAM DESIGN AND A KEY THAT SHOWS WHAT SYMBOLS MEAN).

- MOTHER-DAUGHTER DYADS CREATE ONE GENOGRAM TOGETHER WITH AT LEAST THREE GENERATIONS ON POSTER BOARDS.

- GENOGRAMS SHOULD MAINLY INCLUDE SEXUALITY RELATED EVENTS SUCH AS; ABORTIONS, TEENAGE PREGNANCIES, SEXUALLY TRANSMITTED INFECTIONS, RAPE, SEXUAL DYSFUNCTIONS, AFFAIRS, PROMISCUITY, SEXUAL ORIENTATIONS, SEXUAL ADDICTIONS, ETC.

- GENOGRAMS SHOULD ALSO INCLUDE: SOCIAL ECONOMIC STATUS, COMMUNICATION DYNAMICS, RELIGION, VIOLENCE, MIGRATION, EDUCATION LEVEL, ETC. (KEEP GENOGRAMS AT END OF SESSION TO BE USED FOR NEXT SESSION).

- ALLOW MEMBERS 10-15 MINUTES TO PROCESS THOUGHTS, FEELINGS, ETC ABOUT TODAY’S ACTIVITY.
Transgenerational Themes:

Maternal Side:
- 5 women on maternal side had teenage pregnancies (before age 18) including mother.
- 3 women on maternal side suffered physical intimate partner violence
- 6 family members on maternal side struggled with alcoholism
- 2 family members on maternal side contracted a Sexually Transmitted Infection
- 2 marital relationships ended in divorce on maternal side
- 4 extramarital affairs took place on maternal side including in mother’s marriage
- 4 mothers on maternal side had conflicting, cut-off, or distant relationships with their daughter(s) including the mother-daughter dyad in therapy

Paternal Side
- 2 women on paternal side suffered from incest sexual abuse
- 3 marital relationships on paternal side struggled with extramarital affairs including in father’s marriage
- 2 women on paternal side had abortions
- 2 women on paternal side had distant relationships with their daughters

Note to the therapist: This example Genogram did not include all family members. It mainly focused on the female family members and their relationships. Each dyad can mainly focus on the female relationships especially if they have large extended families to save time and space on their Genogram.
**GOAL:** TO HIGHLIGHT TRANSGENERATIONAL PATTERNS FROM GENOGRAM TO BEGIN TO EXPLORE THESE PATTERNS AND TO FURTHER CONNECT WITH GROUP MEMBERS.

**MATERIALS:**
- HANDOUT #2: “TRANSGENERATIONAL PATTERNS”/ “PATRONES TRASGENERACIONALES”
- WRITING BOARD & MARKERS
- GROUP MEMBER JOURNALS & PENS

**THIRD SESSION**

- SILENCE BREAKER: EACH MEMBER ANSWERS 3 FUN QUESTIONS IN ROTATION FORM; FAVORITE FOOD, COLOR, AND DESSERT.

- PASS OUT COMPLETE GENOGRAMS FROM SECOND SESSION TO EACH DYAD AND HANDOUT #2 TO EACH GROUP MEMBER.

- USE A VOLUNTEER’S GENOGRAM TO SHOW HOW TO FIND TRANSGENERATIONAL PATTERNS.

- EXPLAIN THAT THEY WILL LIST THE FAMILIAL PATTERNS THAT THEY WISH TO KEEP FOLLOWING UNDER “DESIRED PATTERNS” AND THOSE FAMILIAL PATTERNS THAT THEY WISH TO NOT CONTINUE UNDER “UNDESIRED PATTERNS”.

- EACH MEMBER SHARES THEIR LIST AND DISCUSSES FEELINGS, CONCERNS, ETC THAT ARE RELATED TO THEIR FINDINGS (THERAPIST POINTS OUT COMMONALITIES AMONG THE GROUP MEMBERS TO INCREASE UNIVERSALITY AND LISTS THESE AND FEELINGS ON BOARD AS THEY COME UP). ONLY A FEW MEMBERS WILL GET THEIR TURN, THE REST WILL SHARE IN NEXT SESSION.

- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

**If Genograms are not completed, complete them at beginning of this session**

**Give 10-15 min Break when you deem appropriate**
GOAL: TO HIGHLIGHT TRANSGENERATIONAL PATTERNS FROM GENOGRAM TO BEGIN TO EXPLORE THESE PATTERNS AND TO FURTHER CONNECT WITH GROUP MEMBERS.

