

1-1-2013

Exploring African American and White 18-19 Year Old Males' Communication Experiences With Their Parents and Partners About Sex and Contraception

Charlotte Toole Galloway
University of South Carolina

Follow this and additional works at: <https://scholarcommons.sc.edu/etd>



Part of the [Public Health Education and Promotion Commons](#)

Recommended Citation

Galloway, C. T.(2013). *Exploring African American and White 18-19 Year Old Males' Communication Experiences With Their Parents and Partners About Sex and Contraception*. (Doctoral dissertation). Retrieved from <https://scholarcommons.sc.edu/etd/1363>

This Open Access Dissertation is brought to you by Scholar Commons. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Scholar Commons. For more information, please contact digres@mailbox.sc.edu.

EXPLORING AFRICAN AMERICAN AND WHITE 18-19 YEAR OLD MALES'
COMMUNICATION EXPERIENCES WITH THEIR PARENTS AND PARTNERS ABOUT
SEX AND CONTRACEPTION

by

Charlotte Toole Galloway

Bachelor of Science
Clemson University, 2000

Master of Science
University of South Carolina, 2005

Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Philosophy in

Health Promotion, Education, and Behavior

Arnold School of Public Health

University of South Carolina

2013

Accepted by:

Sara J. Corwin, PhD, Major Professor

Donna L. Richter, EdD, FAAHB, Committee Member

Mary S. Prince, PhD, Committee Member

David S. Simmons, PhD, Committee Member

Lacy Ford, Vice Provost and Dean of Graduate Studies

© Copyright by Charlotte Toole Galloway, 2013
All Rights Reserved.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my dissertation chair, Dr. Sara J. Corwin, for her constant encouragement, guidance, and support throughout this process. I sincerely thank my committee members, Dr. Donna L. Richter, Dr. Mary S. Prince, and Dr. David S. Simmons, for their valuable insight and contributions. I would like to thank Dr. Andre Walker and Mr. Shaun Owens for offering their time and skills to moderate the focus groups. This research would have not been possible without the organizational and financial support of the South Carolina Campaign to Prevent Teen Pregnancy. I wish to express my sincerest gratitude to the young men who participated in the focus groups and shared their personal thoughts and experiences. Finally, my deepest gratitude is extended to my family for their love, encouragement, and support in all that I do.

ABSTRACT

Background: Increasing parent-child and partner communication about sex and contraception have been identified as protective factors that are amenable to change by teen pregnancy prevention programs.

Purpose and Methods: From June through July 2012, a total of six focus groups (N=30) were conducted with African American and White 18-19 year old males to retrospectively explore their communication experiences with parents and partners about sex and contraception, and their attitudes and beliefs about sex, pregnancy, and contraception.

Results: Most participants felt that parent-child sexual risk communication would be more effective when parents had a history of open communication and a good relationship with their sons. Participants felt that an open and honest relationship could be established when parents were a constant presence and participated with their sons in daily activities. Participants (as they reported that their parents did) believed that abstinence should be promoted first, but condoms should be encouraged if a teen chooses to become sexually active. The participants felt strongly that they did not want to become teen fathers, but reported inconsistent contraceptive use especially with casual partners. Participants felt that using contraception was a “shared” responsibility between the male and the female partners. Overall, participants felt that it was the male’s responsibility to “wear a condom” and the female’s responsibility to use a hormonal

method of contraception. When asked about partner sexual risk communication, participants admitted that it is easier to talk with a serious partner, who they have an actual relationship with, than a casual partner.

Conclusions: This study provides insight about the characteristics and quality of parent-son and partner sexual risk communication from the adolescent male perspective. Health promotion professionals interested in reducing adolescent sexual risk behaviors should carefully consider the findings of this study. The results may be useful for developing pilot interventions to support the improvement of parent-child and partner sexual risk communication among African American and White males.

TABLE OF CONTENTS

| | |
|---|-----|
| ACKNOWLEDGEMENTS..... | iii |
| ABSTRACT | iv |
| LIST OF TABLES | x |
| CHAPTER 1: INTRODUCTION | 1 |
| STATEMENT OF THE PROBLEM | 1 |
| STUDY PURPOSE | 3 |
| OVERVIEW OF THE STUDY | 3 |
| SPECIFIC AIMS | 4 |
| PUBLIC HEALTH SIGNIFICANCE..... | 5 |
| CHAPTER 2: LITERATURE REVIEW | 7 |
| TEEN PREGNANCY IN THE UNITED STATES | 7 |
| RACIAL DIFFERENCES IN SEXUAL BEHAVIORS AND USE OF CONTRACEPTION | 8 |
| TEENS AND SEXUALLY TRANSMITTED DISEASES | 10 |
| RACIAL DISPARITIES AND SEXUALLY TRANSMITTED DISEASES | 11 |
| RISK AND PROTECTIVE FACTORS RELATED TO TEEN PREGNANCY | 11 |
| PARENTING STYLES | 14 |
| PARENT-CHILD SEXUAL RISK COMMUNICATION | 15 |
| MALE BELIEFS AND ATTITUDES ABOUT SEX AND CONTRACEPTION | 18 |
| INFLUENCE OF PARENTAL COMMUNICATION ON PARTNER COMMUNICATION | 19 |

| | |
|--|-----|
| EXPERIENCES OF PARTNER COMMUNICATION | 20 |
| MALE ATTITUDES ABOUT PREGNANCY AND ROLE IN THE USE OF CONTRACEPTION | 21 |
| ENCOURAGING PARTNER COMMUNICATION | 22 |
| CONCEPTUAL FRAMEWORK | 23 |
| PUBLIC HEALTH SIGNIFICANCE..... | 27 |
| STUDY PURPOSE | 28 |
| SPECIFIC AIMS | 28 |
| PUBLIC HEALTH IMPLICATIONS | 28 |
| CHAPTER 3: METHODS..... | 31 |
| PRELIMINARY RESEARCH..... | 31 |
| STUDY PURPOSE | 34 |
| OVERVIEW OF RESEARCH DESIGN | 35 |
| STUDY AIMS AND RESEARCH QUESTIONS..... | 35 |
| STUDY PROCEDURES..... | 37 |
| CHAPTER 4: RESULTS | 47 |
| MANUSCRIPT 1: EXPLORING ADOLESCENT MALES COMMUNICATION EXPERIENCES WITH THEIR PARENTS ABOUT SEX AND CONTRACEPTION..... | 47 |
| MANUSCRIPT 2: EXPLORING THE COMMUNICATION EXPERIENCES THAT ADOLESCENT MALES HAVE WITH THEIR PARTNERS ABOUT SEX AND CONTRACEPTION..... | 90 |
| CHAPTER 5: DISCUSSION | 131 |
| SPECIFIC AIM 1 | 131 |
| SPECIFIC AIM 2 | 136 |
| USE OF THEORY | 142 |
| LIMITATIONS OF THE STUDY | 145 |

| | |
|---|-----|
| IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE | 147 |
| CONCLUSIONS | 149 |
| REFERENCES | 151 |
| APPENDIX A – CONCEPTUAL MODEL CONSTRUCT DEFINITIONS | 157 |
| APPENDIX B – FOCUS GROUP ITEMS | 158 |
| APPENDIX C – SOCIODEMOGRAPHIC QUESTIONNAIRE | 159 |
| APPENDIX D – INFORMATIONAL LETTER | 161 |
| APPENDIX E – FLYER/EMAIL TEXT | 163 |
| APPENDIX F – INFORMED CONSENT FORM..... | 164 |
| APPENDIX G – FOCUS GROUP IMPLEMENTATION GUIDE..... | 166 |
| APPENDIX H – RESEARCH MEMOS | 170 |

LIST OF TABLES

| | | |
|-----------|---|-----|
| Table 4.1 | Demographic and Behavioral Characteristics of Focus Group Participants (N=30)..... | 83 |
| Table 4.2 | Summary of Commonly Expressed Themes and Sub-Themes by Race..... | 84 |
| Table 4.3 | Demographic and Behavior Characteristics of Focus Group Participants (N=30)..... | 125 |
| Table 4.4 | Summary of Commonly Expressed Themes and Sub-Themes by Race..... | 126 |

CHAPTER 1

INTRODUCTION

Statement of the Problem

In 2010, the Centers for Disease Control and Prevention (CDC) added *Adolescent Health* as a stand-alone topic area to Healthy People 2020. The goal is to improve the healthy development, health, safety, and well-being of adolescents and young adults. Related to this area, the goal for *Family Planning* is to improve pregnancy planning and spacing, and prevent unintended pregnancy (United States Department of Health and Human Services [USDHHS], 2010). Three objectives of the *Family Planning* goal are related to this study: 1) increase the proportion of adolescents who talked to a parent or guardian about reproductive health topics before they were 18 years old; 2) increase the proportion of adolescents aged 17 years and under who have never had sexual intercourse; and 3) increase the proportion of sexually active persons aged 15 to 19 years who use condoms to both effectively prevent pregnancy and provide barrier protection against disease (USDHHS, 2010).

Furthermore, teen pregnancy prevention is one of the CDC's top six priorities, a "winnable battle" in public health, and of vital importance to the health and quality of life for youth in the United States (Centers for Disease Control and Prevention [CDC], 2012). This is a prevention priority because of its substantial impact on the teen parent, the

children, families and society as a whole. Pregnancy and birth are significant contributors to high school drop out rates among girls (Perper, Peterson, & Manlove, 2010). The children of teenage mothers are more likely to have lower school achievement, lower high school graduation rates, more health problems, increased likelihood of being incarcerated at some time during adolescence, becoming a teen mom, and facing unemployment as a young adult (Hoffman, 2008). Moreover, teen pregnancy accounts for nearly \$11 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers (National Campaign to Prevent Teen and Unplanned Pregnancy [NCTPTUP], 2011).

In 2010, a total of 367,752 infants were born to women aged 15–19 years, for a live birth rate of 34.3 per 1,000 women in this age group (Hamilton, Martin, & Ventura, 2011). This was a record low for U.S. teens in this age group, and a drop of 9% from 2009 (Hamilton et al., 2011). Birth rates fell 12% for women aged 15–17 years, and 9% for women aged 18–19 years (Hamilton et al., 2011). Nearly two-thirds of all teen pregnancies and births are to older teens age 18 to 19 years old (Suellentrop, 2010).

Despite these declines, the U.S. teen pregnancy, birth, sexually transmitted disease, and abortion rates are substantially higher than those of other western industrialized nations (Singh & Darroch, 2000). Furthermore, significant racial and ethnic disparities also exist within the U.S (Mathews, Sutton, Hamilton, & Ventura, 2010). In 2009, birth rates for African American teens (59.0 per 1,000 females) and Hispanic teens (70.1 per 1,000 females) were more than twice that of White teens (25.6 per 1,000 females) (Pazol et al., 2011).

Emerging Answers (Kirby, 2007) explores the primary research results of 450 studies about factors that influence sexual risk-taking behaviors in adolescence. In this report, Kirby identified both risk and protective factors that affect teens' sexual behavior. Research indicates when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). Partner support for condom and contraceptive use was also identified as a protective factor (Kirby, 2007). Several studies (Whitaker, Miller, May, & Levin, 1999; DiClemente et al., 2001) have linked teenagers' communication with their partners about sex and contraception with discussions that teenagers have had with their parents about sex.

Study Purpose

The purpose of this qualitative study was to retrospectively explore African American and White 18-19 year old males' communication experiences with their parents and partners about sex and contraception, and their attitudes and beliefs about sex, pregnancy, and contraception. This study provides insight into the characteristics and quality of parent-son sexual risk communication and partner sexual risk communication from the adolescent male perspective. Participants' recommendations for promoting parent-son sexual risk communication and partner communication related to sex and contraception are also provided.

Overview of the Study

The study design was a combination of phenomenology (i.e., attempting to understand the lived experience of adolescent males) and modified grounded theory using

a constant comparative method to determine if observations are holding true to the theory constructs of interest (Van Manen, 1990; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Qualitative data was collected through six focus groups. Widely used, focus group research involves collecting qualitative data from a small group of people in an informal discussion ‘focused’ around a particular topic of interest (Morgan, 1998; Wilkinson, 2004; Krueger & Casey, 2000; Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). Focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from “information-rich cases” for the development of future programs and interventions (Patton, 2002).

From June through July 2012, a total of six focus groups (i.e., three with African American males and three with White males aged 18-19 years old) were conducted. This study stratified the sample by race with focus groups held separately with African American males and White males. This stratification was based on the finding from the literature that different races may have unique family dynamics and parenting styles, distinct attitudes about sex, and sexual behaviors (CDC, 2010). The stratification also presented the opportunity to examine racial differences across results.

Specific Aims

This study addressed the following specific aims.

Specific Aim 1: To explore African American and White 18-19 year old males’ experiences of sexual risk communication with their parents during early adolescence and how these experiences affected their attitudes and beliefs about sex, pregnancy, and contraception.

Specific Aim 2: To explore African American and White 18-19 year old males' experiences of sexual risk communication with their partners, how these experiences were affected by parental sexual risk communication during early adolescence, and how to promote sexual risk communication among partners.

Public Health Significance

Research indicates that when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). The influence of parental sexual risk communication on adolescent sexual risk-taking behavior is well documented (Jaccard, Dittus, & Gordon, 1996; DiClemente et al., 2001; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Clawson & Reese-Weber, 2003; Kirby, 2007; Somers & Ali, 2011). Although there is a great deal of literature in this area, there are few qualitative studies that have deeply examined this topic for purposes of informing the development of sexual risk reduction interventions for racially and ethnically diverse adolescent males.

Furthermore, while parent-daughter sexual risk communication is well documented in the literature, parent-son communication is not as well understood (DiClemente et. al, 2001; Hutchinson, 2002; Hutchinson et. al, 2003). This study provided insight into the characteristics and quality of parent-son sexual risk communication from the son's (18-19 year old African American and White male) perspective. In addition, the study explored the impact of parent-son sexual risk communication during childhood/early adolescence on future partner communication about sex and contraception in late adolescence/early adulthood.

This research can be used to develop pilot interventions supporting: 1) the improvement of sexual risk communication among African American and White males and their parents; and 2) the improvement of partner communication about sex and contraception among adolescent African American and White males and their partners.

