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Abstract

The purpose of this study was to determine if, when and how African American parents discussed health issues and sexual risks with their teenagers. Interviews were conducted with thirty African American families connected to the South Side of Syracuse. The participants had connection to the South Side of Syracuse through residency, employment, or church membership. I explore the context in which these conversations take place. When it came to teenage sexual relationships, discussions included other influences in the teenagers' lives, as well as, how the information received outside of the home compared to what they were hearing from their parents. This study examined the effect these conversations or lack thereof have on African American teenagers' decisions to become sexually active or delay sexual behavior. Chosen participants were from neighborhoods slated as high risk for STIs/HIV infections in Central New York. Data was collected through audio-recorded qualitative face-to-face interviews.

The study revealed that African American parents see the need for sexuality discussions and they are interested in being sexuality educators for their teenagers. Teens reported feeling uncomfortable, but preferred parents as educators. African American families would benefit from supportive programs to ease the uncomfortable feelings. Findings support the need for (a) culturally sensitive skill building classes to assist parents with communication, (b) African American teenage educators for the teenagers, (c) improved knowledge base of STIs/HIV in low-income neighborhoods, and (d) training of African American clergy and lay people to educate church members and the community about STIs/HIV.

African American Parent-Teen Communication Regarding Sex, Dating and Risk of STIs

by

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DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
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Dedication

To my parents Willie and Gloria Franklin who are no longer physically here to witness this monumental occasion, but who before transitioning from earth covered this very day with their prayers and daily reminders of love and pride in my accomplishments.

To my children Atu, Holly and Douglas who constantly reminded me that it is okay to pursue my dreams and goals.

To my grandchildren Juan Jr., Rayjaun, Javier, Jaunni, Jasaun, Yeong-Ja, and Eryn whose very existence provided countless refreshing and beautiful lessons of laughter and patience during moments when I most needed it.

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The amount of support received from family and friends through personal time and financial gifts surpasses awesome. Their unselfish generosity has changed my life. In addition to their monetary support, I would like to recognize the following people to whom I owe mountains of gratitude for other kind gestures. To my uncle, Dr. Isaac Moore, whose extensive and informative conversations helped me to realize and embrace the fact that I am not on this path for my personal gain. My aunt, Juanita Legree, for her unconditional and everlasting love and prayers. To aunt and uncle, Attorney Mittie and Dr. Ronald Smith, who opened their home to me and provided unmatched mental and emotional support and guidance. Aunt Mercedes Fennell, for her willingness to sacrifice financial support whenever called upon. To my husband, Rev. Larry S. Howard, for creating an atmosphere that strengthened my relationship with God. A special thanks to Dr. Classia Foats for accepting the divine appointment to become my mentor. I am forever grateful to my best friend, Nancy McFarland. She is a rare treasure whose presence and unwavering prayerful expressions of encouragement cheered me on countless times. And, of course, my cousin, Dr. Vera Cole, who without hesitation accepted my invitation to return to graduate school with me and together navigate this tumultuous ride to earning our doctorates.

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INTRODUCTION

Statement of the Problem

STI rates and racial disparities

Teenagers and young adults continue to be at risk for sexually transmitted infections (STI) including the human immunodeficiency virus (HIV). Adolescents aged 15–24 account for four times the rate of other age groups when gonorrhea and chlamydia cases are considered and two times the reported rate of the total population for syphilis (CDC, 2015; Weinstock, Berman & Cates, 2004). Those under age 35 accounted for 56% of new HIV infections in 2010 (ages 13–24 representing 26% and those 25–34 representing 31%; CDC, 2012). Documented rates of STIs are much more prevalent in the African American community than in white communities in the United States (Biello, Kershaw, Nelson, Hogben, Ickovics, & Niccolai, 2012; Newman & Berman, 2008; Hogben & Leichter, 2008). In 2011, rates of syphilis, gonorrhea, and chlamydia for African Americans were reported to be three to 17% higher than rates for Hispanics and Whites (CDC, 2013c). With regard to gender, men were infected with syphilis at eight times the rate of women. Gonorrhea rates between the genders showed no significant differences; however, women were infected with chlamydia at two and half times the rate of men (CDC, 2013b). In 2014, the rate of gonorrhea for African Americans was 405.4 cases per 100,000. This rate was 10 times that of whites; which was 38.3 per 100,000 (CDC, 2015).

Pregnancy statistics

Another result of unprotected sex is unplanned and even undesired pregnancy. These rates are not as high as they were in 1957 when recorded teen births reached their highest (Lane, 2008). Hamilton, Mathews & Ventura (2013), report that between 2007 – 2011 teen birth rates fell 15% or more. The rates fell from 41.5 per 1,000 in 2007 to 31.3 per 1,000 in 2011

representing an historical low. African American teen birth rates represented the largest decline falling more than 60% from 1991 to 2011. For African American teens aged 15 – 19, the birth rate in 1991 was 118.2 per 1,000. In 2007 their birth rate was 62.0 per 1,000 and in 2011 the birth rate had declined to 47.4 per 1,000. Although the rates of teen pregnancy have decreased, signs of unprotected sexual activity remain high through STI rates.

National and Local Statistics

According to the CDC's Morbidity and Mortality Weekly Report (2011), one in five or 21% of Americans are unaware of their HIV positive status. Individuals who are unaware of their HIV status can be more likely to participate in risky sexual behavior (Marks, Crepaz, & Janssen, 2006). Risky sexual behavior, in turn, is associated with the transmission of HIV infection (CDC, 2012). Presently, approximately 50% of Americans know someone who is HIV positive compared to 43% in 2009 (Kaiser Family Foundation (KFF), 2009). For African American youth, the rate of HIV infection is seven to 11 times that of whites for males and females, respectively. The rates of African American male and female youth HIV infection are three and four times the rates of Hispanic male and female youth, respectively (CDC, 2012). For African American youth, the STI rate is reported to be as high as 19 times that of whites (CDC, 2012). Thus, the reported sexual behavior of African American adolescents is of paramount concern to public health (CDC, 2008a). Adolescents in general represent a disproportionate rate of STIs, which equates to increased financial and social costs (CDC, 2012; Kost & Henshaw, 2013).

The CDC (2012), reports that most often adolescents become infected with an STI through unprotected sex. For instance, in Onondaga County, the focal point of this study, STI rates continue to rise among teenagers; the county is rated amongst the counties in New York

State with the most infections of chlamydia, gonorrhea, and syphilis (NYSDOH, 2011). For example, the Onondaga Health Department (OHD) reports that syphilis cases between 2008 and 2011 rose from six to 20. This is more than triple the number of syphilis cases reported in 2008. In addition, an article in the *Syracuse Post Standard* (2010) newspaper revealed a sudden increase in young males under the age of 25 testing positive for HIV.

Teenagers' sexual activity is not limited to vaginal-penile intercourse, but can include anal and oral sexual activity (KFF, 2009). Staras, Cook & Clark (2009) add that the sexual risky behavior of a person's sex partner can be a predictor of incidence of STIs. Given that a great number of teenagers are engaging in unprotected sex, prevention efforts are crucial.

Education and Prevention Programs

In 2010, the U.S. Department of Health and Human Services (USDHHS) acknowledged this epidemic and initiated Healthy People 2020 (HP2020). This organization defines its goal is to "promote healthy sexual behaviors, strengthen community capacity, and increase access to quality services to prevent sexually transmitted diseases and their complications" (USDHHS, 2012). Basically, this national STI prevention program is aimed at improving the health of adolescents by reducing sexual risk and decreasing the rates of STI. Furthermore, HP2020 recognizes "that the spread of STIs is directly affected by social, economic, and behavioral factors." And, "among certain vulnerable populations, historical experience with segregation and discrimination exacerbates the influence of these factors." The certain vulnerable populations referred to include African Americans and Hispanics whose STI rates remain higher than rates for whites.

In addition, HP2020 prevention program proclaims that parent-child relationships can influence a teenager's decision about engaging in risky sexual behavior. Increased

communication between parent and child has been found to have a positive impact on the reduction of risky sexual behavior (Crosby, Hanson, & Rager, 2009; Eisenberg, Sieving, Bearinger, Swain, & Resnick, 2006; USDHHS, 2012). Other researchers agree that a close and supportive parent-child relationship can play an important role in a teenager's sexual behavior (Huebner & Howell, 2003; Regenerus & Luchies, 2006; Rodgers, 1999; Stanton, Pack, Cottrell, Harris & Burns, 2002; Voisin, DiClemente, Salazar, Crosby & Yarber, 2006). These same researchers find that supportive parents' show they care by communicating with their teenagers about an array of topics including friend choice, school, after school activities, dating and sex. Even with this positive parental communication, teenagers interact with influential peers. Henry, Schoeny, Deptula & Slavick (2007) found that when teenagers perceive that their counterparts are sexually active they are more prone to become sexually active.

In fact, almost 50% of high school students report having had sexual intercourse with percentages rising for each year of age (CDC, 2010). The reported racial differences for these percentages are significant. For African American males, 72.1% report having engaged in sexual intercourse compared to 39.6% of white males who report having engaged in sexual intercourse. This survey also found that close to 14% had multiple partners, 40% had not used condoms and 80% had not used birth control during last sexual encounter (CDC, 2010). Consequences of these unprotected sexual experiences can lead to social problems such as teenage pregnancy. For the past two decades, pregnancy rates among adolescent females in the United States have dramatically decreased (Hamilton & Ventura, 2012; Lane, 2008). The U.S. reported its lowest pregnancy rates ever in 2010. The teen birth rate declined 44% from 1991 to 2010.

Hamilton and Ventura (2012) report that despite declining teen pregnancy rates our youth remain vulnerable to health risks. Aronowitz & Eche (2013) report that approximately 40% of

new HIV infection is among 15- to 24-year-olds. African Americans accounted for 70% of new HIV infections in 2006 and 48% of African American females aged 14–19 were infected with an STI (CDC, 2009).

Local and national agencies continue to develop education and prevention programs to halt the transmission and reduce the STI rates within our community. Two such programs are the Community Preventive Services Task Force and the SisterLove initiative located in Atlanta, Georgia. The Community Preventive Services Task Force project found adolescent males more receptive to their comprehensive risk reduction interventions than adolescent females. In addition, this project recorded a reduction in prevalence and frequency of sexual activity among adolescents (Sipe, Chin, Elder, et al. 2012). The SisterLove initiative provides knowledge and support to heterosexual African American women through several hours of a mobile interactive educational workshop. The workshop is made accessible to the women through any location they choose (Painter, Herbst, Diallo, & White, 2014).

Aim of Present Project

As a social worker and an African American woman, I was positioned to witness from inside the community some of the daily challenges families' experience. The issue of STI rates resonated with me due to my work as a facilitator of HIV support groups, recruiter and trainer of perspective foster care and adoptive parents, and community liaison at the Dunbar Association. While working with these families, I observed their strengths of caring for and supporting each. There were days when we had conversations on strategies for overcoming some daily obstacles, such as food shortages and pregnancy prevention resources.

This present study will be an innovative intervention and strategy that can positively influence endeavors to reduce risk of STIs. Statistics prove that STIs have not decreased to a

rate where we should not be concerned. Therefore, conversations and STI prevention measures should continue. It is imperative that consistent conversations about sexual behavior are held and accurate information about STI/HIV is disseminated in the African American community. This present study can add to the body of research that highlights what resources African American parents and teenagers desire to guide and strengthen their STI prevention conversations and behavior.

For five years, I was employed as a social worker at the Dunbar Association, Incorporated. Locals affectionately referred to this community-based organization as “The Dunbar Center.” The Dunbar Center has been a vibrant institution on the south side of Syracuse, in the city’s African American community, for over 100 years. Throughout the years, the center has provided programs for the entire family. The wide range of programs included after-school activities for school aged children, Each One, Teach One for teenagers, family counseling, Adoption & Foster Care, HIV/AIDS support groups, a food pantry, fresh food give-away, as well as a senior’s program. My position spanned several programs including HIV/AIDS, Adoption & Foster Care, and the after-school program.

My present research was borne out of an unexpected conversation with the mother of a teenager with whom I worked. The teenage daughter was a participant in one of the after-school groups. Home visits were required as a condition for her involvement in the program. During one of these home visits, the mother appeared distracted and unresponsive to the comments I made regarding her daughter’s participation in the program. I found this to be out of character for the mother and asked her if everything was okay. She asked me to sit on the porch with her. Once we were alone on the porch, she began to express her concern.

Her concern was that her daughter had informed her that the school had shown a video on sex education. This mother found the incident “not necessary” for her daughter and “disrespectful” to her as the mother. She was totally against her daughter being able to watch this video at school. She was adamant that it was not the school’s place to teach her teenage daughter about sex. This was her stance even though her daughter had shared her observation of schoolmates actively involved in sexual behavior on school grounds. This mother was equally opposed to her husband’s decision to have family time where their teenage daughter and teenage son were both seated at the dining room table to participate in discussions about sexual responsibility and consequences of unprotected sexual behavior. Some of her mindset was rooted in personal experience as a teenager. She remembered being falsely accused in this way, “my mom accused me of having sex in high school and I wasn’t doing a thing.”

Initially, she voiced ambivalence about when her daughter learns about sex. As the conversation continued, it was determined that she was hesitant to discuss anything about sex and pregnancy, or even couple relationships with her daughter. As a teenager, she had not been educated in her home about these topics. Furthermore, she explained that she chose to believe her daughter did not need to learn about sex or intimate relationships “until she graduated high school and became an adult.” This reluctance speaks to indications by several researchers that some parents have their own inhibitions and believe their children to be too young or immature to be taught about sexuality (Byers, Sears, & Weaver, 2008; Frankham, 2006; Jerman & Constantine, 2010; Lin, Chu, Lin, 2006; Wilson, Dalberth, Koo, & Gard, 2010).

I found this mother’s response surprising. Somewhere inside of my mind I had determined that contemporary parents were more open with their teenagers about sex than my parents had been with me. Listening to this mother’s comments took me back to my teenage

years. As a teenager, I remember my parents' only comment to me was "you'd better not get pregnant." As a parent, during my children's teenage years, I talked openly with them about sexual behavior—i.e., what to expect and how it may influence your life. Their friends referred to me as "the condom lady." In our home, condoms were deliberately placed in bowls in the bathroom and in the living room for the convenience of them and their visiting friends. More recently, as a grandmother, I did not hesitate to answer questions from my then 10-year-old grandson when he asked where babies came from and specific questions about his anatomy. In addition to answering questions, we purchased books to read with him that further explained sexual relationships, conception, and pregnancy.

This mother's comments piqued my interest, and I began to wonder if her perspective or mine was more prevalent in the African American community. For years, my interest had been in discovering and implementing strategies to make HIV testing more appealing to people of color. After speaking with this mother, I wondered how our society and especially the African American community, could become comfortable with HIV testing if we are unable or unwilling to engage in discussion about sexual behavior, unplanned pregnancies, and the risk of STIs. Along with this, how do African American parents navigate this conversation with their teenagers in the atmosphere of systemic racial and socioeconomic oppressions in the form of continuing racism, disproportionate incarceration, and economic struggles for people of color?

Overview of zip code 13205.

Population. To understand better this mother, it is helpful to become familiar with her environment. The participants fulfilling this study reside in zip code 13205 of the city of Syracuse. Syracuse is located in Central New York. In 2010, the reported population was 145,170 (Lane, Rubenstein, Bergen-Cico, Jennings-Bey, Fish, Larsen, Fullilove, Schimpff,

Ducre, & Robinson, 2017). According to the United States Census Bureau (USCB, 2015), the population for zip code 13205 is recorded at 19, 201 with 5,566 people per square mile.

Residents of this zip code are mainly African-American consisting largely of 20 to 40 year olds and senior citizens. The ethnicity breakdown is as follows: African-Americans—10,660 (55%), Whites—6,731 (35%), Bi-Racial—746 (3.9%), Asians—489 (2.5%), American Indians—263 (1.4%), (USCB, 2015).

Household income. The median household income is \$31,501. Females represent 55% and males represent 45% of zip code 13205. Single guardian households total 34% while two parent households total 23%. In the city of Syracuse, 35% of the population lives below federal poverty line (USCB, 2015; Lane et al., 2017). This picture of poverty is seen through the employment status of 13205 residents with 44% reporting no earnings, 31% reporting full-time hours, and 25% reporting part-time hours. Consequently, the majority of households earn less than \$25,000 per year (USCB, 2015).

Lack of employment. The disintegration of this city is linked to urban renewal during the early 1960s when African-American families were displaced, businesses uprooted, mortgage discrimination was persistent, and Whites relocated to suburbs to make way for expressways. Following that, New York State's 1973 Rockefeller Drug Laws provided a context for disproportionate incarceration rates for drug use and drug sales. Recently, Lane and associates (2017) found that while there was no racial disparity of drug use by pregnant African-American and White females, "drug related sentencing was 98 times higher for African Americans" (p.3). In addition, the manufacturing jobs once available to provide adequate living wages those without a college education have been replaced. Presently, the major employers in Syracuse are universities and hospitals, which lack the pay and benefits once offered by manufacturing jobs.

Education. When education is brought into the equation, high school graduates compose 52% and residents with less than a high school education represent 22% of the population. New York State Department of Education report more than half of the public schools in Syracuse are failing (Lane et al., 2017). Adults earning an Associate's degree total 8.2%, Bachelor's degree total 9.0%, Master's degree total 5.7%, and Doctorate's total 2.0% (USCB, 2015). Lane and associates (2017) report that most African American and Latino college graduates find employment out of the area due to the existing racism and lack of employment opportunities. These low employment rates and low education percentages are results of Syracuse's decades' long declining economy (Lane et al., 2017).

Neighborhood Violence. Violence appears to be a by-product of unemployment and low graduation rates. The per capita murder rate for 2013 in Syracuse was higher than any city in New York State. Syracuse police documented 38 gunshot injuries between January and May 2015 (Lane et al., 2017). That same year, the July 4th weekend marked a sharp increase when 11 people were shot. Two of those gunshots were fatal. Syracuse's gang members are held responsible for 78% of homicides between 2009 and 2014. The national average for homicides during that time period was 12% (Lane et al., 2017). Zip code 13205 is one of the two zip codes in Syracuse experiencing the highest number of gunshots and murders (Lane, et al., 2017). The USCB (2015) rates Syracuse's crime index at 8 out of 100; with 100 being the safest.

Structural violence. These social determinants, i.e. living conditions, work environments, and inadequate schools can have great impact on an individual's health. Zip code 13205 has the highest per capita hospital admission rate of any zip code in the county (USCB, 2015). As one considers the structural forces endured in the African American community, it is essential to point out that, for many, the negative impact of these structural forces begin in the

womb. Lane (2008) refers to this as structural violence. She highlights one means of structural violence through tobacco use by pregnant women. Lane explains how a pregnant mother's cigarette smoking harms the unborn child "causing low birth weight" and "impairing the child's life-long cognitive ability" (p. 88). Not only is the child's health weakened, but the parent is at risk for respiratory illnesses like lung cancer. The risk for parent and child is increased with use of the more pathogenic mentholated cigarettes, which are deliberately advertised and promoted at every store in predominantly African American communities.

Lemelle (2002) imparts clarity to the African American experience as he describes how "full participation in society is restricted" by social structure of the racialized social system (p. 136). For instance, you follow the school-aged child who was born with cognitive deficiency due to side effects of mentholated cigarette smoke. He attends an underfunded school where staff may not be appropriately sensitive to his underachievement causing him to not excel and possibly drop out of school. Dropping out of school excludes him from securing sufficient employment that will support himself and possibly a family. Unemployment leads to arrests. Incarceration limits the available African American men for women to date or marry in the young adult community (Weisz, Lozyniak, Lane et al., 2011). A consequence of this fact is that the women have to share partners, although they do not want to (Weisz, Lozyniak, Lane et al., 2011; Lane, Rubenstein, Keefe, et al., 2004). Furthermore, those who escape incarceration may lose their lives to street violence or police brutality. Each of these circumstances is connected through social policies and design of the educational system by the dominant culture for poor and African American communities (Lemelle, 2002).

