A Study of Father/Son Communication Relative to Contraceptive Attitudes

by

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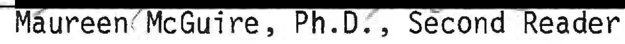

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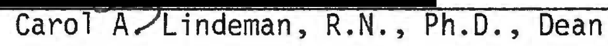

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CHAPTER I

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Introduction

Over the past decade attention and concern have been focused on the problems associated with increasing adolescent sexual activity and a consequent rise in adolescent pregnancy. Adolescent pregnancy rates rose dramatically from 1950 to 1970 and remain high, with a startling estimate that one in ten teenage girls between age 15 and 19 becomes pregnant each year, the majority while unmarried (Alan Guttmacher Institute (AGI), 1981).

The social, psychological and medical risks associated with pregnancy in school-age women are substantial. Adolescent pregnancy carries an increased rate of mortality and morbidity, including increased labor complications, higher rates of preclampsia and anemia and an increased number of ceasarean births (Chilman, 1980). There is an increased risk for premature birth, and the mortality rate for infants born to mothers under age 15 is nearly twice as high as for women in their twenties (Menken, 1980; Smith, 1980). Teen pregnancy has been viewed as the forerunner of a dismal future of unemployment, poverty, and emotional, social, and health problems for the mother and child (AGI, 1981; Chilman, 1980; Smith, 1980).

In light of the problems associated with early sexual activity, venereal disease, and adolescent pregnancy, efforts must be undertaken to evaluate the preparation of young people for responsible sexual behavior. Most research and subsequent program development has focused on the female and has ignored her sexual partner. It is understandable that most programs are female oriented. After all, the woman is the one who becomes pregnant and bears much of the responsibility for the resolution of the pregnancy, either through abortion, adoption or parenting.

It has been found that contraceptive methods most popular with youth are "the pill," condoms and withdrawal. Two of these three methods rely heavily on active participation and cooperation on the part of the male partner (Kantner & Zelnik, 1972; Scales, 1977). Yet only recently have males of any age been considered as active participants in contraceptive behavior and been recognized for their role in pregnancy, parenting or resolution of pregnancy decisions (Moore, 1980; Pannor, 1971; Parke, Power & Fisher, 1980). The feelings and attitudes young men have about use of contraceptive methods may play a dominant role in a young woman's decision to take a risk with pregnancy (Balswick, 1972; Luker, 1975; Scales, 1977). However, to date the manner in which males are involved in pregnancy prevention has been a subject of limited research. A major objective of this study is to examine males and their attitudes towards contraception as a beginning step in the exploration of the male's role in contraceptive behavior.

A basic assumption of this study is that male participation in the decision and practice of birth control will facilitate effective contraception in the teenage couple. Furthermore, it is assumed that male involvement will be facilitated by positive attitudes toward contraception and the male role in it. Therefore, this study will attempt to describe male adolescent attitudes toward contraception. Further, these attitudes will be compared to those of the subjects' fathers in an effort to ascertain the extent to which socialization of attitudes towards contraception may be a function of interaction with the male parent.

There are many areas in which children are socialized to sexuality issues, but the home is the major setting for early sexual learning. Many teens view their parents and families as important sources of advice and information (Babson, 1980). Research from limited studies had shown the mother to be a more active information source than fathers for both male and female children (Bloch, 1979; Fox & Inazu, 1980; Gagnon, 1977; Inazu, 1980). However, with a newfound interest in the father as "the forgotten parent," research has intensified in the interest of understanding fatherhood and its importance in child and adolescent development. This research focuses on fathers and their role in the development of their sons' attitudes towards sexuality by first examining and comparing fathers' and sons' attitudes toward contraception and second, by exploring their verbal communications about sexuality topics.

It is hoped that the information gathered in this study will be of value to health care providers and health educators. Insight into males' attitudes, how they are formed and how they may be influenced will assist family planning counselors as well as health educators when counseling clients, either male or female, adolescent or adult, regarding their decision about birth control.

Review of the Literature

The importance of the familial environment as a setting for sexual socialization and attitude development has been given some attention in recent research. The role played by the father as a socializing agent has also been a topic of current but limited research. This review will begin with a discussion of family communication on sexuality issues and focus on parents as socializing agents, giving special attention to the father, and then will proceed to a discussion of male involvement in contraceptive behavior. The conceptual framework developed for this study will then be presented.

Family Communications on Sexuality

Within the environment of the family, attitudes toward sexuality influence the child from birth. Although this process has yet to be described precisely, it is believed that a parent's negative or positive attitudes toward sexual topics such as nudity, masturbation and genital curiosity and appropriate gender role behavior in childhood sets the stage or the emotional and social climate in which other

aspects of sexual growth will be handled as the child matures (Gagnon, 1977; Kelley, 1979).

Through an extensive exploratory study of Cleveland parents in 1975, Roberts, Kline and Gagnon (1978) investigated parents' roles in the sexual learning of their children. The sample was comprised of 1,400 fathers and mothers from dual and single parent families. The parents' ages ranged from 16 to 60. The group formed a statistically representative sample of parents in the Cleveland area. All parents had children ages 3 to 11. Using questionnaires and in-depth interviews, the researchers obtained information regarding parents' sexual values and attitudes and the communication of the values to their children. The research team focused on the following variables: communications regarding gender role learning, life style and family roles, love, affection and intimacy, body learning, and erotic behavior and its consequences as major content message areas through which parents transmit their values and attitudes to their children.

They found that the level of direct verbal communication between parent and child on issues related to sexuality was extremely low in most families. The discussions that did occur centered around such topics as physical differences between men and women, pregnancy and birth, marriage or divorce. However, only 30% to 50% of fathers had ever discussed even these topics with their sons and daughters. Only 6% to 10% of all parents had ever mentioned venereal

disease, and 2% to 6% had ever discussed contraception. Instead, Roberts, et al., reported that parents often communicated with "caution messages" to their children, telling them not to behave in a certain manner which could lead to some social difficulty. It was found that parents rarely initiated discussions about sexuality, but <u>the children</u> often raised questions about sexual issues. The attitude taken in responding to children's questions created the atmosphere for further questioning.

Roberts, et al., found that parents frequently repeated styles and patterns of communication about sexuality that were established during their own childhood. For example, parents whose own parents only briefly discussed changes at puberty, also confined their discussion to these topics. The authors noted that many parents felt "once is enough," and suggested that this tactic severely limits a child's learning because a child's need for knowledge changes with physical and social growth.

In that study, parents reported that it was the mother who usually answers children's questions about sex. The authors commented that males and females alike saw sexuality as a woman's issue and believed sexual teaching was the mother's responsibility. This conclusion was supported by the findings that 1) more fathers than mothers reported that "nothing yet" had brought about sexual discussions, and 2) that in many homes the fathers did not know that conversations had occurred or what had been communicated.

Furthermore, fathers in this study were no more likely to talk with sons than daughters. This may explain the findings that many fathers often reported their sons asked "no one" in the family. The findings of this study suggest then, that boys either talk with their mothers, or go outside the home for their information or remain uninformed.

The above findings of this study are limited by the fact that they represent only the parents' perceptions of their communications and not the children's. This limitation is common to many parent-child communication studies. In addition, this type of study cannot provide observational data which could reveal more about the situation and mood in which these communications take place.

Of the studies that have included both a parent and child as subjects, the mother-daughter dyad has been highlighted as the major avenue of sexual communication within the family (Bloch, 1979; Fox & Inazu, 1980; Inazu & Fox, 1980). These studies, too, found that mothers who had discussions with their daughters confined the conversations to "easy topics," such as menstruation, but most mothers inadequately discussed the details of conception and birth control (Bloch, 1979). These reported discussions did not take place more often than once every six months (Fox & Inazu, 1980).

The life style of the mother, including her marital status and sexual experience, has been found in some studies to be relevant factors affecting familial sexual communication

and the sexual behavior of children (Akpom, Akpom & Davis, 1976; Furstenberg, 1976; Kantner & Zelnik, 1973; Roberts, et al., 1978). Akpom, et al., (1976) in their survey of 303 white teenage clients at a family planning clinic, reported that mothers who did have premarital sexual experience had more frequent discussions with their daughters about birth control than mothers who did not have premarital sexual experience. Single mothers were more likely to have discussed birth control than mothers in dual parent households. Daughters of women who headed families were found to have more frequent sexual activity and at an earlier onset than young women from dual parent families. Kantner and Zelnik (1973) reported similar findings.

Furstenberg (1976) studied 404 pregnant teens and 350 of their mothers in a five-year longitudinal study of the various social consequences of adolescent pregnancy. The sample was comprised of predominantly low-income black families, of which 38% were headed by females. Furstenberg states that:

> If anything, the lower class is even more puritanical and prudish about sexual matters than families of higher incomes. Despite this, 59% of the mothers had frequently attempted to talk to their daughters about sex and 92% had had at least occasional discussions on the subject (p. 275).

Sixty-one percent of the mothers and 45% of the daughters said birth control had specifically been discussed. However,

given that all these young women were pregnant, it appeared that instructions were not sufficient to help their daughters avoid pregnancy, even though 52% of these young women had had some experience with contraception.

Furstenberg's sample differed from those of other studies in the higher percentage of mothers reporting they have discussed birth control, and in the high number of female headed households. Furstenberg did not question mothers regarding their own childbearing experience but the question might be asked: How many of these mothers had experienced unwanted pregnancy? Could this be a factor in motivating them to discuss birth control with their daughters? Extending this comment to fathers and sons, it might be argued that the father's marital and sexual history may also influence similar communications between fathers and sons. However, at this point there are no data to support such a statement.

In addition to messages portraying attitudes about premarital sex and use of birth control, another important area of familial sexual communication that may affect contraceptive attitudes and behavior are those messages children receive about childbearing, especially those regarding family size and composition. Philliber (1980) noted that the literature on this subject demonstrates that at early ages young people can express how many children they desire, and offer preferences regarding family size and the sex of their children. Her own study of 163 families supported these findings.

In addition, she found that 60% of the older children studied also knew their mothers' family size preference within one child although most mothers denied direct verbal communication with their children about this subject. What children learn about such topics as the appropriate age for marriage, the appropriate age to begin childbearing or the value of children, and what they learn about the appropriate sequencing of these events all have relevance in formation of attitudes toward family planning. The role the father plays in communicating these values has yet to be explored.

Fathers' Roles as Socialization Agent

To date, no study with the exception of that of Roberts, et al., (1978) has been encountered in which fathers have been asked about the amount or kind of sexual information they impart to their children. In fact, all major studies questioning teenage and college-age males found that fathers were rarely (10% to 15%) cited as primary sources of sex information. Peers continue to be frontrunners as the primary sources of sexual information (Finkel & Finkel, 1975; Gebhard, 1977; Pannor, 1971; Spanier, 1977b). Contrary to Roberts, et al., (1978), Finkel and Finkel (1975) found that fathers were cited twice as much as mothers as primary information sources; however, fathers still were cited only 9% of the time. This low percentage does not necessarily mean that fathers do not contribute to their son's sexual development, but that the role the father plays

is perhaps less visible, more subtle and more difficult to measure.

Some researchers (McCallister, 1979; Parke, et al., 1980; Scales, 1977) have tried to explain why there is an apparent lack of overt communication remembered by adolescent males. They surmise that it may be due in part to the manner in which reproductive "biology lessons" are handled in our culture. For example, when a cat has a litter of kittens, a child may find out all about where the kittens came from and how they will be nourished but rarely do they hear how the cat became pregnant. Boys and young men do not grow up with the early opportunities afforded women for the understanding of the workings of the reproductive system. Via conversations with their mothers about the birth of children and preparation for menstruation and in later years about birth control and pregnancy, girls have more opportunities to talk with their mothers regarding various sexuality subjects than do boys.

Another reason for the apparent lack of discussion between fathers and sons may be the father's (parent's) perception of his inability to function as a sex educator for his son. A 1974 telephone survey in Cincinnati illustrates this point. The survey was conducted to assess community attitudes toward sex education. The original random sample of 1,535 resulted in 905 participants with a mean age of 41 years and an age range from 18 to 92 years. Thirty-five percent of the sample were males. The poll domonstrated

that 70% of the adults felt that most parents want to be the main sex educators of their children, but 78% thought parents need additional training in order to teach their children about sex. Another key finding in this poll was that many parents (41%) believed that their children did not want to talk to them about sex. The researchers realized that the external validity of this study is limited by a 40% attrition rate which resulted from call recipients hanging up or refusing to be surveyed. Non-respondents could have represented a portion of the population with very different views. Nevertheless, the researchers tentatively concluded that parents wanted to be involved in the sex education of their children but found themselves inadequately prepared to do so and reluctant to initiate conversations about sex (Gordon and Everly, 1978). One might further deduce that parents, including fathers, find themselves in this dilemma of wanting to talk to their children but not being comfortable with the information. Therefore, fathers wait for their children to come to them, or may not communicate much at all, or perhaps confine their discussions to topics such as body changes or puberty and the basics of conception.

Although the literature provides little evidence of father-son communication, it does support the belief that the father does play a role in the sexual socialization of children. In the following section, the role of the male in family planning and a contraceptive behavior is discussed in

terms of social history, societal norms and current hypotheses regarding males' contraceptive attitudes.

Male Involvement in Family Planning

The male's role in family planning is a largely neglected area of study, and few programs exist which focus on male reproductive health. This is understandable given the history of mankind's effort to control fertility. Prior to 1930 and the discovery of the female's fertile period, condoms were the primary methods of birth control. The march for reproductive freedom by Margaret Sanger resulted in women assuming responsibility for family planning. From the 1950's through 1960's, some research endeavors were aimed at increasing males' use of birth control, such as, condoms (Rainwater, 1960; Misra as cited by Balswick, 1972). With the advent of the pill in the early 1960's, women became the target population in family planning and reproductive research. In the mid-1970's increased criticism and concern about the potential side effects of the IUD and the pill led to a resurgence of interest in males as contraceptors. In addition, the women's movement with its emphasis on sexual equality and the breakdown of the double standard seemed to renew discussion of the male's role in contraception.

The concept of a sexual double standard has been blamed for the lack of male responsibility in family planning. The double standard finds its roots in the Judeo-Christian ethic which emphasized male superiority. Traditionally, the American family has been a strong patriarchal system. Sex

roles were established within this system that reinforced males' control over government, business, cultural and family affairs. Emerging from traditional sex roles was the sexual double standard (Lance, 1979). Within our culture, males are socialized to sexual behavior differently. Studies on parent-child communication all point out that boys receive less information about sexuality from their parents, especially their fathers than do girls (Gagnon, 1977; Roberts, et al., 1978; Scales, 1977). In addition, the persistence of the double standard in sexual behavior has supported the concept of the male as being the "aggressor" in sexual behavior and the female entering sexual relationships for love as opposed to fulfillment of sexual drives (Goldberg, 1978; Weinstein & Goebel, 1979). Although the number of sexually active females is rising in proportion to males, the male still begins sexual intercourse earlier, has more partners (Jessor & Jessor, 1975) and is more sexually active than the female (AGI, 1976, 1981).

The increase in the proportion of sexually active females as compared to males over the last decade indicates that the double standard has been somewhat weakened. Ira Reiss (1967) through his investigations of the double standard identified a "split" in the concept. One type of standard he called the "strict orthodox," that is, males have freedom but females do not. A second transitional standard calls for freedom for males under any circumstances while females may engage in intercourse if they are in love or

engaged. However, other authors question the complete demise of the old double standard (Lance, 1979; Scales, 1977).

Sexual standards among 941 high school students from a southeastern metropolitan and rural areas were studied by Lance (1979). This author postulated the continued existence of the traditional double standard. Instead, he found that an egalitarian standard was favored by 44.6% of the students. Among females, 49.6% favored the equal standard, 27% the double standard and 23.4% actually preferred a reverse double standard. Males were more evenly distributed in their opinions with 38% favoring the egalitarian standard, 32.3% the double standard and 29.7% the reverse.

Looking more specifically at males' contraceptive attitudes in relation to their attitudes toward sex-role assignment in contraceptive responsibility, Weinstein, et al., (1979) undertook a study in 1977 of 62 men who comprised a convenience sample of one-third male students and two-thirds males in the work force, ages 16 to 35. Seventy-one percent of the sample was married or had been married. Weinstein, et al., tested the hypothesis that those males who most strongly subscribed to stereotypic beliefs about their sex role would have the most negative attitudes towards contraceptive use. The authors hypothesized that active contraceptive use for men would be potentially threatening to those who held stereotypic beliefs about their masculinity. These beliefs required them to act in ways that were aggressive and impulsive and this behavioral style would not allow them

to premeditate or interrupt their sexual drive, a behavior often necessary for effective birth control. Hence, these men would respond with negative attitudes towards male use of contraception.

