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FLORIDA INTERNATIONAL UNIVERSITY

Miami, Florida

EXPLORING THE DYNAMICS OF SEXUALITY CONVERSATIONS BETWEEN HAITIAN AND JAMAICAN PARENTS AND THEIR ADOLESCENTS

A dissertation submitted in partial fulfillment

of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

PUBLIC HEALTH

By

Kemesha S. Gabbidon

2017

To: Dean Tomás R. Guilarte
Robert Stempel College of Public Health and Social Work

This dissertation, written by Kemesha S. Gabbidon and entitled Exploring the Dynamics of Sexuality Conversations between Haitian and Jamaican Parents and Their Adolescents, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this dissertation and recommend that it be approved.

William W. Darrow

Jessy G. Dévieux

Florence George

Amy R. Paul-Ward

Mary Shaw-Ridley, Major Professor

Date of Defense: March 23, 2017

The dissertation of Kemesha S. Gabbidon is approved

Dean Tomás R. Guilarte
Robert Stempel College of Public Health and Social Work

Andres G. Gil
Vice President for Research and Economic Development
and Dean of the University Graduate School

Florida International University, 2017

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DEDICATION

I dedicate this dissertation to my wonderful mother Pauline Muirhead. You have offered the greatest level of support and encouragement throughout this entire process. I am deeply grateful for your endless optimism and willingness to listen to my ideas.

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Geralda Duverny, Rev. Dennis Archibald, and other community leaders, and educators you all have been tremendously helpful by allowing your organizations to serve as resources for my research study. To my research participants, I am deeply indebted to you for sharing your personal stories. Thank you for your candor and enthusiasm, without you none of this would have been possible. To my research team and current and former members of the Social and Health Disparities Research Working Group: Rachel Clarke, Jahdiel Murray, Katie McInvale, Brionna Powell, Cherrelle Dorleans, and Dr. Dudith Pierre-Victor, my sincerest gratitude for your feedback and hands on assistance. To my mother, Pauline Muirhead, sister Lackrishan Campbell and grandparents Louise and George Henry, thank you for your optimism and unconditional support. Thank you to the unnamed faculty members, members of my PhD cohort, and wonderful friends for your priceless encouragement. My sincerest appreciation to the University Graduate School for financial support in the form of the Dissertation Evidence Acquisition Award and the Dissertation Year Fellowship. Most importantly, I thank God for guidance, provision, and motivation.

ABSTRACT OF THE DISSERTATION

EXPLORING THE DYNAMICS OF SEXUALITY CONVERSATIONS BETWEEN HAITIAN AND JAMAICAN PARENTS AND THEIR ADOLESCENTS

by

Kemesha S. Gabbidon

Florida International University, 2017

Miami, Florida

Professor Mary Shaw-Ridley, Major Professor

Parent-teen sex conversations reduce Black adolescents' HIV/STI risk. Nationally, most studies about Black teens' sexual risk behaviors omit Afro-Caribbean groups whom are disproportionately burdened by HIV/STIs. Therefore, this exploratory study guided by the PEN-3 model (a) characterized the nature, perceptions, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and adolescents and (b) explained the relationship between sexuality conversations and adolescent sexual activity.

Using narrative inquiry, 6 Haitian and 8 Jamaican mother-teen dyads' and triads' (N=31) experiences were used to characterize the nature, perceptions, enablers, and nurturers of parent-teen sex conversations. Thematic content analysis generated common themes. In phase two, Black adolescents (African American, Haitian, and Jamaican) N=157, completed a validated 52-item questionnaire. Scales included ASAI; measuring recent pre-coital and coital activities; FSCQ measuring families' orientation towards sex-conversations, and PTSRC-III measuring sexual topics discussed with each parent. Linear

and logistic regression determined the relationship between parent-teen sex conversations and teens' sexual activity.

Mothers' mean age was (41.85±5.50) and teens' mean age was (16±1.31). Qualitative findings suggest that Afro-Caribbean mothers' limited childhood and adolescent sex conversations and outcomes of those interactions shaped mothers' existing attitudes, beliefs, and behaviors about sexual topics, and hindered their ability to discuss sex with their teens. Dyads believed modifying parents' approach, improving parents' sexual health knowledge, and increasing families' comfort with sex- conversations would improve sexual discussions.

Survey participants' mean age was (16±1.49) and mean age of penile-vaginal/anal sexual debut was (14.95±1.71). Twenty percent of sexually active teens had their first parent-teen sex conversation after penile-vaginal/anal sexual debut, p=.01, and 27% after penile-oral/vaginal-oral sexual debut, p=.001. Haitians had lower comfort with family-sex conversations than African Americans, p=.03 and Jamaicans, p=.004. African American teens' higher comfort for family-sex conversations was predictive of delayed penile-vaginal/anal sexual debut, p=.009 and virginity, OR=1.5, 95% CI [1.154, 1.866]. Teens who never spoke to their fathers about protection from HIV/STI were four times more likely OR= 4.41, 95% CI [1.466, 13.30] to not use condoms. In summary, culturally-responsive, family focused interventions are needed to equip Afro-Caribbean parents for sex conversations with their teens in order to reduce teens' sexual risk.

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ABBREVIATIONS AND ACRONYMS

ADD health	National Longitudinal Study of Adolescent Health
ADOLEC	Adolescent Health Database produced by London School of Hygiene and Tropical Medicine
AIDS	Acquired Immune Deficiency Syndrome
ASAI	Adolescent Sexual Activity Index
CDC	Center for Disease Control and Prevention
CHAMPS	Collaborative HIV Adolescent Mental Health Program
FL	Florida
FSCQ	Family Sex Communication Quotient
HIV	Human Immunodeficiency Virus
MeSH	Medical Subject Heading
PICO	Patient Intervention Comparison Outcome Search strategy
PMP	Parent Matters Program
PsycINFO	Database produced by the American Psychological Association
PTSRC-III	Parent-teen Sexual Risk Communication Scale
STI	Sexually Transmitted Infection
U.S.	United States
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

CHAPTER I

Introduction and Problem Statement

Approximately 36.7 million people worldwide are living with human immunodeficiency virus (HIV), half of whom are unaware of their HIV status (United Nations Programme on HIV/AIDS [UNAIDS], 2016a). In the year 2015, an estimated 2.1 million new HIV infections occurred globally (UNAIDS, 2016a, 2016b). Additionally, 35% of all new HIV infections worldwide occurred among those between the ages 15 and 24 years (UNAIDS, 2016b). According to the Center for Disease Control and Prevention (CDC), an estimated 1.2 million people are currently living with HIV in the United States (U.S.) and one in eight are unaware of their HIV status (CDC, 2014a). Among Black teens living in the U.S., the rate of HIV diagnosis was 38.2 per 100,000 compared to 1.9 per 100,000 for White teens (CDC, 2015). Despite public health prevention efforts, the incidence of HIV has remained relatively stable over the last decade at an estimated 50,000 cases annually in the U.S. (CDC, 2014a).

As of 2014, Florida ranked first in the nation in the number of newly diagnosed HIV cases (Florida Department of Health, 2014a; CDC, 2016a). Per recent reports, HIV is the third leading cause of death for Black women ages 25-44 years and the fifth leading cause of death among all Blacks living in Florida (Florida Department of Health, 2015a). This is a recent decline as HIV/AIDS was the leading cause of death for Blacks ages 25-44 years in the state of Florida for the previous 22 consecutive years (Florida Department of Health, 2015a). Furthermore, 17% of all new HIV cases in Florida, occurred among those under the age of 25, 68% of which were categorized as Black (Florida Department of Health, 2012a). Similarly, among female adolescents living with HIV in Florida, 72%

are Black (Florida Department of Health, 2015b). Teens remain at high risk as young women diagnosed with HIV before age 30 were likely infected during their teen years or early twenties (Florida Department of Health, 2015b).

Of the nearly 48,000 Blacks living with HIV in Florida, 16% are Haitian (Florida Department of Health, 2012b). Haitians make up 7% of all HIV cases in the state of Florida while making up only 2% of the state's population (Florida Department of Health, 2012b). Currently, Black residents account for 50% of all AIDS cases and 42% of all people living with HIV in Miami-Dade County (Florida Department of Health, 2015a). Haitians make up 23% of the HIV cases among Blacks and 11% of the total HIV cases in Miami-Dade County (Florida Department of Health, 2015a). The Florida Department of Health (2014b) reported that there were 12,445 Haitian-born immigrants and 1,746 Jamaican-born immigrants living with HIV in Florida as of 2013. These numbers however may be an underestimation of the true number of Haitians and Jamaicans living with HIV in Florida as many immigrants are undocumented and face structural barriers to HIV testing and care (Marc et al., 2011). African Americans, Haitians, and Jamaicans make up the largest number of non-Hispanic Blacks living with HIV in south Florida (Florida Department of Health, 2012b, 2012c).

Unfortunately, Black youth and young adults continue to be disproportionately affected by HIV/AIDS and other sexually transmitted infections (STIs). Since 2011, the U.S. had an estimated 20 million new STIs occurring annually and those between the ages of 15 and 25 years accounted for 50% of all cases (CDC, 2013a). Young women made up 28% of chlamydia, 5% of gonorrhea, and 18% of syphilis cases in Florida (Florida Department of Health, 2015a). In 2015, the Youth Risk Behavior Survey

(YRBS) results showed that 41% of adolescents were sexually active and boys (43%) were more likely to report sexual activity than girls of the same age. Additionally, 3.9% of all teens reported sex before age 13, 11.5% had sex with 4 or more sexual partners, and 6.7% reported one or more incidences of forced sex. Having sex under age 13 was most prevalent among Black adolescent boys (12%) compared to Hispanic adolescent boys (7%) and White adolescent boys (3%) (CDC, 2016b).

In Miami-Dade County, 16% of adolescents had four or more sexual partners thus far, 34% of teens did not use a condom in their last sexual encounter, and 21% were not taught about STIs and HIV in school (CDC, 2014b). Presently, only 38% of sexual health programs in Miami-Dade County includes information to help parents promote safe sex to their adolescents (CDC, 2014b). In view of these findings, the Miami-Dade County health department has expanded HIV/ STI testing locations and incorporated the use of mobile vans to increase the number of youth screened for HIV and other STIs (Disare, 2014).

Additionally, the state of Florida has adopted abstinence only sexual education programs where abstinence, sex within the context of marriage, and negative outcomes of teen sex are the primary topics presented (Guttmacher Institute, 2017). The state does not mandate sex or HIV education and only requires that programs be age-appropriate. The sexual-health information taught is not required to be medically accurate or culturally appropriate (Guttmacher Institute, 2017). The programs also do not address sexual orientation, sexual coercion, sexual-health decision making or family-sex communication (Guttmacher Institute, 2017). These findings suggest, that youth and young adults may have limited sexual health knowledge and may engage in unsafe and irresponsible sexual

practices that increase their risk of HIV and other STIs (Sales et al., 2012). Therefore, future youth HIV, STI, and pregnancy prevention efforts will likely require more comprehensive, consistent, family, and community-based approaches.

The scholarly literature provides strong evidence that parents influence the sexual practices of youth and young adults. More specifically, open, frequent, and positive communication between parents and their adolescents has been associated with safer sex practices, less drug use, and less adolescent violence (Donenberg, Wilson, Emerson, & Bryant, 2005; Sales et al., 2012; Sneed, Somoza, Jones, & Alfaro, 2013; Wang et al., 2013). Wang et al. (2013) conducted a three-year longitudinal study following 934 Bahamian six grade students. The study showed parental monitoring and parent-teen sexuality conversations to be linked with delaying sexual intercourse among Bahamian adolescents (Wang et al., 2013). High quality parent-teen sex conversations assist adolescents in developing responsible sexual attitudes and has been predictive of increased condom use, fewer lifetime sexual partners, and later age of sexual debut (DiClemente et al., 2001; Dilorio, Pluhar, & Belcher, 2003; Guilamo-Ramos et al., 2012; Wang et al., 2013). Sales et al. (2012) conducted a study to examine the association between parent and adolescent sexuality conversations and the sexual practices of African-American adolescents with their sexual partners. Study findings indicated that fewer sexuality conversations between parents and adolescents was associated with a lack of condom use during sexual intercourse, less communication with the their sexual partners, and limited safer sex negotiation skills for the adolescent (Sales et al., 2012).

Research studies provide evidence that sexuality conversations between Black parents and their adolescents are effective in reducing risky sexual behaviors (Sales et al.,

2012; Wang et al., 2013). Unfortunately, many sexual health studies including Black populations fail to differentiate between ethnic and cultural groups within the Black race. Additionally, many teen sexual health studies do not include culture as an important factor in understanding, explaining, or modifying sexual behaviors. However, some recent studies have explored how cultural beliefs shape Black adolescents' sexual health and sexual decision making (Browes, 2015; Katz et al., 2012). Wyatt et al., (2012) further encouraged health educators and interventionists to build on the strength and capacity of a cultural group to encourage behavior change. Therefore, the heterogeneity of the Black race necessitates that researchers and practitioners acquire a more in-depth understanding of sexual attitudes and behaviors within an ethnic and cultural context. Understanding the role of culture in shaping sexual attitudes and behavior will assist HIV and STI prevention interventionists in designing more effective programs and services. Given the disproportionate burden of HIV and STIs among Blacks and the growing number of Caribbean immigrants in the U.S., especially in south Florida, it is important for public health and health promotion professionals to understand the (a) the nature of sexuality conversations between Afro-Caribbean parents and their adolescents, and (b) the impact of sexuality conversation on Afro-Caribbean adolescents' sexual activity. However, few studies have validated the relationship between sex conversations and Afro-Caribbean teens' sexual activity and even less have reported both parent and teen perspectives (Akers, Holland, & Bost, 2011).

Purpose of the Study

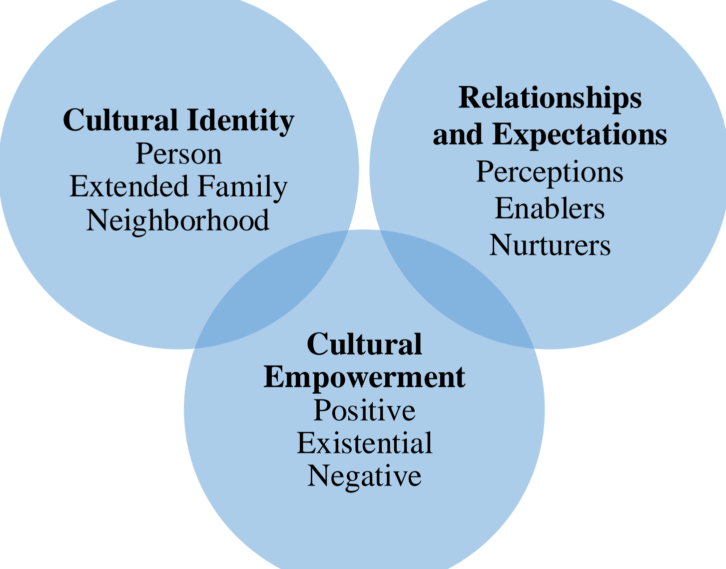
The two-fold purpose of this exploratory study was to (a) characterize the nature, perceptions, enablers, and nurturers of sexuality conversations between Haitian and

Jamaican parents and their adolescents and (b) explain the relationship between sexuality conversations and adolescent sexual activity among ethnically diverse Black teens.

Theoretical Foundations

The PEN-3 model was used with permission (Appendix A) to guide the study design, data analysis, and interpretation of findings. Developed by Dr. Collins Airhihenbuwa in 1989, the PEN-3 model has culture at the core of its foundation and promotes knowledge and understanding of community level factors to develop culturally tailored programs (Airhihenbuwa & Webster, 2004; Airhihenbuwa, 2010; Iwelunmor, Newsome, & Airhihenbuwa, 2014).

Figure 1. PEN 3-Model (Airhihenbuwa & Webster, 2004; Airhihenbuwa, 2010).



The model has three domains: cultural identity, relationships and expectations, and cultural empowerment each with three key constructs (Airhihenbuwa & Webster, 2004). Since cultural considerations were essential to the design of the exploratory study, the PEN-3 theoretical model provided the cultural framework to examine: (a) teen sexuality

within the context of a parenting community environment, (b) parent-teen relationships and expectations specific to sex conversations, and (c) considered the extent to which parent-teen sex conversations may or may not empower the teen. In the cultural identity domain, potential entry points for interventions were explored using three constructs: (a) person, (b) extended family, and (c) neighborhood. In the relationships and expectations domain the study examined (a) perceptions, (b) enablers, and (c) nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents. All three constructs were utilized to assist with characterizing the personal, cultural, and community influences on parent-teen sex conversations. Finally, in the cultural empowerment domain, the study examined (a) positive, (b) existential, and (c) negative influences on sex conversations. The PEN-3 model has been successfully used to explore cultural underpinnings of behaviors to design, implement, and evaluate health promotion and chronic disease prevention programs and interventions for population health (Iwelunmor et al., 2014).

Research Questions and Hypotheses

The following research questions guided the study. Hypotheses were tested at the .05 level of significance.

Research Question 1. What characterizes the nature of sexuality conversations between Haitian and Jamaican parents and their adolescents?

Research Question 2. What characterizes the perceptions, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents?

Research Question 3. What is the relationship between sexuality conversations and adolescent sexual activity?

Hypothesis 1. Adolescents who score higher on the Family Sex Communication Quotient (FSCQ) would have lower Adolescent Sexual Activity Index (ASAI) scores.

Hypothesis 2. Adolescents who score higher on the FSCQ would report a later age of penile-vaginal/anal sexual debut.

Hypothesis 3. Parent-teen conversations about condoms would predict teens' condom use.

Hypothesis 4. Teens with higher FSCQ scores would be more likely to report virginity.

Delimitations

The study was delimited by the following:

1. Included only adolescents between ages 14 and 18 years.
2. Included only African Americans, Haitians, and Jamaicans living in Miami-Dade County.
3. Study included only first generation Haitian and Jamaican parents and their teens.
4. Adolescent participants had to speak, read, and understand English to complete questionnaires.

Limitations

The study was limited by the following:

1. The small sample size limits generalizability to all Haitians and Jamaicans.
2. Non-probability convenience and snowball sampling strategies may not provide a representative sample of Haitians and Jamaicans living in Miami-Dade County.
3. Relying on participant recollection may introduce recall and social desirability bias.

4. Cross sectional study design may limit study findings to associations.
5. Only English speaking Haitian adolescents were included therefore limiting generalizability of study findings to all Haitian adolescents.

Assumptions

The study was based on the following assumptions:

1. Participants provided honest responses to questions.
2. Participants comprehended questions to which they were responding.
3. Study procedures were free from coercion.
4. Issues of confidentiality did not threaten participants.

Definitions of Terms

For the purposes of this study the following terms are defined:

Adolescent. This term refers to individuals who fall between the ages of 10 and 19 years (World Health Organization [WHO], n.d.-a).

Culture. The term is defined as shared values, norms, and codes that collectively shape a groups belief, attitudes, and behavior through interaction with their environment (Airhihenbuwa, 1999).

Enabler. The term is defined as cultural, societal, systematic, and structural forces affecting behavior change (Cowdery, Parker, Thompson, & Matters, 2010).

First generation Haitian or Jamaican. This phrase refers to individuals who were born in Haiti or Jamaican and have migrated to the U.S. for residence.

Nurturer. The term is defined as the degree to which attitudes, beliefs, and actions are influenced, mediated, and nurtured by extended family, friends, peers, and community (Airhihenbuwa & Webster, 2004).

Open communication. This phrase refers to verbal exchange of words where all participants can freely express ideas and thoughts to each other.

Perception. The term is defined as knowledge, attitudes, and beliefs that influence the health behavior of interest, affecting the individual, family, and the community (Airhihenbuwa & Webster, 2004).

Positive communication. This phrase is defined as a verbal exchange of words where all participants feel heard, the conversation must be devoid of emotional strain and negativity.

Second generation Haitian or Jamaican. This phrase refers to individuals that are U.S. born children of at least one Haitian or Jamaican immigrant

Sexuality. This term is defined as sex, gender identities, gender roles, sexual orientation, pleasure, intimacy, reproduction and is experienced in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships (WHO, n.d.b).

Sexuality conversation. This phrase is defined as verbal communication about sex, gender identities, gender roles, sexual orientation, sexual pleasure, intimacy, and reproduction.

Sexual debut. This phrase is defined as first sexual intercourse (Baumgartner, Waszak Geary, Tucker, & Wedderburn, 2009).

Study Significance

Adolescent sexual health remains one of the most challenging public health issues of the past two decades as the rate of HIV, STIs, and pregnancies have remained disproportionately high among teens ages 15-19 years (CDC, 2016a). Even more pressing

is the tremendous burden faced by Black teens as they continue to face the highest rates of HIV and teenage pregnancy (CDC, 2016a; Mojola & Everett, 2012). Hence, addressing protective factors shown to reduce Black teens' sexual risk has become crucial for public health interventionists, particularly within underserved communities. Findings from this study advance scientific knowledge about the role of culture in shaping the nature of parent-teen, sexual-health conversations among Afro-Caribbean immigrants, one of the fastest growing Black ethnic groups in south Florida and other eastern U.S. metropolitan coastal areas. Results illustrate ethnic and cultural differences in Black families' orientation towards sexual discussion and how this affects parents' ability to engage in sex and sexual health conversations that facilitate teens' sexual learning. Results also validate the need for quality parent-led and culturally-sensitive, sexual-health messaging to be an integral part of the evidence-based strategies utilized by health promotion professionals and public health agencies. Culturally-tailored family and community focused prevention programs will better equip Afro-Caribbean parents and teens to have the sometimes-challenging conversations about sex, sexual health, and sexual expectations. Public health agencies and health educators can use these results to tailor adolescent HIV/STI and pregnancy prevention programs to be more cognizant of ethnic variation in cultural values and behaviors as the number of Black immigrants continue to increase in south Florida and beyond.

CHAPTER II

Literature Review

This chapter presents a comprehensive review of the scholarly literature covering key proximal and distal level factors affecting adolescent sexuality with a special focus on culture, gender, and parental influences. The following topics are included: (a) adolescents as sexual beings, (b) acculturation, culture, and sexuality (c) Black cultural constructions of gender and sexuality, (d) protective and risk factors of adolescent sexual activity (e) parental influence on adolescent sexual activity, (f) barriers and facilitators of sexuality conversations (g) evidence based programs and interventions addressing parent and adolescent sexuality conversations and (h) application of the PEN-3 Model.

Literature Review Methodology

Using the patient, intervention, comparison, and outcome (PICO) literature search strategy described in Richardson et al., (1995), key and medical subject heading (MeSH) search terms included but were not limited:

- Patient/population: “Afro-Caribbean” “Caribbean” “West-Indian” “Black” African-American” “Haitian” “Jamaican” “Caribbean immigrant” and “first and second generation immigrant”.
- Intervention: “parent-teen sex conversations” “sex-communication” “family-sex conversations” and “sexuality conversations”.
- Comparison: “parental monitoring” “parental connectedness” “culture” “gender” “risk factors for adolescent sexual behaviors” and “protective factors for adolescent sexual risk behaviors”.

- Outcome: “adolescent sex” “early sexual debut” “number of sexual partners” “HIV/AIDS” “STI/STIs” “pregnancy” and “condom and contraceptive use”.

Relevant literature published between 1995 and 2017 were selected, analyzed, and synthesized to present current knowledge on the factors affecting adolescent sexuality. Databases and search engines used to gather scholarly text included Scopus, Web of Science, PubMed, Google Scholar, ADOLEC, Wiley Online library, SAGE journals, Science Direct, PsycINFO, Taylor and Francis Journals, and Florida International University’s Green Library.

Adolescents as Sexual Beings

Adolescence is a transitional period with crucial biological, cognitive, psychological, and social development (Commendador, 2010; “Stages of Adolescent Development,” 2008). In this period, teens become sexually curious and are biologically capable of having children, yet are often naïve regarding their susceptibility for pregnancy and contracting a STI (Commendador, 2010). During this developmental stage, the frontal cortex of the brain is markedly underdeveloped limiting teens’ ability to engage in healthy sexual decision making and planning. While undergoing frontal cortex maturation, adolescents become better equipped to make responsible sex and sexual health decisions (Commendador, 2010). Similarly, psychosocial development involves changes in a teen’s sense of identity, autonomy, intimacy, and sexuality (Commendador, 2010). The evolution of their identity results in the development of a self- concept including their self-esteem (Commendador, 2010; “Stages of Adolescent Development,” 2008).

Per the World Health Organization (WHO), adolescence spans ages 10 to 19 years, and is characterized by three stages (WHO, n.d.-a). These stages are: early adolescence ranging from ages 10 to 13 years, middle adolescence from ages 14 to 16 years, and late adolescence spanning ages 17 to 19 years (Sales et al., 2012). The varying stages of adolescence are marked by diverse physical, cognitive, and emotional development that dictate differing responses to sexual situations and sexual health decision making. Early adolescence is typically identified by the onset of reproductive development giving rise to sexual curiosity ("Stages of Adolescent Development," 2008). Youth in early adolescence typically lack the capacity to assess the consequences of their actions thoroughly, making responsible decisions about sexual behaviors challenging (Blakemore & Robbins, 2012). Middle adolescence is identified by continued physical development as well as a more pronounced focus on one's self-concept (Salazar et al., 2004; "Stages of Adolescent Development," 2008). Late stage adolescence is distinguished by increased cognitive ability causing youth to demonstrate an improved capacity for understanding the risk associated with their behaviors. Adolescents in this stage also develop a solid sense of self shaped by social, cultural, and interpersonal influences ("Stages of Adolescent Development," 2008).

Adolescents' underdeveloped frontal cortex also contributes to their impulsivity (Steinberg, 2008; Widman, Noar, Choukas-Bradley, & Francis, 2014). This results in early and middle adolescents engaging in riskier sexual behaviors compared to older adolescents and adults (Sales et al., 2012). Teens in early and mid-adolescence are prone to engage in unprotected sex, rapid-serial sexual relationships, and sexual intercourse with high-risk sexual partners. This is a direct result of their high-impulsivity, sensation-

seeking, poor sexual health knowledge, and limited condom and sexual refusal self-efficacy (Frankel, 2012; Nguyen et al., 2012; Sales et al., 2012). Adolescents' high-risk behaviors are compounded by barriers to sexual health services including: underutilization of STI testing services, concerns about privacy and confidentiality, and lack of sexual health resources (CDC, 2012; Diclemente et al., 2004; Paz-Bailey et al., 2005; Wang et al., 2013; Wingood et al., 2011).

When adolescents decide to participate in sexual activities they develop what has been termed a cost and benefit ratio (Blakemore & Robbins, 2012; Deptula, Henry, Shoeny, & Slavick, 2006). Teens who were not sexually active tended to report greater "costs" associated with sex compared to sexually active teens (Deptula et al., 2006). Additionally, adolescents' perceptions of their peer's sexual behaviors whether accurate or not served as an influential factor in determining if an adolescent would engage in sex (Gibbons, Helweg-Larsen, & Gerrard, 1995). Teens would most commonly perceived their peers as sexually active would then be more likely to engage in sexual activities (Gibbons et al., 1995).

Despite strong evidence in support of pre and early-adolescence sexual health education, prevention interventions are often introduced when youth are in late or middle adolescence (Miller et al., 2010). Introducing sexual health interventions at later ages increases the likelihood that teens will be sexually active before receiving the skill-development and educational information needed to make healthy sexual decisions. This delay may be a result of societal and parental comfort discussing sex at later ages. Parents have previously indicated discomfort initiating sexuality conversations before a child reaches middle adolescence opting instead to discuss sex when they perceive adolescents

to be a mature age or curious about sex (Beckett et al., 2010). However, some adolescents may initiate pre-coital and coital behaviors in middle-adolescence making it important to encourage prevention efforts during earlier years.

Shaping adolescent sexual attitudes and behaviors are important for teens' current and future sexual behaviors. In a 2013 study conducted with an ethnically diverse sample of American men ages 21-44 years, early age of penile-vaginal/anal sexual debut was predictive of concurrent sexual relationships in adulthood (Nield, Magnusson, Chapman, & Lapane, 2013). Teenage behavior at the time of sexual debut is most predictive of their future sexual behaviors. To illustrate, if an adolescent used condoms or other contraceptives at the time of penile-vaginal/anal sexual debut they were more likely to continue using preventive measures in future sexual encounters and throughout adulthood (Dorjgochoo et al., 2011; Miller et al., 2010). Therefore, it becomes important to encourage responsible and healthy sexual decision making in adolescents' earlier ages.

Acculturation, Culture, and Sexuality

Cultural beliefs and practices are shared from one generation to another through individuals, families, and communities. Race and ethnicity are often used as proxies for culture, however culture reflects shared norms, beliefs, and practices of a group (Wyatt et al., 2012). Cultural practices and beliefs can serve as both facilitators and barriers to sex and sexual health conversations and may have far reaching implications for adolescent sexuality. Understanding cultural differences improves researchers' ability to tailor interventions that can improve adolescent sexual health decision making (Bell, Bhana, Petersen, & Mckay, 2008; Kreuter & Wray, 2003). However, a systematic review of electronic research articles published between 1988 and 2010 for bio-behavioral,

behavioral, and psychosocial HIV/STI risk reduction and prevention interventions identified that most of the 166 interventions did not address cultural beliefs, practices, or norms (Wyatt et al., 2012). For interventions that included cultural beliefs, culture was rarely defined making it difficult to assess how it influenced behavior. Wyatt et al. (2012) recommended that interventions be based on the strengths and beliefs of a cultural group in order to engender appropriate behavior change (Wyatt et al., 2012).