CHAPTER 2

LITERATURE REVIEW

Teen Pregnancy in the United States

Teen pregnancy prevention is one of the Centers for Disease Control and Prevention's top six priorities, a "winnable battle" in public health, and of vital importance to the health and quality of life for youth in the United States (CDC, 2012). This adolescent health issue is a prevention priority because of its substantial impact on the teen parent, their children, families and society as a whole. Pregnancy and birth are significant contributors to high school drop out rates among girls (Perper et al., 2010). The children of teenage mothers are more likely to have lower school achievement, to have lower high school graduation rates, to have more health problems, to have increased likelihood of being incarcerated at some time during adolescence, to become a teen parent, and to face unemployment as a young adult (Hoffman, 2008). Teen pregnancy accounts for nearly \$11 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers (NCPTUP, 2011).

In 2010, a total of 367,752 infants were born to women aged 15–19 years, for a live birth rate of 34.3 per 1,000 women in this age group (Hamilton et al., 2011). This

was a record low for U.S. teens in this age group, and a drop of 9% from 2009 (Hamilton et al., 2011). Birth rates fell 12% for women aged 15–17 years, and 9% for women aged 18–19 years (Hamilton et al., 2011). Nearly two-thirds of all teen pregnancies and births are to older teens age 18 to 19 years old (Suellentrop, 2010).

Despite these declines, the U.S. teen pregnancy, birth, sexually transmitted disease, and abortion rates are substantially higher than those of other western industrialized nations (Singh & Darroch, 2000). Furthermore, significant racial and ethnic disparities also exist within the U.S (Mathews et al., 2010). In 2009, birth rates for African American teens (59.0 per 1,000 females) and Hispanic teens (70.1 per 1,000 females) were more than twice that of white teens (25.6 per 1,000 females) (Pazol et al., 2011).

Racial Differences in Sexual Behaviors and Use of Contraception

While reasons for the declines in teen birth rates are not clear, it is likely that teens are delaying sexually activity, and more of those who are sexually active are using contraception than in previous years (Martinez, 2011). Over the last two decades, teens have engaged in fewer sexual risk-taking behaviors. Sexual risk-taking behaviors are those behaviors that contribute to the occurrence of unintended pregnancy and sexually transmitted infections, including such behaviors as lack of condom or birth control use (CDC, 2010).

According to the 2009 National Youth Risk Behavior Survey (YRBS), the percentage of 9-12th grade students who reported ever having sexual intercourse decreased from 54% in 1991 to 46% in 2009 (CDC, 2010). Among male students, the

percentage who ever had sexual intercourse was highest among African American students (72%) followed by Hispanic (53%) and white students (40%) (CDC, 2010). Although the overall percentage of female and male students who ever had sexual intercourse decreased over the last decade, the decrease among African American male students leveled off starting in 2001 (Pazol et al., 2011).

The 2009 YRBS also demonstrated racial differences in the age of sexual initiation and number of partners. The percentage of male students who had sexual intercourse before the age of thirteen years was higher among African American (25%) males than white (4%) males (CDC, 2010). Likewise, the percentage of male students who had sex with four or more people in their life was higher among African American (39%) than their white (11%) counterparts (CDC, 2010).

Results of the 2009 YRBS showed that 12% of sexually active students did not use any method of contraception at last sexual intercourse, a decrease from 16% in 1991 (CDC, 2010). In 2009, both for female and male students, the percentage who did not use any method of contraception at last sexual intercourse was higher among Hispanic students (females, 23%; males, 16%) and African American students (females, 20%; males, 12%) than white students (females, 10%; males, 6%) (CDC, 2010).

Among the students that reported being currently sexually active, 61% used a condom during last sexual intercourse, an increase from 46% in 1991 (CDC, 2010). The percentage of male students that reported being currently sexually active that used a condom during last sexual intercourse was higher among African American (73%) than white (71%) males (CDC, 2010).

During 1999-2009, condom use without birth control pills or injectable contraception (Depo-Provera) remained the most commonly used contraceptive method; the percentage of students who used dual methods (condoms with birth control pills or Depo-Provera) was low, but increased from 5% in 1999 to 9% in 2009 (CDC, 2010). However, whereas this increase occurred among male and female students overall, it was only observed among white students (CDC, 2010).

Teens and Sexual Transmitted Diseases

The Centers for Disease Control and Prevention estimates that a total of almost 19 million new sexually transmitted infections occur each year and costs the U.S. health care system as much as \$15.9 billion annually (CDC, 2011). Estimates suggest that even though young people aged 15–24 years represent only 25% of the sexually experienced population, they acquire nearly half of all new sexually transmitted diseases (STD) (Weinstock, Berman, & Cates, 2004).

Chlamydia and gonorrhea are the two most commonly reported STDs in the United States; more than 1.5 million cases of chlamydia and gonorrhea were reported in 2008 (CDC, 2011). Rates of chlamydia infection among persons aged 15–19 years and 20–24 years continue to increase (CDC, 2011). According to the CDC's Sexually Transmitted Disease Surveillance Report (2011), females aged 15–19 years had the largest reported number of chlamydia and gonorrhea cases (409,531) when compared to any other age group, followed closely by women ages 20-24. Overall chlamydia and gonorrhea rates increased 2.8% and 1.4%, respectively, for those aged 15–19 years

between 2009 and 2010 (CDC, 2011). Among males 15-19 years, chlamydia rates increased 6.0% and gonorrhea rates increased 2.1% (CDC, 2011).

Racial Disparities and Sexually Transmitted Diseases

The CDC's Sexually Transmitted Disease Surveillance Report (2011) documented that African Americans continue to be more disproportionately affected by STDs than any other racial or ethnic group (CDC, 2011). In 2008, African Americans represent 12 percent of the U.S. population, but accounted for about seventy-one percent of reported gonorrhea cases and almost half of all chlamydia (48%) and syphilis (49%) cases (CDC, 2011). Gonorrhea rates among African Americans are higher than any other racial or ethnic group and 20 times higher than that of whites (CDC, 2011). The rate of chlamydia among African Americans was more than eight times the rate among whites (CDC, 2011).

Chlamydia and gonorrhea rates were highest for African Americans aged 15–19 and 20–24 years in 2010 (CDC, 2011). Among males aged 15–19 years, the chlamydia rate for African Americans was 13 times the rate among whites (1,654 and 117 cases per 100,000 population, respectively) (CDC, 2011). Likewise, African Americans men age 15–19 years had a gonorrhea rate of 1,024.7 cases per 100,000 men, which was 37 times the rate among white men in the same age group (27.4 cases per 100,000) (CDC, 2011).

Risk and Protective Factors Related to Teen Pregnancy

Emerging Answers (Kirby, 2007) is considered the authoritative paper in the field of teen pregnancy prevention; this work explores the primary research results of 450 studies of factors that influence sexual risk-taking behaviors in adolescence. In order to be included in Kirby's review, studies of pregnancy prevention programs had to meet the

following criteria: conducted in the United States; completed or published between 1990 and 2007; focused on teens age 12 to 18; examined the impact of factors on initiation of sex, frequency of sex, number of partners, use of condoms or contraceptives, pregnancy, birth or STD/HIV rates; reasonably strong experimental or quasi-experimental design; had a sample of 100 teens for significant results and 200 teens for nonsignificant results; met scientific criteria required for publication in professional peer-reviewed research journals; and included multivariate analyses (Kirby, 2007).

In the report, Kirby identifies over 500 risk and protective factors that affect teens' sexual behaviors or consequences of those behaviors. Risk factors are those factors that encourage behavior that could result in a pregnancy or STD, or discourage behavior that could prevent pregnancy or disease (Kirby, 2007). Protective factors are factors that discourage behavior that could lead to a pregnancy or STD or encourage behavior that prevent them (Kirby, 2007). The presence of more risk factors and fewer protective factors in a teen's life increases the chance that the teen will have unprotected sex or become pregnant (or cause a pregnancy) or acquire an STD (Kirby, 2007).

Kirby (2007) classifies the risk and protective factors into four key areas: 1) individual biological factors (e.g. age, physical maturity, gender, race); 2) disadvantage, disorganization and dysfunction in the lives of the teens and their environments (e.g. rates of substance abuse, violence, divorce, levels of education); 3) sexual values, attitudes, and modeled behavior (e.g. teens' own values about sexual behavior as well as those expressed or modeled by parents, peers, and romantic partners); and 4) connection to adults and organizations that discourage sex, unprotected sex, or early childbearing. (e.g. attachment to parents and other adults in their schools and places of worship). Some

factors are related explicitly to sexuality (e.g. greater intention to use condoms, peer use of condoms, discussing sexual risks with partner) while other important factors are considered nonsexual (e.g. plans for the future, being involved in sports, having a religious affiliation) (Kirby, 2007). Kirby (2007) found that of all known risk and protective factors, a teen's own sexual beliefs, values, attitudes, and intentions are the more strongly related to sexual behavior.

In *Emerging Answers*, Kirby describes both the factors that influence adolescent sexual behavior and the extent to which these factors can be changed by an intervention or program, whose goal is to reduce teen pregnancy rates. Research indicates when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). Increasing parent-child communication about sex and contraception is identified as a protective factor that is most amenable to change directly by a pregnancy prevention program (Kirby, 2007). Partner support for condom and contraceptive use was also identified as a protective factor, although more difficult to change without having specialized services as part of an intervention or program (Kirby, 2007). Discussing sexual risks and pregnancy prevention with partner were also identified as highly-changeable protective factors (Kirby, 2007). Several studies (Whitaker et al., 1999; DiClemente et al., 2001) have linked teenagers' communication with their partners about sex and contraception with discussions that teenagers have had with their parents about sex.

Parenting Styles

The impact of parent/teen communication depends on overall parenting style, including the degree of parent/child closeness (Miller, Benson, & Galbraith, 2001). In the late 1960s, Diane Baumrind revised the concept of parenting style to capture normal variations in parents' attempts to control and socialize their children (Baumrind, 1966). Parenting style encapsulates two important elements of parenting: parental responsiveness (i.e., parental warmth, supportiveness, closeness), and parental demandingness (i.e., behavioral control) (Baumrind, 1991). Baumrind (1991) believed that parents may differ in the extent and style that they try to control or socialize their children, but that the primary role of all parents is to influence, teach, and control their children.

Baumrind (1991) described four types of parents: “authoritative,” “authoritarian,” “indulgent”, and “rejecting-neglecting”. “Authoritative” parents are both responsive and demanding; they provide clear standards for their children’s conduct but are not intrusive or restrictive (Baumrind, 1991). “Authoritarian” parents are highly demanding and directive, but not responsive; they provide an orderly environment and expect orders to be obeyed without explanation (Baumrind, 1991). “Indulgent” (also called “permissive”) parents are more responsive than demanding; they do not require mature behavior, allow considerable self-regulation, and avoid confrontation (Baumrind, 1991). “Rejecting-neglecting” (also called “uninvolved”) parents are neither demanding nor responsive; they do not structure and monitor, and are not supportive (Baumrind, 1991). Baumrind’s (1991) parenting style typology should not be understood to include deviant parenting, such as might be observed in abusive or neglectful homes.

Parent-Child Sexual Risk Communication

Kirby's *Emerging Answers* (2007) provides an overview of primary research results on factors that influence sexual risk-taking behaviors in adolescence. One of the key findings from this seminal report is related to parent-child communication. Research indicates when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). Some of studies that provided basis for Kirby's conclusion, and more recent research are detailed below.

Jaccard, Dittus, & Gordon (1998) surveyed 745 African American male and female adolescents (ages of 14-17 years old) and their mothers/female caregivers on measures related to family influences on adolescent sexual behavior, including adolescent sexual behavior, parental orientations towards premarital sex, satisfaction with the relationship, global communication about sex, communication about specific topics, demographic variables, and peer perceptions. Parent and adolescent reports about whether specific sexually based conversations occurred did not match (Jaccard et al., 1998). One of this study's conclusions was that mothers tend to account for all attempts to talk to their teens about sex, whereas, the teens likely only reported communication that they considered noteworthy (Jaccard et al., 1998). Findings also showed that adolescent perceptions and reports were more predictive of sexual behavior than maternal reports (Jaccard et al., 1998). The researchers conceded that there are errors in both efforts to measure the true amount of sexual risk communication, but a stronger case can

be made for using teen reports for the purposes of predicting teen sexual behavior (Jaccard et al., 1998).

Utilizing key constructs from the Theory of Planned Behavior (Ajzen, 1985), researchers focused on the extent to which parent sexual risk communication, specifically from mothers, influenced the sexual behaviors of their 12 to 19 year old adolescent daughters (Hutchinson et al., 2003). Three self-reported sexual risk behaviors were evaluated from a sample of 219 (68% African American; 32% Latina) sexually experienced females: number of male sexual partners, number of episodes of sexual intercourse, and number of episodes of unprotected intercourse (Hutchinson et al., 2003). The study found that higher levels of mother–daughter sexual risk communication were associated with fewer episodes of sexual intercourse and unprotected intercourse at 3-month follow-up (Hutchinson et al., 2003). Mother–daughter sexual risk communication was not significantly associated with adolescents’ reports of numbers of male sexual partners (Hutchinson et al., 2003). The study findings further supported the notion that mothers who communicate with their daughters about sex can have a positive impact on some of their daughters’ sexual behaviors (Hutchinson et al., 2003).

The study also identified several areas for future research. Because sexual communication patterns vary by the gender of both parent and adolescent (Dutra, Miller, & Forehand, 1999; Hutchinson, 2002), future studies should focus on fathers and sons. Qualitative approaches to studying parent-child sexual risk communication would also be useful by providing “richer data” about the how these interactions influence adolescent sexual behavior (Hutchinson et al., 2003).

Clawson and Reese-Weber's study (2003) examined the relationship between sexual risk-taking behaviors and the timing of parent-adolescent sexual communication. The study, based on Socialization Theory (Philliber, 1980), documented that timing is an important factor in predicting sexual risk-taking behavior. Two hundred and fourteen participants (101 males and 113 females) between the ages of 18 and 21 years of age completed the study questionnaire for extra course credit; the sample was 82% White and 9% African American. Clawson and Reese-Weber (2003) concluded that emphasis should be placed on encouraging parents to discuss sexuality early in their adolescents' development, preferably prior to initiation of sexual activity. The study also suggested several areas for additional research including having a sample with more diversity, especially looking at African American adolescents, who are more likely to be sexually active than Whites (CDC, 2010). Future research should also focus on identifying if discussion of certain topics (e.g., pregnancy, sexually transmitted infections) are more strongly correlated with sexual risk-taking behavior than others (e.g., prostitution), and investigating the specific content of parent-child sexual risk communication and perceived parental attitudes related to discussions (Clawson & Reese-Weber, 2003).