Another author sums up structural violence as "any constraint on human potential due to economic and political circumstances that structure or exacerbate inequality" and "structural

violence of policy mandates sustains inequalities and inaccessibility to critical resources, leaving poverty unresolved” (Davis, 2006). Being aware of these inequalities and constraints, this mother’s comments both startled me and motivated me to better understand her position in relation to the greater issue of STI education and prevention for teenagers.

Purpose of the Study

The purpose of this study is to determine if, and when, African American parents engage in conversations with their teenagers about sex and STI/HIV. Coupled with this is an interest in understanding African American parents’ perceptions and challenges in communicating with their teenagers about sex and STI/HIV. While studies exist on parent-teen communication (Aronowitz & Eche, 2013; Fasula & Miller, 2006; Kapunga, Baptiste, Holmbeck, McBride, Robinson, Sturdivant, Crown, & Paikoff, 2010; Sneed, 2008) about dating and sex, their research is not specific to actually interviewing African American parents and teenagers and documenting their communication about these topics.

In the African American community, parents face many troubling issues with their children. Their children face risks of STI/HIV infection at alarming rates. Coupled with this risk of STI/HIV infection are the underlying issues of dating and pregnancy. These issues are especially critical for young African Americans in-light-of the epidemic of heterosexually transmitted STI/HIV and the fact that infant birth rates for African Americans and Hispanics adolescents are more than twice the infant birth rate for white adolescents (Martin, Hamilton, Osterman, Driscoll & Mathews, 2017). In addition, for African American families, the context in which parent-child sexuality communication, or the lack of communication, takes place is one of continuing racism, disproportionate incarceration, and economic struggles for people of color.

Until this past decade, very few studies centered on African American parents and the conversations with their teenagers regarding sexual relationships and the possibility of them becoming infected with an STI or HIV. In fact, a PubMed search resulted in less than 50 studies on African American parent-child sex education/STI prevention communication. Many of the studies found focused on families with youth known to be sexually active, specifically poor, inner-city youth, or only families found through STI clinics (Hutchinson, Jemmott, Jemmott, Braverman & Fong, 2003; Miller, Forehand, Kotchick, 1999). Emerging studies are discussing how African American parents communicate with their teenagers about sex education and risk of STIs (Cederbaum, Hutchinson, Duan, & Jemmott, 2013; Hutchinson, 2007; Hutchinson & Montgomery, 2007; Lee, Cintron, & Kocher, 2014; Sutton, Lasswell, Lanier & Miller, 2014). Conducting research, such as this study, that is devoted to discovering the motives for teenager's risky sexual behavior can serve as a beacon to preventive program development (DiClemente, Salazar, & Crosby, 2007). These prevention programs are important steps to decreasing financial and social costs (Cates, Herndon, Schulz & Darroch, 2004). The outcomes of this study regarding communication about sex and STIs, in African American families, can provide strategies for enhancing conversations between parents and teenagers. These strategies can then equip African American teenagers with the correct knowledge to make informed choices when it comes to sexual behavior.

Significance of Study

This study addresses African American parent-child communication regarding dating, intimacy, sexual relationships and the risk of contracting STIs, including HIV. It documents what information is known and shared about STI/HIV amongst African American families living in Syracuse, New York. The study includes qualitative interviews with 30 African American

parents and 30 separate interviews with their teenagers. The focus on content and the process of parents' communication with their children about dating, intimacy, and sexual risks imparts a keener perspective. Teenagers added to the process by confirming or denying conversations with parents and adding how the conversations influenced their decision to engage in sex or not to engage in sex. Their perspective can be the viable instrument when developing programs that enhance communication between parents and teenagers about dating, intimacy, and risk of STIs. When considering teenagers' experiences with dating, sexual relationships and exposure to STIs, it is necessary to hear from them as well as their parents. Hearing from both parent and child will allow for better assessment of the conversations.

Innovative and practical curriculum represent prevention measures that will afford many parents, physicians, community leaders, and STI/HIV organizations with effective solutions to decrease or eliminate the number of STI/HIV infections among African American men, women, and children. Effective programs and curriculum will assist African American families in making the decision to become educated about STI/HIV and to not engage in unprotected sexual activity, thus reducing the rate of new STI/HIV infections. A reduction in STI/HIV infection rates in the African American community is beneficial for both African American families and this country.

The African American community is faced with convincing adolescents to both acknowledge these STI rates and act on the knowledge by protecting themselves. Open discussions within the homes, schools, churches, and health care centers about the high incidence and prevalence of STI/HIV infection within the African American population may be the key to reducing this risk. Many studies point out that children whose parents discuss sexual health and risk prevention with them usually resist engaging in risky sexual behavior (DiClemente et al.,

2001; Karofsky, Zeng, & Kosorok, 2001; Miller, Benson, & Galbraith, 2001). Therefore, this study specifically targeted African American parents to determine their level of knowledge and the degree of communication taking place with their youth about sex and the risk of STI/HIV infection.

Research Questions

One key area of concern is the avenue in which teenagers gain knowledge about consequences of risky sexual behavior and HIV/AIDS. The primary research questions for this study provided answers for this concern (See Appendix 1).

The goals of this study are to explore:

- (1) if and how parents talked to their teenagers about dating, intimacy, and sexual risk taking in relationships;
- (2) the parents knowledge about dating and sexual activity;
- (3) what knowledge was shared with their children;
- (4) if teenagers would confirm these discussions and;
- (5) what impact parental communication about sex had on teenagers' decision to engage in sexual activity.

With these goals in mind, African American parents were interviewed about the discussions they may or may not have had with their teenagers about dating, intimacy, and sexual risk. Also examined was the role these conversations, or lack thereof, seem to play in this group of African American teenagers' decisions to become sexually active or delay sexual behavior.

Definition of Terms

Adolescent—according to the CDC (2013a) refers to persons ages 13–29. In this study will be used interchangeably with the reference *youth and teenager*.

Acquired immunodeficiency syndrome (AIDS)—the final stage of HIV infection CDC, 2013a).

African American—Americans of African descent (American Heritage Dictionary, 1997)

High Risk—Men having sex with men (MSM), intravenous drug users (IDU), partners of MSMs and IDUs. (CDC, 2013a).

Family structure—refers to single parent or two-parent headed household

Human immunodeficiency virus (HIV)—an infection that attacks the body’s immune system. It is the virus that causes AIDS. (CDC, 2013a).

Mother—primary caregiver (including biological mother, grandmother, and ‘other mother’).

Two-parent household—For this study, the term describes a household represented by a mother and father or male and female guardian.

Overview of Chapters

Chapter 1 is the introduction, which includes statement of the problem, purpose of the study, significance of the study, research questions, definition of terms, and overview of chapters. Chapter 2 presents a literature review on the importance of parent-child communication; factors influencing parents’ decisions to communicate about sex; barriers to parent-teen communication; and communication that reduces risky sexual behavior. Chapter 3 is the methodology section, which stipulates the process for obtaining permission from the

university to perform qualitative research; defines the study design (ethnographic); describes participant recruitment, eligibility, consenting procedure and retention; and states the methods used for data collection and transcription. Chapter 4 analyzes the findings from interviews of the parents and teenagers. Chapter 5 is the conclusion and recommendations for future topics of research on sex education in the African American community.

CHAPTER 2

LITERATURE REVIEW

The synthesis of relevant literature focuses on four topics: (a) Elements of Parent-Teen Communication, (b) Factors Influencing Parents' Decisions to Communicate, (c) Barriers to Parent-Teen Communication, and (d) Communication That Reduces Risky Sexual Behavior. These four topics provide information on what is known about parent communication with their teens on reducing risky sexual behavior. The general consensus among researchers is that parents do influence their children's sexual behavior through communication but lack the knowledge and skill to effectively communicate (Byers, Sears, & Weaver, 2008); Frankham, 2006; Jerman & Constantine, 2010; Lin, Chu, & Lin, 2006; Wilson, Dalberth, Koo, & Gard, 2010). Parents need support and encouragement through school and community resources to build their communication skills and knowledge.

Theme 1: Elements of Parent-Teen Communication

There has been an ongoing debate in the literature about whether or not parent-child communication has any impact on subsequent sexual behavior (Hutchinson, Jemmott, Jemmott, Braverman, and Fong, 2003). Recent research has shown, however, that parents may exert much more influence than previously thought (Beckett et al., 2010; Bennett & Dickinson, 1980; Clemmitt, 2010; Crosby, Hanson, & Rager, 2009; Eisenberg, Sieving, Bearinger, Swain, & Resnick, 2006; Lefkowitz & Stoppa, 2006; Lin, Chu, & Lin, 2006; Somers & Surmann, 2004). Evidence greatly favors parents influence on their teenager's use of protection, decision to become sexually active, and their sexual values (Malcolm, 2014). A great deal of research claims that, both general family communication and family sexual communication aide in adolescents' sexuality decisions (Coyle, Kirby, Parcel, Banspach, et al 2001).

Bronfenbrenner's Model of Parenting. Bronfenbrenner (1979) claims that environmental influences shape a child's development. Bronfenbrenner's ecological theory believes children develop primarily through interaction with their families and the context in which these interactions take place. His model supports the proximal model of parenting encompassing context, characteristics, and interactions which sets the stage for what a child is to become (Bronfenbrenner & Evans, 2000). Distal parenting styles are often the result of a parent's experiences of abuse during childhood. Thus, parents who experienced abuse in childhood model dysfunctional interactions with their children. The parent's childhood experiences shape their personalities and psychological attitudes, which determines how they treat their children (Belsky, 1984; Hurlbut, Culp, Jambunathan, & Butler, 1997; Martin & Martin, 2002). Abuse affects caregiving potential for parents. Children from these households display disruptive and dysfunctional behaviors (Vondra & Belsky, 1993). In proximal parenting, some contend that abuse affects self-esteem (Belsky, 1984; Hurlbut, et al., 1997; Martin & Martin, 2002; Meyers & Battistoni, 2003). For instance, low self-esteem can lead to drug abuse which provides a pathway to participate in risky behavior (Meyers & Battistoni, 2003). For too many of teenagers it could mean risky sexual behavior. Furthermore, teenage pregnancy has influence based in self-esteem (Herrenkohl, Herrenkohl, Egolf, & Russo, 1998). Generally, teenagers with low self-esteem incorporate physical punishment with their children and do not possess great knowledge of children's developmental milestones (Meyers & Ballistoni, 2003). It has been documented that parents with low self-esteem lack the ability to properly care for their children's needs (Belsky, 1984). Interestingly, a parent's history of sexual abuse has been found to render them more empathetic to parent-child roles (Haskett, Johnson, & Miller (1994).

Bandura's Social Cognitive Theory. Some point out that, the importance of parents in communicating information and attitudes to teens about sexual health is rooted in Bandura's (1986) Social Cognitive Theory of Learning (Guilamo-Ramos, Jaccard, Dittus, & Collins, 2008). Bandura taught that children learn by modeling adults, particularly parents and other significant models in their lives, and having conversations with these role models. Most researchers agree with the principles of the Social Cognitive Theory of Learning as defined by Bandura (1986). Children engage in behavior of which they have knowledge, and feel skillful and confident in (Guilamo-Ramos et al., 2008). As such, researchers have focused on identifying the kind of knowledge given to children by their parents and significant others and the extent to which parents have engaged them in conversation.

Mother-daughter communication. Pluhar and Kuriloff (2004), for example, suggest that research on the process of African American mother-daughter sexuality communication shows that the parent-child bond, parental psychological control, and parent-child communication work together to shape a youth's sexual behavior. Pluhar identified the two processes of affective and stylistic communication. Affective communication includes anger, comfort, connection, empathy, and silence. Stylistic communication includes interactive versus didactic, and uses a variety of persuasive techniques like body language and the setting in which the communication takes place (i.e., car). Pluhar further showed that the impact of sexual communication is linked to the degree of connectedness or disconnectedness between mother and daughter. The more connected mothers and daughters are, the greater the impact of their sexuality conversations. The less connected they are, the weaker the impact of any sexuality conversations between them.

Parents as primary sexuality educators. Wycoff and associates' (2008) research of African American parents and preadolescent patterns of sexual communication identified parents to be the primary and most important sex educators in children's lives, pointing out that parents influence children's decision about sexual behavior more than anyone else. They suggest that parents are well suited for this position because they can talk to their children before they become interested in sexual intercourse or before they initiate sexual activity. Also, there can be continuous sexuality conversations between parent and teen, and teen's questions can be answered immediately. During these conversations, parents can effectively impart their values, beliefs, and knowledge about sexual behavior and build their children's confidence. Wycoff et al. contend that sexual prevention communication is most effective when discussed before sexual debut.

Effective communication. There is some agreement among researchers that parents are important in communicating with their children about sexual health, if the communication is effective. Specifically, their contention is that effective parent-child communication is paramount to adolescent development of sound judgment in relation to sexual behavior, and that parents can help to reduce risky sexual behavior among their children if they use effective communication strategies (Cederbaum, 2012; DiIorio, Pluhar, & Belcher, 2003; Wycoff et al., 2008). Not all researchers agree, however, about what is meant by effective communication.

Knowledge and skill based. Effective parent-child communication has been defined as knowledge-based and skill-based communication that is conversational and frequent; establishing parental beliefs and values positively influences teenagers to behave in a sexually healthy and responsible manner (Cederbaum, 2012).

Father involvement. Other researchers (DiIorio et al., 2003; Wycoff et al., 2008) have defined it as getting fathers involved, having frequent conversations about prevention and morality, not just conversations about puberty and reproduction, but utilizing established community programs has shown to be effective in helping avoid the risk of STI infection. Contrary to some researchers, Roopnarine and Hossain (2013) found that African American and Hispanic fathers engage with their children comparably to fathers of European descent. When discussing very young children, these fathers have higher levels of positive interaction than European American fathers, and showed strong desire to be involved with their children. Establishing such bonds at a young age provides a foundation for parent-teen communication in general which can transition into parent-teen sexuality communication.

Open communication. Effective communication has also been defined as keeping the lines of communication open (DiIorio et al., 2003; Wycoff et al., 2008). In order for parents to effectively communicate their beliefs and values and positively influence teenagers to behave in a sexually healthy and responsible manner, both open communication and parental responsiveness must occur. This open communication implies that effective parent-child communication about adolescent sexual behavior is based on the parent's actual conversations and attitudes about sex.

Possessing affect. Effective communication has also been defined as parents having affect in the conversation, such as a smile or look of concern, which in turn could stimulate the child to open up and talk about what's going on in his or her life including conversation on specific sexuality topics (Pluhar and Kuriloff, 2004). Most parents consider conversations with their children about puberty, menstruation, and dating content as having had a conversation with them about sexuality. Their children may not recognize this as providing information about what

sex is or how to avoid negative consequences of sexual intercourse. What really matters is that parents having a conversation about sexuality with teens and employing affective qualities in the conversation that keep the conversation going or that disconnect it (Pluhar and Kuriloff, 2004). Findings from the Pluhar and Kuriloff (2004) study of actual videotaped conversations on sexuality between mother-daughter pairs showed that what is important in the parent-child conversation is not just content but also the process of parent-child communication. Talk is meaningless outside the affective context of mother-daughter relationships. Affective qualities of anger, comfort, empathy, and silence in the conversation between mothers and daughters were found to play a major role in connection and disconnection of conversation.

Aspy and associates' (2007) findings show that youth are much less likely to have initiated sexual intercourse if their parents have taught them to say NO, set clear rules, and talked about what is right or wrong about delaying sexual activity. These researchers studied 1,083 youth aged 13 to 17 from an inner-city area of two cities in Oklahoma to determine the role of parent communication and instruction in the youth's sexual behavior. Interviews and questionnaires were used to measure the youth's risky behaviors. If youth were sexually active, they were more likely to use birth control if taught at home about delaying sexual activity and about birth control. Additionally, youth from households with lower annual incomes and who had been taught how to say no were less likely to report ever being sexually active. Sexually active youth were more likely to have only one sexual partner if their parents had communicated their love and high aspirations for them.

Hutchinson et al., (2003) found that an important determinant of the use of condoms is parent communication with daughters about unprotected sexual intercourse. He and colleagues studied 219 sexually experienced 12- to 19- year-olds from a Philadelphia inner-city clinic

setting. Mother-daughter sexual communication and selected sexual risky behaviors were examined among this group. According to Hutchinson et al. (2003), emerging research has shown parents to exert more influence than previously thought on teen sexual behavior. Parent-child communication appears effective in the delay of sexual activity. For example, Hutchinson et al. (2003) report fewer episodes of sexual intercourse and unprotected intercourse with higher levels of mother-daughter sexual risk communication. Specifically, parents of inner-city adolescent females were able to influence the sexual attitudes and behaviors of their adolescent children.

In toto, effective parent-child communication is open, knowledge- and skills-based, possessing positive affect and topic specific. While most parents will typically feel knowledgeable about puberty, reproduction, what sex is, and will have discussions with their teens on these topics, teens will be given more detailed information on sexual health, especially information about prevention if the parent has experienced AIDS or a STI (Cederbaum, 2012). Overall, preadolescence may be the prime time for parents to engage children in sexuality discussions. And, as Wycoff et al. (2008) contend, encouragement and support builds parents' influential role as health educators while children are preadolescent and receptive to parental communication.

Theme 2: Factors Influencing Parents' Decisions to Communicate

Factors this researcher will highlight regarding parents' decisions to communicate about sex include social norms, religion and moral standards, and teenagers' dating relationships.

Social norms. Social norms can affect parents' decisions to communicate with their children about sex. For instance, Askelson et al. (2011) found that mothers' intentions to discuss sexuality with daughters were dependent on the mothers' attitudes and the age at which they

planned to have their daughters vaccinated. Askelson (2011) conducted a study on mothers of daughters aged 9 to 15 years that examined the influence the HPV vaccination had on the mothers' intention to talk to their daughters about sex. The Theory of Planned Behavior was used as a framework. Askelson determined that parents talk to their children about sex when they are willing to comply with intent to vaccinate (HPV vaccination), have a planned age to have their daughters vaccinated, when they have a positive attitude towards talking about sex, and when they believe in their ability to talk about sex. Askelson's study is important because it is the first study to highlight teachable situations parents can take advantage of to communicate with their teenagers about sex.

Another factor influencing parental sexual communication is their history of receiving sexuality information from their parents. Byers, Sears, & Weaver (2008) found that parents are likely to talk about sex with their children if they have received health education from their own parents and if they feel knowledgeable and satisfied with the education they received from their parents (not if they wished their parents had talked to them more). For parents who feel providing knowledge/information about sexual topics is important, their comfort level in providing sexual health is higher, and they perceive comprehensive school-based sexual health education as important (Byers et al., 2008). These parents are more likely to provide better quality sexual health education to their children and encourage more questions. Findings from Byers's (2008) study pointed out that even though parents with "better" sexual health education from their own parents were somewhat more successful in discussing biological topics, they had difficulty discussing more sensitive topics such as sexual coercion and assault, and sexually transmitted infections. The age level of child or grade level influenced the depth in which

parents discussed these subjects with their children. Parents talked in greater depth to children in higher grades who were older.

Lehr, Demi, DiIorio, and Facticeau (2005) found that some fathers have been prompted by male pubertal development to begin educating their sons about what sex is and how to avoid negative consequences (i.e., contracting diseases, pregnancy, and the responsibility of fatherhood). Mainly, fathers who are less educated, who have general open communication with the family, and whose fathers talked to them about sexual topics are most likely to talk to their children about sexual topics (Lehr et al., 2005). There appears to be a connection between the age fathers were educated about sexuality by their fathers and the age present day fathers discuss sexuality with their sons (El-Shaieb & Wurtele, 2009).

Religion and morality. Results from the McCree, Wingood, DiClemente, Davies, and Harrington (2003) study show a strong positive association of engagement in religious activities and ability to negotiate safer sex for African American female adolescents. African Americans are reported to be the most religious people in the industrialized world. The religious beliefs of this population are strong influences and have been shown to serve as a protector against risky behaviors, such as sexual initiation (McCree et al., 2003). Additional studies concur with McCree and associates' finding that religious belief and practice links with a delay in sexual activity, decreased frequency of sexual activity, and a lower number of sexual partners (Gold, Sheftel, Chiappetta, Young, Zuchoff, DiClemente & Primack, 2010; Manlove, Terry-Humen, Ikramullah, & Moore, 2006). Parents' religious beliefs and moral standards can have an effect on the initiation of sexuality discussions with their children.