The findings of Weinstein, et al., (1979) supported their hypothesis, especially in the younger portion of their sample (20 high school and college students). The authors tentatively concluded that the stereotypic belief that contraception is a female responsibility was upheld more strongly by younger men because "they have more to prove," that is, achieving the "macho" image of power, aggression and freedom in their sexual pursuits. The life experiences of having and raising children had not yet made a significant impact on their family planning behavior. A serious limitation of this study was its small, non-random volunteer sample. Nevertheless, these findings support the notion that males' contraceptive attitudes are related to their sex role identification.

Gagnon (1977), Way (1977) and Goldberg (1979) agree with Weinstein, et al. Identification with masculine ("macho") image has been a major block in the formation of more positive attitudes towards males' involvement in birth control and family planning. According to Scales (1977), the sexual double standard which supports sexual adventurousness for males may allow males to feel little responsibility for making plans for birth control. Hence, the sexual double standard remains a significant factor in the male's acceptance of and participation in birth control practices.

What are current male attitudes towards contraception? Supporters of programs emphasizing male involvement in family planning claim that there is widespread interest and encouragement on the part of men to become more involved in sharing the responsibilities of contraception. McCallister (1979), as chairperson of Washington State Men's Caucus on Family Planning, claims that most men are starving for information, and that the negative attitudes demonstrated by men often reflect their ignorance and lack of opportunity for discussion. As support of this statement, he refers to the study at Florida State University (Moore, 1980). The study volunteers including 165 male and 84 female college-age students, were given factual information about sexuality and contraception in a 90-minute workshop. One of the workshop aims was to engender more responsible and positive attitudes toward contraception. Participants were pre and post-tested for attitude change on four concepts: sexual intercourse, male contraceptives, female contraceptives and pregnancy. The results showed that attitude measures changed little regarding pregnancy and intercourse, but there were positive attitude changes regarding male and female contraceptives. McCallister (1979) and other supporters of male reproductive health programs believe that males, given opportunity, encouragement and information, could develop more positive attitudes towards their roles in contraception and family planning.

In addition to lack of knowledge, other factors have

been associated with acceptance of a contraceptive method by couples. These include the degree of role division, role sharing, and the quality of communication within a dyad. In addition, personal preference for a method of contraception, motivation to prevent pregnancy and access to contraceptive information and methods have been cited (Oresky & Ewing, 1978).

The issue of availability of information and methods has been found to be a major obstacle barring males' entrance into the system (Swanson, 1980; Moore, 1980; Hanley, 1981). Many men gain access to a clinic only when a problem such as venereal disease, pregnancy, abortion or sterilization occurs. Men have little reason to visit a family planning facility on their own. Weinstein (1979) points out the realities of male contraceptive methods, "one is usually irreversible, two are unreliable and all may limit pleasure in some way."

According to Swanson (1979) the sexual biography of an individual (that is, his personal experience with sex and relationships) may make significant impact on his use of contraception and the adoption of a family birth control plan. Swanson points out that a couple's contraceptive behavior will partially be dictated by these individual experiences, but how these biographies intersect will actually determine to what extent contraception becomes a shared responsibility. He emphasizes that health care providers influence these biographies by the manner in which clients

are approached when counseling and prescribing birth control methods.

Summary of the Literature Findings

The recent research which addresses family communication regarding sexuality issues brings out several themes which pertain to this study. Most authors agree that in many families discussion of most topics related to sexuality take place on a very limited basis. The discussions seem to be confined to less threatening topics such as body changes at puberty (Akpom & Akpom, 1975; Bloch, 1979; Fox & Inazu, 1980; Robert, 1979). Few parents report having talked to their children about intercourse and birth control, although they may communicate about these topics by the use of warning or caution messages about the consequences of premarital sex (Roberts, et al., 1978).

Traditional sex-role stereotyping seems to influence the patterns of familial sexual communication, as well as male use of contraception. Male children are less often involved in such discussions at home than female children and rely more on outside sources for information. Mothers seem to be more involved in conversation about sex than fathers. Perhaps the mother has more contact with the child and/or has been socialized to take on this aspect of child rearing. However, today's changing patterns in parenting, which encourages more paternal involvement in other areas of child development and increased role sharing between couples, may lead to a change in the sexual socialization of children.

The literature suggests several variables which may influence family communications on sexuality. Past research has looked at a mother's past sexual history and marital status. Sexual knowledge of the parents has also been suggested as an influencing variable. Parents' comfort with their own sexuality, a concept more difficult to measure, is also thought to influence communication. Two studies in medical education have shown that medical students' comfort with sexuality was positively related to their ability to talk with patients about sexuality issues (Lief, 1976; Vines, 1974).

This study addresses not only family sexual communications but also contraceptive attitudes. Some of the recent literature lends support to the notion that a relationship may exist between these phenomena. Parents are thought to communicate their attitudes about various aspects of sexuality, including those pertaining to childbearing, such as the proper age for becoming a parent, family size and composition, population control and family planning. Attitudes parents and children hold about these issues may have importance in the formation of attitudes towards birth control and its use. Further development of this conceptual link follows in the discussion of the study's conceptual framework.

Conceptual Framework

Much of the literature in the areas of both family communication on sexuality and the male role in family planning behavior speaks to the importance of attitudes in relation to subsequent behavior. Exploration of theory regarding

attitudes and behavior and the concept of attitude acquisition assisted in the formation of the conceptual framework for this study. Major tenets from these areas are presented in the following discussion.

Attitudes and Sexual/Contraceptive Behavior

The relationship between certain attitudes and specific behaviors has been a subject of much debate and some research. Generally, some correlation has been found but has been less significant than might be expected. This point was well demonstrated by Roberts, et al., (1978) in the study of Cleveland parents when the majority of parents voiced liberal gender role attitudes but had difficulty translating those attitudes into behavior and retained traditional sex-role division of labor in their homes.

Fishbein (1967, 1972), in an attempt to explain the lack of evidence for a causal relationship between attitudes and behavior proposed the behavior intention equation (Figure 1).

Figure 1

Behavior-Intention Equation

$$B \sim BI = [Aact]\ w_o + [NB\ (Mc)]\ w_1$$

B = overt behavior; BI = behavioral intention; Aact = Attitude toward the act; NB = normative belief; Mc = motivation to comply with the normative belief and w_1 and w_o are empirically determined weights (Ajzen, Fishbein, 1967).

This model emphasizes that an individual's intention to perform a certain behavior is influenced both by his attitude and the social norms governing that behavior. Fishbein and

other researchers found support for this model in studies on premarital sexual behavior (Davidson & Jaccard, 1975; Fishbein, 1966, as cited by Ajzen & Fishbein, 1973; Fishbein, 1972). Fishbein also suggests its application to the study and understanding of contraceptive behavior. As an example, a teenage boy may believe that contraception is a good thing and would like to share in the responsibility for using it, but receives messages from his peer group to let the girl take care of it. This young man's positive attitudes may not carry as much weight as the negative social norms. Therefore, although he may have fully intended to purchase condoms, he is deterred by the social pressure of this peer group. Nevertheless, attitudes remain a significant component in the equation and under other circumstances may carry more weight and counterbalance the social norms.

Acquisition of Sexual/Contraceptive Attitudes

It is a major assumption of this study that a male's favorable evaluation of birth control generally, and more specifically his role in the decisions about the use of birth control method, will enhance a couple's contraceptive effectiveness.

If attitudes can be a significant factor in the determination of sexual/contraceptive behavior, what are they and how are they acquired? Katz (1960) defines attitudes as "the predisposition of an individual to evaluate some symbol or object or aspect of his world in a favorable or

unfavorable manner (p. 168)" and points out that attitudes can be expressed in a non-verbal manner.

The consensus among most theorists is that attitudes are learned (Greenwald, 1968; Halloran, 1967; Katz, 1960). The learning of attitudes begins early in childhood as part of the process of socialization, a concept emerging from the interactionist theory of Mead (1938). Basic to the interactionist thought is the premise that development of attitudes does not occur in isolation. They are learned in interaction with others, who may be specific others or, more "generalized" others in the environment (society) (Mead, 1938).

Other theories also emphasize the transfer of attitudes from significant others in the child's environment. Social learning theorists would stress reinforcement and imitation behavior as modes by which attitudes are learned. Also, they recognize that a great deal of social learning is incidental and unintentional and point out that some accidental actions by children can be reinforced by parents (Greenwald, 1968; Halloran, 1960). The role theorist would focus on the effects of role modeling, that process in which a child learns what behaviors, attitudes and beliefs are appropriate to his role (Halloran, 1960). All of these perspectives regarding socialization and attitude acquisition would agree that parents as socializing agents would have a great impact on the formation of their children's attitudes (Halloran, 1967; McNab, 1967). In this study, the father is studied as a socialization agent for sexual attitudes.

Concepts relative to socialization formed the basis for the development of a conceptual framework used by Philliber (1980) in the study of fertility socialization and behavior. According to Philliber there are four general "content areas" pertinent to fertility socialization; sexuality, contraceptive use, family formation and composition and family function. Within the area of contraceptive use, the author suggests that attitudes towards birth control, and knowledge of birth control along with social norms serve as variables strongly influencing contraceptive behavior.

Spanier (1977) coined the term "sexualization" for his discussion of sexual socialization which he defines generally as the "process of becoming sexual." This lifelong process takes place through the learning of appropriate gender role behaviors as well as learning skills, knowledge and attitudes which allow an individual to function sexually in a given cultural setting. He, too, views the acquisition of sexual attitudes as a significant aspect of sexual development. He emphasizes that attitudes can act as motivational forces in sexual behavior (positive attitudes toward birth control act to motivate the use of birth control), but that behavior is also influenced by a variety of social norms (i.e., the double standard, accessibility of contraceptives) in addition to the knowledge and skills of the individual regarding a behavior. He also suggests this process is not "uni-directional." It is conceivable that acquiring new knowledge as through formal or informal sex education may

result in an adjustment of sexual attitudes, and the individual may be motivated to act in a different manner.

Greenwald (1968) points out that attitudes represent an integration of elements (habits, cognitions and emotions) and that attitudes may guide behavior but are not the only factor in determining a behavior. This investigator also agrees that although contraceptive attitudes seem to be an important component in determining contraceptive behavior, there are other factors such as psycho-sexual maturation, availability of services and the knowledge of contraception that may effect contraceptive behavior. These other factors have not been discussed in this review because the focus here is the attitude, not the behavior.

The literature gives us evidence that overt sexual/ contraceptive behavior is rarely role modeled by parents, and most data indicate that parents often have difficulty talking specifically about sexual/contraceptive behavior to their children (Bloch, 1979; Fox & Inazu, 1980; Gagnon, 1977; Gebhard, 1977; Roberts, et al., 1978). However, theory and some research suggest that there is some transference of attitudes from parents to their children and that these attitudes may be significant in determining adolescent sexual and contraceptive behavior. With parents increasingly expressing a desire to be sex educators for their children (Kelley, 1979; Otto, 1978), further investigation of this issue is needed. One way of assessing this might be to compare sexual/contraceptive attitudes of parents and

their children. High congruence would lend credence to the assumption that parents do manage to transmit their own attitudes to their offspring. The question then remains how does this take place if parents are, in fact, reluctant to discuss specific topics, do not role model and in some instances have difficulty putting their own attitudes into action? The purpose of this study is to attempt to answer some of these questions with a special focus on the adolescent male and his father.

Research Questions

In an effort to provide information relative to the more general questions mentioned above, the following more specific research questions are proposed.

1. What are fathers' and sons' attitudes toward contraception?
2. Do fathers and sons have similar attitudes towards contraception?
3. Do fathers and sons think they have the same attitudes towards contraception?
4. Do fathers and sons talk about birth control and other sexuality topics?
5. Do fathers and sons feel they can communicate comfortably about birth control?

CHAPTER II

METHODS

The Setting and Sample

The population for this sample included families with sons in the 10th grade in a suburban high school. This public high school draws students from primarily middle to upper middle class families living in a suburb adjacent to a large northwestern city. The population is mostly white with 5% minority students. The political climate is generally viewed as conservative.

The primary advantage of this setting was that the administrator and health education teacher granted permission to allow the survey to be administered in their school. A disadvantage of this setting was that it did not have a heterogeneous population. This factor limits the generalizability of the study's findings to other populations.

Most of the adolescent subjects were drawn from one course, a mandatory health education course taken in the 10th grade. The course covers several topic areas, including mental health, alcohol and drug abuse, marriage and family relationships, and sexual health and responsibility. In the 9th grade, students review the reproductive cycle and are introduced to birth control methods.

Little information was known about the fathers of these

adolescents except that they have the common tie of a 10th grade son presently taking the health education class.

The Design

A survey questionnaire was utilized in this study. The questionnaire was designed to answer the following research questions: 1) What are fathers' and sons' attitudes towards contraception? 2) Are they similar? 3) Do fathers and sons think they have similar attitudes toward contraception? 4) Do fathers and sons talk about birth control and other sexuality topics? and finally 5) Do they feel they can communicate comfortably about issues relating to sexuality?

Collection of Data

Obtaining written permission from the school principal to conduct the study was the first step in data collection (Appendix I). Then on a scheduled day, the investigator visited each health class. At this time the study was briefly introduced and male students' participation requested. The discussion was as open as possible, encouraging the students to ask questions. However, caution was taken not to bias student responses by discussing male role or responsibility in family planning. One hundred forty-three male students were approached on this day.

Eighty-five male students volunteered to take a sealed envelope home to their fathers. The envelope contained an introductory letter and consent form (see Appendix F & G). The letter briefly described the problem of adolescent pregnancy, the need for research addressing males and why their

participation was requested (see Appendix F). The letter was signed by the researcher and chief advisor. The consent form requested the signature of both the father and the son. In addition their address and phone number were requested to allow for distribution of the questionnaire after consent had been obtained.

Twelve fathers and sons agreed to participate by returning their signed consent forms, and 11 were mailed the study materials. One consent form did not have the address filled in. Those who consented were mailed a packet containing all the materials necessary to complete the survey. A letter with specific instructions was included in each packet as well as a stamped addressed return envelope (see Appendix H). Each father and son was requested to complete the Male Contraceptive Attitude Inventory (MCAI) (Appendix A, B), communication questionnaire (Appendix C, D), and a background information form (Appendix E, F). The letter emphasized that both participants complete their questionnaires privately and not discuss the questions or their answers until the forms had been returned. They were also encouraged to complete the questions honestly and to feel free to add comments regarding either the questions or their responses. Each questionnaire was coded with numbers that were used to rejoin the responses of the father and son pairs for data analysis.

In order to assure completion of as many paired questionnaires as possible, follow-up postcards were mailed

three weeks after the study materials were mailed out. This postcard also served as a "thank you" note to those who had already completed their questionnaires.

Due to the low response rate, two additional sets of questionnaires were completed by acquaintances of the researcher at her request. These data were included along with that from the high school because these father and son pairs were of similar age and SES level.

The Consent Procedure

In view of the fact that adolescent sexuality, sex education and parent-teen relations are sensitive, if not controversial subjects, concern for the rights of families to choose freely to participate or not participate was of utmost consideration. Of course, there is also equal concern to protect subjects' right to retain anonymity and confidentiality. At times, concern for these issues of privacy, anonymity and condidentiality can prevent obtaining reliable results in survey research. In this study these issues became very apparent in overcoming the obstacles frequently encountered when attempting research regarding children, their parents and sexuality.

The first obstacle was the need for parents' consent for doing research involving minor subjects. This standard represents the primary area which impedes researchers' attempts at gaining access to a sample population of adolescents. A representative group of parents and students is best found through the public school where there is a higher

chance of securing a heterogeneous sample. Access to this group usually involves the cooperation and the support of the school's administrators. However, it was observed that many administrators were reluctant to even ask parents to participate because they realized the sensitive nature of this subject and were afraid of repercussions from parents. They were also concerned with the protection of the privacy of their students and families. The parents, too, might have had opinions about research in this area. Some may have been afraid that the survey questions would: 1) give the adolescents ideas about sexuality they did not feel comfortable with, 2) teach them values and attitudes they disagreed with, 3) raised questions the parents were uncomfortable with (Howe, 1980).