Cultural views of sex, sexual behavior, and sexual expectations can vary across countries. In many developing nations including some Caribbean countries, relationships between younger women and older men are considered culturally and socially acceptable (Gómez, Speizer, Reynolds, Murray, & Beauvais, 2008). Cross-generational sexual relationships like these are often characterized by transactional sex, power imbalances and can adversely affect the treatment of young girls (Dévieux, Rosenberg, Saint-Jean, Bryant, & Malow, 2013; Gómez et al., 2008). Transactional sex is described as the exchange of sex for money, goods, or services. Consequently, teens in the Caribbean reportedly face higher levels of inappropriate touching and forced sex than their U.S.-born counterparts. In 2012, a national survey conducted in Haiti, showed that 26% of teens reported unwanted sexual attempts and inappropriate touching beginning at a mean age of 13 (Sumner et al., 2015). A community-based household survey of youth ages 15-19 years showed that 30% of females and 20% of all teens reported being forced to have sex at least once in their lifetime (Baumgartner et al., 2009). Similarly, in Jamaica, the National Reproductive Health Survey indicated that 24% of women aged 15-24 years engaged in sexual intercourse before age 14 (Baumgartner et al., 2009). Economic hardship, cultural, and societal expectations are factors affecting early ages of debut and

coerced sexual encounters (Baumgartner et al., 2009; Geary, Wedderburn, McCarraher, Cuthbertson, & Pottinger, 2006; Stockman, Lucea, & Campbell, 2013).

Cultural views of sex also affect attitudes toward sexual health prevention efforts. One study sampling adolescent girls (ages 11-17 years) and their female guardians living in Boston, Massachusetts assessed cultural and ethnic differences between African-American and Haitian immigrant women and their knowledge, attitudes, and beliefs towards the HPV vaccine (Joseph et al., 2012). Haitian mothers felt that protecting their children from "adult diseases" was outside their scope of responsibility. Although parents and adolescents agreed that parents were responsible for teaching and guiding a child, Haitian mothers were particularly uncomfortable engaging in sexuality conversations with their daughters (DeSantis, Thomas, & Sinnett, 1999; Joseph et al., 2014). In a comprehensive sexual education intervention study conducted with Ethiopian teens ages 12-19 years, the cultural context influenced the interpretation and execution of intervention components. Teachers in the study emphasized and prioritized abstinence-based messages where the curriculum called for more comprehensive and informed discussions. Teachers also largely adhered to heteronormative discussions and role-playing. These modifications were believed to be a result of premarital and homosexual sex being considered sinful within the cultural group (Browes, 2015). In a similar study conducted with youth in Uganda, culture-based teachings affected teens' sexual decision making. Views of premarital sex as sinful were linked to both protective and risk factors including creating barriers to condom use while being linked to reducing the incidence of teen sexual intercourse (Katz et al., 2012). However, an individual's cultural beliefs may

be modified as they begin to adopt or borrow traits from a new cultural group, undergoing a process known as acculturation.

Acculturation is defined as the process of learning a culture to adapt to the environment (DeSantis et al., 1999). The degree of acculturation will affect how much of the new cultural beliefs and practices an individual adopts. Among a group of Haitian parent and adolescent immigrant dyads living in south Florida, the greatest conflict in beliefs and attitudes occurred among first and second generation immigrants (DeSantis et al., 1999). Second generation immigrants more readily adopted the new culture in comparison to first generation immigrants (DeSantis et al., 1999). Similarly, notable differences are often reported in the health statuses of first and second generation immigrants. In one study, second generation immigrants were more likely to have four or more lifetime sexual partners and one STI diagnosis compared to first generation immigrants (Lee & Hahm, 2010). Using a cross sectional probability sample of U.S. residents, researchers identified that Caribbean immigrants generally had lower sexual risk overall but faced high-risk of HIV transmission compared to the general U.S. population (Saint-Jean, Dévieux, Malow, Tammara, & Carney, 2011). In fact, Caribbean immigrants did not have favorable attitudes towards condoms and possessed lower intentions for regular condom use compared to African Americans (Saint-Jean et al., 2011). In one study conducted in Broward County, FL, researchers found that Haitian-Creole speaking participants were least likely to report using condoms compared to their English-speaking Haitian and other Afro-Caribbean counterparts (Villanueva et al., 2010). Afro-Caribbean participants also reported lower perceived risk of HIV compared to African Americans (Villanueva et al., 2010).

Black Cultural Constructions of Gender and Sexuality

Caribbean cultural constructions of masculine and feminine identity may be associated with earlier ages of sexual debut and increased sexual risk for teens (Bombereau & Allen, 2008). In one study that assessed the intergenerational differences between Haitian mothers and adolescents, both groups reported an expectation of premarital sex for adolescent males, but mothers reported stricter attitudes towards girls having premarital sex (DeSantis et al., 1999). In another study assessing parents' perceptions of HPV vaccination for adolescent males, researchers identified that parents believed that some level of sexual activity was expected for males more so than females of the same age (Perkins et al., 2013). Secondly, in some Caribbean groups, it is culturally-appropriate for a man to serve as the primary or only financial provider in a romantic or sexual relationship. The expectation of men as primary breadwinners introduces power differentials, supports cross-generational relationships, and encourages transactional sex in short-term relationships (Bombereau & Allen, 2008; Dillon et al., 2010). Thirdly, in many cultures, sex or sexual experimentations at an earlier age may be considered more acceptable for males than females. In fact, early sex for males may be rewarded as a form of hyper-masculine or heterosexual expression while such behaviors are culturally inappropriate for females (Bombereau & Allen, 2008).

Gender roles and cultural norms may also influence the nature and frequency of parent-adolescent sexuality conversations (Harris, Sutherland, & Hutchinson, 2013). Social and gender norms may dictate which parent will participate in sexuality conversations and with which adolescent it is acceptable or expected (Harris et al., 2013). Moreover, engaging in sex and sexual health discussions may contradict cultural norms,

among Haitians. For example, sex is not traditionally discussed with girls (Dévieux et al., 2013). When compared to African-American mothers, Haitian mothers had trouble engaging in sexuality conversations with their daughters, yet there was the cultural expectation that women would be responsible for contraception use in a sexual relationship (DeSantis et al., 1999; Joseph et al., 2014). With the purpose of gaining insight into the African-American adolescent and parent perspective of sexuality, Akers et al. (2010) conducted a study with 21 focus groups on topics of sexual health, contraception, family planning, and abortion. Parents indicated that they were more likely to provide condoms for their sons rather than providing access to any contraceptives for their daughters (Akers et al., 2010). These biases ensure that adolescent boys were more likely to have the tools to engage in safer sexual intercourse compared to adolescent girls (Akers et al., 2010). There is also a persistent expectation across many cultures that girls remain chaste and less knowledgeable about sex compared to boys further contributing to the power imbalances in sexual relationships (Bombereau & Allen, 2008).

Overall, parental, individual, and cultural influences create gender-related differences in concepts of sexuality and associated sexual behaviors. Dévieux et al. (2013) made a case for the use of a comprehensive approach to the design of HIV/STI health interventions for adolescents. The researchers concluded that there is an intertwined relationship between culture, economics, and gender. They asserted that multiple sexual partners among males and serial monogamy among females are gender-related issues that should be addressed as a part of HIV/STI prevention efforts (Dévieux et al., 2013).

Protective and Risk Factors of Adolescent Sexual Activity

Protective factors. As defined by the WHO Commission on Social Determinants of Health (2015), social determinants are the "conditions in which people are born, grow, live, work, and age". The differences in circumstances are a result of the unbalanced distribution of power and resources and the policies that create these disparities (Viner et al., 2012). Social determinants directly affect the health and well-being of individuals and communities and can be categorized as protective or risk factors when associated with specific conditions. Protective factors are defined as individual and environmental protections that enhance an adolescent's ability to combat stressful life events and develop skills necessary to deal with those situations (Blinn-Pike, 2004). Reports from the Caribbean Youth Health Survey suggests that protective factors may have a stronger impact on sexual behaviors than risk factors (Bombereau & Allen, 2008)**.**

To determine protective factors for adolescent sexual behaviors these behaviors must be measurable. For the purposes of this literature review, adolescent sexual activity was measured using the following: (a) age of penile-vaginal/anal sexual debut, (b) number of sexual partners, (c) condom and contraceptive use, (d) STI diagnosis, and (e) pregnancy (Kirby & Lepore, 2007). There is evidence of protective factors operating at the state, community, interpersonal, and individual levels. At the state level, higher education attainment of the residents, implemented state programs and policies targeting teen pregnancies, and greater per capita income are inversely linked to pregnancy rates among adolescents (Dévieux et al., 2016). Also, local communities with higher socioeconomic statuses have lower rates of early sexual debut (Kirby & Lepore, 2007).

At the community level, having area middle and high schools offering HIV education, contraception instruction, and condom distribution were linked with reducing adolescent sexual risk (Kirby & Lepore, 2007). Researchers investigating interpersonal level factors report that having peers who encouraged prevention and delaying sex were also protective for adolescents (Dévieux et al., 2016; Kirby & Lepore, 2007; Viner et al., 2012).

Better academic performance and exhibiting high levels of religiosity were protective for teens' sexual debut, frequency of sex, number of sexual partners, use of condoms, other contraceptive use, and pregnancy (Blinn-Pike, 2004; Boislard & Poulin, 2011; Davis & Friel, 2001; Doljanac & Zimmerman, 1998; Jayakody et al., 2011; Kirby & Lepore, 2007; Viner et al., 2012). Furthermore, conservative attitudes towards sex increases the likelihood of maintaining virginity among adolescents (Aalsma et al., 2013; Blinn-Pike, 2004). Similarly, a decline in religiosity has been linked with an increase in sexual experience and a decrease in conservatism towards sex (Aalsma et al., 2013). Interestingly, religious affiliation has shown a complicated relationship with sexual activity. Conservative or religious women were more likely to delay sex yet were also more likely to fail to use a condom when they did engage in sex (Agha, Hutchinson, & Kusanthan, 2006; Jaccard, Dittus, & Gordon, 2000; Shaw & El-Bassel, 2014). Protective factors occurring at various levels can be enhanced to improve adolescents' engagement in responsible sexual behaviors, reducing their risk of HIV/AIDS, STIs, and unwanted pregnancies.

Risk factors. As defined by Blinn-Pike et al. (2004), risk factors are individual and environmental harms that increase an adolescent's vulnerability to negative

outcomes. As with protective factors, risk factors are present at multiple levels. At the societal level, media messaging has the power to undermine positive concepts of sexuality that an adolescent may have previously developed and has also been linked with adversely impacting teens' sexual health knowledge and risk (Baptiste et al., 2009; Romer et al., 2009). Consequently, more exposure to sexually explicit content creates more permissive attitudes towards sex which increases sexual risk taking among adolescents, specifically lowering their age of sexual debut (O'hara, Gibbons, Li, & Sargent, 2012). At the state level, higher unemployment rates, a higher portion of the population on welfare, and income inequality are directly linked to more adolescents being sexually active, earlier ages of sexual debut, and a higher frequency of sex (Kirby & Lepore, 2007; Viner et al., 2012). At the community level, the higher the proportion of single parent homes in a neighborhood the higher the number of sexual partners that teens reported (Cleveland & Gilson, 2004). Economic and urban development in communities are believed to adversely affect traditional families which increases the influences of peer groups in an adolescent's life (Viner et al., 2012). Therefore, at the interpersonal level, developing friendships with older peers, having sexually active friends, and peers with permissive attitudes towards sex all served as risk factors for adolescents' sexual debut, frequency of sex, number of sexual partners, and condom and other contraception use (Kirby & Lepore, 2007; Viner et al., 2012). Additionally, being in a romantic relationship over one year was associated with earlier sexual debut, higher frequency of sex, more sexual partners, limited condom and contraceptive use, and pregnancy (Bailey, Pollock, Martin, & Lynch, 1999; Bailey, Camlin, & Ennett, 1998; Blinn-Pike, 2004; Doljanac & Zimmerman, 1998; Kirby & Lepore, 2007).

In conjunction with societal, community, and interpersonal level factors, individual factors such as substance use and permissive sexual attitudes increased teens' sexual risk. Based on a systematic review of 12 studies linking alcohol use and sexual risk-taking, an increase in alcohol uptake was linked to an increase in intention to have unprotected sex (Rehm, Shield, Joharchi, & Shuper, 2012). Similarly, substance use was associated with earlier sexual debut (Boislard & Poulin, 2011). Secondly, the link between attitudes and behaviors show that adolescents with permissiveness attitudes towards sex had a higher likelihood of sexual debut, more frequency of sex, higher number of sexual partners, and less condom use (Jemmott, Jemmott, & Fong, 1998; Kirby & Lepore, 2007). Likewise, adolescents who showed no motivation to use condoms were three times more likely to not use condoms in their last sexual encounter (Bailey et al., 1998).

Parental Influence on Adolescent Sexuality

Several parental factors have been shown to affect adolescent sexual risk. Research suggests that living in a two-parent household, higher parental education, parental disapproval of sex, and having a supportive family were all protective factors for adolescents' sexual risk (Boislard & Poulin, 2011; Cleveland & Gilson, 2004; Devieux et al., 2016; Jaccard et al., 2000; Kirby & Lepore, 2007; Pilgrim & Blum, 2012). Using the first wave of data from the National Longitudinal Study of Adolescent health (Add Health) researchers showed that for girls, a mother's education level was linked to the daughter's number of sexual partners (Cleveland & Gilson, 2004). Adolescents who also lived with both parents or a mother alone had reduced sexual risk compared to those not living with a family member (Carver, Dévieux, Gaston, Altice, & Niccolai, 2014;

Dittus, Jaccard, & Gordon, 1997). Equally important are mothers' restrictive attitudes about adolescent sex that have been shown to delay teens' sexual debut (Davis & Friel, 2001).

Parents as sexual socializing agents. Socialization is the induction of one into society and dictates that adolescents are taught acceptable and expected behaviors from family, peers, and others. Concepts of sexuality are often shaped in pre-adolescence, however these influences may go as far back as infancy (DeSantis et al., 1999). Parents serve as the primary sexual socializing agents for their adolescents by shaping adolescents' beliefs, attitudes, and values of sex (Donenberg et al., 2005; Frankel, 2012; Wang et al., 2013). Parental influence is evidenced through parents' use of discipline, monitoring, and communication which are known to be protective for adolescent sexual debut, frequency of sex, number of sexual partners, use of condoms, pregnancy, and STIs (Cohen, Farley, Taylor, Martin, & Schuster, 2002; Dittus et al., 1997; Guilamo-Ramos et al., 2012; Kirby & Lepore, 2007). Extended family members have also been shown to affect the adolescent's concepts of sexuality (Carver et al., 2014; DiClemente et al., 2001; Donenberg et al., 2005; Wang et al., 2013). Research suggests that parental influence may be strongest in early and middle adolescence, typically losing influence in late stage adolescence (DiClemente et al., 2001). Finally, parental connectedness has been shown to be most protective for those under the age of 16 (Blum et al., 2003).

Parental monitoring. Parental monitoring has been defined as a "set of parenting behaviors that involve attention to and tracking of a child's whereabouts, activities, and adaptations" (Dishion & McMahon, 1998). Parental monitoring can be real or perceived and both have been inversely linked with substance use, violence, and adolescent sexual

risk (Caruthers, Van Ryzin, & Dishion, 2014; Dévieux et al., 2013; Donenberg et al., 2005; Viner et al., 2012; Wang et al., 2013). A three-year longitudinal study using 934 sixth grade Bahamian students was conducted to determine the effects of parental monitoring and parental communication on adolescent's engagement in delinquency, substance use, and sexual behaviors (Wang et al., 2013). Study results suggested that perceived parental monitoring was protective for adolescents' risk behaviors over the course of the study (Wang et al., 2013).

Parental monitoring may vary across race and ethnicity as previous research indicates that White adolescents are less monitored than their Hispanic and non-Hispanic Black counterparts (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003). An assessment of 24 studies on parental monitoring and youth sexual behaviors found that monitoring was more protective for ethnic minority males than females (Kincaid, Jones, Sterrett, & McKee, 2012). However, parents monitored their daughters more often and more rigidly than their sons (Borawski et al., 2003; Cohen et al., 2002; Kincaid et al., 2012). Similarly, in other studies, parental monitoring was high among Haitian parents particularly with girls more so than boys (Colin, 2001; Dévieux et al., 2016). In a predominantly African-American sample of adolescents who were unsupervised after school, sexually active adolescents were more likely to have sexual intercourse in a boy's home in the hours immediately after school (Cohen et al., 2002). Teens who are engaged in after school activities or had adult supervision in the hours directly after school usually had limited opportunities to engage in sex. However, to be effective, parental monitoring must be balanced with increased autonomy of the adolescent gradually increasing teens' level of responsibility. High levels of behavior control from parents can prevent an adolescent

from developing decision making skills which can leave the adolescent vulnerable to risky sexual practices (Kincaid et al., 2012).

Parental communication. Communication can be both verbal and non-verbal, verbal communication includes an exchange of thoughts and ideas and non-verbal communication is the transfer of beliefs and values without using words (Dittus, Jaccard, & Gordon, 1999; Lefkowitz & Stoppa, 2006). Non-verbal communication though more difficult to quantify can be observed in parent's personal dating habits, sexual behaviors, religious views, and attitudes towards sex (Dittus et al., 1999). Adolescents' sex-role and sexual socialization has been strongly linked to parent and adolescent sexual communication (Lefkowitz & Stoppa, 2006).

Parent and adolescent sexuality conversations have been documented as a protective factor for African-American adolescents' sexual risk (DiClemente, Sales, Danner, & Crosby, 2011; Sneed et al., 2013). Studies have identified that adolescents who engage in open, positive, and frequent conversations with parents about sex experienced later sexual debut, fewer sexual partners, increased condom use, and improved condom self-efficacy (DiClemente et al., 2001; Harris et al., 2013; Kapungu et al., 2010; Sneed et al., 2013). Problematic conversations between parents and teens are shown to have the opposite impact on teens' sexual activity (Guilamo-Ramos et al., 2012). The quality of the conversations also determines the teens' receptivity and how they internalize their parents' sexual health messages (Rogers, 2015). Improving parents' communication skills minimizes the likelihood of high-conflict communication between parent and teen which may reduce the sexual risk behaviors of adolescents and decrease

the risk of adolescents contracting STIs (Baptiste et al., 2009; Harris et al., 2013; Ladapo et al., 2013; Wang et al., 2013).

Parents' perceptions of their child's level of sexual activity typically determined the breadth and depth of parent-teen sex conversations. In a study assessing parents timing of sex conversations, results lent support to the notion that parents who believed their child had not yet initiated sex would focused more on expressing their values of adolescent sex (Beckett et al., 2010). Meanwhile, parents who believed their adolescents were sexually active would begin discussing birth control and STI prevention (Beckett et al., 2010). However, parents overwhelmingly did not consider their teens to be at-risk for pregnancy, STIs, or HIV (Beckett et al., 2010). In a study conducted in Trinidad and Tobago, similar parental perceptions have been linked to parents delaying the age of first sexuality conversations (Baptiste et al., 2009). Beginning conversations after teens' sexual debut have been less effective in reducing their sexual risk compared to discussions before any sexual activity (Clawson & Reese-Weber, 2003).

The content of sexuality conversation is important in reducing adolescent sexual risk. Parental conversations are often informal, impromptu, and can fit the evolving educational needs of an adolescent (Miller et al., 2009). Parents can also tailor their discussions to reflect their personal and cultural beliefs about sex. In 2011, Guilamo-Ramos et al. reported findings of a study assessing the efficacy of a parent-based intervention for Latin and African-American parents and adolescents. Researchers identified that adolescents were more likely to be responsive to messages on social rather than health consequences when making decisions about sex, yet most parents focused almost exclusively on health consequences such as STIs and unwanted pregnancies

(Guilamo-Ramos et al., 2011). Another study suggested that parents were successful using messages of career and life goals to deter sex at a young age and to discourage unprotected sex (Akers et al., 2010). The researchers also reported that when parents engaged in discussions on birth control they did not always possess accurate and comprehensive knowledge on preventive measures (Akers et al., 2010). Both parents and adolescents demonstrated limited knowledge of available contraceptive methods except for birth control pills and male condoms (Akers et al., 2010).

Family-sex conversations during parents' formative years shape their sexual socialization attitudes and behaviors. Many parents however express frustration with the limited sex and sexual health knowledge they received from their parents during their formative years (Grossman, Charmaraman, & Erkut, 2013). They attributed the limited family-sex discussions to the belief that sex was a taboo topic in their household (Grossman et al., 2013). Parents expressed that these experiences adversely affected their approach to sexuality conversations with their own children (Grossman et al., 2013). Despite these challenges, parents have the unique opportunity to provide time-sensitive, appropriate, and incremental information about sex to their adolescents (Miller et al., 2010).

Role of the mother. Mothers and fathers may differ in their approach, style, comfort, and value of sexuality conversation. They may also play different roles in the sexual socialization of their child. Several research studies showed that adolescents were overwhelmingly more likely to discuss sexual topics with their mothers (Baptiste et al., 2009; DeSantis et al., 1999; Kapungu et al., 2010; Miller et al., 2009; Sneed et al., 2013). Adolescents also preferred to discuss sex with their siblings, and other female relatives

rather than their fathers (Schouten, van den Putte, Pasmans, & Meeuwesen, 2007). Mothers reportedly discussed sexuality more frequently with their daughters than their sons (Akers et al., 2010; Kapungu et al., 2010). Unfortunately, teens and parents sometimes have incongruent reports of their experiences with sex conversations, when this occurs, teens do not internalize preventive messages and are more likely to report being sexually active (Kapungu et al., 2010).

Mothers' comfort and confidence affected their ability to engage in sex conversations with their teens. If mothers were comfortable and confident they were more likely to engage in sexuality conversations with their adolescents and the adolescents in turn were more receptive to sexual health messages (Guilamo-Ramos et al., 2012). Mothers' knowledge, comfort, and communication skills determine their sexual communication responsiveness. Mothers with high sexual communication responsiveness were more likely to discuss abstinence, puberty, and reproduction (Kapungu et al., 2010). Additionally, mother's attitudes towards sex directly affected their daughter's sexual attitudes and likelihood of engaging in sex (Cleveland & Gilson, 2004; Davis & Friel, 2001).

Role of the father. The role of fathers in the sexual socialization of adolescents has been minimally evaluated (Guilamo-Ramos et al., 2012). Although adolescents report mothers' as their primary source of information on sexuality, it is believed that fathers also play a role in the socialization process albeit minimally understood (Dittus et al., 1997). It appears that fathers having sexuality conversation with adolescents may not reduce adolescent sexual risk to the degree that having sexuality conversations with

mothers would (Dutra, Miller, & Forehand, 1999). The current state of knowledge does not provide information on fathers' values, beliefs, and attitudes towards sexuality conversations and whether they differ based on culture and ethnicity. One study however, reported that fathers who did engage in sexuality conversations with their daughters were more likely to discuss their paternal attitudes towards intercourse and abstinence while mothers were more likely to discuss pregnancy and STIs (Kapungu et al., 2010).

Although both male and female adolescents reported being more likely to discuss sexual topics with their mothers, boys did prefer to discuss condoms with their fathers (Guilamo-Ramos et al., 2012; Sneed et al., 2013). Despite the limited knowledge of father's influence on teens' sexual activity, father and teen connectedness have been associated with later age of penile-vaginal/anal sexual debut, abstinence, and condom use (Guilamo-Ramos et al., 2012). More research is required to understand the role of fathers in the sexual socialization of adolescents (Guilamo-Ramos et al., 2012; Roopnarine, 2013). Researchers have suggested the need for a more comprehensive understanding of the role of each parent in the sexual socialization of the adolescent while improving parents' knowledge, timing, and communication skills (Bastien, Kajula, & Muhwezi, 2011; Beckett et al., 2010; Guilamo-Ramos et al., 2012; Kapungu et al., 2010). Knowing the role of each parent in teens' sexual socialization helps to develop mother-specific and father-specific intervention studies that expand the opportunities to address adolescent sexual health (Guilamo-Ramos et al., 2012).

Barriers and Facilitators of Sexuality Conversations

Barriers and facilitators of sex conversations include known factors that directly influence parents' and teens' ability to engage in sex conversations including parents' and teens' attitudes, beliefs, and communication skills.

Barriers. Barriers to sexuality conversations are complex and often occur at the individual and interpersonal levels however, there are some distal level influences that adversely impact sexuality conversations. Barriers to sexuality conversations may be a result of poor communication skills between parent and teen and discomfort with the subject matter. Common barriers to sexuality conversations include: (a) bypassing, (b) frame of reference, (c) language skills, (d) listening skills, (e) emotional interference, (f) feelings of embarrassment, (g) limited knowledge, (h) and discomfort (Aung, 2011; Bastien et al., 2011; Greenberg, Jerrold, Bruess, & Oswalt, 2012; Jaccard et al., 2000; Kapungu et al., 2010; Ladapo et al., 2013; Miller et al., 2009).

Bypassing is defined as attaching a different meaning to words than was initially intended by the speaker (Greenberg et al., 2012). Frame of reference is based on an individual's set of experiences and its influence on their understanding of what has been communicated (Greenberg et al., 2012). Recurring barriers to communication also include feelings of embarrassment, limited knowledge, lack of confidence, and discomfort about sexuality conversations (Aung, 2011; Baptiste et al., 2009; Jaccard & Dittus, 2000; Kapungu et al., 2010). A parent's comfort level can directly impact their ability to socialize their child (Lefkowitz & Stoppa, 2006). In a 2006 study, authors believed that parents who did not possess a positive sense of themselves as a sexual being were least likely to engage in sexuality conversations with their adolescents (Lefkowitz &

Stoppa, 2006). Many parents may also avoid engaging in in-depth conversations with their adolescents about sex because they believe such conversations may encourage an adolescent to engage in sex, or that the child may become afraid or embarrassed about the content of the conversation (Greenberg et al., 2012). Greenberg et al. (2012), reported that most parents (91%) and adolescents (87%) reported that delaying teen's sexual initiation would be easier if they could engage in sexuality conversations with each other (Greenberg et al., 2012). Finally, socio-cultural and psychological factors may negatively affect communication. Socio-cultural factors include media influences, gender differences, culture, religion, and peer influence. Likewise, psychological factors such as emotional responses may limit the openness and frequency of parent-teen sex conversations (Greenberg et al., 2012). Miller et al. (2009) makes the point that by continued engagement in sexuality conversations parents will increase their sexual health knowledge, reduce feelings of discomfort, and increase their confidence.

Facilitators. Miller et al. (2009) indicated that parent's sexual health knowledge, high comfort level, good communication skills, and confidence were facilitators of frequent, positive, and open sexuality conversations between parents and their adolescent. Specifically, parents who possessed these qualities were more likely to discuss abstinence and reproductive health with their adolescents (Miller et al., 2009). To improve the frequency, breadth, and value of sexuality conversations between parents and adolescents, interventions should aim to eliminate barriers and enhance known facilitators of sexuality conversations. These interventions should focus on improving parents' confidence, comfort level, knowledge, parenting, and communication skills

(Baptiste et al., 2009; Bell et al., 2008; Campero, Walker, Atienzo, & Gutierrez, 2011; Miller et al., 2010).

Evidence Based Programs and Interventions

Most interventions and programs designed to improve sexuality conversations between parents and adolescents have been implemented while youth were in middle and late adolescence and often provided minimal information on STIs or HIV (Baptiste et al., 2009). However, some effective interventions have targeted youth in early adolescence (Kitchen & Huberman, 2011; Miller, 2014). These interventions and programs have successfully improved the frequency, content, and quality of sexuality conversations between parents and adolescents (Baptiste et al., 2009; Bell et al., 2008; Campero et al., 2011; Eastman, Corona, & Schuster, 2006; Guilamo-Ramos et al., 2011; Ladapo et al., 2013; Miller et al., 2010). Evidence-based programs and interventions must provide contextual and experiential training to address the public health problem.

Some of the most effective interventions to improve sexuality conversations and reduce adolescent sexual risk include Talking Parents Healthy Teens, Keepin' it Real Mothers Adolescent HIV Prevention Program, Saving Sex for Later, Focus on Kids Plus Impact, Youth AIDS Prevention Program, Reducing the Risk, the Collaborative HIV Adolescent Mental Health Program (CHAMPS), and Parents Matters Program (PMP) (Kitchen & Huberman, 2011). Shared components of successful interventions improving sexuality conversations included: (a) a theoretical framework (b) communication skill-building, (c) improving parents' self-efficacy to engage in sexuality conversations, (d) HIV knowledge (e) and problem solving (Akers et al., 2011; Campero et al., 2011). Theoretical frameworks included the Problem Behavior Theory, Social Cognitive

Theory, Social Learning Theory, Theory of Reasoned Action, Integrated Care Model, Self-Determination Theory, Diffusion of Innovation, Theory of Planned Behavior, and the Theory of Triadic Influences (Akers et al., 2011; Bell et al., 2008). When successful these interventions and programs have improved parents' comfort level, attitudes towards sexuality conversations, and the breadth of sexuality topics discussed. These programs have also increased parents' HIV and STI knowledge, enhanced adolescents' condom self-efficacy, and reduced teens' sexual risk (Akers et al., 2011). CHAMPS and PMP are two successfully and widely implemented evidence based programs that have improved parental influence on adolescent sexual behaviors across several cultures.

CHAMPS. CHAMPS was developed in the U.S. to reduce the spread of HIV among youth. The program has been successfully implemented in South Africa and the Caribbean (Bell et al., 2008; Kapungu et al., 2010). It was designed to enhance the protective influences of families on the sexual socialization of adolescents (Bell et al., 2008). CHAMPS is a theory based intervention that uses ten, 90-minute sessions to increase HIV-related knowledge, reduce stigma, increase parental monitoring and connectedness, and parents' comfort with sexuality conversations (Bell et al., 2008). Furthermore, the CHAMPS program aims to improve the functionality of neighborhoods, as well as improving parents' problem solving capacity when parenting their adolescents (Baptiste et al., 2009; Bell et al., 2008). Unlike other programs, CHAMPS attempts to counter social, cultural, and personal factors that foster unhealthy sexual behaviors and uses the power of the parent to provide a "protective shield" around the adolescent (Baptiste et al., 2009). The program has demonstrated success in increasing HIV knowledge, reducing HIV associated stigma, and improving parental monitoring

(Baptiste et al., 2009). CHAMPS has an increased chance of sustainability due to the reliance on local community educators and facilitators (Bell et al., 2008). The CHAMPS program also increased HIV knowledge, parent and adolescent communications, and attitudes towards HIV/AIDS when adapted for use in Trinidad and Tobago (Baptiste et al., 2009).