Regnerus's (2005) study found that African American parents who consider themselves religious report communicating more with their children about birth control and sex than any

other races. On the subject of sexual morality, it was found that African Americans and Mormons discuss this topic with equal frequency with their children. However, Regnerus's (2005) study concludes that religious parents who say they discuss sexuality with their children are actually discussing the morality of sexual behavior. Sinha, Cnaan, and Gelles (2007) point out those individuals who are connected to a faith community exhibit more positive social behavior.

Weekly church attendance is rated higher among African American youth than Caucasian youth and higher among girls than boys (McCree et al., 2003; Sinha et al., 2007). Religion and prayer have a higher level of influence on African American youth than Caucasian or Latino youth (Gold et al., 2010; Manlove et al., 2006; McCree et al., 2003). Church attendance and religious beliefs are introduced early in the lives of African American adolescents by their parents (Manlove et al., 2006). It has been documented that affiliation with a church and participation in church activities have positively affected a teenager's choices in resisting the temptation to become sexually involved (Gold et al., 2010; Manlove et al., 2006). The religiosity and spirituality of African American youth are associated with their choices of healthy behaviors, including lower levels of sexual intercourse (Rasic, Kisely, & Langille, 2011; Rew & Wong, 2006). In toto, findings from these studies suggest religious involvement, for African American youth, is a protective factor against early and risky sexual behavior (Gold et al., 2010; Manlove et al., 2006; McCree et al., 2003; Rew & Wong, 2006; Sinha et al., 2007).

Role of African American church. Therefore, the church must become more aware of the role they play in the delay of teenage sexual behavior and take more of an active role in the African American community in influencing delay of teenage sexual behavior as well as prevention of STIs and pregnancy (Stewart, Rogers, Bellinger, & Thompson, 2016). Promoting

awareness, prevention, and testing is essential in the battle to reduce STIs and rid the African American community of high rates of STIs and unplanned pregnancies. Many African American churches face the challenges of overcoming barriers and the traditional conservative mindset of abstinence, religious norms, and stigma related to contracting certain STIs. The primary stigma attached STI is HIV. An HIV diagnosis in males is commonly related to homosexuality (Beadle-Holder, 2011; Bluthenthal, Palar, Mendel, Kanouse, Corbin, & Derose, 2012; Coyne-Beasley & Schoenbach, 2000; McKoy & Petersen, 2006; McNeal & Perkins, 2007).

There is evidence that some pastors in the African American community refuse to acknowledge that there are some in the community who are at high risk for STIs (Baldwin, Daley, Brown, August, Webb, Stern, & Devieux, 2008; Eke, Wilkes, & Gaither, 2010; McKoy & Petersen, 2006). On the other hand, churches that have overcome these barriers have major collaborations and support systems throughout the community and their congregation. These churches have recognized that in order to provide intervention efforts there must be members of the congregation who are willing to organize and lead sexuality discussions with parents and teenagers, and prevention and testing workshops. To begin with, the pastor and members who are health professionals must acknowledge and support the need. Secondly, they must work together to develop and implement interventions that will help reduce the rate of teenage pregnancies and STIs in the African American community (Brown & Williams, 2006; Coyne-Beasley & Schoenbach, 2000; Harris, 2010; Khosrovani, Poudeh & Parks-Yancy, 2008; McNeal & Perkins, 2007; Stewart & Dancy, 2012).

Teen dating. The conceptual framework for parental management of romantic relationships Madsen used found that parents manage dating and peer relationships through the four roles of designer, mediator, supervisor, and consultant. According to Madsen (2008),

parents design the environment from which adolescents choose a peer by selecting the neighborhood in which the family resides. Mediation is handled when parents suggest activities for their children to become involved in or by providing transportation for their dates. Madsen (2008) states that as supervisors, parents provide rules aimed at eliminating undesirable activities or peer contact. In the consulting role, parents provide advice to their adolescents when they face problems with their peers or date.

Findings from Madsen's (2008) study suggest that parental management of peer relationships is prompted by the parent's goals and beliefs, as well as perceptions of their children and their children's friends. Further findings suggested that dating rules were usually set by mothers and used more often with daughters than with sons. The dating rules for daughters were more supervisory in nature. Madsen (2008) found that supervisory roles enable parents to gain access to their child's dating activities, prohibit undesirable activities, and guide teenagers to desirable behaviors. Madsen (2008) proposed that communication of rules is key in producing healthy outcomes, and parents who clearly state dating rules better manage their teenagers' dating habits and decisions.

Three dimensions of sexuality. Researchers concur that discussing sexuality can be a complicated matter (Byers et al., 2008), especially as children begin to date and experience puberty (Byers and Sears, 2012). Kar, Choudry & Singh (2015) posit that "puberty is a major landmark in the development of sexuality" (p. 70). Physical and hormonal changes occur in both males and females during puberty. Males experience enlarging genitals, growth of beards and mustaches, and a more masculine physique. Females develop breasts, begin menstruating, and their physique appears more feminine (Kar et al., 2015). These hormonal changes directly impact teenager's interest in the opposite sex or teenagers becoming interested in sexual

behavior. Influences of human sexuality include “physical appearance, psychological and social factors, cultural norms, and past experiences” (Brown, 2000).

Biological aspect. One must consider the three dimensions of sexuality when approaching teenagers for sexuality discussions. These dimensions include biological, sociocultural, and psychological aspects. Biologically, during mid to late adolescence, partnered sexual behaviors such as “kissing, breast and genital touching, partnered masturbation, fellatio, cunnilingus, penile-vaginal intercourse, and penile-anal intercourse” become prominent (Fortenberry, 2013). Also, other sexual behaviors like phone sex via electronic media have emerged (Fortenberry, 2013; Harris, 2010). This broad access through television and the internet exposes adolescents to sexually content that influences their perception about sex and relationships (Kanuga & Rosenfeld, 2004).

It is important to acknowledge that pain can be experienced initially and throughout sexual experiences (Landry & Bergeron, 2011). This painful experience for females does not prevent continuation of coitus because in some ways it confirms their womanhood and fulfills partner’s sexual need (Jones & Furman, 2011; Meier & Allen, 2009). Adolescent males are more prone than adolescent females to identify sex as pleasurable (Latka, Kapadia, & Fortin, 2008). Additionally, females are trained to discount their own bodily experiences of sexual desire because they lack the cultural basis to acknowledge and meaningfully interpret such feelings and experiences (Tolman & Diamond, 2001).

Sociocultural aspect. Based on research by Shoveller, Johnson, Langille, & Mitchell (2004), the sociocultural aspect highlights that sexual behavior patterns are perceived as “acceptable” or “unacceptable” by family, community, and society. Parents’ attitude toward sexuality, their parenting style, peer relationship and cultural influences play a significant role in

an adolescent's sexual development (Kar et al., 2015). In most communities, a young female is viewed as promiscuous if she's sexually active with more than one male. On the other hand, a young male is considered "a man" if sexually involved with more than one female. Shoveller et al., (2004) further explain that depending on the family's history and status, some teens maybe unable to escape these perceptions. In this manner, a young person's family status significantly impacts their sexual experiences.

Psychological aspect. The psychological aspect of sexuality points out that, sexual relationships are a dyadic process. A person's STI risk level can be determined by the context of their relationship with another person. For example, a partner maybe more inclined to practice self-protection when sexually involved with someone known to be at risk for an STI (Harman, O'Grady, & Wilson, 2009; Ellen, Adler, Gurvey, Millstein, & Tschann, 2002; Reisen & Poppen, 1999). In other words, usually, partners give more thought to condom use when aware of their partner's previous STI risk. However, this may not be the case for young ladies in relationships where they feel intimidated by their partner and give into participating in unprotected sex against their will (Lane, 2008). Therefore, partner perception has great impact on sexual behavior in a relationship.

Gender and power. On the other hand, misperception can place either partner at increased risk for and STI (Drumright, Gorbach, & Holmes, 2004). Meaning, sexual partners considered to be in a committed relationship are less likely to use condoms than sexual partners considered to be in a casual relationship (Macaluso, Demand, Artz, & Hook, 2000; Senn, Scott-Sheldon, & Carey, 2014). Should one partner engage in condomless sex outside of committed relationship the risk of STIs increase (Cornelius & Kershaw, 2017; Senn, Carey, Venable, Coury-Doniger, & Urban, 2009). For adolescents, lack of satisfaction and relationship instability

may contribute to an increase in sexual partners leading to sexual behavior which increases STI risk (Kershaw, 2010, 2013). In terms of gender and power, females tend to communicate about sexual risk (Albritton, Fletcher, Diviney, Gordon, Magriples, & Kershaw, 2014) and males tend to discuss sexual preferences or desires (Kershaw, Arnold, Gordon, Magriples, & Niccolai, 2012). In summary, “family and society’s attitude, as well as cultural influences on changes during puberty play a major role in an adolescent’s sexual behavior after puberty” (Kar et al., 2015).

Socialization. There is limited research on how parents socialize their children to form romantic relationships; however, parenting adolescents who have begun dating is challenging (Madsen, 2008). Madsen (2008) examined a group of 165 Caucasian parents and their romantically involved teenagers to determine how parents set dating rules and the degree of control the rules provided. The degree of control was coded as supervision, restriction, and prescription. Reportedly, most parents employed dating rules, but the rules varied by parents’ and teens’ gender. Mothers set more rules than fathers, and rules for daughters were more restrictive than rules for sons. Madsen (2008) determined that at least 70% of individuals begin dating as adolescents while living with their parents.

Other researchers agree that parents who communicate clearly and concisely to children about their values, expectations, and rules regarding dating and sexual activity have children who either delay sex initiation or who take precautions to avoid negative consequences of sexual intercourse (Aspy et al., 2007; Usher-Seriki, Bynum, & Callands, 2008). Parents can influence partner selection, dating values, and relationship behavior norms (Miller et al., 2009; Teitelman, Ratcliffe, & Cederbaum, 2008).

Theme 3: Barriers to Parent-Child Communication

Pluhar and Kuriloff (2004) present that a wide range of affective factors influencing parent-child communication about sex. Most often mentioned are affective dimensions such as feelings of embarrassment and discomfort during these discussions. In addition, some teenagers do not feel parents trust them, which evoke feelings of anger from the adolescents. Compounded with this lack of trust, adolescents can be faced with sexual pressure from peers. Some youth may be unequipped to resist this sexual pressure and feel uncomfortable talking to parents about it.

Michigan Study. Along similar lines, the 1995 Detroit Area Study examined social influences and their effect on respondent's mental health and personal life (Watkins, Pittman, & Walsh, 2013). The study found that multiple demands on parent's time, attention, and finances can create an obstacle to them making life-style changes. This could include making a conscious effort to discuss sexuality with their teenagers. Constant work overload and conflicts at home can produce parental emotional distress (Paden & Buehler, 1995) leading to negative parent-child interactions and child behavior problems (Bowen, 1998). The more children are exposed to parent's conflicts the higher their risk for problematic behavior (Cavanaugh & Huston, 2006). Researchers tend to find this more often in African American families (Nievar & Luster, 2006). Studies found that children of single female-headed households are at higher risk for conduct disorders and depression (Mowbray, Bybee, Oyserman, Allen-Meares, & Hart-Johnson, 2004; Mufson, Normura & Warner, 2002).

Structural violence. The overarching barrier that African American families face is structural violence which has been defined as "preventable harm or structurally built-in damage through inequalities of power and economic disadvantage" (Keefe, Lane, Rubenstein, Carter,

Bryant, & Thomas, 2017). These policies are all encompassing through local, state, and national policies discouraging father involvement (Keefe, Lane, Rubenstein, Carter, Bryant, & Thomas, 2017; Lu, Jones, Bond, Wright, Pupmpuang, Maidenberg, Jones, Garfield, & Rowley, 2010; McLanahan, 2009). Many argue that these policies favor disproportionate incarceration rates of African Americans and have direct effect on the high unemployment rates of African Americans (Lane, Rubenstein, Webster, Cibula, Rosenthal, & Dowdell, 2004; Lu, et al., 2010).

Implementation of these policies result in African Americans living in disease-ridden environments (Lane, et al., 2004) and prevent low-income families from having access to adequate health care. Inadequate health care causes disproportionate rates in certain illnesses and death. In this context, one can make argument for the disproportionate STI rates among African American teenagers.

Embarrassment, discomfort, & anger. Byers et al. (2008) found that when parents perceive they lack sexuality knowledge they have reservations about discussing sex topics for fear of being asked questions for which they do not have answers. Byers's (2008) study of close to 4,000 parents' self-reported information showed that parents fail to talk to their children in detail if they have concerns about their inadequate knowledge, their comfort level for these discussions, and because they have negative attitudes towards comprehensive sexual health education. Other reasons parents are hesitant to discuss sexual topics with children are, if parents feel uncomfortable talking to youth; parents' belief that talking about sex encourages sexual behavior; and the perceived social norm that to discuss sexuality with youth is inappropriate in the eyes of someone whose opinion the parent respects i.e., a close friend or clergy person (Byers & Sears, 2012).

Also, some parents appear to accept adolescent sexual intercourse as inevitable and are unable to perceive their influence in adolescents' decisions regarding sexual behavior (DiIorio, Hockenberry-Eaton, Maibach, Rivero & Miller, 1996). DiIorio suggested that embarrassment or discomfort when discussing sensitive sexuality topics, and being skeptical about the type of information to provide and when to provide it are added hindrances for some parents. DiIorio contends that these parents could be overwhelmed by the lack of energy or time needed to monitor children's behavior. Another challenge for parents can be a lack of resources and a lack of direction as to how to provide alternative choices that divert involvement in sexual activity (DiIorio et al., 1996).

Anger has been acknowledged as a deterrent for both parties; most importantly, for adolescents, the perception that their parents make assumptions or unfounded judgments regarding their sexual behavior prevents communication. Adolescents prefer that their parents trust them and are open to talking to them about sex without thinking they are sexually active.

Comfort levels. Generally, parents in this study varied in comfort level with talking to their teenagers about sexuality. Some parents had the ability to comfortably engage in discussion with their teenagers because it had become an ongoing topic while others experienced less comfort due to their perception of lacking knowledge and skills to begin and continue the conversation. Still, one parent was more comfortable avoiding any face-to-face conversations with her teenagers and preferred scheduling appointments for them to be informed by health personnel at community organizations. Many of the teenagers in this study displayed discomfort initially by shifting in their seats, smiling and giggling a lot, and shrugging their shoulders. This display often dwindled after the second lead question. Thus, it appeared that the longer they were engaged in conversation about dating, sex, and risk of STIs, the comfort level increased.

For this population, more parents appeared uncomfortable much longer than most of the teenagers.

Teen self-efficacy and peer pressure. Even though Hutchinson et al., (2003) research on mother-daughter communication showed that higher levels of mother-daughter communication are associated with fewer episodes of sexual intercourse, there was evidence that condom use self-efficacy of the daughter mediated the communication relationship. Hutchinson et al. (2003) report that self-efficacy is one of the most important determinants of condom use intentions and use. Sexually active teenagers who lack the confidence to negotiate condom use are unlikely to propose condom use with partners. These youth are more vulnerable to being coerced into unprotected sexual intercourse which makes them susceptible to becoming infected with an STI or experiencing an unplanned pregnancy.

Often this pressure involves the coercion to participate in sexual activity without the use of condoms (Teitelman et al., 2008). Some females have been known to experience violence in the relationship when they do not sexually perform as their mate wishes (Teitelman et al., 2008). Sexual pressure is experienced by most teens and usually it is the male partner who imparts the pressure and persuades the female to give in to his wishes (Teitelman et al., 2008). African American females living in lower-income communities are reported to have higher incidences of violent relationships and some feel they have no recourse except to participate in unwanted and unprotected sex (Teitelman et al., 2008).

Epstein and Ward (2008), report that many African American males are receiving most of their information on sex from peers and the media. These researchers examined boys' conversations with peers and found that most of the information shared between them is about dating, sexual behaviors, and feelings. Researchers grant that a teenager's peers can have

influence over when and how sexual intercourse occurs (Boyas, Stauss, & Murphy-Erby, 2012). Sexually active teenagers can influence peers to follow their example. Unfortunately, their sexual practices are often risky (Boyas et al., 2012).

Akers et al. (2011) conducted a study on parent-adolescent communication about sex where the issue of intimate partner violence emerged out of the data. Akers found that ten to thirty percent of high school students report experiencing some type of physical, sexual, or emotional abuse from dating partners. The most affected age group is young adult females from 16 to 24 years of age. Akers concludes that this level of victimization increases the chances of sexually risky behaviors, STI/HIV infection, and pregnancy.

Theme 4: Communication That Reduces Risky Sexual Behavior

Researchers suggest that parents can help to reduce risky sexual behavior of their children if they use effective communication strategies. Examples of these strategies are having open and frequent conversations about prevention and morality, not just conversations about puberty and reproduction, getting fathers more involved in discussing sexual topics, continuing mother-daughter sexual communication, and utilizing established programs that have shown to help parents effectively communicate with adolescents about sex, dating relationships, and avoiding the risk of STI infection.

Interactive communication. In open communication there is dialogue between parent and child that allows them both to state concerns and to ask questions about sex in a comfortable, less embarrassing and negative environment (Boyas et al., 2012). Teenagers whose parents have open communication with them about sexual topics are more apt to refrain from risky sexual behavior (Lagus, Bernat, Bearinger, Resnick, & Eisenberg, 2011; Teitelman et al., 2008) when they perceive their parents as supportive and knowledgeable about sexuality (Miller et al., 2009).

Parents who engage in open communication with their children rear children who are well informed about sexuality.

Open communication is interactive and allows the children to express their feelings, thoughts, and questions without the parent being judgmental or controlling the conversation. Information discussed during these conversations can then be internalized by the children. Consequently, children who accept their parents' actions as loving and protective, and are made to feel comfortable, are more inclined to engage in communication with them about sex-related topics (Pluhar & Kuriloff, 2004; Regnerus, 2005; Reisch, Anderson & Krueger, 2006). The messages parents convey can impart family values that enable teenagers to tailor sexual activity and establish less risky sexual behavior once sex is initiated (Teitelman et al., 2008; Wycoff et al., 2008). This connected parent-child relationship supports an open communication style where the child is more prone to disclose information. In essence, a trusting relationship is built between parent and child.

Mother-daughter communication. Mothers are found to be the primary sexuality educators for both genders but more often with daughters (DiIorio, Kelley & Hockenberry-Eaton, 1999; Rosenthal, Senserrick, & Feldman, 2001; Raffaelli, Bogenschneider, & Flood, 1998). Researchers consistently indicate that mother-daughter communication about sexual topics result in more daughters delaying sex initiation or more condom use once they become sexually active (Hutchinson, 2002; Hutchinson et al., 2003). African American mothers are more likely than African American fathers to discuss sexuality with teenagers (Bennett & Dickinson, 1980; DiIorio et al., 2003; Rosenthal & Feldman, 1999; Usher-Seriki et al., 2008). Mothers who actively discuss sexuality are more knowledgeable about sexuality, more comfortable discussing sex, and possess more self-efficacy than mothers who are hesitant about

discussing sexuality (Byers et al., 2008; Guilamo-Ramos et al., 2008; Pluhar and Kuriloff, 2008). African American mothers appear more comfortable and confident than mothers of other races discussing sex related topics (Wycoff et al., 2008). However, Wycoff et al., (2008) posits that most of these discussions center on puberty, menstruation, reproduction, and dating, followed by what sex is and abstinence, with the least discussed topic being sexual risk prevention i.e., condoms and HIV.

DiIorio (1996) point out that parents' message content and style differed between sons and daughters. Messages to daughters focus on setting limits and are more protective in nature (Wycoff et al., 2008). Several studies positively associate mother-daughter communication about sex and STIs and the reduction in daughters' sexual risk behaviors (Aspy et al., 2007; Hutchinson, 2002; Teitelman et al., 2008). Other studies described mother-daughter communication as mutual and expressive, and mother-son communication as more directive with sons being more withdrawn (Pluhar & Kuriloff, 2004). One study found that the more sexual information received by teenagers from their parents, the more prone they were to become sexually active (Lehr et al., 2005). One constant, however, is that teen's delay sexual debut if they perceive that their parents disapprove of sexual behavior (Harris, Sutherland & Hutchinson, 2013). In toto, though research has produced mixed results, more studies agree that parent-child communication about sexual topics delays the onset of sexual activity.