The second obstacle faced when undertaking research on sexuality issues is that of anonymity. For some people the smallest chance of identification may be too much to risk. Therefore, they simply do not respond. In this study those who joined the study had to sign and mail back their consent forms including their names, addresses and phone numbers. They were, in a sense, taking a risk of being identified with the study. Therefore, the protection of the confidentiality and anonymity of the subjects' responses was essential. The code numbers of the questionnaires mailed to consenting participants were not recorded and matched with their names. The researcher knew only who agreed to participate, not who completed the study or their responses.

The consent form and letters, therefore, were designed to assure fathers and sons that, although their participation was valuable, it was entirely voluntary, and that their responses would remain confidential. They were informed of the sensitive nature of some of the questions but advised that by completing the survey they might learn something about themselves and their sons. They were also assured that although they might benefit by participating, there would be no penalty for not participating.

Measurement of Variables

Father and Son Contraceptive Attitudes

The first major study variable was fathers' and sons' attitudes towards contraception. Varying conceptual definitions for contraceptive attitudes have been offered. These definitions include attitudes towards family planning, population control and personal willingness to use birth control. For this study the conceptual definition for contraceptive attitude was modeled after the framework suggested by Fishbein (1972) as described in the previous chapter. He stressed that, when measuring attitudes, instruments must be designed to measure the attitude toward performing the behavior as well as measure the motivational forces and normative beliefs. These concepts guided the investigator when creating the Male Contraceptive Attitude Inventory (MCAI) used in this study. The fathers' and sons' contraceptive attitudes were operationalized in terms of their scores on the MCAI.

The MCAI is divided into three subscales. The first

subscale (Responsibility) consists of five statements measuring attitudes towards traditional gender-assigned responsibility for contraceptive use (Appendix A, B; Statements 1, 5, 8, 13, 16). These statements are designed to measure the normative component of attitudes as described by Fishbein (1972). The second subscale (Birth Control) is designed to measure attitudes towards the prevention of unwanted pregnancy (Statements 3, 7, 9, 12, 19), which represents the motivational component of the model. The final subscale (Personal Use) measures the males' attitudes towards their personal willingness to participate in the use of birth control (Statements 2, 4, 6, 10, 11, 14, 15, 17, 18, 20). Here Fishbein's concept of the attitude towards the act is being tested.

The responsibility subscale statements were derived from Weinstein and Goebel's (1979) study. Gough's (1975) questionnaire for population control provided some guidelines in the development of the attitude statements towards pregnancy prevention, as did Miller's (1980) survey of adolescent sexual attitudes. The remaining statements, including most of those in the attitude toward personal use of birth control subscale, were investigator-created maximizing on concepts revealed in previous studies (Moore, 1980; Henley, 1981; Weinstein, et al., 1979) and advice from practicing professionals. During the phase of questionnaire design the questionnaire was completed and critiqued by six male medical and nursing students for input regarding the phrasing of the

statements and the readability of the questionnaire. Their suggestions were incorporated into the final draft of the questionnaire.

The MCAI was designed to measure both the subject's attitude as well as his perception of his father's/son's attitude. The subject marked his agreement or disagreement with the statement on a 6-point Likert-like scale. He then indicated his perception of his father's/son's opinion on a matching scale. A "don't know" option was offered for those who really felt they could not express their father's/son's opinion.

Father-Son Communication

Father/son communications on sexuality issues, especially communication which focuses on birth control was another variable of major interest in this study. This variable was operationalized in terms of the answers the father/son dyad provided on the communication questionnaires (see Appendix C and D). This portion of the survey consisted of several multiple-choice questions pertaining to the content and the circumstances in which fathers and sons may discuss sexuality issues. In addition there was a question designed to assess the feelings of fathers and sons when discussing sexual issues. These questions provided data utilized in answering the fourth and fifth research questions which related to father/son discussion of sexual topics and their comfort in talking about these issues. This questionnaire

also provided some descriptive data regarding patterns in father/son communication.

The questions were generated through discussions among the investigator, her advisors and other experts in the field of family communication. The studies by Fox and Inazu (1980) and Bloch (1979) on mother/daughter communication were helpful in determining the content of the questions in this questionnaire.

Unfortunately, due to time limitations and the problem of sample access, neither questionnaire was fully pre-tested. Therefore, this study served as a pilot study for the questionnaires.

The Interacting Variables

Age, race, socioeconomic status (SES), prior sex education course, legal relationship between father and son, as well as a brief assessment regarding living arrangement between father and son were considered to be the potential interacting variables (Appendix E & F). The age of the subject, especially age of the father, is likely to influence his attitudes towards sexuality both due to adult psychosexual development and the influence of social movements over the last decade. For fathers, age was stipulated by five-year intervals, ranging from age 25 to 56 and over. The sons indicated their age more exactly by specifying their age in years.

Difference may also exist between different ethnic backgrounds and socioeconomic groups due to differing

socialization norms of various cultures and subcultures. Ethnic background was operationalized by choosing between Black, White, Asian, Spanish surnamed or other. Socioeconomic status was operationalized by use of the Hollingshead's two-factor index of social position (1957). Fathers' education and occupation were used to calculate socioeconomic status (SES).

The legal relationship between fathers and sons was also considered to be a possible interacting variable. The amount of communication which takes place between a biological father and his son may be very different than that which occurs between stepfather and son. This relationship (natural, adoptive or step) was measured by Question C on the son's background information demographic questionnaire (Appendix E). Question D on the son's background information questionnaire was used to describe the amount of time a father may have available to talk with his son. Finally, because sexual knowledge has been identified as a variable influencing contraceptive behavior and attitudes as well as father and son communication, in Question E fathers and sons were asked to indicate if they had taken a sex education course prior to the survey. They then indicated when they took the course.

Data Analysis

The fathers' and sons' responses on the MCAI were analyzed by means of descriptive statistics. Mean and median scores were computed for each group on each item, the

subscales, and the questionnaire as a whole. The fathers' and sons' scores were compared using the Pearson r coefficient and matched pair t-tests.

Validity and reliability tests were carried out on the MCAI and subscales. Using the mean scores on each item, the variance, co-variance and the number of items, coefficient alphas were computed. This was done for fathers' attitudes, sons' attitudes, fathers' perceptions of sons' attitudes and sons' perceptions of fathers' attitudes as measured by each subscale and the test as a whole. The coefficient alpha indicates the extent to which the items measure the same construct. A high value of the coefficient reflects a more homogeneous index or construct.

Descriptive statistics were also used to analyze the data from the communication questionnaire. Fathers' and sons' answers were compared as individual pairs and as groups by preparing cross-tabulation tables. Then the computed Pearson's r values were used to compare fathers' and sons' answers for each question.

The demographic data obtained were used to describe the sample.

The statistical analysis was done through the cooperation of the Nursing Research Department of the Oregon Health Sciences University using the Statistical Package for the Social Sciences.

CHAPTER III

RESULTS

The results of this survey are presented in this chapter. The following research questions will serve as the framework for the presentation of the study findings. What are fathers' and sons' attitudes toward contraception? Are their attitudes similar? Do fathers and sons think they have the same attitude towards contraception? Do fathers and sons talk about sexuality and birth control and how do they feel about communicating on these subjects? Before presenting data to answer these questions, the sample characteristics and the reliability of the Male Contraceptive Attitude Inventory (MCAI) and its subscales are described. The final section of the chapter presents some of the incidental findings of this study.

Descriptive and inferential statistics were used to analyze: 1) the attitudes of fathers and sons, 2) the comparison of their attitudes, 3) the perceptions of one another's attitudes and 4) their communication patterns. The results of these analyses are presented along with tentative interpretations of their significance in this research. In Chapter IV the findings are discussed in relation to other studies of contraceptive attitudes and parent/child communication.

Characteristics of the Participants

This sample of fathers and sons most definitely represents a volunteer convenience sample. Participation in the study was offered to 157 teenage boys at a local high school. At this time only the young men were present in the classroom. Eighty youths volunteered to take an envelope home and give it to their fathers. The envelopes were sealed and students were requested to have their fathers open them first because of legal technicalities that requires parental consent for minor participation in research.

Of the 80 envelopes that were taken by the students, only 12 signed consents were returned to the researcher. One father/son pair did not supply their return address so their consent was discarded. Eleven survey packets were mailed to the fathers and their sons. Nine completed questionnaires were returned. One questionnaire was not usable because the father had not completed most of his portion. Three acquaintances of the researcher volunteered names of father/son pairs they knew who might be willing to complete the survey. All three were mailed the consent forms and study materials. Two of these three pairs completed the survey and their data are included, resulting in a total sample size of ten father/son pairs.

The sample appears very homogeneous with respect to race, SES, age and the legal relationship between fathers and sons. They were all white, with the exception of one American Indian. Using the Hollingshead (1957) two-factor

index of social position, it was found that four fathers would be ranked in Class I, five in Class II and one in Class III. No fathers in this sample fell in the lower two classes. This was a well educated sample with nine of the ten fathers employed in professional or white collar occupations.

The modal (4) age bracket of fathers was 36 to 40 years with an equal number (3) reporting to be either 41 to 45 or 46 to 55. Five of the sons were 15 years old, four were 16 and one was 17 years. Three pairs participated as stepfather and son, the remainder were natural father/son pairs. Nine fathers and sons reported that they live together and see one another daily while one pair reported that due to a busy schedule they see each other less frequently. The demographic data for the fathers are presented in Table 1.

It is very clear that due to the nature of this small volunteer sample that no generalizations can be made about the larger population to which they belong. Herein lies the greatest limitation of this study. The significance of responses is likely to be most meaningful when looked at individually and in a purely descriptive sense.

Instrument Reliability

Determination of the reliability of the attitude instrument (the MCAI, Appendix A) was the first step taken in the data analysis. Knowledge of an instrument's reliability is essential for the interpretation of the research findings. In this study Cronbach's coefficient alpha was used to test

Table 1

Demographic Characteristics of Fathers

Characteristic		Frequency (N=10)
Age:	36 - 40	4
	41 - 45	3
	46 - 50	3
Race:	White	9
	American Indian	1
Socioeconomic Status:	Class I	4
	Class II	5
	Class III	1

*As measured by Hollingshead (1957) two-factor index for social position.

the reliability of the MCAI and its subscale. The coefficient alpha indicates the extent to which items measure the same construct. The range of the coefficient alpha is -1.0 to +1.0 and a higher value reflects a greater degree of internal consistency. Normally, 0.70 is an acceptable value for reliability prediction in research (Polit & Hungler, 1978). However, the validity of judging the instrument reliability on the basis of this small non-randomized sample is questionable.

The measure of contraceptive attitudes (MCAI) was a 20-item Likert type scale, which was completed by both fathers and sons. Subjects also indicated what they perceived the

other party's attitude to be. The questionnaire was conceptually divided into three subscales. The Responsibility subscale consisted of those items pertaining to the individual's belief in mutual or shared responsibility in contraception. The Birth Control subscale consisted of the statements pertaining to an individual's attitude toward the importance of using birth control to prevent unwanted pregnancy. The Personal Use subscale was composed of the items which apply to a person's attitude towards the behaviors involved in contraception. The subscales and their question items are listed in Table 2.

Table 2

Question Items of the Male Contraceptive Attitude Inventory (MCAI) Listed According to the Three Subscales: Responsibility, Birth Control, and Personal Use

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Responsibility Subscale

1. The major responsibility for avoiding pregnancy rests with my partner rather than myself.

5. I'd have no objection to birth control devices as long as my partner was the one who used it.

8. Taking precautions to prevent pregnancy should be a shared responsibility.

13. When a pregnancy results from not using birth control, both the man and the woman are responsible.

16. If the woman says birth control and pregnancy is her business and responsibility, then it is okay with me to let her decide about birth control.

Birth Control Attitude Subscale

3. Before I'd have sex with anyone, I'd personally make sure we were using birth control.

7. No one should have sex without taking precautions to avoid unwanted pregnancy.

9. I'd enjoy sex more if I felt sure my partner wouldn't get pregnant.

12. It can be exciting to take a chance on getting my partner pregnant.

19. Using birth control involves tampering with nature, such things should be left to God, fate or luck.

Personal Use of Birth Control Subscale

2. I'd be willing to suggest that I use a rubber as a birth control method.

4. I'd go to a doctor's office or clinic with my partner to obtain a birth control method.

6. I'd be willing to go to the drug store to buy condoms (rubbers) or contraceptive jellies and creams.

10. So many birth control methods are messy and involve too much preparation and planning.

11. I would be willing to wait while my partner used foam or a diaphragm before making love (having intercourse).

14. I would not be willing to have intercourse if neither my partner nor I were able to use precautions to avoid pregnancy.

15. I'd be willing to use withdrawal before ejaculation as a pretty good way of avoiding pregnancy if we had no other choice.

17. Sex doesn't seem as satisfying when using certain types of birth control.

18. The use of some birth control devices spoils the mood and spontaneity of love making.

20. The disadvantages of most birth control methods outweigh the advantages.

The MCAI and its three subscales were tested for reliability in four situations giving 16 reliability predictions for the instrument. These analysis are presented in Table 3.

Table 3

Reliability Analysis for the MCAI and Subscales Tested for Fathers' Attitudes, Sons' Attitudes and Their Perceptions of Each Other's Attitudes

MCAI and Subscales	Father's Attitude	Son's Attitude	Father's Perception of Son	Son's Perception of Father
Total MCAI	.813*	.450	.796*	.843*
Responsibility	.170	.767*	.296	.670
Birth Control	.535	.504	.451	.520
Personal Use	.813*	.396	.815*	.872*

*alpha coefficient $\geq$ 0.70 is acceptable for use in research.

These computations show that the instrument as a whole to be reliable for fathers' attitudes, their perceptions of their son's attitudes and the sons' perceptions of the fathers' attitudes but not for the sons' attitudes. The Responsibility subscale was reliable for sons' attitude only. The Birth Control subscale demonstrated no internal consistency for fathers' and sons' attitudes. The Personal Use subscale was reliable for fathers' attitudes, their perceptions of their sons' attitudes and the sons' perceptions of their fathers' attitudes.

Discussion of the significance of these reliability tests and their implications for this study is offered in the next chapter. It is recognized that for the most part the subscales are not cohesive and the instruments as a whole may

not be stable for both fathers' and sons' attitudes toward contraception. However, it is believed that the instrument did provide some useful data that can be used to explore the research questions regarding contraceptive attitudes.

Fathers' and Sons' Attitudes Toward Contraception

The first major research question of this study asks about the nature of fathers' and sons' attitudes toward contraception. For the most part, the majority of the fathers and sons demonstrated fairly liberal attitudes as measured by their scores on the MCAI. A high mean score on the MCAI is interpreted as a liberal attitude toward contraception and a low score as a conservative one (range 0-6). A low score would then reflect less-than-favorable attitudes toward contraception in general, sharing the responsibility for contraception and personal use of birth control. The reader should be aware that the response to Questions 1, 5, 12, 16, 17, 18, 19, 20 were reversed in the scoring to reflect a positive contraceptive attitude.

Fathers' Attitudes Toward Contraception

The fathers' mean scores on the MCAI ranged from 3.0 to 5.7 from a possible range of 0 to 6. The mean score for the group was 4.65 and the median 4.97. Most of the fathers showed a fair amount of agreement with the items on the questionnaire. The fathers generally scored lower on the Personal Use subscale than on the other two scales. The reader may refer to Table 4 which displays the mean scores of the fathers on the MCAI and its subscales.

Table 4

MCAI Subscales

Mean Scores of Fathers and Sons

MCAI Subscales	Mean Scores	
	Fathers	Sons
Responsibility	4.55	5.56
Birth Control	5.24	5.75
Personal Use	3.97	4.24
TOTAL $\overline{X}$	4.65	4.85

The questionable reliability of the subscales, however, clouded the interpretation of the data. Therefore, the individual items were examined. Some interesting trends are visible and may be of some significance in the study of contraceptive attitudes and behavior.

All fathers strongly agreed with the statement that "taking precautions to prevent unwanted pregnancy should be a shared responsibility." However, the fathers moderately disagreed with the statements that "the major responsibility for avoiding pregnancy rests with my partner rather than myself"; and "I'd have no objection to birth control devices so long as my partner was the one who used it." In a sense, the fathers agreed that birth control should be a shared responsibility but in reality the major responsibility does fall on the female partner in that most methods used by

married couples (pill, IUD, and diaphragm) remain in the control of the female partner.

