Overview of sexual communication between parents and adolescent

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Abstract. Recently, the issue of sexual violence cases in Indonesia is relatively increasing. This study aims to explore parents' comprehension of sexual communication and identify supporting and inhibiting factors in its implementation. A descriptive qualitative approach was employed using FGDs and observations. Participants were selected through purposive sampling, with the criteria of parents who have adolescent children aged 11-18 years old in Malang. A total of 17 mothers with homogeneous characteristics were involved to minimize socio- economic bias. Data analysis was conducted using thematic coding, with source, method, and researcher triangulation applied to enhance research credibility. Findings indicate that sexual communication within families remains centered on religious values with a one-way approach, while biological and psychological aspects are insufficiently integrated. Key barriers include parental discomfort, limited communication skills, and the absence of fathers in sexual discussions. Conversely, religious communities and schools serve as alternative information sources, although their effectiveness remains suboptimal. This study recommends strengthening parental capacity through training that integrates religious and scientific perspectives and encouraging active paternal involvement in sexual communication.

1 Introduction

Nowadays, the issue of sexual violence cases in Indonesia tends to increase from year to year, even the victims are not only adults but infants, children and adolescents are also victims. According to [1] the increase in cases of sexual violence against adolescents shows how a safe social environment for children is increasingly narrow and difficult to find. The world of children, which should be filled with the joy they get from their social environment and family, instead provides a blurry picture and portrait of fear because today children have become subjects of sexual violence, which can even come from their own families. Data from the Ministry of Women's Empowerment and Child Protection (KemenPPPA) shows that there is an increase in cases of violence and sexual harassment that occur in Indonesia every year experienced by adolescents. It was recorded that in 2020 there were 7,053 cases, in 2021 there were 9,078 cases, in 2022 there were 9,962 cases, in 2023 there were 11,324 cases, in 2024 there were 12,168 cases and in 2025 in January- February there were 1,034 cases [2].

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So, in total the cases of abuse that occurred in adolescents from 2020 to February 2025 were 50,619 cases.

The high rate of sexual violence against children, especially adolescents, shows that children are one of the most vulnerable age groups because of the assumption that they are weak, helpless individuals, and children have a high level of dependence on the adults around them [3]. In addition, children also cannot make any resistance and rebuttal when the perpetrator threatens, forces, and provides bribes in any form [1]. This is what makes victims feel helpless when threatened to keep what they experience a secret. Almost every case revealed the perpetrator is someone who knows the victim well [3]. It is not uncommon for the perpetrator to be someone who has more power over the victim, such as parents and teachers. Most victims of sexual violence such as teenagers do not have an understanding of good and appropriate sexual education.

One example from the online newspaper is one case that occurred in Jimbaran-Bali, where in the last 5 months there has been an increase in the number of cases of HIV/AIDS patients by 36 cases, 3 of which are adolescents who are still in school. Most likely the victims were infected due to their promiscuity and free sex. The Jimbaran Health Office continues to socialize the dangers of HIV/AIDS in schools and communities, especially parents. This is done to prevent increasing cases both accidental and cases that are deliberately transmitted by irresponsible people. After conducting an investigation, it was discovered that the fetus came from a pair of teenage lovers, namely (TM) 17 years old and (AY) 18 years old. This case was revealed when the perpetrator was being treated at the hospital for bleeding due to an abortion. Currently, the case has been transferred to the PPA section of the Polresta for further investigation. From these two examples of cases, it is found that these adolescents most likely do not know and get sexual education through sexual communication optimally from their parents or teachers at school.

Adolescence is defined as a transitional developmental period from childhood to adulthood in the range of 11-18 years which includes biological, cognitive, and social-emotional growth and development. Adolescence is a transitional age from child to adult characterized by changes and identity formation, exploration, and initiation of sexual problems [3] . The hormonal changes experienced result in increased sexual activity in adolescents. This increase in sexual activity needs to be supported by education about reproductive health, including boundaries between the opposite sex. However, if the increase in adolescent sexual activity is not balanced with appropriate education, it can increase the risk of adolescents becoming perpetrators of sexual harassment or becoming victims of sexual harassment. Providing education on sexual and reproductive health can be effective in increasing the level of knowledge and attitudes of adolescents in preventing sexual harassment [3]. With the right sexual and reproductive education program, adolescents can delay involvement in sexual activity and reduce risky behavior.

When these adolescents have not received optimal sexual education through sexual communication, they are vulnerable to risky sexual behavior. Some types of adolescent risky sexual behavior include promiscuity, free sex, rape, sodomy, pregnancy outside of marriage, abortion, living together outside of marriage, and other violations of moral values [4]. Meanwhile, adolescent sexual risk behavior usually starts with dating, continues with holding hands, then kissing, then petting, and finally having intercourse without a legal marital status. At this stage, adolescents usually ignore values, norms, and beliefs, so they have a tendency to act carelessly, trial and error [5]. The importance of parents conducting sexual communication with children is to prevent sexually transmitted diseases, HIV/AIDS transmission and also prevent pregnancy outside of marriage.