FOURTH SESSION

MATERIALS:

HANDOUT #2:
“TRANGENERATIONAL PATTERNS”/“PATRONES TRASGENERACIONALES”

GROUP MEMBER’S GENOGRAMS

GROUP MEMBER’S JOURNALS

- SILENCE BREAKER: GO AROUND IN ROTATION PLAYING “WORD ASSOCIATION”. START WITH A SEXUALITY WORD AND EACH MEMBER THEN SAYS THE FIRST THING THAT THEY THOUGHT ABOUT WHEN THEY HEARD THE WORD AS IT IS THEIR TURN.

- PASS OUT COMPLETED GENOGRAMS FROM SECOND SESSION TO EACH DYAD AND HANDOUT #2 TO EACH GROUP MEMBER.

- MEMBERS THAT DID NOT GET TO SHARE ON LAST SESSION SHARE THEIR LIST AND DISCUSS FEELINGS, CONCERNS, ETC THAT ARE RELATED TO THEIR FINDINGS (THERAPIST POINTS OUT COMMONALITIES AMONG THE GROUP MEMBERS TO INCREASE UNIVERSALITY AND LISTS THESE AND FEELINGS ON BOARD AS THEY COME UP).

- ENCOURAGE DISCUSSION AFTER EACH MEMBER HAS SHARED THEIR HANDOUT #2.

- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

**Give 10-15 min Break when you deem appropriate**
FIFTH SESSION

GOAL: TO EDUCATE GROUP MEMBERS ABOUT THE BASICS OF COMMUNICATIONAL INTERACTIONS AND TO INTRODUCE THE GROUP PROCESS TO COMMUNICATION TOPICS.

MATERIALS:

HANDOUT #3:
PSYCHOEDUCATION “THOUGHTS AND THE BASICS OF SEXUALITY COMMUNICATION” / “PENSAMIENTOS Y LO BASICO DE LA COMUNICACION”

GROUP MEMBER’S JOURNALS

**Give 10-15 min Break when you deem appropriate**

- SILENCE-BREAKER: PLAY “TELEPHONE” IN WHICH THE THERAPIST WHISPERS A MESSAGE TO A MEMBER AND ALL MEMBERS RELAY THE MESSAGE IN THE SAME MANNER. WHEN THE MESSAGE COMES BACK TO THE ORIGINATOR; HAS IT REMAINED THE SAME? OR HAS IT BEEN CHANGED? PROCESS THE EXPERIENCE.

- HANDOUT #3: IS PASSED OUT TO EACH MEMBER IN THE LANGUAGE EACH PREFERENCES AND DISCUSS THIS IN THE GROUP.

- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.
Thoughts and the Basics of Sexuality Communication

Lo Basico de la Comunicación Sexual

• Es normal que los padres se sientan incómodos con el tema del sexo, muchos padres se sienten de esta manera cuando se trata de comunicar acerca de esto con sus hijos. La ansiedad de padres sobre los temas sexuales puede ser mayor si estas discusiones no han comenzado temprano en la vida del niño/a.

• No espere a iniciar discusiones sobre la sexualidad.

• Inicie conversaciones de sexualidad temprano y no espere hasta que sus hijos empiezan a hacer preguntas acerca de la sexualidad, ya que algunos nunca lo harán.

• Ofresca explicaciones breves y sencillas a su hijo/a. A medida que sus hijos vayan creciendo puede dar explicaciones más sofisticadas y detalladas sobre la sexualidad.

• Mientras que educa a sus hijos sobre la sexualidad use términos anatómicos correctos como "Pene" y "Vagina".

• Utilice descripciones correctas de funciones como por ejemplo "el pene se pone erecto cuando se excita sexualmente" y "la vagina se lubrifica cuando se excita sexualmente" en vez de usar términos vulgares.

• Debido a que la mayoría de adolescentes estarán expuestos a estos términos vulgares relacionados a la sexualidad es útil para ellos discutir y saber estos términos pero aún así deben ser conscientes de que esa no es la mejor manera de comunicar acerca de la sexualidad.

• Proporcionar términos e información científica a los adolescentes les da información precisa acerca de los cambios normales asociados con la pubertad.

• Algunos padres encontrarán resistencia mostrada por sus adolescentes como ignorar, despedir, o discutir cuando traten de hablar con sus hijos adolescentes sobre el sexo y la sexualidad.