The three items that generated the most negative responses from fathers were statements 10, 17 and 18. "So many birth control methods are messy and involve too much preparation and planning"; "sex doesn't seem as satisfying when using certain types of birth control"; and "the use of some birth control devices spoils the mood and spontaneity of love making." Fathers' low scores on these items may reflect that the negative aspects of some birth control methods may have contributed to the attitudes of these men and may, therefore, influence their behavior in regard to some birth control practices.

Sons' Attitudes Towards Contraception

The sons showed less variance in their attitude scores. The range of the son's individual mean scores was only 4.1 to 5.6 on a scale of 0-6. The mean for the group was 4.85 and the median 4.75. The sons, like their fathers, showed generally favorable attitudes toward contraceptives. The sons' highest scores were recorded on the Birth Control sub-scale. They had a mean score of 5.75 on this scale which demonstrates that these sons are strongly in favor of using birth control to prevent unwanted pregnancy as measured by this instrument.

The examination of individual items also provide some data regarding sons' attitudes. On three statements (numbers 8, 9 & 13), the sons showed no variance in their responses.

All indicated that they strongly agreed that taking precautions should be a shared responsibility, that unwanted pregnancy is the responsibility of both partners and that they would enjoy sex more if they felt secure that their partners would not get pregnant. These findings may indicate that the questions were not sensitive enough to pick up differences in the group or that these opinions are universally held by all in the group. Whatever the reason, it seems that for this group of sons concern about the prevention of unwanted pregnancy is strong, and they believe that unwanted pregnancy is a responsibility that should be shared by both partners.

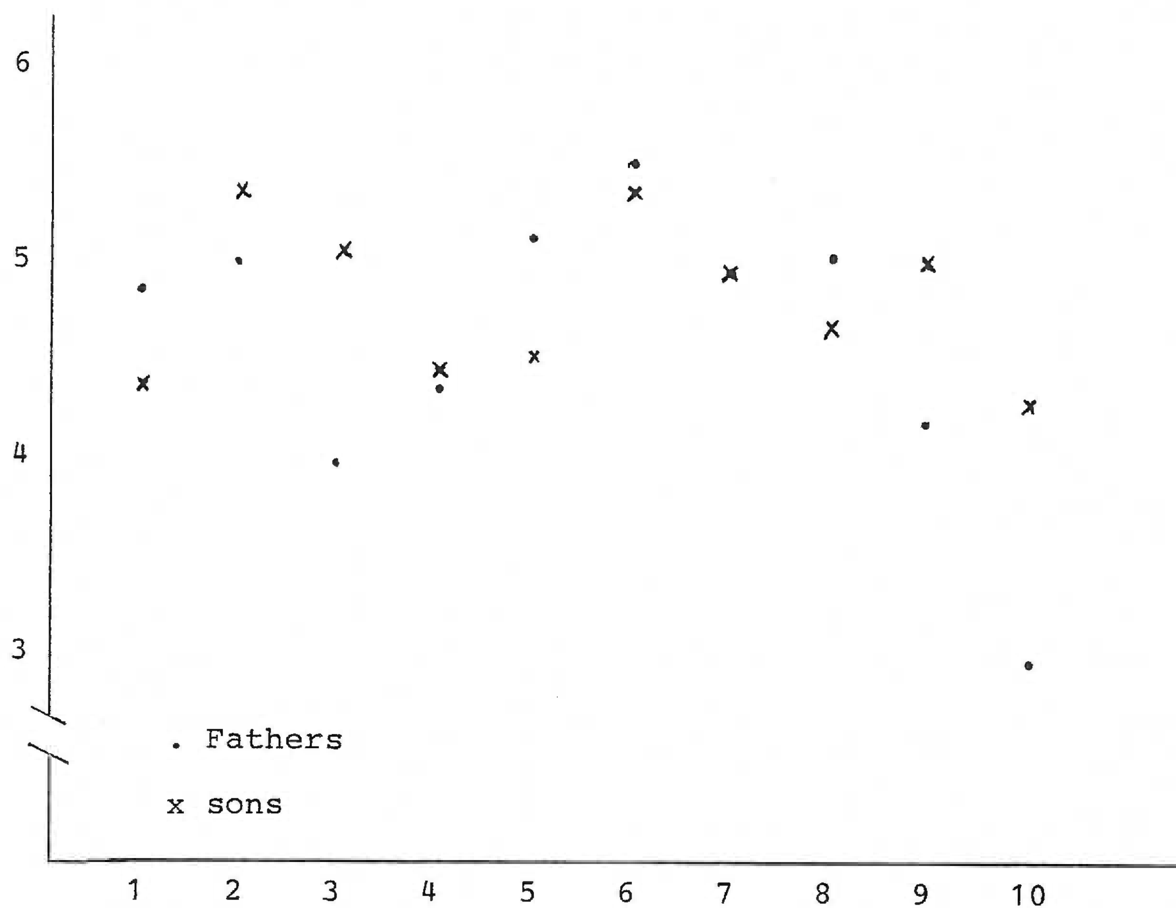
As with the fathers, the scores on items regarding the personal use of birth control were lower than their scores on the other subscales. The questions which address some of the negative aspects of birth control (inconvenience, interruption of love making, decreased satisfaction) seemed to have elicited lower scores than the other items.

Comparison of Fathers' and Sons' Attitudes

The second research question concerned the similarity of fathers' and sons' attitudes. Fathers and sons were compared as individuals and as groups. It was noted that the most conservative father was matched with the most conservative son. The most liberal father was also paired with one of the most liberal sons. The largest variance between the mean scores of the individual father/son pairs was 1.5, the smallest was zero. These comparisons are diagrammed on Figure 2.

Figure 2

MCAI Mean Scores of Father-Son Pairs



Pearson correlation coefficients were computed for the fathers' and sons' total scores as well as their scores on the subscales. For example, the fathers' scores on the Responsibility subscale were correlated with their sons' scores on the Responsibility subscale, fathers' Birth Control scores with sons' Birth Control scores and so on. The Pearson r coefficients do not suggest a strong correlation between fathers' and sons' scores except in the area of birth control use. The correlation coefficients and their statistical significance are shown in Table 5.

Table 5

Correlation Between Fathers' and Sons' Scores on the MCAI and its Subscales

Measure	Correlation Coefficient*
Responsibility	.24
Birth Control	.18
Personal Use	.57*
Total MCAI	.42

*p < .05, def = 8, 1-tailed test

Matched pair t-tests were computed between all scales for fathers and sons. No significant differences were found between fathers' and sons' attitudes in any of the three subscales or the MCAI as a whole. Table 6 lists the t-test values comparing fathers' and sons' mean scores on the MCAI and its subscales.

Table 6

Mean Scores of Fathers and Sons Compared by t-test for the MCAI and Subscales

	Mean Scores			
MCAI Subscales	Fathers' $\bar{X}$	Sons' $\bar{X}$	t-test value	p Value
Responsibility	5.44	5.56	1.21	.26
Birth Control	5.24	5.74	-1.84	.10
Personal Use	3.97	4.24	-0.92	.38
Total	4.65	4.85	-0.89	.40

The highest correlations were found between fathers' and sons' attitudes towards personal use of birth control, yet their difference approached significance in their attitude towards the prevention of unwanted pregnancy.

For further explanation of these results, the individual questionnaire items were examined. To determine which items produced different responses from fathers and sons, t-tests between fathers' and sons' scores on each item were computed. The items were then ranked from the most significant t-values to the least significant. The ranked items were placed along the abscissa of the graph in Figure 3 from the most significant t-value to the value of least significance. Along the ordinate the range of mean scores were placed. Finally, the mean scores of fathers and sons on each item were plotted on the graph.

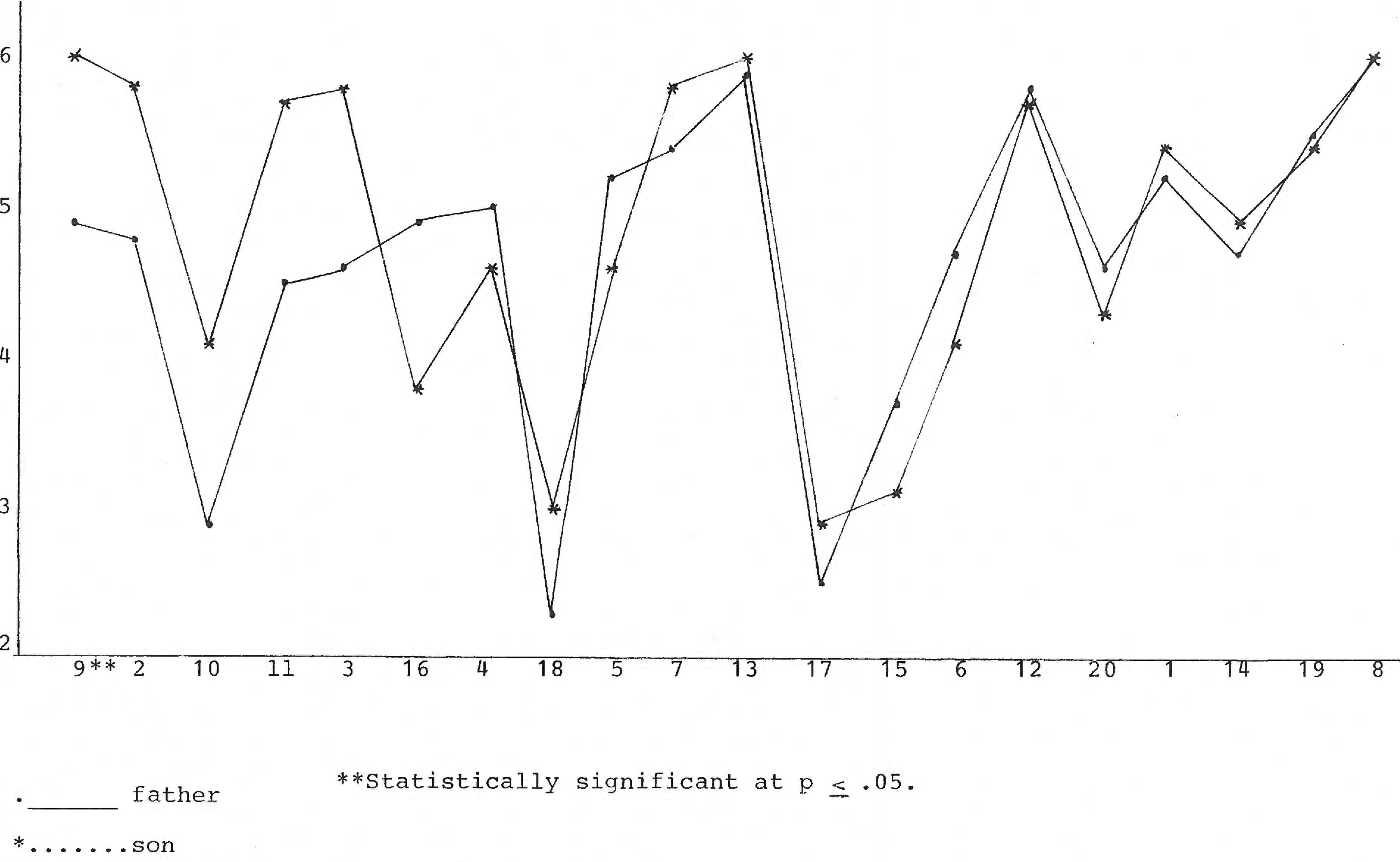
The graph demonstrates the similarity of fathers' and sons' scores on several questions. Once again it can be seen that fathers and sons were in strong agreement that birth control and pregnancy should be a shared responsibility (Questions 8 and 13). In addition, both have lower scores on the items that address the drawbacks associated with some birth control methods (Questions 10, 17, 18).

As noted in the section on sons' attitudes, they strongly supported the use of birth control to prevent unwanted pregnancy. Using the graph, it can be seen that sons scored higher on the questions which addressed this issue (Questions 3, 7 & 9) than their fathers did. This

Figure 3

Means Scores of Fathers and Sons

by MCAI Items Ranked by T-test Values



**Statistically significant at $p \leq .05$.

difference could be explained by the fact that the consequences of unwanted pregnancy could be much greater for sons than for fathers.

There are two other items where the difference between fathers and sons is interesting but not unexpected. Sons expressed considerably more willingness to use a condom for birth control than their fathers did (Question 2). Condoms are reported to be one of the most popular birth control methods used by teenagers (Finkel & Finkel, 1975; Scales, 1977) because they are more easily available. However, fathers showed a more favorable attitude towards visiting a family planning facility or doctor's office (Question 4). It has been observed that family planning clinics are set up for the female consumer or are viewed as being unreceptive to young male clients (McCallister, 1979; McKenna, no date).

In summary then, there seem to be some trends that are visible in the study findings regarding fathers' and sons' attitudes. Generally, both groups appear liberal in their attitudes. They seem to support the concept of shared responsibility in birth control practice. For sons it seems especially important to prevent unwanted pregnancy so they support the use of birth control. However, for both groups their attitudes toward personal involvement in birth control practices may be influenced in the negative direction by some of the drawbacks of our present-day methods.

Correlation between Fathers' and Sons' Perceived Attitudes

The focus of the third research question was the extent

to which fathers and sons were familiar with each other's attitudes. The data used to answer this question were obtained from the fathers' and sons' answers to the second portion of the MCAI. In this portion the men were asked to respond to statements as they thought their fathers or sons would respond. In Figures 4 and 5 total and subscale mean scores for fathers' and sons' actual attitudes are displayed along with their mean scores for their perceptions of one another's attitudes.

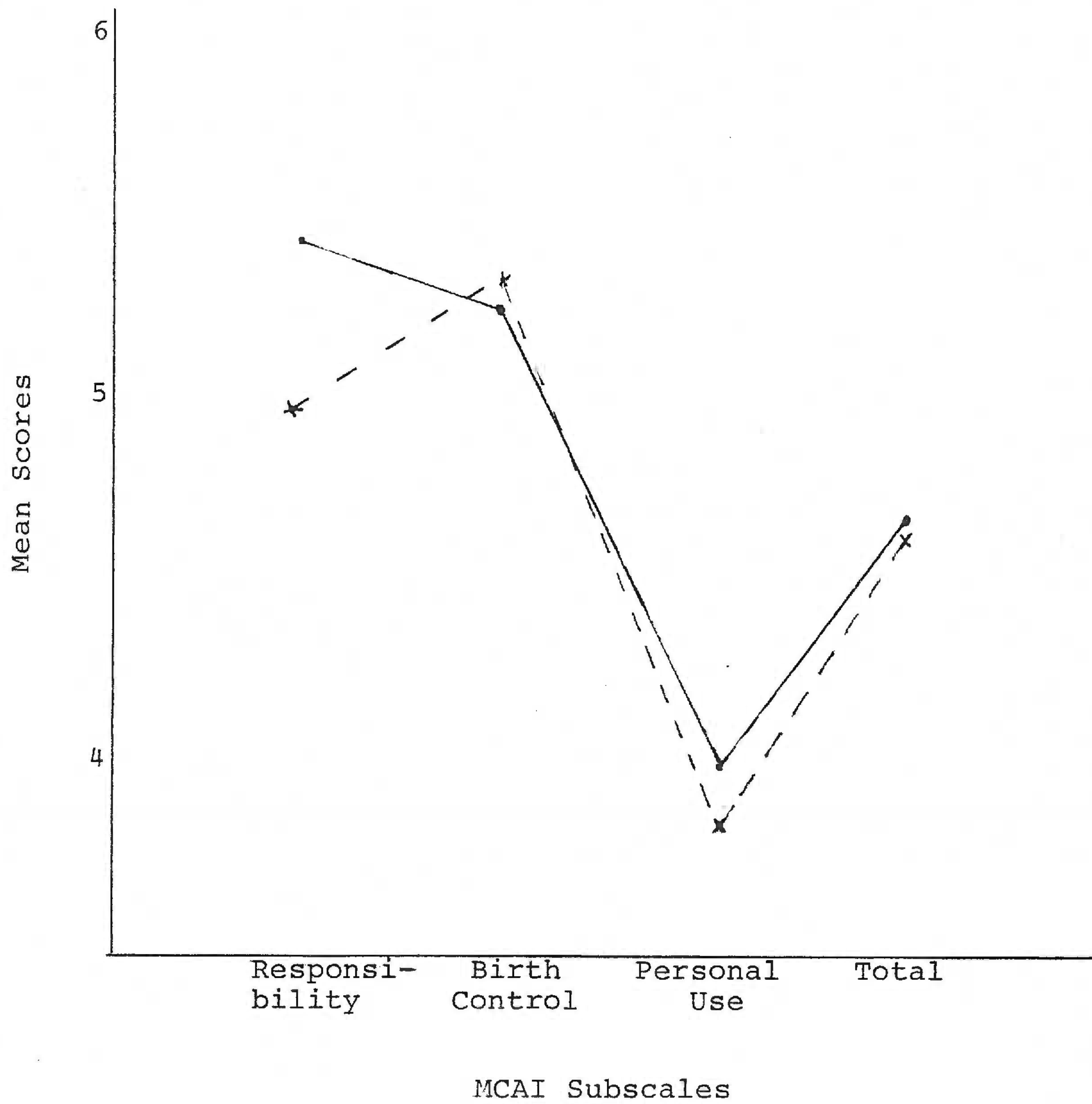
On the graph in Figure 4, a similarity between fathers' attitude scores and their scores on their perceptions of their sons' attitudes can be seen. The highest correlation between fathers' attitudes and their perceptions of their sons' attitudes was the Personal Use subscale ($r = 0.90$, $p = .003$). Their total MCAI score also correlated highly with their total scores for their perceptions of their sons' attitudes ($r = .82$, $p = .003$). The correlations on the Birth Control subscale were also high ($r = .64$, $p = .021$). The Responsibility subscale correlation between father's attitudes and their perceptions of their sons was the lowest ($r = .46$, $p = .089$). These close correlations between the fathers' attitudes and their perceptions of their sons' opinions suggest that these fathers think their sons think as they do on these subjects. However, in general the fathers' perceptions of their sons' attitudes were more conservative than the measure of sons' actual attitudes.