Sexual communication can be carried out by families or parents who function as the first educators who also play an important role in the sexual development of their children. Sexual communication carried out by parents and adolescents effectively will have a strong influence

on children's decisions to engage in premarital sexual behavior, increase adolescents' knowledge about reproductive health, prevent risky sexual behavior, build better relationships between parents and children [6]. However, unfortunately there are still many people who are not ready to accept sex education to be taught at home or at school. In general, people think that sexual education is something "taboo" to talk about with children, especially adolescents.

According to [7], there are two important reasons for parental sexual communication to adolescents, namely practical and theoretical reasons. Practically, parents have an important obligation to deliver sexual education so that it will shape adolescents' views, attitudes and awareness of the risks that may occur. In addition, parents can be an example in communicating openly and honestly about sexual health, so that they can apply it in their daily lives. While theoretically, sexual communication from parents to adolescents will directly or indirectly affect adolescents' sexual behavior. When sexual communication goes well, adolescents tend to have a more mature understanding in making decisions related to interpersonal relationships and sexual activity. Conversely, a lack of effective sexual communication can lead adolescents to seek information from other sources that are not necessarily accurate or in accordance with the values taught in the family.

Every year various studies try to find out the factors that influence adolescents to engage in sexual behavior. There are several factors that influence adolescents in engaging in sexual behavior, namely knowledge, attitudes, religiosity, self-concept, information media, the role of parents and the role of peers. Parents have a major role in controlling adolescent behavior by building effective and open sexual communication. Parents play a role in shaping adolescent attitudes and behavior, including in terms of sexual behavior. Many parents actually want to communicate with their children regarding sexual communication, but they do so with limited or no communication, because they do not have the necessary communication skills, knowledge, or comfort [7].

Premarital sexual conduct in teenagers may arise as a result of parents' neglect and ignorance of reproductive health education. This is due to the fact that many teenagers receive their sexual and moral instruction from peers and the internet rather than from their parents. Communication about sexuality between mothers and daughters is extremely uncommon; mothers tend to steer clear of conversations about sexual reproductive health because they feel embarrassed and that discussing sexual issues is culturally unethical. Instead, mothers communicate with their children about the physical changes that occur during puberty. In actuality, a large number of Indonesian parents lack the knowledge and abilities necessary to engage in acceptable and productive sexual communication. Confusion when responding to questions, fear of disclosing family secrets, unpreparedness when parents learn of their children's sexual behavior, fear of being labeled as outdated, and discomfort when discussing sex-related topics are all factors that influence parents' readiness to engage in sexual communication with adolescents.

Based on this explanation, the researcher wants to know the description of sexual communication that has been carried out by parents with teenage children. In this study, parents are expected to be able to work together to improve their competence in understanding, providing and conducting sexual communication to adolescents effectively and optimally. This study aims to produce further information about the ability of parents to recognize and understand sexual communication, identify supporting and inhibiting factors and efforts to implement sexual communication in adolescents. The benefits of this study are to know in general the description of sexual communication that has been done by parents with adolescents, supporting factors, inhibiting factors, and efforts that have been made by parents and add to the treasure of knowledge in the field of Psychology.

2 Method

2.1 Participants

The research subjects were determined through purposive sampling, which is a sampling technique based on specific considerations to ensure relevance to the research objectives purposive sampling is a sampling technique based on certain considerations. The criteria for subjects in this study include:

1. Parents who live in Malang Regency.
2. Have teenage children aged 11-18 years.
3. Willing to fully participate in all stages of the research.

The selection of these criteria is based on the need to understand the dynamics of communication in families who actively care for adolescents, while ensuring that participants have real experience related to the research topic.

2.2 Research Instrument

The descriptive qualitative approach applied in this research was conducted using Focus Group Discussion (FGD) and observation methods. This method was chosen to gain a more in-depth understanding of sexual communication in the family. Thus, the data collection methods are:

2.2.1 Focus Group Discussion (FGD)

Data collection was conducted by dividing participants into several groups. Each group consisted of 5-6 participants with one facilitator, and the discussion lasted for 45-60 minutes. FGDs were conducted through the following stages:

a. Warm-up Stage

The discussion began by asking participants to define "sexual communication" to identify their initial perceptions. This step was taken because the topic is still considered taboo in society

b. Theoretical Exposure

A brief explanation of sexual communication is given based on [8] including the purpose of sexual communication in preventing risky behavior in adolescents. This stage aims to equalize perceptions before entering the core discussion.

c. Thematic Discussion

The discussion was directed at five main aspects:

1) Parents' desire to discuss sexual topics with their teenagers.
2) Concrete efforts in opening dialog.
3) Challenges and obstacles faced.
4) Themes that have been discussed.
5) Communication strategies or methods used.

2.2.2 Observation

Observations were made of environmental conditions and various activities related to sexual communication in the family. This process includes recording on the observation sheet regarding the situation, conditions, and behavior of the research subjec.

