

Family factors associated with talking about sexuality issues with the adolescents of Thai parents

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Received: 9 August 2024 **Revised:** 26 September 2024 **Accepted:** 6 October 2024 **Available online:** May 2025

DOI: 10.55131/jphd/2025/230203

ABSTRACT

This analytical cross-sectional study aimed to investigate the association between family factors (adolescents, parents, and families) and parents' talking about sexuality issues with their adolescents. Study samples consisted of 787 parents with adolescents (aged 13-19 years), and were involved in their child-rearing. Stratified cluster random sampling was employed. Data were collected in 2022 after the decline of the COVID-19 pandemic. Instrument, created by the researchers, were composed of: 1) general demographic information of adolescents, parents, and families, 2) parents' perceptions of adolescent sexual risk behaviors, and 3) parents' talking about sexuality issues with adolescents. Content validity index (CVI) was 0.89. Multiple logistic regression was performed to analyze the association between family factors and parents discussing sexuality issues. Results showed most parents were mothers (70.90%), and the average age was 45.30. The prevalence of parents talking about sexuality issues was higher (79.03%) than those who do not talk about such issues (20.97%). Multivariate analysis found only parents' sex and ages were associated with talking about sexuality issues. Mothers were 2.30 times more likely to talk about sexuality issues compared to fathers (AOR=2.30, 95% CI: 1.41-3.19, p-value < 0.001). Parents under 40 years of age were found to be 6.97 times more likely to talk about sexuality issues compared to parents over 60 years of age (AOR=6.97, 95% CI: 1.65-26.19, p-value = 0.006), and parents in the age range of 40-60 years old were found to be 6.24 times more likely to talk about sexuality issues compared to parents over 60 years of age (AOR=6.24, 95% CI: 1.62-21.73, p-value = 0.005). Results suggested that parents should be encouraged to talk about sexuality issues with their adolescents as young as possible to decrease the parent-adolescent generation gap. Fathers, alongside mothers, need to be empowered to initiate conversations about sexuality issues to promote adolescent sexual health.

Keywords:

parents; talking; sexuality issues; adolescent

Citation:

Kesinee Saranrittichai, Kessarawan Nilvarangkul, Pongdech Sarakarn, Phoowasit Phoolawan, Nuttaporn nidthumakul, Bhunyabhadh Chaimay, Linda L. Shield, Alison Hutton, Ampornpan Theeranut. Family factors associated with talking about sexuality issues with the adolescents of Thai parents. *J Public Hlth Dev.* 2025;23(2):27-41 (<https://doi.org/10.55131/jphd/2025/230203>)

INTRODUCTION

Adolescence is the transition from childhood to adulthood when a host of changes occur as the result of puberty, all of which are dependent upon personal stages of development and life circumstances¹. For example, there are a range of health and social challenges. These changes contribute to global health concerns in terms of the sexual and reproductive health of adolescents. In particular, the initiation of sexual activity can result in unwanted pregnancies, unsafe abortions, and sexually transmitted infections, such as HIV/AIDS², as well as cervical cancer. Women, who are living with HIV, are 6 times more likely to develop cervical cancer compared to women without HIV³.

Families play an important role in reducing adolescent behavior related to sexual risks^{4,5}. Although parent-adolescent sexual communication is important, adolescents have found that there are challenges and gaps in discussions about sexual and reproductive health problems within these communication⁶. In particular, it was found that parents who have lower levels of education and limited knowledge about sexual and reproductive health were less likely to communicate with their adolescents on these topics^{6,7}, especially in low-income families⁷. One qualitative study found that adolescents did not talk with their parents about sex due to concerns about the awkwardness of the conversation and the fear of negative reactions⁸. A previous study found that barriers to parent-adolescent communication about sex had been the parental belief that adolescents were too young to discuss these issues, an uncomfortable conversational environment⁹, parental sex, age, shame, a lack of parental interest, and cultural rejection of sexual communication¹⁰. A qualitative study found that parents talked with their adolescents about sex in order to protect adolescents from risks⁸. Studies involving parents found that factors such as having no difficulties in sexual and reproductive communication, having favorable attitudes, and not having previously experienced sexual and reproductive health problems were associated with poor parent-

female adolescent sexual and reproductive communication¹¹.