PMP. Few programs have been identified as evidence based by the CDC for young people and only a few have been considered effective for high-risk youth (Miller et al., 2010). PMP is one such program that focused on youth in pre-adolescence and early adolescence. Pre-adolescence is the stage at which youth may begin to experience sexual behaviors and is often where sexual socialization is most recognizable and malleable. The program aims to instill positive behavior rather than modify pre-existing ones (Miller et al., 2010). It has successfully increased sexuality conversations between parents and adolescents and has reduced adolescents' sexual risk (Miller et al., 2010). Much like the other communication interventions, PMP proposes to assist parents in the development of essential skills needed to effectively communicate with their adolescents about their values and beliefs while providing sexual health knowledge (Miller et al., 2010).

PMP is delivered in multiple sessions and provides parents with information about current issues their child may be facing, tools to improve communication with their adolescent, improve relationship quality, and develop monitoring skills (Miller et al., 2010). This programs also adapts to the needs of the population including meeting at more suitable times for the target population, providing child care services, and assisting

parents to become more active in other aspects of their child's life (Miller et al., 2010). PMP has been successful among African Americans demonstrating a significant increase in communication, abstinence, HIV/AIDS health education, and condom use. The program was culturally-adapted and nationally-adopted for use in Kenya and renamed the Family Matters Program. The goal of the program was to lower adolescent sexual risk, raise the age of sexual debut, and improve parenting skills (Miller, 2014). Evidence based programs particularly those that are theoretically and skill-driven have proven effective in improving parent and adolescent sexuality conversations and reducing adolescent sexual risk. Although there is a wealth of knowledge on parental influences on adolescent sexual activity, few studies have validated the relationship between sexuality conversations and sexual behaviors in Caribbean populations, including Caribbean immigrants in the U.S. (Bombereau & Allen, 2008; Waldron, Hutchinson, Hewitt, Kahwa, & Hamilton, 2012).

Application of the PEN-3 Model

The PEN-3 model has been successfully used to design and evaluate health education, prevention, and intervention studies among various racial and ethnic groups. The model developed by Dr. Collins Airhihenbuwa in 1989 has been used to guide studies investigating HIV prevention, screening, and treatment, domestic violence, diabetes prevention, nutrition, cervical and breast cancer prevention, depression, health management, malaria, and other public health concerns (Airhihenbuwa et al., 2009; Iwelunmor et al., 2014; Melancon, Oomen-early, & Rincon, 2009; Scarinci, Bandura, Hidalgo, & Cherrington, 2012). It has been used to shape several research designs and methodologies including in-depth interviews, focus groups, needs assessments,

generative rhetorical criticisms, surveys, interventions, and evaluations (Iwelunmor et al., 2014). The PEN-3 model has also been used as a cultural framework to guide studies hoping to tailor health meassages, provide culturally-appropriate content, develop the appropriate structure of interventions, inform study implementations, and develop educational curriculums (Iwelunmor et al., 2014). In one study, the model was used to analyze socio-cultural findings from the evaluation of an STI and HIV/AIDS prevention effort known as the Mpumalanga Female Condom Project (Webster, 2003). The study identified gender relations in a cultural context and how they affected women's negotiation skills and sexual decision making (Webster, 2003). Findings highlight the disadvantage women face in negotiating safer sex practices with their sexual partners.

The PEN-3 model has been used to guide data collection, data analysis, and interpretations of qualitative findings. Application of the PEN-3 model results in emergent themes which are often cross-tabulated using the relationship and expectations and the cultrual empowerment domains. This develops a 3 x 3 table that shows how the two primary domians overlap to contextuaize those themes (Iwelnumor et al., 2014). Results from studies using the PEN-3 model highlight cultural context, emphasize the role of the collective (extended family and community), and address the postive aspects of a culture in health-decision making (Melancon et al., 2009; Airhihenbuwa, 2010).

In the context of HIV/AIDS studies, the PEN-3 model was used to examine the cultural context of stigma and HIV disclosure in South Africa. In 2009, Dr. Airhihenbuwa and his research team explored the meaning of HIV/AIDS-related stigma in South African families and health care facilties (Airhihenbuwa et al., 2009). Using

focus group findings, The PEN-3 model was used to identify families' and health providers' positive (non-stigmatizing), existential, or negative (stigmaizing) perceptions, enablers, and nurturers (Airhihenbuwa et al., 2009). Findings showed that positive enablers included health care providers being supportive of people living with HIV/AIDS while negative enablers included using color coding to signify patients with HIV/AIDS (Airhihenbuwa et al., 2009). Negative perceptions included people living with HIV/AIDS being judged as different, immoral, and promiscuous (Airhihenbuwa et al., 2009). Finally, existential nurturers included caring for family members when sick (Airhihenbuwa et al., 2009). The authors of this study concluded that culture was a primary component of understanding the nature and context of HIV/AIDS-related stigma in South Africa (Airhihenbuwa et al., 2009).

Summary of Literature Review

This chapter presented a comprehensive review of the scholarly literature covering key proximal and distal level influences on adolescent sexual activity particularly among Black and Caribbean populations. Adolescents are at high risk for HIV, STIs, and pregnancy. This risk has been partially linked to their underdeveloped frontal cortex which affects their ability to make responsible sexual decisions. This review reinforces the importance of parents as their child's primary sexual socializing agent and illustrates the barriers families' face initiating and sustaining frequent and open sexual discussions that may reduce their teens' sexual risk. The literature shows how cultural constructions of gender and sexuality may shape parents' and teens' sexual attitudes and the content of sexuality conversations. Therefore, the use of culturally-

sensitive, parent-oriented, adolescent sexual health programs may improve parent-teen sex conversations within Afro-Caribbean communities. However, little research has explored the nature, cultural norms, and perceptions of sex conversations between Haitian and Jamaican parents and their teens.

CHAPTER III

Methodology

This chapter describes the research methodology of this study and is organized into five sections. The sections are (a) study design, (b) population and sample, (c) protection of human participants, (d) instrumentation, and (e) procedures used to collect data, and conduct data analysis.

Prior to commencing the study, Florida International University's Institutional Review Board approved the study protocol (approval number IRB-15-0425; Appendix B). Approval was also obtained from the Miami-Dade County School Board’s Research Review Committee to include two area high schools in the study (approval number 2118 Appendix C). The original qualitative study guided by the PEN-3 model was expanded to include a small scale quantitative component to investigate whether parent-teen sexuality conversations were protective for Haitian and Jamaican adolescents.

Research Design

A cross-sectional mixed methods approach was used to explore the nature, perceptions, enablers, and nurturers of sex conversations between Haitian and Jamaican parents and their teens. The qualitative phase used a narrative inquiry approach to capture human experiences using stories. The approach allows for detailed descriptions of participants’ experiences with sexuality conversations. Participants’ social constructions of their experiences were explored using open-ended questions which captured a holistic understanding of their lived experiences with sex and sexual health conversations (Crossley & Watson, 2003).

Cross-sectional research survey methodology was used in the second phase of this study to examine the relationship between parent-teen sexuality conversations and teens' sexual activity among ethnically diverse Black adolescents living in Miami-Dade County, FL. Surveys are widely used in basic and social sciences to explain and understand associations (Sheatsley, 1983; Groves et al., 2011). They are also used to gather statistics that characterize larger populations (Groves et al., 2011).

Population and Sample

The target population for this study were first generation Haitian and Jamaican parents and their teenage children between ages 14 and 18 years residing in Miami-Dade County, FL. The qualitative phase of the study included 14 Afro-Caribbean mother and teen dyads/triads (N=31); eight Jamaican dyads and six Haitian dyads/triads. In some families, more than one adolescent was interviewed. The quantitative phase included 157 Black adolescents (African Americans, Haitians, and Jamaicans) between ages 14 to 18 years also residing in Miami-Dade County, FL.

Sampling strategies and recruitment. Using convenience sampling strategies adolescent and parent participants were recruited through (a) youth-serving organizations, (b) area high schools, (c) neighborhood churches, (d) community health fairs (e) and barbershops and beauty salons.

For interviews, the eleven-week recruitment phase began on March 19th and continued through June 7th, 2016. Recruitment began in ZIP codes 33169 and 33127 in local churches and barber and beauty salons then later expanded to ZIP codes 33150, 33056, and 33138. Recruitment strategies began with presentations at local churches, radio interviews, and distributing flyers (Appendix D) to congregants and patrons of

beauty salons and barbershops. Additional subjects were reached using snowballing sampling strategies.

For surveys, the 17-week recruitment phase began March 30th and continued to July 16th, 2016 beginning with a local community church in 33169 and expanding to youth serving organizations in 33138 and 33056. The recruitment later extended to two area high schools in 33161 and 33014. Subjects were recruited through presentations at a local community health fair, churches, community based organizations and schools. Interested persons were provided information on the purpose, procedures, risks, and benefits of the study.

Inclusion and exclusion criteria for interview participants. For a family unit to be eligible, at least one parent and one teen had to participate in the interview and both parent and teen had to reside in the same home. An additional eligible parent or teen could participate if they desired. Adolescent participants were all between the ages of 14 and 18 years and enrolled in a high school at the time of the study. Teens had to be unmarried, self-identify as first or second generation Haitian or Jamaican, and read, speak, and understand English. Qualified parent participants had to self-identify as a first-generation Haitian or Jamaican immigrant. In addition, parents had to speak either English or Haitian-Creole, however no parents opted to complete the interview in Haitian-Creole.

Screening for interview participants. Interested participants contacted the primary investigator via phone or in person. They were then vetted using a 12-item screening tool (Appendix E) constructed using the study inclusion and exclusion criteria. The screener also included questions to assess whether participants' home afforded

enough privacy to conduct the interviews, this included having two rooms separated by closed doors. If participants did not meet privacy requirements or preferred the interview done outside the home, they were advised to meet the interviewer at a predetermined community-based location in Miami Gardens, FL.

Inclusion and exclusion criteria for survey participants. Black adolescents between the ages of 14 and 18 years were eligible to participate in the survey if they or at least one of their parent was born in Haiti or Jamaica. Likewise, African-American adolescents were eligible to participate if they and both their parents were born in the U.S. Teens were not eligible if they were married, pregnant, or did not speak English.

Protection of Human Participants

Consent Process. The general consenting procedures included: (a) conducting the consent process in a location that ensured privacy, (b) providing adequate information about the study at a reading level understandable to the participant, (c) providing opportunities for the participant to consider all options, (d) responding to any questions posed by participants, and (e) ensuring the participant understood the information provided.

For interviews, teen's ages 14 to 17 years completed the consent process in the same room as their parents. For adolescents 18 years of age, the consent process was completed separately from their parents. Once separated, both parent and teen were asked by their respective interviewers, if there were any further questions before the interview began. Participants were reminded of the voluntary nature of the study, the confidentiality of their responses, and their right to terminate the interview or skip a question at any time. Teens who were 18 years old completed an adult consent form for interview

participation. For teenagers 14 to 17 years of age, both child assent and parental consent forms were collected. A signed copy of the appropriate consent forms was provided for participants and a copy was retained by the primary investigator.

For survey participation, teens 14 to 17 years of age completed child assent forms while their parents completed parental consent forms. For teens 18 years of age, an adult consent form was completed. In school and youth-based organizations, teens were granted a one week period to return the appropriate signed assent and consent forms. While in other settings, parents and teens could complete the consent process in one sitting. A signed copy of the appropriate consent or assent forms were provided for participants and copies retained by the primary investigator.

Confidentiality and Privacy. All data gathered was treated confidentially. Forms and surveys were carried from study site to storage in a locked case. All electronic interview data has been encrypted and all related consent forms have been stored under lock and key. Consent forms have been stored separately from survey hard copies. Survey responses were anonymous and did not require encryption.

Instrumentation

Qualitative Instrumentation. A researcher developed interview guide was used to gather qualitative data. The instrument was developed using the domains of the PEN-3 model. The interview guide contained; (a) 19 questions in the relationships and expectations domain focusing on the perceptions, enablers, and nurturers of parent-teen sexuality conversations, (b) 11 questions in the cultural empowerment domain addressing positive, existential, and negative influences on sexuality conversations, and (c) 6 questions items in the cultural identity domain addressing the role of the parent, teen,

extended family, and the neighborhood on sexuality conversations. Some interview questions applied to more than one domain.

An expert panel was convened to evaluate the researcher developed interview guide (Appendix F). The panel consisted of two experienced sexuality researchers and one lay person. All panel members were of African descent and included both men and women. Members of the expert panel were provided an evaluation rubric (Appendix G) and were requested to assess the guides' face and content validity (White and Simon, n.d.). The interview guide was then pilot tested with two Afro-Caribbean dyads to evaluate the cultural appropriateness, study procedures, and develop appropriate probes for study interviews. The instrument was then revised based on feedback from the expert panel. The final interview guide contained 23 questions for parents and 22 questions for adolescents.

Quantitative Instrumentation. The questionnaire (Appendix J) consisted of demographic measures, three established scales and indexes, and four researcher-developed measures. Demographic measures included nativity, age, years lived in the U.S., gender, ethnicity, living in a two-parent household, and parent's education level. The survey was comprised of three scales: Adolescent Sexual Activity Index, Family Sex Communication Quotient, and the Parent-Teen Sexual Risk Communication Scale (PTSRC-III). The four researcher-developed items measured: (a) condom use, (b) age of penile-oral/vaginal-oral, penile-vaginal/anal sexual debut, (c) ever having penile-oral/vaginal-oral or penile-vaginal/anal sexual intercourse and (d) age of first parent-teen sexuality conversations.

The ASAI was developed to identify the range and progression of sexual involvement among adolescents (Hansen, Paskett, & Carter, 1999). The scale is psychometrically sound and uses conservative language to minimize respondent's discomfort. The 13-item instrument has high internal consistency (α=0.93-0.94) for Whites, Blacks, females, and males. This scale was assessed with teens living in the U.S. (Hansen et al., 1999; Harrington et al., 2001). Construct validity shows the developmental pattern of sexual activity (Hansen et al., 1999). The scale provides an overall score from 0 to 10 with higher scores showing more recent sexual activity. Questions 1-10 use dichotomous response choices "yes" or "no". While questions 11-13; the number of times teens had sex in the past 30 days and the number of sexual partners in the last 30 days and last 12 months use categorical response choices from "never had sex" to "4 or more" times or "4 or more" partners.

FSCQ was developed to measure family orientation towards discussions of sex. The 18-item quotient measures three areas: comfort, information, and value attributed to family-sex conversations. The scale provides an overall score from 18-90; (18-39) is low, (40-69) is moderate, and (70-90) is high. Each subscale (comfort, value, and information) provides a score ranging from (6-30). A five point Likert scale was used to measure individual item responses from strongly agree to strongly disagree with higher scores indicating more agreement. Strongly agree received a score of 5, agree a score of 4, neutral a score of 3, disagree a score of 2, and strongly disagree a score of 1. The comfort statements measure the perceived openness of parent and adolescents. Items 2, 5, 8, 11, 14, and 17 measure comfort. The information statements measure the perception of information shared and discussed in sexuality conversations. Items 3, 6, 9, 12, 15, and 18

measure information. Value statements measure perceived importance of the parent's role in the sexual development of the adolescent. Items 1, 4, 7, 10, 13, and 16 measure value. However, six items are reverse coded: items 4, 9, 10, 13, 14, and 16 (Warren, 2011). The average alpha coefficient for FSCQ is above .90. All dimensions of the scale have high internal consistency (above .80) (Warren, 2011). Statements used in the three dimensions of the FSCQ show face and criterion validity (Warren, 2011). FSCQ has been assessed with American, Canadian, and Danish participants, however there we no reports on the racial makeup of those samples (Warren, 2011).

PTSRC-III is an eight-item scale featuring common sex and sexual health topics discussed between parents and adolescents. Topics include contraception, STIs, condoms, peer-pressure, and delaying sex (Hutchinson, 2007). The scale is duplicated for each parent as adolescents may discuss more topics with one parent than the other. PTSRC-III has been used with Jamaican mothers and female adolescents between the ages 13 to 17 years. Internal reliability of the scale has an alpha of 0.92 for mothers and 0.93 for daughters (Hutchinson, 2007). Consistency in results show cross-cultural validity and reliability and the scale shows strong inter-item correlations ranging from 0.51 to 0.80 (Waldron et al., 2012). Each item had response choices "1=none", "2=a little", "3=some", "4=a lot" and "5=extensive", scores ranged from 8-40.

Data Collection Procedures

Phase 1. Qualitative Procedures. A team of six trained interviewers consisting of Afro-Caribbean public health professionals were available for conducting the study interviews. Interviews were all gender matched and the team included one male to

conduct interviews with sons and fathers and one Haitian-Creole and French speaking member to conduct interviews with Haitian-Creole speaking parents. However, only three members of the trained interview team were needed to complete interviews and all parent participants were mothers. Interviews were scheduled at a time most convenient for both parent and teen. The interviews were always conducted separately and behind closed doors to ensure privacy. All interviews were voice recorded with participant's permission. Once interviews were completed all participants were required to sign an incentive receipt form (Appendix G) showing proof that they received their compensation. For teens, a $15 Walmart or iTunes gift-card was provided and a $20 Walmart gift-card was provided to all parent participants. After every interview, the interviewer completed an interview contact summary form (Appendix I) detailing information on the atmosphere and context of the interview and key points raised by the participant.

Phase 2. Quantitative Procedures. Once completed consent forms were returned, teens were permitted to complete the paper-pencil questionnaire. Surveys were always completed away from parents in a designated area for survey administration. Completed surveys were returned in a sealed envelope by all participants. Each teen was then asked to sign and date an incentive receipt form. This form confirmed that participants received incentives for their time and participation. Teens received two hours of community service or a $10 Walmart or iTunes gift-card. Teens who participated through their schools were only allowed to receive community service hours.

Data Analysis

Qualitative data analysis. Before beginning data analysis, five members of an ethnically diverse team of research assistants were trained by a faculty researcher to use thematic content analysis for making sense of the interview data collected. This form of analysis was used to identify patterns of meaning across the dataset that provided answers to the research questions posed. These patterns are identified through a process of data familiarization, data coding, and theme development (Crabtree & Miller, 1999). Thematic content analysis is best used to address research questions about participants' experiences, views, and perception and to construct meaning of a phenomenon (Crabtree & Miller, 1999). The analysis was conducted inductively and included the following steps: (a) data collection and familiarization (b) coding of the data, (c) applying templates of codes (d) connecting codes and identifying themes (e) and corroborating and validating themes.

Stage 1. Data collection and familiarization. Interviews were transcribed by the primary investigator and with the use of a transcription service. Each transcript was reviewed for accuracy by listening to the voice recordings while reviewing the transcripts. False starts and pauses were omitted from the transcripts to improve clarity. Members of the data analysis team thoroughly reviewed interview transcripts to become familiar with the full data set. This was particularly important for those who were not present during the interviews. This allowed for better identification of meaningful units characterizing participant's experiences.

Stage 2. Coding the data. Five members of the data analysis team highlighted meaningful segments of text. Meaningful units were those that captured participants' experiences, attitudes, and beliefs and were keywords, phrases, or paragraphs of participants' responses. Members of the team independently reviewed text and developed codes. Members would then meet on several occasions and through a consensus building process, preliminary codes were determined by reviewing highlighted meaningful units. Preliminary codes were clear and succinct and captured the phenomenon. After several discussions, the team agreed upon a set of codes each with its own unique definition. These codes would serve as the preliminary codebook from which themes would be developed. The researchers continued to code additional interviews paying attention to new codes as they emerged.

Stage 3. Applying template of codes. The codebook was developed using Microsoft Excel. Preliminary codes were placed in an Excel spreadsheet and each question included a set of codes with supporting parent and teen responses. Analysis at this stage was guided by but not restricted by the preliminary codes. New codes emerged inductively through reviewing the data.

Stage 4. Connecting codes and identifying themes. In this stage, clustering of previously identified codes was used to determine themes and patterns in the data. Through a consensus building process major comprehensive themes emerged. This process helped to identify areas of consensus and divergence in participants' responses and captured their shared and unique experiences. Resulting in a comparison of Haitian

and Jamaican experiences as well as parent and teen experiences with sexuality conversations.

Stage 5: Corroborating and validating themes. The final stage included a process of clustering the themes that were previously identified from the coded text. The clustered themes were reviewed to ensure that they were representative of the preliminarily assigned code. The process required several iterations of reviewing text, codes, and themes before moving to the interpretive phase of the analysis. Themes were again clustered and assigned concise phrases that described the meaning that characterized the theme. Interpretation was conducted with one Haitian and one Jamaican member of the analysis team and was interpreted to address the research questions posed. Dyads were matched by a unique code that allowed comparison of mother and teen responses. Analyses were conducted across ethnic groups, genders, and dyads.

Triangulation

To improve rigor, data from two research methodologies was triangulated using multiple data analysts. First, an ethnically diverse team of trained research assistants (Haitian and Jamaican analysts) compared data across dyads and ethnic groups to examine similarities and differences in participant responses. This is largely done for consensus building and to unfold a deeper and broader understanding of the phenomenon. Secondly, the researcher compared qualitative data with survey results to explain and interpret concepts related to family openness, value, and information shared in sex conversations. Triangulating quantitative with qualitative findings provided

interconnections between thin data independent of intentions or circumstances with thick data that gives the context of an experience (Holliday, 2007).

Quantitative data analysis. Quantitative data was analyzed using IBM SPSS 21 (IBM Corp., 2013). Descriptive analysis was used to characterize the population while frequency analysis showed the mean age of first parent-teen sexuality conversation, percentage of teens sexually active, percentage of teens reporting recent sex, mean age of oral and vaginal and or anal sexual debut, and the percentage of teens who reported sexual debut before ages 13 and 15 years.

Hypothesis 1. Adolescents who scored higher on the FSCQ would have lower scores on the ASAI. Here, the ASAI score is the primary outcome variable of interest. Linear regression was used to determine if FSCQ scores were predictive of ASAI scores in the overall sample and for each ethnic group (African American, Haitian, and Jamaican). Linear regression was also used to determine if the FSCQ sub-scores (comfort, value, and information) were predictive of adolescent's ASAI scores. Additionally, a one-way ANOVA and post hoc Bonferroni was used to compare the mean ASAI scores across the three ethnic groups. One-way ANOVA was also used to determine if FSCQ scores differed across the three ethnic groups. Box-plots and the one-way ANOVA were used to identify differences in the FSCQ subscales across the three ethnic groups.

Hypothesis 2. Adolescents who score higher on the FSCQ would report a later age of penile-vaginal/anal sexual debut. Linear regression was used to determine if FSCQ scores were predictive of age of sexual debut. Linear regression was also used to determine predictors of age of sexual debut. Additionally, a one-way ANOVA and post

hoc Bonferroni were used to compare age of oral, vaginal, or anal sexual debut across three ethnic groups.

Hypothesis 3. Parent-teen conversations about condoms and protection would predict teens' condom use. Logistic regression was used to determine if conversations with either parent about condoms and protecting one's self from HIV and STIs were predictive of condom use during teens' first and last penile-vaginal/anal sexual encounters. Logistic regression was also used to identify all predictors of ever having penile-vaginal/anal intercourse. Again, regression was completed across the whole sample and then per ethnic group.

Hypothesis 4. Teens with higher FSCQ scores would be more likely to report virginity. Logistic regression was used to determine if FSCQ scores predicted teens ever engaging in penile-vaginal/anal sexual intercourse. Logistic regression was later used to identify all predictors of ever having sex. Analysis was completed across the full sample and then per ethnic group. Finally, Pearson Chi-Squared Test was used to determine if any significant differences existed in sexual activity across ethnic groups.

Summary of Methodology

The chapter presented an overview of research methodologies used to explore parent-teen sex conversations in Haitian and Jamaican families. It provided detailed descriptions of the selected study sample, human subject's considerations, and data collection and data analysis procedures. Using a narrative inquiry approach, the qualitative phase of the study included in-depth face-to-face interviews with 14 Haitian and Jamaican parent-teen dyads (N=31) to gather information on their experiences engaging in sex and sexual health conversations. An ethnically diverse team of

researchers extrapolated themes characterizing the nature, perceptions, enablers, and nurturers of parent-teen sex conversations within an Afro-Caribbean cultural context. In phase two, a small scale cross-sectional paper-pencil survey administered to 157 Black adolescents (Haitian, Jamaican, and African American) was used to determine the associations between measures of parent-teen sex conversations and Black teens' sexual activity.

Chapter IV-VI

Results

The two-fold purpose of this exploratory study was to (a) characterize the nature, perceptions, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents and (b) explain the relationship between sexuality conversations and adolescent sexual activity. The qualitative phase of the study characterized the nature, perceptions, enablers, and nurturers of parent-teen sex conversations within an Afro-Caribbean cultural context. The quantitative phase determined the associations between measures of parent-teen sex conversations and Black teens' sexual activity.

Chapters IV, V, and VI present a detailed description of the study findings and are displayed in three manuscripts formatted for journal submission. Chapter IV, Manuscript #1 entitled, *Sex is a sin: Afro-Caribbean parent and teen perspectives on sex conversations* addresses research question 1: What characterizes the nature of sexuality conversations between Haitian and Jamaican parents and their teens? Chapter V, Manuscript #2 entitled, *Using the PEN-3 model to characterize Afro-Caribbean family sexual health conversations: teen and parent perspectives,* addresses research question 2: What characterizes the perceptions, enablers, and nurtures of sexuality conversations between Haitian and Jamaican parents and teens? Chapter VI, Manuscript #3 entitled, *Ethnicity, parent-teen sex conversations, and teen sexual activity: Implications for health promotion*, addresses research question 3: What is the relationship between parent-teen sexuality conversations and teens sexual activity?

CHAPTER IV

Sex is a sin: Afro-Caribbean parent and teen perspectives on sex conversations

Kemesha S. Gabbidon

Abstract

Objective: Understanding the dynamics of parent-teen sex conversation within underserved Black immigrants may improve teen sexual health promotion interventions. This study (a) explored the nature of Afro-Caribbean parents' childhood and teenage experiences with sex conversations and (b) characterized parents' and teens' perceptions of current sex conversations.

Methods: Utilizing a narrative inquiry approach, 14 dyads comprised of Haitian and Jamaican mothers and teens (ages 14-18 years) living in Miami-Dade County, Florida were interviewed about their experiences with parent-teen sex conversations. Participants experiences were gathered using a semi-structured interview guide developed using the domains of the PEN-3 model. Thematic content analysis was used to generate themes and compare findings across ethnicities and dyads.

Results: Mothers' mean age was 41.85, SD=5.50 and teens' mean age was 16, SD=1.31. Mothers' limited childhood and teenage sexual communication experiences and outcomes of those interactions shaped parents' existing sexual attitudes, beliefs, behaviors, and ability to talk with their own teens about sex. Teens described sex conversations as uncomfortable yet believed the conversations improved their sexual decision making. Other teens reported receiving fear-based messages from parents that adversely affected their ability to discuss sex.

Conclusions: Adolescent sexual health is a health promotion imperative and Afro-Caribbean parents require a culturally sensitive approach that addresses cultural norms that may restrict sexuality conversations.

Introduction

Parents serve as their child's earliest and most influential sexual socializing agents by shaping adolescents' sexual beliefs, attitudes, and values (Davis & Friel, 2001; Donenberg et al., 2005; Frankel, 2012; Lefkowitz & Stoppa, 2006; Wang et al., 2013). Parents often share their expectations for teenage sexual behaviors through role modeling, monitoring, supportive relationships, and sexual discussions (Kao, Guthrie, Loveland-Cherry, & Caldwell, 2012; Kitchen & Huberman, 2011). Positive, open, and frequent parent-child sex and sexual health discussions have been linked to responsible sexual decisions among adolescents. More specifically quality sex-communication between parent and teen results in delayed sexual debut, more consistent condom and contraceptive use, and fewer sexual partners for the adolescent (Baptiste et al., 2009; DiClemente et al., 2001; Harris et al., 2013; Kao et al., 2012; Sneed et al., 2013). Despite its benefits to adolescent's sexual health, parent-teen sexuality conversations continue to lack depth and frequency. Research findings indicate that parents are often unprepared for sex conversations and face issues of embarrassment and limited sexual health knowledge (Baptiste et al., 2009; Jaccard, Dittus, & Gordon, 2000). Using a racially diverse sample, authors Greenberg, Bruess, and Oswalt (2012), reported that the majority of parents and teens reported that delaying teens' sexual debut would be easier if they each had skills to engage in sexuality conversations. Similarly, in a study exploring Black parents' and teens' perspectives on contraception and family planning, only half of the girls and a third of the boys reported ever receiving sex-related information from their parents (Akers, Schwarz, Borrero, & Corbie-Smith, 2010).

Parents' sexuality conversation with their families when they were children and teenagers are believed to influence the approach, content, and comfort of sexuality conversations they have with their children (Grossman et al., 2013). Many parents expressed frustration with the limited sexual knowledge they received from their own parents during their childhood and adolescent years (Grossman et al., 2013). They also attributed the limited discussions to the belief that sex was a taboo topic in their household (Grossman et al., 2013). Parent-teen sex and sexual health discussions may also contradict culture and gender norms. For example, sex is not traditionally discussed with Haitian girls and these cultural and gender associated beliefs require careful consideration when designing intervention studies (Dévieux, Rosenberg, Saint-Jean, Bryant, & Malow, 2013). In addition, religious beliefs may be strongly intertwined with cultural practices and could affect the comfort and content of sex and sexual health conversations. For instance, some Christian parents have historically been opposed to discussions about sex and sexual health and often do not welcome sexual discussions initiated by their children (Hutchinson et al., 2012). Haitians and to a lesser extent Jamaicans are highly religious cultural and ethnic groups that may face barriers to open parent-teen sex conversations because of their religious beliefs (Hayward & Krause, 2015).