2.3 Data Analysis Techniques

Data analysis was conducted through thematic coding, which is the process of identifying patterns or themes from qualitative data by grouping codes based on similarities in meaning [9]. The stages include: (1) verbatim transcription of FGD and interview recordings, (2) development of a priori coding according to the interview guide, (3) identification of main themes (e.g. religious dominance), and (4) triangulation of data to validate findings. This method was chosen because it was able to organize the data systematically while preserving the richness of the socio-cultural context. The data is stored in an encrypted format and can only be accessed by authorized parties stored online (cloud storage such as Google Drive) with access only given to authorized teams.

3 Result and Discussion

3.1 The Dominance of Religious Values in Sexual Communication

Religious Coping Theory explains the use of religious values as a mechanism to cope with anxiety and uncertainty, especially in the context of parenting. In this study, parents utilized religious norms such as the obligation to cover the intimate parts (or *aurat* in Bahasa) and the prohibition of adultery as a basis for sexual communication with adolescents. Religion functions as an orienting system that directs adolescents to life goals that are considered morally "right". However, this approach tends to be instrumental, where religion is used to control adolescent behavior through normative prohibitions, without being balanced with open dialogue about reproductive health. The concept of spiritual tension arises when parents are trapped in a conservative paradigm, separating sacred aspects (religious prohibitions) from biological knowledge (such as body changes during puberty). The dominance of religious values also triggers dependence on religious institutions, whose material is limited to norms without integration of science, thus hindering the transformation of adolescents' understanding of sexuality as a natural part of life.

Parents use religious values as a way to instill moral meaning in adolescents. For example, the emphasis on the obligation to cover the intimate parts and the prohibition of adultery illustrate parents' efforts to connect adolescent behavior with sacred values (worship, purity). Here, religion functions as an orienting system that helps parents direct adolescents to the "right life goals". This approach is instrumental (religion is used as a tool), where religion is used to control behavior, not to provide understanding related to reproductive health. Discussions by parents such as body autonomy or reproductive health are rarely discussed because they are considered unrelated to things that are considered "sacred". As a result, there is a separation between what is considered sacred (prohibition) and what is considered normal (biological knowledge). This makes adolescents see sexuality as a forbidden topic, not as a natural part of life.

These findings confirm the urgency of integrating religious values with health science that sexual communication requires not only instilling doctrine, but also strengthening the dimensions of knowledge (biological knowledge) and ethics (social responsibility). For example, parents can utilize informal moments (communication as sharing meaning) to discuss puberty while linking it to the value of chastity in religion. Multidisciplinary collaboration between religious institutions, health workers and psychologists is needed to design a holistic education module, combining religious interpretations with scientific data on sexual risks. Thus, religious dominance is no longer a barrier, but a foundation for building adolescents' full understanding of sexuality, as can be seen in Table 1.

Table 1. Domination of Religious Values in Sexual Communication.

No.	Aspect of Findings	Theoretical Context	Pattern of Findings
1.	Use of religious norms	Positive religious coping (Pargament)	Moral control is effective, but minimal dialogue on reproductive health.
2.	Prohibition of adultery without explanation	Negative religious coping (Pargament)	Adolescents do not understand the social-health consequences, only fear of sin.
3.	Menstrual education with ritual focus	Spiritual tension (Pargament)	Biological knowledge is neglected, triggering misinterpretation of body changes.
4.	Reliance on religious institutions	Proxy agency (Bandura)	Materials are limited to norms, not addressing adolescents' practical needs.

Religious values become the main foundation for sexual communication between parents and adolescents, with an emphasis on norms such as covering up and prohibition of adultery. Parents use religion as a tool to build a sense of security and moral control (positive religious coping), for example through the teaching of dressing modestly according to Sharia. However, this approach tends to be rigid and avoids open dialogue about reproductive health (negative religious coping), such as biological explanations of puberty or the risk of sexually transmitted diseases. Attachment to religious norms creates spiritual tension [10], where parents want to protect their children but are trapped in one-way communication patterns that focus on prohibitions. This is expressed as:

"For me, it's everyday (sexual communication), if the other things are about menstruation, how to wash and so on". (S5.E:44)

This makes adolescents not understand aspects of reproductive health as a whole. The dominance of religion is also seen in the dependence on religious institutions (*Taman Pendidikan Qur'an*, Islamic schools) whose materials are limited to norms without integration of science. This shows the need for an educational approach that integrates religious values with scientificknowledge, for example explaining that covering the intimate parts is not only a religious obligation, but also protects the body from environmental risks.

One concrete form of dominance of religious values is seen in determining the limits of physical interaction with the opposite sex. Parents use religious norms to overcome anxiety about the risk of promiscuity or abuse, such as prohibiting certain touches between men and women. This falls under the category of positive religious coping, where religion is used to establish a sense of security and order through restrictions that are perceived to protect adolescents' morals. One participant described a gradual strategy in setting these boundaries:

"When the child is able to distinguish between men and women, it needs to be conveyed that men and women have limits. So they are not immediately allowed to play for example, but there are limits, you can play this but which ones can be touched and which ones cannot be touched. If the child has reached the age of pre- baligh, then it means that more needs to be added, so that the child will not menstruate first and then be told, it's too late. If they are adults, it means, for example, if they have a boyfriend or girlfriend, it is allowed or not". (S5.E:62).