Involving fathers. Prevention efforts for STI/HIV have not been as successful in the African American community as in some other communities such as Caucasian communities (El-Sadr, Mayer & Hodder, 2010). Prevention of sexual transmission of HIV has proven to be most difficult. Several factors to be considered when determining the reason these prevention efforts appear less effective, include limited federal resources, stigma and fear of testing and diagnosis,

and higher incarceration rates of African American males (Baillargeon, Giordano, Rich, Wu, Wells, Pollock, & Paar, 2009).

For instance, a high rate of African American male incarceration causes a gender imbalance in the community (Weisz, Lozyniak, Lane, Silverman, Koumans, DeMott, & Aubry, 2011; Lane, Keefe, Rubenstein, Levandowski, Freedman, Rosenthal, Cibula, & Czerwinski, 2004; Lane, Rubenstein, Keefe, Webster, Rosenthal, Cibula, & Dowdell, 2004). This imbalance creates a smaller pool of African American men available as sexual partners. The missing male partners is the key risk factor for the increase in single mothers. This unbalanced ratio provides the opportunity for an HIV-infected male to be sexually involved with several women. In some cases, these sexually-available partners may be sexually active with another male or several women. This behavior increases the likelihood of STI/HIV transmission throughout the community (Adimora, Schoenbach, & Doherty, 2006). Also, many of the men become infected with HIV while incarcerated, which is a key risk factor for the HIV epidemic among women of color (Weisz, Lozyniak, Lane et al., 2011; Lane, Keefe, Rubenstein, et al., 2004). High rates of African American male incarceration are not only limited to adults but are inclusive of teenagers as well.

DiIorio et al. (2003) found that only 13 of the 95 studies conducted between the years 1980–2002 related to parent-child sexuality communication were conducted with African American families. Glenn et al. (2008) studied a sample of 70 African American fathers derived from a southern church and the fathers' influence on their sons' attitudes and ability to be abstinent or practice safer sex. Glenn et al.'s (2008) study found that sons displaying strong confidence and healthy sexual behavior had fathers who communicated with them about sex and HIV prevention. The results of this study also found that there is a relationship between the

son's perception of his father's attitude about HIV prevention and the son's self-efficacy for abstinence. If the son perceived his father to have a positive attitude about HIV prevention and possess high sexual standards, the son's level of confidence was heightened. African American families continue to be understudied and African American fathers, in particular, have been undervalued in many of those studies (Glenn et al., 2008).

However, fathers are extremely concerned about their children's health and play a crucial role in their children's ability to abstain from sexual intercourse and resist sexual pressure (Glenn et al., 2008). Generally, fathers are reported to have fewer conversations with their children about sex than mothers (DiIorio et al., 1999). The conversations that are held by fathers are commonly between father and son (Glenn et al., 2008). Additionally, fathers should express their insight on healthy and risky sexual activity, and fathers can have confidence in their children's ability to refrain from behavior that can lead to STI and HIV infections (Glenn et al., 2008). Other studies found fathers to be more comfortable discussing male puberty and condom use with sons (DiIorio et al., 1999; Hutchinson et al., 2003; Wilson, Dalberth, & Koo, 2010). Wycoff et al. (2008) suggest that fathers may not feel comfortable or knowledgeable enough to discuss sexuality with daughters. The implication is that fathers better understand and are more familiar with these sexuality topics than they are with discussing menstruation with daughters.

Wilson et al. (2010) contend that fathers are aware that sexuality is a normal part of a child's development, and the fathers they studied believe that to discourage teenagers from having sex only makes them more curious about it. Wilson et al. (2010) found fathers to be more suited for enlightening daughters about how boys think and warning them about sexual predators. Fathers were found to be more permissive with sons and more restrictive and protective with daughters. In addition, fathers viewed emphasizing life goals and discipline as

more of their responsibility (Wilson et al., 2010). A study of African American adolescents aged 14 to 17 years found there were lower incidents of sexual initiation when African American fathers disapproved of teenage sexual activity (Ohalete, 2007). Also, according to Teitelman et al. (2008), girls whose fathers informed them about sexual pressure were five times more likely to use condoms during sexual intercourse.

Wilson et al. (2010) report that children who have a close relationship with their parents, especially fathers or father figures, are less inclined to become sexually active during adolescence. However, a study conducted by Menning, Holtzman, and Kapinus (2007) found close relationships with parents produced less inclination for *sons* to become sexually active, but not for both genders. Menning et al.'s (2007) conclusion was based on data provided by the National Longitudinal Study of Adolescent Health surveying seventh through 12th graders in the early 1990s.

A contrasting study on low-income African American adolescent males found those living in homes where the father was absent displayed more promiscuous behavior and lack of attachment to sexual partners (Harris, 2013). Furthermore, adolescents who lacked paternal attachment displayed an attitude of toughness and focused on quantity of sexual conquests to define masculinity (Harris, 2013).

The implication from these studies is that the father's presence in the home and communication with their sons about sex and STI prevention builds a son's confidence and supports his development of a healthy attitude about sexual behavior. These studies support the fact that father's involvement as sexuality educators matters in the lives of adolescents and makes a difference in the timing of adolescents' sexual debut.

Abstinence only vs. comprehensive sex education. The incidence of STIs among our youth have caused ongoing debate between proponents of abstinence only and comprehensive sex education programs. Among others, researchers Kirby (2008) and Eisenberg, Bernat, Bearinger, and Resnick (2008) explored both the abstinence only and the comprehensive sex education programs. In 2008, Kirby conducted a review of 56 studies that assessed abstinence and comprehensive sex curricula and their impact on adolescents' sexual behavior. Results of his review favored comprehensive sex education programs over abstinence only programs. Eisenberg and associates (2008) examined parents' perceptions of school involvement in sexual education.

Kirby's (2008) review of 56 abstinence programs focused on earlier studies using the "Teens In Control," "My Choice, My Future," and "Heritage Keepers Life Skills Education" curricula which were used in 2007 by Trenholm and Clark. Kirby (2008) deemed these studies important because they evaluated the impact of four different abstinence programs and tracked youth for four to six years. Both studies found that abstinence only curricula "had no effect on initiation of sex, age at initiation of sex, abstinence in the previous 12 months, number of sexual partners, or condom use during sex" (p. 20). An earlier study conducted by Kirby in 1997. evaluated the impact of the "Postponing Sexual Involvement" curriculum which found no positive effect on youth's sexual behavior. The overall evidence from Kirby's (2008) studies of a variety of curriculum-based sex education programs strongly favored comprehensive sex education programs and their ability to "delay adolescents' initiation of sex, reduce the frequency of sex, reduce the number of partners and increase condom or contraceptive use" (p. 24).

Additionally, Eisenberg and associates (2008) conducted a telephone survey study with 1,605 mostly Caucasian parents to determine their attitude toward sexuality education being

taught in the schools. These researchers discovered that a majority of parents is in favor of schools teaching abstinence and use of contraceptives to students as early as middle school. Also, Eisenberg et al. (2008) found that on average many students receive fewer than 20 hours of sexuality education in school, suggesting that many areas of sexuality are not covered in sufficient detail. Eisenberg et al. (2008) contend that a more effective approach to educating youth and protecting them from STIs and pregnancy is a comprehensive sexuality education program that includes information about abstinence and contraception. Santelli et al. (2006) assert that providing abstinence as the only option for adolescents is unethical and scientifically problematic. He adds that few Americans wait until marriage to become sexually active and most begin sexual activity in their adolescent years.

In contrast, proponents for comprehensive sex education programs emphasize abstinence and condom/contraceptive use for sexually active youth to avoid STIs and pregnancy. Their claim is that providing information on abstinence and condom use is not confusing to youth, but more realistic for and acceptable by them (Kirby, 2008).

Even though parents believe they should be the main source for sex education, many mothers believe they share this role with teachers, and fathers prefer to share the role with religious leaders (Lagus et al., 2011).

Still, R-Almendarez and Wilson (2013) found that those in favor of abstinence only programs consider their programs as the only way youth can avoid unwanted pregnancies or STDs. These proponents view condom and contraceptive use as a means of reducing the chances of youth becoming pregnant or infected with an STI. Consequently, their stance is risk elimination versus risk reduction. Comprehensive programs are seen by proponents of abstinence only programs as sending mixed messages about sexual behavior, confusing the

youth, and encouraging youth to have sex. These proponents of abstinence only programs further claim that if abstinence only prevents sexual activity among youth their lack of sex greatly impacts teen pregnancy and STI rates.

Communication curriculum implementation. Strategies for strengthening parent-child communication about sex, dating relationships, and risk of STI/HIV infection have begun to look at long term curricula that present a holistic family and community approach. Programs that utilize this approach include Congress's Personal Responsibility Education Program (PREP), which is a five-year federally-funded curriculum teaching both abstinence and contraception (CDC, 2012; R-Almendarez & Wilson, 2013); the Parents Matter! Program (PMP), a 12-month curriculum teaching African American parents sexual communication to preteens (Miller et al., 2011); and the Parent-Adolescent Relationship Education (PARE) program, which uses interactive role playing to focus on strategies that help parents cope with difficult situations through a two-year curriculum.

These fundamental skill-building efforts are essential in the development of parent and adolescent self-efficacy with regard to sexual communication and decreasing risky sexual behavior. For instance, findings from the PMP confirmed that parents significantly increased the range of sex topics discussed with children, and parent's knowledge, skill, and confidence in communicating about sexual topics was increased (Miller et al., 2011). In addition, as R-Almendarez and Wilson (2013) project, if adolescents have access to consistent and accurate information about sex through a comprehensive sex education program, sexual debut and negative consequences may be reduced.

African American parent's influence is arguably essential for either inspiring youth to refrain from sexual relationships or to use precautions (i.e. condoms, birth control pills) should

they decide to participate in sexual activity. Parents in this study report concerns for healthy sexual development of their teenagers. Parents can use social norms as an in-road for discussing sex, dating, and risk of STIs. The example used in this literature review is the HPV vaccination. An example of social norms for African American families in this study is the teenage murder rates in their neighborhoods. Strategies for reducing risky sexual behavior include open communication and comprehensive sexual education. Open communication allows both parent and child to freely express themselves. The more comfortable youth are and the genuine youth perceive parents to be the less likely youth are to become sexually active. Beginning a discussion about a topic that an adolescent can relate to helps to put them at ease. It is important for both parent and child to feel comfortable to reduce the level of embarrassment or anger. Either of these emotions can shut off communication.

Also, teenagers dating experiences are likely the result of parental environmental design. For example, the neighborhood in which they live, whether parents serve as chauffeur to their activities and by the advice parents give them on peer interactions and dating. The African American community is strongly influenced by religion and it has been found that African American youth who are active in their churches delay sexual debut. Even when parents follow all the suggested steps, peer pressure can be persuasive, especially as it pertains to sex. Participation in this study allowed parents the opportunity to recognize the advantage of using the social norms of their community to begin and continue open and effective communication about sex, dating, and risk of STIs. The gap for these families is the lack of social support. Parents residing in impoverished neighborhoods would benefit from social support which may lessen the stress of parenting and strengthen parent-child communication about sex and risk of STIs.

CHAPTER 3

METHODOLOGY

Design and Methods

This chapter describes the design and methods, recruitment and retention of participants, demographics, data collected, field notes, participant eligibility, interview questions and discussion of data analysis process.

This research focuses on the African American community primarily located in the south and southwest areas of the city of Syracuse, New York. These communities were chosen because of the reported high rate of teenage pregnancies, STIs, and HIV/AIDS. To better understand parent-child sexuality communication in this community qualitative interview methodology was used to examine what was said by parents and what was said by the teenagers. The ultimate interest of this researcher was to discover and document the common behaviors and experiences of the participants and how these behaviors and experiences connected to the shared feature of having or not having conversations about couple relationships and sexual relationships, including STIs.

In this study, the methods of data collection used were face-to-face interviews and, when necessary, telephone interviews for clarification regarding a comment that I felt needed additional explanation. The primary activities this researcher engaged in during the interviews consisted of audio-recording and note-taking. The population participants were drawn from was African American teenagers and their parents or guardians who reside in high-risk neighborhoods. To be considered eligible for inclusion, it was necessary for both the parent and the teenager to sign written consent forms and self-identify as African Americans.

Qualitative face-to-face interviewing was best for my research because my focus—HIV/AIDS and Parent-Teen Communication—is a very sensitive and private topic. The face-to-face interviews supported my delving deeper into parents' beliefs and values and the effect these beliefs and values have on their action of having or not having a conversation with their teenagers about health issues and sexual relationships.

Meeting the families face-to-face in their environment gave them a sense of safety and security. In addition, the participants were able to see my facial expressions and any other body language, as well as hear the tone of my voice. In this way, face-to-face interviewing helped build rapport and emphasized to them that I was genuinely interested in what they had to say. My interest in what they had to say is further supported by the fact that I was willing to leave my comfort zone, travel to them and spend time in their environment in order to hear firsthand their input on this topic.

Furthermore, as the individuals shared their stories with me, I was able to view their body language, as well as the physical environment (i.e., family photos, which offer additional information about them). The body language or physical environment prompted me to ask questions not previously considered. As the conversations progressed, exposed details led to follow-up questions providing a well-rounded idea of the interviewees' thought process and handling of situations in their lives.

During the interview, the researcher looked directly at them when speaking, smiled appropriately, and reassured each participant that there was no right or wrong response to any of the questions, adding that the researcher was interested in their story told in their words. Traveling to them gave them the impression of a home field advantage. This gesture was used to secure in their minds that the study was a team effort and not a leader-follower relationship.

Qualitative researchers usually have an area of interest and seek to learn more through data gathered from the interviews. As an African American mother, I have some understanding on this topic of parent-teen communication regarding sex, dating and risk of STI/HIV. I discovered reasons parents did or did not talk to their teenagers about love and sexual relationships. In addition, I found out how these conversations or lack of conversations influenced teenagers' sexual behavior, teen pregnancy, and the rate of teen STIs.

Qualitative research methodology enabled me “to learn from the participants in a setting the way they experience it, the meanings they put on it, and how they interpret what they experience” (Richards & Morse, 2007, p. 30). Furthermore, this method allowed me to discover and analyze how these families justify their behaviors and view their experiences. The goal was to then share their ideas and practices and construct realistic theory based on the data versus my own assumptions. What I was interested in discovering was “What do teenagers learn from their parents about health issues and sexual relationships?” My research question is “What is the parent-teen communication about health issues and sexual relationships?” The desired study population was identified. To gain access to the study population, this researcher contacted African American clergy and organizations on the south side of the city of Syracuse to request their assistance in recommending possible participants to be interviewed.

The benefits and risks to their participation and a clear explanation of how the interviews would be kept confidential were given to each participant. For instance, instead of using their names a number was assigned. In addition, if the participant had questions about the research, the consent form listed the name and contact information for the faculty member working with this researcher. Before the interview began, I explained to each participant the expected benefit—for both the participants and the researcher—of directly receiving concrete information

from the parents and teens and allowing their voices to be heard in the development of intervention efforts for the community with regard to health issues and sexual relationships. I did not perceive any physical risks for participants. However, I did perceive the possibility of emotional or perhaps psychological risk. With that in mind, this researcher offered to contact one of the clergy members in the community or provide the telephone number for the Syracuse Community Health Clinic.

Additionally, I stated that even though their conversations with me are confidential, I was ethically responsible to report to authorities if I deemed any of their comments or behavior to be self-destructive or harmful to others. The interviews did not proceed until the participants responded with a verbal response, such as “yes, I understand” when asked if they understood what I had stated. Each participant was made aware that the tape recorder would be turned in to the lead researcher’s office and kept in a locked safe until interviews were transcribed to prevent any of their personal information being made public. If there were questions about their rights as a research participant, the name and contact information for Syracuse University’s IRB were listed on the consent form presented to each participant.

Adult consent forms stated that they were 18 years of age or older and that a copy of the consent form would be given to them. The consent forms concluded with two separate lines for the printed name and signature of the participant and two separate lines for the printed name and signature of the researcher. Consent forms for those under the age of 18 had an additional set of lines for their parents to print and sign their names assuring permission for their teens to participate in the study.

Upon enlisting the assistance of clergy and organizations, the goal was to then identify and interview 30 African American families living in the targeted community. One parent and

one teenager from each family were interviewed producing a total of 60 interviewees. At the time of recruitment, the teenager was required to be between the ages of 14 and 19. The adult had to be either the biological parent or guardian of the participating teenager. The term guardian refers to the adult actually caring for the teenager, not necessarily a legal guardian. During the initial telephone contact, the prospective interviewees were thanked for their willingness to participate, received an explanation of the interview process and confirmation of a time and place for the interview to occur.

This sample of 60 participants assured that most important issues were covered and saturation was reached. Saturation presumes that new data or additional interviews would not provide any additional information on the topic (Mason, 2010). Researchers vary in their guidelines to qualitative studies sample size. For instance, sample sizes range from as few as 15 (Guest, Bunce & Johnson, 2006) to possibly 25 (Charmaz, 2006) to a range of 20 to 30 (Green & Thorgood; Creswell, 1998). Ritchie, Lewis, & Elam (2003) suggests that most often the sample size is below 50 participants. On the other hand, sample sizes can be as large as 350 (Morse, 1994).

According to Bogdan and Biklen (2003), qualitative interviews may be used in conjunction with other techniques. For this project, the researcher decided to conduct open-ended questions coupled with “structured interviewing” as a part of the interview process. Open-ended questions have the promise of creating a variety of responses which is essential in gathering the “rich data” to which Denzin and Lincoln (1997) prescribe. Structured interviewing involves asking each person in the study nearly identical questions. These structured questions, or the “interview guide” was created by the interviewer. An interview guide of approximately ten questions was used with each participant.

Interviews were conducted for one to 1 ½ hours each on pre-scheduled days. The sessions were audio recorded making it easier to focus on the interview. According to Patton (1990) a tape recorder is “indispensable” (p. 241). Recording the sessions had the advantage of capturing data more faithfully than hurriedly-written notes. Accompanying the audio recordings were field notes, which are descriptions of settings, people, activities, and sounds observed during the interview (Lofland & Lofland, 1984). It is recommended that these field notes be written out in full soon after interviews end.

The research explored values and beliefs of participants as it pertains to discussing sexual relationships through guide questions designed for the interviewees. Was it discussed in household when parent was a teenager? What prompted the discussions? Pregnancy, age of teen, health concerns? Also of interest was their knowledge of STIs, including HIV/AIDS. The primary collection of data was through face-to-face audio recorded interviews. Interviews were conducted at the participant’s home, on-campus, or any mutually agreed upon location between the interviewer and the participant.

Recruitment and Retention of Participants

Participants for this study were initially recruited through a church located on the south-side of Syracuse, New York. To gain support and endorsement of the legitimacy of this study permission was granted from the church’s pastor to make an announcement during Sunday morning service. It has been documented that contacting gatekeepers in the African American community is beneficial for gaining access to the population (Coker, Huang & Kashubeck-West, 2009; Mason, 2005; Smith et al., 2007) A hard copy of the announcement had to be pre-approved by him prior to the announcement being made (see Appendix 2). Seven people signed up after service that day. One had to be turned down because the child was only 13 years old.

Although the child would soon be 14 years old, the birthday did not fall within the study's time frame.

Following this initial announcement, additional participants were recruited through various means, such as word of mouth, recommendations from initial participants, referrals from community based organizations, and recommendations from other pastors in the community. Several participants were recruited by the researcher while standing in line at the grocery store or stopping along the street to talk to teenagers. To further inform the public about this study, I was a guest on a Sunday afternoon radio broadcast. Three families responded to this on-air promotion. Overall, there were a total of 60 participants. Each participant received a stipend of \$20 cash for participating in the interview.