In Figure 5 the sons' mean attitude scores are graphed

Figure 4

MCAI Total and Subscale Attitude Scores for

Fathers, Fathers' Perceptions of Sons



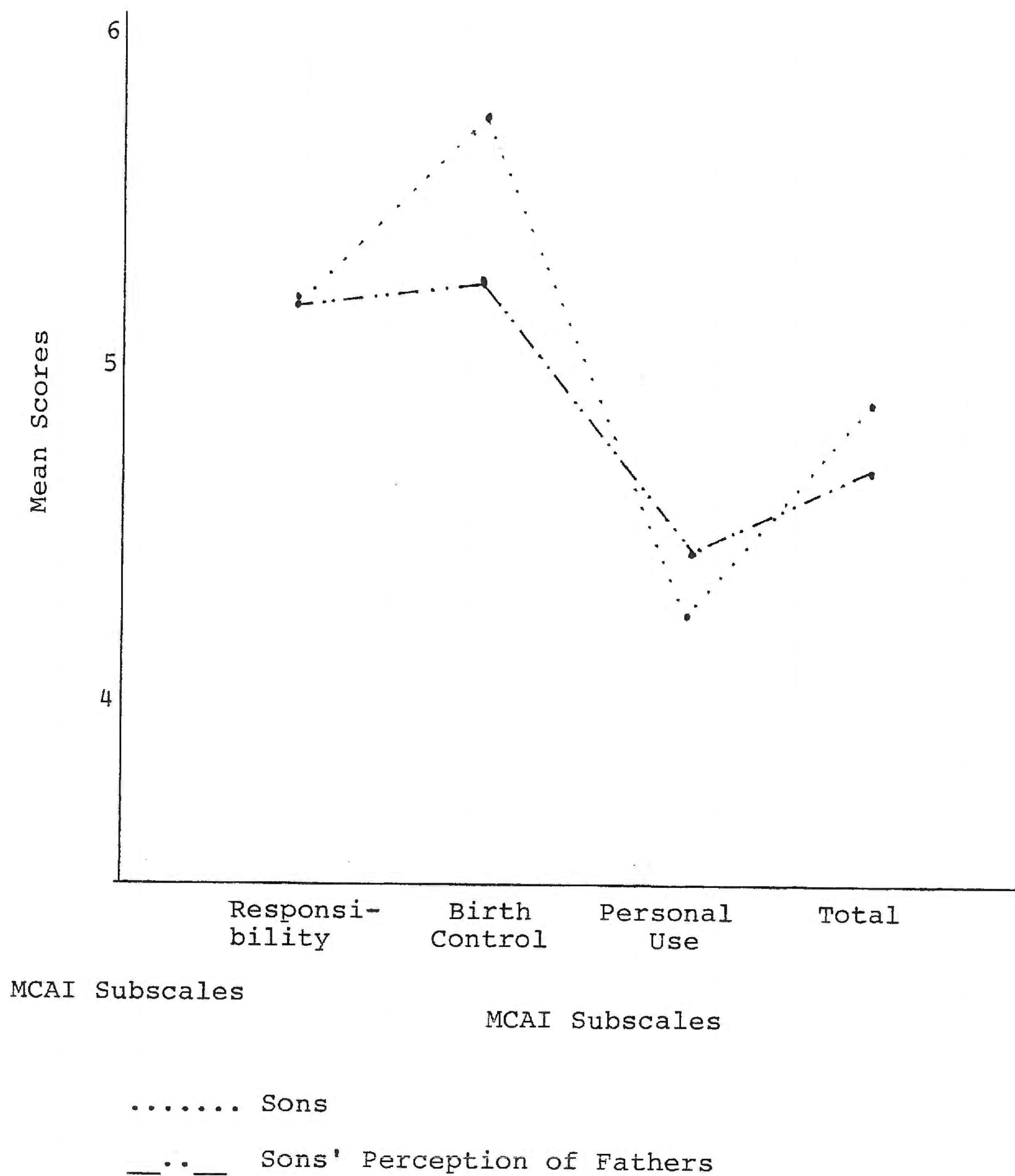
_______ Fathers

------- Fathers' Perceptions of Sons

Figure 5

MCAI Total and Subscale Attitude Scores for

Sons, Sons' Perceptions of Fathers



along with their mean scores for their perceptions of their fathers' attitudes. They perceived their fathers as being more conservative than themselves on the Birth Control subscale, but they actually predicted their fathers' actual attitude very closely on this subscale. For the Responsibility subscale, the sons' attitudes correlated highly with their perceptions of their fathers' attitudes ($r = .93$, $p = .000$). Their attitudes also correlated highly with their perceptions of their fathers' attitude on the Personal Use subscale and the MCAI total score ($r = .89$, $p = .003$; $r = .82$, $p = .002$, respectively). The lowest correlation was on the Birth Control subscale ($r = .64$, $p = .021$). Here again as with the fathers, sons thought their fathers held opinions very similar to their own.

Once again it must be emphasized that reliance on statistical analysis for the interpretation of this data is not suggested. However, it might be said that fathers expect their sons to have the same attitudes towards a behavior as they do.

Findings Related to Communication Between Fathers and Sons

The data collected on the communication questionnaire were tabulated and analyzed in answering the fourth and fifth research questions. The questions ask: Do fathers and sons talk about birth control and other sexuality topics together? Do fathers and sons feel they can communicate comfortably about birth control?

Nine of ten fathers said they had discussed various

sexual topics with their sons. Nine sons also reported having talked to their fathers about sexual topics. However, the father and son who said they had not talked were not of the same pair. In fact, when fathers' and sons' responses were placed side by side, there appeared to be quite a difference in topics which each recalled having talked about.

The topics and the number of fathers and sons who had discussed the subjects is shown in Table 7. Six fathers and

Table 7

Frequency of Reported Discussion
of Sexual Topics by Fathers and Sons

Sexual Topic	Fathers (N=9)	Sons (N=9)
1. Having sex before marriage	6	5
2. Moral aspects of sex	5	4
3. Bodily changes	8	5
4. Birth control methods	6	6
5. How pregnancy occurs	7	4
6. Responsibilities of fatherhood	7	6
7. Effect of unplanned pregnancy	9	4
8. Population control	3	0
9. Kissing/necking/petting	5	4
10. Venereal disease	8	2
11. Biological changes in women	7	4
12. Sexual preferences	7	3
13. Other--masturbation, premature ejac.	0	1

sons agreed that they had talked about birth control methods. Generally, it seems that most sons reported having talked about fewer topics than their fathers reported.

Descriptive information about the circumstances in which discussions took place was assessed by means of question C (Appendix B & C). The questions ask how many times in the past year the father and son had talked about the sexuality topics mentioned in Table 7. There were four descriptions of types of consersations: 1) topics are just mentioned in passing, 2) brief words of caution or advice, 3) brief conservations and 4) longer conversations. The fathers and sons were instructed to indicate the number of times in the past year they had utilized each conversation type. The data here was not as clear. Several fathers did not complete each portion of the question. A brief conversation pattern was used by eight fathers at least once a year or more frequently. Once or twice a year was indicated most frequently by both fathers and sons as the number of times all types of conversations took place.

Question D asks who initiated the discussions between the pair. Six of nine fathers who had discussed the sexual topics felt that discussions were initiated equally by both themselves and their sons. No father thought his son had initiated the discussions. However, three sons claimed to be the initiator and only two agreed that they and their fathers equally began the conversation.

Question E asked how they felt about discussing the

topics with their father/son. Eight of nine sons indicated that they thought their fathers had good advice and did not mind talking with them. Only one indicated that he did not think that this father knew what to tell him so he did not talk to him. Eight of the nine fathers who answered the question responded that they felt quite comfortable talking about these subjects with their sons. Only one father indicated that "although talking about the topics can be uncomfortable, I think it's important so we talk about them."

Question F was designed to gather information regarding some of the reasons many parents and children find it difficult to communicate about sexuality. Following each reason fathers and sons were to indicate if they thought the reason was "very important," "somewhat important," or "not important." In order to clarify the data and to determine which statements were viewed as valid reasons for difficulties in sexual communication between parents and children, the data from the first two choices were collapsed resulting in two categories, important and not important. Table 8 lists the reasons and the number of fathers and sons who indicated that the reason was important or not important.

By comparing just the numbers of fathers and sons who chose the "not important" category, it appears that more than half of these fathers and sons viewed these reasons as "not important." It could be for this sample, that the reasons offered really may not be important, since it appears that these fathers and sons may have overcome many of the

Table 8

Reasons Fathers/Sons Find it Difficult to Talk About Sexuality Topics by the Frequency of Fathers' and Sons' Responses of "Important" or "Not Important"

	Fathers (N=10)		Sons (N=10)	
	Important	Not Important	Important	Not Important
1. My father/son and I don't see eye to eye on most subjects dealing with sex so we don't discuss it much.	2	8	4	6
2. The right opportunity to talk just doesn't come up.	4	6	3	9
3. I find it so uncomfortable, I can't discuss it easily.	3	7	4	6
4. He doesn't/I don't know what to tell him/me, so we don't discuss it often.	3	7	3	7
5. I don't think my son/I am is ready for sexual involvement so discussion of these topics is not necessary yet.	3	7	3	7
6. Our relationship just isn't open enough to talk about very personal things like sexual behavior.	2	8	4	6
7. He hasn't/I haven't been around when the subject has come up.	4	6	4	6
8. My son/father seems so nervous about it that I hate to bring it up.	1	9	3	9
9. I don't think one should talk about sex with his children.	0	10	0	7
10. I think I/my son would rather get this information from his friends at school.	3	7	0	7

communication barriers reported by other studies who had looked at this problem.

When fathers and sons were looked at individually, however, five fathers and eight sons found at least one reason to be important in their case. In fact, the father who reported that he had not discussed any topics with his son chose seven of the ten items as being important reasons for his difficulties in talking about sexuality with his son. One of the reasons he chose was that of his own lack of knowledge about what to say. Two other fathers agreed with him. Three sons also indicated that their fathers did not know what to tell them.

It is also interesting to note that three sons chose the statement, "I don't think one should talk about sex with their father" as an important reason for difficulties in parent/child sexual communications. Two of these same sons agreed that they found the subject uncomfortable and not easily discussed by indicating that Item #3 was an important reason.

Incidental Findings

The questionnaire included several questions which were not specific to a research question but were considered to be of importance to a study of parent-child communications on sexuality issues.

Both fathers and sons were asked to indicate which statements they thought described the role parents, especially fathers, should take in sons' learning about sexual

issues (see Appendix B, C, Question G). Only one father indicated that because the boy's mother handled these subjects, he did not need to. Eight fathers agreed that sex education should be a responsibility shared by most parents. Six indicated that they felt that they were one of the best sources of sexual information, and they could offer their sons good advice. Only two fathers thought the school should be doing most of the sex education of teenagers. The majority of sons agreed with their fathers that parents should share the responsibility of sex education, and that their fathers were good sources of information. Only two young men indicated that they saw the school as being primarily responsible for sex education. Both of these participants had previously indicated that their fathers had discussed only a few (0 to 2) sexual topics with them. However, their fathers both indicated that at least nine of the sexual topics had been discussed and responded that parents should share the responsibility of the children's sex education.

Participants were encouraged to write in comments about the questionnaire and thoughts they may have had about the study of family learning regarding sexuality issues. One son expressed a concern that the churches' influences on sexual learning had not been included. Another young man made this comment about his father:

> My father and I have a very open and close relationship. Although, I do get a lot of information from school

through my health class, I usually ask my father because he usually gives me a fair view and tells me how things were when he was young. He's completely honest and I appreciate that.

Fathers were asked if they had any sex education classes in school. Five had had a course, three in high school and two in college. The remaining five had had no courses in sex education. There appears to be no difference between the two groups in their attitude scores or their responses to the communication questions. However, three of the five fathers who had not had a course indicated that not knowing what to tell their sons about sex was an important factor which made communication with their sons difficult for them.

CHAPTER IV

DISCUSSION

In this chapter the results of this survey will be examined and compared to the findings of other studies. The limitations of this study, critique of the instrument, the attitudes of fathers and sons relative to contraception, the correlations between fathers' and sons' attitudes and their perceptions of each other's attitudes and the pattern of sexual communication found in this study are included in this discussion.

Limitations of the Study

In Chapter II, the obstacle presented by the requirement of parental consent in conducting research with minors was discussed, as were design considerations pertinent to the anonymity and confidentiality of research studies. The first obstacle can make access to a representative sample population difficult. For this study these concerns are believed to have had a marked effect on the response rate and a high attrition of the sample. The initial steps taken to access a population were unsuccessful in four area high schools. School administrators were reluctant to allow an outside researcher in their schools and even less willing to permit the researcher to approach parents with a sexuality survey. When the search for a population was finally

successful, it was decided by the principal and health educator that the study should be introduced to the students first and to allow them to make the decision to approach their fathers. Student response at first was exciting with 80 of 157 young men volunteering to take an envelope to their fathers and ask them to join the study with them. However, only 13 consents were returned. The following explanations can be offered for the low response rate in this study.

First, the high number of volunteers was perhaps really a false representation of young men who intended to even try to approach their fathers; they may have taken an envelope because many of their peers did. Some may have taken the envelope and forgotten it, although they were reminded several times during the following week.

Second, it could be that some fathers refused to join their sons in the study. They may not have had time or they may not have wanted to participate in a sexuality survey.

And finally, the sensitive nature of the study topics may also have impeded these young men from approaching their fathers. They may have feared that a study about sexuality might expose something about themselves. Simply approaching their fathers with a request to join a sexuality survey may have been a dialogue for which they were not ready.

It might be assumed then that the young men who did manage to approach their fathers showed a fair amount of responsibility and at least some degree of comfort with the

subject and their fathers. Therefore, the volunteer father/son pairs who participated in this study may represent a special group comprised of fathers and sons who may already be open to discussion of sexuality topics both in their homes and in public. The bias created by such a sample is one that frequently frustrates research in human sexuality and thus prevents the findings of the research from being generalized to other populations.

The resulting small sample of only ten fathers and sons represents the greatest limitation of this study and the interpretation of its findings. Statistical analyses of the data gathered in this study were carried out for descriptive purposes only. However, use of statistical analysis on such a small sample is really not appropriate when the sample is very small. The value of the findings is really best viewed when the fathers and sons are examined individually and as pairs.

The instruments utilized in the study also present a limitation to the interpretation of study results. The MCAI appears to have an acceptable reliability for fathers but not for sons. In the following section a critique of the instrument is provided beginning with a review of conceptual framework that guided the researcher in the development of the tool. Then the instrument is broken down into its sub-scale and the problems encountered with certain items are addressed.

Instrument Critique

"An ideal measuring instrument is one which results in measures that are relevant, accurate, sensitive, unidimensional and efficient" (Polit & Hungler, 1978, p. 421). The challenge of meeting these stringent requirements are especially evident in this study. The measurement of contraceptive attitudes is especially difficult because this attitude may be determined by several components. Contraceptive attitudes may include an individual's general attitude towards fertility control, attitudes towards various techniques of contraception (e.g., chemical versus natural methods) as well as the individual's attitude towards the specific behaviors required to participate in birth control. These attitudes can also be expected to vary across different populations which may be defined by age, religion, nationality or contraceptive/sexual experience.