Studies in Asia found that parent-adolescent sexual communication in Singapore had been associated with factors such as the parents' relationships with the children, ethnicity, educational levels, and their perceived levels of comfort and confidence in sexual communication¹². A majority of parents had considered talking to their children about sexuality issues, such as abstinence, the consequences of pre-marital sex, and condom usage, and had considered these topics as important. However, only some felt comfortable and confident in doing so. Interestingly, 32.5% had not talked about sexuality issues with their children, in the past year¹². In addition, Chinese parents had tried to effectively socialize their adolescents regarding sexuality issues, and their adolescents pretended to be attentive in order to avoid talking about sex with them¹³.

Studies conducted in Thailand involving adolescents in urban areas in the Central region found that sexual communication between parents and adolescents at a rate of 39.50%¹⁴. Moreover, adolescent sexual risk behaviors were associated with family sexual communication and were not related to the adolescents' knowledge and the expenses incurred by parents¹⁴. Studies conducted in the Eastern region of Thailand among middle adolescents (age 15 -18 years) found that the prevalence of sexual communication between mother and daughter had been 54.7%¹⁵. Studies conducted in a local area in the Northern region found that parent – adolescent boy sexual communication had positive effects on the prevention of sexual risk behaviors in teenage boys¹⁶. In addition, parents – adolescent girls' sexual abstinence communication also had positive effects on the intention to abstain from sex as well¹⁷. However, studies found that parent-adolescent sexual communication was related to the parents' knowledge or education, but not to the ages and sexes of the parents, or the sex of the adolescents¹⁸. Furthermore, a study conducted on Thai urban families showed that adolescent

girls and parental perception of adolescent sexual risk behaviors were significantly related to an increase in sexual communication¹⁹. Thus, studies related to factors associated with parent-adolescent conversations about sexuality issues had not been consistent based on the Thai context.

Sexual health, Sexuality, Sexual risk behaviors and Sexuality issues

Sexual health

Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality, and is not merely the absence of disease, dysfunction, or infirmity²⁰. The ability of people to achieve sexual health and well-being depends on comprehensive and good-quality information about sex and sexuality, knowledge about risks, and the ability to protect from sexual risk behaviors, including living in an appropriate environment. Sexual health is fundamental to the overall health and well-being of individuals, couples and families, as well as the development of society. The four sexual health intervention areas are as follows: 1) Comprehensive education and information; 2) Gender-based violence prevention, support and care; 3) Prevention and control of HIV and other sexually transmissible infections; and 4) Sexual function and psychosexual counselling²⁰. Thus, the 4 interventions within the family consist of education and information, prevention, support, or counselling that the parents provide their adolescents in order to help them achieve sexual health.

Sexuality

Sexuality is a person's identity in relation to the gender(s) to which they are typically attracted and is composed of sex, gender, gender identity and sexual orientation. Sexual health requires a positive and respectful approach to sexuality, sexual relationships, and having pleasurable and safe sexual experiences, as well as being free of coercion, discrimination and violence.

Sexual risk behaviors

Sexual behavior is any individual activity that is related to sexual needs, contexts²¹, and cultural values and norms, which are ranked from low risk to high risk²². *Sexual risk behaviors* contribute to adverse health outcomes in individuals. Adolescent sexual risk behaviors included being very close to friends, having a wide social circle, going out for enjoyment at night, returning home late at night, drinking alcohol, smoking, paying less attention to learning, and not listening to or not following the advice of parents²². Adolescent sexual behaviors have been studied in the context of adolescent sexual activities, sexual relationships, reproductive health, and sexually transmitted diseases (STDs), including family contexts. Studies have shown that parents influence adolescent sexual risk behaviors⁴, and their impact can have both negative and positive outcomes²³.

Sexuality issues

Sexuality issues represent a wide range of sexual health-related information, which encompass sexual orientation, gender identity, sexual expression, relationships, and pleasure, as well as the consequences of the physical, emotional, mental, and social dimensions that are related to sexual health²⁰

The study showed that parents initiate the process of talking about sexuality issues with their adolescents so that they can protect their adolescents from sexual risks⁸. Parents' conversations about sexuality issues with adolescents are part of communication within the family, which reflects family roles²⁴. The role that parents play in providing effective communication to their adolescents is crucial to shield them from risky sexual behaviors so that the sexual health of their adolescents can be fostered. Sexual health is one of the outcomes representing adolescent well-being. This parental intervention is related

to the parents' activities, such as providing appropriate information and support and giving counselling in order to prevent their adolescents from participating in risky sexual behaviors and to promote their sexual health.