Parent-teen sex conversations are important as they reduce adolescents' sexual risk for HIV, STIs, and pregnancy (Baptiste et al., 2009; Wang et al., 2013). Among Black adolescents, African Americans, Haitians, and Jamaicans bear the highest burden of HIV, STIs, and pregnancy (CDC, 2016a). However, sexuality research on Black adolescents in the U.S. have focused primarily on African Americans, leaving Black

immigrant groups at risk and underserved. Hence, very little research has been conducted to investigate parent-teen sex conversations in Haitian and Jamaican households and the role of culture in shaping Afro-Caribbean parent-teen sex and sexual health discussions remains largely unexplored. Adolescent sexual health promotion and HIV/STI prevention research could benefit from a better understanding of how Afro-Caribbean parents' personal experiences shape their ability to engage in sex and sexual health conversations with their teens. Therefore, the purpose of this paper was to (a) present findings that characterized the nature of Afro-Caribbean parents' childhood and teenage experiences with sex conversations and (b) how these experiences affect current parent-teen sex and sexual health conversations. The implications for public health, health promotion, and health education researchers and practitioners will also be discussed.

Methods

Florida International University's Institutional Review Board approved the study protocol. This research is part of a larger mixed methods research study undertaken to (a) characterize the nature, perceptions, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents and (b) explain the relationship between sexuality conversations and adolescent sexual activity (Gabbidon, Shaw-Ridley & George, 2017).

Qualitative Approach and Paradigm

A qualitative methodology was used to explore a poorly understood phenomenon including the subtleties and complexities associated with parent-teen sex and sexual health conversations. A narrative inquiry approach was used to capture the nature of the conversations as expressed through human experience stories, allowing for cultural and

personal influences to be part of the storytelling. Data was gathered using face-to-face in-depth interviews and participants' social constructions of their experiences were explored using open-ended questions aimed at capturing a holistic understanding of the lived experiences with sexuality conversations.

Population and Sample

Using convenience sampling strategies, participants were recruited through youth-oriented, community-based organizations and local churches. The sample size was determined based on a review of the literature which recommended that studies using narrative inquiry include between two to 14 participants (Lal, Suto, & Ungar, 2012). Therefore, a total of 14 parent-teen dyads/triads (N=31) were successfully enrolled to complete face-to-face in-depth interviews. Eligibility criteria included: (a) family units having at least one parent and one teen aged 14-18 years who agreed to participate; (b) qualified parents who self-identified as first-generation Haitian or Jamaican immigrant and lived in the home with the participating teen; and (c) the family unit resided in Miami-Dade County, FL. Fathers were not willing to be interviewed, therefore only mothers were successfully enrolled in the study.

Instrumentation

The researcher developed interview guide was designed using the domains of the PEN-3 model, an internationally recognized model for better understanding behavior within an ethnic and cultural context. The PEN-3 model has three domains (a) cultural identity, (b) relationships and expectations, and (c) cultural empowerment (Airhihenbuwa & Webster, 2004). Face and content validity was established through a panel of sexual

health researchers who reviewed the interview guide. The guide was then pilot tested with two Afro-Caribbean dyads to evaluate cultural appropriateness, study procedures and develop appropriate follow-up probes as necessary for the interview questions. The final parent and teen interview guides contained six questions related to the cultural identity domain, 19 questions in the relationships and expectations domain, and 11 questions related to the cultural empowerment domain. This paper will focus on six interview guide questions that were developed to best characterize the nature of parent and teen experiences with sex and sexual health conversations (one from the cultural empowerment domain, one in the cultural identity domain, and four in the relationships expectations domain. [Insert Table 4.1].

Data Collection Procedures

Interviews were either conducted in the families' home or in a predetermined community based location in Miami Gardens, Florida. Interviews were scheduled at a time that was most convenient for parents and teens. Parents and teens were provided opportunities to pose questions before beginning the interview. A copy of the signed written adult consent and/or child assent forms were provided for all participants and copies retained by the primary investigator. Parent and teen interviews were always conducted separately and behind closed doors to ensure privacy. All interviews were voice recorded with participant's permission and were conducted in less than 60 minutes with a trained interviewer. Interviews were gender matched to improve participants comfort sharing sensitive information.

Data Analysis

Descriptive data was analyzed using IBM SPSS 21 (IBM Corp., 2013). Interview data analysis employed a thematic content analysis approach to identify patterns of meaning across the dataset. Thematic content analysis is best used to address research questions about participants' experiences, views, perceptions, and to construct meaning of a phenomenon (Crabtree & Miller, 1999). The analysis was conducted inductively and included: (a) data collection and familiarization (b) coding of the data, (c) applying templates of codes (d) connecting codes and identifying themes (e) and corroborating and validating themes. To improve rigor, data was triangulated using data analyst methods. This included using multiple analysts from several ethnic backgrounds including Afro-Caribbean members to conduct cross-case analyses and develop appropriate codes and themes. Consistent with an interpretivist paradigm, meanings emerged during the analysis process. Categorical response codes based on the parent and teen interview answers were identified. This included recognizing repeated or similar key words and phrases. The parent and teen categorical response codes were then collapsed into emergent themes.

Results

Fourteen Afro-Caribbean mother-teen dyads/triads (N=31) completed separate face-to-face in-depth interviews. Dyads consisted of six Haitian and eight Jamaican families. Jamaican dyads included; six mother-daughter dyads and two mother-son dyads. Haitian dyads included, two mother-daughter dyads, one mother-son dyad, and three dyads including mothers and two teens. Mothers' mean age was 41.85, (*SD*=5.50) and

ranged from age 35 to 51 years. The mean years that mothers reported living in the U.S. was 23.5, (*SD*= 9.87) years ranging from 6 to 42 years. Most mothers reported some college education. Teens' mean age was 16, (*SD*= 1.31) years. Most adolescents were girls (58%) and 43% of teens reported their mother as their primary source of sexual health information followed by their peers (23%) and another family member (33%).

[Insert Table 4.2]

Question 1: Afro-Caribbean cultural beliefs and practices towards parent-teen sex conversations

Dyads were asked to describe cultural beliefs and practices towards parent-teen sex and sexual health conversations. These were described as: (a) restricted or little practice within the cultures; (b) generational differences in how participants engaged in sex-conversations; and (c) a positive cultural view of parent-teen sex conversations. Mothers described traditional or customary practice of parent-teen sex conversations within their cultures as limited or restricted sexual discussions. This was described as infrequent discussions which focused on avoiding: boys, pregnancy, and sex. Mothers reported not being provided details on why they should avoid sex and boys which left them with a lack of sexual health knowledge. Haitian mothers characterized the cultural view of parent-teen sex conversations as *forbidden* or *taboo*. Meanwhile, Jamaican mothers did not use this terminology, instead they overwhelmingly expressed avoidance of sex conversations as a common practice within their culture. Despite the expressed taboo status of parent-teen sex conversation, some mothers reported that they recognized a generational shift occurring in how their cultures viewed parent-teen sex conversations.

Mothers mentioned that younger parents were more open to parent-teen sex discussions compared to their predecessors. Haitian and Jamaican teens also reported that sex was not typically discussed within their cultures, reinforcing mothers' statements. One Jamaican mother and a Jamaican girl reported positive cultural views of parent-teen sex conversations. The mother asserted that the cultural group believed that parents should openly discuss sex with their children.

One Jamaican mother-daughter dyad described the cultural views of parent-teen sex conversations:

> *It's like they scorn [parent-teen sex conversations], it's like don't touch that topic, don't, that's something we don't talk about in here or not in this house*
>
> -Jamaican mother
>
> *They don't have the conversation*-Jamaican daughter

A Haitian mother-daughter dyad also characterized the cultural views of parent-teen sex conversations:

> *It's taboo almost. We just didn't talk about it, it's not until somebody a teenager comes home pregnant even then the younger ones would have to leave the room to have this conversation*-Haitian mother
>
> *In my opinion, I feel they kind of don't want to talk about [sex]*-Haitian daughter

One Jamaican mother and daughter dyad captured the change in generational views and positive cultural views of sex conversations

It was a more hush hush, now [sex conversations are] more open-Jamaican mother

They probably think you should like just tell them as early as you can to prevent any consequences-Jamaican daughter

Question 2: Parent's childhood and teenage experience with sex conversations

Mothers were asked to reflect and share their childhood and teenage experiences discussing sex and sexual health with their parents. Two overarching emerging themes described parents' childhood and teenage experiences with sex conversations: (a) forbidden and/or no experience with sex and sexual health conversations; and (b) messages characterized by warnings and punitive discipline.

Forbidden or no experience with sex and sexual health conversations. Most Haitian and Jamaican mothers expressed having no sex and sexual health conversations with their parents during their childhood and teenage years. However, Haitian mothers again uniquely characterized parent-teen sex and sexual health conversations as *forbidden*. Meanwhile, Jamaican mothers reported receiving information from other sources including books and sexual education courses rather than direct information from their parents.

When I was growing up, I never had that conversation with my parents, never. I learn about the simple things at school. I never learned [about sex] at home -Jamaican mother

I'm from the Caribbean you know. My parents had this thought process that you don't need to know none of this or we don't need to talk about [sex]. When adults

are talking about [sex] you need to get lost, get out of the room, it's not for you, it's for an adult-Haitian mother

Messages characterized by verbal warnings and punitive discipline. When parents did engage in parent-teen sex conversations during their childhood, the messages were characterized as warnings about sexual expectations occasionally accompanied by physical discipline if they were perceived to be sexually curious or sexually active. This would include messaging about practicing abstinence and avoiding boys and pregnancy.

Don't talk to boys. That's it. Period. They can't call you. They can't look at you. It was just like don't talk to boys. They never got to why not talk to boys. Why not hang out with boys? Why not have that relationship with boys? It just was don't do it. Boys are not allowed-Haitian mother

They did tell us abstinence was the rule of the house-Haitian mother

At the age of 16, I did kiss a boy and the reaction of my mother was not nice. She actually spanked me in front of all my friends-Jamaican mother

Question 3: Effect of childhood experiences on parents' sexual beliefs and practices

Mothers were asked to share how their childhood and teenage experiences with sex communications shaped their views of sex, sexual behaviors, and sex conversations. Parents' responses to their childhood and teenage experiences with sex conversations resulted in a range of outcomes including clear positive, negative, and existential or non-specific influences on sexual attitudes and beliefs.

Positive outcomes. Despite limited sexual discussions during their formative years, Haitian mothers reported several positive outcomes from their childhood

experiences with sex conversations including: (a) encouragement to engage in sex and sexual health conversations with their kids, (b) respect and appreciation for their dating partners, (c) ability to promote a healthy outlook of sex to their children, and (d) developing feelings of worthiness as it relates to sex. Jamaican mothers reported avoiding boys, pregnancy and STIs as positive outcomes from their childhood and teenage experiences with parent-teen sex conversations.

> *I'm gonna talk about me, I didn't have [parent-teen sex conversations]. I didn't want to do the same thing my parents did to me*-Haitian mother
>
> *I keep myself away from boys cause I didn't want to catch no disease and I didn't want to get pregnant*-Jamaican mother

Negative outcomes. Mothers however most commonly reported negative outcomes from their childhood experiences with sex communications. Both Haitian and Jamaican mothers expressed similarity in the negative outcomes they experienced because of no or limited sex and sexual health discussions with their parents. This largely included developing feelings of fear about sex, boys, and men. Mothers also reported that high-conflict interactions around sex and dating resulted in them engaging in *rebellious* or unsafe sexual behaviors oftentimes resulting in pregnancy. Jamaican mothers reported some additional negative outcomes including: (a) a lack of sexual health knowledge, (b) poor communication skills, and (c) discomfort with sexual topics.

> *Instead of preparing me, my parents tried to keep stuff from me. The more [my mother] kept stuff from me, the more curious I got. The more I wanted to know. What are you keeping from me? Why can't I talk to boys? The minute I could have*

sex, I went out and I did. It was disastrous. I got pregnant as a teen-Haitian mother

I was literally afraid of boys because I was told that if they touch you or whatever you gonna get a baby-Jamaican mother.

Existential or non-specific outcomes. These conversations shaped parents' views in ways that cannot be characterized as positive or negative. Some views had religious connotations including viewing sex as a sin, sex as precious, and describing sex as being limited to procreation.

I look at sex as a sin. Even when I was married, it felt wrong. I can't wrap my mind around sex being a normal thing-Haitian mother

I wouldn't have been very promiscuous with [sex], like not caring or thinking having a one night stand is okay, if you would have got taught out the gate, then you would have known, I'm going to save myself, I'm going to wait. I'm worthy -Haitian mother

[Parents] put fear inside of you because sex is a sin having sex out of marriage in Jamaica is like murder, like you kill somebody, because the bible say you must not fornicate. So, fornication is a very big sin, so you can't do that-Jamaican mother

Question 4: Parent and teen current experiences with sexuality conversations

Both parents and teens were asked to describe their current experiences with sex and sexual health discussions. This was done to highlight how mothers' childhood and teenage experiences with sex conversations may have influenced their current ability to discuss sex with their teens. These experiences were categorized in three themes

including (a) feelings associated with the conversations, (b) context and content description, and (c) limited or no engagement in parent-teen sex conversations [Insert Table 4.3].

Feelings associated with sex conversations. Most mothers expressed being more comfortable engaging in sex conversations than their teens. However, some parents did reveal regret with how little they had prepared their teens for sexual decision making. One Haitian mother-daughter-son triad captured the varying comfort levels between mothers and teens:

> *In all honesty, I really enjoy talking to [them], matter of fact I'll give you a scenario. My daughter had first had her menstrual, her period the first time, that's when I make a decision that following weekend we went and have breakfast and we talk about it-* Haitian mother
>
> *It was like awkward well she started it like around the time I started menstruation or whatever she made a big deal about it she took me to dinner-* Haitian daughter
>
> *Oh, I could say it gets kind of awkward. I know my mom sat me down, had a good dinner so we could talk about how my life was going, if I had a girlfriend*-Haitian son

Context and content description. Both mothers and teens characterized current conversations as warnings, rules, and expectations about sex. Mothers and teens reported discussing inappropriate touching, abstinence until marriage, STIs, and pregnancy. Mothers however, uniquely reported engaging in age-appropriate conversations as a part of their experience talking with their children. Parents also noted that menstruation was

often the prompt for the first conversation between girls and mothers and would inevitably lead to messages about pregnancy risk. TV shows and condom commercials were considered prompts for sex conversations by adolescent girls and for three boys being romantically linked was reported as a prompt for sexual discussions.

One Jamaican mother-son dyad captured the typical content of sex conversations: *Basically, about the diseases that's going around. Sex is something that's between two people that love each other until they are going to marry that person at that time*-Jamaican mother

Protection, not trying to get diseases and all that stuff. Like you could have HIV and all that, use a condom and stuff-Jamaican son

Limited or no engagement in sex conversations. Some mothers and teens reported never engaging in sex conversations, while some mothers reported avoidance, hesitation, and difficulty broaching the topic with teens. When asked this question, Haitian mothers discussed how their lack of experiences talking with their parents about sex directly influenced their inability to discuss sex with their children openly. Compared to parents, teens were more likely to report that the conversations were *limited* and sometimes lacked useful or practical content. One Haitian mother-son dyad captured the limited engagement that some families experienced with sex conversations:

Me and my son, we don't really talk about sex. I've made references. I've attempted to. I guess because of my upbringing, it's not something you just talk about- Haitian mother

We don't talk about [sex] too much but they have taught me at this point in time, that I shouldn't really be thinking about those types of things just yet- Haitian son

Another Haitian mother-daughter dyad captured families' sometimes discordant perception of engaging in sex conversations:

*We've had conversations about [sex] from they were about eight, nine maybe even before that-*Haitian mother

*Well we haven't really talked about [sex]...I know because of classes and stuff because we talk about sexual health, but other than that it's like we haven't sat down and said this is that and be protected-*Haitian daughter

Question 5: Gender of the teen and its influence on sex conversations

Mothers and teens were asked to share if and how the teens' gender affected the conversations. Themes related to gender and the nature of sex conversation included (a) gender of the child affecting the content of the conversation, (b) same and cross gender conversations (c) gender affecting sexual expectations, and (d) no gender differences. While some mothers and teens reported that gender did not influence the conversations, most participants reported some differences. Both mothers and girls reported an emphasis on pregnancy risk and abstinence as a part of messaging for girls. Mothers and teens also reported that there were implicit biases that allowed more sexual freedom for boys. One Jamaican mother-daughter dyad expressed the gender based differences:

I have two [children] and I know when [my son] gets to that age, what I would tell [my daughter], what I try to embed in [my daughter]'s brain I wouldn't per se do it to [my son], which is wrong- Jamaican mother

Boys have it easier. Boys with their mom, it's gonna be practically the same [as] daughters and the father. The father now is gonna praise the son, the mother [is]not going to really praise the daughter but she's going to be understanding - Jamaican daughter

Additionally, mothers and sons both reported that messages to sons uniquely emphasized respect and the financial responsibility of taking care of a family or child. Finally, mothers and daughters both believed that their shared gender made sex and sexual health conversations easier, while some mothers revealed difficulty talking to their sons about sex. One Haitian mother-son dyads' response expressed mother and son dynamics shared by some families as well as the difference in messages for boys:

I know I'm supposed to, so I've made some attempts to [talk about sex], but I have no idea how, especially being a woman and him being a boy. It was easier with my girls, but with him, I don't know where to start- Haitian mother

I believe there's a big difference because the way my dad talks, he's talking to me like I'm going to be taking care of not only the woman I want to spend my life with but also our kid financially…they usually have more conversations with my sisters-Haitian son

Question 6: Influence of sex conversations on teens' sexual beliefs and behaviors

Teens were asked to describe their perception of how current parent-teen sex conversations shaped their sexual beliefs, sexual behaviors, and parent-teen sex conversations. Much like their mothers, teens reported both positive and negative outcomes from childhood and teenage experiences with parent-teen sex conversations

[Insert Table 4.4]. Positive outcomes included engaging in responsible sexual behaviors and a perceived increase in sexual health knowledge. Negative outcomes included negative emotions associated with sexual discussions, diminished parent-teen relationship quality, and difficulty discussing sex with parents.

Positive outcomes. Both Haitian and Jamaican teens reported that parent-teen sex and sexual health conversations resulted in them avoiding hazards that were characterized as STIs and pregnancies. Girls reported a broader range of positive outcomes than boys. Both Haitian and Jamaican girls believed conversations encouraged abstinence and avoiding boys. One Haitian girl reported viewing sex as normal and natural because of sex conversations. As a result of parent-teen sex conversations, Jamaican girls perceived an increase in their sexual health knowledge compared to their knowledge before parent-teen sex conversations. Haitian boys uniquely reported developing feelings of respect and appreciation for future or current romantic partners.

Negative outcomes. Both Haitian and Jamaican girls reported feelings of fear about sex that resulted from fear-based messages used by their parents. One Jamaican girl reported that she perceived sex conversations to be uncomfortable and her parents' harsh responses during sexual discussions resulted in a lack of closeness between her and both parents and negatively affected her ability to talk with either parent about sex.

Discussion

The purpose of this paper was to (a) present findings that characterized the nature of Afro-Caribbean parents' childhood and teenage experiences with sex conversations and (b) how they affected current parent and teen dyads' sex and sexual health conversations. Most mothers in this study reported some college education, therefore this

sample may be more educated than the general target population. Results also showed mothers were the single most common source of sex and sexual health information compared to any other family member, community member, or peer. These findings support mothers being the most common parental source of sex and sexual health information for their sons and daughters (Baptiste et al., 2009; Kapungu et al., 2010; Miller et al., 2010). Therefore, the nature of mother's childhood experiences was explored to identify how they shaped mothers' ability to engage in sex conversations.

Nature of mothers' childhood experiences with sex conversation

Mothers were asked to describe their childhood and teenage experiences engaging in sex and sexual health conversations with their parents. Mothers characterized the nature of these experiences as (a) forbidden or no experience with sex conversations and (b) messages characterized by verbal warning and punitive discipline. Both Haitian and Jamaican mothers overwhelmingly reported receiving limited sex and sexual health information from their parents during their childhood and teenage years. Some mothers believed these experiences motivated them to better prepare their children in ways their parents did not yet also left them with a lack of skill and knowledge to communicate safe sex messages effectively. Haitian mothers linked their parents' failure to educate them to the cultural belief that sex conversations were taboo or forbidden. This finding reinforced previous reports that parents sharing limited sexual health information with their teens were believed to be a result of cultural taboos (Grossman et al., 2013).

Traditional Haitian sexual values encourage abstinence until marriage and are deeply rooted in religious beliefs (DeSantis et al., 1999; Kobetz et al., 2011; Stephens & Thomas, 2013). By extension these beliefs may restrict openness to sexual discussions. It

is important to note that mothers indicated that younger parents appeared to be more open to sex conversations with their teens compared to older generations. These findings may suggest that younger parents may be responsive to sexual health promotion interventions hoping to improve their communication skills and sexual health knowledge. Interventions will assist parents with communicating messages on safe sex and delaying sex to their teens more effectively. Jamaican mothers also reported a similar lack of discussions but more commonly described it as avoidance and shyness with sexual discussions. Jamaican mothers' lack of engagement in parent-teen sex conversations may also be linked to religious beliefs and reflect a lack of communication skills and limited sexual health knowledge which have been passed down from one generation to another.

For mothers who did engage in some form of sexual discussions during their formative years they often categorized discussions as warning messages, occasionally accompanied by physical discipline. These experiences likely did not afford parents (then teens) the opportunity to respond openly to their parents' messages on sexual expectations. Despite the varying reasons, Haitian and Jamaican mothers both described limited childhood experiences with their family's role in their sexual learning leaving them woefully unprepared for sexual discussions with their children.

Implications of mother's childhood and teenage sex communication experiences

Despite these experiences, Haitian mothers reported that childhood sex conversations helped them develop healthy views of sex and encouraged them to engage in sex conversations with their teens. Mothers felt it important to prepare their teens for responsible sexual decision making in better ways than their parents did during their

formative years. Secondly, childhood conversations about sex assisted Haitian mothers in developing feelings of self-worth, self-respect, and respect for their dating partners.

Mothers also reported several negative outcomes circled around skills, comfort, and behavior. Many mothers reported that their limited childhood discussions and high-conflict interactions with their parents led to rebellious sexual behaviors which often resulted in pregnancy. This corroborates reports suggesting that frequent but negative parent-teen sex conversations results in high-risk sex during adolescent years (Guilamo-Ramos et al., 2012). In some cases, this messaging had religious undertones where sex was viewed as sinful. This created difficulty for some in perceiving that even marital sex was moral and appropriate. Additionally, mothers also reported that their limited discussions left them with a lack of comfort and knowledge for initiating and engaging in sex conversation with their teens. These results support the need to help parents improve their skill and sexual health knowledge because of the potential deficits and discomfort they may experience stemming from their childhood sexual conversations.

Current experiences with sex conversations: the need for public health intervention

Dyads were asked to describe their current experiences with sex and sexual health conversations. Findings illustrated that mothers' childhood experiences, families' comfort, culture, and gender norms all influenced the current nature of parent-teen sex conversations within Haitian and Jamaican families. For families' current sexual conversations, both mothers and teens typically characterized sex conversations as warnings about sexual risk and messages on sexual expectations. Common discussions topics were as expected: abstinence, STIs, pregnancy, and safe sex practices (Sneed et al.,

2013). However, mothers and teens seldom reported ever engaging in discussions about resisting sexual pressure or contraceptives. First, parents may not have the skills to help teens develop sexual refusal self-efficacy, they may not value the importance of sexual refusal messaging or parents may not recognize the level of sexual pressure teens may face. Secondly, parents primarily avoid conversations about contraceptives because they perceive such discussions as encouraging sex (Caal, Guzman, Berger, Ramos, & Golub, 2013; Commendador, 2010). Parents may also forgo these discussions because they typically do not possess a wide range of knowledge on various contraceptive methods and therefore may feel embarrassed about their lack of knowledge (Akers et al., 2010).

While mothers and teens typically agreed on the context and content of sex-conversations, dyads showed some discordant perspectives on feelings associated with the conversations and having engaged in discussions. Teens commonly characterized sex conversations as *uncomfortable*, *weird*, and *awkward* meanwhile mothers typically expressed little discomfort with sexual discussions. However, family-sex conversations may be more parent-dominated, with parents expressing their expectations in an authoritative style that allows minimal input from teens. This parental approach has been linked to discomfort and does not support open dialogue, this may likely explain why teens considered conversations important but uncomfortable (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; Rogers, 2015). Also, despite mothers reporting being comfortable engaging in sex conversations, some mothers did reveal reservations about initiating these discussions. Some mothers even relied on the same fear-based messages they previously received in their childhood. This may best be rectified by improving Afro-Caribbean parents' communication skills that allow quality, open dialogue between

parents and their teens and assisting parents to develop tools to create a comfortable atmosphere to discuss sensitive matters with their children.

Despite all teens being high-school aged, some families had never engaged in sexual discussions together. Teens would instead receive messages from other family members or peers. Dyadic responses indicated that some teens did not perceive having engaged in sex conversations while mothers were more likely to perceive having had some sexual discussions with teens. This finding corroborates previous reports that suggests that parents and teens may have incongruent perceptions of having engaged in sex conversations (Akers, Holland, & Bost, 2011). Teens who report these discordant experiences have also been more likely to engage in higher risk sexual activities (Akers et al., 2011). This would indicate that if conversations are in fact happening that teens are not internalizing those messages. Teens may also not perceive warnings or rules as actual conversations or discussions. Although participants were encouraged to share their experiences without worry of judgment, some parents may experience social desirability bias where they provide information they perceive as more favorable to avoid negative judgment by the interviewer, this may account for some discordant perspectives. Parents, particularly mothers, ought to be trained to engage in early and frequent sex conversations beginning in teens' pre-adolescent years or earlier to improve their comfort discussing sexual topics and for youth to internalize responsible sexual messages more effectively (Miller et al., 2009).

Influence of gender on the nature of sex conversations

Mothers and teens were asked to share if and how the teen's gender may have shaped the nature of the conversation. Mothers and girls both reported that sharing a gender made conversations more comfortable and relatable. However, findings showed that mothers expressed some difficulty talking to their sons about sex and sexual health. This finding suggests the need for specific interventions to assist single mothers and potentially single fathers to engage more comfortably in cross-gender, sex conversations. Gender also affected the content of the conversation. Parents and teens reported that parents were more likely to promote sexual freedom for boys and abstinence for girls. This finding supports previous reports on Caribbean constructions of masculinity and femininity which supports sex or hypersexual behavior among boys yet encourages chastity and sexual naivety for girls (Bombereau & Allen, 2008; Dévieux et al., 2013).

Interestingly, messages to sons tended to include statements on the financial responsibility associated with caring for a family, particularly child care. These messages emphasized social consequences and personal responsibility for boys if their sexual behaviors resulted in pregnancy. Incorporating the potential social ramifications of early and unprotected sex has been shown to reduce the sexual risk of Black teens more so than solely relying on messages about health risks (Akers et al., 2010). Finally, one Haitian mother-son dyad reported discussions of consent and consensual sex. This is an important finding as it indicates the general lack of discussion about sexual consent. However, parents should be encouraged to discuss consent and consensual sex with their teenagers to help reduce the incidence of non-consensual sex which is common among teenagers and young adults (Beres, 2007).

Strengths and Limitations

The study is the first to explore the nature of parent-teen sex conversations in Afro-Caribbean families and how it affects mothers' ability to communicate sexual health messaging to their teens effectively. Results show that some Afro-Caribbean mothers lack sexual health knowledge and skills to have sex conversations with their teens effectively. This deficiency stems in part from parents' childhood and teenage experiences with discomfort around sex conversations in their families. Despite the new and significant findings, the study has some limitations. These included the cross-sectional study methodology and small sample size that limit generalizability to Haitian and Jamaican families. Secondly, the study only included English speaking participants and may not be generalizable to all Haitians living in Miami-Dade County, FL, or other areas of the U.S. However, the findings have important implications for better understanding cultural influence on sexual beliefs, attitudes, and parent-teen sex conversations. Although 50% of mothers participating in the study were married, no fathers were willing to be interviewed. Results are limited to the experiences of mothers and mother-teen dyads. However, mothers are the most common parental source of sex and sexual health information for teens. Additionally, most mothers in the study were college educated and may not be representative of Haitian and Jamaican mothers living in Miami-Dade County.

Implications for Practice

To encourage open and frequent parent-teen sex conversations in Afro-Caribbean families, sexual health promotion practitioners and researchers should educate parents on the importance of sex conversations and provide tools to increase their comfort, modify

their approach, and improve their sexual health knowledge. To accomplish this, practitioners should develop workshops and resources specifically tailored for Afro-Caribbean parents of adolescents. Second, health care professionals (i.e. nurses, family physicians) should inform Afro-Caribbean parents of the benefits of discussing sex and sexual health with their adolescents. Third, practitioners should develop social marketing campaigns and strategic messages to promote parent-teen sexual health conversations in Afro-Caribbean families. Fourth, researchers should develop resources to increase parent's sexual health knowledge. Finally, health educators and public health agencies should provide resources that target parents' sexual health communication self-efficacy.

Conclusion

The study findings characterized the nature of parent-teen sex conversations in Afro-Caribbean families by highlighting mothers' childhood experiences and how they shaped their current conversations with their teens. Mothers' cultural beliefs and childhood experiences heavily influenced their ability to engage in sex-conversations. Teens characterized conversations as awkward and uncomfortable, yet considered them important for their sexual decision making. Some teens however reported receiving fear-based messages and experienced diminished relationship quality with parents after difficult sexual discussions. Sexual health educators and public health professionals should (a): develop culturally-sensitive, parent-oriented, adolescent sexual health programs and (b) train Afro-Caribbean parents to have well-informed, open dialogue about sexual topics and facilitate healthy relationship dynamics.