Due to the lack of a previously tested instrument, the development of a reliable tool for the measurement of males' contraceptive attitudes became a task of this study. Fishbein's model of behavioral intention was used as the theoretical guideline for the development of the Male Contraceptive Attitude Inventory (MCAI) (see Chapter I, p. 21).

According to Fishbein ". . . an individual's intention to perform any behavior is a function of his (1) attitude toward performing the behavior and (2) his beliefs about the norms governing the behavior weighted by his motivation to comply with those norms" (Fishbein, 1972, p. 217). He

emphasizes that the attitude component here is concerned with an attitude toward performing a specific behavior in a given situation, rather than an attitude toward a given object, person, value or institution. The normative belief component refers to a specific behavioral expectation or desire in a given situation. For this study then an individual's contraceptive "attitude," which could also be viewed as a factor in his intent to perform or participate in contraceptive behavior, was conceptualized in three components. The components would be measured by examining the individual's attitude towards his personal use of birth control (attitude toward the act), his feelings about his responsibility or participation in birth control (normative beliefs) and finally his beliefs about birth control and the importance of family planning (motivation). The subscales of the MCAI were designed using these tenets as their foundation.

Under ideal circumstances this instrument would have been tested for its reliability and validity on several random samples of males representing various populations. However, due to time and financial constraints as well as sample access, this approach was not feasible. Therefore, after minor revisions were made to improve the clarity and readability of some of the items, the MCAI was pilot tested on this sample of fathers and sons.

It is not surprising then that the instrument did not prove to be reliable for both fathers and sons and the

subscales do not seem to have internal consistency and may lack validity in measuring the constructs. It is recognized that due to the small, biased sample the computation of reliability coefficients probably did not provide accurate reliability measurements but give only an estimate. The computed coefficient alphas can be used to guide in the improvement of the instrument's validity and reliability. In the following paragraphs, the instrument is examined more closely in an effort to explain why the reliability measures are low in some areas and to suggest ways to improve the instrument's validity and reliability.

Table 2 lists the statements as they appeared in the questionnaire. The reader should note that the scores on Questions 1, 5, 12, 16, 17, 18, 19 & 20 were reversed so that all high scores would reflect liberal attitudes.

The responsibility subscale consisted of Questions 1, 5, 8, 13 & 16. The attitude towards Birth Control subscale included Questions 3, 7, 9, 12 & 19; and the remaining questions belong to the attitude towards Personal Use of Birth Control subscale (see Table 2).

For the Responsibility subscale, the calculated alpha levels for the fathers and sons differed considerably; .170 for fathers and .767 for sons, respectively. The discrepancy here is due in part to the low degree of variance of many of the sons' answers. In fact, on Questions 8 & 13, there was no variance, all answering "strongly agree." There is no way to know if these opinions were universally

held by all or if the statement was not sensitive enough to measure differences within the group.

Question 16 on this subscale also seemed to be problematic. It is conceivable that the statement taps two areas of opinion. An individual could disagree with the woman who states that birth control is her business and responsibility but agree that if she wants to take care of contraception she can go ahead. However, what if the woman does not want to use any birth control? Then how would a respondent reply? This question is not clear and may have been confusing to the respondents. If the question is deleted from the subscale, the alpha level for fathers can be raised to .43, and for sons to .88.

The Birth Control attitude subscale did not prove to be reliable for either fathers and sons or their perceptions of each other's attitudes. In this subscale one item, Question 9, also had no variance for the sons. All sons strongly agreed they would enjoy sex more if they felt sure their partner would not get pregnant. It cannot be assumed for this question or any other question where there was no variance in the scores, that the opinion was equally strong for each individual. Perhaps a 7- or 8-step Likert scale would have been more sensitive in picking up their differences. Item 12 says, "It can be exciting to take a chance on getting my partner pregnant." To make this more consistent with the construct of the subscale, the phrase "by not using birth control," should be added. But removal of this item may

also improve the reliability of the scale. The fifth item in this subscale, Question 19, brings in the ideas about God, fate and luck; and may measure _something_ about what the individual believes about birth control use. However, the construct is not quite the same as in the other items where the emphasis is on avoidance of pregnancy as a motivator for the use of birth control.

In the final subscale, the attitudes toward personal use of birth control, there is again considerable discrepancy in the coefficient alphas; .813 for fathers and .396 for sons, respectively. As a measure of attitudes towards specific behaviors, it is probably that the sexual and contraceptive experiences of the respondents may influence their opinions of the behavior. It is understandable that a difference might be encountered. Perhaps not all the questions were valid for sons because they may not have experience with the behavior (i.e., Questions 10, 17, 18 & 20).

Question 15 also has its flaws. Again, it can be broken down into two statements. First, the respondent is asked about his willingness to withdraw, then is asked to make a judgment about the effectiveness of withdrawal as a form of birth control. For some men who have had sex education, this statement may seem almost contradictory to what they have learned. Again, this question may measure _something_ about what men think about their role in contraception. However, it is confusing just what is being measured, men's willingness to withdraw or his perception of withdrawal as

an adequate method of birth control. The deletion of this item would improve the reliability of this subscale to .86 for fathers and .60 for sons.

In re-examining the responses of fathers and sons, it became evident that not all were consistent in their answers. For example, three fathers and four sons agreed with Question 7, that no one should have sex without taking precautions to prevent unwanted pregnancy. However, these same people disagreed with Question 14, that they would not be willing to have intercourse if neither partner could take precautions against pregnancy. The negative phrasing of this question could have confused the response of some participants.

If this instrument is used in the future, rewording and refinement of the subscales and some of the items as mentioned in this discussion is suggested. The question of using the same instrument on both adolescents and their fathers must also be addressed. It is probable that attitudes toward contraception are influenced by an individual's sexual partners and experiences, his previous encounters with the use of contraception and its failures, and his experiences with fathering and family planning. The influence of these and other factors on contraceptive attitudes of fathers and sons as evidenced by this study and other research is addressed in the following discussion.

Attitudes of Fathers and Sons

The males in this study can be described as generally having liberal attitudes towards contraception. There was

universal agreement among fathers and sons that contraception should be a shared responsibility.

Although the liberal attitudes of these men cannot be generalized to other populations, other recent studies support the presence of liberal attitudes toward male involvement in contraception (Gebhard, 1977; Hanley, 1981; Moore, 1980; Whay, 1977). Two studies regarding male contraceptive pills (Gough, 1979; WHO, 1982) demonstrated a high proportion of men who showed liberal attitudes toward contraception and would take a male pill when one becomes available. The supporters and organizers of male reproduction health facilities report that males are concerned about ways they can become more sexually responsible including more active involvement in contraception (McCallister, 1979; Whay, 1977). Arnold (1972) and Finkel and Finkel (1975) concluded that young men do worry about the possibility of their partners becoming pregnant; and will, if encouraged, take greater responsibility for contraception. The sons' strong positive response to items regarding the avoidance of unwanted pregnancy by use of birth control would support this viewpoint.

Identification with masculine ("macho") image and the sexual double standard has been viewed as a major blockade in the formation of more positive attitude towards male involvement in birth control and family planning (Scales, 1977; Weinstein, 1977). However, the responses of the males in this study do not support this contention. The males in this study seem to have a favorable attitude towards a sharing of contraceptive responsibility.

It must be recognized that even given the liberal attitudes of these males towards contraception does not necessarily imply that they would as easily accept the use of a contraceptive method. However, using the Fishbein model, a positive attitude toward a behavior can be a significant component in the adoption of a behavior.

Comparison of Fathers' and Sons' Attitudes

The statistical analysis used to compare fathers' and sons' attitudes on the MCAI subscales did not show that their attitudes were strongly correlated, nor did it show any area where the attitudes were very different. However, there were some items that showed some differences in their opinions. It was also noted, in comparing individual fathers' attitude scores with their sons' scores, that the most conservative father had the most conservative son, the most liberal had one of the most liberal sons. Further discussion of these differences in light of previous research is presented in order to further delineate the variables that may influence contraceptive attitude and behavior.

An individual's life situation and sexual history has been stated to be an important variable in the development of contraceptive attitudes (Swanson, 1979). The influence of this variable appears to be evident by the variance in fathers' and sons' responses to several questions on the MCAI. It was found that sons expressed considerably more willingness to use a rubber than their fathers did. Condom use was the most frequently used form of birth control next

to withdrawal cited by teenage males in Finkel and Finkel's (1975) study and is one of the most accessible forms of birth control. Fathers, however, may have a different attitude toward condom usage. In the 1950's and 1960's when they were growing up, condom usage was frequently associated with promiscuity, prostitution and venereal disease (Free & Alexander, 1976). This negative attitude of the past may influence their opinion. In addition, condom usage represents only 9% of the contraceptive methods used by married couples (Free & Alexander, 1976).

A lack of accessibility to family planning facilities has been viewed as a barrier to the formation of favorable attitudes towards male involvement in contraception (Hanley, 1981; McCallister, 1979; Moore, 1980; Swanson, 1979). Fathers in this study showed a more favorable attitude towards visiting a family planning facility or doctor's office than their sons did. This may reflect public sanctions that make it easier for older, partnered men to enter these situations. Also, as noted in the study of female contraceptive behavior, the act of going to a clinic for birth control is a major step because it involves the acknowledgment of their involvement in sexual activity (Luker, 1975). For males, acknowledgment of sexual experience, at least among peers, has been reported to be a factor influencing further pursuit of sexual encounters. However, the kind of public announcement required of an adolescent male in entering the adult world of a clinic with his girl friend is a different matter.

Perhaps some of the same factors that are thought to influence female contraceptive behavior also influence the behavior of their male partners.

The limited data gathered in this study suggest several factors which may influence male attitudes towards contraception. Various situational variables have come to light, such as an individual's position in the life cycle. Another situational variable which appears to be a factor in this study is the issue of availability of information, services and methods. In this study the differing views of fathers and sons towards some of the personal use items may reflect the importance of contraceptive and sexual experiences. The next section discusses what was learned about the role of the father in the acquisition of contraceptive attitudes on the male adolescent in this study.

Comparison of Fathers' and Sons' Perceptions of One Another's Attitudes

Gathering information regarding how attitudes are acquired was also a concern of this study. It was assumed that some transference of parental attitudes takes place during the process of sexual socialization. This assumption generated the research question regarding the similarity and perceived similarity of fathers' and sons' attitudes.

These fathers and sons were shown to have fairly liberal attitudes towards contraception. However, when their attitudes were compared using the Pearson's r correlation, the correlations between their attitudes were not statistically

significant. The findings related to this third research question regarding fathers' and sons' perceptions of one anothers' attitudes showed that both fathers and sons perceived each others' attitudes as being similar to their own. However, their predictions of one anothers' attitudes were not very accurate; both fathers' and sons' actual attitudes were more liberal than their attitudes were perceived to be by each other.

An explanation for the finding that perceptions actually correlated most closely with their own attitudes, especially for fathers, is offered by one of the young men in the study. "I think some fathers assume their sons are doing the right thing so they don't ask." It appears that fathers perceived their sons to have the same opinion as they do. Perhaps fathers and sons present a more conservative front to one another because that is what they expect from each other.

For further explanation regarding the transference of attitudes in parent-child pairs, a closer examination of studies in attitude formation which were not included in the review for this study is necessary. However, an observation made by Acock and Allen (1978) in their study of predictability of parent/child religious and political orientations adds insight to the understanding of transference of attitudes. They found a relatively high predictability from parent to child in religious and political orientations (R up to .67), however, they found this predictability stronger

for mothers than fathers. They remarked that they could not be certain whether parents had influenced the children, or if both were affected by forces in the broader society. This question holds true for these fathers and sons as well. It is not known whether increased sex education focused on male involvement or more egalitarian sex role attitudes may have influenced the opinion of both fathers and sons.

An objective of this study was also the investigation of the effect of overt communication on attitude formation in the child. An attempt was made to compare individual father's and son's attitudes in relation to the number of sexual topics discussed. No trend could be seen between the fathers' and sons' individual attitudes and their reports of discussions of birth control and sexuality issues. Nevertheless, this does not mean that the communication between these fathers and sons did not influence one another's attitude but probably reflects the inadequacy of the MCAI in measuring attitudes and the communication questionnaire in assessing the amount of communication that really takes place between these fathers and sons. Therefore, no conclusions regarding how communication pattern influence attitude formation can be drawn from this study.

Sexual Communication Between Fathers and Sons

Most researchers report that very little overt communication about sexuality takes place between parents and children (Roberts, et al., 1978; Fox, 1980; Gebhart, 1977), and that fathers are less active than mothers (Fox, 1980;

Bennett, 1980). For the present study, the dialogue pattern in question was that between fathers and sons. Contrary to other studies, these fathers and sons demonstrated a degree of communication in that nine fathers and eight sons indicated that they had discussed some of the topics relating to sexuality. But not all father/son pairs agreed on the number of topics discussed or which topics had been covered. Fathers usually listed more topics than their sons listed. It is possible that sons and fathers define "talked about" in a different manner. It is also possible that when the conversation took place the son was not ready to hear the information and did not listen. Nevertheless, several sons expressed a high degree of confidence in the information and advice offered by their fathers in the area of sexuality. It is probable, however, that these fathers and sons represent a group of parents and children in which an open dialogue pattern may have been previously established. Information regarding the communication patterns of their peers and their fathers is not available, and they may represent a very different group.

There were two sons who indicated that they did not think they should discuss sex with their fathers, and they found the subject uncomfortable and not easily discussed with their fathers. It might be, that for these two sons, their own comfort with sexuality plays a part in their perceptions of their fathers as persons with whom they can discuss their ideas and questions regarding sexuality issues.

A written statement by one of the sons adds insight to sons' views of their fathers in regard to this subject:

> I think the breakdown of communication in the area of sex education is due to assumptions. The young assume the parents won't understand or they are embarrassed that their values will not be in line with their fathers. I think some fathers would like to assume their sons are doing the right thing but are afraid to ask.

In light of the fact that most of the sons indicated a good deal of confidence in their fathers' advice, and that most of these sons were able to approach their fathers and initiate discussions with them, it could be that rapport between the father/son pair is another important variable influencing familial sexual communication. This finding would lend support to the work of Bennett (1980) and Welbourne (1978) who found positive correlations between rapport and/or parental openness and discussion of sex related topics.

In this group of what may be considered as highly communicative fathers and sons, there was substantial support by both fathers and sons for parental sharing of the sexual teaching of children. Bennett (1980) also found this to be true of the majority 18 and 19-year-old students in her study. In fact, 67% of these students declared a preference for parents as primary sex educators. There is, however, ample evidence from other studies that despite this

preference by some students, that parents are seldom either the first or more important source of sex education for most young people. Rather peers typically provide most sex education (Gebhard, 1977; Gordon & Everly, 1978; Roberts, et al., 1978).

The following comment was made by a father who had not discussed any topic with his son. He gives his reason why birth control had not been discussed with this son.

> This questionnaire has really opened my eyes to the fact that I have not discussed sex with my son. I think the main reason is that for the past 15 years (my son is 16) I have never had to worry about pregnancy - my wife has had her tubes tied - consequently I have never had to use any source of contraceptive. I think I am the type of person that would have discussed contraceptives with my son if I had to use them. I guess what I am trying to say is since I did not have to worry about unwanted pregnancies I just put it out of my mind.

His comments suggest that the sexual history variable influences communication with children, and therefore, influences their attitudes.

One other variable which has been said to influence parent/child communication is that of sex education. Three of the five fathers who had not had a course indicated that they did not know <u>what</u> to tell their sons. Gordan and Everly (1978) also found this to be a frequent response in

their survey of parents regarding the sex education of their children.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The summary, conclusions, implications for nursing practice associated with this study are presented in this chapter. Recommendations for further research conclude the chapter.

Summary

A review of literature revealed that most of the past research on the contraceptive behavior of the adolescent has focused on the female, and the study of the male role in family planning has been largely neglected. It also revealed that although the father is reported to be less active in the sexual socialization of his children than the mother, there has been little research of the male's sexual socialization role. Research in the males' attitude towards contraceptive behavior and his role in the familial sexual communication is needed. Of particular interest in this study was the investigation of the relationship between parent/child sexual communication and the acquisition of contraceptive attitudes.