A previous study showed that Thai parents have a positive attitude towards sex education and accept the idea of teaching their adolescents about sex²⁵. However, parents and adolescents reported feeling embarrassed when talking about sex with each other²⁶. The parents believed that their adolescents could learn sex education by themselves. Yet, talking about sex may lead to situations in which adolescents easily engage in early sexual initiation²⁵. According to Thai culture, talking about sexuality issues with adolescents is difficult from the parents' perspectives¹⁵. The studies, which focused on prevalence, had mostly concentrated on sexual health problems in physical dimensions, in particular STDs, HIV/AIDs, unintended pregnancies², and cancer³, etc. Communication between parents and adolescents about sex had focused on problems^{6,7,8}, associated factors^{11,14,18}, and program interventions¹⁶. A study conducted exclusively in the Eastern region of Thailand investigated the association of talking about the risks related to sex between mothers and daughters. Mothers had talked to their daughters at a frequency (54.7%) and had felt that discussing this topic was convenient (51.6%)¹⁵. However, the prevalence of talking about sexuality issues with adolescent children across all regions of Thailand by both fathers and mothers is still unknown. Previous studies have focused only on some parts of Thailand^{15, 18, 19,26}. Thus, the factors that are associated with parents' talking about sexuality issues with their adolescents remain unknown for the overall population in Thailand.

A *system* is composed of interdependent components that share common goals, interrelated functions,

boundaries, and an identity. *Systems theory* is the study of interaction processes, attempting to find characteristics and relationships among its components, as well as the way they act or behave with each other²⁴. Studies within the *family system* have primarily focused on interactions within the family system such as mother and daughter¹⁵, parents and adolescents^{6,7,9,18}, parents and adolescent boys¹⁶, parents and adolescent girls¹¹. Thus, system theory was used to investigate family function (talking about sexuality issues) in the subsystem (parents-adolescents), and the relationship between factors contributing to this family function in this study.

The purposes of this study were to examine the prevalence of parents who discuss sexuality issues with their adolescents across Thailand and to identify family factors that are associated with these discussions based on the family system theory. These factors were as follows: adolescents, parents, and family factors. The results of prevalence in this study can contribute to our understanding of the impact of family functioning, initiate by parents on sexuality communication within family. Results can also contribute to understanding what factors need to be considered for promoting communication about issues related to sexuality between parents and their adolescents within the family settings and can also help parents initiate effective conversations with their adolescents in the future.

Study objectives

This study aimed to investigate the following:

1. The prevalence of parents, who talk about sexuality issues with their adolescents
2. The family factors (adolescents, parents, and family factors) that are associated with parents talking about sexuality issues with their adolescents

- 2.1 Adolescents: the adolescents' education; adolescents currently live with their parents; and the parents' perceptions of their adolescents' sexual risk behaviors
- 2.2 Parents: places, sexes, ages, ages of spouses, marital statuses, educational levels, educational levels of the spouses, occupations, and the occupations of the spouses
- 2.3 Families: regions, family incomes

METHODS

This analytical cross-sectional study was performed among parents with adolescents (13-19 years old), who, at the time of this research study, were studying in a junior provincial high school or a senior provincial high school. The sample population consisted of parents who: 1) were actively involved in raising their adolescent children; 2) had adolescents (13-19 years old), who were studying at the time of study; and 3) had the ability to read and write in the Thai language.

Sample size

The sample size was calculated by the researcher using the following formula for analyzing relationships in Multiple Logistic Regression²⁷:

$$n = \frac{P(1 - P)(Z_{1-\alpha} + Z_{1-\beta})^2}{[B(1 - B)(P_0 - P_1)^2]}$$

The study "Parent-Teen Communication about Sex in Urban Thai Families"¹⁹ reported that the proportion of parents who talk about sex with their children in Thailand varies by gender. The findings indicated that different genders

have different levels of communication with their children about sex as follows: $n = 239.35$

In order to adjust the sample size to analyze the factors associated with talking about sexuality issues with adolescents using multiple logistic regression and to control for the effects of other confounding variables, the sample size needed to be adjusted using the Variance Inflation Factor (VIF). This adjustment helped to prevent overfitting and ensured accurate estimation of relationships between variables. The formula for adjusting the sample size was as follows:

$$n_p = \frac{n_1}{1 - \rho^2_{1,2,3,\dots,p}}$$

n_p = Adjusted sample size with ρ predictors

n_1 = Initial sample size calculated without adjusting for other variables

$\rho^2_{1,2,3,\dots,p}$ = Coefficient of determination (R-squared) for the independent variables