According to de Visser (2005), parent-child communication about sexuality is an area which deserves further attention from both researchers and those involved in health promotion. de Visser's (2005) qualitative study focused on young adults' (18-25 year old males and females; study did not define race of participants) beliefs about how to promote condom use for sexually transmitted infections (STI) prevention. Some of the focus group participants stated that parents could play a greater role in sexuality education (de Visser, 2005). The study found that there is a need for exploring the best

ways to develop parents' skills and motivations for communicating with their children about sexual health (de Visser, 2005).

In a recent study, Somers and Ali (2011) examined the role of parents on adolescent sexual risk-taking behavior in a more comprehensive manner, and not just focused on one or two predictor variables. The study collected adolescents' perspectives about multiple variables, including mother and father approval of premarital sex, parent-adolescent communication about sexuality, and parental social support (Somers & Ali, 2011). Study participants were 194 male (n=89) and female (n=105) students in the 7th and 8th grades (12-15 years old) from two middle schools; all were African-American or Hispanic of lower socioeconomic status (Somers & Ali, 2011). None of these parenting variables predicted adolescents' intentions to avoid pregnancy, plans sexual intercourse debut, or plans for continuing sexual intercourse if already started (Somers & Ali, 2011). The researchers concluded that it is likely that the teens in the study seeking parental communication about sexuality are already curious about or engaging in sexual behavior (Somers & Ali, 2011). This finding necessitates more, earlier communication by parents (Somers & Ali, 2011). In fact, older adolescent age has been suggested as the strongest predictor of sexual communication and behavior in prior research (Somers & Paulson, 2000).

Males Beliefs and Attitudes about Sex and Contraception

While more than fifteen years old, a focus group study was conducted with 27 inner city African American young men ages 15 to 19 years to assess the attitudes and beliefs associated with decisions to have sexual intercourse and use condoms (Gilmore, DeLamater, & Wagstaff, 1996). Four sets of beliefs emerged as key themes: what it

means to be a man, the good (physical pleasure) and bad (disease and unwanted pregnancies) things about sexual intimacy, condom use and AIDS as a serious threat (Gilmore et al., 1996). Although the young men generally endorsed condom use, there were numerous contradictory comments; such as condoms diminish sexual pleasure and women requesting condom use indicates the potential presence of sexually transmitted diseases (Gilmore et al., 1996). Ultimately, decisions about the use of condoms appeared to be correlated with the young men's perception of the woman being "clean" or "dirty" and how long he has known her (Gilmore et al., 1996). Another key finding suggests that there is a belief or fear that one's partner is lying, which may hinder partner communication about birth control and condom use (Gilmore et al., 1996). The researchers acknowledged their "high risk" sample may not be representative, but encouraged future studies that focus on relationships between African American men and their female partners (Gilmore et al., 1996).

Influence of Parental Communication on Partner Communication

Whitaker et al. (1999) interviewed 372 African American and Hispanic adolescent-mother pairs, where the adolescent (14-16 years old) reported having engaged in penile-vaginal intercourse at least once. The interview measures included sexuality discussions, sexual risk discussions, parental responsiveness, partner communication, and condom use (Whitaker et al., 1999). Sexuality and sexual risk discussions with parents were positively related to partner communication (Whitaker et al., 1999). In addition, adolescents' communication with their partners about sexual risk was associated with increased condom use (Whitaker et al., 1999). However, both of these findings only hold true when parents communicate with their teens in a skilled, open, and comfortable

manner (Whitaker et al., 1999). The researchers recommended examining both the content and the process of parent-teenager communication about sex to increase the field's understanding of how that communication affects adolescents' sexual behavior (Whitaker et al., 1999).

DiClemente et al. (2001) administered a Social Cognitive Theory (Bandura, 1986) -guided survey to 522 sexually active African American females (ages 14-18 years old) to explore associations between parent-child sexual risk communication and partner communication. Supporting the findings from an earlier study, the research team found a positive association between parent-adolescent sexual risk communication and adolescent communication with sex partners (DiClemente et al., 2001; Jaccard et al., 1996). Female adolescents who reported less frequent communication with parents were more than three times less likely to report frequent communication with their male partners about sex, including how to prevent pregnancy and sexually transmitted infections (DiClemente et al., 2001). The study further suggested that parents “may be key agents in the promotion of open and honest communication about sex between maturing adolescents and the sex partners they select” (DiClemente et al., 2001).

Experiences of Partner Communication

Coleman and Ingham (1999) used in-depth interviews with fifty-six 16-19 year olds (77% female; study did not define race of participants) to investigate the obstacles that prevent some young people from discussing contraception, particularly prior to their first intercourse with a new partner. The most prominent reason that participants gave for not talking to their partner was fear of a negative reaction (Coleman & Ingham, 1999). The researchers found that this concern was largely unjustified, and suggested that this

finding should be widely publicized to encourage partner communication. Several men said that their hesitancy to have a discussion stemmed from the idea that talking about contraception is admitting an intention for intercourse (Coleman & Ingham, 1999). There were some other indications of gender differences in responses; and because the sample was predominantly female, future investigations should look at males or other social classes (Coleman & Ingham, 1999).

Researchers conducted a study to examine the relationship between general sexual communication and contraceptive use, and predictors of open communication from characteristics of adolescent couples and individual adolescents (Widman, Welsh, McNulty, & Little, 2006). In the study, seventy-three adolescent dating couples aged 14-21 years old (91% White and 8% African American) completed measures to assess general sexual communication, contraceptive communication, contraceptive use, relationship satisfaction, commitment, and self-silencing (Widman et al., 2006). The results indicated both male and female adolescents who were more satisfied in their relationship were more open to communicating about sexual topics, and that this association led to increased contraceptive use (Widman et al., 2006). Findings suggest that it is important to convey to young people that open partner communication about sexual issues is essential for avoiding risky sexual behaviors (Widman et al., 2006).

Male Attitudes about Pregnancy and Role in Use of Contraceptives

Johnson and Williams (2005) conducted in-depth interviews with 20 men (ages 21-48 and 95% White) who have fathered at least one unintended pregnancy to explore their communication with partners, contraceptive beliefs, and contraceptive behaviors. The interviews were analyzed using a thematic framework; two themes clearly emerged:

“deference” and “denial” (Johnson & Williams, 2005). In terms of discussion, planning, decision-making, contraception, the majority of participants deferred to their partner (Johnson & Williams, 2005). The denial theme related to the fact that participants were aware of the risks of unintended pregnancy and yet chose behaviors that increased the likelihood of conception (Johnson & Williams, 2005). The participants typically relied on their partners to use contraception and most said that they had only a “supporting role” (Johnson & Williams, 2005). One of the surprising findings from this study was that men, including their well-educated sample, did not have accurate information about contraceptive methods (Johnson & Williams, 2005). The study team concluded that men need increased knowledge about contraception, and additional research should focus on male’s role and responsibility in contraceptive use and partner communication (Johnson & Williams, 2005). The current study’s sample was predominantly White and educated, so future research should involve males from varied racial and ethnic groups and socioeconomic backgrounds; (Johnson & Williams, 2005).

Encouraging Partner Communication

Landry and Camelo (1994) used focus groups to explore how 76 unmarried young men (16-29 years) and women (20-29 years) define men's role in contraception and why they do or do not use a method. Twelve focus groups were divided by gender and race/ethnicity: 3 groups with Hispanic males (n=19), 1 group with Hispanic females (n=8), 3 groups with African American males (n=16), 1 group with African American females (n=7), 3 groups with White males (n=18), 1 group with White females (n=8) (Landry & Camelo, 1994). Researchers found that the main motivation to use contraceptives is to prevent both pregnancy and sexually transmitted diseases,

particularly HIV/AIDS (Landry & Camelo, 1994). The participants said that the method of contraception used is dependent on the type of relationship involved; condoms are used more frequently in casual sexual relationships (Landry & Camelo, 1994). Males said they rarely discussed contraceptive use with a casual partner and that women initiated most conversations about contraception (Landry & Camelo, 1994). The study also demonstrated despite awareness of the risks of STDs and pregnancy, both men and women report that they occasionally use no method at all or relied on a method other than condoms with casual partners (Landry & Camelo, 1994). Most participants relied upon "instinctive" criteria, rather than sexually transmitted disease testing, in making the decision to switch from condoms to another form of birth control in longer term relationships (Landry & Camelo, 1994). The researchers suggested that future studies and interventions should focus on methods to increase partner communication and contraceptive method use (Landry & Camelo, 1994).

Conceptual Framework

The conceptual framework for this study is composed of constructs from three theories: Socialization Theory (Philliber, 1980), Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991) and Social Judgment Theory (Sherif, Sherif, & Nebergall, 1965).

Socialization Theory is based on the idea that children and adolescents learn attitudes and behaviors early in life from adult role models, such as parents (Philliber, 1980). Typically, parents are the first and most important influence on their children. The attitudes and behaviors modeled by parents are learned by their children and manifested in adolescence and adulthood (Philliber, 1980). Parents' behaviors, such as having open and honest discussions with their children about risky sexual activities, will

result in certain adolescent behaviors, such as delaying initiation of sexual intercourse (Miller & Fox, 1987). Based on this theory, an adolescent's sexual behavior can be partially predicted by how he or she was socialized by their parents. Socialization Theory has provided the basis for several related studies, including Clawson and Reese-Weber's (2003) examination of parent-adolescent sexual communication in relation to adolescent sexual behavior. This study explored African American and White 18-19 year old males' attitudes and behaviors in the context of their experiences of sexual risk communication with their parents during early adolescence. [N.B. nomenclature in the literature uses "parent-child," but researchers recognize that many children/youth are not raised in traditional households. In this study, therefore, parent or parental was used to represent an adult guardian or significant adult in the child's life.]

The Theory of Planned Behavior (TPB) assumes that *behavioral intention* is the most important determinant of a given behavior (Ajzen, 1985; Ajzen, 1991). According to TPB, a person's attitude towards a behavior (*attitude toward behavior*) and whether individuals who are important to the person approve or disapprove of the behavior (*subjective norm*) are the primary determinants of behavioral intentions (Ajzen, 1985; Ajzen, 1991). In this study, African American and White 18-19 year old males attitudes and beliefs towards sexual risk-taking behaviors were explored in the context of their experiences of communicating with their own parents about sexual risks and using contraception during childhood. The focus groups assessed African American and White 18-19 year old males' intention to use condoms and contraception by inquiring about their thoughts and attitudes towards pregnancy at this point in their lives.

Ajzen's TPB (Ajzen, 1985; Ajzen, 1991) evolved from Fishbein's Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980); both concentrate on the relationship between behavior and beliefs, attitudes and intentions. The TPB differs from the Theory of Reasoned Action in the addition of *perceived behavioral control* as a construct (Ajzen, 1985; Ajzen, 1991). Perceived behavior control is a person's perception of the controllability of a behavior, when it is influenced by factors beyond their control (Ajzen, 1985; Ajzen, 1991). The TPB has been used by studies in the literature related to adolescents' sexual risk-taking behaviors, including Hutchinson's work (2003) where the research team used the theory to explore the role of mother-daughter communication in reducing teens' sexual risk behaviors. In the case of this study, African American and White 18-19 year old males were asked about their role in the use of contraception with sexual partners, which may clarify their perceived control related to engaging in sexual risk behaviors.

The final component of the study's conceptual framework is from Social Judgment Theory (Sherif et al., 1965), which is an interpersonal communication theory. Social Judgment Theory (Sherif et al., 1965) explains how individuals judge the messages they receive. According to the theory, a listener judges how much a message agrees or disagrees with his or her own attitude or belief system (Sherif et al., 1965). Attitudes are broken down into one of three latitudes: acceptance, rejection, and non-commitment. The latitude of acceptance consists of alternatives which are regarded as acceptable in the sense that they are closest to the person's own attitudes about the subject (Sherif et al., 1965). The latitude of rejection is made up of alternatives the person feels are objectionable or undesirable (Sherif et al., 1965). Alternatives that do not fall in

either the latitude of acceptance or the latitude of rejection are considered to be within the latitude of non-commitment, where an individual feels undecided about or has no opinion on the idea (Sherif et al., 1965).

According to SJT (Sherif et al., 1965), attitude towards an issue is dependent on an individual's most preferred position (their anchor point), the individual's latitude judgment, and the individual's level of ego-involvement with the issue. Attitude change is a major component of Social Judgment Theory (Sherif et al., 1965). Positive attitude change refers to a person's change in the direction of the communication (Sherif et al., 1965). Negative attitude change, sometimes called the boomerang effect, is said to occur when a person changes away from a position advocated rather than toward it (Sherif et al., 1965).

Social Judgment Theory (Sherif et al., 1965) was applied to the study in three ways. First, the theory supported the focus group question designed to elicit ideas from the participants about ways to increase parent-child communication about sex and contraception. Second, the individual sexual-risk communication experiences of African American and White 18-19 year old males and their partners were explored. The focus group participants were asked about the specific details of the conversation(s) about sex and contraception with their partners and how receptive their partners were to the conversations. Lastly, the theory supported the final focus group question designed to elicit ideas from the participants for intervention strategies to increase partner communication about sex and contraception.

Please refer to Appendix A for the definitions of the study's constructs.

Public Health Significance

While considerable research has been conducted to identify the effects of parent-child sexual risk communication on the sexual risk behaviors of adolescents, the majority of the literature has focused on the impact on females' sexual risk behaviors (Coleman & Ingham, 1999; DiClemente et al., 2001; Hutchinson et al., 2003). This research has been used to develop promising interventions, such as HORIZONS (DiClemente et al., 2009), that target adolescent females to reduce sexual risk behaviors. There are few qualitative studies that have deeply examined this topic for purposes of informing the development of an adolescent male sexual risk reduction intervention, which is the long-term goal of this research. In addition, this study adds to the existing literature by examining the quality of conversations, in terms of the information that adolescent males perceive as accurate and trustworthy.