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Table 4.1

Interview questions categorized by domains of the PEN-3 model and linked to emerging themes and categorical codes.

Domain	Interview Questions	Categorical Codes	Emerging Themes
Cultural Empowerment	Question 1: What do you think the Haitian/Jamaican cultural view is on parent-teen sex and sexual health conversations?	No conversation Taboo/Forbidden Limited Content Avoidance/shyness	Restricted or little cultural practice with parent-teen sex conversations
		Generational Shift	Generational difference in cultural perspectives on parent-teen sex conversations
Relationships and Expectations	Question 2: Think back on your childhood and describe your experience having sex and sexual health conversations with your parents? (parents only)	No conversation Taboo/Forbidden No pregnancy prevention information provided Book provided	Forbidden or no experiences with sex and sexual health conversations
		Warnings: avoid pregnancy, avoid boys, no sex before marriage Warning/Action Taken	Messages characterized by verbal warnings and punitive discipline
	Question 3: Tell me how your childhood experiences with sex and sexual health conversations have influenced your ideas on sex, sexuality, and sexual behaviors? (parents)	Encouraged conversations Respect/Appreciation Promoting healthy outlook of sex Worthy of waiting Avoid hazards: boys, STIs, and pregnancy Responsible intimacy	Positive outcomes from childhood/teen sex and sexual health conversations with parents
		Fostered fear Difficulty having conversations Lack of knowledge Uncomfortable with subject Rebellious sexual behaviors Poor outlook on sex Sex as bad	Negative outcomes from childhood/teen sex and sexual health conversations with parents
		Sex is a sin Sex for procreation Sex as precious	Existential outcomes from parent-teen sex conversations

Domain	Interview Question	Categorical Codes	Themes
		Book was helpful Learned from sex education	No direct parent-teen sex conversations
	Question 4: How would you describe your experience having sex and sexual health conversations with your teen(s)? (parent) Question 4: How would you describe your experience having sex and sexual health conversations with your parent(s)? (teen)	Descriptive	Feelings associated with parent-teen sex conversations
		Age appropriate Warning/Rules about sex Nature of the conversation	Characterization of Content
		No talk/no action Characterization of experience with parent	Limited or no engagement in sex conversations
Cultural Identity	Question 5: How does the gender of the child affect the conversation? (parent) How does your gender affect the conversation? (teen)	Emphasis on abstinence and pregnancy prevention for girls Talk with boys about respect and responsibility Being sensitive with girls	Gender of the child affects the content and approach of the conversations
		Mother relates to daughter Father praises son's sexual behaviors Mother expresses difficulty talking to son(s)	Same and cross-gender conversations
		Double standard; more sexual freedom for boys	Gender affects sexual expectations
		No difference	No gendered differences
	Question 6: Tell me how these conversations have influenced your ideas on sex, sexuality, and sexual behaviors? (teens)	Avoid hazards: boys, STIs, pregnancy, Sex is natural, Respect appreciation, Abstinence, Responsible intimacy	Positive outcomes from parent-teen sex and sexual health conversations
		Fostered fear Created distance between parents and teens	Negative outcomes from parent-teen sex and sexual health conversations

Table 4.2

Participants' Demographic Characteristics

Variable	Response	N	Percentage
Mothers' mean age	41.85, *SD*=5.50	14	
Mean years lived in the U.S.	23.5, *SD*=9.87		
Number of children 18 or under living in the home	One	7	50.0
	Two	6	42.9
	Three	1	7.1
Mothers' Marital status			
	Married	7	50
	Single, never married	4	28.6
	Divorced	2	14
	Unmarried, living with romantic partner	1	7
Mothers' Education Level			
	Some College	9	64.3
	Bachelor Degree	3	21
	Vocational Training	1	7
	Advanced or Professional Degree	1	7
Employed			
	Yes	13	92.9
	No	1	7.1
Dyads' Ethnicity			
	Haitian	6	43
	Jamaican	8	57
Teens' Mean Age	16, *SD*=1.31	17	
Teens' Gender			
	Male	7	42
	Female	10	58
Teens' born in the U.S.	Yes	14	82.4
	No	3	17.6

Table 4.3

Emerging themes of parent and teen experiences with current sex conversations

Themes	Categorical Codes	Supporting Quotes
Theme A: Feelings associated with parent-teen sex and sexual health conversations	A1: Comfort level	"I could say it gets kind of awkward I know my mom sat me down had a good dinner so we could talk about how my life was going if I had a girlfriend obviously. She had talked to me about sex and how to be safe" -Haitian boy "I don't think that she's open with me and she's extremely uncomfortable when I'm talking to her about sex" -Jamaican mother
	A2: Regret or Hope for improvement	"Not bad and maybe I didn't do enough. Maybe I don't talk on a regular basis"-Jamaican mother
Theme B: Context and Content Description	B1: Age Appropriate	"Its different levels of [sex conversations], at a young age there are certain things you would kind of understand and you keep it to that level"-Haitian mother
	B2: Warning/Rules about sex	"There's not really conversations there are warnings about not getting pregnant and catching STDs" -Jamaican girl
	B3: Nature of the conversation	"She had talked to me about sex and how to be safe"-Haitian boy
Theme C: Limited or no engagement in sex conversations	C1: No talk/no action	"Every time she talked to me or tried to talk to me about [sex], I'd shut her down."-Jamaican girl
	C2: Characterization of experience with parent	"I didn't have [sex conversations] growing up, I already had to warn myself, like when I have a kid, I want to be able to talk about [sex]"-Haitian mother
	C3: Little conversation	"We have. Not a lot. Not really in depth"-Jamaican girl

Table 4.4

Teens' perceived outcomes of engaging sexuality discussions with their parents

Themes	Codes	Supporting Quotes
Theme A: Positive outcomes of parent-teen sex and sexual health conversations	A1: Avoid hazards; boys, STIs, pregnancy	"I didn't want to get pregnant, I don't want to get any sexually transmitted disease. I just don't want to get in trouble"-Jamaican girl "I just stay away from anything that would get me in trouble"-Haitian girl
	A2: Respect/Appreciation	"I know how to be respectful to a girl and know her, what she wants and not to go above that and force her into doing stuff"-Haitian boy
	A3: Abstinence	"I shouldn't have sex outside of marriage"-Haitian female "Oh, no sex 'till marriage"-Jamaican girl
	A4: Responsible Intimacy	"It would be okay for me to have a girlfriend but not be intimate with her"-Haitian boy
	A5: More knowledge	"It made me more knowledgeable, because if for instance I didn't have those conversations, where I would be now? I could have a had a disease by now, I could have been pregnant by now"-Jamaican girl
Theme B: Negative outcomes from parent-teen sex and sexual health conversations	B1: Fostered fear	"It made me very afraid to have sex or even date anybody"-Jamaican girl
	B2: Created distance between parent and teens	"It just made you close off from them. I just draw away from [my parents]. I don't really tell them" -Jamaican girl

CHAPTER V

Using the PEN-3 model to characterize Afro-Caribbean family sexual health conversations: Teen and parent perspectives.

Kemesha S. Gabbidon

Abstract

Purpose: Characterize the perceptions, enablers, and nurturers of parent-teen sex conversations between Haitian and Jamaican parents and their adolescents.

Methods: Utilizing a narrative inquiry approach, 14 dyads/triads (N=31) consisting of Haitian and Jamaican mothers and teen (ages 14-18 years) were interviewed using a semi-structured interview guide developed using the PEN-3 model. The interviews explored the perceptions, enablers, and nurturers of parent-teen sex conversations within an Afro-Caribbean cultural context. Dyads were recruited from churches and community organizations in Miami-Dade County, FL. Thematic content analysis was used to generate common themes and compare findings between ethnicities and dyads.

Results: Mothers' mean age was 41.85, (*SD*=5.50) and teens' mean age was 16, (*SD*=1.31). Mothers and teens reported favorable perceptions on the importance of parent-teen sex conversations and parents' role in teens' sexual health and learning. However, mothers reported several negative enablers that prohibited their ability to engage in and sustain frequent and open sex conversations including: lack of readiness, discomfort, and limited sexual health knowledge. Findings also demonstrated the importance of relatives, religious leaders, peers, and community educators in reinforcing positive sexual health messages by encouraging and facilitating open sex and sexual health dialogue within Haitian and Jamaican communities.

Conclusion: Findings support parents, extended family, and community as integral aspects of Afro-Caribbean teens' sexual development. Public health agencies serving Black immigrant groups should train families for initiating and continuing sexual discussions throughout child's formative years.

Introduction

Scholarly literature suggests that adolescents' sex-role and sexual socialization have been linked to parent and adolescent relationship satisfaction and parent-teen sexual communication (Lefkowitz & Stoppa, 2006). Adolescents who engaged in frequent, open, and positive conversations with parents about sex and sexual health are more likely to delay sexual debut, have fewer sexual partners, and practice safer sex (DiClemente et al., 2001; Harris et al., 2013; Kapungu et al., 2010; Sneed et al., 2013). However, sexual discussions between parents and teens have limited depth and frequency largely due to parents' lack of sexual health knowledge and discomfort. Parents also avoid in-depth sexual conversations because they believe such discussions may encourage sex, or that the child may become embarrassed by the content (Greenberg, Jerrold et al., 2012). Feelings of discomfort, embarrassment, and limited sexual knowledge may all be strongly associated with cultural beliefs and attitudes. Within some Caribbean cultural groups, sex is not openly discussed with teenagers, particularly adolescent girls (Dévieux et al., 2013). Other members of the cultural group including community members and extended family also help to socialize teens by sharing cultural beliefs and expectations of teens' sexual behaviors (Carver et al., 2014; DiClemente et al., 2001; Donenberg et al., 2005; Wang et al., 2013). Extended families within minority cultural groups play a large role in the sexual development of teens and may serve as alternate sexual health education sources for teens (Grossman, Tracy, Richer, & Erkut, 2015).

Cultural practices and beliefs however can facilitate or hinder sex and sexual health conversations and may have far reaching implications for adolescent sexuality. Understanding potential cultural influences on parent-teen sex conversations may

improve researchers' ability to tailor evidence based programs to improve adolescents' sexual health decision making (Bell et al., 2008; Kreuter & Wray, 2003). However, the vast majority of bio-behavioral, behavioral, and psychosocial HIV/STI risk reduction and prevention interventions did not address cultural influences (Wyatt et al., 2012). Furthermore, very few studies have validated the relationship between sexuality conversations and sexual behaviors in Caribbean populations (Bombereau & Allen, 2008; Waldron et al., 2012). Therefore, identifying cultural, societal and community level influences of sex conversations are imperative to improving parents' sexuality conversations skills. For the purposes of this study the following terms have been defined; (a) *culture* is defined as shared values, norms, and codes that collectively shape a groups belief, attitudes, and behavior through interaction with their environment (b) *perception* is defined as knowledge, attitudes, and beliefs that influence the health behavior of interest, affecting the individual, family, and the community, (c) e*nabler* is defined as cultural, societal, systematic, structural factors to support behavior change and, (d) *nurturer* is defined as the degree to which attitudes, beliefs, and actions are influenced, mediated, and nurtured by extended family, friends, peers, and community (Airhihenbuwa et al., 1999; Airhihenbuwa & Webster, 2004).

The purpose of this study is to characterize the perceptions, enablers, and nurturers of parent-teen sex conversations between Haitian and Jamaican parents.

Methods

Florida International University's Institutional Review Board approved the study protocol. This study is part of a larger mixed methods study aimed at (a) characterizing the nature, perceptions, enablers, and nurturers of sexuality conversations and (b)

explaining the relationship with adolescent's sexual activity among ethnically diverse Blacks (Gabbidon, Shaw-Ridley, & George, 2017). This study will characterize the perceptions, enablers, and nurturers of parent-teen sexuality conversations among Haitians and Jamaicans.

Research Design

A qualitative methodology was used to explore a poorly understood phenomenon and capture the subtleties and complexities associated with parent-teen sex and sexual health conversations. A narrative inquiry approach was used to capture the cultural perceptions, enablers, and nurturers of sex conversations. Data was gathered using face-to-face in-depth interviews and participants' social constructions of their experiences were explored using open-ended questions aimed at capturing a holistic understanding of the parents and teens experiences with sexuality conversations.

Population and Sample

Participants were recruited from local churches and youth-oriented, community-based organizations using convenience sampling strategies. The sample size was determined based on a review of the literature recommending 14 participants for studies using narrative inquiry (Lal et al., 2012). A total of 14 parent-teen dyads (N=31) were enrolled to complete in-depth interviews. Eligibility criteria included: (a) family unit had to reside in Miami-Dade County, (b) family units having at least one parent and one teen (ages 14-18) who agreed to participate; and (c) parent participants had to self-identify as a first-generation Haitian or Jamaican immigrant and live in the home with the participating teen.

Instrumentation

The researcher developed interview guide was designed using the PEN-3 model, developed by Collins Airhihenbuwa in 1989. The model has three domains: cultural identity, relationships and expectations, and cultural empowerment each with three key constructs (Airhihenbuwa & Webster, 2004). An expert panel consisting of three members was convened to evaluate the guide's face, and content validity. The guide was then pilot tested with two Afro-Caribbean dyads to evaluate cultural appropriateness, the study procedures, and develop appropriate follow-up probes for the interview questions. The final parent and teen interview guide contained six questions in the cultural identity domain, 19 questions in the relationship and expectations domain, and 11 questions in the cultural empowerment domain. This paper will focus on 10 interview questions developed from the relationship and expectations domain to characterize the perceptions, enablers, and nurturers of parent-teen sex conversations. Some questions have been categorized under more than one domain [Insert Table 5.1].

Data Collection Procedures

A 12-item screening tool was used to determine if interested participants were eligible for study inclusion. Interviews were then conducted in the families' home or in a predetermined community based location in Miami Gardens, FL. Interviews were scheduled based on the dyads' availability as both teen and parent had to be available to complete interviews. Interviews were always conducted separately and behind closed doors to ensure privacy. With participants' permission interviews were voice-recorded and conducted with a trained interviewer. Interviews were gender matched to improve

participants' comfort sharing sensitive information. Once interviews were completed all participants filled out an incentive receipt form indicating they were compensated for their time and participation. For teens, a $15 Walmart or iTunes gift-card was provided and a $20 Walmart gift-card to all parent participants.

Data Analysis

Demographic data was analyzed using IBM SPSS 21 (IBM Corp., 2013). Thematic content analysis approach was used to identify patterns of meaning across the dataset. Thematic content analysis is best used to construct meaning of a phenomenon and explain participants' experiences, views, and perceptions (Crabtree & Miller, 1999). The data analysis process included: (a) data collection and familiarization (b) coding of the data, (c) applying templates of codes (d) connecting codes and identifying themes (e) and corroborating and validating themes. Data was triangulated using multiple analysts from several ethnic backgrounds including Afro-Caribbean members to conduct cross case analyses and develop appropriate codes and themes. Analysts identified similar and repeated words and phrases that were used to develop categorical codes. The parent and teen categorical response codes were then condensed into emergent themes.

Results

Mothers' mean age was 41.85, (*SD*=5.50) and ranged from age 35 to 51 years. The mean years that mothers reported living in the U.S. was 23.5 years (*SD*=9.87) ranging from 6 to 42 years. Teens' mean age was 16 (*SD*= 1.31). Most adolescent participants were girls (58%) and 43% of teens reported their mother as their primary

source of sexual health information followed by another family member (33%;) and their peers (23%) [Insert Table 5.2].

Perceptions of sex, sex-conversations, and parents' role in teens' sexual development

Perception of sexuality. Parents and teens were asked to define *sexuality*. They described it as: (a) sex, sex behaviors, and sexual risk (b), sexual orientation, (c) gender identity, and (d) sexual attitudes, values, and beliefs. Teens additionally described sexuality using physical attributes and parents additionally described it as a shift in growth and development. Two Haitian dyads described sexuality:

> *It's a healthy view of sex, the role sex plays in your life, your family's life, sex in the community, the community view of it. It's just like a holistic view*-Haitian mother
>
> *Gay, straight, pan sexual*- Haitian daughter
>
> *Sexuality. I guess sin, tabooed. Private*-Haitian mother
>
> *Gay straight, sexual orientation*-Haitian son

Perception of adolescent sexuality. Dyads were then asked to describe their perception of adolescent sexuality. Adolescent sexuality was characterized like sexuality including themes of sexual behaviors, sexual orientation, and gender identity but was additionally described as a period of sexual experimentation. Parents distinctly described adolescent sexuality as lacking emotional and spiritual connection. Parents and teens also commonly differentiated adolescent sexuality from adult sexuality by denoting that sexual intercourse should not be an aspect of adolescent sexuality.

Adolescents' sexuality should not involve physical sexual contact, they definitely need to start learning about the role sex plays in life in general. But I would say the scope of sexuality is different for adolescents than for adults-Haitian mother

I would think that means young adults and their sexual preference and sexual understanding-Jamaican mother

Virgin's interest in the whole experience or they are trying some kind of way but they are not sexually active-Jamaican girl

Importance of parent-teen sex conversations. Dyads were also asked to share what value they perceived from their engagement in parent-teen sex conversations. Parents and teens perceived sex and sexual health conversations as important because they: (a) prepared teens for future sexual encounters, (b) provided guidance on appropriate sexual behaviors, (c) helped parents and teens develop their relationship and improve communication, and (d) served as a means for parents to share their knowledge and expertise. It was also important for parents to serve as their child's first source of sexual health education [Insert Table 5.3].

Perception of parents' responsibility to adolescent sexuality. Dyads were then asked what they believed a parents' responsibility was for their adolescent's sexual development. Both parents and teens believed that a parents' responsibility regarding adolescent sexuality was to (a) actively prepare teens for future sexual encounters, (b) monitor teens activities and whereabouts (c) provide quality and appropriate communication, (d) help teens increase their comfort for parent-teen sex conversations, and (e) improve their sexual attitudes.

Actively prepare teens for future sexual encounters. Parents prepared teens through education, direct action, warning, and providing a context for sex. However Jamaican parents would also report educating teens on alternatives to sex. A Jamaican mother-daughter dyad reported the following:

> *One of the main responsibility is sex education, you have to teach them or tell them about the whole sexual thing, getting pregnant or getting someone else's child pregnant because there's so much STIs out there some can [be] cured and some can't be cured*-Jamaican mother
>
> *The only thing the parent can do is tell that child about consequences and the dangers [of sex]*-Jamaican daughter

Monitoring or awareness of teens' whereabouts. Parents and teens agreed that one of parents' responsibilities should be monitoring teens' whereabouts, friends, and behaviors.

> *Their responsibility is to keep track of their kids and see how they're doing*
> -Haitian boy

Provide quality and appropriate communication. Parents and teens described parent's responsibility as facilitating open and honest communication with teens. Parents also believed their responsibility was to engage in frequent conversations with teens and provide age-appropriate sexual information.

> *Making your door an open door for your child to be able to come and talk to you*
> -Jamaican mother

Yeah, to talk to their child be really open don't just say that they'll listen to their child, but when their child tells them something they don't want to hear about sex they get upset about it. They need to really be open minded-Jamaican daughter

Improve teens' comfort and sexual attitudes. Both parents and teens agreed that parents' responsibility was to create a comfortable atmosphere for sexual discussions. However, parents also reported that one of their responsibilities was to help teens develop a healthy outlook on sex which was described as difficult by some parents.

Don't scare them with [sex]. You have to embrace them with it and its natural, its normal-Jamaican mother

Their responsibility is to teach their kids, make them comfortable, and have them speak to you. Ask questions-Haitian mother

Enablers of parent-teen sex and sexual health conversations

Negative enablers of parent-teen sex and sexual health conversations. Parents and teens were asked to describe barriers to conversations about sex and sexual health. Both parents and teens agreed that sex conservations occurring after teens have had sexual intercourse made conversations more difficult for both parents and teens. They also mentioned that a lack of readiness, discomfort, negative perceptions of sex conversations, difficult sexual experiences, and parents' limited childhood and teenage sex communications adversely affected parents' and teens' ability to engage in sex conversations. Parents went on to explain that teens' sexual orientation could also make conversations more difficult for them. A Haitian mother-son dyad and a Jamaican mother-daughter dyad described discomfort and parents' childhood experiences with sex conversations as barriers to sex conversations:

I don't think it's difficult to talk about. But in my child's case I think for them, they kind of feel a little bit uncomfortable I don't know why but I think it's uncomfortable for them-Haitian mother

It's kind of a sensitive topic… and sometimes [they] feel uncomfortable in discussing what they've done, because their parents might be kind of mad at them or irritated with them because they taught them better-Haitian son

One of the difficult thing for a parent is we didn't grow up with our parent's talking to us, so now to talk to our kids it's kind of hard sometimes-Jamaican mother

It's the situation where it's like, a parent wouldn't want to like picture their child doing-Jamaican daughter

Positive enablers of parent-teen sex and sexual health conversations. Dyads were then asked to share what they believed would make sex and sexual health conversations less difficult for them. Parents and teens however reported that early sex conversations, improved communication skills, and combating families' discomfort with sex conversations would be helpful for facilitating sexual health discussions. They also mentioned that parent-specific factors such as their approach, sexual health knowledge, and potential mentorship for parents could help families initiate and sustain frequent and open sex conversations. For some teens, their comfort was predicated on which parent they spoke with about sex. They also noted that parents who were supportive rather than argumentative were much easier to speak with about sex. Haitian parents believed that an effective strategy to making conversations more impactful was to make them relatable by sharing personal experiences [Insert Table 5.4].

Cultural beliefs on adolescent sexual behaviors

Cultural view of appropriate adolescent sexual behaviors. Parents and teens were asked to share the Haitian and Jamaican cultural views on adolescent sexual behaviors. Haitian and Jamaicans similarly described appropriate adolescent sexual behaviors as delaying sex until marriage. However, parents of both ethnic groups reported a cultural perception that most adolescents were sexually active or at least curious about sex. Three Jamaican teens and two Haitian parents reported that premarital sex among teens was common in their homeland, while another teen expressed that living in America created more pressure on teens to delay sex. Jamaican adolescents also reported an expectation of chastity for girls and heterosexuality for teens as expected culturally-appropriate adolescent sexual behaviors.

> *There's no such thing as teenage sex. It's non-existent. It's not like [America] you can have sex if you love them. No. You don't have sex until you're married. That's it. There's no such thing. Before you're married, there's no sex. Sex does not exist, so there's no need to talk about it because you're not supposed to be doing it. It's like find a husband, get married, then we'll talk about sex*-Haitian mother
>
> *First you cannot be gay, that's the first thing, you cannot be gay. You can't even question it*-Jamaican girl
>
> *I feel like if you live in Jamaica it's the norm, like everyone is having sex like everyone is getting pregnant young, everyone is having a bunch of kids its normal but when you are up here [in America] it's more of caution like I don't want you to*-Jamaican girl

Cultural influence on sexual attitudes and beliefs. Families were then asked to share how they believed their culture influenced their sexual attitudes and beliefs**.** Ten of the 17 teens did not perceive that their culture shaped their sexual attitudes and beliefs or views on sex conversation. One teen however reported that cultural views made them feel ashamed of their premarital sexual behaviors. Mothers on the other hand reported that their cultural views heavily shaped their sexual beliefs and attitudes. Mothers' cultural views also directly influenced their comfort and confidence for engaging in sex conversations due to the limited discussions they experienced in childhood.

My dad's a pastor, I think the religious part that both I learned on my own and that my parents instilled in me still scares me-Haitian mother

[Culture] does shape [parent-teen sex conversations] because Jamaican culture is still not as open as the American culture in discussing sexual health, sexuality, and adolescent sex, it's not as open-Jamaican mother

Their beliefs on the topic just makes it seem like until I get to a certain age, I can't like do anything sexual-Haitian boy

Nurturers of parent teen sex conversations

Common nurturers of parent-teen sex conversations included the extended family, community members, and peers which generally served positive roles, encouraging more sexual discussions in families.

Role of the extended family. Mothers and teens were asked to share how extended family members may have influenced parent-teen sex conversations. Other than parents, relatives including: grandparents and teens' or parents' siblings. Mothers and teens reported that the extended family either encouraged family-sex conversations or

had no direct role with sexual discussions. One Jamaican teen reported that families could sometimes discourage sexual discussion because they did not recognize the level of sexual pressure teens faced.

> *[My mother] ask a question, she makes it in a joking way, you know so she's a little bit more open now talking about stuff with [my kids] than she was with [me and my siblings]*-Jamaican mother
>
> *[My family] believe[s] the same thing, they all believe in waiting until marriage and finding the right person, like a biblical belief, Christianity*-Haitian boy

Role of community. Dyads were also asked to share how community members may have shared sex and sexual messages with teens. Members of the community had similar roles as the extended family. A small group reported that members of the community had no direct role with their conversations, many reported that community members encouraged or provided sexual health education themselves. This included sharing what was perceived as culturally-appropriate sexual behaviors. Community nurturers of teen sexual education and parent-teen sex conversation included health educators, religious leaders, peers, and community leaders. One Haitian mother-daughter-son triad captured common community based nurturers and their roles in sex conversations:

> *Our church, the youth leaders…Before I used to refuse to let [my children] participate in school, but as they grow up I let them go around, 11 and 12, I let them participate because I already did my job, so I let the school teach them also* -Haitian mother

Teachers… they tell us to wear protection, but people like pastors…they tell us that it's not right to, even if it's with protection, if you're not married or it's not the right person, mainly if you're not married, that it's not okay-Haitian son

Friends, we would talk about it... Church leaders Of course, no sex before marriage-Haitian daughter

Discussion

The purpose of this paper was to characterize the perceptions, enablers, and nurturers of parent-teen sex conversations in Afro-Caribbean families. Teens (43%) reported mothers as their single most common source of sex and sexual health information compared to any other family member, community member, or peer. However, the large portion of teens gaining sexual health information from other family members also reinforced the importance of the extended family in Afro-Caribbean teens' sexual learning (Carver et al., 2014; Wang et al., 2013).

Perceptions shaping parent-teen sex conversations

Mothers and teens were asked to describe their perception of sexuality, adolescent sexuality, the value of parent-teen sex conversations, and parents' responsibility for adolescents' sexual development. Mothers and teens described sexuality in several ways including sex behaviors, sexual orientation, gender identity and expression, sexual attitudes, and sexual beliefs. Within perceptions, Haitians notably and existentially characterized premarital sex as taboo or forbidden however both cultural groups agreed that appropriate sexual behavior for teens was to abstain from sex until marriage. This reflected traditional Haitian cultural beliefs and may also reflect traditional Jamaican sexual values (DeSantis, Thomas, & Sinnett, 1999; Stephens & Thomas, 2012).

Findings from this study presented new insight on Afro-Caribbean perceptions of parents' responsibility in adolescent sexual development. Parents believed that their primary responsibility was to educate their teens about sex preferring to serve as their teen's first source of sexual health information. Dyads viewed parent-teen sex conversations as valuable because they allowed parents the opportunities to share sex and sexual health knowledge with their teens and to reinforce messages on delaying sex and safe sex. In addition to recognizing the value of parent-teen sex conversations, dyads believed parents served other roles in teens' sexual development and sexual health decision making including providing (a) access to safe sex methods and (b) reproductive and sexual health services. These findings highlighted parents' role in teens' sexual learning and health. As it relates to the *person* construct in the cultural identity domain of the PEN-3 model, mothers are one of the primary decision makers for adolescents' health which highlights their role in teens' sexual development (Airhihenbuwa et al., 2009).

Mothers recognized the importance of monitoring their child's whereabouts to restrict risky and early sexual debut. This may support other findings that parental monitoring is highly prevalent among Blacks compared to their White and Hispanic counterparts (Borawski et al., 2003). Parental monitoring is also believed to occur consistently among Haitians and may also be common among Jamaicans (Borawski et al., 2003; Colin, 2001). Findings illustrated mothers' importance as their teens' primary sexual socializing agent by shaping teens' sexual attitudes and beliefs. However, parents' limited capacity for sex conversations often created barriers that affected their ability to engage in open and well-informed sexual discussions (Gabbidon & Shaw-Ridley, 2017). Mothers also expressed the importance of age-appropriate conversations and may benefit

from skill development to help them initiate and continue sexual health discussions with their children at varying stages beginning in pre-and early adolescence.

Enablers of parent-teen sex conversations

Enablers are cultural, societal, systematic, and structural factors that affect sex conversations (Airhihenbuwa & Webster, 2004). Enablers included communication barriers, facilitators, and cultural beliefs of adolescent sex and sex conversations. Despite believing that beginning sex and sexual health discussions in earlier years would be effective, some parents and teens reported never engaging in sex discussions together. Previous research suggests that parents may not perceive their teens to be at risk, likely delaying sex conversations until they perceive their teens to be romantically linked and at risk for HIV, STIs, or pregnancy (Beckett et al., 2010). Additionally, dyads reported parents' approach as a negative enabler lending support to previous research suggesting that parents' authoritative style limits open dialogue (Borawski et al., 2003; Rogers, 2015). Additional common barriers such as lack of knowledge, discomfort, and embarrassment were also described as negative enablers of parent-teen sex conversations with these two Afro-Caribbean groups (Aung, 2011; Baptiste et al., 2009; Greenberg, Jerrold et al., 2012). These individual skills negatively affecting sex conversations reflect parents' lack of engagement or lack of awareness and access to skill and communication development opportunities in their local communities.