The researcher chose $p=0.65$ as the minimum sample size for the study by considering the Variance Inflation Factor (VIF) of 2.86. This indicated that each independent variable had shown an acceptable level of correlation with other variables. Specifically, the VIF of an independent variable is equal to $1/\text{tolerance}$, ranging from 1 to infinity. A higher VIF implies a greater correlation between the independent variables, while having a VIF of close to 1 indicates a minimal correlation among the variables. According to Myers (1990)²⁸, a VIF greater than 10 suggests that there is significant evidence of multicollinearity $n = 684$. To account for a potential 15% data loss, the sample size was increased to 787. However, due to the awareness of the non-response rate due to schools' vacations during the

decline of the COVID-19 pandemic, the 34% non-response rate was noted. Thus, the sample size was adjusted to 1050.

Sampling technique

Stratified cluster random sampling was performed by using the following steps: 1) stratifying the random sampling by four regions: north, northeast, central and south; 2) conducting cluster randomised sampling of the provinces within each region; 3) recruiting representative high schools in each province; 4) performing stratified random sampling by classes - six levels (three junior and three senior), which included early, middle, and late adolescents; 5) conducting simple random sampling to retrieve the target classes in each level; 6) carrying out simple random sampling to select target students living with their parents; and 7) selecting 787 parents of target students in 4 regions of Thailand (Northern= 201, Northeastern=191, Central = 224, and Southern = 171). The sampling flow was published elsewhere²⁹.

Research Instruments

Questionnaires, which were created by the researchers, were used in this study. System theory was employed to extract the study factors: adolescents, parents, and families. The relationships among the factors with regard to parental conversations about sexuality issues from within the setting of the family were examined. The questionnaire was composed of 3 parts: 1) the general demographic information about the adolescents, parents, and the families, 2) parents' perception of adolescent sexual risk behaviors (yes/no answer), and 3) parents' discussion about sexuality issues with adolescents (yes/no answer). Content validity was evaluated by experts in the fields of academic staff, family nurses, and family researchers. The content validity index (CVI) was calculated to be 0.89. The reliability test was not performed due to the fact that the collected data was factual, and

the study variables were of nominal scale. However, inter-rater reliability (IRR) was performed to justify the degree of agreement among the researchers in order to ensure that the questionnaire remained consistent across different researchers.

Data collection

Data collection was done onsite in schools during the decline of the COVID-19 pandemic in 2022. Directors of all target schools in the 4 regions of Thailand were informed about study details and obtained permission to talk to the homeroom teachers and the target students. Researchers and co-researchers in all 4 regions requested students to forward the informed consent forms and questionnaires to their parents at home. Parents answered the questionnaires and returned them to their adolescents. The completed questionnaires were then placed in a drop box provided in students' classrooms. After that, the researchers collected the returned questionnaires from drop boxes at the schools. School vacations took place periodically while data were collected during the decline of the COVID-19 pandemic.

Data analysis

The data were analyzed using STATA version 15 (licensed by Khon Kaen University). Descriptive statistics were reported as frequencies, percentages, means, standard deviations, and medians, as well as minimum and maximum values. Multiple logistic regression with backward elimination was performed in order to identify the associations between independent variables and the parents' discussions about sexuality issues with their adolescents. Using simple logistic regression, univariable analysis was first conducted to assess the associations between each independent variable and parental discussions on sexuality issues. Independent variables with p-values of less than 0.25, or those deemed potentially

relevant based on the literature review and without multicollinearity, were included in the multivariable analysis. Multivariable logistic regression, which was adjusted for all factors, was then applied. The significance level for the study was set at 0.05³⁰. Results are presented as odds ratios (OR), adjusted odds ratios (AOR), and 95% confidence intervals (CI). The interpretation of ORs was as follows: an OR greater than 1 indicated a higher likelihood of discussing sexuality issues, an OR less than 1 suggested a lower likelihood, and an OR that includes 1 showed no association.

Ethics

Three ethical principles from the Belmont report (1979)³¹ were employed in this study: respect for the person, beneficence, and justice. Approval was attained from the Center for Ethics in Human Research at Khon Kaen University, Thailand (HE622145).