Although limited, the studies that have explored adolescent partner communication from the males' perspective were conducted more than ten years ago. Often, these studies (Landry & Camelo, 1994; Gilmore et al., 1996) reflect the mid-1990s emphasis on HIV/AIDS prevention. Given the time lapse and the evolving perspective of HIV/AIDS from a death sentence to a chronic disease (Mandell, 2010), there is reason to explore males beliefs, attitudes and behavioral intentions related to contraception and partner communication. Results from this study may be used to inform the development of intervention strategies to promote increased partner communication about sex and contraception.

Study Purpose

The purpose of this qualitative study was to retrospectively explore African American and White 18-19 year old males' communication experiences with their parents and partners about sex and contraception, and their attitudes and beliefs about sex, pregnancy, and contraception. This study provided insight into the characteristics and quality of parent-son sexual risk communication from the son's (18-19 year old African American and White male) perspective. In addition, the study gathered information from the male late adolescent perspective about how to promote improved parent sexual risk-communication and partner communication related to contraception.

Specific Aims

This study addressed the following specific aims.

Specific Aim 1: To explore African American and White 18-19 year old males' experiences of sexual risk communication with their parents during early adolescence and how these experiences affected their attitudes and beliefs about sex, pregnancy, and contraception.

Specific Aim 2: To explore African American and White 18-19 year old males' experiences of sexual risk communication with their partners, how these experiences were affected by parental sexual risk communication during early adolescence, and how to promote sexual risk communication among partners.

Public Health Implications

In 2010, a total of 367,752 infants were born to women aged 15–19 years, for a live birth rate of 34.3 per 1,000 women in this age group (Hamilton et al., 2011). This was a record low for U.S. teens in this age group, and a drop of 9% from 2009 (Hamilton

et al., 2011). Birth rates fell 12% for women aged 15–17 years, and 9% for women aged 18–19 years (Hamilton et al., 2011). Nearly two-thirds of all teen pregnancies and births are to older teens age 18 to 19 years old (Suellentrop, 2010).

Despite these declines, the U.S. teen pregnancy, birth, sexually transmitted disease, and abortion rates are substantially higher than those of other western industrialized nations (Singh & Darroch, 2000). Furthermore, significant racial and ethnic disparities also exist within the U.S (Matthew et al., 2010). In 2009, birth rates for African American teens (59.0 per 1,000 females) and Hispanic teens (70.1 per 1,000 females) were more than twice that of white teens (25.6 per 1,000 females) (Pazol et al., 2011).

In 2010, the CDC added *Adolescent Health* as a stand-alone topic area to Healthy People 2020. The goal is to improve the healthy development, health, safety, and well-being of adolescents and young adults. Related to this area, the goal for *Family Planning* is to improve pregnancy planning and spacing, and prevent unintended pregnancy (USDHHS, 2010). Three objectives of the *Family Planning* goal are related to this study: 1) increase the proportion of adolescents who talked to a parent or guardian about reproductive health topics before they were 18 years old; 2) increase the proportion of adolescents aged 17 years and under who have never had sexual intercourse; and 3) increase the proportion of sexually active persons aged 15 to 19 years who use condoms to both effectively prevent pregnancy and provide barrier protection against disease (USDHHS, 2010).

Research shows that when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of

sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). The influence of parental sexual risk communication on adolescent sexual risk-taking behavior is well documented (Jaccard et al., 1996; DiClemente et al., 2001; Hutchinson et al., 2003; Clawson & Reese-Weber, 2003; Kirby, 2007; Somers & Ali, 2011). Although there is a great deal of literature in this field, there are few qualitative studies that have deeply examined this topic for purposes of informing the development of adolescent male sexual risk reduction interventions.

Furthermore, while parent-daughter sexual risk communication is well documented in the literature, parent-son communication is not as well understood (DiClemente et. al, 2001; Hutchinson, 2002; Hutchinson et. al, 2003). This study gained insight into the characteristics and quality of parent-son sexual risk communication from the son's (18-19 year old African American and White male) perspective. In addition, the study explored the impact of parent-son sexual risk communication during childhood/early adolescence on future partner communication about sex and contraception in late adolescence/early adulthood.

This research can be used to develop pilot interventions to support: 1) the improvement of sexual risk communication among African American and White males and their parents; and 2) the improvement of partner communication about sex and contraception among adolescent African American and White males and their partners.

CHAPTER 3

METHODS

This chapter begins with a summary of the previous research that informed and guided the development of this study. The study methodology is then described for the research conducted.

Preliminary Research

The development of the study was based on preliminary work conducted by the South Carolina Campaign to Prevent Teen Pregnancy (SCCPTP), where the researcher currently works as a research and evaluation coordinator. This preliminary work was completed as part of two larger projects implemented by SCCPTP. The purpose of one initiative was to reduce teen pregnancy rates among older youth (18-19 years olds) in South Carolina by working with colleges and universities to increase access to reproductive health information and services. The second project was specifically designed to reduce teen pregnancy rates in Horry and Spartanburg counties of South Carolina.

Nearly two-thirds of all teen pregnancies and births are to older teens age 18 to 19 years old (Suellentrop, 2010). Although this population can be difficult to reach, college campuses offer a concentration of older youth. In the report *Population Left Behind*, SCCPTP documented the lack of available sexual health information and health services on two and four year college campuses in South Carolina (Kershner & Flynn, 2009). The

report made the recommendations to increase the availability of sexual health information and to increase the availability of affordable and accessible contraceptive options for two and four year college students through creative, innovative and consistent mechanisms (Kershner & Flynn, 2009). Subsequently, SCCPTP implemented an initiative to work with college campuses to address these recommendations with the long-term goal of reducing teen pregnancy rates among older youth. *Population Left Behind* also demonstrated the need for additional research to be conducted with older youth (18-19 years old) “to identify best practices and promising approaches in providing sexual health information and services” (Kershner & Flynn, 2009). The current study’s sample population was based on this preliminary research and work on college campuses.

In additional preliminary work, the SCCPTP commissioned the University of South Carolina’s Institute for Public Service and Policy Research (USC IPSPR) to conduct a study of public opinion related to parent-child communication about sex and contraception. The main survey period was from March 25 to May 5, 2011. In Horry County, 477 adults completed interviews, while in Spartanburg 483 adults completed interviews. In each county, parents of children between the ages of 10 and 19 were oversampled; 262 of the respondents in Horry County and 264 of those in Spartanburg were parents of a child in this age group. The survey results were weighted so that the characteristics of the sample reflect those of the counties’ population, age 18 or older, on the basis on age, sex, and race. In Horry County, the demographics of the sample included 52% female, 14% African American and 85% White. In Spartanburg County, the demographics of the sample included 52% female, 20% African American and 78% White. Key findings from the survey are detailed below (USC IPSPR, 2011).

Parents in both Horry and Spartanburg Counties generally felt comfortable in talking with their teens about sex. In Horry County, 91.2% of parents strongly agreed that they talk openly with their child about waiting to have sex; 69.7% strongly agreed that they talk openly with their child about using condoms or birth control methods; 63.2% said they felt very comfortable talking with their child about sex or sexual intercourse; and 61.9% were very comfortable talking with their teen or pre-teen about condoms or birth control methods. In Spartanburg County, 86.5% of parents strongly agreed that they talk openly with their child about waiting to have sex; 58.3% strongly agreed that they talk openly with their child about using condoms or birth control methods; 58.5% said they felt very comfortable talking with their child about sex or sexual intercourse; and 54.2% were very comfortable talking with their teen or pre-teen about condoms or birth control methods. (USC IPSPR, 2011)

Although parents generally felt that they talk openly with their children about sex, the community perception was less certain about the extent to which such discussions occur. While more than 98% of Horry County respondents strongly or somewhat agreed that parents should talk openly with their children about waiting to have sex, only 25.5% strongly agreed and 31.4% agreed somewhat that most parents do so. Similarly, while about 95% believe either strongly or somewhat that parents should talk openly with their children about using condoms or birth control methods, only 26.8% strongly agreed that parents in their community do so, and another 35.6% agreed somewhat. More than 97% of Spartanburg County respondents strongly or somewhat agreed that parents should talk openly with their children about waiting to have sex, but only 25.2% strongly agreed and 36.2% agreed somewhat that most parents do so. Similarly, while about 93% believe

either strongly or somewhat that parents should talk openly with their children about using condoms or birth control methods, only 21.0% strongly agreed that parents in their community do so, and another 37.8% agreed somewhat. (USC IPSPR, 2011)

The striking discrepancies between what parents say they are doing (in terms of talking to their teens about sex and contraception) and what community members (including parents) think that most parents are doing, highlighted an area for additional research. This finding leads us to believe that it is possible that parents may be overestimating the amount of open communication that is taking place between themselves and their children about sex and contraception.

Study Purpose

The purpose of this study was to learn about African American and White 18-19 year old males' communication experiences with their parents and partners about sex and contraception, and their attitudes and beliefs about sex, pregnancy, and contraception. In addition, the study gathered information from males about ways to promote open, honest conversations about sex and contraception with their partners. The study addressed gaps in the literature by focusing on male perspectives, and by utilizing focus groups to explore the specific content of parental discussions about sex and contraception, and the influence that these discussions have on partner communication in late adolescence. Both African American and White males were included in the focus groups to present the opportunity to examine racial differences. In addition, information was gathered from the male late adolescent perspective about how to promote improved parent sexual risk-communication and partner communication related to contraception.

Overview of Research Design

The study design was a combination of phenomenology (i.e., attempting to understand the lived experience of adolescent males) and modified grounded theory using a constant comparative method to determine if observations are holding true to the theory constructs of interest (Van Manen, 1990; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Qualitative data was collected through focus groups. Widely used, focus group research involves collecting qualitative data from a small group of people in an informal discussion ‘focused’ around a particular topic of interest (Morgan, 1998; Wilkinson, 2004; Krueger & Casey, 2000; Onwuegbuzie et al., 2009). In qualitative studies, the objectives are to describe the range of experiences in the population and to capture the variability of responses. Focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from “information-rich cases” for the development of future programs and interventions (Patton, 2002). Some of the advantages of using the focus group approach include: 1) obtaining qualitative data from many participants in a relatively fast and efficient manner (Krueger & Casey, 2000); 2) creating a socially-oriented environment that produces information that can be difficult to obtain through interviews and helps participants feel safe to share experiences (Peters, 1993; Vaughn et al., 1996); and 3) allowing interaction among participants that can yield important data and clarify perspectives – thus enriching the quality of the data (Morgan, 1988; Duggleby, 2005).

Study Aims and Research Questions

Specific Aim 1: Explore African American and White 18-19 year old males’ experiences of sexual risk communication with their parents during early adolescence and

how these experiences affected their attitudes and beliefs about sex, pregnancy, and contraception. To achieve Specific Aim 1, qualitative research was conducted with African American and White 18-19 year old males. Focus groups were used to elicit information about participants' attitudes and behaviors towards sex and contraception learned in the context of sexual risk communication with their parents during early adolescence and how it affects their attitudes, beliefs and behaviors in late adolescence.

Specific Aim 2: Explore African American and White 18-19 year old males' experiences of sexual risk communication with their partners, how these experiences were affected by parental sexual risk communication during early adolescence, and how to promote sexual risk communication among partners. To achieve Specific Aim 2, qualitative research was conducted with African American and White 18-19 year old males. Focus groups were used to elicit information about participants' experiences communicating with their partners about sex and contraception and how this may have been influenced by their own communication experiences with their parents/guardians. In addition, focus groups were used to identify key intervention strategies to promote increased partner communication about sex and contraception.

Specific research questions addressed include:

1. What experiences did African American and White 18-19 year old males have with their parents communicating with them about sex and contraception when they were young?
2. What are African American and White 18-19 year old males' beliefs and attitudes about sex and contraception?

3. What do African American and White 18-19 year old males think should be the nature of the communication between parents and their children?
4. What are the experiences that African American and White 18-19 year old males have had with communicating with their partners about sex and contraception, and what is the potential connection to childhood parental communication?
5. What do African American and White 18-19 year old males think about pregnancy at this point in their life?
6. What do African American and White 18-19 year old males think is their role in the use of contraception?
7. What do African American and White 18-19 year old males think should be the nature of strategies promoting partner communication about sex and contraception?

Study Procedures

Provision for Human Subjects

Formal approval was obtained from the University of South Carolina's Institutional Review Board (IRB) for the study because human subjects were involved. Data collection, analysis, and disposal was managed in accordance with the University of South Carolina's IRB policies and procedures.

Study Participants and Sampling

To be included in the study, participants were: 1) African American or White; 2) male; 3) age 18-19 years old; 4) sexually-active heterosexual; 5) childless; 6) not living in a household where they are the parental figure to a child/children; 7) able to read and

speak English fluently; 8) without cognitive challenges that would prevent them from participating or responding to written and oral questions; and 9) willing to engage in a group discussion with other males about sexual risk communication.

For this study, purposive sampling was used to identify participants. This sampling strategy is useful because it allows the researcher to purposefully select participants who can provide the desired information for the study (Patton, 1990). Additional recruitment of study participants occurred via word-of-mouth, or the commonly used “snowball sampling” technique (Biernacki & Waldorf, 1981). Participants meeting the inclusion criteria were chosen because the researcher is interested in using the focus group findings to develop interventions supporting: 1) the improvement of sexual risk communication among African American and White males and their parents; and 2) the improvement of partner communication about sex and contraception among adolescent African American and White males and their partners.

This study stratified the sample by race with focus groups held separately with African American males and White males. This stratification is based on the finding from the literature review that different races may have unique family dynamics, parenting styles, distinct attitudes and sexual behaviors (CDC, 2010). Both African American and White males were included in the focus groups to present the opportunity to examine racial differences.

Sample Size

Sample size is based on the qualitative research principles of saturation and sufficiency (Strauss & Corbin, 1998; Morse & Field, 1995; Seidman, 1998; NIH, 1999; Glaser & Strauss, 1967). Saturation focuses on the data acquired from participants, and

according to Strauss and Corbin (1998) refers to the point in the study at which analysis of the focus group data results in no new properties or dimensions. Morse and Field (1995) add the greater the amount of useful data obtained from participants, the smaller number of participants required for saturation; thus, well-devised and conducted focus groups with skilled probing reduces the need for large sample sizes in order to fully assess the phenomena under study. Unlike saturation, sufficiency relies on the nature of the participants.