This study focused on the contraceptive attitudes and sexual communication patterns of adolescent males and their fathers. The major research questions that were addressed in this study were: 1) What are the attitudes of fathers

and sons toward contraception, 2) Are fathers' and sons' attitudes similar in regard to contraception, 3) Do fathers and sons think they have similar attitudes, 4) Do fathers and sons talk about birth control and other sexuality issues, and 5) Are they comfortable in their communications regarding these topics?

Access to a population of fathers and sons was a major study obstacle. Study participation was offered to 157 teenage men. Eighty volunteered to ask their fathers. Thirteen consents were returned. Only ten fathers and sons participated in the study by completing a 20-item contraceptive attitude questionnaire and a brief questionnaire regarding their communications on sexual topics. The study was a pilot test for the Male Contraceptive Attitude Inventory (MCAI), which was conceptually divided into three subscales measuring male attitudes toward responsibility, birth control, and personal use of birth control. The instrument was shown to be reliable for fathers, but not sons. The subscales did not have internal consistency. The survey data were analyzed using descriptive and inferential statistics.

It was found that these fathers and sons had generally liberal attitudes toward contraception, although they were somewhat less liberal on items that measured their attitudes toward personal use of birth control. The fathers and sons showed favorable attitudes toward sharing the responsibility of contraception. Support for the use of birth control for

the prevention of unwanted pregnancy was especially evident in the sons' attitude scores.

The fathers and sons differed somewhat in their attitudes towards the personal use of birth control. This difference in their opinions is believed to be influenced by the different sexual, contraceptive and life experience represented by fathers and sons. Both fathers and sons perceived one another's attitudes to be similar to their own. Fathers estimated that their sons' attitudes to be more conservative than the son's actual attitudes were.

Nine of these fathers and sons reported to have talked about several sexuality topics, although the sons recalled having talked about fewer topics than their fathers reported. The most frequently reported topic that fathers had discussed was the effects of unwanted pregnancy followed by venereal disease and bodily changes. Sons most frequently recalled birth control and responsibility of fatherhood. Due to the inadequacy of the communication questionnaire, it is not clear how frequently the topics were discussed but probably not more than one to two times per year for most fathers and sons. However, most of the fathers report that they felt comfortable talking with their sons on these issues. Sons agreed that their fathers had good advice and were comfortable talking with them on this issue.

Two incidental findings are of interest in the study of familial sexual communication. There was substantial support on the part of both fathers and sons that the sexual

teaching of children should be shared by both parents. It was also found that some of the men who had not had sex education expressed that the lack of confidence in their knowledge about sexuality hampered their ability to talk to their sons.

Conclusions

The following conclusions can be drawn from the findings of this study:

1. The fathers and sons expressed favorable attitudes towards sharing the responsibility of contraception, using birth control to avoid unplanned pregnancy and towards some of the behaviors involved in the personal use of birth control.
2. Fathers' and sons' attitudes were found to be fairly similar. However, some differences in their opinions were evident in areas that may be influenced by sexual and life experiences.
3. The fathers perceived their sons' attitude to be similar to their own attitude. This was also true for the sons.
4. Most of these fathers and sons had communicated but to an unknown extent on various sexuality topics including birth control. Sons recalled having talked about fewer topics than their fathers did.
5. These fathers and sons expressed a fair amount of confidence and comfort in their communication on sexuality topics.

Implications for Nursing Practice

In addition to providing more general information about the factors that influence contraceptive attitudes, the study has several specific implications for nursing practice. These implications may be especially important for school nurses, nurse practitioners and nurses involved in family planning and childbearing.

The positive attitudes of these fathers and sons towards their role in contraception is encouraging. They may not be representative of all men, but they do represent some percentage of the male population. This favorable attitude of males toward family planning has been reported by other researchers (McCallister, 1979; McKenna, no date; Oresky & Ewing, 1978; Swanson, 1979; WHO, 1982). However, one of the barriers to increasing male involvement in family planning that has been cited in these studies is the attitude taken by health care providers. This attitude is one that assumes males are not interested, willing or cooperative in efforts to improve the contraceptive effectiveness of couples. As a result the opinions of the male partner are often not assessed and his presence in birth control counseling visits is rarely invited.

An assumption of this study was that a positive attitude on the part of the male partner may be a key factor in a couple's use of birth control to prevent unwanted pregnancy. It seems then that nurses, as primary health care providers, need both to examine their own opinions about

males' responsibility and involvement in contraceptive behavior, and to look at their own practice to see how they can facilitate the participation of males in family planning.

The cultivation of positive attitudes toward sexuality begins with infancy. Nurses and nurse practitioners who care for children and their families can promote healthy, sexual growth in the children and adolescents by facilitation and encouragement of discussions between parents and children regarding sexuality. This study gives evidence that fathers are willing to take up dialogues about sexuality with their children.

Recommendations for Further Research

The findings of the present study suggest several recommendations for further research. First, both the MCAI and the communication questionnaire should be further tested and revised in order to improve their reliability and validity. The questions which have doubtful meanings should be eliminated. The MCAI should be tested on males of several age groups to determine if separate instruments should be developed to access attitudes at different life stages. An important component of contraceptive attitudes not included on the MCAI may be attitude toward male and female sterilization. The communication questionnaire also should be expanded and improved by developing questions that access the frequency and circumstances in which sexuality discussions take place.

Second, the study should be replicated on a large group of fathers and sons, preferably a random sample. Perhaps

finding access to such a group would be easier if the researcher begins with fathers rather than sons.

Third, this study gives some evidence that the male's sexual and contraceptive experience may be related to his contraceptive attitudes and his communications about sexuality with his father/son. The relationship of the variable of sexual history to attitude formation and familial sexual communication should be investigated in further research.

Fourth, further research is needed to investigate the relationship between parental rapport, communication and attitude formation.

In summary, the findings of this study have provided a beginning from which further study of contraceptive attitudes and family sexual communication can be designed. Such research will provide direction for health care providers in their efforts to prevent unwanted pregnancy and foster healthy family growth.

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APPENDIX A

Male Contraceptive Attitude Inventory for Sons

APPENDIX A

Male Contraceptive Attitude Inventory for Sons

DIRECTIONS

FIRST Read the statement and circle the one which best expressed your reaction to the statement. Use the following choices:

- #1 Strongly Disagree
- #2 Moderately Disagree
- #3 Slightly Disagree
- #4 Slightly Agree
- #5 Moderately Agree
- #6 Strongly Agree

SECOND Now, read the statement again and think about how your father would respond to the statement. Using the second group of numbers, circle the number which best corresponds to his opinion.

	Statement	Your Opinion						How you think your Father would answer						
		DISAGREE			AGREE			DISAGREE			AGREE			
		Strongly	Moderately	Slightly	Slightly	Moderately	Strongly	Strongly	Moderately	Slightly	Slightly	Moderately	Strongly	Don't Know
1.	The major responsibility for avoiding pregnancy rests with my partner rather than myself.	1	2	3	4	5	6	1	2	3	4	5	6	DK
2.	I'd be willing to suggest that I use a rubber as a birth control method.	1	2	3	4	5	6	1	2	3	4	5	6	DK
3.	Before I'd have sex with anyone, I'd personally make sure we were using birth control.	1	2	3	4	5	6	1	2	3	4	5	6	DK
4.	I'd go to a doctor's office or clinic with my partner to obtain a birth control method.	1	2	3	4	5	6	1	2	3	4	5	6	DK
5.	I'd have no objection to birth control devices as long as my partner was the one who used it.	1	2	3	4	5	6	1	2	3	4	5	6	DK
6.	I'd be willing to go to the drug store to buy condoms (rubbers) or contraceptive jellies and creams.	1	2	3	4	5	6	1	2	3	4	5	6	DK
7.	No one should have sex without taking precautions to avoid unwanted pregnancy.	1	2	3	4	5	6	1	2	3	4	5	6	DK
8.	Taking precautions to prevent pregnancy should be a shared responsibility.	1	2	3	4	5	6	1	2	3	4	5	6	DK
9.	I'd enjoy sex more if I felt sure my partner wouldn't get pregnant.	1	2	3	4	5	6	1	2	3	4	5	6	DK
10.	So many birth control methods are messy and involve too much preparation and planning.	1	2	3	4	5	6	1	2	3	4	5	6	DK
11.	I would be willing to wait while my partner used foam or a diaphragm before making love (having intercourse).	1	2	3	4	5	6	1	2	3	4	5	6	DK
12.	It can be exciting to take a chance on getting my partner pregnant.	1	2	3	4	5	6	1	2	3	4	5	6	DK
13.	When a pregnancy results from not using birth control, both the man and the woman are responsible.	1	2	3	4	5	6	1	2	3	4	5	6	DK
14.	I would not be willing to have intercourse if neither my partner nor I were able to use precautions to avoid pregnancy.	1	2	3	4	5	6	1	2	3	4	5	6	DK
15.	I'd be willing to use withdrawal before ejaculation as a pretty good way of avoiding pregnancy if we had no other choice.	1	2	3	4	5	6	1	2	3	4	5	6	DK
16.	If the woman says birth control and pregnancy is her business and responsibility, then it is okay with me to let her decide about birth control.	1	2	3	4	5	6	1	2	3	4	5	6	DK
17.	Sex doesn't seem as satisfying when using certain types of birth control.	1	2	3	4	5	6	1	2	3	4	5	6	DK
18.	The use of some birth control devices spoils the mood and spontaneity of love making.	1	2	3	4	5	6	1	2	3	4	5	6	DK
19.	Using birth control involves tampering with nature, such things should be left to God, fate or luck.	1	2	3	4	5	6	1	2	3	4	5	6	DK
20.	The disadvantages of most birth control methods outweigh the advantages.	1	2	3	4	5	6	1	2	3	4	5	6	DK

APPENDIX B

Male Contraceptive Attitude Inventory for Fathers

APPENDIX B

Male Contraceptive Attitude Inventory for Fathers

DIRECTIONS

FIRST Read the statement and circle the one which best expressed your reaction to the statement. Use the following choices:

#1 Strongly Disagree
#2 Moderately Disagree
#3 Slightly Disagree
#4 Slightly Agree
#5 Moderately Agree
#6 Strongly Agree

SECOND Now, read the statement again and think about how your SON would respond to the statement. Using the second group of numbers, circle the number which best corresponds to his opinion.

	Your Opinion						How you think your Son would answer						
	DISAGREE			AGREE			DISAGREE			AGREE			
	Strongly	Moderately	Slightly	Slightly	Moderately	Strongly	Strongly	Moderately	Slightly	Slightly	Moderately	Strongly	Don't Know
1. The major responsibility for avoiding pregnancy rests with my partner rather than myself.	1	2	3	4	5	6	1	2	3	4	5	6	DK
2. I'd be willing to suggest that I use a rubber as a birth control method.	1	2	3	4	5	6	1	2	3	4	5	6	DK
3. Before I'd have sex with anyone, I'd person-ally make sure we were using birth control.	1	2	3	4	5	6	1	2	3	4	5	6	DK
4. I'd go to a doctor's office or clinic with my partner to obtain a birth control method.	1	2	3	4	5	6	1	2	3	4	5	6	DK
5. I'd have no objection to birth control devices as long as my partner was the one who used it.	1	2	3	4	5	6	1	2	3	4	5	6	DK
6. I'd be willing to go to the drug store to buy condoms (rubbers) or contraceptive jellies and creams.	1	2	3	4	5	6	1	2	3	4	5	6	DK
7. No one should have sex without taking precautions to avoid unwanted pregnancy.	1	2	3	4	5	6	1	2	3	4	5	6	DK
8. Taking precautions to prevent pregnancy should be a shared responsibility.	1	2	3	4	5	6	1	2	3	4	5	6	DK
9. I'd enjoy sex more if I felt sure my part-ner wouldn't get pregnant.	1	2	3	4	5	6	1	2	3	4	5	6	DK
10. So many birth control methods are messy and involve too much preparation and planning.	1	2	3	4	5	6	1	2	3	4	5	6	DK
11. I would be willing to wait while my partner used foam or a diaphragm before making love (having intercourse).	1	2	3	4	5	6	1	2	3	4	5	6	DK
12. It can be exciting to take a chance on get-ting my partner pregnant.	1	2	3	4	5	6	1	2	3	4	5	6	DK
13. When a pregnancy results from not using birth control, both the man and the woman are responsible.	1	2	3	4	5	6	1	2	3	4	5	6	DK
14. I would not be willing to have intercourse if neither my partner nor I were able to use precautions to avoid pregnancy.	1	2	3	4	5	6	1	2	3	4	5	6	DK
15. I'd be willing to use withdrawal before ejaculation as a pretty good way of avoid-ing pregnancy if we had no other choice.	1	2	3	4	5	6	1	2	3	4	5	6	DK
16. If the woman says birth control and preg-nancy is her business and responsibility, then it is okay with me to let her decide about birth control.	1	2	3	4	5	6	1	2	3	4	5	6	DK
17. Sex doesn't seem as satisfying when using certain types of birth control.	1	2	3	4	5	6	1	2	3	4	5	6	DK
18. The use of some birth control devices spoils the mood and spontaneity of love making.	1	2	3	4	5	6	1	2	3	4	5	6	DK
19. Using birth control involves tampering with nature, such things should be left to God, fate or luck.	1	2	3	4	5	6	1	2	3	4	5	6	DK
20. The disadvantages of most birth control methods outweigh the advantages.	1	2	3	4	5	6	1	2	3	4	5	6	DK

APPENDIX C

Communication Questionnaire for Sons

APPENDIX C

Communication Questionnaire for Sons

A. HAVE YOU AND YOUR FATHER TALKED ABOUT ANY OF THE FOLLOWING TOPICS LISTED BELOW REALTED TO SEX AND/OR BIRTH CONTROL? (CIRCLE YOUR ANSWER.)

1. Yes, go to Section B 2. No, Skip to Section F

B. IF YOU ANSWERED YES TO SECTION A, PLEASE CHECK ✓ ALL THE FOLLOWING TOPICS THAT YOU REMEMBER HAVING TALKED ABOUT.

1. _____having sex before marriage.
2. _____moral aspects of sex.
3. _____bodily changes (such as beard and pubic hair growth, wet dreams and erections).
4. _____birth control methods.
5. _____how pregnancy occurs.
6. _____responsibilities of fatherhood.
7. _____the effect of unplanned or unwanted pregnancy.
8. _____population control (zero population growth).
9. _____kissing/necking/petting.
10. _____venereal disease.
11. _____biologic changes in women (menstruation, breast changes, sexual response).
12. _____sexual preferences (homosexual and heterosexual relationships).
13. _____other, please specify_____________

C. DURING THE PAST YEAR WHEN YOU'VE TALKED TO YOUR FATHER ABOUT SEX AND BIRTH CONTROL, HOW OFTEN HAVE YOU HAD:

	Never	1-2 times per year	3-4 times per year	5 times or more a year
1. The topics are just "mentioned in passing?"	1	2	3	4
2. Brief words of caution or advice?	1	2	3	4
3. Short brief conversations?	1	2	3	4
4. Longer - more detailed discussions?	1	2	3	4

D. WHO USUALLY BEGINS OR INITIATES THESE TALKS? (PLEASE CIRCLE ONE.)

1. _____I do 2. _____My father does 3. _____We do about equally

E. WHICH OF THE FOLLOWING DESCRIBES HOW YOU FEEL WHEN TALKING TO YOUR FATHER ABOUT THESE TOPICS? (PLEASE CHECK ONE.)

1. _____When we talk about sex, I feel uncomfortable but I'm glad we talked.
2. _____I don't think my father knows what to tell me, so I don't ask him anything.
3. _____Usually my father has good advise, so I don't mind talking to him about sex.

F. LISTED BELOW ARE SOME OF THE REASONS WHY COMMUNICATIONS ABOUT SEXUALITY BETWEEN PARENTS AND CHILDREN IS OFTEN DIFFICULT. USING THE SCALE PROVIDED, PLEASE RATE THE IMPORTANCE OF THESE REASONS FOR YOU AND YOUR FATHER. (CIRCLE YOUR ANSWER.)