RESULTS

A total of 1,050 questionnaires were distributed to parents in 4 regions. After taking data loss and the non-response rate

into consideration, a total of 787 parents took part in the study. Thus, the sample size was sufficient to consider the statistical methods used. The results were composed of three parts: 1) general information about parents and families, 2) prevalence of discussions about sexuality issues with adolescents, and 3) relationship between factors and parents' talking about sexuality issues with adolescents.

General information of parents and families

The sample consisted of 787 parents. The number of parents selected from the Northern, Northeastern, Central, and Southern regions were 201, 191, 224, and 171, respectively. Most of the parents were female (70.90%), with an age average of 45.30, and their spouses' age average was 46.14. The minority of parents were married (14.99%), while the majority were living in urban areas (67.98%), and had the perception that their adolescents did not exhibit any sexual risk behaviors (97.46%). The occupations of both parents and their spouses were agricultural workers, followed by self-employed individuals. (The details are shown in Table 1).

Table 1. General information of parents and families (n = 787)

Baseline	Number (n)	Percentage (%)
Region		
North	201	25.54
Northeast	191	24.27
Central	224	28.46
South	171	21.73
Place		
Urban	535	67.98
Rural	252	32.02
Sex		
Male	229	29.10
Female	558	70.90

Baseline	Number (n)	Percentage (%)
Age		
< 40	177	22.49
40-60	597	75.86
>60	13	1.65
Mean=45.30 S.D.=6.16 Min=30 max 65		
Spouse's Age		
< 40	156	19.82
40-60	609	77.38
>60	22	2.80
Mean=46.14 S.D.=6.70 Min=20 max 69		
Marital status		
Marriage	118	14.99
Widow /Divorce/ Separate living	669	85.01
Education		
Primary school	193	24.52
high school / vocational	218	27.70
Bachelor / Master/Doctoral degree	376	47.78
Spouse's education		
Primary school	194	24.65
high school/ vocational	251	31.89
Bachelor / Master/Doctoral degree	342	43.46
Adolescents' education		
Matthayomsuksa 1-3	444	56.42
Matthayomsuksa 4-6	343	43.58
Family income/month		
<=10,000	145	18.42
>10,001-50,000	457	58.07
>50,001-100,000	163	20.71
>100,000	22	2.80
Mean=39,617.5 S.D.=36281.99 Min=1200 max 400,000		
Occupation		
Government officer	189	24.02
Company employee	89	11.31
Agricultural worker	267	33.93
Self-employee	242	30.75
Spouse's Occupation		
Government officer	157	19.95
Company employee	105	13.34
Agricultural worker	288	36.59
Self-employee	237	30.11
Adolescent currently live with parent		
No	755	95.93
Yes	32	4.07
Perception of your adolescent sexual risk behavior		
No	767	97.46
Yes	20	2.54

Baseline	Number (n)	Percentage (%)
Perception of sexual socialization with your adolescent		
Trust	269	34.18
Strictness	69	8.77
Exhaustion	33	4.19
Flexibility	416	52.86

Prevalence of talking about sexuality issues with adolescents

Results revealed that the prevalence of parents talking about sexuality issues with their adolescents was 79.03% (95% CI: 0.76-0.81). (The details are shown in Table 2).

Table 2 Prevalence of talking about sexual issues with adolescent (n=787)

Prevalence of Talking about sex with adolescent	number	Percentage	95% interval conference
Yes	622	79.03	0.76-0.81
No	165	20.97	0.18-0.23

Relationship between factors and parents' talking about sexuality issues with adolescents

The results indicated significant factors associated with parents talking about sexuality issues with their adolescents. Mothers were found to be 2.30 times more likely to talk about sexuality issues with their adolescents compared to fathers (AOR=2.30, 95% CI: 1.54-3.46, p-value < 0.001). Parents under 40 years of age were 6.97 times more likely to talk about sexuality issues with their adolescents compared to parents who were over 60 years of age (AOR=6.97, 95% CI: 1.76-27.57, p-value = 0.006), and parents with 40-60 years of age were 6.24 times more likely to talk about sexuality issues with their adolescents compared to parents over 60 years of age (AOR=6.24, 95% CI: 1.72-22.64, p-value = 0.005). (The details are shown in Table 3).