For this study, a total of six focus groups were conducted with African American and White adolescent male (18-19 years old) participants. Three focus groups were conducted with only African American adolescent males (n=14) and three focus groups were conducted with only White adolescent males (n=16).

Participant Recruitment

Recruitment sites (i.e., community-based organizations, recreation facilities, local employers, apartment complexes, churches, local college campuses and organizations) in the Columbia community were identified by the researcher. Flyers with a description of the study, inclusion criteria, and contact information for participating in the study were shared with each of the sites. The majority of study participants were recruited via word-of-mouth, or the commonly used “snowball sampling” technique (Biernacki & Waldorf, 1981).

To enroll in the study, interested participants were asked to either email or call the researcher. All potential participants were screened to ensure they met the study’s inclusion criteria.

Data Collection Procedures

From June through July 2012, a total of six focus groups – three with African American males and three with White males – were conducted. The groups were held at either the University of South Carolina or the South Carolina Campaign to Prevent Teen Pregnancy. The groups were scheduled at the convenience of participants: three groups occurred during lunch time hours (i.e., 11:00 a.m. – 1:00 p.m.) and three groups occurred during dinner time hours (i.e., 5:00 p.m. – 7:00 p.m.). Each focus group was held in a private, quiet room with a large table and comfortable chairs, in a set-up that allowed participants to be face-to-face during the discussion.

To increase participants' comfort level during the discussion, the focus groups were conducted by two African American males aged 30-40 years old. The two moderators worked under the supervision of the researcher and had previous experience facilitating focus groups with young people. The focus groups, ranging in length from 90-120 minutes, were digitally audio and manually recorded. The researcher served as the observer/note-taker during the focus groups and kept detailed notes of the participants' responses and characteristics of group dynamics.

To ensure consistency, the moderators used a detailed focus group implementation guide, which included a script for the moderator leading the discussion. The researcher and moderators participated in a training session, where the focus group implementation guide and Institutional Review Board (IRB) procedures were reviewed.

Focus Group Protocol

Participants, in accordance with the University of South Carolina Institutional Review Board (IRB) guidelines, were clearly informed both in writing and verbally of the

purpose of the focus groups. Informed consent was obtained from each participant; and, assurance was given that the information discussed would be kept confidential.

Participants were also informed that they could withdraw from the discussion at any time without repercussions.

At the beginning of each focus group, the moderator acknowledged the tape recorders and explained why the session was being recorded and answered related questions. Then, the moderator reviewed focus group ground rules, such as using a clear, audible voice and speaking one at a time.

Once the ground rules had been explained, participants were asked to complete a 13-item, paper-pencil, sociodemographic questionnaire developed to provide descriptive information (e.g., gender, age, race, education, family background, sexual history.) about the participants. The participants were asked to not write their name or other identifying information on the questionnaire. The data collected from the sociodemographic questionnaire was used to provide a group level summary of the characteristics of each group.

The discussion portion of the focus group began after participants completed the questionnaire. Participants were asked to introduce themselves using only a first name or an alias. Focus group questions were asked in the order of the script in the focus group implementation guide. When a question was asked, participants were given time to express their opinion and describe their experiences. The focus group questions were carefully written to provide answers to the research questions. Moderators used comprehensive probes (Stewart & Shamdasni, 1994) to obtain and clarify responses from

participants. For example, the moderator may ask “Would you give me an example of what you mean?” or “I’m not sure I understand, could you explain further?”

Refreshments were provided during the groups and, at the close of the sessions, participants were given a \$25 gift card in appreciation for their time. Contraception and STI/STD prevention health education materials (e.g., brochures, pamphlets, and community resource information) were also offered to participants.

Pilot Test

In June 2012, the focus group implementation guide and sociodemographic questionnaire were pilot tested by the researcher with a convenience sample (n=7) of African American males in their early to mid-twenties. The pilot test served as a test run of the procedures for the study, to assess the understandability of questions, and to time the length of the discussion. No revisions were made to the implementation guide, questions, or procedures based on the pilot test.

Data Management

Each focus group session was audio recorded. High-quality recording equipment was used to ensure quality and complete recording of all comments. The researcher monitored the recorder during each focus group to make sure that it was functioning properly. Following each focus group, the researcher downloaded the audio (wav) files from the recorder to an on-line transcription service. The digital audio files from the focus groups were then transcribed verbatim into Microsoft Word by the (on-line) professional transcription service with experience in social and behavioral research. The transcription service emailed complete transcripts of each focus group to the researcher. For confidentiality purposes, all transcripts were edited to remove all personal identifiers.

The researcher compared the digital audio files to the transcripts to ensure that they were consistent, accurate, and de-identified. Once the accuracy of transcripts was confirmed, the digital audio files were deleted from all computer storage devices and the devices were reformatted. All electronic copies of the transcripts were password protected and hard copies were destroyed according to the terms stipulated by University of South Carolina Office of Research Compliance. Manual field notes were referred to for clarification when necessary.

Data Analysis

Verbatim transcripts of the audiotapes, observer notes, and the sociodemographic participant questionnaires were the primary data for analysis. Content analysis was used in analysis and interpretation of the data. The Microsoft Word text files (verbatim transcripts) were entered into QSR NVivo v.10.0 (2012), a qualitative data management program, for coding, text retrieval, intensive data organization, and content analysis. When necessary, observer notes were referred to for clarification. Data collected from the sociodemographic questionnaires was entered and analyzed using SPSS 19.0. Univariate analysis was run to provide descriptive statistics (e.g., frequencies, percents, means, etc.) for all variables.

In order to develop a codebook, one transcript each from the focus group types (African American and White) were selected at random and independently read by the researcher and the researcher's advisor. Each reader used the discussion guide as an initial framework and, when encountering an idea or meaning, manually marked the text segments and assigned a semantic code. The readers compared their ideas and codes to determine if they arrived at similar interpretations of the data. During this "open coding"

process consensus was reached about the definition of each code and a list of codes was agreed upon and finalized (Strauss & Corbin, 1998). A master code book was drafted by integrating and conceptually organizing the lists of codes. Each transcript was then re-coded using this master codebook, and when necessary, new codes were added to the codebook.

To obtain inter-coder agreement, transcript excerpts from each focus group type were manually coded independently by the researcher and advisor. Afterwards, the researchers met face-to-face and counted the number of times they agreed on codes and disagreed on codes. The number of matched codes was divided by the number of mismatched codes plus the total number of matched codes. This fraction indicated the percent of coder agreement; inter-coder agreement of .80 was achieved for the transcripts.

QSR NVivo allows for on-screen coding and analysis of large amounts of text across multiple themes, participant responses, and group types. By using QSR NVivo's output function, all of the coded data were printed out by code type, reviewed for accuracy, and examined for links to other codes. This "axial coding" process was used to connect code categories and to identify relationships between codes which are suggestive of themes (Strauss & Corbin, 1998). Additionally, comparing and contrasting focus group themes within and across groups ("constant comparison method") detected similarities and differences in the data (Strauss & Corbin, 1998). Verbatim quotes from the focus group participants were used to validate the researcher's coding, interpretation, and conclusions.

Trustworthiness of the Data

Although there are no perfect methods for evaluating the validity of the data or trustworthiness of conclusions, there are accepted techniques for increasing the credibility of qualitative research findings (Onwuegbuzie & Leech, 2007). Leaving an audit trail and member checking are two of these recognized strategies.

The researcher may leave an audit trail in the form of field notes and memos that have been kept throughout the study design, implementation and analysis phases (Halpern, 1983). Memos may record thoughts about patterns in the data and document how personal experiences or bias influenced the researcher's decisions throughout the study (Halpern, 1983; Miles & Huberman, 1994). Research memos written during the study are included in Appendix H and notable findings will be summarized with the results.

Member checking is another technique for assessing the “truth value” of the qualitative research (Onwuegbuzie & Leech, 2007). Member checking, also known as informant feedback, requires the researcher to systematically obtain feedback from the study participants about data interpretations and conclusions (Gupa & Lincoln, 1989). Member checking may be formal or informal and occurs continuously throughout the study. According to Maxwell (1992), member checking is “the most effective way of eliminating the possibility of misrepresentation and misinterpretation of the voice” of the study participants.

In this study, the member checking strategy was employed through two approaches. First, the researcher obtained necessary clarification of comments from the study participants at the end of each focus group. In addition, the final question of the

focus group implementation guide provided the participants with an opportunity to share additional thoughts or comments. Secondly, at the conclusion of each focus group, the researcher requested volunteers who would agree to participate in a follow-up conversation. After the transcripts were coded and analyzed, the researcher contacted a subset of the study volunteers (n=3) and reviewed the initial interpretation of findings emergent themes. Volunteers were asked if the themes accurately represented the essence of their focus group conversations. Relevant information from the interviews will be summarized in the results section.

CHAPTER 4

RESULTS

Manuscript 1: Exploring Adolescent Males Communication Experiences with their Parents about Sex and Contraception¹

¹ Galloway, C.T., Corwin, S.J., Richter, D.L., Prince, M.S., Simmons, D.S. To be submitted to *Family Relations*.

ABSTRACT

Increasing parent-child communication about sex and contraception is identified as a protective factor that is most amenable to change directly by a teen pregnancy prevention program. The purpose of this study was to explore African American and White 18-19 year old males' sexual risk communication with their parents during early adolescence and how these experiences affected their attitudes and beliefs about sex and contraception. From June through July 2012, a total of six focus groups (N=30) were conducted. Qualitative coding and analysis revealed themes related to parenting style, males experiences communicating with their parents about sex and contraception, and beliefs and attitudes about sex and contraception. Supporting qualitative data are presented in connection with each theme. This study gained insight about the characteristics and quality of parent-son sexual risk communication from the son's perspective. Implications for interventions promoting improved parent-child sexual risk communication are discussed.

Key Words: Parent-child communication, Teen Pregnancy, Sex, Contraception, Males

INTRODUCTION

Teen pregnancy prevention is one of the Centers for Disease Control and Prevention's top six priorities, a "winnable battle" in public health, and of vital importance to the health and quality of life for youth in the United States (CDC, 2012). This adolescent health issue is a prevention priority because of its substantial impact on the teen parent, their children, families and society as a whole. Pregnancy and birth are significant contributors to high school drop out rates among girls (Perper et al., 2010). The children of teenage mothers are more likely to have lower school achievement, to have lower high school graduation rates, to have more health problems, to have increased

likelihood of being incarcerated at some time during adolescence, to become a teen parent, and to face unemployment as a young adult (Hoffman, 2008). Teen pregnancy accounts for nearly \$11 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers (NCPTUP, 2011).

In 2010, a total of 367,752 infants were born to women aged 15–19 years, for a live birth rate of 34.3 per 1,000 women in this age group (Hamilton et al., 2011). This was a record low for U.S. teens in this age group, and a drop of 9% from 2009 (Hamilton et al., 2011). Birth rates fell 12% for women aged 15–17 years, and 9% for women aged 18–19 years (Hamilton et al., 2011). Nearly two-thirds of all teen pregnancies and births are to older teens age 18 to 19 years old (Suellentrop, 2010).

Despite these declines, the U.S. teen pregnancy, birth, sexually transmitted disease, and abortion rates are substantially higher than those of other western industrialized nations (Singh & Darroch, 2000). Furthermore, significant racial and ethnic disparities also exist within the U.S (Matthew et al., 2010). In 2009, birth rates for African American teens (59.0 per 1,000 females) and Hispanic teens (70.1 per 1,000 females) were more than twice that of white teens (25.6 per 1,000 females) (Pazol et al., 2011).

Research indicates when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007).

Increasing parent-child communication about sex and contraception is identified as a protective factor that is most amenable to change directly by a pregnancy prevention program (Kirby, 2007).

REVIEW OF LITERATURE

Parenting Styles

The impact of parent-teen communication depends on overall parenting style, including the degree of parent-child closeness (Miller et al., 2001). In the late 1960s, Diane Baumrind revised the concept of parenting style to capture normal variations in parents' attempts to control and socialize their children (Baumrind, 1966). Parenting style encapsulates two important elements of parenting: parental responsiveness (i.e., parental warmth, supportiveness, closeness), and parental demandingness (i.e., behavioral control) (Baumrind, 1991). Baumrind (1991) believed that parents may differ in the extent and style that they try to control or socialize their children, but that the primary role of all parents is to influence, teach, and control their children.

Baumrind (1991) described four types of parents: “authoritative,” “authoritarian,” “indulgent,” and “rejecting-neglecting”. “Authoritative” parents are both responsive and demanding; they provide clear standards for their children’s conduct but are not intrusive or restrictive (Baumrind, 1991). “Authoritarian” parents are highly demanding and directive, but not responsive; they provide an orderly environment and expect orders to be obeyed without explanation (Baumrind, 1991). “Indulgent” (also called “permissive”) parents are more responsive than demanding; they do not require mature behavior, allow considerable self-regulation, and avoid confrontation (Baumrind, 1991). “Rejecting-neglecting” (also called “uninvolved”) parents are neither demanding nor responsive;

they do not structure and monitor, and are not supportive (Baumrind, 1991). Baumrind's (1991) parenting style typology should not be understood to include deviant parenting, such as might be observed in abusive or neglectful homes.

Parent-Child Sexual Risk Communication

Kirby's *Emerging Answers* (2007) provides an overview of primary research results on factors that influence sexual risk-taking behaviors in adolescence. One of the key findings from this seminal report is related to parent-child communication. Research indicates when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). Some of studies that provided basis for Kirby's conclusion, and more recent research are detailed below.

Jaccard et al. (1998) surveyed 745 African American male and female adolescents (ages of 14-17 years old) and their mothers/female caregivers on measures related to family influences on adolescent sexual behavior, including adolescent sexual behavior, parental orientations towards premarital sex, satisfaction with the relationship, global communication about sex, communication about specific topics, demographic variables, and peer perceptions. Parent and adolescent reports about whether specific sexually based conversations occurred did not match (Jaccard et al., 1998). One of this study's conclusions was that mothers tend to account for all attempts to talk to their teens about sex, whereas, the teens likely only reported communication that they considered noteworthy (Jaccard et al., 1998). Findings also showed that adolescent perceptions and reports were more predictive of sexual behavior than maternal reports (Jaccard et al.,

1998). The researchers conceded that there are errors in both efforts to measure the true amount of sexual risk communication, but a stronger case can be made for using teen reports for the purposes of predicting teen sexual behavior (Jaccard et al., 1998).