• Si hay una desconexión y falta de disponibilidad de los padres y no dar suficiente tiempo para conectarse y comunicarse de forma coherente con sus adolescentes (por ejemplo debido a largas horas de trabajo) estos adolescentes tendrá más dificultades para comunicarse con sus padres distantes sobre la sexualidad.

• La educación sexual en general es más eficaz cuando se expresa de manera positiva y menos eficaz cuando se expresa negativamente.

• A pesar de que no todos los niños y adolescentes se sentirán inclinados a masturbarse, todos ellos y ellas pueden ser enseñados/as a sentir que no es una actividad culpable o vergonzosa ya que no hay consecuencias negativas científicas relacionadas con esta exploración personal.

• Como un límite apropiado, se puede explicar que la autoexploración es algo que se hace en privado.
Benefits of Positive Sexuality Communication with Your Teens

• Less risky sexual behavior from teens like consistent condom use.

• Less following of the guidance of their peers.

• A greater belief that parents provide the most useful information about sex.

• When sex communication is frequent parents exhibit positive styles of communication, both about sex and in general (such as stating clear expectations and not reacting).

• Young women who discuss sex with their parents before becoming sexually active are less likely to initiate sexual intercourse than those who do not discuss sex with their parents.

Avoidance of Sexuality Communication

• Teens who do not discuss sexual issues with a parent follow the guidance of their peers more.

• When sex communication is infrequent, parents tend to engage in negative styles of communication like yelling and cutting off all verbal communication.

• Parents who are strict and overprotective, parents who hold conflicting cultural norms about sexuality, parents who think conversations can wait regarding sexuality and parents who think their teenagers are getting sexuality information elsewhere might face barriers that impede parents to communicate with their adolescents (and vice versa) about sexuality.

• Adolescents typically withhold personal information from their parents and avoid conversations about sex when disclosure is expected.


**Lo Basico de la Comunicación Sexual**

- Es normal que los padres se sientan incómodos con el tema del sexo, muchos padres se sienten de esta manera cuando se trata de comunicarse de éstos temas con sus hijos. Si estas estas conversaciones no comienzan a temprana edad, los padres pueden sentirse ansiosos acerca de hablar sobre sexualidad.

- No espere a iniciar discusiones sobre sexualidad.

- Inicié conversaciones de sexualidad temprano y no espere hasta que sus hijos empiezan a hacer preguntas acerca de esto ya que algunos nunca lo harán.

- Ofresca explicaciones breves y sencillas a su hijo/a. A medida que sus hijos vayan creciendo puede dar explicaciones más sofisticadas y detalladas sobre sexualidad.

- Mientras que educa a sus hijos sobre la sexualidad use términos anatómicos correctos como "Pene" y "Vagina".

- Utilice descripciones correctas aserca del funcionamiento de los organos reproductivos, por ejemplo; "el pene se pone erecto cuando se excita sexualmente" y "la vagina se lubrifica cuando se excita sexualmente" en vez de usar términos vulgares.

- Debido a que la mayoría de adolescentes estarán expuestos a estos términos vulgares relacionados a la sexualidad, es útil para ellos discutirlos y saberlos, pero deben ser conscientes de que esa no es la mejor manera de nombrar a sus organos reproductivos.

- Proporcionar términos e información científica a los adolescentes les da información precisa acerca de los cambios asociados con la pubertad.

- Algunos padres pueden encontrar cierta resistencia de sus hijos, para hablar acerca de sexualidad.

- Si hay falta de disponibilidad de los padres a no dar suficiente tiempo para comunicarse de forma coherente con sus adolescentes, (por ejemplo debido a largas horas de trabajo) estos adolescentes tendrán más dificultades para comunicarse con sus padres distantes sobre sexualidad.

- La educación sexual en general es más eficaz cuando se expresa de manera positiva que cuando se hace de manera negativa.

- A pesar de que no todos los niños y adolescentes se sentirán inclinados a masturbarse, todos ellos y ellas pueden ser enseñados/as a sentir que no es una actividad culpable o vergonzosa ya que no hay consecuencias negativas según estudios científicos, en relacion a la masturbación.