Table 3. Relationship between factors and parents' talking about sexual issues with adolescents (n=622)

Factors	Number (N)	Percentage of talking about sexual	Crude OR	95% CI	Adj. OR	95% CI	p-value
Region							
North	139	69.50	1		1		
Northeast	157	82.63	2.13	1.32-3.45	1.37	0.74-2.52	0.314
Central	187	82.74	2.25	1.41-3.58	1.40	0.78-2.54	0.254
South	139	81.29	1.93	1.19-3.15	1.15	0.62-2.11	0.649
Sex							
Male	155	68.28	1		1		
Female	467	83.39	2.40	1.68-3.43	2.30	1.54-3.46	<0.001*
Age							
< 40	143	80.34	9.46	2.75-32.56	6.97	1.76-27.57	0.006*
40-60	475	79.70	8.85	2.68-29.23	6.24	1.72-22.64	0.005*
>60	4	30.77	1		1		

Factors	Number (N)	Percentage of talking about sexual	Crude OR	95% CI	Adj. OR	95% CI	p-value
Spouse's Age							
< 40	115	74.19	1.35	0.51-3.56	1.18	0.35-3.93	0.786
40-60	492	80.66	1.96	0.78-4.92	1.29	0.43-3.90	0.647
>60	15	68.18	1		1		
Marital status							
Marriage	537	80.27	0.63	0.40-0.98	1.49	0.91-2.41	0.105
Widow /Divorce/ Separate living	85	72.03	1		1		
Education							
Primary school	132	68.39	1		1		
high school / vocational	173	79.36	1.77	1.14-2.78	1.26	0.69-2.29	0.454
Bachelor / Master/Doctoral degree	317	84.31	2.53	1.68-3.82	1.61	0.84-3.09	0.146
Spouse's education							
Primary school	135	69.23	1		1		
high school/ vocational	203	80.88	1.90	1.22-2.94	1.24	0.68-2.27	0.475
Bachelor / Master/Doctoral degree	284	83.28	2.14	1.41-3.24	1.18	0.63-2.22	0.608
Family income/month							
<=10,000	106	73.61	1		1		
>10,001-50,000	357	77.78	1.31	0.85-2.01	0.80	0.47-1.35	0.411
Income/month	141	86.50	2.36	1.32-4.21	1.03	0.48-2.22	0.938
>50,001-100,000							
>100,000	18	85.71	2.33	0.65-8.31	1.31	0.33-5.17	0.698
Occupation							
Government officer	161	84.74	2.16	1.33-3.51	1.33	0.64-2.79	0.444
Company employee	73	82.02	1.71	0.94-3.14	1.18	0.55-2.54	0.673
Agriculturist /employee	194	72.66	1		1		
Self-employee	194	80.50	1.56	1.03-2.37	1.00	0.53-1.89	0.998
Spouse's Occupation							
Government officer	130	82.80	1.73	1.06-2.81	0.87	0.43-1.78	0.710
Company employee	89	84.76	1.99	1.10-3.61	1.25	0.58-2.68	0.565
Agriculturist /employee	212	73.61	1		1		
Self-employee	191	80.59	1.53	1.01-2.32	1.19	0.64-2.22	0.574

Abbreviation: OR - Odds Ratio, Adj. OR - Adjusted Odds Ratio, CI- Confidence interval
p-value - * significant at $p < 0.05$

DISCUSSION

The results showed the prevalence of parents who discuss sexuality issues with their adolescents in Thailand was higher (79.03%) than those who did not (20.97%). Meanwhile, in the Eastern region of the country, the percentage was 54.7%¹⁵, and in the Central region, the figure was quite low at 39.5%¹⁴. In the Northern and Southern regions, the prevalence could not be determined for this study. The results showed that the overall prevalence of parents talking about sexuality issues in Thailand was much higher than in the Eastern and Central regions. This implies that incidences of having discussions about sexuality issues in the Northern and Southern regions may be higher than in the Central and Eastern regions. Studies, which can examine prevalence of such discussions in the Northern and Southern regions need to be conducted. In addition, a lower prevalence of parents talking about sexuality issues was found in the Central region. This may be due to differences in the backgrounds of the people living in this region. The gap between the urbanized society in Bangkok and the countryside is much higher. In the countryside, there is an agricultural society with extended family groups. People live in the community on their farms and spend their time socializing their children until their death³². Fewer conversations with adolescents about sexuality issues contributes to having lesser relationships between parents and adolescents¹². In the Central region, encouraging parents to talk about sexuality issues represents a big challenge. However, focus needs to be placed on discussing this issue among the members of an urbanized society.