The researcher is of the same ethnicity as the participants and the interviews were conducted in English. Whenever possible (90% of the time), parents were interviewed first. Written informed consent forms were signed by the parents for their participation and a consent form was signed by the parents for the subsequent interview with their teenager. Written informed consent was also obtained from the teenager prior to engaging in the interview.

Demographics

Number of participants. This study was composed of a total of 60 participants, 30 parents or guardians and 30 teenage children. The teenagers were composed of thirteen males and seventeen females. Twenty-one mothers and one grandmother were interviewed. Seven fathers and one uncle were interviewed. Though this sample appears small, other researchers have used similar sized groups of participants in studies about African American teen sexuality communication (Moore, Berkley-Patton, Bohn, Hawes, & Bowe-Thompson, 2015; Weekes, Haas, & Gosselin, 2013).

Ages . Of the total number of parents, 73% were mothers compared to 27% fathers. Most of the parents (46.7%) were aged 30–39, followed by 40% who were aged 40–49 and 13.3% aged 50–59 (see Table 1). Of the teen participants, a majority (56.7%) was female compared to 43.3% male. The majority age group was 16- to 17-year-olds (53.3%), followed by age group 14–15 (33.3%) and 13.3% aged 18–19 (see Table 1).

Household Composition and Income. Two-parent households were represented by five of the eight men (62.5%) three of the 22 women (13.6%). Single-parent households were represented by 22 single parents: 19 women and three men. One of the mothers included in the single-parent households actually had a live-in grandmother. Another mom was a divorcee (see Table 1).

With the exception of one mother, all of the adults were employed. Most of the mothers had an annual salary of less than \$30,000. One mother was a medical doctor with her own practice. She had an annual income of over \$80,000. The registered nurse claimed an annual income of \$55,000. The one unemployed grandmother was guardian to her grandchildren and supported by her husband. The majority (six) of the fathers claimed an income of less than \$40,000 or less. The politician/realtor claimed an annual income of \$40,000 while three fathers claimed annual salaries of \$30,000 and two fathers reported annual incomes of \$20,000 to \$25,000. The remaining two fathers claimed annual incomes of \$60,000—the pastor who had a second job and the print shop owner.

Education. A total of four mothers did not graduate from high school (see Table 1). Two mothers had completed some college course work. Three of the mothers were professional women: one was a registered nurse, one was a clinical social worker, and one a medical doctor. The remaining 13 women were high school graduates.

Table 1. Participant Demographics (N = 60)

Demographic Characteristic	Adults (n = 30)				Teenagers (n = 30)			
	Male (n = 8)		Female (n = 22)		Male (n = 13)		Female (n = 17)	
	<i>N</i>	%	<i>n</i>	%	<i>n</i>	%	<i>N</i>	%
Adults' Ages								
30–39	1	12.5	13	59.1				
40–49	5	62.5	7	31.8				
50–59	2	25.0	2	9.1				
Total	8	100.0	22	100.0				
Teenagers' Ages								
14–15					5	38.5	5	29.4
16–17					6	46.1	10	58.8
18–19					2	15.4	2	11.8
Total					13	100.0	17	100.0
Household Composition								
Two-parent household	5	62.5	3	13.6				
Single-parent household	3	37.5	19	86.4				
Total	8	100.0	22	100.0				
Marital Status								
Married	5	62.5	3	13.6				
Unmarried	3	37.5	18	81.8				
Divorced	0	0.0	1	4.5				
Highest Level of Education								
Less than High School	1	12.5	4	18.2				
High School Graduate	2	25.0	13	59.1				
Some College	2	25.0	2	9.1				
College Graduate	3	37.5	3	13.6				

Three of the fathers held college degrees: one was a pastor, one owned a printing company, and one was a politician and realtor. Of the remaining five, two had some college education, two graduated high school, and one had less than a high school education.

Data Collection

The one-hour interviews included questions about their demographics, work history, age, education, marital status, number of children, and their biological families. Additional information was gathered through the researcher's ten prepared lead questions. Data were collected through face-to-face tape-recorded interviews.

Field Notes of Interview Locations

A majority of interviews were conducted in the homes of the participants, either in their living room, kitchen, dining room, family room, or bedroom. One was conducted in the family van. Several were conducted on Syracuse University's campus at Bird Library or in Sims Hall, and two were conducted at the researcher's apartment. In general, the interviews were conducted without incident or concern. However, there were a few cases where the researcher was a bit apprehensive. Three cases stand out.

The first case was held in the kitchen of a participant who had just been released from the hospital. I felt very uncomfortable in the environment. The living space was extremely unkempt. While interviewing the teenager in the kitchen visitors arrived and his mother could be heard cursing in a very loud voice. She was soon quieted by her boyfriend, but these were extremely nervous moments for me. The second case took place in a housing project where several shootings had recently occurred. It appeared as though we walked through a maze to reach the apartment. I was particularly cautious when walking to and from the participant's apartment. After driving about a block away from the building, I was pulled over by the police

who questioned my reason for not coming to a complete stop at the stop sign. I explained my reason for being in the neighborhood and that I was nervous. It was approximately 6:00 p.m. and dark due to the winter season. My explanation was accepted and I was allowed to continue on my way.

The third case was held at the home of a teenager whom I had met on the street. She recommended her mother. Upon entering the house and seeing the mother, my initial thought was that she was an active drug user. Fear set in as I thought about the sea of negative possibilities. However, the daughter appeared very interested in participating as did her mother. The house was very large and there was too much activity. There was constant teenage traffic going up and down the stairs. We encountered difficulty locating a working electrical outlet. During the move from the dining room into the living room, I panicked momentarily when I could not find my cell phone. After finding it in my car, I decided to relax and proceed with the interview. It progressed well.

As a matter of precaution, each time I left for a scheduled interview I either gave my son the address and telephone number of the participant or left a voice mail message on his cell phone. After reaching my destination, I wrote a description of the surrounding area with the person's name, address, telephone number along with my name and reason for being there in a small notebook I kept in the glove compartment of my car. My thought was that if the worst happened to me—kidnapping or homicide—the police and my family would have some information to begin an investigation into my disappearance or death. I developed this habit of writing notes describing my surroundings as a result of suggestions and concerns from family members. Through my history of traveling alone, especially on long distance drives, I wrote down anything I perceived to be out of the ordinary, such as cars trailing me for long periods or

pulling off the highway behind me. I would leave these notes in the glove compartment of my car with hopes that they would and could be used during an investigation of an unfortunate fatal accident or my disappearance. This practice was carried over into travel experiences of the fieldwork for my dissertation.

Eligibility of Participants

To be eligible for inclusion, both the parent and the teenager had to sign written consent forms, self-identify as African American, and agree to participate in the interview process (see Appendices 3 & 4). At the time of recruitment, the teenagers had to be between the ages of 14 to 19. The adults had to be the biological parent or guardian of the teenager. All families had to have a connection to the south side of Syracuse, either as a resident, because they had family members living in the area, or because they were connected to an institution such as a church or a recreational center. From a total of 40 families contacted, ten were found to be ineligible for the following reasons: two never returned telephone calls, three rescheduled more than twice, one refused to open their apartment door after ringing the researcher into the building, one was ill, two thought their teens were too young for the topic discussions, and one had a child who was only 13 years old.

A specific geographical location was selected for participant recruitment. This location is in Syracuse, New York, a city located in central New York State. The researcher chose appropriate families from within the 13205 zip code where the majority of participants resided. Participants residing in other areas of the city all had ties to the south side of Syracuse and the 13205 zip code.

Data Analyses

Qualitative data analysis methodology involves taking large amounts of information from the interviews and placing the information on a chart under headings of patterns, themes, or categories. The goal is data reduction and to produce an interpretation of the data that represents the essence of the participants' comments (Marshall & Rossman, 1989). This process of analyzing the data results in research (LeCompte, 2000).

Initially, all tape-recorded interviews were transcribed word for word by an outside transcriptionist. The transcriptions were usually completed within the week of the actual interview. This was done to ensure accuracy in transcribing and enabled the researcher to more accurately correct transcription mistakes. This researcher checked the transcripts by reading them and making comparisons with field notes to verify accuracy. Insertions or corrections were made wherever necessary for any mistakes. Corrections were necessary because of misspelling of names and interviewee accents with which the transcriber was unfamiliar. In some cases, sections of the tape were inaudible due to background noise such as voices or music within the interview environment.

After organizing the material, content of each interview was reviewed and constantly compared. This process allowed for identifying responses that were repeated. Once commonalities were discovered between participants, a coding system was developed. A variety of highlighter colors were used to differentiate each theme. This coding system was developed for each category of information identified through the literature. The narrative material for each participant was coded by theme of each category onto a chart so that responses for each interview could be retrieved easily. I identified those interviewees with similar responses and

found conversations that were similar or different for each theme. Commonalities among conversations were later used to specify examples of each category.

Data was coded to identify topics and themes similar to and different from findings grounded in the literature. For example, one of the literature topics was Characteristics of Parenting Communication. A table of the key findings from the literature was designed to represent the main themes emerging. The data were further analyzed to detect differences or similarities in the conversation of mothers and fathers. Analyses began by coding the findings into four major categories identified through the literature search.

CHAPTER 4: FINDINGS

This chapter provides a brief description of my ability to make the participants feel comfortable, a discussion of outlier cases, and the presentation of findings from parents and their teenagers on sexuality communication.

Nature of Interviews. Due to the sensitive nature of this research on dating, sex, and risk of STIs, my inclination was to put the participants at ease. The goal was to ensure that they felt comfortable which I had hoped would enable them to confide in me. The aim was to hear from both the parents and teens their views on and experiences with discussing dating, sex, and STIs. I felt convinced that their first impression of me would guide the progression of the interviews. Having reared three children of my own and having discussed these topics with them, I am somewhat aware of parents' interest in guiding teens to behave in manners that protect them from painful emotional experiences in dating and protect them from the physical experience of contracting an STI. Also, I can remember the responses of avoidance, embarrassment, and indifference from my children. In addition, I remember that weeks later one of my children would mention that their friends "couldn't believe" I had talked to them about sex and condom use and wished that they could talk to their mom like that. With these experiences in mind, I decided to make the interviews as conversational as possible.

Establishing rapport and comfort. The initial moments spent with participants was focused on increasing their level of comfort. This was done, in part, by keeping a smile on my face as I entered their home, or as I approached them at a scheduled meeting place outside of their home. Usually, I made small talk about the weather, commented on the smell of food cooking, commented on the environment in which we were meeting, or complimented them on their home decorating style. Once we were settled in our seats to begin the interview, I thanked

them for their willingness to be a part of my research and allowing me to interview them. They were also reminded that the interviews would be confidential.

It is important to note that both the parents and teens generally appeared somewhat nervous about discussing the topic of sex and STIs. Many parents expressed that this was not a subject discussed in their home when they were teenagers. Most of these same parents stated it was important to discuss dating, sex, and STIs and each later shared with me their unique way of broaching the subject with their children. The teenagers attempted to joke around and make light of this serious topic during the interview. Once they were reminded about the seriousness of the topic, the joking ended. Sometimes it ended with the admittance of their feelings of nervousness.

Initial tag questions. During the first few moments of the recording teenagers were encouraged to talk about their day in school and parents were asked to tell me about the family they grew up in. This was done as an effort to help them see me as non-threatening and empower them to engage in conversation with me. Once I observed decreased nervousness in their tone and body language, I would then ease into asking the teenagers what they knew about STIs or what was taught in school about STIs. With the adults, I asked what their parents discussed with them about dating, sex, and STIs. This approach enabled the interview to begin. As the interview progressed the parents and teens became more relaxed, opened-up more, and were more candid in responses to the questions asked.

Outlier cases. The following outlier cases show examples of some extremes I encountered with parents.

One mother admitted to me that she felt totally neglected and misused by her husband. She felt he married her out of necessity for a place to sleep. In addition, she expressed her

feelings of ineffectiveness as a parent to her daughters due to the abusive marriage. She admitted that her husband was verbally abusive and affectionately withdrawn. This was compounded with the statement that her daughters dismissed any comments or advice and consistently reminded her of how she subjected herself to their father's abusive behavior.

I used the opportunity of her experiences to ask questions. For instance, I asked her how she felt her relationship with her husband influenced how she talked to her daughters about dating relationships and how it influenced the daughters to choose a mate. She shared with me that because of what they witnessed at home they disrespected her and chose boyfriends who were physically, emotionally, and verbally abusive.

One of the younger mothers had a nervous laugh as she answered the questions. I acknowledged that she was appearing very uncomfortable. She agreed. We discussed the uneasiness of the topic in terms of it being intimate and revealing, but appropriate and necessary for our youth to gain knowledge and mature. She commented that she wished her mother had discussed these topics with her as she was growing up. Despite any nervousness, she was able to continue the interview. At the end of the interview, this young mother expressed how much she enjoyed the conversation.

One of the fathers kept referring to himself as an "angel". After several references, I jokingly asked where he got this notion that everyone thought he was such an angel. Well, that opened a can of worms as he began to share some not so angelic choices he had made in life and how it affected parenting practices with his two daughters. For example, he shared that as a very young boy he had experienced sexual intercourse which led him to believe that if he had an interest, as a youngster, other boys would too. He added that as a young man he had misled many young women so that he could become intimately involved with them. This father

admitted that these experiences caused him to be more open with his daughters about what he believed boys would do or say to persuade them into becoming sexually active. This appeared to be somewhat of a breakthrough. I had not expected this but the interview continued in a more focused manner from that point on.

MAJOR THEMES AND FINDINGS

The key purpose of this study is to analyze the kind of communication that teens and parents are having about STI and its prevention. Within the context of dating, intimacy, and risky sexual behavior, four themes that emerged from prior research were explored to fully understand the kind of communication that occurs between parents and teens. These categories are: (1) *Parent-teen Knowledge about STIs*, (2) *Factors Influencing Parent Communication*, (3) *Barriers to parent-teen communication*, and (4) *Communication that reduces risky sexual behavior*.

Theme 1: Parent-Teen Knowledge About STIs.

The questions guiding the analyses of parent-teen knowledge about STIs is how knowledgeable are parents and teens about STIs and STI prevention, how detailed is the information that parents share with their teens and what do teens say about condom use based on what they know of STI. As was presented in Chapter 3, parent knowledge is a key element in the parent-teen communication process (DiIorio et al., 2003; Pluhar & Kuriloff, 2004; Wycoff et al., 2008) and given that if parents have the knowledge they will share with their children. Researchers (Hutchinson et al., 2003) also state that when teens are knowledgeable of sexuality topics, they are more likely to delay sexual debut and more prone to use condoms if they are sexually active. This knowledge sets the stage for initiating and continuing STI prevention discussions between parents and teenagers. The analyses addressed the questions of how

knowledgeable parents and teens are about STIs and STI prevention, what information are parents sharing with their teens about STIs, and where do teens feel they receive the best information about STIs?

Knowledge and detail percentages. Each parent in this study either stated or implied that they felt communication was a necessary component to reaching teenagers and guiding them away from risky sexual behavior. In this study, personal interviews indicated that 96% (29) of the parents were equipped with some degree of knowledge and ability to discuss sexuality and STI prevention. Of that 96%, 59% (18) generally discussed birth control or abstinence, but 37% (11) spoke from a more defined knowledge-based position, providing more detail when discussing information about sexuality and STIs and educating their teenagers about the developmental process and STI prevention. Throughout this chapter the names have been changed to protect the confidentiality of each participant.

The sources of parents' knowledge. Sources of parent knowledge varied. One parent was taught, as a teenager, by his parents; another learned from reading applicable pamphlets and books; two had personal experiences that led to gaining knowledge on STIs; two worked in a clinical setting; three remembered what they were taught in health class at school; and one attended seminars to learn about sexuality and STI prevention. Below are sample statements of how parents gained knowledge and shared it with their children; and their child's response to this shared knowledge. These examples move from the more general conversation about birth control to knowledge gained through personal experience and ends with an example of a parent who attended training sessions.

Shelley's conversation with her daughter, Thomasina, (teen 151) indicates a moderate level of understanding of STIs. She says:

But you know, I told them but, I did make a point. If it's gonna happen, please, if something, if it does happen, please let me know cause you need some kind of, you need to have birth control—talk about issues about birth control—condoms—I said because HIV, these diseases today are lots worse than the diseases when I was coming up. These things, these diseases take your life. I mean, instantly. (#151, p. 8)

Maya (parent 152) had been infected with an STI and took the initiative to go to the library and educate herself on STIs, serving as an example of a parent who provided detailed information to her son Barry (teen 153). Maya stated:

Um, we talk about what HIV and AIDS is, and HIV and AIDS two different stages. You know, the exposure level and certain windows that you have to.....and then AIDS is the actual disease...the outbreak of the disease showing itself. And really it's like attacking the immune system. It's not, you know people think it's like a disease that wanders through your brain, but it's really that your immune system is no more. It ain't competent of fighting against any simple colds or pneumonia.

This mother considers herself well versed on STIs through her own experience of an STI and subsequent self-determination to become educated about STIs as a response to this experience. Earlier in the interview she stated how direct and detailed she had been in her discussions about sexuality and STIs with all her children.

Community. One father worked as an HIV community educator and sourced statistics to convey information about STIs to his daughters:

Being the proponent of the education of our community about HIV and AIDS, I gave them statistical information. That it is the number one killer of African-American women, of which in the demographic their ages fall in many instances. And the census tracks of where they live. That um, sexually transmitted diseases within this community is on the rise, which means that there is gonorrhea and syphilis and chlamydia. They could also have been exposed to HIV. So that they understood and know the ravages of it. I didn't give the ignorance of the gay man's disease. (#156, p.8)

This parent explains how she sought out information to share with her children:

As a foster parent, we go through the seminars and things, so I had a lot of information on herpes, AIDS, all kinds of stuff. And I'd come home, and talk to them. And I'd talk to the boys. I'd tell them about um, having unprotected sex and, and um, my daughter, I have to try and keep up with her because she's um, she's delayed. But my boys, I tell

them about you know, having unprotected sex and the things that they can catch and like if I find some little stuff, I bring it home and tell 'em read it or you know. And we watch a lot of those health programs and such. Parent #164 (30)

By attending educational seminars, dealing with personal experience of STIs and reading educational material about STIs, these parents felt well prepared and confident in their ability to openly discuss sexuality and STI prevention with their children. Both parents are examples of Wycoff et al. (2008) and Cederbaum's (2012) definition of effective communication. Their definition incorporates having open and frequent knowledge- and skill-based conversations with children. In addition, the parents' actions of sharing their past and watching health programs with their children provided a comfortable environment for these conversations. The children could perceive this scenario as more loving and less controlling which increases sexuality conversations between parent and child (Pluhar & Kuriloff, 2008; Regnerus, 2005; Reisch, Anderson, & Krueger, 2006).

Parents in this study reported various sources for gaining knowledge about sex and STIs. These parents revealed several sources for STI knowledge, including community and relatives. Some parents confessed that there was no discussion with their parents about dating, intimacy and risk of STIs as they were growing up. The following excerpts show a range of sources, from a high school coach and teacher to aunts, sisters, as well as parents.

Coach. For instance, Luke, a 43-year-old married father of three remembered his high school coach educating the team about condoms and STIs this way:

When, when condoms, when that came in the conversation, I was in high school. But prior to that there was no talk of condoms. I mean I had a, what I found out about condoms was at that time, we didn't know how to get 'em or you know it really wasn't a necessity because it was a rare thing somebody was having sex at that time. We were busy banging, we weren't getting nowhere (laughter). But, um, during that time, you know, the first conversation that we had and it wasn't even in health class, it was our basketball team in high school. We played in the summer league and our coach was Ted Naylor, and Ted sat

us down, this black male. He was a black male and he sat us down and had the conversation about birth control, about condoms, about STDs, about proper use of condoms and about how to carry yourself as respectful young men. Ted Naylor sat us down. Not the school district, but Ted did! (#125, pg. 3)

Teacher. Both mothers and fathers reported some school-based curriculum and personal experience as sources. Tina grew up in an adoptive home with a mother who was 60 years old when she was 12 years old. She didn't learn about sexuality at home and doesn't remember a school-based curriculum, but does remember one of her middle school teachers giving her a book to read that explained her monthly cycle.