Dyads were asked to share the Haitian or Jamaican cultural beliefs on appropriate adolescent sexual behaviors to better understand how they may shape family sexual discussions. Dyads expressed some dichotomy in views and practices surrounding adolescent sex. Despite premarital sex being viewed as contrary to traditional Haitian and

Jamaican cultural beliefs some Jamaican teens expressed that high rates of pregnancy and premarital sex among teens in their homeland contradicted their parents' expectations of abstinence for them. However, the high rates of pregnancy among Jamaican girls has been linked to poverty which increases girls' likelihood of engaging in cross-generational relationships and transactional sex which put them at high risk for HIV, STIs and pregnancy, this however is not as commonly experienced with American teens (Bombereau & Allen, 2008). Similar findings have been shown in another study exploring socio-cultural factors affecting Haitian girls' risk of HIV (Dévieux et al., 2013). Additionally, Caribbean teens may have less access to sexual health information, condoms, and contraceptives than their American counterparts. Therefore, these perceived dichotomous cultural views that participants reported may be due in large part to economic hardship that adversely affects native Haitian and Jamaican teens' sexual risk and may not actually contradict cultural attitudes.

As first generation immigrants, mothers were more likely to report culture shaping their views while teens overwhelmingly did not believe their cultural background affected their personal views of sex and sexual behaviors. However, most adolescents were second generation immigrants and may align more with American culture values than that of their parents. American cultural views were considered less traditionally conservative and more open to sexual conversations than that of Afro-Caribbean immigrants. Finally, some Jamaican participants shared the cultural disapproval of sexual minorities; including those with a minority gender identity or sexual orientation that contrasted with traditional sexual expectations and gender roles. Jamaican LGBTQ youth

may then experience even greater difficulty engaging in sex and sexual health discussions with their parents.

Nurturers of parent-teen sex conversations

Nurturers are the degree to which attitudes, beliefs, and actions are influenced, mediated, and nurtured by extended family, friends, peers, and community (Airhihenbuwa & Webster, 2004). Using constructs of the cultural identity domain, nurturers also characterized the role of the extended family and neighborhood in parent-teen sex conversations, typically emphasized in studies using the PEN-3 model (Iwelunmor, et al., 2014). Results suggested that the extended family and community members often reinforced the messages shared by parents to teens, provided tangible support for parents, or served as sexual health resources for adolescents. Results reinforced the importance of family and community members in the sexual learning of youth and proved particularly important for Haitian and Jamaican teens (Carver et al., 2014; DiClemente et al., 2001)

Strengths and Limitations

The study is the first to use a cultural framework to understand and explain the perceptions, enablers, and nurturers of sex conversations between Haitian and Jamaican mothers and their teens. Findings showed that both mothers and teens believed sex conversations were useful in helping teens' make responsible sexual decisions. Study findings provide evidence to support the value of the extended family and the local community for sharing sexual messages with teens and encouraging parent-teen sexual discussions. Despite these supportive findings there are some limitations to be discussed. These included the cross-sectional study methodology and small sample size that limit

generalizability to other Haitian and Jamaican families. The study also only included English speaking participants and may not be generalizable to all Haitians living in Miami-Dade County or other areas of the U.S. Finally, fathers were not willing to be interviewed, limiting study findings to the experiences of mothers and their teens. Additionally, most mothers in the study were college educated and may not be representative of Haitian and Jamaican mothers living in Miami-Dade County.

Conclusion

The purpose of the study was to characterize the perceptions, enablers, and nurturers of parent-teen sexuality conversations in Haitian and Jamaican families. Afro-Caribbean families expressed perceived importance of sex conversations and the value of the extended family and community for sharing sexual health messages with teens. However, parents and teens experienced several negative enablers that prohibited open and frequent sex conversations, some of which were linked to cultural views. To tackle these barriers within an Afro-Caribbean cultural context, sexual health promotion practitioners and interventionists should address the traditional Afro-Caribbean sexual expectations that may create difficulty discussing sex. Sexual health promotion professionals should assist parents in developing skills to reduce their discomfort and communication difficulties. Previous interventions targeting international communities have been successful in addressing cultural beliefs that hinder sex conversations and have improved parenting and communication skills (Baptiste et al., 2009; Bell et al., 2008). Therefore, U.S.-based programs focused on Black teens' sexual risk should apply culturally-sensitive, sexual health promotion programs to target underserved Black ethnic groups such as Afro-Caribbean immigrants.

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Table 5.1

Interview questions categorized by the domains of the PEN-3 model

Domains	Interview Questions
Cultural Empowerment	What makes sex and sexual health conversations important? What makes sex and sexual health conversations difficult? What makes sex and sexual health conversation less difficult? What would the Haitian/Jamaican culture consider appropriate adolescent behavior regarding sex?
Relationships and Expectations	What is your perception of sexuality? What is your perception of adolescent sexuality? What makes sex and sexual health conversations important? What makes sex and sexual health conversations difficult? What makes sex and sexual health conversation less difficult? What would the Haitian/Jamaican culture consider appropriate adolescent behavior regarding sex? Reflect on Haitian/Jamaican cultural beliefs about sex and sexual health and tell me how they affect your views on sex, sexual health and sex conversations between you and your teen/parent?
Cultural Identity	What role have other family members played in sex and sexual health conversations between you and your teen/parent? What role has others such as community leaders, religious leaders, teachers, or friends played with sex and sexual health conversations?

Table 5.2

Demographic profile of study participants

Variable	Response	N	Percentage
Mothers' mean age	41.85, *SD*=5.50	14	
Mothers' mean years in the U.S.	23.5, *SD*=9.87		
Number of children 18 or under living in the home	One	7	50
	Two	6	42.9
	Three	1	7.1
Mothers' Marital status			
	Married	7	50
	Single, never married	4	28.6
	Divorced	2	14
	Unmarried, living with romantic partner	1	7
Mothers' Education Level			
	Some College	9	64.3
	Bachelor Degree	3	21
	Vocational Training	1	7
	Advanced or Professional Degree	1	7
Employed			
	Yes	13	92.9
	No	1	7.1
Dyads' Ethnicity			
	Haitian	6	43
	Jamaican	8	57
Teens' Mean Age	16, *SD*=1.31	17	
Teens' Gender			
	Male	7	42
	Female	10	58
Teens born in the U.S.	Yes	14	82.4
	No	3	17.6

Table 5.3

Emerging themes and codes on importance of parent-teen sex conversations.

Themes	Codes	Supporting Quotes
Theme A: Preparing teens for future sexual encounters	A1: Potential Consequences/Risk	"There's the obvious teenage pregnancy, STDs, and things like that, but I feel more the psychological effect that having sex when you're not ready can have on you mentally"-Haitian mother
	A2: Educate (prepare/provide skills)	"[sex conversations] important cause it's mostly they teaching me how to get through life and all that" -Jamaican boy "It's important for families to have that conversation and obviously, that is going to influence how they feel about themselves how they treat other people and to be able to process information from other folks and make decisions" -Haitian mother
	A3: Healthy view of sex	"So, that kids, teens, and youth could have a healthy view of sexuality" -Haitian mother
	A4: Other teen sexual activity	"Because kids nowadays their pregnancy rates and sexually transmitted disease rate is going up" -Jamaican girl
Theme B: Provide guidance on appropriate sexual behaviors	B1: Limiting curiosity	"Not thinking too much and want to go experiment" -Jamaican mother
	B2: Context for sex	"Well to be honest there are many people that don't know responsibility and abstinence where there is a time where you shouldn't be rushing into [sex]"-Haitian girl
Theme C: Develop quality parent-teen communication and relationship	C1: Open/Honest Communication	"Just to be comfortable, no matter how disturbing or how inappropriate the question is"-Jamaican girl
	C2: Develop Close Relationship	"[sex conversations are] important because the more comfortable the child is, I mean the more they will open up"-Haitian mother
Theme D: Motivated to share knowledge and experience with teens to avoid risk behaviors	D1: First/Primary Source of Information	"I want to be the first one to bring this to their attention or make them aware"-Jamaican mother
	D2: Experience as a motivator	"When I was growing up, I never had that conversation with my parents, never. I didn't want my kids to be green-Jamaican mother

Table 5.4

Positive enablers of parent-teen sex conversations

Theme	Codes	Supporting Quotes
Theme A: Parent-specific factors affecting conversations	A1: Parent approach	"Just easing into it, not just going straight forward into the conversation. Talking to your child...normal, not being angry at them"-Haitian boy
	A2: Parents' knowledge and skill development	"Help parents, try to teach them how to actually bring [sex] out to their kids"-Jamaican mother
	A3: Mentorship	"I find therapy very easy, cause you have somebody else that's there that's knowledgeable, that can actually guide you when you don't have parents that did the same thing to you"-Haitian mother
	A4: Positive reaction	"That type of trust within your parent to know that my parent won't get mad if I just tell them the truth and just let them know what is happening then it would be easier"-Jamaican girl
	A5: Which parent talks	"Because [my mother's] a girl it's easier to talk to her"-Haitian girl
Theme B: Before sexual activity	B1: Early Conversations	"Start from they are young, don't just start in the middle of their teenager years"-Jamaican mother
	B2: Not having sex	"I feel like the only way it's easier to have that kind of conversation is if you're not having sex"-Jamaican girl
Theme C: Communication and Comfort	C1: Being open and honest	"Be straightforward because beating around the bush is gonna leave them with questions and that's where the problem would lie"-Jamaican mother
	C2: Comfort and Comfortable Atmosphere	"We should make a friendly atmosphere, like my kids know I'm strict but they can come talk to me, and I tell them that"-Haitian mother
	C3: Content relatable	"Find opportunities, because they're everywhere. Bring up real life scenarios and discuss and ask them how they feel about [sex]"-Haitian mother
Theme D: Direct Action	D: Action	"You just have to sit down and do [talk about sex]"-Jamaican mother
Theme E: Information Outside the Home	E: Talking to peer	"It might be easier on a one on one or maybe just easier with the sister or the brother"-Jamaican mother

Table 5.5

Perceptions, enablers, and nurturers of sex conversation categorized by the cultural empowerment and relationships and expectations domain

	Positive	Existential	Negative
Perceptions	Parent should prepare teens for future sexual encounters Parents should provide quality and appropriate communication Parents' should improve teens' comfort for sex-conversations Sex conversations provides guidance on appropriate sexual behaviors	Sexuality described as a healthy view of sex Traditionally conservative views of sex Sex is a sin	Sex conversations considered taboo
Enablers	Greater sexual health knowledge Mentorship for parents Greater family comfort discussing sexual topics	Expectation of abstinence until marriage, especially girls No homosexuality	Parents' lack of readiness and denial Family discomfort discussing sex Parents' limited childhood and teenage sexual communication experiences Teens' fear about parents' response to sex discussions
Nurturers	Extended family, community members encouraged families to have sex conversations Provided sexual health information to teens		Family may discourage discussions

CHAPTER VI

Ethnicity, parent-teen sex conversations, and teen sexual activity: Implications for health promotion

Kemesha S. Gabbidon

Abstract

Background: Sexuality studies have often overlooked ethnic and cultural differences affecting parent-teen sex conversations in Black families and the implications for teens' sexual activity.

Purpose: Examine the relationship between parent-teen sex conversations and teens' sexual activity among ethnically diverse Black adolescents.

Methods: Using convenience sampling, 157 Black (African American, Haitian, and Jamaican) adolescents (ages 14-18 years) were recruited through community serving organizations, churches, and schools in Miami-Dade County, FL to complete a 52-item questionnaire. Linear and logistic regression was used to determine the relationship between measures of parent-teen sex conversations and teens' sexual activity.

Result: Mean age of the sample was 16, (*SD*= 1.49) and 60% were female. African Americans reported more sexual activity while Jamaicans reported earlier sexual debut. Of the three groups, Haitians expressed less openness and importance for families' role in sexual learning. Although cultural differences may affect families' ability to have safe sex conversations, teens benefited from parents' messages on delaying sex and safe sex.

Conclusion: Findings support the necessity of early parent-teen sex conversations and an understanding that families' role in teens' sexual learning may be culture-bound. Public health interventionists should improve parents' comfort and skill-level for sex conversations particularly in communities where these conversations contradict cultural norms.

Introduction

An estimated 1.2 million people are currently living with human immunodeficiency virus (HIV) in the United States (U.S.) (CDC, 2014). In 2014, Florida ranked 1st in the nation for the number of newly diagnosed HIV cases (Florida Department of Health, 2014). Seventeen percent of all new HIV cases in the state occurred among those under age 25 years, and 68% were categorized as Black (Florida Department of Health, 2012). Currently, Black residents account for 42% of all people living with HIV in Miami-Dade County (Florida Department of Health, 2015). African Americans, Haitians, and Jamaicans make up the largest number of non-Hispanic Blacks living with HIV in Miami-Dade County (Florida Department of Health, 2014).

Nationally, HIV and sexually transmitted infections (STIs) continue to disproportionately affect Black youth. As of 2011, youth between ages 15 and 25 years accounted for half of the estimated 20 million new STIs occurring annually in the U.S. (CDC, 2013a). Black teens' [ages 15-19 years] rate of HIV diagnosis in 2014 was 38.2 per 100,000 compared to 1.9 per 100,000 for White teens (CDC, 2015). In 2015, the Youth Risk Behavior Survey (YRBS) results showed that 41% of adolescents were sexually active (CDC, 2016). In Miami-Dade County, 34% of teens did not use a condom in their last sexual encounter and 21% were not taught about STIs and HIV in school (CDC, 2013a).

Among sexual health programs in Miami-Dade County schools, only 38% incorporated information to help parents promote safe sex to their adolescents (CDC, 2013b). However, there is strong evidence supporting positive parental influence on teens' sexual beliefs and practices. Open, frequent, and positive parent-teen sex

conversations have been associated with teens' increased condom use, later age of sexual debut, and fewer sexual partners (Dinaj-Koci et al., 2015; Rogers, 2015; Sales et al., 2012; Sneed et al., 2013; Wang et al., 2013). Studies have shown that Black teens also benefit from parent-teen sexuality conversations in the same way (DiClemente et al., 2001; Wang et al., 2013). However, despite the growing number of foreign born Blacks in the U.S., many sexuality research studies do not consider potential cultural differences between Black ethnic groups that may affect how public health interventionists make sense of and explain sexual health behaviors. South Florida is one of the largest regions for Caribbean born blacks in the U.S. therefore it has become increasingly important for public health promotion professionals in the state to evaluate cultural influence on teens' sexual activity among the largely underserved Black immigrant populations (Anderson, 2015). Furthermore, very few studies have validated the relationship between sexuality conversations and sexual behaviors in Afro-Caribbean populations (Bombereau & Allen, 2008; Waldron et al., 2012).

The purpose of this study was to examine the relationship between parent-teen sexuality conversations and sexual activity among ethnically diverse Black adolescents. Researchers hypothesized that (a) adolescents who score higher on the Family Sex Communication Quotient (FSCQ) *would* have lower scores on the Adolescent Sexual Activity Index (ASAI)*;* (b) adolescents who report higher scores on the FSCQ w*ould* report later ages of penile-vaginal/anal sexual debut***;*** (c) parent-teen conversations about condoms and protection w*ould* predict teens' condom use***;*** and (d) teens with higher FSCQ scores *would* be more likely to report virginity.

Methods

The Florida International University's Institutional Review Board and the Miami-Dade County School Board's Research Review Committee approved the study protocol. This study is a part of a larger mixed methods study guided by the PEN-3 model to explore the nature, perceptions, enablers, and nurturers of parent-teen sex conversations and its relationship with sexual activity among African American, Haitian, and Jamaican adolescents.

Sample and Procedures

A convenience sample of 157 Black adolescents (ages 14-18 years) completed the 52-item questionnaire. Teens were recruited from schools, churches, and youth-serving organizations. Eligible participants included first and second generation Haitian and Jamaican teens and self-described Black/African American teens who along with their parents were born in the U.S.

Instrumentation and measures

The survey consisted of three scales: the ASAI, the FSCQ, and the Parent-teen Sexual Risk Communication Scale (PTSRC-III). The survey included a researcher developed questionnaire measuring condom use, age of sexual debut, and ever having sex. A demographic questionnaire captured sample characteristics: nativity, ethnicity, years lived in the U.S., age, gender, living in a two-parent household, and parent's education level. ASAI is a 13-item instrument using categorical response choices to measure pre-coital and coital activities within the last 30 days (Hansen et al., 1999). Scores range from 0-10, a score of 6 indicates being at risk for sexual activity and a score of 8 indicates being sexually active. FSCQ is an 18-item quotient using a 5-point Likert

scale for each item and an overall score. Scores can range from 18-90; a score of 18-39 is low, 40-69 moderate, and a score of 70-90 is considered high family orientation towards sexual discussions. The quotient provides sub-scores for comfort, information, and value for family-sex conversations (Warren, 2011). PTSRC-III is an eight-item scale measuring frequent sexual topics such as pregnancy, STI/HIV, condoms, and sexual pressure discussed between each parent and their teen, scores range from 8-40 and responses use a 5 point-Likert scale, (*1=never* to *5=extensively)* (Hutchinson, 2007). All scales have high internal validity and reliability. Cronbach alpha for all researcher developed measures were at least (α =.77) suggesting good internal consistency.

Data Analysis

Data was analyzed using SPSS Version 21 (IBM Corp., 2013). Agree/strongly agree Likert responses were condensed to agree, similarly disagree/strongly disagree Likert responses were collapsed because they provide near equal meaning. Linear regression determined predictors of recent sexual activities and age of sexual debut. Logistic regression determined predictors of virginity and condom use. Stepwise linear modeling was used to determine which predictors had the greatest influence on R^2 values. If a collinear predictor was detected, the variables with the least impact on the R^2 value were removed. All remaining predictors were independent.

Results

The sample included (N = 157) Black teens, 41% African American, 30% Haitian, and 29% Jamaican. The mean age of the sample was 16, (*SD*= 1.49) and most participants (60%) were female. [Insert Table 6.1]

Characterizing Parent-teen Sex Conversation

The mean age of first parent-teen sex conversation was 12.98 years, (*SD*= 2.21). Twenty percent of teens including 26% of Haitians, 22% of Jamaicans, and 13% of African Americans reported never having parent-teen sex conversations. African Americans' mean mother-teen PTSRC-III score was 28.04, (*SD*= 9.29), Haitians 21.4, (*SD*= 8.09) and Jamaicans 26.34, (*SD*= 9.07), Haitians reported significantly lower breadth of mother-teen sex conversations compared to African Americans, $p= .001$ and Jamaicans, $p=.03$. This score represents the frequency of common sexual topics discussed between teens and their mothers, higher scores indicate more frequent discussions. Teens reported lower father-teen PTSRC-III scores, Haitians 17.4, (*SD*= 9.70), Jamaicans 20.14, (*SD*=10.89) and African Americans 18.88, (*SD*= 10.69), no significant differences across ethnicities. This score represents the frequency of common sexual topics discussed between teens and their fathers.

Additionally, mean FSCQ score for Jamaicans was 63.80, (*SD*= 15.02), African Americans 61.49, (*SD*= 14.33), and Haitians, 54.93, (*SD*= 12.56), $p=.01$. All ethnic groups reported a moderate orientation towards family-sex conversations, however Haitians reported a lower orientation than the other two ethnic groups. FSCQ value, comfort, and information scores can range from 8-30, Jamaicans' mean comfort scores was 21.17, (*SD*= 6.26), African Americans 20.04, (*SD*= 6.44), and Haitians 16.85, (*SD*= 5.71). Haitians showed the greatest differences compared to African Americans, $p= .03$ and Jamaicans, $p= .004$. Haitians reported a lower openness towards family-sex conversations compared to Jamaicans and African-American teens. Similarly, Jamaicans' mean value score was 20.26, (*SD*= 5.49), African Americans 20.18, (*SD*= 5.46), and

Haitians 17.57, (*SD*= 4.65). Haitians had significantly lower scores than African Americans, *p*= .03 and Jamaicans, *p*= .03. Haitians reported a lower importance of their families' role in their sexual learning and development. Mean information score was 21.35 (*SD*= 4.69*)* with no significant differences across ethnicities.

Recent Sexual Activity

Hypothesis 1*:* Adolescents who score higher on the FSCQ would report lower scores on the ASAI. Linear regression showed that FSCQ scores were not predictive of ASAI scores, β = -.019 t (157) = -.231, *p*= .82. African Americans reported a mean ASAI score of 4.77, (*SD*= 3.01), Haitians 3.53, (*SD*= 2.6), and Jamaicans, 3.08, (*SD*= 2.6). African Americans reported higher scores compared to Haitians, *p*= .03 and Jamaicans, *p*= .004. All ethnic groups reported relatively low levels of sexual activity as a score of 8 indicates sexual activity and a score of 6 indicates being at risk for sexual activity.

Predictors of recent sex. Controlling for ethnicity, age, and gender, significant predictors of ASAI scores were age, discussions with mother, parent-teen sex conversations in the last year, and living in a two-parent household. [Insert Table 6.2]

For African Americans, regression results showed that three predictors accounted for 54% of the variance in ASAI scores, adjusted R^2 = .54, F (3, 38) = 17.24, *p*<.0001. Age, β = .53, *p*<0.0001 and *extensive* talks with mother about STIs, β = .492, p<.0001 were predictive of higher ASAI scores, while *no* discussions with father about ways to protect yourself from HIV/STIs, β = -.26, *p*= .02 were predictive of lower ASAI scores.

For Haitians, regression results showed that five predictors accounted for 70% of the variance in ASAI scores, adjusted R^2 = .70, F (5, 20) = 13.11, *p* <.0001. *Extensive* talks with fathers about condoms, β = .50, *p*<.0001, *some* talks with father about

protecting yourself from HIV/STIs, β= .43, *p*<.001 and teens feeling uncertain about being able to speak to parents freely about sex, β = .25*, p*= .04 were predictive of higher ASAI scores, while mothers having some college//vocational training, β = -.45, *p*= .001 and teens agreeing that sex was an important topic for parents and teen to discuss, β = -.46, *p*= .001, were predictive of lower ASAI scores.

For Jamaicans, regression results showed that four predictors accounted for 38% of the variance of ASAI scores, adjusted R^2 = .38, F (4, 73) = 13.20, *p*<.0001. Age, β = .51, *p*<.0001 and *extensive* talks with mother about STIs, β= .29, *p*= .002 were predictive of higher ASAI scores. Meanwhile, never having parent-teen sex conversations, β= -.26, *p*= .007, and living with father, β= -.21, *p*= .03 were predictive of lower ASAI scores.

Age of sexual debut

The mean age of penile-oral/vaginal-oral sexual debut was 15.23 years, (*SD*= 1.97), 36% of teens reported ever having penile-oral/vaginal-oral sex. Mean age of penile-oral/vaginal-oral sex debut for Jamaicans was 14.44 years, (*SD*= 1.51), African Americans 15.23 years, (*SD*= 2.44) and Haitians 15.81 years, (*SD*= 1.13). The mean age of penile-vaginal/anal sex debut was 14.95 years, (*SD*= 1.71), with 45% of teens reporting sexual intercourse. Jamaicans' mean age of penile-vaginal/anal sexual debut was 14.15 years, (*SD*= 1.51), African Americans 15.09 years, *(SD*= 1.94*)*, and Haitians 15.38 years, (*SD*= 1.46). Results were not statistically different across ethnicities.

Hypothesis 2: Adolescents who report higher FSCQ scores would report a later age of penile-vaginal/anal sexual debut. FSCQ scores were not predictive of a later age of penile-vaginal/anal sexual debut, β= -.15 t (157) = -1.206, *p*= .23.

Predictors of age of penile-vaginal/anal sexual debut. Predictors of age of penile-vaginal/anal sexual debut included age, gender, first parent-teen sex conversations, and parent's discomfort discussing sex. For African Americans, regression results showed that three predictors accounted for 40% of the variance in age of penile-vaginal/anal sexual debut, adjusted R^2 = .40 (3, 25) = 7.349, *p*=.001. *Little* talks with father about resisting sexual pressure, β = -.493*, p*= .002, believing sex was the least important topic to discuss with parents, β = -.569, p= .002, and being male, β = -.352, *p*=.04 were predictive of younger ages of penile-vaginal/anal sexual debut. For Haitians, three predictors accounted for 73% of the variance in age of penile-vaginal/anal sexual debut, adjusted R^2 = .73 (3,14), *p*< .0001. Living with mother alone, β= -.530, *p*=.001 and believing that sex was not too personal to discuss with parents, β =-.369, *p= .011* were predictors of younger ages of penile-vaginal/anal sexual debut, while age, β = .531, *p*=.001 was predictive of delayed sexual debut. For Jamaican, one variable accounted for 50% of the variance in age of penile-vaginal/anal sexual debut, adjusted R^2 = .50 (1, 11) = 13.183, *p*= .004. Teens' FSCQ comfort scores, β= -.738, *p*= .004 were predictive of younger ages of penile-vaginal/anal sexual debut. [Insert Table 6.3]

Condom use

Most sexually active teens reported using a condom during their first (68.4%) and last (66.7%) sexual encounter, no significant ethnic differences. Results indicated that conversations with parents about condoms and ways to protect themselves against HIV/STIs were associated with condom use.

Hypothesis 3: Parent-teen conversations about condoms and protection would predict teens' condom use. Results suggest that conversations about condoms did predict condom use.

Predictors of condom use. Logistic regression results suggested that teens who spoke to their mother *a lot* about protecting themselves from HIV/STIs were 79% less likely OR= .21, 95% CI [.05, .873] to report not using condoms and teens who reported *no* discussion with fathers about ways to protect themselves from HIV/STIs were four times more likely OR= 4.41, 95% CI [1.466, 13.30] to report *no* condom use during their last sexual encounter. Additionally, teens who reported *no* talks with fathers about ways to protect themselves from HIV/STIs were six times more likely, OR= 6.67, 95% CI [2.190, 20.295] to report *no* condom use at first sexual encounter. Similarly, teens who reported *a lot* of conversations with their mothers about protecting themselves from HIV/STIs were 86% less likely to report *no* condom use, OR= .14, 95% CI [.032, .649], teens who disagreed that sex was an important topic to discuss were almost five times more likely to report *no* condom use during their last sexual encounter, OR= 4.97, 95% CI: [.832, 29.309], and teens being uncertain about speaking to parents when needing sex-related information were four times more likely to report *no* condom use in their last sex encounter, OR= 4.413, 95% CI [1.152, 16.903].

Ever having sex

Fifty-six percent of African Americans, 39% of Haitians, and 34% of Jamaicans were sexually active, differences were not statistically significant, $p = .057$. However, there were significant differences in oral sex with 47% of African Americans, 30% of Haitians, and 24% of Jamaicans reporting ever having penile-oral/vaginal-oral sex, *p*=

.04. Twenty percent of sexually active teens reported having their first parent-teen sex conversation after penile-vaginal/anal sexual debut, X^2 (2, 99) = 9.09, *p*= .01, while 27% of teens report first parent-teen sex conversation after penile-oral or vaginal-oral sexual debut, X^2 (3, 147) = 15.84, *p*= 0.001.

Hypothesis 4*:* Teens with higher FSCQ scores will be more likely to report virginity. Controlling for ethnicity, gender, and age, predictors of ever having sex included age, importance of family-sex conversations, and discussing STIs with mother [Insert Table 6.4].

Predictors of ever having sex. For African Americans, predictors of virginity included FSCQ comfort scores, OR= 1.5, 95% CI [1.154, 1.866], and age, OR= .599 95% CI [.348, .897]. For Haitians, predictors included age, OR= 0.093, 95% CI [0.022, .395], and agreeing that sex was too hard to discuss with parents, OR= 0.047, 95% CI [0.002, .326]. For Jamaicans, teens living with a father/father figure were eight times more likely to report virginity, OR= 8.250, 95% CI [1.498, 45.429].

Discussion

Characterizing sex conversations

Study findings suggest that some teens engaged in sexual intercourse before having their first parent-teen sex conversation supporting the need for early parent-teen sexuality discussions. While most teens reported some parent-teen sex conversations, Afro-Caribbean teens were more likely to report *no* discussions compared to African Americans. Afro-Caribbean groups may consider family-sex conversations culturally inappropriate or face more barriers compared to African Americans. Of the two Afro-Caribbean groups, Haitians reported lower breadth, value, and comfort for family-sex

conversations. Haitian responses may reflect perceived inappropriateness or discomfort of families for engaging in sex conversations. Previously, Haitian parents expressed difficulty engaging in sexual health conversations compared to African Americans (Joseph et al., 2012). Within the Haitian household, other influences like religious beliefs may be deemed more important in developing teens' sexual beliefs. In contrast, Jamaican and African-American teens reported higher levels of perceived importance of their family's role in their sexual learning and a higher perceived openness with which sex was discussed in their families. These findings challenge the assumption that members of the Black race are homogenous and encourages an understanding of how ethnic and cultural variation may shape sexual attitudes and behaviors.

Condom use

Teens reported 17% higher levels of condom use compared to the 2015 YRBS results (54%) (CDC, 2016). This corroborates findings that African Americans reported favorable views of condoms and this may extend to other Black ethnic groups (Saint-Jean et al., 2011). Meanwhile, *extensive* discussions about condoms and HIV/STIs were associated with more condom use and more recent sex. To encourage safer sexual practices, parents should specifically discuss condoms and protection from HIV and STIs. Research suggests that parents may begin in-depth conversations about HIV/STIs and condoms if they perceive their teens to be romantically linked or sexually active (Beckett et al., 2010). To avoid relying on parents' perception of their teens level of sexual activity, parents should be encouraged and prepared to engage in sexuality conversations in their child's preadolescent and early adolescent years (ages 9-13 years) and continue throughout later years to reinforce messages of safe sex.