This statement shows how parents utilize religious values to establish a hierarchy of interactions: (1) anatomical boundaries (body parts that are "forbidden" to be touched by the opposite sex), (2) age boundaries (material adjustments according to the before puberty to adult phase), and (3) relational boundaries (prohibition of dating before marriage). This

approach aims to shape the moral awareness of adolescents to avoid violations of Sharia, such as touching that is considered "inviting adultery".

However, this communication tends to be prohibitive and normative, without opening space for dialogue about the concept of consent or adolescents' rights over their own bodies. For example, the prohibition of "no touching" focuses more on religious observance than an understanding of body autonomy or how to respond to abuse. In fact, according to [11], the delivery of good sexual communication can reduce the risk of risky sexual behavior.

The absence of this dimension reflects the limitations of positive religious coping when religious values are only used as a means of behavioral control (external regulation), not as a basis for building critical consciousness. As a result, adolescents may comply with parental prohibitions, but lack the capacity to make independent decisions in ambiguous situations, such as distinguishing between "friendly" and "dangerous" touch.

However, in practice, this approach often becomes negative religious coping when parents associate norm violations with consequences. According to [12], this pattern reflects spiritual tension, which occurs due to the conflict between the desire to protect the adolescent and the inability to establish an open dialog. Instead of being a source of understanding, religion is used as a rigid disciplinary tool, as expressed:

"Yes, Islam has taught what the purpose of adultery is, so I don't tell them that. But if there is a consensual view, that is also fitrah. But the nature of what it is in terms of what it is like is also one of the things" (S10.A:128).

Religious coping is dynamic and can change according to context. However, this change is hampered by binding cultural norms. Conservative societies tend to maintain faith-based sexual communication practices without adaptation, as change is perceived as threatening sacred values. For example, while parents recognize the importance of discussing puberty, they still do not want to involve "secular" perspectives of reproductive health.

This limitation is compounded by the lack of educational resources. School programs such as women's classes only teach religious norms without integration of developmental psychology. As a result, religion does not function as a means of transformation that opens new insights, but as a conservative force that maintains the status quo, as expressed:

"I am also helped by the school, my child's school happens to have a women's class, so on Fridays when the boys go to prayer, the girls attend the women's class, so so far when her sister has menstruated, she already knows, so I am helped by that". (S4.S:66)

The dominance of religious values in sexual communication is not only about individual coping, but also about the cultural hegemony that governs the way society views sexuality. Parents feel "obliged" to use religion because it is the only availableand socially accepted framework. On the other hand, personal experience with religion also plays a role. Parents who are active in Aisiyah recitations are more confident in using religion as a basis for communication. In contrast, parents who feel alienated from the religious community tend to avoid sexual topics altogether.

3.2 Psychological Barriers and Reactive Strategies in Sexual Communication

Health Belief Model theory emphasizes that individual behavior is influenced by perceptions of threats, benefits, and barriers. In the context of sexual communication, parents are aware of the threat of risky behaviors such as extramarital pregnancy or sexually transmitted diseases [13]. However, psychological barriers such as shame, ignorance, and low communication skills reduce their motivation to have proactive discussions. Perceptions of

adolescents' vulnerability to sexual risks are heightened when parents feel incompetent to answer critical questions, so they tend to be reactive-only responding when there is an external trigger such as an HIV case or a direct question from the child. The perceived benefits of sexual communication are also reduced due to reliance on the media or school as a "safer" source of information. This phenomenon reflects parents' low self-efficacy, which is rooted in a lack of mastery experience and observation of others' failures (vicarious experience).

Sexual communication between parents and adolescents is not only affected by religious norms, but also by complex psychological barriers. Most parents admitted to experiencing a deep sense of shame when discussing the topic of sexuality, as expressed by a participant.

"Heum yess, that is taboo . It's hard to talk about it". (S1.A:54; S3.F:50).

This discomfort is not random, but rather rooted in cultural stigmas that regard sex as a private topic that should not be discussed openly. In societies with conservative religious values, talking about the body or intimate relationships is often associated with moral transgressions, so parents feel pressured to maintain "modesty" by avoiding such discussions. Research by [12], states that parental discomfort in sexual communication is often triggered by concerns about social judgment, where discussing this topic is considered to damage the family image or create the impression that adolescents are "unchaste". This phenomenon is in line with the concept of perceived barriers in the Health Belief Model (HBM), where emotional discomfort is perceived to outweigh the benefits of communication [13]. In the context of the communication model of [8], this pattern leads to communication as information transfer, which is one-way communication that focuses on transferring norms without building dialog. For example, parents only convey the prohibition "do not get close to the opposite sex" without explaining health or psychological reasons, so adolescents do not understand the full context of risk. Parents' lack of skills and knowledge exacerbates this barrier, it was revealed:

"Yes, Islam has taught what the purpose of zina is. But if there is a consensual view it is also fitrah.". S10.A:128.

In addition to shame, lack of skills and knowledge is a significant barrier. One mother expressed her anxiety:

"To convey this is just scientifically lacking."S9.Y:58.