- Como un límite apropiado se puede explicar que la autoexploración, es algo que se hace en privado.
**Beneficios de la Comunicación Sexual Positiva Con Sus Hijos Adolescentes**

- Uso mas consistente del condón de los adolescentes.
- Menos influencia de compañeros en la vida sexual.
- Una mayor creencia de que los padres proporcionan la información más útil sobre el sexo.
- Cuando los padres con frecuencia hablan sobre sexualidad los padres exhiben estilos positivos de la comunicación, tanto en el sexo y en general (por ejemplo indicando expectativas claras y no reaccionar).
- Las mujeres jóvenes que suelen hablar de sexo con sus padres antes de comenzar su vida sexual, son menos propensas a iniciarse en la sexualidad, que aquellas que no tienen ese acercamiento.

**Falta de la Comunicación Sexual**

- Los adolescentes que no hablan de temas sexuales con uno de los padres siguen la guía de sus compañeros mas cercanos.
- Cuando la comunicación sexual es poco frecuente, los padres tienden a involucrarse en estilos negativos de comunicación como, gritando y cortando toda comunicación verbal.
- Los padres que son estrictos y sobreprotectores que tienen normas culturales en conflicto con practicas sexuales, los que piensan que las conversaciones pueden esperar respecto al sexo, y los padres que piensan que sus adolescentes están siendo educados de la sexualidad por otras personas podrían enfrentar barreras que les impiden comunicarse con sus adolescentes (y viceversa) sobre sexualidad.
- Los adolescentes típicamente retienen información personal de sus padres y evitan conversaciones sobre el sexo cuando se espera que ellos y ellas compartan información sobre su vida sexual.
- En ocasiones los padres están preocupados de que al compartir información acerca de cómo llevar la vide sexual y los riesgos que implica significa que están enviando el mensaje a sus adolescentes de tener relaciones sexuales.
- A veces los adolescentes sienten resentimiento cuando no pueden comunicarse abiertamente con sus padres acerca de sexualidad.
GOAL: TO HELP GUIDE GROUP DYADS IN LEARNING ABOUT THEIR SPECIFIC COMMUNICATIONAL INTERACTIONS WITH EACH OTHER.

SIXTH SESSION

MATERIALS:

HANDOUT #4:
“COMMUNICATION INTERACTION CYCLE” / “CIRCULO DE COMMUNICACION INTERACCIONAL”

GROUP MEMBER’S JOURNALS

- SILENCE-BREAKER: ASK IF ANY MEMBER WOULD LIKE TO SHARE A JOURNAL ENTRY. OR READ SOMETHING FROM THE ANONYMOUS BOX.

- ALLOW THOSE MEMBERS THAT DID NOT GET TO SHARE IN LAST SESSION TO BRIEFLY SHARE THEIR FINDINGS FROM HANDOUT #4.

- HANDOUT #4: IS PASSED OUT TO EACH MEMBER IN THE LANGUAGE EACH ONE PREFERENCES. AND HAVE EACH DYAD PRESENT THEIR FINDINGS FROM THIS EXERCISE IN A SHORT (1-2 MIN) ROLE-PLAY.

- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

**Give 10-15 min Break when you deem appropriate**
COMMUNICATION
INTERACTION CYCLE
SEVENTH SESSION

MATERIALS:

HANDOUT #5: "YOU AND I MESSAGES" / "MENSAJES DE TU Y YO"

GROUP MEMBER’S JOURNALS

*SILENCE-BREAKER: GO AROUND IN A CIRCLE AND HAVE MEMBERS SHARE CULTURAL PHRASES THEY HAVE HEARD ABOUT SEXUALITY MESSAGES (I.E “NO SALGAS CON TU DOMINGO 7”).

*HANDOUT #5: IS PASSED OUT TO EACH MEMBER IN THE LANGUAGE EACH ONE PREFERENCES. AND HAVE EACH DYAD PRACTICE THIS NEW EFFECTIVE COMMUNICATION WITH EACH OTHER ONE DYAD AT A TIME.

*PROCESS WHAT IT WAS LIKE FOR THEM TO OWN THEIR FEELINGS AND SPEAK IN THIS WAY.

*PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

**Give 10-15 min Break when you deem appropriate**

GOAL: TO PROVIDE A COMMUNICATION INTERVENTION SO THAT MOTHER-DAUGHTER DYADS CAN BEGIN TO SPEAK TO EACH OTHER MORE EFFECTIVELY AND POSITIVELY.
Mensajes de- TU

Ejemplo: Tu no sabes nada de sexo. Tu solo eres una niña. Tu eres muy joven para pensar y aprender sobre tu sexualidad.