She never sat down and talked to me about nothing. Even when I got my period. I didn't even know what that was. I thought I got cut. And she, and then I took my clothes and I hid them, 'cause I didn't know what was going on. So, I guess she found them and she was like, did you get your period? And I'm looking at her like, what is that? But I had a teacher before I left New York—his name was Mr. Leonard. And he adored me. That was my fifth and sixth grade teacher. He gave me a book to read cause for some reason he must have sensed something. So, he gave me a book to read—Are You There God? It's Me Margaret, by Judy Blum. It tells you about your period and stuff like that. I read it, but still didn't understand until after I got my period and she said it. Then I put it together. Then I went back to the library and got that book and started reading it again. 'Cause I didn't understand what it meant. (#122, p.4)

Aunts or Sisters. As a teenager, Brenda, who began using birth control at age 15, felt comfortable talking to an aunt and shared this:

Well you know, I go over, I ask her questions, she'll be honest. She'll tell me everything and then, you know, she'll try to get me, she got me on birth control and stuff like that. (#128, p.3)

Millie, a high school graduate, stated her mother refused to engage in conversation with her about sex or birth control. Millie had become sexually active, but did not want to tell her mother, but did not want to become pregnant. When she approached her mother about getting birth control, her mother responded, “*you shouldn't think about that.*” However, Millie's maternal aunt was available to assist her:

Well, I asked her what I should do. And, um, she just kinda, you know, she said, well if mom doesn't want to take you, you know, you just need to use condoms and you know, protect yourself and make sure. She always said her biggest thing was me catching an STD. That was her biggest thing.

Older sisters were a common information source for sex education and STIs for younger sisters. Robin shared that her mother would have “*private talks with her older sisters concerning birth control*” (#154,p.1), but never with her. She believed her mother’s assumption was that the sisters would share the information with her. Robin’s sisters shared the same sentiment of most older sisters; that of “*protection*” and “*birth control*” (#154, p.2).

On the other hand, even though Bernice’s parents and brothers insisted she never have sex, Bernice’s older sisters gave her a more thorough explanation about making the decision to become sexually active:

From my sisters they said if I ever did want to have sex or anything, they told me that first of all, you have to make sure the guy use a condom and you should be aware of what you're doing and make sure if you're going to do anything, make sure it's with someone that actually, you both actually like each other. Just don't do it just because the boy said, I like you. Liking a person doesn't mean that, that that's what he really wants. He doesn't like you, he might like you for one thing only. So, that's a lot of things that they taught me. And just be very careful, and just they told me that, remember there's diseases out there, it's worse these days, but back then, you know, for the ones that were out there, then just be careful with what you do and before you do make a step like that, make sure you come to talk, speak with us. That's what I learned from my older sisters. (#150, p.1)

Maria, who describes her family as dysfunctional, also consulted her sister. Maria’s sister encouraged her to have sex for the fun of it:

Actually, my first encounter in a sexual ordeal, I wasn't quite sure what was happening and um, so I asked my older sister about sex. And she was like sure, do it, it's fun. So sure, I did, it was fun, but you know, she didn't tell me about protection and all that other stuff and so as a result I have a thirty year old. I got pregnant when I was fifteen. So um, and then, I think like it was my sister. (#152, p.1)

No Discussion. Many of the parents participating in this research commented that when they were growing up there had been little to no conversations between them and their parents regarding sexuality. Direct statements, generally addressed to females, were some variation of “*Keep your legs closed*” (Yvonne, #146, p.1) or “*you’d better not do it*” (Bernice, #150, p.1) or “*don’t mess with boys*” (Jane, #158, p.1). The general statements made to males were “*wear a condom*” (Stan, #149, p.1) and “*don’t get anybody pregnant*” (Harold, #156, p.1). Some of this study’s parents added more detail to their responses when asked what they learned from their parents. Forty-year-old Larry describes it this way:

We didn’t discuss that. Being a family of, coming from a family of 12 siblings, we didn’t discuss anything regarding sex. There was no reason to. There was no type of media, radio or television that the children today are exposed to. So, we didn’t discuss it. (#142, p.1)

A 34-year-old uncle reared by his father and presently serving as legal guardian of his niece explains:

Well, when I grew up I didn’t hear a lot about um, well I heard the gossip part of the relationship, but I never had anybody in my adolescent time or teenage time just sit me down and talk about, you know, sex, you know coming from a small country town and stuff like that. People just really didn’t do it, you know. (#144, p.1)

Lucinda, a 35-year-old mother, confesses to having her first sexual encounter at age 15 while drinking. When asked about what her parents said to her regarding sex and STIs, she responded:

Nothing at all. Anything I learned, I learned from listening to my friends. My parent wasn’t the type to be open, and be like... Well, I mean basically she told us to stay away from boys and that was that. So, that didn’t work. (#132, p.4)

Harold, a 45-year-old pastor and father of three, said that he had little conversation at home about sex:

There was little or no conversation about it at all. It was just very limited, if any. Everything was don't, don't. Religious position of the parents was emphasized so there was little or no conversation at all. (#156, p.1)

The kind of sexuality information given by his parents to 52-year-old Brad, a father of five with some college education, focused on the results of unprotected sex and responsibilities of parenthood:

Well personal responsibility was probably the first. Personal responsibility is absolute. It cannot be transferred. It is not negotiable. Secondly, that at all times I was to protect myself and I'm responsible for all children that I create. This is not negotiable either. Because it doesn't depend on whether I like the mother or dislike the mother. It doesn't depend on anything. It is because I am absolutely responsible for the children that I produce. I better be careful about where I make these children. (#136, p. 1)

Abstinence. Ryan, the son of a Methodist pastor, recalls being quite inquisitive about sex at a very young age. His personal experiences with sex included secretly looking at naked pictures of girls in his father's Playboy magazines. Though his father “preached abstinence and it was wrong to have sex before marriage” (pgs. 2&3), Ryan remembers that as early as age eight or nine he was having thoughts and feelings about sex. This scenario is a glimpse into his childhood curiosity:

Ok, when I was younger it just fascinated me you know. I can remember um, one time being in the back of my grandparents car and this was, this had to be, I don't even know if I was in kindergarten or not, maybe in kindergarten, probably about kindergarten. But I remember young lady in the back, the young, another girl, kid in the back, um, and I was curious and I'm like, let me see, let me see. Just let me see. Um, I was, I was, I was asking um, basically to see her genitalia. Now she said no and made a fuss and I remember my grandmother turning around to me, and we was on our way to, this was on a Sunday in the afternoon. We was on our way to a um, in the South they had what they call homecoming, and basket meetings, and we was going to Howard's Creek. And I remember when I said that and she says, no, and she said it loud enough to where my grandmother could hear it. My grandmother turned around and she said what's going on back there? And the young lady says, he's being nasty. And she looked at me and she said Ryan are you being nasty? I said no ma'am. And she turned back around. I just asked

her why did you say that, 'cause I'm going ask you again. Um, I was just curious I don't know why, I was just curious. Just being honest. (#116, p2)

In contrast, there were parents who had received sex education at home. One was reared by her grandmother in the south, along with siblings and cousins. She recalls no discussion about STIs, but does remember what she considers her grandmother's version of sex education:

She always taught us about morals. You don't lay around, you know. And one of her sayings was a man can take off his clothes and lay in the ditch naked, go home and take bath, wash the mud and stuff off and still be a man. A girl, a woman can't go that far. So, you always live so you can hold your, walk with your head up and not be ashamed. (#164, p.1)

Education not Sex. The conversation Amanda's parents had with her leaned toward education first before anything else. Amanda grew up in a home with both parents and three siblings; two brothers and one sister. One comment from her father stood out in her mind:

My father warned me about the diseases that's out there. Well, they, when I was growing up they told us that when, even before you had sex or whatever, make sure you wear protection. You can catch stuff from it, and stuff like that. And as I was growing up, just listening to my parents, 'cause I wasn't really into sex like that, when I was growing up and there's just a lot of things that my mother and my father taught me. They said before you think about having sex or whatever, finish school 'cause you don't wanna have no kids at no young age. ((#160, p.1)

Ann grew up in what she described as "a very strict" home. She was not allowed to have a boyfriend. So, whenever a boy visited her she would introduce him as a friend and discreetly met him outside of her home. What her mother said to her about sex was:

Well, basically, you shouldn't have sex until you're married. Sex is sacred. You can't just have sex with just anybody. There's diseases behind it and, on my behalf, you can get pregnant and sometimes the men are always, they always leaving and you stuck with the child. (#112, p.8)

Father/Son vs. Mother/Daughter. Generally, the fathers in this study spoke more openly with their sons about sex, dating, and risk of STIs. Perhaps, the mistake or missed opportunity

here is that fathers believe they are ill equipped to have sexuality conversations with their daughters. Father's guidance in sexual relationships and STI education has proven to make a positive impact on daughters' decisions to delay sexual debut (Hutchinson & Montgomery, 2007; Teitelman, et al. 2008).

Of course, there were fathers who did converse with their daughters. These fathers expressed that they wanted to keep an open line of communication between them and their children so they would feel comfortable coming to them about anything, including dating and sex. Mostly, conversations with daughters were geared toward preventing pregnancies. However, during the interview revelations happened to help parents begin to think that sons needed to be educated on preventing pregnancies as well. This is the case for Luke. As he was explaining what he is doing differently, regarding sexuality education, with his children than his parents did with him, he had an epiphany. He realized that he should possibly have the same conversation with both children.

These were his comments:

Well, we basically, really nothing is taboo. We let the kids know that they can talk to us. I think that more so, and it's funny now, because this is starting me thinking, I'm probably with my daughter, with my 17-year-old, I'm a lot more open and forward with her. I'm probably afraid she's going to get pregnant? And, but on the other hand, with my son, could get someone pregnant. But and, I also see that my son is not as outgoing as my daughter is. That um, he's a little more sheltered than she is. So, um, really the lines are really open with her, to keep her careful and I see that with my son being not as fast... but, you know, not realizing it, he doesn't have to be that fast – the right girl could be that fast. (#125, p. 4)

As far as dating, Luke admitted there were double standards when it came to girls versus boys:

But, um, the way that society is, you know, with girls as opposed to boys, um, you know, boys it's more acceptable for boys to go out and make mistakes. It's more acceptable for boys to go out and have multiple relationships. It's not as acceptable for girls to. Because, you know, kids are gonna be kids and things do happen. And peer pressure's there, but the one thing that I've done with her, is you know, let her know that yes, she can talk about birth control. Let her know that I don't want her to have sex until she's 105. But, if she does feel like that, I don't want her to sneak. I want her to come to us and

that way we can take her to the doctor – we can take her to the right place so she can get on birth control. So, she can have educated decisions when she decides to take that step. And we had that conversation, you know, it was apparent that a young man was liking her – she was liking him and so, we definitely had the conversation, and we've been reinforcing that conversation. Although their dating only lasted through a couple dates. (125, p. 5)

One father admitted to talking to his daughters since infancy about sex and the risk of STIs. He stated his daughters and wife accuse him of being a little to blunt. He shared some of the conversations with his daughters:

As they was growing up – even in grade school – I would sit down and I would tell em, um, I would tell them the dangers of sex, uh like, you know, fact that you could get AIDS, STD's. Um, I would sit down and would have discussions. I would ask them like is there anything that you wanna ask me. You know, when they were real small, they would respond –you know what I'm saying? They would – um, they would ask me questions like um, well daddy um, why does, what do, why do boys always, why are boys always trying to get us to do this, and so on and so forth. And I would be as straight as possible. I wouldn't try to um, cover it up. I wouldn't try to sugar coat it. I wouldn't try to give em one of the little nursery rhyme type things. I would tell it to em as I saw it. As they grew older, they would only come to me, um, just rare occasions, you know, like I would ask em, I would ask em questions and I would tell em about um birth control. I would tell em about more of the emotions and the burdens if you become pregnant. They knew um, maybe it was my fault. They knew that um, I wouldn't like it if I knew that they were sexually active at a young age. They kinda knew this. (Ryan, #116,p. 6)

On the other hand, mothers more often communicated with both genders about sex, dating and risk of STIs. However, there were mothers who voiced that they would have preferred having a male discuss some of the topics with their sons (i.e. STIs and how to treat a girlfriend).

The grandmother in this study, Caroline, was quite knowledgeable about dating and STIs. For close to 20 years, she taught a biblically based sex education class, entitled Purity, to teenagers attending her church. Purity classes are a common curriculum in the Church of God In Christ (COGIC) denomination. Caroline explains the classes this way:

I teach the children how to seek God, how to stay pure, how to keep their bodies pure, how, we teach em morals, we teach em what sex is and what it was, instrument, what God

intended it to be, and the way it is used now, and the way it should be used, and, we teach abstinence. That sex before marriage is a no-no. You do not have to sex. You do not have to have sex to please a young man. And the young men don't have to have sex to please the young women or other young men. You have to think for yourself. You have to know that God sees and knows all and if he said in the word that you do not have sex, than that's it – you don't have sex. Sex is for married women and men.” (#102, p. 2)

Caroline admitted being influenced by religion when it came to matters of sex. Having custody of her grandson, she found herself back in the position of providing guidance and sex education.

But I try to tell him that that is not all in the game. Sex is not everything, and then once you have sex, then there's these consequences. You going be prepared to take care of babies, cause I'm not. His mother's not. Can he work and support a baby and go to school and do all the things that he wanna do? No. The best thing to keep from getting in that trap is don't do it. Cause you can't rely on condoms; you can't rely on birth control pills, but you can rely on no, get that.” (#102, p.3)

Teens' knowledge about STIs

Where do they say they learn information about STIs? If teens have detailed information about STIs, researchers say they are more likely to delay sexual debut and more prone to use condoms if they are sexually active. The teens in this study confirm these findings. Of the 27 eligible teens, almost as many stated they had general knowledge of STIs as having detailed information on STIs—13 teens compared to 14 (Table 2 below). Most of the teens reported that they were not sexually active (59%), but as expected a large proportion (72%) of those teens who stated having received detailed information on STI were not sexually active. In addition, teens who were sexually active used condoms at higher rates than those not using condoms—eight teens compared to three (Table 2 below).

Table 2. Teen Knowledge and Statements Regarding Condom Use

Type Of Information Received	Sexually Active w/ Condoms	Sexually Active w/o Condoms	Not Sexually Active	Total
General Information	5(39%)	2(15%)	6 (46%)	13 (100%)
Detailed Information	3(21%)	1(7%)	10(72%)	14 (100%)
Total	8(30%)	3(11%)	16(59%)	27 (100%)

Thomasina, a 16-year-old female, is as an example of a teen who received general knowledge from a parent, but also stated that she is not sexually active. For example, the general knowledge included awareness of condoms, pills and abstinence as birth control measures. She stated abstinence was promoted mostly by her mother, who reminded her that boys are neither reliable nor supportive. When asked about birth control, she reported not remembering her mother talking about birth control or condoms, but she remembers learning about birth control in a class at school. Even though this daughter reports not remembering the conversation, her decision rests with delaying sexual debut. This decision appears to be based on a combination of her mother's advice on abstinence and observations of her friends' relationships. When asked if her mom discussed sexual behavior, her response was simply:

Um, not that I remember. I know about birth control from school. She just said I just shouldn't do it. I think she, she's right, because some girls, they just do it because it make them feel important. And sometimes, the boy, that's all the boy wants. So when she find out that that's all the boy wants, they feel heartbroken. And they feel hurt. So, it's better not to, it's better to just wait. (#151)

One son, who is in a non-sexual relationship with his girlfriend of one year, shares what his mother told him about sex:

She said just don't go around having sex with anybody cause a lot of diseases is going around and you should just wait until you get your life together and you do all that. 'Cause I don't want to have no babies so, she just told me to take it slow and don't be

rushing, and don't rush. It made me think like, 'cause I talk, I ain't gonna lie. I talk to a lot of girls but I don't have sex like that. But I was listening to her and I was thinking about what she was saying cause like, a lot of people running around Syracuse and rumors get out saying such and such burning or all this and I, some of the people I be knowing. Some of them be going to my school. So I be thinking, I just look at 'em like, that's nasty. They shouldn't be going out having sex with anybody. I ain't that type of person, you know. (Teen #165—16-year-old male)

Condom use for sexually active teens. Barry, an 18-year-old male who is sexually active is an example of a teen who received detailed knowledge from his mother and stated that he uses condoms. When asked about what he knew about STIs and how he gained knowledge about STIs, Barry stated:

I personally, I know a lot. I went, I found out a lot of stuff for myself, and like, going to Southwest Center, the FACES program. Yeah, they take, like they have like, like you go there and they have a place where you can pick up condoms and stuff like that. And like, they tell you, like, they give you a quiz before they even give you anything. Like, do you know this and do you know that, and they like, after a while I like knew just about every question they could ask me. Like, oh what happens with this, and I'd give them the answer. Yeah.

In addition, with reference to his comfort with talking to his mother he adds:

Like she knows I'm sexually active and she like makes sure, like oh yeah, you use condoms, blah, blah, blah. All that stuff. Yeah, she knows. I have it pretty good compared to some other teens. I have a pretty good relationship in that area with my mother.

From this teenager's comments about picking up condoms at a local community based program and voluntarily educating himself on STIs, it would appear that his mother's messages of condom use and safe sex, and the initiative he took to seek out more detailed knowledge from other sources have made a positive impact. Also, it appears those messages are being applied in his sexual behavior to use condoms during sexual intercourse. Perhaps, his initiative to visit the community-based organization was influenced by his mother's open and direct conversations with him about condom use.

The conversations between this mother and son, and the resulting action on his part to wear condoms during sexual intercourse, align with the literature. Lagus et al., (2011) states that parents engage in sexuality discussions with their teenagers when they are knowledgeable and comfortable with sexuality topics; and youth are more prone to use condoms when they have had condom use discussions with parents (Teitelman et al., 2008; Wycoff et al., 2008)

In terms of where teens learn information about STIs, contrary to findings from the literature, most teens in this study recalled receiving information from their schools, however, more so than from the parents. They also had some knowledge of how to prevent STIs (condom use), but the teens say that abstinence is learned mostly from the parents. Even teens who received detailed information from their parents took initiative to seek out additional information for the school or other programs.

Table 3. Teen Knowledge of STI and Sources of Knowledge

	# Males	% Males	# Females	% Females	Total # M/F	Total % M/F
STI Knowledge	10	91%	15	94%	25	93%
Unaware of STI	1	9%	1	6%	2	7%
Total	11	100%	16	100%	27	100%
Source of Knowledge						
Parent Only	1	10%	6	40%	7	28%
School Only	2	20%	6	40%	8	32%
CBO Only	1	10%	1	7%	2	8%
Parent & School	4	40%			4	16%
Parent & CBO	1	10%			1	4%
Parent /School/CBO Combined	1	10%	1	7%	2	8%
Planned Parenthood			1	7%	1	4%
Total	10	100%	15	100%	25	100%

Table 3 above shows that the school plays a major role in educating teenagers about STIs more so than parents. Out of 27 teenagers reporting that they were aware of STIs, eight (32%) reported the school as their only source of information compared to 28% stating that parents are their only source of knowledge on STIs. It also shows that for females either the parents or the school are the main source of information on STIs. These percentages support findings in the literature that found comprehensive sexual education on abstinence and condom use to be more realistic and acceptable by youth (Kirby, 2008). Also, Lagus et al., (2011) point out mothers' awareness of sharing the sexual educator position with teachers.

The teenage population consisted of 11 males and 16 females. Of the 11 teenage males interviewed for this study, one reported not being educated about STIs. Of the remaining 10, 36% reported being taught by both a parent and school-based sex education curriculum. Eighteen percent learned only through school curriculum. One reported learning from a combined effort of parents, school, and a community-based organization. Of the remaining three, one was taught by parent only, one was educated only through the community-based organization, and one learned about STIs from a parent and community-based organization.

Of the 16 teenage females, the percentages were identical for receiving STI information from parents and school-based curriculum. Thirty-eight percent reported parent only STI education and 38% reported school-based only STI education. One female reported learning about STIs through Planned Parenthood, one gained information through a combination of parent, school, and a community-based organization, one was taught by a community based organization only, and a final female did not report having any STI knowledge.