This reflects parents' uncertainty in explaining reproductive health concepts or answering adolescents' critical questions. According to the Health Belief Model (HBM) theory expressed by [13], cognitive barriers such as these reduce parents' perceptions of the benefits of sexual communication while increasing adolescents' perceived vulnerability to the risks of harmful sexual behavior. However, the absence of adequate knowledge keeps parents trapped in a cycle of avoidance. For example, expressions such as:

"Maybe because the child has asked so I explain and straighten out the information that the child received from his friends". (S8.H:100).

This reactive pattern suggests that parents only act when there is an external trigger, such as a question of a child or a viral health case, instead of initiating a proactive conversation. This limitation is not only individualized but also influenced by the lack of clear communication models in the local culture. Parents tend to rely on personal experience or the

advice of fellow mothers in recitation, rather than structured educational sources. One participant confessed:

"I am helped by the women's class at school, but the material given is only about aurat and menstruation, not up to husband-wife relationships" (S4.S:66).

This indicates that even educational institutions are not fully able to bridge the gap between religious norms and adolescents' biological-psychological knowledge needs. Thus, the biological-psychological knowledge needs of these adolescents are not fulfilled. In fact, a complete understanding of body changes, emotions, and relationships with the opposite sex is very important to build self-awareness and responsibility in interacting. If education in schools only highlights aspects of morality without accommodating the practical needs of adolescents, then adolescents will seek answers from other environments that do not necessarily provide accurate information or in accordance with the principle of balance between religion and science.

Table 2. Psychological Barriers in Communication

No	Aspect Findings	Aspects of HBM Theory	Pattern of Findings
1.	Shyness to discuss sensitive topics	Perceived barriers	Emotional discomfort is perceived to outweigh the benefits of the communication.
2.	Concern of misinformation	Perceived vulnerability	Parents avoid the topic because they feel incompetent to answer complex questions.
3.	Ignorance about male puberty	Perceived severity	Lack of knowledge about male puberty reinforces avoidance.
4.	Reliance on external media	Perceived benefits	Parents perceive media as "safer" as it avoids direct Interaction.
5.	Reactive communication when there is an external case	Cues to action	Discussions only arise when there is an external trigger (negative news), not proactively.

Psychological barriers such as embarrassment, fear of being wrong, and lack of skills are major barriers to sexual communication. Parents often feel uncomfortable discussing sensitive topics (perceived barriers in HBM), especially when dealing with opposite-sex children. Fear of misinformation (perceived vulnerability) makes them tend to avoid discussions or rely on external sources such as books or schools (proxy agency). For example, one mother admitted to having difficulty explaining sensitive topics to her son because she felt she did not have sufficient knowledge, as expressed:

"Ee so far I have not conveyed about when my son is a 16-year-old boy. When I am embarrassed to ask what puberty is like, right, we are girls, women and men, I also experience this, to convey this is just scientifically lacking". (S9.Y:58)

Reliance on the media or external cases (such as news of diseases caused by risky sexual behavior) as communication triggers (cues to action) indicates that dialogue is often reactive, not proactive. This finding is in line with the Health Belief Model, where low parental self-efficacy reduces motivation to communicate. To address this, interventions that increase parental self-efficacy through communication skills training and provision of practical guidance are needed.

Self-Efficacy Theory explains in detail the current dynamics. Parents' self- efficacy - the belief in their ability to guide adolescents - is very low in the context of sexual communication. This low efficacy is triggered by two main factors: (1) vicarious experience (observation of others' failures) and (2) lack of mastery experience (successful experience in discussing sensitive topics). For example, participant S9.Y who failed to explain male puberty tended to avoid similar topics in the future due to feeling incompetent. This phenomenon is in line with research by [12] that parental unpreparedness is often rooted in the absence of training or concrete guidance.

There are several factors that hinder communication between parents and children in discussing sensitive issues. In the category of emotional barriers, shame and cultural stigma are the main factors that hinder open communication. Individuals find it difficult to talk about certain topics due to inhibiting social perceptions, as described in the HBM, where stigma can decrease one's intention to communicate. In addition, the pressure of social norms also impacts self-efficacy levels, leading to low confidence to initiate discussions.

Barriers also arise in the cognitive aspect, especially in the form of lack of knowledge and inability to answer children's questions. Ignorance increases perceptions of vulnerability in HBM, where parents feel they do not have enough information to provide appropriate answers. In self-efficacy theory, low mastery experience makes individuals feel less confident in conveying information, hindering effective communication.

"To convey to the child more precisely it is still lacking, just lacking knowledge maybe, we are afraid that later if we convey the child so misunderstood or what". (S9.Y:56).

In addition, there is a reactive communication pattern, where parents tend to only respond when their children initiate questions or when there are external cases that attract their attention. In the HBM perspective, communication is only considered useful when there is a real or external threat that triggers discussion. Meanwhile, in self-efficacy theory, this action is driven more by vicarious experience, where events in the neighborhood become the main triggering factor for parents to start talking about a topic.