Mensajes de-YO

Ejemplo: Yo no creo sentirme comoda de educarte sobre el sexo. Yo me siento preocupada de que tu seas muy joven para pensar sobre tu sexualidad. Yo me asusto de que tu vallas a tomar decisiones malas sobre el sexo.
You-Messages

Example: You do not know anything about sex. You are just a girl. You are too young to think and learn about sexuality.

I-Messages

Example: I am not sure I feel comfortable teaching you about sex. I feel worried that you are too young to think about your sexuality. I feel scared that you will make bad choices regarding sex.
EIGHTH SESSION

GOAL: TO GUIDE GROUP MEMBERS IN EXPLORING HOW THEIR BELIEFS AND ATTITUDES ABOUT THEIR SEXUALITY HAVE OR ARE BEING SHAPED.

**MATERIALS:**
- WHITE BOARD/ CHALK BOARD
- GROUP MEMBER’S JOURNALS

- SILENCE-BREAKER: GO AROUND THE GROUP AND HAVE MEMBERS SHARE NICKNAMES THAT THEY KNOW OF FEMALE BODY PARTS IN ANY LANGUAGE THEY PREFER.

- ENGAGE GROUP IN EXTENSIVE PROCESS CONVERSATION REGARDING HOW THEIR RELIGION, CULTURE, VALUES & BELIEFS, FAMILY, LANGUAGE, ETC SHAPES AND IMPACTS THE WAY THAT EACH MEMBER SEES, FEELS, BEHAVES, AND COMMUNICATES ABOUT SEXUALITY TOPICS. (FOCUS MAINLY ON THE MOTHERS).

- WRITE DOWN ANY FEELINGS MENTIONED ON WHITE BOARD/ CHALK BOARD.

- HOMEWORK ASSIGNMENT FOR DAUGHTERS ONLY: EACH DAUGHTER WILL WRITE A LETTER TO THEIR MOTHERS THAT SPEAKS TO WHAT THEY DESIRE FROM THEIR RELATIONSHIP WITH THEIR MOTHER IN GENERAL BUT ALSO SPECIFICALLY REGARDING SEXUALITY COMMUNICATION. THEY MUST ALSO USE ART ON THE LETTER’S ENVELOPE TO ILLUSTRATE THE CONTENTS OF THE LETTER. (THEY NEED TO BRING IT TO THE NEXT SESSION).

- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

**Give 10-15 min Break when you deem appropriate**
Example Process Questions for Session Eight

- What does your religion say about sexuality? (virginity, orgasm, sexual orientation, masturbation, etc)
- What does your culture (values, expectations, beliefs, etc) say about sexuality?
- How did you mother, family, friends, and or school educate you about sexuality?
- What would you have liked to be different about how you learned about your sexuality?
- What feelings come up for you as you share how you learned about sexuality?
- How do you think the American culture views sexuality?
- Has the American culture influenced your view on sexuality? If at all, how?
- What important values, beliefs, customs, etc are important for you to retain and pass down to your daughter(s) about sexuality?
- How has your style of communication influenced your relationship with your daughter?
- How has your communication style influenced how you educate your daughter about her sexuality?
- What would you change in your communication style with your daughter? And why?
- How do you plan to incorporate what you have learned in this therapy group once the last session is over?
- If you were an adolescent parent yourself how has this influenced the way you speak or do not speak to your daughters about sexuality?

These are a few example questions to ask during the intensive group process session. These questions are meant to summarize and synthesize what the group members (specifically the mothers) have learned through the previous seven sessions. This is also an opportunity for the group leader(s) to assess the progress each dyad has made in terms of insight, motivation to change, and desire and plan to implement what has been learned thus far.
GOAL: TO ALLOW DAUGHTERS TO VOICE TO THEIR MOTHERS WHAT THEY DESIRE FROM THEIR MOTHER-DAUGHTER RELATIONSHIP AND ALLOW GROUP PROCESS OF THESE NEEDS.