Of all teenagers combined percentages for gaining STI knowledge followed these rates: school-based curriculum (30%); parent only (26%); parent and school-based (15%); and parent,

school-based, and community-based organization (.07%). Almost 72% of students gained STI knowledge through a combined effort of parents as sex educators and through the school-based curriculum.

Theme II: Factors Influencing Communication

While researching what prompted parents to begin conversing with their teens about sex and relationships several scenarios were mentioned; including noticing their physical development and observing changes in their behavior. Usually, parents noticed that girls had become more vocal. Also, parents began hearing from their children about the behavior of peers. Some were prompted by awareness of their teens' sexual debut. For instance, one parent of two teenagers became aware of her son's sexual activity through his own admittance. He had not taken seriously her attempts to talk to him about his unhealthy sexual behavior. She reports it this way:

I believe when I started hearing those stories about him with girls and stuff, I feel like I had to sit down and talk to him 'cause at the time....at the time his dad was locked up so he couldn't really talk to him. So I feel that I had to step up and try to talk to him you know. He thinks it's funny. Well, I was talking to him about that it's not right for him to be running around with all these different girls, because not only are you having sex with them, you still playing with these girls emotions. You know...he has a habit of telling them that he loves them when he don't. And I told him, I said it's not how you treat women period. You know, and I tried to talk to him about the importance of protection. That goes out the window too. So he, he basically wanna do his own thing. Sandy, 35 year old mom, parent #132

Because of his seemingly rebellious attitude of being sexually involved with several girls at the same time and not using protection, she decided to talk to her daughter, who had not become sexually involved, about the dangers and consequences of having unprotected sex especially with several individuals simultaneously. According to Sandy, her son's behavior prompted her to have a conversation with her daughter, 16-year-old Louvenia. Sandy stated:

It's the things that I'm going through with him, so I want to catch her before she gets started. I mean he has a lot of girlfriends. And he, I don't know, he has it in his mind...I know he's sexually active. And when I talk to him it's like I'm talking to the wall. You know, it's like he don't use protection, and um, I mean, he thinks it's cool to have a lot of girlfriends. He always talk about getting somebody pregnant. So with her, me hearing how he thinks, so I'm like well let me talk to her, cause I know, well as far as I know she's not sexually active. But she at that age, so I want to get to her before she get out there, so she don't end up making mistakes, especially the mistakes I made... Sandra is a single mother who admits to having her children during her teenage years. Sandy, 35-year-old mom, #132

She moved to Syracuse from New York City after visiting a sister who was living in Syracuse. The sister later moved out of town leaving Sandy and her two children without any blood relatives in the city. She was referred to me by another participant. Sandy's apartment was about a local bar on the south-side of town. The apartment was sparsely furnished but tidy. I interviewed her in the living room. She appeared quite comfortable with the interview. Once we had completed our interview she went out in the hall to call for her daughter. The daughter was interviewed in the bedroom.

The bedroom was furnished with a chair, a mirror leaning against the wall, and an uncovered mattress on the floor. Initially, Louvenia appeared very shy and her responses were barely audible. After sharing with me how her day had gone at school she relaxed and professed her desire to have a boyfriend and fear that she wouldn't because of her looks. I was able to encourage her telling her how beautiful she was and getting her to promise me she would look in the mirror every morning and tell herself how beautiful she is. This brought a smile to her face. Afterwards, I noticed that she no longer fidgeted with her finger nails, she spoke in a more audible tone, and even laughed a couple of times during the remainder of the interview. Louvenia explained that she is aware of her brother being sexually active and their mother bringing him condoms. She added that her mother spends a lot of time talking to her about sex

and boyfriends because they only have each other and not a lot of friends. When I asked her what specifically her mother said to her about sex she said:

Tells me to wait. But she knows when I do start thinking of it, she said to tell her. She wants me to use protection—that's number one. Louvenia, 16-year-old female, #133

More responses, however, dealt with the parent's religiosity or the onset of dating. This was determined by asking parents two guiding questions about what influenced them to talk to their teens about sex. One question was "What prompted you to have the conversation with your teens about sex?" The answers most often were affiliated with parents' moral stance and religious beliefs or the teens' interest in the opposite sex and dating. As previously discussed in chapter 3, daughters were given the morality talk more often than sons. However, both genders were reminded of the biblical teaching which discouraged premarital sexual intercourse. As one grandmother shared, her entire conversation about sex was biblically based. She taught a biblically based curriculum about what sex is and what sex is used for to children at her church. These teachings were carried over into her home with her own children. She taught that God says sex is for married women and men to procreate.

The second guiding question asked of parents about what influenced them to initiate the discussion of sex with their teens was "At what age was your child when you began the conversation about sex?" Most parents showed little hesitation and easily responded to this question. These parents stated that they began talking to their children at ages as young as 12, but typically age 13. With some parents, I was able to ask this question early on in the interview. With others, the question was asked later in the interview. I suggest that because of their life experiences more time was needed to allow them to feel comfortable enough with me to answer questions about sex. For instance, Stella who was a mother of four children by the age of 21

discussed her experience of becoming a mother at the age of 16 and compared it to her daughter becoming pregnant at the age of 15. She pointed out to her daughter the responsibilities that having a child would entail. To help her daughter understand the responsibilities she allowed a close relative leave her infant overnight for the 15-year-old to watch. The reality of diaper changes, overnight feedings and cries through the night helped the daughter conclude that becoming a parent at 15 years old was not something she wanted. Her ultimate decision was to have an abortion.

Religion and Morality. Parents stressed the importance of teenagers, especially daughters, living a life of high moral standards. However, from a religious stance, parents reinforce the biblical teaching of abstinence until married. Parents reiterate to both adolescent males and females the message of “saving yourself” until marriage. Moore and associates (2015) in their recent study using a focus group approach with African American teen churchgoers, report 80% or more of teens having discussed STIs and delaying sex with their parents. Also, 70% stated a discussion about condom use. More than half of these teens stated they intended to “delay sex until marriage” (p. 1814).

One father, Gregg, is that he has instructed his children well on proper behavior and by having them baptized they will obey his rules and not engage in premarital sex. He explains it this way:

I don't really have to discuss that. I think parents who need to discuss that in my opinion, sex with their children, have children who are at risk for certain behaviors. I think if you run your ship the right way, and you do what you're supposed to do....put God first in your life, have the kids baptized like I did....Have them baptized knowing that they are the children of God, my earthly children, my heavenly brothers and sisters—and you put God first and you raise 'em, and you teach them lessons as you go on. You don't need to touch base on all those particulars too much. I don't really have to discuss it because of the rigidity, it's almost like they know not—you know what I mean? If you raise 'em right, you know. Gregg, 40-year-old, #142

Gregg is a 40-year-old married father of three teenagers. He and his family reside in the suburbs, but he is employed in the city and was reared in the city where his mother and most of his siblings still reside. He has admitted that some of his parenting practices were mimicked from his parents and the way they reared him and his siblings. During the interview with his 15-year-old son, Aaron, I asked if his parents had ever had a conversation with him about sex and what was said. The following is Aaron's response:

Uh, they kinda like, it's not really like a conversation. It's kinda like a speech. Like you know you're not supposed to do this and that sex isn't something you should be doing...It's not a conversation, 'cause I don't really talk about sex more than five minutes. Basically it was just like you know you're not supposed to be doing this. Like having sex with so and so it shouldn't be on your mind. You should be worrying about school and stuff like that. Aaron, 15-year-old male, #143

As we continued our interview, I later asked what he had learned from the church about sexual behavior. He responded:

Well churches are like the complete opposite of what they tell you. To focus on God and then you won't have to have sex. Wait 'til you're married and stuff like that. Basically, the church is trying to tell you stay with us and we'll lead you up to the point where we want you to be. That's how I see it. And church, and our religion isn't like a big, big part of what we do in life. (Aaron, 15-year-old male, #143)

Based on the responses from this father and son, it appears that the son confirms that his father has briefly discussed with him to not engage in premarital sex. However, he does not confirm that his father has explained it to him from a biblical stance. According to Aaron, his parents mentioned that his focus should be on school as opposed to sex. When specifically asked about the church's teaching on sex his response hinged on doubt that people actually wait until marriage to engage in sex. And he commented that church and religion was not a big part of their life. Which is the opposite of the picture his father painted about how rigid he is and

how he promotes putting God first in all things. The father's teaching, thus far, have caused Aaron to delay sexual intercourse.

Another parent who was more involved in church activities was a grandmother who taught sex education classes at her church. She taught children from a biblically based curriculum about what sex is and what it should be used for. These teachings were also used in her home with her children and now her grandson. Mrs. Santella stated that she had been talking to her grandson since the age of 11 about sex and dating. He is now 15 years old. Below is an excerpt of her response when I asked her about the classes she taught:

I teach the children how to seek God, how to stay pure, how to keep their bodies pure. We teach 'em morals, we teach 'em what sex is and what it was, an instrument, what God intended it to be, and the way it is used now, and the way it should be used, and, we teach abstinence. That sex before marriage is a no-no. You do not have to have sex. You do not have to have sex to please a young man. And the young men don't have to have sex to please the young women or other young men. You have to think for yourself. You have to know that God sees and knows all and if he said in the Word that you do not have sex, then that's it—you don't have sex. Sex is for married women and men.” (Parent #102 (2))

Her tenth-grade grandson who reports that he is not sexually active states he is comfortable talking to his grandmother and confirms that she has taught him about abstinence. This teenager's demeanor was quiet, yet comfortable and alert. He presented as a mature 15-year-old looking directly at me when answering questions. I believe he took the interview very seriously and gave me no reason to think his answers were not honest. I asked him to share with me the conversations between he and his grandmother about sex and he said:

“Well, there wasn't really that many conversations about the issue. I mean she told me basic stuff like wear a condom if I have sex, and you shouldn't have sex really until you get married. Yes, to wait until married to have sex.” (Teen #104—15-year-old male)

Another father mixed biblical teachings with pamphlets used during outreach to convey messages of abstinence to his daughter. He elaborated on protecting yourself, your partner and your child's life should you become pregnant:

“...That it is a disease that would, that does not discriminate and doesn’t care how wealthy, how rich, how poor. And that you need to protect your life and your partner’s life. Your children’s life. And that one, one night of ignorance and passion, can affect you for the rest of your life. And your children, and your child and your body and tell them that their body, and I tell my daughters, your body is a temple and um, even in my preaching and talking to the kids in church. And um, you know some preachers are probably,. I mean, I’ve shared this, they’re like man, I never thought about that. That, when Mary became, you know for those who embrace Christianity, when Mary became pregnant with Jesus, by the overshadowing of the Holy Spirit – scripture says, and Joseph knew not his wife until she delivered her first born. And I shared with them, I said, I just took it to a whole lesson – that when a woman becomes pregnant, that her body insulated the fetus, insulates the baby. But her vaginal cavity can still become infected and that as, if her partner has some sexually transmitted disease, such that when the child is born and passes through the vaginal cavity, that’s why they use silver nitrate – that’s why babies are being treated and they can be infected. I said, ergo, Jesus needed to come into the world without any contamination at all. So, Joseph was never introduced to Mary. He never knew her. He was not intimate with her so that when Jesus passed through there was no man, no one’s contact except God. So, I use that to say to the young people, you need to be careful about who’s coming into contact with your destiny. What you’re carrying. Because, as you deliver it, it can become infected. It can become blind and halted and withered. So, you have to be careful about whose speaking into your womb of your spirit and who’s speaking into you, because as you get ready to deliver your dream, it could be crippled.” (#156, p.8)

A forty-two-year-old mother of two sons mentioned that the church should be involved in teaching teens about STIs. She admits to having a religious upbringing and being a regular church attendee. I asked how religious beliefs influenced the way she related to her sons about topics of sex and STIs. This is what she had to say:

“Well, I know that I’ve been through a lot you know, in my 42 years. And I know that God can change things. And I just tell them you know, you gotta do the right things in life, because when you don’t do the right things in life, God frowns at you. I mean – you need to honor your mother and your father. You just need to try to do the best that you can to go straight, because the devil is out there ready to just chew people up and spit em right out. I don’t want my boys to, you know to, go through hell if I shall say, you know, coming up. When I’ve taught you what you should and should not do, and you know right from wrong so you just have to make the right choices in life, you know.” (Tammy, #114)

As I interviewed her son, he appeared a little hurried. The interview took place on a Friday evening and I soon found out that he was excited about attending a house party with some of his friends. Madison has a girlfriend whom he enjoys taking to the movies. He reports that they are not sexually active. This 14-year-old, Madison, was asked when his mother began talking to him about sex, what she said to him, and what he learned in church about sexual relationships. He stated simply:

“About 12. She said don’t have no kids. Always wear protection and that’s all I know. When I go to church they don’t talk about sexual relationships. No. I heard about lust. They said lust is a sin”. Madison, 14 year old son, #115

Madison further stated that he was aware of where to get condoms for protection should he need them. However, he thought he was too young for sex and spent more time talking about playing video games with his friend, Abdullah. This mother-son dyad is an example of parents talking to their children before they become interested in sex to help delay the onset of sexual activity.

The literature links teaching of religion and morality with strong parental ties to a church or religious organization (Gold et al., 2010; Manlove et al., 2006). Parents and teens in this study confirm findings in the literature which suggest that parents with religious standards who share these beliefs with their teens can have a positive effect on teenagers’ decisions to delay sexual debut. All of the teenagers in my study, whose parents reported being explicit with them about the biblical teaching of sexual intercourse, reported that they were not sexually active.

Dating. Inez was asked if she talked to her children about choosing a partner. This is her response:

Yes. I told them, I talked with them and I, I tell them, if you got one little girl and she’s nice, you treat her right. You don’t have to see how many notches you can put in your belt. And you do nice things like go to church with her. Have her come to church with

you. Invite her here for dinner, you know. Or I'll drive you guys, to the movies, and I'll come and pick you up, but don't just be laying with everything that, you know, that wants to lay down. Because you don't know what you're getting. Inez, mother #164

Her son Grady has been dating his girlfriend for one year. He reports that they are not sexually involved. Asked what do you all talk about or do together. He responded:

We just talk and have fun and hold each other and laugh and watch movies. like we talk about what we gonna do with our life when we get older and we laugh about funny stuff like if we watchin' a good movie and we sitting next to each other. We might laugh and then get on another subject. We don't be doing nothing really. We just be talking to each other. Ain't no sex or nothing like that going on right now. (Grady, 16-year-old male, #165)

Grady appears to have taken his mother's advice on choosing a girl who is not interested in laying around. He and his girlfriend have made a decision to not become sexually active and are making plans to further their education.

Asked Ms. Wiley what age was her daughter when she started talking to her about sex and STIs:

...She may have, maybe about 11, when I kinda started talking to her. She did start her um, I believe she started her period at 12, but the doctor kinda, was like she's going to start soon. Um, so he was kinda prepping me for that stage of it, because he said as, you know as big as she was, as far as like her height and her weight and he said that does play a factor in children starting their cycles early. Girls starting their cycles early, so that made me feel like I need to hurry up and you know, at least start talking to her about it, so that's kinda how we started.

...cause I know she's talking on the phone to boys and things like that you know, and I talk about her making sure she carries herself properly when she goes places, and stuff like that. You know, not to let boys hang all over you, and you know, touch you out in public and things like that. You know, hugging up on you, that kind of stuff and I start off jokingly and then most of the time it turns into real conversation, but she does say she knows better. (Ms. Wiley, 32-year-old mother, #124)

Her daughter Jennifer responded:

Now we talk more about relationships and like, how to carry yourself in a presentable manner. Like she tells me don't go around chasing after every boy I see, because that's not appealing and that's like, not carrying yourself with respect and dignity. And, how I

should stay focused in school and stuff like that. Like, not getting so carried away with cute boys that I let my grades drop because nobody wants to be with somebody stupid, who can't get their grades right so, it would all be pointless. My mom's a very funny character so... just random stuff like that.” (Jennifer, 15-year-old female, #129)

“so she's like, if or when I get in a relationship, make sure it's full of respect and trust and it's not just like physically based or sexually based. Make sure that it's for my good. Somebody who's not going to hold me back. Gonna not keep me focused from school. Stuff like that.” (Jennifer, 15-year-old female, #129)

Theme III: Barriers to Parent-Teen Communication

Parents can sometimes face challenges when engaging their teenagers in substantive conversations about sexuality topics. Embarrassment and discomfort are prominent affective dimensions that hinder parent-teen sexuality discussions (Byers et al., 2008). Some parents have deferred to community centers or medical personnel as primary resources for their teenagers to access information and discuss sexuality topics. Other parents are completely uncomfortable with the whole idea of talking to their teenagers about sexual topics. There was one parent (the outlier) who found it impossible to have this discussion with her daughters. She expressed how uncomfortable and embarrassed she became whenever one of her daughters would approach her to talk about sexual topics. After several attempts by the daughter to get her to discuss what sex is all about, the daughter has now informed her that she is no longer a virgin. This mother referred her daughters to medical personnel. She explains it this way:

I didn't know where to begin. There was just so much stuff going on that I really did not know, 'where do you start talking to your child about sex?' It's hard enough trying to figure out the menstrual period and how you're supposed to do this and do that, especially with girls. So after I got over that initial shock, I figured that if they were going to be sexually active—the older girls that is—it would be better for them if they couldn't talk to me that at least they'd have birth control and a contraceptive to keep them from getting pregnant and without me having to be involved—that's why I took them and registered them at Planned Parenthood. They could go up there and get condoms. They could go up there and get birth control. They could go up there and get tested. They can go up there and do everything as long as they were initially brought up there, and without being afraid to come and say something to me—all they had to do was go ahead and go up there 'cause they were already registered. Parent #100 (1)

This parent is obviously agonizing over what to say or how to discuss sexuality topics with her daughter. She does realize that her daughter needs support, protection, and guidance now that she is sexually active, but decides it is too much for her as a parent to handle. This mother resolves the issue by scheduling an appointment for her daughter at Planned Parenthood. As the daughter revisits this experience, she views it as a positive decision. The daughter points out the benefit to visiting Planned Parenthood:

I would rather she told me, even though she was mad at me, I would have rather she sit down and talk to me, but being at Planned Parenthood also was an advantage, because I was able to say what was on my mind. Cause with mother, I hold back some of the stuff that I want to say sometimes. I was able to ask a lot of questions. I was able to get better information on birth control than my mother was giving me and like, she was like the information on birth control she gave me was just to stop having sex. Like she didn't even want to think about—she didn't want me doing it at all. The other issues on my mind were like what would the side effects be by me having birth control, taking birth control? What would the side effects be by me becoming infected with a disease? What if I didn't catch the infection or something in time—what would happen? And like, who would I talk to, who would I get the medication and stuff from without telling my mother or something if that were to actually happen to me? (Teen #101—18-year-old female)

This mother-daughter dyad shows that parents sometimes struggle with educating their teenagers about sexuality and community-based programs or clinics are helpful in reaching teenagers and fulfilling the need for STI knowledge and prevention methods. Ms. Tims was so uncomfortable with this discussion that she insisted the interview between us be conducted inside her van and not inside her home. She explained to me that sitting in the van made her feel more confident that none of the children could hear what she was saying. Her van was parked in an empty lot adjacent to her property. It was a warm afternoon so we sat inside the van with the side door open. In the background, I could hear the sounds of cars passing by, people walking by and talking to each other, as well as the sounds of laughter from her children sitting on the steps and front porch. Her demeanor was pleasant and her comments were long and laced with

profanity. I was a bit uncomfortable with her use of the “f” word, but chose to keep my feelings to myself. My thought was that she might withdraw and not continue to be as open and honest with me. Rather than lose what I considered a good interview I kept quiet. In retrospect, my speaking up most likely would not have changed anything.

Peer Pressure. Not many of the sexually active adolescents interviewed referred to peer pressure as the reason for becoming sexually active. However, Sally who was pregnant at the time of the interview did state that she wanted to experiment because “sex is very common in school...it’s an average thing to do” p. 8 lines 245-248. And Cleon implied being sexually active at 16 years old, because if you have not had sexual intercourse by age 16 friends think you are gay (p.6 line 145).