	Very Important	Somewhat Important	Not Important
1. My father and I don't see eye to eye on most subjects dealing with sex so we don't discuss it much.	1	2	3
2. The right opportunity to talk just doesn't come up.	1	2	3
3. My father seems to uncomfortable about it we can't discuss it easily.	1	2	3
4. My father doesn't know what to tell me.	1	2	3
5. I'm not ready for sexual involvement, so discussing these topics is not necessary.	1	2	3
6. Our relationship just isn't open enough to talk about very personal things like sexual behavior.	1	2	3
7. He hasn't been around when the subject has come up.	1	2	3
8. I get so nervous thinking about it I hate to bring it up.	1	2	3
9. I don't think you should talk about sex with your father.	1	2	3
10. I would rather get my information from my friends or school.	1	2	3

GO ON TO THE NEXT QUESTION

G. WHICH OF THE FOLLOWING DESCRIBES HOW YOU FEEL ABOUT YOUR FATHER AND YOUR LEARNING REGARDING SEXUAL ISSUES (CHECK ALL THAT APPLY).

1. _____I can get plenty of information from other places (school, t.v., friends) so I do not need him.
2. _____My mother usually handles those subjects so I do not need to talk to my father.
3. _____I think sex education is a responsibility that both my parents should share.
4. _____I feel my father is one of the best sources I have for sexual information.
5. _____I think the school should be doing most of the sex education for teenagers.

H. IF THE STATEMENTS ABOVE DO NOT ADEQUATELY DESCRIBE HOW YOU SEE YOUR FATHER IN REGARD TO YOUR OWN SEXUAL LEARNING, FEEL FREE TO ELABORATE ON THE BACK SIDE OF THE PAGE.

Thank you very much for answering these questions. I realize some may have been difficult to answer. If you have any more ideas about fathers and sons and their ability or inability to talk about sexual matters, feel free to tell me what is on your mind. If not, please go on to the next page to answer a few questions about yourself.

APPENDIX D

Communication Questionnaire for Fathers

APPENDIX D

Communication Questionnaire for Fathers

A. HAVE YOU AND YOUR SON TALKED ABOUT ANY OF THE FOLLOWING TOPICS LISTED BELOW RELATED TO SEX AND/OR BIRTH CONTROL? (CIRCLE YOUR ANSWER.)

1. Yes 2. No (Skip to Section F)

B. IF YOU ANSWERED YES TO QUESTION A, PLEASE CHECK ✓ ALL THE TOPICS THAT YOU REMEMBER HAVING TALKED ABOUT.

1. ______having sex before marriage.
2. ______moral aspects of sex.
3. ______bodily changes (such as beard and pubic hair growth, wet dreams and erections.
4. ______birth control methods.
5. ______how pregnancy occurs.
6. ______responsibilities of fatherhood.
7. ______the effect of unplanned or unwanted pregnancy.
8. ______population control (zero population growth).
9. ______kissing/necking/petting.
10. ______venereal disease.
11. ______biologic changes in women (menstruation, breast changes, sexual response).
12. ______sexual preferences (homosexual and heterosexual relationships).
13. ______other, please specify______________

Go on to next question.

C. DURING THE PAST YEAR, WHEN YOU'VE TALKED TO YOUR SON ABOUT SEX AND/OR BIRTH CONTROL, HOW OFTEN DID YOU HAVE:

	Never	1-2 times per year	3-4 times per year	5 times or more a year
1. The topics are just "mentioned in passing"?	1	2	3	4
2. Brief words of caution or advice?	1	2	3	4
3. Short brief conversations?	1	2	3	4
4. Longer - more detailed discussions?	1	2	3	4

D. WHO USUALLY BEGINS OR INITIATES THESE TALKS? (PLEASE CHECK ONE.)

1. ______I do 2. ______My son does 3. ______We do about equally

E. WHICH OF THE FOLLOWING BEST DESCRIBES HOW YOU FEEL WHEN TALKING TO YOUR SON ABOUT THESE TOPICS?

1. ______Although talking about these topics can be uncomfortable, I think it's important so we talk about them.
2. ______I feel pretty comfortable talking about these subjects with my son.

F. LISTED BELOW ARE SOME OF THE REASONS WHY COMMUNICATIONS ABOUT SEXUALITY BETWEEN PARENTS AND CHILDREN IS OFTEN DIFFICULT. USING THE SCALE PROVIDED, PLEASE RATE THE IMPORTANCE OF THESE REASONS FOR YOU AND YOUR SONS. (CIRCLE YOUR ANSWER.)

	Very Important	Somewhat Important	Not Important
1. My son and I don't see eye to eye on most subjects dealing with sex so we don't discuss it much.	1	2	3
2. The right opportunity to talk just doesn't come up.	1	2	3
3. I find it so uncomfortable, I can't discuss it easily.	1	2	3
4. I don't know what to tell him, so we don't discuss it often.	1	2	3
5. I don't think my son is ready for sexual involvement, so discussion of these topics is not necessary yet.	1	2	3
6. Our relationship just isn't open enough to talk about very personal things like sexual behavior.	1	2	3
7. I haven't been around when the subject has come up.	1	2	3
8. My son seems so nervous about it that I hate to bring it up.	1	2	3
9. I don't think one should talk about sex with his children.	1	2	3
10. I think my son would rather get this information from his friends or the school.	1	2	3

Go on to next question.

G. WHICH OF THE FOLLOWING DESCRIBES HOW YOU SEE YOURSELF WITH REGARD TO YOUR SON'S LEARNING ABOUT SEXUAL ISSUES (CHECK ALL THAT APPLY).

1. ______He can get plenty of information from other places (school, t.v., friends) so he does not need me.
2. ______His mother usually handles those subjects so I do not need to.
3. ______I think sex education is a responsibility that should be shared by both parents.
4. ______I feel like I'm one of the best sources my son has for sexual information because of my experience and personal interest in his development.
5. ______I think the school should be doing most of the sex education for teenagers.

H. IF THE STATEMENTS ABOVE DO NOT ADEQUATELY DESCRIBE HOW YOU SEE YOURSELF IN REGARD TO YOUR SON'S SEXUAL LEARNING, FEEL FREE TO ELABORATE ON THE BACK SIDE OF THE PAGE.

Thank you very much for answering these questions. I realize some may have been difficult to answer. If you have any more ideas about fathers and sons and their ability or inability to talk about sexual matters, feel free to tell me what is on your mind. If not, please go on to the next page to answer a few questions about yourself.

APPENDIX E

Background Information for Sons

APPENDIX E

Code No. ____

Background Information for Sons

Please answer the following general questions about yourself.

A. How old are you?

1. 15 Years Old
2. 16 Years Old
3. 17 years old
4. 18 Years Old
5. Other, Please Specify__________

B. What is your ethnic background?

1. White
2. Black
3. Chicano (Spanish Surnamed)
4. Native American
5. Asian
6. Other, what?____________

C. Your father who is participating in the study is your:

1. Biologic/natural father.

2. Adoptive father. If so, how old were you when he became your father? __________years.

3. Step-father. How long has he been married to your mother? __________years.

4. Other, please describe ________________________________.

D. I am interested in knowing how much opportunity you have to be with your "father." Check ____ the answer which best describes your situation.

1. _____I live with my father and see him daily.

2. _____I live with my father but because of his job (or busy schedules) I often see him less than everyday (for example, 1-2 times per week).

3. _____I live with my father part-time because my father and mother are separated/divorced.

4. _____I visit my father at least once a week because my mother and father are separated/divorced.

5. _____I see my father infrequently because my parents are separated/divorced.

APPENDIX F

Background Information for Fathers

APPENDIX F

Code No. ____

Background Information for Fathers

Please answer the following general questions about yourself. Circle the right answer.

A. How old are you?

1. 25-30 Years Old
2. 31-35
3. 36-40
4. 41-45
5. 46-55
6. 56 or Over

B. What is your ethnic background?

1. Black
2. White
3. Chicano (Spanish Surnamed)
4. Native American
5. Asian
6. Other, What?________

C. How many years of formal education have you had? (Include trade school, apprenticeships, etc.)

1. 8 or fewer
2. 9-11
3. 12-13
4. 14-16
5. 17-19
6. More than 19

D. Please state your occupation: ____________________

Ei. Have you ever taken a course in school that included information about birth control methods and their use?

1. Yes____
2. No____

Eii. If so, when?

1. In High School____?
2. In College ____?
3. Other, Specify__________

F. I am interested in knowing how much opportunity you have to be with this son. Check ____ the answer which best describes your situation.

1. _____I live with my son and see him daily.
2. _____I live with my son but because of my job (busy schedule) I see him less than daily (for example, 1-2 times per week.
3. _____My son lives with me part-time because my wife and I are separated/divorced.
4. _____I visit with my son at least once a week, because my wife and I are separated/divorced.
5. _____I see my son infrequently because my wife and I are separated/divorced.

APPENDIX G

Introductory Letter

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Department of
Family Nursing

3181 S.W. Sam Jackson Park Road Portland Oregon 97201 (503) 225-8382

CONSENT

Study: Father-Son Communications Relative to Contraceptive Attitudes.

Investigator: Sue Meyer, R.N., B.S.

Dear Sir:

My name is Sue Meyer. I am a graduate student at the Oregon Health Sciences University School of Nursing, and I'm currently conducting research for my master's thesis project. During my nursing career I have specialized in the health care of pregnant women and their families. During this time I have frequently been confronted by the many problems associated with adolescent pregnancy. Despite much research regarding teenage pregnancy few studies have addressed how parents can be involved in the prevention of adolescent pregnancy. As professionals, nurses have not utilized or assisted parents enough in their efforts to understand and influence their children. Fathers and sons have been chosen as subjects for this research not only because they have been largely neglected in previous research but because males, too, play a role in the prevention of unwanted pregnancy.

I am asking you and your son to participate in a study of "Father and Son Communications Relative to Contraception." Your son will have heard about the study in his health class. Should you and your son mutually agree to participate in the study, you will be mailed the survey materials and instructions. Each one of you will be requested to complete two short questionnaires, one pertains to family planning attitudes and the other to father and son communication in these areas. The questionnaires can be completed in 15-20 minutes in the privacy of your home or office. Fathers and sons will be completing slightly different forms and should complete them separately and without discussion.

Some of the questions may seem very personal and at times this type of question makes some people uncomfortable. However, sometimes men find that the questions help them clarify their feelings about the subject or perhaps understand why they feel or act a certain way. Because I know these are sensitive topics for most of us, I want to assure you that no names will be associated with the questionnaire

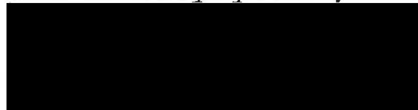
answer sheet so you will remain anonymous and your answers confidential. Only code numbers will be used and data will be reported for groups, not individuals.

If you and your son agree to participate in the survey, please complete the enclosed Consent Form and mail it back to me. By mail you will receive the questionnaire packets with instructions for completing the survey. Please complete and return this Consent Form by February 28.

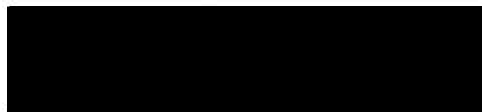
If you choose not to join the study, please indicate this on the Consent Form and return it to me. Neither you or your son will be contacted again; although I acknowledge the loss of your opinion is regretful.

Thank you for your consideration. If you have any further questions, please feel free to call me or my thesis advisor, Carol Howe, C.N.M., D.N.Sc.

Sincerely yours,



SUE A. MEYER, R.N., B.S.N.
1139 S. W. Gibbs
Portland, OR 97201
Phone: 222-4185



CAROL HOWE, C.N.M., D.N.Sc.
Associate Professor
Director, Nurse Midwifery Program
School of Nursing
Phone: 225-8382

APPENDIX H

Consent Form

CONSENT FORM

If you agree to participate, please read and sign the following.

My son and I have agreed to participate in the study of "Father and Son Communication Relative to Contraceptive Attitudes" which has been explained in the letter we received. The study will be conducted by Sue Meyer, R.N., and her advisor, Dr. Carol Howe, C.N.M. We understand that our participation is voluntary and the primary benefit we will receive is that by participating we may learn more about ourselves. We understand that there is no risk to us by participating.

____
FATHER

____
SON

____
DATE

Please complete the following so that I can send you the study materials.

Your addresses ______________________, ____________, ______
Street City Zip

Your phone ______________________

If you do not wish to participate, please read and sign the following.

My son and I do not wish to participate in the study of "Father and Son Communications Relative to Contraceptive Attitudes." We understand that refusing to participate will not in any way affect my son at school or any present or future contact we may have with the Oregon Health Sciences Center.

____
FATHER

____
SON

____
DATE

APPENDIX I

Directions

APPENDIX I

Directions

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Department of
Family Nursing

3181 S.W. Sam Jackson Park Road Portland Oregon 97201 (503) 225-8382

Master's Thesis Project
Sue A. Meyer, R.N., B.S.N.

Directions to

MALE CONTRACEPTIVE ATTITUDES

and

FATHER SON COMMUNICATION

This survey is designed for you to express some of your attitudes towards male involvement in contraception. The first page of this packet is the attitude survey. Please complete the questions by circling the answer that best fits your opinion. Then reread the question and in the second column circle the answer that you think best fits what your father/son would think about that statement.

It is important that you answer each question as thoughtfully and frankly as possible if the questionnaire is to be helpful and accurate in describing the attitude of men regarding the part they play or don't play in the use of birth control.

The second page is a questionnaire designed to help us learn more about the what, who, when and whys of father and son communications about sexual issues. Once again please read the questions carefully and answer them thoughtfully.

Since the questionnaire is still in the process of being refined, we would appreciate your including any additional comments regarding your opinions about these topics or the questionnaire itself. Feel free to use the margins or the back sides.

It is very important that both of you complete your portion of the questionnaire. However, you should answer in private and don't discuss or show each other your answers until you have returned the questionnaires. The envelope provided should hold both of your questionnaires if you tear off this direction page. If you prefer, you may mail them back in separate envelopes. Please complete the survey by March 15 and mail them to the following address:

Male Attitude Survey
1139 S. W. Gibbs
Portland, OR 97201
c/o Sue Meyer

****Last but not least!

Your answers will be completely confidential. No one but the investigator will have access to this information.

APPENDIX J

School Consent Letter

APPENDIX I

School Consent Letter

January 24, 1983

Sue Meyer
1139 S.W. Gibbs
Portland, OR 97201

Dear Ms. Meyer:

On behalf of , I am indicating to you that we are familiar with your proposed research study and we have agreed to allow you access to a select group of 10th grade students. We understand that the results of any information gained from boys and their fathers would be held in strictest confidence.

We further realize that a students' choice to participate or not participate will not affect his relationship with the school in any way. We would, however, like to be given appropriate information that results from the study for our use in our health classes.

We look forward to the possibility of working with you and wish you best wishes in your very worthwhile professional effort.

Sincerely,

Jim Carlile

JC:pc

AN ABSTRACT OF THE THESIS OF

SUE A. MEYER

For the MASTER OF NURSING

Date of receiving this degree: June 10, 1983

Title: FATHER/SON COMMUNICATION RELATIVE TO CONTRACEPTIVE ATTITUDES.

Approved: ____
Carol A. Howe, CNM, DNSc Professor Thesis Advisor

The primary objective of this research was to explore the attitudes of males toward contraception and their roles in pregnancy prevention. The desired goal of the study was to gain further understanding of the role of the father in acquisition and socialization of contraceptive/sexual attitudes in the adolescent male.

The sample consisted of ten high school males and their fathers. Each father and son completed a 20-item Likert scale questionnaire (the Male Contraceptive Attitude Inventory (MCAI). This investigator-created instrument was designed to measure three aspects of contraceptive attitudes: 1) responsibility, 2) prevention of pregnancy, and 3) personal use of birth control. Upon completing the questionnaire, participants repeated the inventory responding to each

item as they thought their father/son would. They also completed another questionnaire which consisted of questions regarding the verbal communications regarding sexuality that have taken place between them. These questions addressed the content of the conversations, the frequency of conversations, the feelings of each party when talking about sexuality issues with the other, and explores reasons for these feelings. The questions for both questionnaires are based on the review of previous studies and the conceptual framework.

Descriptive and inferential statistical analysis were used to describe and compare the attitudes of fathers and sons as well as their perception of each other's attitudes. The tool and its subscales were analyzed for its reliability and validity ($r = .81$ for fathers, but .40 for sons).

Both the fathers and sons were found to have generally liberal attitudes toward sharing the responsibilities of birth control. They showed ample support for the use of birth control to prevent unplanned pregnancy. Sons were somewhat more liberal than fathers in their attitudes towards personal use of birth control. There were no significant differences between the fathers' and sons' attitudes and what they thought the other party would think.

This group of fathers and sons reported a higher level of communication than is reported by previous research. However, it is recognized that this group may have represented a biased group of fathers and sons.

Critique of the instrument is presented as well as other study limitations. Implications of the study findings for nursing practices are discussed and recommendations for further research are presented.