NINTH SESSION

MATERIALS:

- WHITE BOARD/ CHALK BOARD
- DAUGHTER’S HOMEWORK LETTERS TO THEIR MOTHERS
- GROUP MEMBER’S JOURNALS

**Give 10-15 min Break when you deem appropriate**

- SILENCE-BREAKER: HAVE EACH MEMBER BRIEFLY SHARE THE ACTIVITY THAT THEY HAVE ENJOYED THE MOST FROM THE SESSIONS THUS FAR.
- EACH DAUGHTER SHARES HER HW ASSIGNMENT LETTER TO THEIR MOTHER IN FRONT OF THE GROUP.
- ENGAGE GROUP IN EXTENSIVE PROCESS AS THE DAUGHTERS SHARE THEIR LETTERS AND MOTHERS LISTEN TO THEIR DAUGHTER’S VOICE.
- WRITE DOWN ANY FEELINGS MENTIONED ON WHITE BOARD/ CHALK BOARD.
- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.
Example Process Questions for Session Nine

To Daughters:

- How was it for you to write this letter to your mom about the relationship that you desire to have with her?
- How was it for you to read your letter out loud to your mom?
- Did you ever feel that you had the opportunity to speak this way to your mom before, if not why?
- Do you feel that you were truly heard by your mom?
- What similarities did you notice you shared with the other daughter members of the group?
- Do you feel that that you can continue to ask your mother openly about what you need from your relationship with her in the future?

To Mothers:

- How was it for you to hear what your daughter wants from your mother-daughter relationships?
- Do you feel that you truly understood and heard your daughter’s voice?
- What similarities did you notice that the daughters shared?
- Do you feel that you can continue to truly listen and understand what your daughter desires from your mother-daughter relationship in the future?
TENTH SESSION

GOAL: TO ALLOW BOTH DAUGHTERS AND MOTHERS TO VISUALIZE WHAT THEY WANT THEIR RELATIONSHIP TO LOOK LIKE THROUGH A SHARED ART ACTIVITY.

MATERIALS:
CONSTRUCTION PAPER, MAGAZINE CUT-OUTS, SCISSORS, MARKERS, AND GLUE STICKS
GROUP MEMBER’S JOURNALS

✧ SILENCE-BREAKER: ASK IF ANY MEMBER WOULD LIKE TO SHARE A JOURNAL ENTRY, OR READ SOMETHING FROM THE ANONYMOUS BOX.

✧ EACH MOTHER-DAUGHTER DYAD WILL CREATE A COLLAGE WHERE TOGETHER THEY SHOW WHAT THEY WANT THEIR RELATIONSHIP TO LOOK LIKE USING MAGAZINE CUT-OUTS.

✧ PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

**Give 10-15 min Break when you deem appropriate**
GOAL: TO ALLOW BOTH DAUGHTERS AND MOTHERS TO PRESENT THEIR VISUALIZATIONS OF WHAT THEY WANT THEIR RELATIONSHIP TO LOOK LIKE AS THEY NAVIGATE THROUGH LIFE.

ELEVENTH SESSION

MATERIALS:

- COMPLETED DYAD COLLAGE
- GROUP MEMBER’S JOURNALS
- EACH DYAD’S DOCUMENT FOLDER

SILENCE-BREAKER: ASK IF ANY MEMBER WOULD LIKE TO SHARE A JOURNAL ENTRY, OR READ SOMETHING FROM THE ANONYMOUS BOX.

- EACH MOTHER-DAUGHTER DYAD WILL PRESENT TO THE GROUP THEIR CREATIVE COLLAGE. ENCOURAGE THEM TO EXPLAIN WHAT THE PICTURES REPRESENT THOROUGHLY.

- ENCOURAGE BRIEF GROUP PROCESS AFTER EACH DYAD HAS PRESENTED THEIR COLLAGE.

- PASS OUT JOURNALS AND ALLOW MEMBERS 10-15 MINUTES TO PROCESS THEIR THOUGHTS, FEELINGS, ETC ABOUT TODAY’S DISCUSSION/EXERCISE.

- PRESENT EACH DOCUMENT FOLDER TO EACH DYAD WHERE THEY CAN NOW TAKE ALL THEIR HANDOUTS/WORKSHEETS, GENOGRAMS, COLLAGE, AND PROCESS JOURNALS HOME.