This reveals that psychological barriers to sexual communication are not just an individual issue, but also the product of interactions between cultural norms, educational limitations and psychosocial dynamics. Shame rooted in social stigma [12] and lack of skills due to lack of training reinforce each other, creating a vicious cycle of avoidance. Dominant reactive patterns - such as waiting for a child's question or an external case - indicate that parents do not feel they have enough behavioral control to initiate proactive conversations. Barriers in family communication can be overcome by making time to communicate, creating an attitude of openness, mutual respect and appreciation and a supportive attitude towards children.

3.3 School and Media Dependence in Sexual Communication

Social Learning Theory emphasizes that learning occurs through observation and modeling. Low self-efficacy in sexual communication causes parents to rely on proxy agencies, such as schools or media, in conveying information to children. Schools as substitute agents tend to only provide normative material, such as the concept of intimate parts, without integrating biological aspects, while the media becomes the main source of unfiltered information for adolescents. This dependency reflects socially mediated agency, where parents lose their role as active regulators due to limited digital skills and lack of material mastery. As a result, a repetitive cycle is formed: parents feel incompetent, schools provide partial information, teenagers seek information through the media, and parents increasingly lose confidence. However, the theory also emphasizes that human agency is dynamic. Parents have the

potential to change these communication patterns through intentionality and self-reflectiveness (critical evaluation of their communication patterns). Unfortunately, the pressure of rigid religious norms often narrows their room for exploration in adopting a more holistic approach to education.

Sexual communication between parents and adolescents is hampered not only by cultural norms and psychological limitations, but also by a significant reliance on external institutions such as schools and the media. This phenomenon can be understood through Bandura's Agent Theory, which emphasizes the capacity of humans as proactive beings who actively shape their environment, while being influenced by the social system around them [14]. However, in the context of this study, reliance on external parties reflects the limitations of parents' individual agency due to low self-efficacy and complex cultural pressures.

Parents tend to rely on school programs such as motherhood classes to fill the knowledge gap about sexuality. According to Agent theory, this reliance falls into the category of proxy agency, where individuals hand over responsibility to other parties such as schools and TPQ, because they feel they do not have the resources or skills to act independently. In this case, schools act as proxies that are expected to deliver materials that are in accordance with religious values but are often limited to normative aspects such as intimate parts and prohibition of adultery, without touching on reproductive health or interpersonal relationship dynamics. This was expressed:

"In TPQ it should be there, but not all can deliver it". (S1.A:90).

This limitation aligns with Bandura's concept of forethought, where parents envision the risks of discussing sensitive topics themselves such as fear of misperception or conflict with cultural values. Instead of developing proactive communication strategies, they choose proxy agencies as a safe route. However, the school materials that are not integrated with the needs of adolescents actually widen the gap between religious knowledge and biological understanding, as seen in the quote:

"Teachers are considered to know better, but the material is only about menstruation, not up to the husband- wife relationship." (S5.E:44).

The limitations in delivering sensitive topics to adolescents encourage parents to also look for alternatives outside of school, one of which is through participants at the At-Tanwir Mosque. Parents take their children to the nearest health facility to ensure reproductive health conditions, such as menstruation or vaginal discharge. This phenomenon shows that although parents realize the importance of transparency in discussing reproductive organs, limited communication skills make them still rely on medical personnel as a proxy agency. One mother expressed this dilemma:

"Ee for me, the difficulty is when children do not dare to express, for example, they are still shy, for example, do you menstruate or have vaginal discharge? Ee can't you be seen later? But I'm embarrassed ... finally ending up going to the doctor he believes in. So in addition to the strength of the parents and creating a sense of trust that we can actually tell you that this is not taboo, sometimes children accept it, sometimes not." (S7.W:76).

This expression reflects the dynamics of socially mediated agency, where dependence on health professionals emerges in response to parents' inability to bridge the child's shame and biological needs. Although parents try to create the belief that reproductive topics are "not taboo", the lack of material mastery and psychological barriers still push them to the safe path by shifting responsibility to doctors. In fact, medical interventions are often curative

(e.g. ensuring menstruation) without touching on holistic education about sexual health, so the information gap remains.

While schools are structured proxy agencies, media and peers act as undirected collective agents. Adolescents tend to seek sexual information from friends or gadgets, a pattern that reflects socially mediated agency. In this case, the media is not just a source of information, but a space where adolescents form an understanding of sexual knowledge that is often unfiltered by family values. Collective agency can be empowering if directed by common goals, but in this context, the absence of supervision actually increases the risk of risky sexual behaviour.

On the other hand, media is an alternative source of information that parents consider "safe", although the content is often unfiltered. Teens prefer platforms such as TikTok or peer groups to learn about sexuality topics, a pattern that reflects communication as community [8]. However, without supervision, the media becomes a space where adolescents are exposed to information that is contrary to family values. This phenomenon is in line with research by [11] who found that parents tend to avoid sensitive topics because they feel incompetent, so adolescents seek answers from external sources. This limitation is exacerbated by parents' lack of digital skills, as expressed by participants:

"Maybe the book is also a medium, meaning that it can, because sometimes the child is embarrassed to convey to anyone, right by reading so it might help" (S5.E:96).