Life Challenges. A prevalent theme in several of the interviews was the many challenges parents were facing in their lives. I contend that life challenges are a barrier to parent-teen communication about sex, dating and the risk of STIs. Parents are trying to discuss pragmatic harm reduction with traditional values within the pressures of perceived danger in a number of areas. Subsequently, parents have to walk a fine line between traditional sexual conversations to be more realistic in their discussion. These parents are doing a heroic job given that they are up against a litany of social issues. The troubling reality of their child being killed or incarcerated is one issue. Stories of police shootings of young African Americans dominate the media. Watching the images of these young men and women night after night is heart wrenching for the general population. So, the physical and emotional pain experienced by parents and relatives of one of these victims of police brutality is unimaginable. Grieving over the death of a child, sibling, or parent lost to street violence is also emotionally taxing. In addition, parents work tirelessly to adopt strategies that will keep a son or daughter’s self-esteem

up in the loss of the absent parent's love and attention. We must not forget that many African American parents are continually coping with the lack of sufficient finances to move into adequate housing. Though African American parents are deeply thoughtful, for many, these issues are a constant as they try to rear children with love and compassion in the midst of daily risk and danger for their children's lives. As evidenced in Ducre's (2012) study of women in Syracuse on how policies and economics affect the safety of their environment. One mother expressed it this way when asked about her fears for her children. "The worst thing I could imagine happening to my son is him being beaten and me not being able to get ahold of him—something bad happening to him. Or a drive-by shooting, or something like that, you know. And me not knowing something has happened to my son" (p. 74). The mother quoted here was not concerned about her son's STI status, nor him graduating from high school or college, but him making it back home alive. Often, these realities of danger take priority over taking time to discuss sexual relationships and the risk of STIs.

Lack of Friendships. The mothers of Louvenia and Sabrina maintain a close mother/friend relationship with their daughters. Louvenia stated this is due to absence of friends in either of their lives. Louvenia shared with me her desire for friends. There are days she misses school due to the isolation she feels while there. On the other hand, her mother is feeling overwhelmed with the inability to get through to her son that his unprotected sexual behavior and spending too much time in the streets is unhealthy. Sabrina's mother works diligently to involve her in activities that have her on track for college. She is fortunate in that a member of her church has shown an interest in Sabrina's future. However, Sabrina is often depressed about the lack of attention her father gives her. Mothers Carrie, Maya, and Sharice are dealing with the

loss of a brother being shot to death in street violence. Grief was evident in their words and tone as they spoke about the devastating losses.

Abusive Relationships. The day-to-day struggles of mothers living in abusive relationships can overshadow focus on sexuality conversations with their teens. Mrs. Fogarty, a married mother of two daughters is concerned about the safety of her daughters, but appears overwhelmed with the additional problems of living in an emotionally and verbally abusive relationship. Her socioeconomic status is also a stressor. Her lack of financial stability is one of the causes the family is living in dilapidated housing. These stressors contribute to family pressures and tensions. So much so that when she attempts to engage in conversation with her daughters about their choices of sexual partners and sexual behavior they are quick to remind her of the ways she allows their father to treat her. Despite these challenges and life experiences, Mrs. Fogarty has survived. She continues to provide the best home she can for her family. As well as, find ways to be supportive and show interest in their health.

Theme IV: Communication that Reduces STI Risks

Communication that reduces STI risky behavior teaches teens about abstinence as well as the various modes of protection from STI infection and pregnancy. A pilot program based in Michigan used a mixed-methods approach providing parents with an audio CD, print materials, and questionnaires to engage parents and teens, as well as, increase parents' efficacy in talking about sex with their teenage sons (Weekes, Haas, Gosselin, 2013). The result was positive for increasing communication about sex with their sons using the multimedia intervention.

Sexuality discussions involving fathers and teens have been proven effective. Parents may approach sexuality discussions differently. These gender differences are mainly with the fathers. Fathers are found to be more comfortable having these discussions with sons than

daughters. This father is a general representation of how fathers view these conversations with daughters:

I really don't know much about birth control. I just more like let her mom talk to her about all the birth control. But I, just like I tell her, if you ever get in, in the moment, I said I know you teenagers, somebody touch you, lovey, dovey, whatever. I said I ain't with you all the time. I say I know there's some things you won't talk to me about but you talk to your mother about. And I tell her, I know for sure, your mother gonna talk to you about birth control, just as well as I talk to your brothers and them about using protection and wearing rubbers. I said that's the number one thing you do if you get out there. You can't help yourself, then make sure you got some protection. If you ain't got no protection, don't do it. Walk away. Parent #162 (29)

Most fathers would prefer that mothers talk to daughters about sexuality topics leaving the discussion of condom use and sexual intercourse between them and sons. This father acknowledges the probability that teens will become sexually active in his reference to “your mother gonna talk to you about birth control.....as well as I talk to your brothers and them about using protection and wearing rubbers.” He maintains that the subject of birth control for daughters should be discussed with mothers only.

On the other hand, there are fathers who will take the time and have in depth conversations with their daughters about the importance of protecting herself during sexual intercourse. Below is an example of such a father and his response when asked about his level of comfortable talking to daughters:

I wasn't uncomfortable talking to my girls about anything... That's because from birth we've been an open discussion family. There was no, you know, don't do this and what's that? We were open and honest with them in conversations of sexuality... Brandon, age 45, parent #156

His 15-year-old daughter says she is not sexually active because she wants to make her parents proud. She confirmed that her father discussed sexuality and STIs with her in the following statement:

Um, well I learned most of the information about STIs and like HIV from my dad because he helps other people in trying to...help them get knowledge of what STIs are, what they can do to you and like what, how they affect your life...and mostly what I know is that a sexually transmitted disease you can get from any sexual, you know, contact and sexual intercourse. Zora, 15-year-old, #157

Another father shared just how detailed he was in conversations with his daughters. He is a father of two teenage daughters. He explains that he has been talking to them and educating them about sex and STIs since their infancy. He adds that through his history of drug abuse and street life he had a lot negative experiences that he wants to warn his daughter about. He explains it this way:

As they was growing up – even in grade school – I would sit down and I would tell em, um, I would tell them the dangers of sex, uh like, you know, fact that you could get AIDS, STD's. Um, I would sit down and would have discussions. I would ask them like is there anything that you wanna ask me. You know, when they were real small, they would respond –you know what I'm saying? They would – um, they would ask me questions like um, well daddy um,... why are boys always trying to get us to do this, and so on and so forth. And I would be as straight as possible. I wouldn't try to um, cover it up. I wouldn't try to sugar coat it. I wouldn't try to give em one of the little nursery rhyme type things. I would tell it to em as I saw it. As they grew older, they would only come to me, um, just rare occasions, you know, like I would ask em, I would ask em questions and I would tell em about um birth control. I would tell em about more of the emotions and the burdens if you become pregnant. They knew um, maybe it was my fault. They knew that um, I wouldn't like it if I knew that they were sexually active at a young age. They kinda knew this. Because they...because they would tell me for the longest, they would tell me, dad you're our best contraceptive, because whenever somebody says something to us, your face is what I see, so you know, I'd tell them no... But, they um, you know one thing that I found out is that the biggest control that you have over your kids is from when their born until they start daycare. When you, when they start um, daycare, preschool or kindergarten, whatever, where they're interacting socially with other kids – their own peers – um, you lose a great deal of your influence over them. (LJ, 54-year-old father, #116)

His daughter, Sylvia reports that her father had these conversations with her and her sister, but she remembers them beginning at a later age:

I was, I felt like he was doing it because, one, we were girls and two, we were his baby girls. So, he wanted to protect us. But then again, I know that he knows we're not going to be babies forever so my daughter's going to have to know one way or another and he'd rather it be through him than the actual experience. So...The main thing was, you know I love you but um, he would tell me like I know you see different things that's going on around you, and from there he would continue on about sex and like, if you wanted a boyfriend, how would you start off as far as what would you jump into – trying to have sex or get to know the boy first. And I let him know, I have to get to know you before you can even think about it – cause one I don't know nothing about you so I don't know if you got something, and two I don't know who you been with. Sylvia, 17 years old, #119

These two fathers are both concerned about their daughters being educated about sex, dating, and the risk of STIs. Both men report beginning these conversations with their children at very young ages—basically when daughters were toddlers and infants, respectively. However, each has a different approach. Brandon's discussions have more of a scientific approach and LJ's approach is more from lived experiences. Brandon explains to his daughter how one becomes infected with an STI and educates her on the various STIs. LJ gives a comprehensive detailed message of love, precaution, and personal consequences of engaging in sexual activity. Both achieved the desired result of having daughters who reported not becoming sexually active in their early teen years.

Summary. In summary, the quotes from parents show that they see the need for sexuality discussions with their children and they are interested in being sexuality educators. For the few parents who feel unable or overwhelmed with sexuality topics, they utilize community or medical resources to assist their children in gaining knowledge about what sex is, condom use, and prevention of unwanted pregnancies or STIs including HIV. These teenagers are examples of references in the literature to what parents teach their children about STI/HIV as well as what is taught in the school system about sexuality and STIs. With regard to religion and morality, it appears that youth understand the message of abstinence, but do not necessarily view it as realistic. Teenagers are also concerned that parents are not as open during sexuality discussions as they perceive themselves to be. Teenagers repeatedly state that they would appreciate it if their parents would “listen to them.” Adolescents understand listening as being able to ask questions and voice their opinions on subjects related to sexuality and STIs.

Even though parents are having in-depth conversations with their children about what sex is, dating, pregnancy and STI/HIV prevention, the CDC (2011) reports higher rates of STIs and pregnancies among African American teens than other ethnic groups. It appears that an important factor in reducing these rates is to implement programs that train parents in effective ways to communicate with their sexually active teens about knowing their STI/HIV status, as well as, the status of their partners. The CDC (2011) reports knowing partners’ status to be valuable to one’s remaining HIV negative. Parents have had conversations about what STIs are, how abstinence or condom use can prevent becoming one from becoming infected, how STIs are contracted, and where to get medical care in case of infection. Not one parent in this study mentioned talking to their teen about being tested or finding out the STI status of their partner.

Three of the teens reported that they discussed STI infection with their partner. These three teens also reported being tested together and finding out the status of their partners.

It appears that teenagers are aware of consequences of unprotected sex and know how to protect each other by using condoms. So, what is missing in the conversations? Are teens aware of partners STI/HIV status? Maybe that is the reason for high STI/HIV rates among African American teens. Parents are talking to them about sexuality topics, but not requesting that they know the status of their partner before engaging in sex. I did not ask parents if they included this request in their conversations and parents did not divulge making this request of their teens. Also, this study revealed that parents are speaking to their teens pragmatically regarding dating, sex, and risk of STIs by making the discussion conversational and using humor. In some cases, parents offered the assistance of community health agencies to their teens by making appointments for them to gain knowledge about healthy sexual behavior. During these conversations, most parents revealed the high rates of STIs and presented a scenario of unplanned pregnancies reminding them of the consequences of unprotected sex and informed the teens of parental responsibilities.

Additionally, only one of the parents reported being involved in a parenting support group. All of the parents voiced concern for the healthy sexual development of their children and many of them expressed their bewilderment with other aspects of parenting such as their child's mental and physical safety. The majority of families interviewed resided in lower-income neighborhoods with increasing violence and drug activity. Parents residing in impoverished neighborhoods would benefit from social support which could possibly lessen the stress of parenting. Mothers would not have to voice their fear of "imagining my son being beaten or a drive-by shooting and me not knowing something happened to my son" (Ducre,

2012, p. 74). Less stress could then open the way for more frequent and comfortable sexuality conversations.

Of course, none of this can be actualized without policies in place to assist parents and teenagers. Community members must elect politicians who value their health holistically. When health policies are created to help the poor and underserved, funds will be appropriated to implement programs that recognize inequalities and work to rectify the gaps.

Chapter 5: Conclusion

The main purpose of this study was to determine if African American parents are communicating with teens about sex, dating, and STI risk and prevention efforts. To my knowledge, no one else has ever conducted in-depth qualitative interviews with African American parents and teens on these topics. This study is a significant contribution to the knowledge base about the conversations going on between parents and teens. This study is different from other studies on African American parent-teen communication about sex, dating, and STI/HIV risk and prevention in that; face-to-face interviews were conducted mostly in the homes of participants, participants were not recruited from STI clinics, and families represented varied socioeconomic backgrounds. This study examined parental sexual communication and its impact on adolescent sexual decisions.

The results of this study present a positive and hopeful view of African American parents and conversations with their teenagers about sexual behavior. These findings represent direct opposition of the media's negative view of African American parents and their efforts in combating risk of STIs and pregnancy rates with teenagers. In this study, I have learned that parents and teens are having detailed discussions about sex, dating, and STI risk and prevention efforts. The parents in this study report talking to their children at early ages, some as early as preschool ages. Furthermore, parents report these conversations continue well into late teenage years with their children. Their goal is to continually educate them about the consequences of unprotected sexual intercourse. These parents advocate condom use and birth control to prevent STIs and pregnancy. All while navigating the injustices of daily lives.

Parents shared their knowledge of STIs which added to the knowledge teens gained in school about STIs. These conversations were initiated when parents noticed that their children were interested in dating, children showed signs of puberty, or if the behavior of one of the teen's peers changed. The religious teachings of abstinence and no premarital sex were added to many of these conversations. Many were uncomfortable but broached the subject despite their feelings. The few parents who reported being too embarrassed or uncomfortable to personally discuss the topics with their teens referred them to a community clinic to gain knowledge. For these parents, the barrier of embarrassment was overcome through community assistance.

The CDC (2013c) has stated that one of the factors for African Americans having high rates of STI/HIV infection is one does not know partners' status. None of the parents in this study reported discussing the need for teens to know their STI/HIV status or that of their partner. Neither did the majority of teens report knowing their STI/HIV status or that of their partner. Out of all 27 teen interviews only three teens discussed having knowledge of their STI/HIV status and that of their partners. However, parents were persistent in their warnings to not participate in unprotected sexual behavior; which is known to be a leading cause in becoming infected with an STI.

This present research confirmed prior research findings that teens whose fathers discussed with them what sex is and condom use were more likely to use condoms if sexually active and daughters were more likely to delay sexual intercourse. Also, this study did find fathers to be active participants in the discussions with teens about what sex is and condom use. Their daughters reported delaying sexual activity because of these conversations. Several of the fathers reported their preference to talk to their sons and leaving the discussion with daughters to mothers. In addition, this study confirmed that mothers talked to teens about sexuality topics

more than fathers. Mothers reported higher levels of confidence talking to both genders than fathers. Both parents expressed more leniencies about dating with sons than daughters. The concern most often mentioned was that of the daughter becoming pregnant. Both mothers and fathers expressed that they did not want their daughters to become mothers during their teen years. Parents viewed teen parenthood as distraction from attaining a college education.

Most of the teens reported that it was “weird” or uncomfortable to talk to their mother about sexuality topics, but added that they do want parents educating them about sex and dating issues. Only one of the thirty teens interviewed was pregnant at the time of the interview, another, the 19-year-old, was a mother, and one was reported to have had an abortion. The remaining 27 teenagers reported never being pregnant or impregnating someone. The 19-year-old was the only teen to report ever having had an STI. The teenagers reported wanting parents to talk to them about sex, dating and risk of STIs. Parents and teens are interested in programs that would enhance parent-teen sexuality communication. In this study, it appears that for the majority of teens discussions with parents had a positive effect on delaying sexual debut and condom use. The age related differences in sexual debut appeared in older teenagers. For participants of this study, active sexual behavior was reported by older teenagers aging 16 to 18 years old, but not the younger ones aging 13 to 15 years old.

Limitations of the Study. This study was limited to a small segment of the African American population residing in Syracuse, New York. The population of this study resided in, was employed in, or attended church in the 13205 zip code. Results from this sample cannot generalize to the greater population due to its small sample size. The average income level for participants was below \$40,000. Also, only one parent and one teenager from each family was interviewed. None of the older or younger children from these families were interviewed. My

insider position was that I am an African American mother who has been employed and attended church service in the 13205 zip code. My outsider position was being affiliated with the university as a graduate student.

Another limitation is that I was the sole researcher. Using two researchers during interviews may have provided a more diverse perspective of participant responses, environmental affect, body language as well as a different interpretation of responses. Using younger researchers or a male researcher may have produced different responses from participants. Of the 27 qualifying teenagers interviewed, only a handful of teens reported being sexually active. There were a couple of instances where I questioned if the interviewee was saying what they thought I wanted to hear as opposed to being honest. Even though I am not their parent, are teenagers going to tell an adult the truth about their sexual behavior? Would filling out anonymous questionnaires and participating in an interview have been a better way to get at the truth? However, for the majority of responses, I believe they were being honest with me.

Recommendations for Future Research. The findings suggest that African American parents are having conversation with their teens early on about sex, dating, and risk of STIs. The majority of younger teens in this study whose parents discussed sexuality topics with them reported that they have delayed sexual debut or implemented condom use if they were sexually active. Older teens reported being more curious about sex and more of them became sexually active with condom use as they matured. The disconnection between African American parent-teen sexuality discussions and the report of continued teen parenthood and rise in teen STI rates remain a concern. Recommendations include developing culturally sensitive curriculum, adding

more comprehensive sexual education programs, and training leaders/directors of CBOs and churches to provide additional community involvement.

Replication of this study is recommended in other cities and urban environments to determine if findings are consistent in other environments. Additional research interviewing only fathers and teenagers would be helpful in determining fathers' impact across socioeconomic backgrounds. Also, it would be beneficial to study parent-teen sexuality conversations between parent-teen dyads from single African American mother headed households versus single African American father headed households, working class African American families living in the suburbs versus working class African Americans living within the city limits, and between low-income African Americans and low-income whites. Conducting face-to-face interviews would add to the literature and give a more realistic view of African American parent-teen communication about sex, dating and STI risk. Having these interviews analyzed by African Americans researchers would also add to the literature.

There is implication here for what parents should be saying to teens, what schools should be teaching, what the community organizations should be pushing about being aware of partners' STI/HIV status before engaging in sexual intercourse. Developing programs that teach parents how to include in sexuality conversations the need to know partners' status is essential in having effective parent-teen communication about dating, sex, and STI/HIV risk and prevention. Many grassroots efforts, as well as local and national policies are necessary in enhancing the effectiveness of parent-teen sexuality communication. There is work for us all in providing an atmosphere of support in developing programs and curriculum that produces mass reduction of STI and pregnancy rates in the lives of our future teenagers.

Appendix 1

RESEARCH QUESTIONS

- How do African American parents engage in conversation with their teenagers about sexual relationships and STI/HIV?
- Are parents well-equipped with correct information and the confidence to have a conversation with their teenagers about sexual relationships?
- Do parents have the skills and support to share information about sexual relationships and health issues with their teenagers?
- Will this information enable teenagers to make well-informed and educated choices when it comes to sexual behavior and health issues?

Appendix 2

RECRUITMENT STATEMENT

The announcement read: “Good morning. I am Deborah Ellerbe, a graduate student at Syracuse University. I have recently received funding to interview 30 African American families. I will interview one parent and one teen from each family. The interviews will last approximately one hour. Both the parent and the teen will be compensated for their time. If you are interested in participating or would like to recommend someone, please see me after this morning’s service. Thank you.”

Appendix 3

ADULT INTERVIEW GUIDE

1. Tell me about the family you grew up in.
2. Talk to me about your family now (spouse, children)
3. What differences do you see between the two families?
4. How would you describe your parent's view of sex and sexual relationships?
5. What was a conversation like in your family when you were a teen about sexual relationships?
6. Where did you get information about health issues, sex, and relationships from?
7. How do you discuss these topics with your teens?
8. At what age did you begin the conversations with your teens?
9. What specifically did you say to them?

Appendix 4

TEEN INTERVIEW GUIDE

1. How much do you know about health issues, sex, and relationships?
2. Where did you gain this knowledge?
3. What do your peers say about these subjects?
4. Are you comfortable having this discussion with your parents?
5. Describe for me an event that took place, regarding these issues, where you would have liked to talk to your parent.
6. What kinds of obstacles/challenges do you see teens facing today
7. What are some of the questions teens have about sex, sexual relationships, and health issues?
8. When do you think parents should begin talking to their children about these subjects?

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