Utilizing key constructs from the Theory of Planned Behavior (Ajzen, 1985), researchers focused on the extent to which parent sexual risk communication, specifically from mothers, influenced the sexual behaviors of their 12 to 19 year old adolescent daughters (Hutchinson et al., 2003). Three self-reported sexual risk behaviors were evaluated from a sample of 219 (68% African American; 32% Latina) sexually experienced females: number of male sexual partners, number of episodes of sexual intercourse, and number of episodes of unprotected intercourse (Hutchinson et al., 2003). The study found that higher levels of mother–daughter sexual risk communication were associated with fewer episodes of sexual intercourse and unprotected intercourse at 3-month follow-up (Hutchinson et al., 2003). Mother–daughter sexual risk communication was not significantly associated with adolescents’ reports of numbers of male sexual partners (Hutchinson et al., 2003). The study findings further supported the notion that mothers who communicate with their daughters about sex can have a positive impact on some of their daughters’ sexual behaviors (Hutchinson et al., 2003). The study also identified several areas for future research. Because sexual communication patterns vary by the gender of both parent and adolescent (Dutra et al., 1999; Hutchinson, 2002), future studies should focus on fathers and sons. Qualitative approaches to studying parent-child sexual risk communication would also be useful by providing “richer data” about the how these interactions influence adolescent sexual behavior (Hutchinson et al., 2003).

Clawson and Reese-Weber's study (2003) examined the relationship between sexual risk-taking behaviors and the timing of parent-adolescent sexual communication. The study, based on Socialization Theory (Philliber, 1980), documented that timing is an important factor in predicting sexual risk-taking behavior. Two hundred and fourteen participants (101 males and 113 females) between the ages of 18 and 21 years of age completed the study questionnaire for extra course credit; the sample was 82% White and 9% African American. Clawson and Reese-Weber (2003) concluded that emphasis should be placed on encouraging parents to discuss sexuality early in their adolescents' development, preferably prior to initiation of sexual activity. The study also suggested several areas for additional research including having a sample with more diversity, especially looking at African American adolescents, who are more likely to be sexually active than Whites (CDC, 2010). Future research should also focus on identifying if discussion of certain topics (e.g., pregnancy, sexually transmitted infections) are more strongly correlated with sexual risk-taking behavior than others (e.g., prostitution), and investigating the specific content of parent-child sexual risk communication and perceived parental attitudes related to discussions (Clawson & Reese-Weber, 2003).

According to de Visser (2005), parent-child communication about sexuality is an area which deserves further attention from both researchers and those involved in health promotion. de Visser's (2005) qualitative study focused on young adults' (18-25 year old males and females; the study did not define race of participants) beliefs about how to promote condom use for sexually transmitted infections (STI) prevention. Some of the focus group participants stated that parents could play a greater role in sexuality education (de Visser, 2005). The study found that there is a need for exploring the best

ways to develop parents' skills and motivations for communicating with their children about sexual health (de Visser, 2005).

In a recent study, Somers and Ali (2011) examined the role of parents on adolescent sexual risk-taking behavior in a more comprehensive manner, and not just focused on one or two predictor variables. The study collected adolescents' perspectives about multiple variables, including mother and father approval of premarital sex, parent-adolescent communication about sexuality, and parental social support (Somers & Ali, 2011). Study participants were 194 male (n=89) and female (n=105) students in the 7th and 8th grades (12-15 years old) from two middle schools; all were African-American or Hispanic of lower socioeconomic status (Somers & Ali, 2011). None of these parenting variables predicted adolescents' intentions to avoid pregnancy, plans sexual intercourse debut, or plans for continuing sexual intercourse if already started (Somers & Ali, 2011). The researchers concluded that it is likely that the teens in the study seeking parental communication about sexuality were already curious about or engaging in sexual behavior (Somers & Ali, 2011). This finding necessitates more, earlier communication by parents (Somers & Ali, 2011). In fact, older adolescent age has been suggested as the strongest predictor of sexual communication and behavior in prior research (Somers & Paulson, 2000).

Males Beliefs and Attitudes about Sex and Contraception

While more than fifteen years old, a focus group study was conducted with 27 inner city African American young men ages 15 to 19 years to assess the attitudes and beliefs associated with decisions to have sexual intercourse and use condoms (Gilmore et al., 1996). Four sets of beliefs emerged as key themes: what it means to be a man, the

good (physical pleasure) and bad (disease and unwanted pregnancies) things about sexual intimacy, condom use and AIDS as a serious threat (Gilmore et al., 1996). Although the young men generally endorsed condom use, there were numerous contradictory comments; such as condoms diminish sexual pleasure and women requesting condom use indicates the potential presence of sexually transmitted diseases (Gilmore et al., 1996). Ultimately, decisions about the use of condoms appeared to be correlated with the young men's perception of the woman being "clean" or "dirty" and how long he has known her (Gilmore et al., 1996). Another key finding suggests that there is a belief or fear that one's partner is lying, which may hinder partner communication about birth control and condom use (Gilmore et al., 1996). The researchers acknowledged their "high risk" sample may not be representative, but encouraged future studies that focus on relationships between African American men and their female partners (Gilmore et al., 1996).

CONCEPTUAL FRAMEWORK

The conceptual framework for this study is composed of constructs from three theories: Socialization Theory (Philliber, 1980), Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991) and Social Judgment Theory (Sherif et al., 1965). [N.B. nomenclature in the literature uses "parent-child," but the researchers recognize that many children/youth are not raised in traditional households. In this study, therefore, parent or parental was used to represent an adult guardian or significant adult in the child's life.]

Socialization Theory is based on the idea that children and adolescents learn attitudes and behaviors early in life from adult role models, such as parents (Philliber, 1980). Typically, parents are the first and most important influence on their children. The attitudes and behaviors modeled by parents are learned by their children and manifested in adolescence and adulthood (Philliber, 1980). Parents' behaviors, such as having open and honest discussions with their children about risky sexual activities, will result in certain adolescent behaviors, such as delaying initiation of sexual intercourse (Miller & Fox, 1987). Based on this theory, an adolescent's sexual behavior can be partially predicted by how he or she was socialized by their parents. Socialization Theory has provided the basis for several related studies, including Clawson and Reese-Weber's (2003) examination of parent-adolescent sexual communication in relation to adolescent sexual behavior. This current study explored African American and White 18-19 year old males' attitudes and behaviors in the context of their experiences of sexual risk communication with their parents during early adolescence.

The Theory of Planned Behavior (TPB) assumes that *behavioral intention* is the most important determinant of a given behavior (Ajzen, 1985; Ajzen, 1991). According to TPB, a person's attitude towards a behavior (*attitude toward behavior*) and whether individuals who are important to the person approve or disapprove of the behavior (*subjective norm*) are the primary determinants of behavioral intentions (Ajzen, 1985; Ajzen, 1991). In this study, African American and White 18-19 year old males attitudes and beliefs towards sexual risk-taking behaviors were explored in the context of their experiences of communicating with their own parents about sexual risks and using contraception during childhood.

The final component of the current study's conceptual framework is from Social Judgment Theory (Sherif et al., 1965), which is an interpersonal communication theory. Social Judgment Theory (Sherif et al., 1965) explains how individuals judge the messages they receive. According to the theory, a listener judges how much a message agrees or disagrees with his or her own attitude or belief system (Sherif et al., 1965). The theory supported the focus group question designed to elicit ideas from the participants about ways to increase parent-child communication about sex and contraception.

PURPOSE AND RESEARCH QUESTIONS

The purpose of this qualitative study was to retrospectively explore African American and White 18-19 year old males' sexual risk communication with their parents during early adolescence and how these experiences affected their attitudes and beliefs about sex, pregnancy, and contraception. This study gained insight into the characteristics and quality of parent-son sexual risk communication from the son's perspective. In addition, the study gathered information about how to promote improved parent-child sexual-risk communication. The study was guided by three research questions. First, "What experiences did African American and White 18-19 year old males have with their parents communicating with them about sex and contraception when they were young?" Second, "What are African American and White 18-19 year old males' beliefs and attitudes about sex and contraception?" Finally, "What do African American and White 18-19 year old males think should be the nature of the communication between parents and their children?"

METHOD

From June through July 2012, a total of six focus groups – three with African American males and three with White males – were conducted. This study stratified the sample by race with focus groups held separately with African American males and White males. This stratification was based on the finding from the literature review that different races may have unique family dynamics and parenting styles, and distinct attitudes and sexual behaviors (CDC, 2010). Both African American and White males were included in the focus groups to present the opportunity to examine racial differences.

PARTICIPANTS

For this study, purposive sampling was used to identify participants. This sampling strategy is useful because it allows the researcher to purposefully select participants who can provide the desired information for the study (Patton, 1990). Additional recruitment of study participants occurred via word-of-mouth, or the commonly used “snowball sampling” technique (Biernacki & Waldorf, 1981). Recruitment sites (i.e. community-based organizations, recreation facilities, local employers, apartment complexes, churches, local college campuses and organizations) in the Columbia community were identified by the researcher. Flyers with a description of the study, inclusion criteria, and contact information for participating in the study were shared with each of the sites. To enroll in the study, interested participants were asked to either email or call the researcher. All potential participants were screened to ensure they met the study’s inclusion criteria.

To be included in the study, participants were: 1) African American or White; 2) male; 3) age 18-19 years old; 4) sexually-active heterosexual; 5) childless; 6) not living in a household where they are the parental figure to a child/children; 7) able to read and speak English fluently; 8) without cognitive challenges that would prevent them from participating or responding to written and oral questions; and 9) willing to engage in a group discussion with other males about sexual risk communication.

The sample included 30 males (14 African American and 16 White). Table 4.1 presents demographic characteristics of the participants. The majority (83.3%) of participants indicated that they currently live with their family, which may be attributed to the fact that the groups took place in June when students are typically not living on campus. It should be noted that compared with African American males (28.6%), a greater percentage of White males (75.0%) lived with both biological/step-parents when they were young. There was a significant difference in the average age of first sexual intercourse among African American males ($M = 14.75$ years, $SD = 2.06$) as compared to White males ($M = 16.14$ years, $SD = 0.69$) in the sample; $t(28) = 2.54, p < 0.05$. None of the participants reported having biological children; however, over a fifth (21.4%) of African American males reported getting a female pregnant. No White males reported getting a female pregnant.

PROCEDURE

The study design was a combination of phenomenology, that is attempting to understand the lived experience of adolescent males, and modified grounded theory using a constant comparative method to determine if observations are holding true to the theory constructs of interest (Van Manen, 1990; Glaser & Strauss, 1967; Strauss & Corbin,

1998). Qualitative data was collected through focus groups. Widely used, focus group research involves collecting qualitative data from a small group of people in an informal discussion ‘focused’ around a particular topic of interest (Morgan, 1998; Wilkinson, 2004; Krueger & Casey, 2000; Onwuegbuzie et al., 2009). Focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from “information-rich cases” for the development of future programs and interventions (Patton, 2002).

The focus groups were conducted by two African American males aged 30-40 years old, trained by the researcher and who had previous experience facilitating focus groups with young people. The moderators used a detailed 9-item focus group implementation guide. Before each group began, informed consent was obtained from each participant. Participants completed a 13-item, paper-pencil, sociodemographic questionnaire developed to provide descriptive information (e.g., gender, age, race, education, family background, sexual history.) The focus group implementation guide and sociodemographic questionnaire were pilot tested by the researcher with a convenience sample (n=7) of African American males in their early to mid-twenties. No revisions were made to the implementation guide, sociodemographic questionnaire, or data collection procedures based on the pilot test.

Focus group questions were asked in the order of the script in the focus group implementation guide. When a question was asked, participants were given time to express their opinion and describe their experiences. The focus group questions were carefully written to provide answers to the research questions. Moderators used comprehensive probes (Stewart & Shamdasni, 1994) to obtain and clarify responses from

participants. For example, the moderator may ask “Would you give me an example of what you mean?” or “I’m not sure I understand, could you explain further?”

The focus groups, ranging in length from 90-120 minutes, were digitally audio and manually recorded. The researcher served as the observer/note-taker during the focus groups and kept detailed notes of the participants' responses and characteristics of group dynamics. Participants were given a \$25 gift card in recognition of their contribution to the study. Contraception and STI/STD prevention health education materials (e.g., brochures, pamphlets, and community resource information) were also offered to participants. The study was approved by the Institutional Review Board (IRB) at the University of South Carolina.

CODING AND DATA ANALYSIS

The digital audio files from the focus groups were transcribed verbatim into Microsoft Word by an (on-line) professional transcription service with experience in social and behavioral research. Verbatim transcripts of the audiotapes, observer notes, and the sociodemographic participant questionnaires were the primary data for analysis. Content analysis was used in analysis and interpretation of the data. The Microsoft Word text files (verbatim transcripts) were entered into QSR NVivo v.10.0 (2012), a qualitative data management program, for coding, text retrieval, intensive data organization, and content analysis. When necessary, observer notes were referred to for clarification. Data collected from the sociodemographic questionnaires was entered and analyzed using SPSS 19.0. Univariate analysis was run to provide descriptive statistics (e.g., frequencies, percents, means, etc.) for all variables.

In order to develop a codebook, one transcript each from the focus group types (African American and White) were selected at random and independently read by two of the researchers (CTG and SJC). Each reader used the discussion guide as an initial framework and, when encountering an idea or meaning, manually marked the text segments and assigned a semantic code. The readers compared their ideas and codes to determine if they arrived at similar interpretations of the data. During this “open coding” process consensus was reached about the definition of each code and a list of codes was agreed upon and finalized (Strauss & Corbin, 1998). A master code book was drafted by integrating and conceptually organizing the lists of codes. Each transcript was then re-coded using this master codebook, and when necessary, new codes were added to the codebook.

To obtain inter-coder agreement, transcript excerpts from each focus group type were manually coded independently by the two researchers. Afterwards, the researchers met face-to-face and counted the number of times they agreed on codes and disagreed on codes. The number of matched codes was divided by the number of mismatched codes plus the total number of matched codes. This fraction indicated the percent of coder agreement; inter-coder agreement of .80 was achieved for the transcripts.