**Give 10-15 min Break when you deem appropriate**
Example Questions for Session Eleven

• What the images chosen represent in your mother–daughter relationship?
• How do you plan to keep the lines of communication open between you and your mother/you and your daughter?
• What do you want your relationship to look like in 5 years?,10 years? In 20 years?
• How do you plan to overcome life struggles with your desired communication between you and your mom/you and your daughter?
• What positive outcomes do you foresee as a result of your desired communication and mother-daughter relationship?
• What shared activities do you plan on continuing to follow to build your mother-daughter relationship?
• How useful was this psychotherapy group for you and your relationship with your daughter/mother?
• What was the most meaningful thing you received from this psychotherapy group?
• What was the most difficult of this psychotherapy group? And why?
APPENDIX B: CURRENT COMMUNITY RESOURCES FOR
LATINA MOTHERS AND ADOLESCENTS IN LOS ANGELES, CALIFORNIA

Hotlines for Adolescents, Child Care and Parenting Resources

Planned Parenthood - (800) 230-7526
Planned Parenthood (Spanish)
http://www.plannedparenthood.org/esp

Will connect the teen to the Planned Parenthood Provider nearest her home. Planned Parenthood is a source for contraception, testing for sexually transmitted infections, prenatal and postnatal care, pregnancy, options counseling, and adoption referrals.

Department of Children and Family Services Adoptions Division - (213) 738-4577
In the event a young teen mother chooses to relinquish their child, she can call this number to set that process in motion.

California Youth Crisis Hotline - (800) 843-5200
Counselors are available to be of assistance if the teen mother or father would like to speak anonymously about problems surrounding pregnancy, impending birth or any other problem.

Cedars Sinai Medical Center - (310) 855-HOPE, (800) TLC-TEEN (toll free)
This is a teen-to-teen hotline where teens help each other.

Alta Med Health CAL-LEARN/Adolescent Family Life Program – (800) 833-6235
East LA - 323-722-8300
Norwalk - 562-462-9009
Teen program offers pregnancy and parenting services, and can assist with Medi-Cal.

Big Sister of LA – (213) 481-3611
Provides mentors for pregnancy or parenting teens, boys ages 7-18 and girls age 6-16.

Friends of the Family – (818) 988-443
(Young Dad's Program/Young Mom's Program)
Information and support group for expecting and parenting young parents between 13-25 years old with babies 0-5 years old. Free transportation, childcare, and meals may be provide

Home-Safe – (323) 934-7979
Referrals for child-care, counseling, and support services for low income and at risk families. Spanish speaking services available and pregnant and parenting teen support groups.
El Nido Family Centers Administrative
Office...........................................................(818) 830-3646
Antelope Valley.............................................(661) 274-4192
Carson..........................................................(310) 768-8030
East Compton..............................................(310) 223-0707
Inglewood....................................................(310) 677-7366
Los Angeles..........................(323) 242-5020 or (323) 971-7360
Mission Hills...............................................(818) 830-3646
Pacoima..........................................................(818) 896-7776
Santa Monica...............................................(310) 828-5617
(Teen parenting program, with parenting classes)

Parents Anonymous – (909) 621-6184
Pregnant and parenting teen support groups.

Project NATEEN at Children's Hospital – (323) 669-5981
Case management for pregnant and parenting teens 18 and under and for teens on CAL-LEAR

Los Angeles Free Clinic – (323) 462-4158
High Risk Youth Clinic; walk-in services for ages 12-23.

1736 Family Crisis Center Dating Violence Hotline & Shelter – (310) 379-3620
Break the Cycle (310) 286-3366
Toll Free – (888) 988-8336

Family Stress Center – (818) 830-0200
Emergencies only – (818) 933-9311

Counseling and treatment for teen victims of sexual abuse and violent crimes.

National Center for Missing and Exploited Children – (800) 843-5678
Operates a hotline for reporting missing children and sightings of missing children.
Offers assistance to law enforcement agents.

Support Groups, Workshops, Retreats
Nuevo Día Spanish Support Group -- (626) 919-1091

International MOMS Club®. (Moms Offering Moms Support)
Many group chapters available in the Los Angeles area.
Dr. Wendy O’Connor Psy. D, LMFT -- (310) 712-1230
Teen Girls Empowerment Group/ Women's Empowerment Group
Miven Trageser, LMFT -- (310) 284-3600
Moms and Daughters as Allies (Workshop): This two-hour workshop for mothers and daughters age 9 to 11 celebrates and strengthens the unique mother-daughter relationship in the important pre-teen years before girls sometimes stop utilizing their mother as a resource. The goal is to establish great communication skills and practice using them, and also look at the complex messages girls and women get about their appearance.

Angeles Crest Christian Camp – (714) 870-9190 or (800) 289-83097
Offers mother daughter retreats and other camp excursions.

The Mother-Daughter Project
temother-daughterproject.com

Familyeducation.com