Sexual debut, ASAI, and sexual activity

Number of sexually active teens (45%) was comparable to recent findings showing 41% of U.S. teens being sexually active (CDC, 2016). Findings corroborate reports that African-American males reported younger ages of penile-vaginal/anal sexual debut compared to males of other racial/ethnic groups (CDC, 2016). As expected being female was predictive of later penile-vaginal/anal sexual debut, this was protective for the overall sample. Additionally, for all teens, perceiving parents as uncomfortable with sexual discussions was predictive of earlier penile-vaginal/anal sexual debut. African-American teens who reported more comfort talking to parents about sex were more likely to report virginity. For Afro-Caribbean teens, more comfort was associated with younger ages of penile-vaginal/anal sexual debut. African American cultures may inherently express more openness with sexual conversations than Afro-Caribbean groups. African-American teens may also be more comfortable discussing sex when they are not sexually active. Additionally, Afro-Caribbean cultural views of sex may create discomfort with sex conversations. However, Afro-Caribbean teens may only become comfortable discussing sex after having earlier sexual experiences. The goal of sexual health professionals is to encourage early engagement in these discussions to provide Afro-Caribbean teens the sexual refusal and condom self-efficacy skills they will need to delay sexual debut. Among African Americans, *little* discussions with fathers about resisting sexual pressure was predictive of earlier penile-vaginal/anal sexual debut. This finding supports the importance of strategic sexual messages from parents that will likely improve African-American teens' sexual refusal self-efficacy. Across the three ethnic groups, extensive talks about postponing sex was predictive of virginity. This finding

supports the need for targeted messages by parents that will encourage later sexual debut. African Americans not valuing sex conversations was also predictive of younger penile-vaginal/anal sexual debut. Teens who engaged in sex at early ages may no longer value sex conversations or a lower value for conversations may lead to earlier ages of debut. The cross-sectional nature of the study makes it unclear the directionality of this finding. This was quite similar to findings presented for Haitian teens as those who found the conversations important were more likely to report less recent sexual activity.

Differences in ASAI scores indicated that Afro-Caribbean teens reported less sexual activity in the 30 days prior to completing the survey compared to African Americans. Family orientation towards sex conversations was not predictive of recent sexual activity or age of sexual debut. However, age was a consistent predictor of sexual activity. For each year increase in an African-American teens' age, there was a 41% decrease in reporting virginity. Among Haitians, every unit increase in age resulted in a 91% reduction in reporting virginity. Haitians who also reported difficulty discussing sex with their parents were 95% less likely to report virginity. This is a logic finding, as adolescents age they are more likely to engage in sexual activity. However, aging shows a more pronounced effect on African-American teens' sexual activity than Haitian teens. This may be a result of the Haitian cultural view that appropriate sexual behavior is abstinence until marriage therefore, age may have a less significant impact on Haitian teens' sexual activity.

Across all three ethnic groups, extensive discussions about STIs were predictive of more recent sexual activity and not having those discussions was predictive of lower ASAI scores for African Americans and Jamaicans. This finding again supports previous

reports that parents increased conversations about STIs when they perceive their teens to be romantically linked or sexually active (Beckett et al., 2010). Haitians were the only group to report that specific family-sex conversation orientation measures predicted recent sexual activity. Haitian teens who did not feel they could openly speak with parents about sex reported more recent sexual activity. For Haitian teens, this may indicate that they seek sexual health information elsewhere or not at all and that puts them at risk for misinformation or risky sexual activity. Contrastingly, teens who felt sex conversations were important reported lower levels of sexual activity. Findings, also supported that value placed on these conversations were protective for Haitian youth.

Although each group reported varying risk and protective factors, results suggests that *no* discussions about resisting sex or postponing sex were associated with earlier sexual debut or being sexually active. To encourage delayed sex, parents should discuss postponing sex and resisting sexual pressure. For Jamaicans, living with both parents was predictive of virginity. Two-parent households increase parents' ability to monitor teens which limits teens' opportunities for sex (Boislard & Poulin, 2011). Carver et al 2014 results suggested that for Haitians residing in Haiti, living with a mother figure alone was protective for teens. However, this study suggests that living with a mother figure alone was not protective for Haitians living in the U.S. This study however supports other research findings emphasizing the benefit of two-parent homes, particularly a father figure (Cohen et al., 2002; Devieux et al., 2016; Kirby & Lepore, 2007).

Strengths and Limitations

The research is innovative because it is the first to investigate ethnic differences in family orientation towards sex conversations and the implications for Black teens'

sexual activity. The findings emphasize the importance of understanding ethnic differences within historically underserved Black communities and how both ethnic and cultural factors shape behaviors. Findings have both practice and policy implications including incorporating the parent-teen dyad as a plausible HIV/STI prevention intervention entry point for evidence-based approaches. More importantly, the study provides evidence for the benefits of strategic sexual health messaging from parents as they delayed teens' sexual debut and increased their condom use.

Despite the generally supportive findings related to parent-teen sex conversations and their relationship to sexual activity, the study has some limitations. First, cross-sectional studies cannot infer causality and therefore results do not assert that sex conversations directly lead to sexual behaviors. Second, the study does not investigate parental monitoring and religiosity which are known predictors of teens' sexual activity (Agha et al., 2006; Borawski et al., 2003). Third, future studies may benefit from using sampling strategies that allow for a more representative sample of Afro-Caribbean youth living in south Florida. Finally, a larger sample size may better detect small yet significant findings. Despite these limitations, the exploratory study advances the essential knowledge base for health promotion practitioners and researchers to refocus adolescent prevention efforts on the parent-teen dyad in family settings where children and teen learn initial values and health promoting behaviors.

Implications for Practice

Caribbean-born Blacks make up a significant portion of Blacks in the U.S. and are concentrated in the Northeast and Southern regions of the nation. The largest populations are centralized in the New York-Newark-New Jersey metropolitan area, Miami-Ft.

Lauderdale-West Palm Beach metropolitan area, Maryland, Massachusetts, Washington, D.C., and other localities (Anderson, 2015). Therefore, public health professionals should begin to address the needs of this growing and largely underserved population. Health promotion professionals must first consider cultural perceptions ethnically diverse Black families have about sex, sex conversations, and how these cultural nuances may affect families' ability to discuss sexual topics. Results from Gabbidon & Shaw-Ridley, (2017) suggests that Afro-Caribbean families may experience cultural taboos related to parent-teen sex conversations and may have even greater difficulty discussing sex than their African-American counterparts. Secondly, while there is much evidence to support the positive influence parent-teen sex conversations can have on teen sexual activity, few HIV/STI and teen pregnancy prevention programs have included parents as an integral part of their prevention efforts (Davis, Evans, & Kamyab, 2013). However, parent-teen sex conversations within the context of healthy parent-teen relationships have the potential to enhance pregnancy and HIV/STI prevention efforts. Perhaps health promotion professionals have missed opportunities to develop parents for engaging in those important conversations. Therefore, families need culturally-sensitive, parent-oriented, evidence-based approaches for improving Black parents' sexual health knowledge and communication skills to communicate responsible sexual messages to their teens more effectively.

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Table 6.1

Demographics of teen survey participants

Characteristics	N	Percentage
Mean age in years 16 (*SD*= 1.49)		
Ethnicity		
African American	64	41.0
Haitian	47	30.0
Jamaican	46	29.0
Gender		
Female	93	59.2
Male	63	40.1
Were you born in the US?		
Yes	116	73.9
No	29	18.5
Mean years foreign born teens lived in the US 10.32, (*SD*= 6.14)		
With which parent, do you live?		
Father only	11	7.0
Mother only	77	49.0
Both parents	62	39.5
Mothers' Education Level		
Less than high school	11	7.0
High School	62	39.5
Some College/Vocational	37	23.6
Bachelors' Degree	19	12.1
Graduate/Professional	11	7.0
Don't Know	13	8.3
Fathers' Education Level		
Less than high school	6	3.8
High school	64	40.8
Some College/Vocational	34	21.7
Bachelors' Degree	11	7.0
Graduate/Professional	6	3.8
Don't Know	20	12.7

Table 6.2

Predictors of recent pre-coital and coital activity using linear regression for all ethnicities

Variable	B	Std. Error	B	*t*
Constant	-8.479	2.717		-3.120
Age	.911	.163	.465	5.586****
Extensive talks with mother about STIs and AIDS	2.234	.665	.289	3.411***
No talks with parents about sex in last 12 months	-.818	.391	-.181	-2.096*
Living in a two-parent home	-1.123	.478	-.191	-2.350*

$R^2 = .34$, $p<0.0001$

*p<0.05, **p<0.01, ***p<0.001, ****p<0.0001

outcome measure is ASAI score

Table 6.3

Predictors of age of penile-vaginal/anal sexual debut for all ethnicities using linear regression

Variable	B	Std Error	B	*t*
Constant	6.283	2.743		2.290
Female	1.350	.407	.383	3.315*
My parents do not feel comfortable discussing sex with me	-1.268	.415	-.352	-3.058*
Age of first parent teen sex conversations	.282	.094	.352	3.014*
Age	.510	.157	.377	3.259*

$R^2 = .44$, $p < 0.0001$.
*$p<0.01$

Table 6.4

Predictors of virginity for all ethnicities using logistic regression

Variable	B	SE	df	Exp (B)	95% CI of Exp (B)
Constant	9.119	2.616	1	9124.430	
Extensive talks with mother about postponing sex	1.142	.530	1	3.133*	1.108, 8.862
Sex should be discussed with the family even if there is not a problem	1.654	.662	1	4.846*	1.429, 19.134
Age	-3.196	1.519	1	.492**	.329, .665

*p<0.05, **p<0.001

Chapter VII

Discussion, Conclusions, and Recommendations

This chapter presents the primary research findings and their implications. The chapter is presented in three sections (a) summary of the study, (b) discussion of study findings, and (c) conclusions and recommendations for the field of health promotion.

Summary of the Study

The two-fold purpose of this exploratory, cross-sectional, mixed methods study was to characterize the nature, perceptions, enablers, and nurturers of parent-teen sex conversations among Haitian and Jamaican families and examine the relationship between parent-teen sex conversations and Black teens' sexual activity. The PEN-3 model was used to guide the study design, data analysis, and interpretation of the data. A narrative inquiry approach was used to gather information from 14 Haitian and Jamaican mother-teen dyads (N=31) living in Miami-Dade County, FL to explore the nature, perceptions, enablers, and nurturers of parent-teen sex conversations. To determine the relationship between parent-teen sex conversations and teens' sexual activity, a diverse sample of Black (African American, Haitian, and Jamaican) adolescents (ages 14-18 years) were recruited to complete a brief 52-item questionnaire.

Discussion

Study results were presented in the form of three manuscripts in Chapters IV-VI. Chapter IV investigated what characterized the nature of parent-teen sex conversations. Forbidden, no experiences, and verbal warnings accompanied by physical discipline characterized the nature of mothers' childhood and teenage experiences discussing sex with their parents. Within the two Afro-Caribbean cultures investigated, parent-teen sex

conversations occurred infrequently in mother's childhood and were in some cases considered taboo. Findings supported previous research indicating that parents' limited childhood experiences affected their comfort, confidence, and ability to engage in sex conversations (Grossman et al., 2013). During current parent-teen sex communications, teens felt uncomfortable, weird, and awkward and characterized parents' messages as warnings, rules, and expectations about sex. Findings from this study also lent support to other reports showing that sex conversations were perceived to increase teens' sexual health knowledge and delay sexual debut (Akers et al., 2011; Aspy et al., 2007; DiClemente et al., 2001). Like previous studies, findings showed that problematic sex conversations were linked to poor parent-teen relationship quality adversely affecting the nature of sex conversations (Wang et al., 2013). Some teens also reported internalized feelings of fear stemming from fear-based messages their parents shared with them. Findings characterized the nature of parents' childhood and teenage sex conversations and current parent-teen sex conversations within Haitian and Jamaican families. Findings support the need to modify some Afro-Caribbean parent's approach and messaging to reduce negative or uncomfortable teen experiences.

Chapter V explored what characterized the perceptions, enablers, and nurturers of parent-teen sex conversations between Haitian and Jamaican parents and their teens. Families perceived parents as an integral part of teens' sexual development including: (a) actively educating and preparing teens for sexual encounters, (b) monitoring teens' whereabouts, (c) providing quality and appropriate sex and sexual health communication, and (d) improving teens' comfort with sexual discussions. Secondly, mothers and teens reported that parents' lack of readiness, discomfort, negative cultural attitudes and beliefs

about sexual discussions, and limited experiences from their childhood served as negative enablers of parent-teen sex conversations. Mothers and teens expressed that modifying parents' approach, improving parents' sexual health knowledge, providing mentorship for parents and enhancing parents' and teens' comfort would successfully enable more open and frequent parent-teen sex conversations. Finally, findings showed the importance of family and community members in reinforcing healthy sexual messages and serving as resources to help facilitate sexual conversations.

Chapter VI, aimed to explain the relationship between measures of parent-teen sex conversations and teens' sexual activity. Table 7.1 shows the outcomes in relation to the study hypotheses.

Table 7.1

Results of study hypotheses.

Hypothesis	Finding	Evidence
Hypothesis 1: Adolescents who score higher on the FSCQ would report lower scores on the ASAI. **H0**: FSCQ scores would not predict ASAI scores	Linear regression, $\beta = -.019$ $t\ (157) = -.231$, $p = .82$.	No evidence to support Hypothesis 1
Hypothesis 2: Adolescents who report higher FSCQ scores would report a later age of sexual debut. **H0**: FSCQ scores would not predict age of sexual debut	Linear Regression, $\beta = -.15$ $t\ (157) = -1.206$, $p = .23$.	No evidence to support Hypothesis 2
Hypothesis 3: Parent-teen conversations about condoms and protection would predict teens' condom use **H0**: Parent-teen conversations about condoms and protection would not predict condom use	Logistic Regression, Teens who spoke to their mother "a lot" about protecting themselves from HIV/STIs were 79% less likely OR=.21, 95% CI [.05, .873] to report not using condoms. Teens who reported "no" talks with fathers about ways to protect themselves from HIV/STIs were six times more likely, OR= 6.67, 95% CI	Evidence to support Hypothesis 3

	[2.190, 20.295] to report “no” condom use at first sexual encounter	
Hypothesis 4*:* Teens with higher FSCQ scores will be more likely to report virginity. **H0**: FSCQ scores would not predict virginity	Logistic regression, For African American teens, FSCQ comfort scores predicted higher odds of virginity, OR= 1.5, 95% CI [1.154, 1.866],	Evidence to support Hypothesis 4

Additional predictors were identified for teens’ in each ethnic group. For African Americans, being male β = .53, $p<0.0001$ was predictive of more recent sex and earlier penile-vaginal/anal sexual debut, β = -.352, p=.04 and supports 2015 YBRS results (CDC, 2016a). Little talks with father about resisting sexual pressure, β = -.493*, p*= .002, and believing sex was the least important topic to discuss with parents, β = -.569, p= .002, were predictive of younger ages of penile-vaginal/anal sexual debut. Results show the possible benefit of specific messages about resisting sexual pressure that may help teens develop sexual refusal self-efficacy.

For Haitians, mothers having some college education or vocational training, β = -.45, p= .001 were predictive of less recent sex and supports prior research showing mothers’ higher education level to be linked to lower teen sexual activity (Kirby & Lepore, 2007). Additionally, for Haitians, living with mother alone, β= -.530, p=.001 was predictive of a younger age penile-vaginal/anal sexual debut.

For Jamaicans, living with a father figure, was predictive of lower levels of recent sex, β= -.21, p= .03 and being eight times more likely to report virginity, OR= 8.250, 95% CI [1.498, 45.429]. As with the Haitian teens, results support the benefit of two-parent home in reducing teens’ sexual risk (Kirby & Lepore, 2007).

Conclusion and Recommendations

The study findings report the limited sexual health knowledge and communication skills many Afro-Caribbean parents face with sex conversations stemming in part from their cultural beliefs and childhood experiences. Specifically, Haitian and Jamaican mothers faced limitations in their abilities to discuss sex with their children potentially affecting teens' sexual learning and decision making. These findings support the need to (a) develop culturally-responsive, parent-oriented, teen sexual health programs and (b) address traditional Afro-Caribbean sexual values and attitudes that may restrict the openness of parent-teen sex conversations. Public health agencies and professionals serving Black parents and teens should design culturally-sensitive health programs that account for ethnic diversity and the differing levels of life-experiences that parents may possess. Study findings justify the need for more attention to the cultural diversity of the Black race and asserts that health promotion interventionists and practitioners should ensure that HIV/STI and pregnancy prevention programs are culturally-responsive to the needs of ethnic minorities. This allows practitioners and researchers to target underserved and at-risk groups more effectively, improve parents' involvement in adolescents' health, and decrease teens' sexual risk.

Strengths and Limitations. This study is the first to explore and characterize the nature, perceptions, enablers, and nurturers of parent-teen sex conversations within an Afro-Caribbean cultural context. The research is innovative because it is also the first to investigate ethnic differences in Black families' orientation towards sex conversations and the implications for Black teens' sexual activity. The findings emphasize the importance of understanding ethnic differences within historically underserved Black

communities and how both ethnic and cultural factors shape sexual attitudes and behaviors. Findings have both practice and policy implications including incorporating the parent-teen dyad as a HIV/STI prevention intervention entry point for evidence-based approaches. More importantly, the study provides evidence for the benefits of strategic sexual health messaging from parents to teens. Caribbean-born Blacks make up a significant portion of Blacks in the U.S. and are concentrated in the Northeast and Southern regions of the nation (Anderson, 2015). Therefore, public health professionals should begin to address the needs of this growing and largely underserved population. Health promotion professionals must first consider cultural perceptions ethnically diverse Black families have about sex and sex conversations, and how these cultural beliefs may affect families' ability to discuss sexual topics.

Despite the generally supportive findings related to parent-teen sex conversations and their relationship to teens' sexual activity, the study has some limitations. First, causality cannot be inferred from cross-sectional studies, therefore results do not assert that sex conversations directly lead to sexual behaviors. Second, non-probability sampling limits generalizability to Haitian and Jamaican groups. Third, a larger sample size may better detect small yet significant findings. Finally, fathers were not willing to be interviewed which limited experiences shared in interviews to that of mothers and their teens. Despite these limitations, the exploratory study advances the essential knowledge base for health promotion practitioners and researchers to refocus adolescent prevention efforts on the parent-teen dyad in family settings where children and teen learn initial values and health promoting behaviors.

Recommendations and Future Direction. The exploratory study reported useful findings to inform adolescent sexual health promotion programs and interventions.

Recommendation 1. Provide tools for parents and teens to develop healthy relationships. Both mothers and teens reported that a poor relationship quality with their parents adversely affected their ability to discuss sensitive topics. Research also suggests that teens are more receptive to parents' messages if they feel connected to them (Kincaid et al., 2012). Thus, parent-teen sex conversations within the context of healthy parent-teen relationships have the potential to enhance pregnancy and HIV/STI prevention efforts across different racial and ethnic groups.

Recommendation 2: Improve Afro-Caribbean parents' ability to initiate and engage in sex and sexual health conversations with their teens. Strategic and informed parent-teen sex and sexual health conversations should be essential components of HIV/STI primary prevention programs and interventions. This study supports previous research on the protective influence of parent-teen sex conversation on teens' sexual activity within an underserved community (DiClemente et al., 2001; Wang et al., 2013). The study also presents information on the barriers Afro-Caribbean parents' face that inhibit sex conversations. Findings suggest that Afro-Caribbean parents require programs tailored to strengthen their communication self-efficacy. Therefore, public health agencies and health educators should promote positive, open dialogue between Afro-Caribbean parents and teens by providing tools that assist parents initiate and sustain sex conversations. Afro-Caribbean parents may benefit from evidence based programs that build on traditional cultural values while addressing negative enablers, and improving their sexual health knowledge and communication self-efficacy.

Recommendations 3: Actively involving the family unit in the sexual development and implementation of adolescent sexual health programs. Findings suggest that parents and extended family members served as positive nurturers of parent-teen sex conversations for Afro-Caribbean adolescents. Furthermore, the role of the extended family in teen sexual development has been previously established and should be encouraged where applicable (Grossman et al., 2015). Incorporating family members in the development and implementation of teen sexual health programs can help to reinforce healthy sexual messages shared with teens.

Recommendation 4: Provide effective, culturally-responsive, parent-oriented, sexual education programs. While there is much evidence to support the positive influence parent-teen sex conversations can have on teen sexual activity, few HIV/STI and teen pregnancy prevention programs have included parents as an integral part of their prevention efforts (Davis et al., 2013). Programs also fail to address cultural views on teen sexual health behaviors (Wyatt et al., 2012). Public health agencies and health educators targeting Black populations should utilize culturally-responsive, parent-oriented, sexual education programs to address the sex communication needs of Black families. These programs should be sensitive to parents' diverse cultural backgrounds and religious beliefs that may affect their comfort and ability to engage in sex conversations. Therefore, to address Afro-Caribbean teens' sexual risk, findings support culturally-responsive, family-oriented, teen sexual health programs that improve parents' sexual communication self-efficacy, families' comfort for discussing sensitive topics, and family connectedness.

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Appendices

Appendix A

Approvals for Instruments

Columbian College of Arts and Sciences
Department of Organizational Sciences and Communication

Permission Letter

2 April 2015

Kemesha Gabbidon
Robert Stempel College of Public Health & Social Work
Florida International University
11200 SW 8th St., AH 5, 505
Miami, FL 33199

Dear Kemesha:

You have requested permission to use my Family Sex Communication Quotient for your mixed methods doctoral dissertation exploring the dynamics of sexuality conversations between Haitian parents and their adolescents. I'm pleased to provide my consent, based on the following terms of agreement:

1. The FSCQ will be used as originally intended and will not be modified for use in your study.
2. The FSCQ will be used for your research study only and will not be sold or replicated for any other purposes.
3. If applicable, you are wiling to provide all publishable reports and articles that make use of the FSCQ.

Sincerely,

Clay Warren

Dr. Clay Warren
Chauncey M. Depew Professor of Communication
and Professor of Organizational Sciences
Chair, Organizational Sciences & Communication
Director, Communication Program
Director, LEAD/USNA Master's Program
The George Washington University
600 21st Street, NW (Room 204)
Washington, DC 20052
202/994-6354 (tel)
202/994-1881 (fax)
claywar@gwu.edu (e-mail)

Department of Biobehavioral Health
The Pennsylvania State University
219 Biobehavioral Health Building
University Park, PA 16802-6509

Phone: 814-863-7256
Fax: 814-863-7525

April 3, 2015

Kemesha Gabbidon
Robert Stempel College of Public Health
& Social Work
Florida International University
11200 SW 8th Street, AHC 5, 505
Miami, FL 33199

Dear Kemesha,

You have my permission to use the PEN-3 model in your research. You agree to the following:

1. The model will be used in the manner in which it was intended with no modifications.
2. The model will be used only for your research and will not be sold or replicated for any other purposes.
3. If requested, you are willing to share all publishable reports and articles using the model.

Good luck with your research and I look forward to learning about your results.

Sincerely Yours,

Collins O. Airhihenbuwa, Ph.D
Professor and Head of Department

College of Health and Human Development

An Equal Opportunity University

BOSTON COLLEGE

WILLIAM F. CONNELL SCHOOL OF NURSING

April 2, 2015

Dear Ms. Gabbidon,

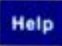
Thank you for your email. Yes you have permission to use the PTSRC-III scale. You also have permission to revise the scale for your own purposes.

I wish you the very best of luck with your study. Please let me know if I can be of any assistance going forward.

Very best,

M. Katherine Hutchinson, PhD, RN, FAAN
Professor and Associate Dean for Graduate Programs
Boston College William F. Connell School of Nursing
140 Commonwealth Ave.
202 Cushing Hall
Chestnut Hill, MA 02467
kathy.hutchinson@bc.edu
617-552-2613

CUSHING HALL, 140 COMMONWEALTH AVENUE, CHESTNUT HILL, MA 02467
TEL: 617-552-4250 WEB: WWW.BC.EDU/CSON



Title:	The Adolescent Sexual Activity Index (ASAI): a standardized strategy for measuring interpersonal heterosexual behaviors among youth:
Author:	William B. Hansen, Electra D. Paskett, Linda J. Carter
Publication:	Health Education Research
Publisher:	Oxford University Press
Date:	Aug 1, 1999

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Licensed content publication	Health Education Research
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Licensed content author	William B. Hansen, Electra D. Paskett, Linda J. Carter
Licensed content date	08/01/1999
Volume number	14
Issue number	4
Type of Use	Thesis/Dissertation
Requestor type	Academic/Educational institute
Format	Print
Portion	Text Extract
Number of pages requested	1
Will you be translating?	Yes
Number of languages	1
Languages	French-Creole
Author of this OUP article	No
Order reference number	None
Title of your thesis / dissertation	Exploring the dynamics of sexuality conversations between Haitian parents and their adolescents
Expected completion date	Apr 2016
Estimated size(pages)	75
Publisher VAT ID	GB 125 5067 30
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Appendix B

IRB Approval

Office of Research Integrity
Research Compliance, MARC 414

MEMORANDUM

To:	Dr. Mary Shaw
CC:	File
From:	Maria Melendez-Vargas, MIBA, IRB Coordinator
Date:	November 16, 2015
Protocol Title:	"Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents"

The Social and Behavioral Institutional Review Board of Florida International University has approved your study for the use of human subjects via the **Full Board Review** process. Your study was found to be in compliance with this institution's Federal Wide Assurance (00000060).

IRB Protocol Approval #:	IRB-15-0425	**IRB Approval Date:**	11/06/15
TOPAZ Reference #:	104125	**IRB Expiration Date:**	11/06/16

As a requirement of IRB Approval you are required to:

1) Submit an IRB Amendment Form for all proposed additions or changes in the procedures involving human subjects. All additions and changes must be reviewed and approved by the IRB prior to implementation.
2) Promptly submit an IRB Event Report Form for every serious or unusual or unanticipated adverse event, problems with the rights or welfare of the human subjects, and/or deviations from the approved protocol.
3) Utilize copies of the date stamped consent document(s) for obtaining consent from subjects (unless waived by the IRB). Signed consent documents must be retained for at least three years after the completion of the study.
4) **Receive annual review and re-approval of your study prior to your IRB expiration date**. Submit the IRB Renewal Form at least 30 days in advance of the study's expiration date.
5) Submit an IRB Project Completion Report Form when the study is finished or discontinued.

Special Conditions: Upon approval from Miami-Dade Public School System's Research Review Committee (M-DCPS RCC), a copy of the M-DCPS RCC approval letter must be submitted to the FIU IRB Office (Office of Integrity) to complete the process.

For further information, you may visit the IRB website at http://research.fiu.edu/irb.

Appendix C

Miami Dade County School Board Research Approval

Superintendent of Schools
Alberto M. Carvalho

Assessment, Research, and Data Analysis

Miami-Dade County School Board
Perla Tabares Hantman, Chair
Dr. Lawrence S. Feldman, Vice Chair
Dr. Dorothy Bendross-Mindingall
Susie V. Castillo
Dr. Wilbert "Tee" Holloway
Dr. Martin Karp
Dr. Marta Pérez
Raquel A. Regalado

March 8, 2016

Ms. Kemesha Gabbidon
11200 SW 8th Street
Miami, FL 33199

Dear Ms. Gabbidon:

I am pleased to inform you that the Research Review Committee (RRC) of the Miami-Dade County Public Schools (M-DCPS) has granted you approval for your request to conduct the "Exploring the Dynamics of Sexuality Conversations Between Haitian and Jamaican Parents and their Adolescent Children" in order to fulfill the requirement of your dissertation at Florida International University – College of Public Health and Social Work.

The approval is granted with the following conditions:

1. **Participation in this study is at the discretion of the principal of the targeted school.**
   Please note that even with the approval of the RRC, it is still the responsibility of the Principal as the gatekeeper of the school to decide whether to participate or not. As stated in the Board rule, ***"... the principal of the individual school has the privilege of deciding if RRC-approved research will be conducted within his/her school."***

   A copy of this approval letter must be presented/and or shared with the Principal of the targeted school.

2. Before conducting any research and/or collecting any data in any M-DCPS site, a researcher who does not have a valid Level 2 security clearance from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, must obtain a level 2 background security clearance from the M-DCPS Fingerprinting Office. The application for District security clearance can be found at:
   http://oer.dadeschools.net/ResearchReviewRequest/ResearchReviewRequest.asp

3. The participation of all subjects (such as students, faculty, or staff) is **voluntary**.

4. As specified in your application, **written** parent consent must be collected before any student can participate in the study.

5. Also, as specified in your application, student **written** assent must be collected before they can participate in the study.

6. This research project will be conducted outside M-DCPS. No data or any other type of information (interviews, surveys) will be collected on-site from students in M-DCPS schools. **Only advertisement materials** with information about the study will be shared at selected Senior High School with the **explicit approval** of the principal of targeted school – Miami Edison.

Assessment, Research, and Data Analysis • School Board Administration Building • 1450 N.E. 2nd Ave. • Suite 208 • Miami, FL 33132
305-995-7091 • 305-995-2691 (FAX) • www.dadeschools.net

Appendix D

Recruitment Flyer

Are you a Haitian or Jamaican parent of a teen interested in sharing your thoughts, views, and experiences with conversations about sex and sexual health between you and your teenager?

If so, you are invited to participate in a research study

Topic: Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and adolescents

Conducted by Kemesha Gabbidon, MPH
Through FIU

•If you agree to participate:

➢**Parents and Teens will each complete a brief interview**

•Who should participate?

➢ **Haitian and Jamaican teens (14-18) and parents who are interested in sharing their experiences discussing sex and sexual health**

➢Parental consent is **required** if teens are under 18.

•We will examine: the role of family, community, and culture in parents' and teens' experience with sexuality conversations.

Where will this take place?

Interviews will take place at your home or another private location.

Will I receive anything for my time?

➢**Parents will receive a $20 gift card for their time.**

➢ **Teens will receive a $15 gift card for their time.**

For more information about this study, please contact Ms. Kemesha Gabbidon at 954-303-9198. She can give you more information about the project and answer all questions that you may have.

Appendix E

Interview Screener/Eligibility Form

Hello and thank you for contacting me regarding the research study. There are few questions I will ask to see if you are good fit for this study.