QSR NVivo allows for on-screen coding and analysis of large amounts of text across multiple themes, participant responses, and group types. By using QSR NVivo’s output function, all of the coded data were printed out by code type, reviewed for accuracy, and examined for links to other codes. This “axial coding” process was used to connect code categories and to identify relationships between codes which are suggestive of themes (Strauss & Corbin, 1998). Additionally, comparing and contrasting focus

group themes within and across groups (“constant comparison method”) detected similarities and differences in the data (Strauss & Corbin, 1998). Verbatim quotes from the focus group participants were used to validate the researcher’s coding, interpretation, and conclusions.

Although there are no perfect methods for evaluating the validity of the data or trustworthiness of conclusions, there are accepted techniques for increasing the credibility of qualitative research findings (Onwuegbuzie & Leech, 2007). Leaving an audit trail and member checking are two of these recognized strategies. The researcher may leave an audit trail in the form of field notes and memos that have been kept throughout the study design, implementation and analysis phases (Halpern, 1983). Research memos written during the study and notable findings will be summarized with the results.

Member checking is another technique for assessing the “truth value” of the qualitative research (Onwuegbuzie & Leech, 2007). Member checking, also known as informant feedback, requires the researcher to systematically obtain feedback from the study participants about data interpretations and conclusions (Gupa & Lincoln, 1989). In this study, the member checking strategy was employed through two approaches. First, the researcher obtained necessary clarification of comments from the study participants at the end of each focus group. Secondly, at the conclusion of each focus group, the researcher requested volunteers who would agree to participate in a follow-up conversation. After the transcripts were coded and analyzed, the researcher contacted a subset of the study volunteers (n=3) and reviewed the initial interpretation of findings emergent themes. Volunteers were asked if the themes accurately represented the

essence of their focus group conversations. Relevant information from the interviews will be summarized in the results section.

FINDINGS

A summary of themes by race appears in Table 4.2. These themes, including racial similarities and differences are described in the sections that follow. The researcher believes saturation was reached after conducting at least two focus groups with each race.

Experiences Communicating with Parents about Sex and Contraception

Participants were asked to “Tell about the conversations that you had with your own parents about sex.” The participants’ responses revolved around four main topics: the parent messenger, the message, parenting style, and timing of the conversations.

The Parent Messenger

The themes that emerged related to the parent messenger were teens’ preference for talking with their fathers, how mothers often initiated conversations, and the importance of their parent-child relationship.

Preference for Talking with Fathers

Regardless of race, many participants said that they would rather talk to their father about sex and birth control. The reason provided for this preference was often related to traditional gender roles within the family, as illustrated by a White teen: “I think dads talk to boys and moms talk to girls.” Participants also expressed a preference for talking to their fathers “cause my dad can relate to me more.” Participants shared stories about their conversations with their fathers. For example, one White male

described a conversation where his father gave his permission for him to become sexually active by saying, “I do remember when I turned 18, my dad told me that he gave me his consent for me to have sex, you know, without feeling morally wrong or something like that 'cause I'm an adult now.” An African American adolescent depicted his conversation with his father as similar to one that he would have with a friend:

So I was like, damn, my daddy's talking about this [sex], so I'm going to try it. So I did. He was talking about sort of like, we'll just keep it real, he talked to me like I was one of his friends or something, like his Ace.

An African American teen recalled an explicit conversation where his father said, “go get what [you] can get...don't do nothing stupid, watch out for the crazy [girls].”

Mothers Often Initiated Conversations

Although most males said that they preferred to talk with their fathers about sex, their mothers did initiate the topic with their sons. This was the case in one single parent home, as described by a White teen: “My parents were also split up before, like right after I was born so my mom was actually pretty open about [sex]. But my dad's never really talked about sex specifically.”

During the focus groups, African American participants most often discussed their mothers' dominant role in talking with them about sex and birth control. An African American teen shared during a follow-up (member checking) interview, “guys want to hear from [the parent] that they are closest to.” One African American teen talked about his experience, “My mom came at it like Denzel off Training Day, she got right down to business.” Teens said that their mothers usually brought up the subject as a result of some event or discovery, such as “finding [an explicit] text message” or other

physical evidence of their son's sexual activity. As an example, one African American teen shared:

I got caught with lube. Like I just left a girl's house and I had some on a black tee shirt. She was washing clothes, she was like, [name], come here, and I was like, oh man. And then we had a conversation about it then.

An African American described his mother's discovery of his condoms:

You know my homeboy's he's like hey man take these [condoms]...so I grabbed a couple of 'em, had 'em in my pocket. I just came in the house from playing basketball... my mom was washing dishes. I walked in and threw my jeans over the chair in the kitchen all I hear is a [sound effect]. [My mom] said your stuff fell out. I looked back and I was like, ah man. She said, well now that I see that you got 'em. I just want you to make sure you know how to put 'em on and you know how to use 'em. She's said we're gonna go to the store and buy some cucumbers. I'm like oh, no we're not.

The Message

The themes that emerged related to parents' messages to their sons were the importance of condom use, abstinence, and pregnancy prevention.

Always Use a Condom

In every focus group, the majority of participants said that their parents' message to them during their conversations about sex and birth control emphasized the importance of wearing a condom. Few teens mentioned that their parents demonstrated how to correctly use a condom. Instead, comments relating to condom use were vague and directive, such as "be safe," "wrap up," "use protection," and "don't do anything stupid." Several males said that their parents provided them with condoms, including one African American teen, who said "they wanted me to be safe so they started buying me condoms."

Abstinence

Males talked about how their parents encouraged them to abstain from sex. These types of comments were offered in every African American group but only one White group. Participants recalled what their parents said to them about abstaining from sex; comments included, “wait to have sex, um, till you're married or whatever so there won't be so many complications and problems,” “wait to have sex until you older,” and “[Mom] was just like, you know, don't do it.” Males felt that their families' religious beliefs were a reason for the abstinence message as demonstrated by the following comments: “the Bible says wait” and “It's, like, a sin to have sex before marriage.” Although abstinence was an important message, once parents became aware that their son was sexually active, condom use was encouraged. For example, one African American teen said,

[Mom] raised me in church so she always used to say wait till you get married to have sex and everything. But when she realized I started getting in serious relationships, that's when she was just like, well, I know you probably gonna try and do it so you know... I just want you to know how to put on a condom and all that. Just be safe.

Pregnancy Prevention

According to the focus groups, males, regardless of race, said that their parents were vocal about avoiding teen pregnancy. Participants shared that their parents said, “You'd better not get nobody pregnant,” and “don't bring home any babies 'cause you know you can't take care of 'em right now.” These messages were often couched in the idea that a teen pregnancy would ruin educational and career opportunities for their sons. One African American teen recalled a conversation with his mother, “[mom said] I want you, you know, what I'm saying be baby free. I want you to go college. Wait 'til after college when you get married to have babies, you know what I'm saying?”

Parenting Style

The themes that emerged related to parenting style were the influence of the parent-child relationship, parents' denial of teens' behaviors and competing life priorities.

Influence of the Parent-Child Relationship

Many participants said that it was easier to talk to their parents about sex and birth control when they had a history of open communication and a good relationship. Comments included "it depends what kind of relationship you have with your parents" and "we have a strong relationship." One White teen said "I mean if you're open and honest about a lot of stuff, then that helps a lot when your parents want to talk about [sex]." Another African American teen shared "If you talk to your kids about [sex], they respect you...they're going to be responsible about whatever [they do], if you've got a tight relationship with your child." Parenting style can influence communication as described by a White teen, "It also depends on the parents, too. If they're more like laidback and goof around all the time or, like, real strict and closed off."

Some participants admitted that despite having a good relationship with their parents, their conversations about sex were uncomfortable. As an example, a White teen said, "I didn't want to hear [about sex] from my parents... they started talking about [sex], I just switched to a different subject like I'm not paying attention." "Sometimes you just don't feel comfortable talking with them about that kind of stuff, because it feels weird," said an African American teen. Recalling a conversation with his mother, an African American male shared:

[My mom] asked me if I had any questions. I was like yeah and she gave me an answer then she explained it...then just questions after questions came...just

trying to make sure I asked everything so we won't have to have this conversation again, 'cause I felt so weird talking to her.

The uncomfortable nature of the conversations was explored in one of the focus groups with White teens:

Moderator: Do you think that your parents are comfortable having these conversations with you?

Participant 3: No.

Participant 4: I think it's just as awkward for them as it is for us.

Participant 5: Yeah, I agree.

Moderator: Okay, so pretty awkward...why?

Participant 5: 'Cause they-they don't want to think you're having sex.

Parents' Denial

When participants were probed about why they thought that parents did not talk to their sons about sex and birth control, the two main reasons provided were parents' denial and life's competing priorities. Several participants said that parents are in denial that their children are having sex. For example, an African American teen shared his mom's comments: "My child ain't having sex, so I ain't worrying about it." Other participants said that their parents "trust their kids too much" and think that "think they're all angels." A White teen felt that his parents thought, "if they just don't bring it up, it won't happen maybe."

Competing Life Priorities

Teens felt that competing life priorities prevented parents from talking to their children about sex and birth control. These types of comments were offered by all of the African American groups and only one of the White groups. Concerns mentioned that prevented parents from talking to their children about sex, included parents handling

difficult siblings, other aspects of their child's lives (i.e., grades, behavior), work and household demands. One African American teen said,

I mean because some parents, you know what I'm saying, they get home, trying to work hard, trying to keep you right and trying to help you out, so they ain't got time to do all that and to talk to you about [sex].

Timing of Conversations

Participants were asked "when did your parents first talk to you about sex and birth control?" In the focus groups with White teens, the majority of participants said that their parents talked to them prior to their first sexual experience. These conversations typically took place around middle school age (12-14 years old). Like many of his White peers in the focus groups, one teen said, "[my parents] talked to around, like, eighth or ninth grade...well before I had sex."

In the focus groups with African American teens, however, the majority of participants said that their parents talked to them after their first sexual experience. These conversations typically took place towards the end of middle school or beginning of high school age (12-15 years old). African American males said that often a conversation occurred after "something happened" or as their parent's response to learning that their teen was sexually active. One African American teen shared, "the only time [parents] probably talk about sex is when like something happened, like she catches you in the house doing something or something like that." Another African American male said, "something's got to happen or they see something on your phone... [mom's asking] 'Why is she always coming over here? You all having sex?' or something like that."

Beliefs and Attitudes about Sex and Contraception

The questions, “What would you want your son to know about sex and birth control?” and “What would you want your daughter to know about sex and birth control?” were used to examine participants’ beliefs and attitudes about sex and contraception. Most participants’ indicated that their responses would be different based on the gender of their child. Two themes emerged males should wear condoms to protect against unintended pregnancy and sexually transmitted diseases and females should practice abstinence.

Males: Use Condoms

In nearly every focus group, participants said that they would emphasize the importance of condom use. Comments offered by teens included “use protection” and “be safe” to prevent an unintended pregnancy or sexually transmitted disease. One White teen said, “I would probably tell my kid to, like my dad told me, you know, use protection. And I'd probably go about it the same way my dad did.” An African American adolescent said, “You’re going to encourage him to go do stuff, your son... tell him to get what he can get, you know? The same my daddy told me...don’t do nothing stupid.”

Females: Practice Abstinence

Both African American and White participants said that they would send a strong abstinence message to their future daughters. One White teen said, “I think I’d be a lot more protective of a girl than I would of like a boy.” Males said that they would use scare tactics (“boys these days use girls just for sex”) and harsh language (“You do it I’m

gonna break your neck”) to discourage sexual activity. Other participants talked about refusing to let their daughters date until they were much older (“You’re not going out till you’re 21”) because of the “liability”. The term “liability” was used in the context of the female carrying the burden of teen pregnancy or being seen as promiscuous (“you feel bad like if your daughter was known to be a ho”). Only a few participants said that it was okay for their daughters to be sexually active if she was “older,” “in a serious relationship” and using birth control.

Nature of the Communication between Parents and their Male Children

Participants were asked “How would you talk to your son about sex and birth control?” and “How can we motivate parents to talk to their sons about sex and birth control?” These questions were used to examine the desired nature of communication about sex and contraception between parents and their male children. Two themes emerged related to this topic: importance of an open and honest relationship and incorporating sensitive subjects into natural interactions. In addition, participants said that parents would be more willing to talk with their sons if they understood that teen pregnancy is a common problem and has lasting impacts on teens’ lives.

Importance of an Open and Honest Relationship

Both African American and White teens said “it’s all in your parenting.” Participants said that it was important to have a history of an “open” and honest relationship with their sons. This idea was expressed by one White male, who said

You can’t just like tell [your son], ‘You can ask me anything’. You have to be with him when he’s young, you know? Like, you can’t just never be home and

then say one day, say ‘you can ask me anything you want to’, ‘cause he won't, you know what I mean? You have to be close with them for years, I guess.

Another African American teen shared,

If you talk to [your son] as a parent and as a friend also, he's gonna feel more comfortable around you and he's gonna be like okay, my dad, he knows what's best for me, you know he's probably already been through this. I should just go to him before I go to anybody else.

Several focus group participants discussed the importance of trust in the parent-child relationship: “if [your son] trusts you... [he] can talk to you.” Teens described how they want to feel that they can “talk about anything, not just sex” with their future sons.

Several participants said that having an open parent-child relationship would motivate parents to talk with their sons about sex and contraception. Participants’ interpretation of an open and honest parent-child relationship included parents being a constant presence (“be with your son when he’s young”) and participating in daily activities with their sons.

Incorporating Sensitive Subjects into Natural Interactions

Focus group participants acknowledged that talking with their son about sex and contraception could be “awkward.” However, both African American and White participants said that “easing into” the subject while doing normal father-son activities, such as working in the garage or “shooting hoops”, may help. One White teen described the circumstances that he envisioned when talking to his future son, “When it’s just me and him and we’re doing something that we usually do, like, I don’t know, watching a game or playing golf or something like that.”