Media dependence is also related to low self-reactiveness. Parents do not feel able to keep up with the speed of digital information, so they fail to be active regulators in the adolescent learning process. This shows the failure of parents as information regulators (socially mediated agency), which is rooted in the lack of mastery experience in managing educational content, as expressed by participants:

"The problem is that junior high school children now seem to know more quickly from their cellphones. If parents don't tell them, they might be afraid of going further"(S2.S:46).

This shows that the absence of mastery experience (successful experience in managing media) reduces parents' self-efficacy, so they tend to be passive in filtering content. In this case, the media is not just a source of information, but a space where adolescents form an understanding of sexuality that is often unfiltered by family values. Collective agency can be empowering if directed by common goals, but in this context, the absence of supervision actually increases the risk of risky sexual behaviour.

Table 3. Dependence on School/Media

No	Aspect Findings	Aspects of Bandura's Theory	Pattern of Findings
1.	School as a substitute for knowledge	Proxy agency	Parents hand over responsibility to schools due to low self-efficacy.
2.	Inability to filter digital information	Socially mediated agency	Parents fail to become information regulators due to lack of digital skills.
3.	Relying on books as a solution	Vicarious experience	Books are not used as a substitute for parent communication skills.
4.	Lack of collaboration with health workers	Collective efficacy deficit	Parents are not confident in themselves, so they rely on external experts.
5.	Role of ustazah in education	External locus of control	Parents consider religious figures more legitimate in discussing sensitive topics.

Parents' low self-efficacy in sexual communication makes them rely on external parties such as schools, media, or religious figures. Schools become a proxy agency (Bandura) that is expected to fill the knowledge gap, for example through women's classes that teach menstruation. However, school materials are often limited to religious norms without explaining biological aspects, such as the function of reproductive organs. On the other hand, parents fail to become digital information regulators (socially mediated agencies), so teenagers access content from friends or gadgets without filters. For example, a mother admitted that she did not know how to choose the right book, while teenagers trusted information from TikTok. This dependency reflects parents' mastery experience deficit in managing sensitive topics. To overcome this, multidisciplinary collaboration is needed: parents are trained to choose valid sources of information, schools integrate reproductive health materials in the religious curriculum, and the government regulates educational content on digital platforms.

Dependence on schools and media does not occur in a vacuum but is the result of the interaction between low parental self- efficacy and cultural dominance that makes sexuality a taboo topic. Human agency is dynamic, where parents actually have the capacity to change the pattern of sexual communication through intentionality or intention and self-reflectiveness or critical evaluation of applied parenting. However, the pressure of rigid religious norms limits the space for exploring a more holistic approach to education. As a result, a repetitive cycle of dependency is formed. Parents feel incompetent in discussing sexuality, so they rely on schools as the main source of information. Schools, which focus more on normative aspects, only deliver material around moral rules without integrating a thorough biological and psychological understanding. This limitation encourages adolescents to seek information from the media, which often presents content without considering cultural context and family values. Uncontrolled exposure to information further makes parents lose confidence, reinforcing a cycle where sexual communication remains an avoided domain within the family.

This cycle is reinforced by triadic reciprocal causation, where personal (low efficacy), environmental (lack of collaborative programs), and behavioral (reactive patterns) factors reinforce each other. Reliance on schools and media also creates a cycle of communication dysfunction. Parents feel incapable of discussing sexual topics independently (low self-efficacy), so they rely on school normative materials. The school, as a proxy agency, fails to provide practical knowledge, encouraging adolescents to seek information in the media. As a result, parents are less confident, reinforcing the triadic reciprocal causation pattern, where personal (low self-efficacy), environmental (school limitations), and behavioral (reactive patterns) factors exacerbate each other.

3.4 School and Media Dependence in Sexual Communication

Family Systems Theory highlights the balance of family members' roles in parenting, with the key concept of differentiation of self (the ability to separate emotions and logic). Fathers' absence in sexual education reflects low differentiation of self, where shame and patriarchal norms lead fathers to avoid responsibility (under-functioning), while mothers take the dominant role (over-functioning). This pattern creates triangulation in the family system, where emotional tensions between husband and wife are "transferred" to the mother as a third party. Consequently, adolescent boys lose access to a role model figure who can guide them in understanding reproductive health, while adolescent girls only get limited information from their mothers. Emotional cutoff between fathers and children exacerbates gender inequality, where sexual education is considered a "mother's job". This pattern of multigenerational transmission reinforces systemic dysfunction within the family.

The absence of fathers in sexual communication is not just a cultural phenomenon but reflects the inequality of differentiation of self in the family system. The family functions as an interdependent emotional unit, where the level of self-differentiation of members consisting of the ability to separate rational thoughts from emotional reactions determines the balance of parenting dynamics. Research findings show that fathers tend to be absent due to cultural norms, while mothers take a dominant role in parenting. This pattern can be explained through the concept of triangulation and emotional cutoff in Bowen's theory.