☐ Are you a parent or an adolescent?	☐ Parent ☐ Adolescent
	If teen: Thank you for your interest, please have a parent or legal guardian contact us in order to move forward.
☐ Where were you born?	☐ Haiti ☐ Jamaica
☐ Are you the parent or legal guardian of a teen between the ages of 14 and 18?	☐ Yes ☐ No
☐ What is the age of the child that will be participating in the study?	
☐ Is the teen willing to participate in the study?	☐ Yes ☐ No
☐ Is the participating teen a parent or expecting a child of their own?	☐ Yes ☐ No
☐ How many of your children 18 and younger live in home with you?	
☐ Does the participating teen live with you half or most of the time?	☐ Yes ☐ No
☐ Does the teen speak English?	☐ Yes ☐ No
☐ Is the teen a boy or a girl?	☐ Boy ☐ Girl

If you agree to participate you and your teen will be asked to each complete a separate face to face interview about your experiences discussing sex and sexual health. You and your child will receive a gift card for your participation.

Are you still interested? _____ Yes _______No

Interviews will be conducted in private rooms either in your home or in a community location.

☐ 1st choice: ____
Home Address

☐ 2nd choice: __901 NW 183rd Street, Miami FL 33169

Interview Date: ____________ Time ________________ Other contact________________________

Appendix F

Interview guides

Parent interview guide

Script

Welcome and thank you for your participation today. My name is _____________ and I am a doctoral student at Florida International University conducting a dissertation study on parent and adolescent sexuality conversations between Haitian and Jamaican parents and their children. Thank you for agreeing to participate in this study, this interview will take about 45 to 60 minutes and will include questions regarding your experiences with sexuality conversations with your adolescent(s). I would like your permission to voice record this interview, so I may accurately document the information you convey. If at any time during the interview you wish to discontinue the use of the recorder or the interview itself, please feel free to let me know. All your responses will remain confidential and will be used to develop a better understanding of how you have experienced sexuality conversations with your adolescent(s). The purpose of this interview is to identify the perception, enablers, nurturers, and nature of sexuality conversations.

At this time, I would like to remind you of your written consent to participate in this study entitled: Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents. You and I have both signed and dated each copy, certifying that we agree to continue this interview. You will receive one copy and I will keep the other under lock and key, separate from your reported responses. Thank you.

Your participation in this interview is completely voluntary. If at any time, you need to stop, take a break please let me know. You may also withdraw your participation at any time without consequence. Do you have any questions or concerns before we begin? Then with your permission we will begin the interview. There are no wrong or right answers just your experience.

Demographic variables

Turn on audio recorder

A. Gender
    a. ☐ Male
    b. ☐ Female
B. Age: _______

C. How long have you lived in the US? __________

D. Is there another parent (mother/father) living in the home? _______

E. How many of your children 18 or under live in your home? _______

   a. How many boys ___ what are their ages? ________________________________

   b. How many girls ____ what are their ages? ______________________________

F. What was the highest level of education you completed?

   a. ☐ less than high school
   b. ☐ high school diploma/GED
   c. ☐ trade/ technical/vocational training
   d. ☐ some college
   e. ☐ 4-year college degree
   f. ☐ Master's Degree
   g. ☐ Doctoral or Professional degree (JD, MD, etc.)

Interview Questions

1. What comes to mind when you hear the word sexuality?

2. What does adolescent sexuality mean to you?

3. This study is about parents and teens discussing sexual topics, how would you describe your experience having sex and sexual health conversations with your adolescent(s)?

4. How often have you had these conversations?

If never ask questions 4a and 4b then skip to 7

   a. How do you convey to your adolescent your expectations for their sexual behaviors?

b. How do you feel if you are NOT able to engage in these conversations with your teen? (skip to 7)

5. How do you feel when you have these conversations with your child?

6. When you engaged in sex and sexual health conversations what topics have you discussed?

7. In your opinion, what do you think makes these conversations important?

8. What age or time did you begin having sex and sexual health conversations with your child?

9. When do you think is the best time for a parent to start having sex and sexual health conversations with their child?

10. What do you think is a parent's responsibility when it comes to their adolescent's sexual health?

11. What makes sex and sexual health conversations difficult?

12. What would or does makes them easy?

13. Think back to your childhood and describe your experience(s) having sex and sexual health conversations with your parent(s)?

14. Tell me how these conversations have influenced your ideas on sex, sexuality, and sexual behaviors?

15. What role have other family members played in sex and sexual health conversations between you and your teen?

16. What role has others such as community leaders, religious leaders, teachers, or friends played with sex and sexual health conversations?

17. Reflect on sex and sexual health conversations in your home, what are the differences between how you and how the other parent engages in these conversations? (**applicable if another parent lives in the home)**

18. Again, reflect on sex and sexual health conversations in your home, how does the gender of the child affect what you say? Is there a difference with what you or others say to girls and what you or others say to boys?

19. What would the Haitian/Jamaican culture consider appropriate adolescent behavior regarding sex?

20. What do you think the Haitian/Jamaican cultural views are on teens and parents having conversations about sex and sexual health?

21. Reflect on Haitian and Jamaican cultural beliefs about sex and sexual health and tell me how they affect your views on sex, sexual health, and sex conversations between you and your teen(s)?

22. What does community mean to you?

    a. What physical place(s) is a part of this community?

23. Where do you think sex and sexual health conversations should be happening in your community and who should be a part of it?

Is there anything else you would like to share on the subject or your experience with this interview?

Thank you for your time and agreeing to be a part of this study

Adolescent Interview Guide

Script

Welcome and thank you for your participation today. My name is ____________ and I am a doctoral student at Florida International University conducting a dissertation study on parent and adolescent sexuality conversations between Haitian and Jamaican parents and their children. Thank you for agreeing to participate in this study, this interview will take about 45 to 60 minutes and will include questions regarding your experiences with sexuality conversations with your parent(s). I would like your permission to voice record this interview, so I may accurately document the information you convey. If at any time during the interview you wish to discontinue the use of the recorder or the interview itself, please feel free to let me know. All your responses will remain confidential and will be used to develop a better understanding of how you have experienced sexuality conversations with your parent(s). The purpose of this interview is to identify the perception, enablers, nurturers, and nature of sexuality conversations.

At this time, I would like to remind you of your written consent to participate in this study entitled: Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents. You and I have both signed and dated each copy, certifying that we agree to continue this interview. You will receive one copy and I will keep the other under lock and key, separate from your reported responses. Thank you.

Your participation in this interview is completely voluntary. If at any time, you need to stop, take a break please let me know. You may also withdraw your participation at any time without consequence. There are no wrong or right answers. Do you have any questions or concerns before we begin? Then with your permission the interview will begin.

Demographic variables

Turn on tape recorder

G. Gender
   a. ☐ Male
   b. ☐ Female
   c. ☐ Transgender (male to female)
   d. ☐ Transgender (female to male)

H. Age: _______

I. Were you born in the US?
   a. ☐ Yes
   b. ☐ No
      i. How many years have you lived in the US? ______

J. Do you live with your?
   a. ☐ Mother/Mother figure
   b. ☐ Father/Father figure
   c. ☐ Both

K. How many siblings do you have? _______
   a. How many brothers? ____what are their ages? _______________
   b. How many sisters? _____what are their ages? ________________

L. With who are you most likely to have conversations about sex and sexual health?
   a. ☐ Mother
   b. ☐ Father
   c. ☐ Sibling
   d. ☐ Other family member ______________
   e. ☐ Friends/Peers
   f. ☐ Other ____

Interview Questions

1. What comes to mind when you hear the word sexuality?

2. What does adolescent sexuality mean to you?

3. This study is about parents and teens discussing sexual topics, how would you describe your experience having conversations with your parent(s) about sex and sexual health?

4. How often have you had sex and sexual health conversations with your parent(s)?

   If never, ask questions 4a and 4b then skip to 7

   a) How then do your parents convey their expectations for your sexual behaviors?
   b) How do you feel if you are NOT able to have these conversations? (skip to 7)

5. How does it make you feel when you have conversations about sex and sexual health with your parent(s)?

6. When you engaged in sex and sexual health conversations what topics have you discussed?

7. In your opinion, what makes sex and sexual health conversations important?

8. To the best of your memory, what age or time did you begin having sex and sexual health conversations with your parent (s)?

9. When do you think is the best time for a parent to start having conversations with their child about sex and sexual health?

10. What do you think is a parent's responsibility when it comes to their adolescent's sexual health?

11. What do you think makes conversations about sex and sexual health difficult?

12. What do you think makes the conversations about sex and sexual health easy?

13. Think back on these conversations with your parent(s) and tell me how it has influenced your ideas about sex, sexuality, and sexual behaviors?

14. What role has other family members played in sex and sexual health conversations between you and your parent(s)?

15. What role has others such as community leaders, religious leaders, teachers, or friends played with sex and sexual health conversations?

16. Reflect on sex and sexual health conversations in your home, what are the differences between how your mother and how your father engages in these conversations? (**applicable if another parent lives in the home**)

17. Again, reflect on sex and sexual health conversations in your home, how do you think your gender affects what your parents say to you? Is there a difference with what is said to boys compared to what is said to girls?

18. What would the Haitian/Jamaican culture consider appropriate adolescent behavior regarding sex?

19. What do you think the Haitian/Jamaican cultural views are on teens and parents having conversations about sex and sexual health?

20. Reflect on Haitian and Jamaican cultural beliefs about sex and sexual health and tell me how they affect your views on sex, sexual health, and sex conversations between you and your parent(s)?

21. What does community mean to you?

a) What physical place(s) is a part of this community?

22. Where do you think sex and sexual health conversations should be happening in your community and who should be a part of it?

Is there anything else you would like to share on the subject or your experience with this interview?

Thank you for your time and for being a part of this study.

Appendix G

Interview Guide Validation Rubric

Please list question numbers that do NOT meet expectations and need to be revised.

Please use the comments and suggestions section to elaborate on recommended revisions.

Criteria	Operational Definitions	Score **1=Unsatisfactory** (question requires major modifications) **2=Below Expectations** (some modification needed) **3=Meets Expectations** (no modifications needed but could be improved with minor changes) **4=Exceeds Expectations** (no modifications needed)			
		1	2	3	4
Clarity	• The questions are precise and/or specific. • Only one question is asked at a time. • The participants are likely to understand what is being asked.				
Wordiness	• Questions are concise. • There are no unnecessary words.				
Negative Wording	• Questions are asked using the affirmative (e.g., Instead of asking, "Which methods are not used?" the researcher asks, "Which methods *are* used?")				
Bias	• The questions are not leading the participants to a preferred/desired response. The questions reflect to the extent possible a neutral tone. • The questions offer a way for individuals with unique experiences to respond				
Use of Jargon and	• The terms used are likely to be understood by the target population.				

Technical Language	• There are no clichés or hyperboles in the wording of the questions. • The use of technical language is minimal and appropriate				
Application to Praxis	• The participants can probably relate to the questions asked and understand them from a practice, area of expertise, or simply knowledge perspective.				
Relationship to Problem	• The questions are sufficient to address the problem and research questions of the study • The questions are sufficient to answer the research questions. • The questions are sufficient to achieve the stated purpose of the study.				
Measure of Construct: **A: (perception)**	• The interview guide adequately measures the construct **perception.** • Perception is defined as knowledge, attitudes, and beliefs that influence the health behavior of interest, affecting the individual, family, and the community. • For this study the health behavior is engaging in parent to child sexuality conversations.				
Measure of Construct: **B: (enabler)**	• The interview guide adequately measures the construct **enabler**. • Enabler is defined as the availability, accessibility, acceptability, and affordability of resources to support behavior change. • For this study, researcher will focus on the *acceptability* of parent and child sexuality conversations in the families and homes of Haitians and Jamaicans.				
Measure of Construct:	• The interview guide adequately measures the construct **nurturer**.				

C: (nurturers)	• Nurturer is defined as the degree to which attitudes, beliefs and actions are influenced, mediated, and nurtured by extended family, friends, peers, and community.				

Other Comments and Suggestions

Thank you for sharing your invaluable expertise to assist me with content validation of the Interview Guide for my dissertation research.

Appendix H

Incentive Receipt Form

Having the Talk: Parents and Teens discussing sexual topics

This form is to signify receipt of incentives (gift card) for your participation in the research study "Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescent" led by Ms. Kemesha Gabbidon a doctoral student at Florida International University.

Research Activities

- ☐ All participants will be asked to each an anonymous survey about family communications on sex, comfort, importance of discussion sex with parents, and adolescent sexual activity.

Participants will receive the following for their participation and completion of the aforementioned activities;

Gift Card Payment $10 after teen completes the Adolescent Communication and Sexual Activity Survey

____

Gift card number

- ☐ I opt to receive 2 hours of community service in lieu (place) of a gift card
- ☐ I opt to receive extra credit points as part of an educational task.

By signing this form, I acknowledge receipt of an incentive for my participation in a research study.

___________________________________ ___________________________________

Print Name Signature of Teen

___________________________________ ___________________________________

Signature of Research Associate Date

Appendix I

Interview Contact Summary Form

1. How would you describe the atmosphere and context of the interview?

2. What were the main points made by the respondent during this interview?

3. What new information did you gain through this interview compared to previous interviews?

4. Was there anything surprising to you personally? Or that made you think differently?

5. What messages did you take from this interview for intervention design?

6. Were there any problems with the topic guide (e.g. wording, order of topics, missing topics) you experienced in this interview?

Appendix J

Adolescent Communication and Sexual Behavior survey

Thank you for agreeing to participate in this study, this survey will take about 20 to 30 minutes and will include 52 questions regarding sexuality conversations and adolescent sexual activity. If at any time during the study you wish to discontinue, please feel free to let me know. Your responses are confidential and will be used to develop a better understanding of how you have experienced sexuality conversations with your parent(s) as well as your sexual activity (if applicable).

At this time, I would like to remind you of your written consent to participate in this study entitled: Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents. Your participation in this study is completely voluntary. If at any time you wish to stop, please let me know. You may also withdraw your participation at any time without consequence. If you have any questions or concerns, please share them now.

The following questions are about specific topics you discussed with a parent.

How much information did your MOTHER/MOTHER FIGURE share with you about:

1. Contraception and preventing pregnancy?
   1. ☐None ☐ A little ☐Some ☐A Lot ☐Extensive

2. Sexually transmitted diseases?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

3. HIV/AIDS?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

4. Ways to protect yourself from STDs and AIDS?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

5. Condoms specifically?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

6. Postponing or not having sex?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

7. Peer pressure and sexual pressure from dating partners?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

8. How to resist sexual pressure from peers and dating partners?
   1. ☐None ☐A little ☐Some ☐A Lot ☐Extensive

How much information did your FATHER/FATHER FIGURE share with you about:

1. Contraception and preventing pregnancy?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

2. Sexually transmitted diseases?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

3. HIV/AIDS?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

4. Ways to protect yourself from STDs and AIDS?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

5. Condoms specifically?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

6. Postponing or not having sex?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

7. Peer pressure and sexual pressure from dating partners?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

8. How to resist sexual pressure from peers and dating partners?
   a) ☐None ☐A little ☐Some ☐A Lot ☐Extensive

The following topics are about sexual activity within the last 30 days.

9. Have you SPENT TIME ALONE with a boy/girl during the past 30 days?
   a) No☐ Yes☐

10. Have you HELD HANDS with a boy/girl during the past 30 days?
    a) No ☐ Yes☐

11. Have you and a boy/girl HUGGED during the past 30 days?
    a) No☐ Yes☐

12. Have you and a boy/girl KISSED during the past 30 days?

a) No☐ Yes☐

13. Have you and a boy/girl CUDDLED with each other during the past 30 days?
 a) No☐ Yes☐

14. Have you and a boy/girl LAID down next to each other during the past 30 days?
 a) No☐ Yes ☐

15. Has a boy/girl put his/her hands under your clothing during the past 30 days?
 a) No☐ Yes☐

16. Have you put your hands under a boy's/girl's clothing during the past 30 days?
 a) No☐ Yes☐

17. Have you or a boy/girl you were with been undressed when you were together (with genitals/sex organs exposed) during the past 30 days?
 a) No☐ Yes☐

18. Have you had sexual intercourse (vaginal/anal) with a boy/girl during the past 30 days?
 a) No ☐ Yes☐

19. How many times have you had sex (vaginal/anal) in the past 30 days?
 a) ☐ I have never had sex ☐0 ☐1 ☐2 or 3 ☐4 or more

20. How many different people have you had sex (vaginal/anal) with in the past 30 days?
 a) ☐ I have never had sex ☐0 ☐1 ☐2 ☐3 ☐4 or more

21. How many different people have you had sex (vaginal/anal) with in the past year (12 months)?
 a) ☐ never had sex ☐0 ☐1 ☐2 or 3 ☐4 or 5 ☐6 or 9 ☐10 or more

The following topics are about discussing sex with your parents.

22. Sex should be one of the most important topics for parents and children to discuss.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

23. I can talk to my parents about almost anything that relates to sex.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

24. My parents know what I think about sex.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

25. It is not necessary to talk to my parents about sex.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

26. I can talk openly and honestly with my parents about sex.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

27. I know what my parents think about sex.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

28. The home should be the primary place for learning about sex.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

29. I feel comfortable discussing sex with my parents.

Strongly Agree Agree Neutral Disagree Strongly Disagree

☐ ☐ ☐ ☐ ☐

30. My parents have given me very little information about sex.

Strongly Agree Agree Neutral Disagree
Strongly Disagree

☐ ☐ ☐ ☐ ☐

31. Sex is too personal a topic to discuss with parents.

Strongly Agree Agree Neutral Disagree
Strongly Disagree

☐ ☐ ☐ ☐ ☐

32. My parents feel comfortable discussing sex with me.

Strongly Agree Agree Neutral Disagree Strongly
Disagree

☐ ☐ ☐ ☐ ☐

33. Much of what I know about sex has come from family discussion.

Strongly Agree Agree Neutral Disagree
Strongly Disagree

☐ ☐ ☐ ☐ ☐

34. Sex should not be discussed in the family unless there is a problem to resolve.

Strongly Agree Agree Neutral Disagree
Strongly Disagree

☐ ☐ ☐ ☐ ☐

35. Sex is too hard a topic to discuss with my parents.

Strongly Agree Agree Neutral Disagree
Strongly Disagree

☐ ☐ ☐ ☐ ☐

36. I feel better informed about sex if I talk to my parents.

Strongly Agree Agree Neutral Disagree
Strongly Disagree
☐ ☐ ☐ ☐ ☐

37. The least important thing to discuss with my parents is sex.

Strongly Agree Agree Neutral Disagree
Strongly Disagree
☐ ☐ ☐ ☐ ☐

38. I feel free to ask my parents questions about sex.

Strongly Agree Agree Neutral Disagree
Strongly Disagree
☐ ☐ ☐ ☐ ☐

39. When I want to know something about sex, I generally ask my parents,

Strongly Agree Agree Neutral Disagree
Strongly Disagree

☐ ☐ ☐ ☐ ☐

40. When did you first begin having conversations with your parent(s) about sex?

☐I have never had conversations with my parent(s) about sex

☐ Before first sex act (oral/vaginal or anal sex) [**select if you have never engaged in a sex act]**

☐After first sex act (oral/vaginal or anal sex)

☐I don't remember

41. What age did you first begin sexuality conversations (discussions about sex, STIs/HIV, pregnancy, dating, sexual orientation etc.) (provide an estimation if you cannot remember the exact age ___________
    a. I never talk to my parents about sexual topics ☐

42. Have you discussed sex with a parent in the last 12months?
Yes ☐ No ☐ Not sure ☐

43. How often have you had discussions about sex in the last 12 months?

Never ☐ Rarely ☐ Some ☐ Often ☐ A lot ☐

44. Have you ever engaged in the following:

a) Oral sex?

1. Yes ☐ No☐
   If yes, what age did you first have oral sex? __________ ☐ I don't know

i. How many times have you had oral sex in the past 30 days?

a. ☐ I have never had oral sex ☐0 ☐1 ☐2 or 3 ☐4 or more

ii. How many different people have you had oral sex with in the past 30 days?

a. ☐ I have never had oral sex ☐0 ☐1 ☐2 ☐3 ☐4 or more

iii. How many different people have you had oral sex with in the past year (12 months)?

a. ☐ I have never had oral sex ☐0 ☐1 ☐2 or 3 ☐4 or 5 ☐6 to 9 ☐10 or more

b) Vaginal sex/anal sex?

1. Yes ☐ No☐, if NO skip to question 45

i. If yes, what age did you first have sexual intercourse (vaginal or anal intercourse)? ______

ii. How old was your first sexual partner (provide an estimate if you are unsure)? ______

iii. Did you use a condom the first time you had sexual intercourse (vaginal or anal sex)? Yes ☐ No☐ ☐Unsure

iv. Did you use a condom the last time you had sexual intercourse (vaginal or anal sex)?
Yes ☐ No☐ ☐Unsure

45. Were you born in the US?
Yes ☐ No☐

a) If no, how many years have you lived in the US_____

b) If no, what country were you born in ____________________

46. Racial/ethnic category, ***check all that apply***

____White non-Hispanic
____Black-non-Hispanic/ African American (born in US only)
_____Haitian
_____Jamaican
_____Hispanic/Latin
_____Native American
_____ Asian
_____Pacific Islander
_____Other *please specify* ______________________________

47. What is your age ______

48. Gender

a) Male ☐ Female ☐ Transgender (male to female) ☐ Transgender (female to male) ☐

49. Language usually spoken at home

a) English ☐ b. Haitian-Creole ☐ c. Other ☐ ________________________________

50. Check all that apply

a) I live with my mother/mother figure ☐
b) I live with my father/father figure ☐

51. About your mother:

a) In what country was she born: _________________________
b) Mother's highest grade completed
   1. ☐Less than high school
   2. ☐High school
   3. ☐Some college/vocational
   4. ☐Bachelor's Degree
   5. ☐Graduate and Professional Degree (MD, PhD, RN etc.)
   6. ☐n/a

52. About your father:

a) In what country was he born: ___________________________
b) Father's highest grade completed
   a. ☐Less than high school
   b. ☐High school
   c. ☐Some college/vocational
   d. ☐Bachelors' Degree
   e. ☐Graduate and Professional Degree (MD, PhD, RN etc.)
   f. ☐n/a

Appendix K

Expert Panel Invitations

December 09, 2015

Jennifer Perkins, PhD, MPH
Walden University

Dear Dr. Perkins,

My name is Kemesha Gabbidon, and currently, I am a public health doctoral candidate at Florida International University. I have received committee and IRB approval to conduct a dissertation study entitled "Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents". I would like to formally invite you to serve as a member of an expert panel assessing the content validity of an Interview Guide for the study.

This study may produce findings that will inform the future of public health and HIV and STI prevention interventions as it aims to capture the role of culture, community, and family in influencing the sexual activities of ethnic minority adolescents. This knowledge is important because on a national and international level, Black youth experience disproportionate numbers of teen pregnancy, HIV, and STI diagnoses. Following African Americans, Haitians and Jamaicans represent the other black ethnic groups disproportionately affected by unwanted teen pregnancy, STIs, and HIV. However, most interventions and health education promotion programs have primarily focused on African Americans leaving other largely affected black ethnic groups underserved. Research has shown consistent and convincing evidence supporting open and frequent parent and child sexuality conversations as a means of successfully encouraging conservative sexual attitudes and responsible sexual behaviors among adolescents. However, despite numerous studies showing the benefit of sexuality conversations between parent and child none have explored the nature of sexuality conversations between parent and child in Haitian and Jamaican families, neither have any studies attempted to explain the

relationship between parent and child sexuality conversation and adolescent's sexual risk among these two ethnic groups.

The two-fold purpose of this study is to (a) characterize the nature, perception, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents and (b) explain the relationship between sexuality conversations and adolescent sexual activity.

You were identified as a leader in the field of adolescent sexuality research. I would greatly appreciate your expertise in reviewing researcher developed Interview Guides for content validity purposes. The Interview Guides will be used to collect data characterizing the nature, perceptions, enablers, and nurturers of sexuality conversations. The parent interview guide contains 18 questions and the adolescent guide contains 17 questions; the questions are quite similar between the groups but there are some key differences. If you accept this invitation, the Interview Guides and an Evaluation Rubric will be provided to guide the review process. Please confirm your willingness and availability to serve as a member of the panel by December 15, 2015.

If you are available to serve on this Expert Panel, you will be asked to complete the review and return the rubric by Friday January 15, 2016. Thank you for considering this request. If you have any questions or comments, please contact me at kgabb002@fiu.edu or 954-303-9198 or Dr. Mary Shaw at marshaw@fiu.edu. Thank you for your time and I look forward to hearing from you.

Kemesha Gabbidon, MPH, CPH
Doctoral Candidate
Health Promotion and Disease Prevention
Florida International University

December 09, 2015

Keon Gilbert, DrPH, MA, MPH
Assistant Professor
Saint Louis University

Dear Dr. Gilbert,

My name is Kemesha Gabbidon, and currently, I am a public health doctoral candidate at Florida International University. I have received committee and IRB approval to conduct a dissertation study entitled "Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents". I would like to formally invite you to serve as a member of an expert panel assessing the content validity of an Interview Guide for the study.

This study may produce findings that will inform the future of public health and HIV and STI prevention interventions as it aims to capture the role of culture, community, and family in influencing the sexual activities of ethnic minority adolescents. This knowledge is important because on a national and international level, Black youth experience disproportionate numbers of teen pregnancy, HIV, and STI diagnoses. Following African Americans, Haitians and Jamaicans represent the other black ethnic groups disproportionately affected by unwanted teen pregnancy, STIs, and HIV. However, most interventions and health education promotion programs have primarily focused on African Americans leaving other largely affected black ethnic groups underserved. Research has shown consistent and convincing evidence supporting open and frequent parent and child sexuality conversations as a means of successfully encouraging conservative sexual attitudes and responsible sexual behaviors among adolescents. However, despite numerous studies showing the benefit of sexuality conversations between parent and child none have explored the nature of sexuality conversations between parent and child in Haitian and Jamaican families, neither have any studies attempted to explain the relationship between parent and child sexuality conversation and adolescent's sexual risk among these two ethnic groups.

The two-fold purpose of this study is to (a) characterize the nature, perception, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents and (b) explain the relationship between sexuality conversations and adolescent sexual activity.

You were identified as a leader in the field of health disparities and men's health. I would greatly appreciate your expertise in reviewing researcher developed Interview Guides for content validity purposes. The Interview Guides will be used to collect data characterizing the nature, perceptions, enablers, and nurturers of sexuality conversations. The parent interview guide contains 18 questions and the adolescent guide contains 17 questions; the questions are quite similar between the groups but there are some key differences. If you accept this invitation, the Interview Guides and an Evaluation Rubric will be provided to guide the review process. Please confirm your willingness and availability to serve as a member of the panel by December 15, 2015.

If you are available to serve on this Expert Panel, you will be asked to complete the review and return the rubric by Friday January 15, 2016. Thank you for considering this request. If you have any questions or comments, please contact me at kgabb002@fiu.edu or 954-303-9198 or Dr. Mary Shaw at marshaw@fiu.edu. Thank you for your time and I look forward to hearing from you.

Kemesha Gabbidon, MPH, CPH
Doctoral Candidate
Health Promotion and Disease Prevention
Florida International University

December 09, 2015

Allistair Archibald
Director of Grace United Learning Center

Dear Mr. Archibald,

I would like to formally invite you to serve as a member of an expert panel assessing the content validity of an Interview Guide for the study. I have received committee and IRB approval to conduct a dissertation study entitled "Exploring the dynamics of sexuality conversations between Haitian and Jamaican parents and their adolescents".

This study may produce findings that will inform the future of public health and HIV and STI prevention interventions as it aims to capture the role of culture, community, and family in influencing the sexual activities of ethnic minority adolescents. This knowledge is important because on a national and international level, Black youth experience disproportionate numbers of teen pregnancy, HIV, and STI diagnoses. Following African Americans, Haitians and Jamaicans represent the other black ethnic groups disproportionately affected by unwanted teen pregnancy, STIs, and HIV. However, most interventions and health education promotion programs have primarily focused on African Americans leaving other largely affected black ethnic groups underserved. Research has shown consistent and convincing evidence supporting open and frequent parent and child sexuality conversations as a means of successfully encouraging conservative sexual attitudes and responsible sexual behaviors among adolescents. However, despite numerous studies showing the benefit of sexuality conversations between parent and child none have explored the nature of sexuality conversations between parent and child in Haitian and Jamaican families, neither have any studies attempted to explain the relationship between parent and child sexuality conversation and adolescent's sexual risk among these two ethnic groups.

The two-fold purpose of this study is to (a) characterize the nature, perception, enablers, and nurturers of sexuality conversations between Haitian and Jamaican parents and their adolescents and (b) explain the relationship between sexuality conversations and adolescent sexual activity.

I would greatly appreciate your expertise in reviewing researcher developed Interview Guides for content validity purposes. The Interview Guides will be used to collect data characterizing the nature, perceptions, enablers, and nurturers of sexuality conversations. The parent interview guide contains 18 questions and the adolescent guide contains 17 questions; the questions are quite similar between the groups but there are some key differences. If you accept this invitation, the Interview Guides and an Evaluation Rubric will be provided to guide the review process. Please confirm your willingness and availability to serve as a member of the panel by December 15, 2015.

If you are available to serve on this Expert Panel, you will be asked to complete the review and return the rubric by Friday January 15, 2016. Thank you for considering this request. If you have any questions or comments, please contact me at kgabb002@fiu.edu or 954-303-9198 or Dr. Mary Shaw at marshaw@fiu.edu. Thank you for your time and I look forward to hearing from you.

Kemesha Gabbidon, MPH, CPH
Doctoral Candidate
Health Promotion and Disease Prevention
Florida International University

VITA

KEMESHA GABBIDON

2003-2007	B.S., Biology Florida State University, Tallahassee, FL
2009-2011	M.P.H., Global Health University of South Florida Tampa, FL
2011	HIV policy intern The AIDS Institute Tampa, FL
2011	HIV health educator Youth Education Services St. Petersburg, FL
2014-2015	Volunteer Research Assistant AIDS Prevention Program Florida International University
2016	Graduate Research Assistant Cancer Prevention Training Program The University of Texas MD Anderson Cancer Center Houston, TX
2012-2017	Doctoral Candidate, Public Health Florida International University Miami, FL

SELECTED PUBLICATIONS AND PRESENTATIONS

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