A study conducted in Singapore showed that talking about sexuality issues in Singapore had been a little higher than in Thailand (more than 80%), but only 8.3% among them had very often discussed sexuality issues with their children¹². It was found that 90% of Singaporeans believed that they had developed close family kinships and 80% had maintained ties with extended family³³. The close relationship within extended families is congruent with extended families in the Thai countryside.

Results from the multivariate analysis found that the sexes and the ages of the parents were the predictors of whether parents would talk about sexuality issues with their adolescents. This evidence shows that the sex of the parent is an important factor, which contributes to appropriately talking about sexuality issues. Mothers are effective sexual socialization agents for their children. This is congruent with a previous study, which found that the sex of the parent had been a factor influencing the barrier between parent-adolescent sexual communication¹⁰. A qualitative study about mother-daughter communication found that mothers influence their daughters' contraceptive attitudes and use of contraceptive methods³⁴. Thus, mothers are key people with regard to the sexual socialization of their children³⁵. Interestingly, a previous study showed that 67.7% of fathers had not received sex education when they were young³⁶. In addition, a review of intervention studies found that discussions surrounding adolescent sexual and reproductive health (SRH) with boys are rare around the world. In particular, there is no intervention in the Eastern Mediterranean region (EMR)³⁷. This may imply that fathers have fewer opportunities to talk with their adolescents and that the

father is the role model for talking less about sexuality issues. However, the study found that fathers provide valuable guidance for reproductive education²³ and want to have close relationships with their children³⁸. Thus, it is important to encourage fathers to be change agents to initiate talking about sexuality issues with their adolescents, which needs to be implemented.

Results showed that the ages of the parents (<40 and 40-60 years old) were predictors of whether parents would talk about sexuality issues with their adolescents. The older the parents, the less likely they were to talk about sexuality issues with their adolescents. A previous study with adolescents found that the parents' ages were a barrier to talking about sexuality issues with adolescents¹⁰. In addition, the major causes of the wider generation gap between parents and children were socialization and economic status³⁹. Thus, supporting parents to talk about sexuality issues with their children could help them to have closer relationships with their children and could lessen the generation gap. Interestingly, economic status is one of the major causes of the wider generation gap³⁹. This finding was congruent with this study; family income is not associated with talking about sexuality issues. Thus, economic status does not contribute to appropriate communication and creating closer relationships.

The strength of this study was the investigation of the prevalence of having conversations about sexuality issues in all 4 regions of Thailand, while the limitation was to include a relatively high non-response rate (34%) due to the extended school vacations during the COVID-19 pandemic, which may have introduced information bias regarding parents' discussions about sexual issues with adolescents. However, study samples are drawn from all 4 parts of Thailand, and the sample size is sufficient to detect significant findings. Thus, the study

demonstrates high precision, as indicated by the narrow 95 % confidence interval.

RECOMMENDATIONS

The results of this study suggested that fathers should be empowered as the agents of change in order to initiate conversations about sexuality issues. Further studies are needed to empower mothers as the change agents for adolescent sexual risk prevention. While fathers need to be supported to overcome sexual communication obstacles with their adolescents in the next study. Another concern is reducing the generation gap by encouraging closer relationships as a way of increasing discussions about sexuality issues from a young age, as soon as children can understand. Furthermore, studies on promoting communication about sexual issues by parents need to be emphasized from an adolescent perspective in future research. In addition, a mixed method approach should focus on examining the prevalence of discussions about sexuality issues and understanding why certain regions in Thailand have higher or lower prevalence rates of such talks.

CONCLUSION

The prevalence of discussions about sexuality issues in Thailand was found to be high. However, only the father's involvement and the age of the parents were determined to be important factors contributing to having these kinds of talks. Fathers need to take the main role in sexual communication alongside mothers. This will assist in lessening the generation gap and in contributing to the achievement of effective sexual communication with adolescents and promoting better sexual health among adolescents.

ACKNOWLEDGEMENTS

The authors would like to express their sincere thanks to the parents and the adolescents who participated in this study.

FUNDING

This research was supported by the Fundamental Fund of Khon Kaen University, which was funded by the National Science, Research, and Innovation Fund (NSRF)/FM-63-001.

CONFLICTS OF INTEREST STATEMENT

The authors declare that there were no conflicts of interest in this study.

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