When fathers feel uncomfortable discussing sexual topics, an issue that is considered taboo in patriarchal culture will form emotional tension between the day and is "transferred" to the mother as a third party (triangulation). The mother, who has higher self-differentiation in the context of parenting, takes over the responsibility of sexual education (over-functioning), while the father withdraws (under-functioning). This creates role polarization that disrupts the balance of the family system. Family System Theory explains that this kind of imbalance often occurs when family values (e.g. religious norms) conflict with educational needs, so that less differentiated family members, in this case fathers, choose to avoid conflict by cutting off active participation (emotional cutoff).

The concept of self-differentiation also explains why communication is more effective with adolescent girls. Mothers, who are considered more "appropriate" to discuss women's bodies, feel more comfortable teaching topics such as menstruation or intimate parts. In contrast, less differentiated fathers tend to project their shame onto sons, creating an emotional disconnect across generations. This was expressed by participant S10.A:

"When I was embarrassed to ask what puberty was like" (S9.Y:58).

Fathers' inability to separate personal (emotional) shame from educational (rational) responsibility reflects low levels of self- differentiation, which according to [15], is stable since early adulthood and difficult to change without intervention. The absence of fathers in sexual education reflects not only gender bias, but also systemic dysfunction in the family. Families with low self-differentiation tend to be rigid in the face of change. This is like adolescents' need for sexual information and relying on non-adaptive response patterns. Cultural norms that stigmatize talk about the male body ("wet dreams") exacerbate the emotional disconnect between father and son.

Table 4. Father Absence in Education

No	Aspect Findings	Aspects of Bowen's Theory	Pattern of Findings
1.	Father's discomfort in discussing sexual topic's	Low differentiation of self	Fathers fail to separate personal shame from parenting responsibilities.
2.	Mother as role taker	Triangulation	Unbalanced family system: mother over-functioning, father under-functioning.
3.	Emotional projection onto son	Emotional cutoff	Father's shame is transferred to son, causing information gap.
4.	Gender inequality in parenting	Nuclear family emotional process	Patriarchal norms influence dynamics: sexual education is considered "mom's job" for girls.
5.	Lack of father-daughter communication models	Multigenerational transmission	Hereditary parenting patterns: fathers are not involved because there is no example from their parents.

Fathers' absence in sexual education reflects gender role inequality influenced by patriarchal norms and low self- differentiation. Fathers tend to be absent because they feel it is taboo to discuss the topic of sexuality with children, especially girls, so mothers take over the role (triangulation). For example, one father admitted to being "reluctant" to discuss puberty with his son, while the mother felt burdened with dual responsibilities. This imbalance exacerbates the information gap, especially for adolescent boys who lose access to critical knowledge about reproductive health. This pattern also shows emotional cutoff, this is the reason why fathers cut off active participation due to inability to manage emotions (shame). As a result, the family system becomes unbalanced (over-functioning mothers and under- functioning fathers), which has the potential to create a similar pattern in the next generation (multigenerational transmission). The solution is a program that specifically involves fathers through a gender-based approach, such as workshops with male facilitators to reduce anxiety.

The strength of the research is that the method used is exploratory, so that it can find out more about the subject's experience in conducting sexual communication. As for the limitations, it was only conducted on one religious group, without looking at several other five religions. In addition, there were no subjects from the father's group, which caused researchers to be unable to find out the encouragement and obstacles experienced by fathers in conducting sexual communication. Therefore, it is hoped that the next research can pay attention to things that need to be improved in the future

4 Conclusion

Sexual communication conducted by parents to adolescents stated that only some parents have conducted sexual communication to their teenagers. All participants agreed that sexual communication is necessary and very important to be done by parents to adolescents. However, parents realize that the lack of skills and knowledge is one of the inhibiting factors in conducting sexual communication. Parents' ability to recognize and understand sexual communication is still limited to a normative, religion-based approach. Religious values such as the obligation to cover the intimate parts and the prohibition of adultery become the main foundation, but communication tends to be one-way (communication as information transfer) without opening a space for dialogue about reproductive health. Parents rely on religious institutions and schools as sources of information, although the materials provided do not integrate biological-psychological knowledge. This causes adolescents to view sexuality as a taboo topic, not a natural part of life. The main inhibiting factors include shyness, lack of communication skills, and father absence due to patriarchal norms. These psychological barriers are compounded by reliance on media and schools that provide partial information, leading adolescents to seek answers from unfiltered sources. Meanwhile, the supporting factor lies in the existence of religious communities that serve as proxy agencies in conveying norms, although not yet optimal. This finding confirms that sexual communication has not been effective due to the lack of collaboration between religious values, health science, and the active role of fathers.

5 Implication

The implication is that it is necessary to strengthen the capacity of parents through sexual communication training that combines religious and scientific approaches. Educational materials should be designed to integrate biological explanations (e.g. puberty, reproductive health) with moral-religious values (prohibition of adultery, social boundaries). For example,

explaining that covering up is not only a religious obligation, but also protects oneself from environmental risks. In addition, the government and related institutions need to develop collaborative programs involving fathers, health workers and psychologists. Gender-based workshops with male facilitators can reduce fathers' reluctance to discuss sensitive topics. In addition, schools should revise the sexual education curriculum to include aspects of reproductive health and involve both parents equally. By doing so, sexual communication can be a holistic process that addresses the needs of adolescents as a whole.

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