Consequences of Teen Pregnancy

In half of the focus groups, participants felt that parents would be motivated to talk about sex and contraception with their sons if they understood that teen pregnancy is a widespread problem and has lasting, negative impacts on teens' lives. These types of comments were offered by both African American and White teens. One White teen said, "Let [parents] know the consequences of what their not talking can lead to." A White adolescent said, "share the statistics...show [parents] the problem." Other participants felt that parents would not want something "messing up their child's life" or jeopardizing "college plans or career choices," so they may choose to talk about this subject. A few participants said that emphasizing the impact that a teen pregnancy would have on the parents' lives may encourage communication; a White teen said "Ask parents do you want to raise your baby's baby? It's not just messing up that teen's life...it's gonna affect the parents as well."

DISCUSSION

This study extends the existing literature by examining male perspectives of parent-child sexual risk communication and by exploring the specific content of these discussions. Focus groups were used to elicit information about participants' attitudes and behaviors towards sex and contraception learned in the context of sexual risk communication with their parents during early adolescence and how it affects their attitudes, beliefs and behaviors in late adolescence. Information was also gathered about ways to promote improved parent-child sexual risk communication. Structured within

the aforementioned conceptual framework and literature, this discussion attempts to address each of the study's research questions.

Parenting Styles

Previous research (Miller et al., 2001) suggested that the impact of parent-child communication depends on overall parenting style (Baumrind, 1991), including the degree of parent-child closeness. This study further supports these findings and suggests that parenting style influences the nature of the communication between parents and their children.

Both African American and White teens said "it's all in your parenting." Participants said that it was important to have a history of an "open" and honest relationship with their sons in order to facilitate more difficult conversations, such as those about sex and contraception. In this study, participants' interpretation of an open and honest parent-child relationship included parents being a constant presence ("be with your son when he's young") and participating in daily activities. The ideals described by the participants align with high levels of parental responsiveness, a hallmark of "authoritative" parenting (Baumrind, 1991).

However, among the African American participants, several mentioned a preference for fathers acting "as a parent and as a friend." Overall, the conversations that African American males had with their fathers were more explicit (i.e., "go get what [you] can get") than those of their White counterparts. These types of conversations may reflect a changing nature of the role of the father into more of a peer or friend. It is also

worth noting that only 42.9% of the African American participants reported living in a household with their biological or step-father when they were young.

Parenting styles are influenced by a range of social factors including cultural values, resources, education, and socioeconomic status and should not be interpreted in isolation (Baumrind, 1991). In this study, one of the reasons that participants thought that parents did not talk to their sons about sex and birth control was life's competing priorities. Such competing priorities, including work and household obligations, and other related social factors could influence parental responsiveness and overall parenting style.

Parent-Child Sexual Risk Communication

In previous studies (Jaccard et al., 1998), adolescents typically only reported parent-child sexual risk communication that they considered “noteworthy.” In this study, participants had to recall experiences from five to ten years earlier. Given this time interval, participants may not have accurate memories of their conversations with their parents. Like such earlier studies, participants may have had a tendency to recall only significant encounters.

However, Jaccard and colleagues (1998) also found that adolescent perceptions and reports were more predictive of sexual behavior than maternal reports. The messages that focus group participants said that their parents most often shared were to use condoms, practice abstinence, and avoid getting a female pregnant. In alignment with Socialization Theory (Philliber 1980), the importance of condom use and abstinence were also messages that participants said that they would encourage with their own [future]

children. Although this message is seemingly conflicting, participants (and their parents) believed that abstinence should be promoted first, but condoms should be encouraged if a teen chooses to become sexually active.

Although most participants said that they preferred to talk with their fathers about sex, their mothers often initiated the topic with their sons. Furthermore, the perspective of an African American teen was that “guys want to hear from [the parent] that they are closest to.” African American participants most often discussed their mothers’ dominant role in talking with them about sex and birth control, which is consistent with previous research (Jaccard et al., 1998). One of the possible reasons for these experiences was that many of the African American participants (50.0%) lived with only their biological or step-mother when they were young.

Clawson and Reese-Weber (2003) concluded that emphasis should be placed on encouraging parents to discuss sexuality with their child prior to initiation of sexual activity. Their study (Clawson and Reese-Weber, 2003) suggested additional research with African American adolescents. In this study, the majority of White teens said that their parents talked to them prior to their first sexual experience. While in the focus groups with African American teens, the majority of participants said that their parents talked to them after their first sexual experience. The conversations took place around the end of middle school or beginning of high school for both African American (12-15 years) and White (12-14 years) participants. According to participant responses to the sociodemographic questionnaire, there was a significant difference in the average age of first sexual intercourse among African American males ($M = 14.75$ years, $SD = 2.06$) as compared to White males ($M = 16.14$ years, $SD = 0.69$) in the sample; $t(28) = 2.54, p <$

0.05. This finding further supports the research (Somers & Ali, 2011) that suggested that parents should talk to their children earlier about sexual risk behaviors.

According to de Visser (2005), there is a need for exploring ways to develop parents' skills and motivations for talking to their children about sexual health. In this study, participants were asked to suggest ways to motivate parents to talk to their sons about sex and contraception. Both African American and White teens said "it's all in your parenting." Many participants felt that parent-child sexual risk communication would be easier when parents had a history of open communication and a good relationship with their son. Participants' felt that an open and honest relationship could be established easier when parents were a constant presence and participated in daily activities. During these normal interactions, such as "shooting hoops," parents should "ease into" tough subjects, like sex and contraception.

Males Beliefs and Attitudes about Sex and Contraception

In the study, the research question about beliefs and attitudes was examined by asking the participants what they would want their future sons and daughters to know about sex and contraception. Most participants' indicated that their responses would be different based on the gender of their child. Similar to the findings from Gilmore and colleagues (1996), participants would emphasize the importance of condom use with their male children. In keeping with Socialization Theory (Philliber, 1980) and the construct of subjective norm of the Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991), participants said that they would encourage their sons to "use protection" in a manner "like my dad told me."

However, with female children, participants' messages quickly changed to stress abstinence. During the focus groups, the concept of "liability" emerged related to participants' desire for their daughters to not bear the physical burden of a teen pregnancy or be viewed as promiscuous (i.e., "a ho"). From the majority of participants' perspectives, this "liability" could be avoided by females maintaining their virginity as opposed to using correct and consistent forms of contraception.

LIMITATIONS OF THE STUDY

Although this study provides insight into a population that has received little attention in this area, it is not without limitations. The males that self-selected for participation may be more comfortable talking about sexuality than those that chose not to participate. Therefore, these results may not accurately represent all 18-19 year old African American and White males. However, focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from "information-rich cases" for the development of future programs and interventions (Patton, 2002).

The researcher's presence during data gathering, which is often unavoidable in qualitative research, could have affected the subjects' responses (Anderson, 2010). To reduce the impact of these "interviewer effects," the focus groups were conducted by gender-concordant moderators (Choi & Comstock, 1975). Additionally, focus group participants may have presented socially desirable depictions of their family relationships. To help reduce this bias, participants were assured that there are no right or wrong responses and that the data was de-identified.

Because the participants were asked to remember their experiences from five to ten years ago, there was the potential for recall bias. Participants may not have accurate memories of their conversations with their parents. However, the decision to use retrospective recall was related to IRB minor consent requirements. If the participants were under 18 years old, parental consent would be required which could have been potentially uncomfortable for both the parent and child, and could have compromised recruitment and sample size. The focus group moderators attempted to address this retrospective limitation by orienting the participants in a way to limit bias. Another related limitation is the lack of data from the parents' perspective.

The researcher acknowledged that there was potential for researcher bias due to the significant reliance on the researcher's experience and judgment when using qualitative methods. However, member checking and field notes were used to mitigate bias. Another potential limitation was changes to the research instrument, when moderators became more proficient and more probing in later focus groups thus producing more rich responses. To address this concern, the moderators used a detailed focus group implementation guide. Furthermore, to ensure familiarity and consistency, all moderators participated in a training session, where the focus group implementation guide was reviewed (Choi & Comstock, 1975).

This study was also subject to the limitations inherent in the conceptual framework, which served as a guide for developing the research questions. However, "open coding" and subsequently "axial coding" of the data allowed the researcher to account for themes that may emerge outside of the original framework (Strauss & Corbin, 1998).

IMPLICATIONS

While considerable research has been conducted to identify the effects of parent-child sexual risk communication on the sexual risk behaviors of adolescents, the majority of the literature has focused on the impact on females' sexual risk behaviors (Coleman & Ingham, 1999; DiClemente et al., 2001; Hutchinson et al., 2003). This research has been used to develop promising interventions, such as HORIZONS (DiClemente et al., 2009), that target adolescent females to reduce sexual risk behaviors. There are few qualitative studies that have deeply examined this topic for purposes of informing the development of an adolescent male sexual risk reduction intervention. In addition, this study adds to the existing literature by examining the quality of conversations between males and their parents. The findings have several implications for research and practice.

Additional research should be focused on the influence of varying parenting styles on parent-child sexual risk communication. Parenting styles are influenced by social and contextual influences. It may be interesting to explore how some of these influences, such as single-parent families and lower socioeconomic status (SES), affect parenting style and sexual risk communication. Furthermore, examining parental perspectives on these topics may also provide additional insights. Another area for exploration is the father-son relationship and its influence on sexual risk communication and behaviors. Specifically, investigating how the changing role of the father into the peer/friend influences the son's sexual risk behaviors.

The findings related to the timing of parent-child sexual risk communication have immediate implications for practice. Teen pregnancy prevention professionals should support programs that encourage parents to incorporate developmentally appropriate

messages into natural interactions with their children during childhood and throughout adolescence. Parents should talk to their children about sex and contraception at an early age prior to sexual initiation. Furthermore, programs should build on the current messages (i.e., “wear protection”) that males are receiving and expand to include a more comprehensive view of sexual health (i.e., information beyond just the importance of wearing a condom).

Table 4.1. Demographic and Behavioral Characteristics of Focus Group Participants (N=30)

| Variable | Sample (N=30)^a | |
|---|----------------------------------|-------------|
| | <i>f</i> | (%) |
| Age | | |
| 18 years old | 24 | 80.0 |
| 19 years old | 6 | 20.0 |
| Race | | |
| African American | 14 | 46.7 |
| White | 16 | 53.3 |
| Current Living Situation | | |
| Living with roommates/friends | 3 | 10.0 |
| Living with family | 25 | 83.3 |
| Other | 2 | 6.7 |
| Living Situation When Young | | |
| Lived with both biological or step-parents | 16 | 53.3 |
| Lived with biological or step-mother | 7 | 23.3 |
| Lived with biological or step-father | 2 | 6.7 |
| Rotated living between biological or step-mother or father | 4 | 13.3 |
| Other | 1 | 3.3 |
| Current Employment Status | | |
| Not employed | 14 | 46.7 |
| Employed <30 hrs./wk. (Part time) | 13 | 43.3 |
| Employed >30 hrs./wk (Full time) | 3 | 10.0 |
| First Member of Family to Attend College, n=29 ^a | | |
| Yes | 3 | 10.3 |
| No | 23 | 79.3 |
| Do not know | 3 | 10.3 |
| Ever Diagnosed by a Doctor as Having an STD | | |
| No | 30 | 100.0 |
| Ever Gotten a Female Pregnant | | |
| Yes | 3 | 10.0 |
| No | 25 | 83.3 |
| Do not know | 2 | 6.7 |
| Current Relationship Status | | |
| Single | 14 | 46.7 |
| Casual Relationship (i.e., hook-ups, dating) | 9 | 30.0 |
| Serious Relationship (i.e., girlfriend) | 7 | 23.3 |
| Variable | <i>M</i> | (SD) |
| Age at First Sexual Intercourse, n=29 ^a | 15.6 | 1.4 |

^aTotal Sample is 30, unless otherwise noted

Table 4.2. Summary of Commonly Expressed Themes and Sub-Themes by Race

| Major Themes and Sub-themes | Groups* | Theory/Construct |
|--|---------|--|
| <i>Experiences Communicating with Parents about Sex and Contraception</i> | | |
| The Parent Messenger | | Socialization Theory/Learned Attitudes and Behaviors |
| Preference for Talking with Fathers | AAM, WM | |
| Mothers often Initiated Conversations | AAM, WM | |
| The Message | | |
| Always Use a Condom | AAM, WM | |
| Abstinence | AAM, WM | |
| Pregnancy Prevention | AAM, WM | |
| Parenting Style | | |
| Influence of the Parent-Child Relationship | AAM, WM | |
| Parents' Denial | AAM, WM | |
| Competing Life Priorities | AAM | |
| Timing of Conversations | | |
| Before First Sex | WM | |
| After First Sex | AAM | |
| <i>Beliefs and Attitudes about Sex and Contraception</i> | | |
| Males: Use Condoms | AAM, WM | Socialization Theory/Learned Attitudes and Behaviors |
| Females: Practice Abstinence | AAM, WM | |
| | | Theory of Planned Behavior/Attitude and Subjective Norms |
| <i>Nature of the Communication between Parents and their Male Children</i> | | |
| Importance of an Open and Honest Relationship | AAM, WM | Social Judgment Theory |
| Incorporating Sensitive Subjects into Natural Interactions | AAM, WM | Theory of Planned Behavior/ |
| Consequences of Teen Pregnancy | AAM, WM | Attitudes and Beliefs |

*AAM=African American Males; WM=White Males

REFERENCES

- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckmann (Eds.), *Action-control: From Cognition to Behavior* (pp. 11-39). Heidelberg: Springer.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179 –211.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Baumrind, D. (1966). Effects of authoritative parental control on child behavior. *Child Development*, 37, 887-907.
- Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. *Journal of Early Adolescence*, 11(1), 56-95.
- Biernacki, P., & Waldorf, D. (1981). Snowball sampling: problems and techniques of chain referral sampling. *Sociological Methods and Research*, 10(2), 141-163.
- Centers for Disease Control and Prevention (CDC). (2010). Youth Risk Behavior Surveillance – United States, 2009. *Morbidity and Mortality Weekly Report*, 59(SS-5), 1–142.
- Centers for Disease Control and Prevention (CDC). (2012). Winnable Battles. Retrieved from <http://www.cdc.gov/winnablebattles/>.
- Clawson, C. L., & Reese-Weber, M. (2003). The amount and timing of parent-adolescent sexual communication as predictors of late adolescent sexual risk-taking behaviors. *The Journal of Sex Research*, 40(3), 256-265.
- Coleman, L.M., & Ingham, R. (1999). Exploring young people's difficulties in talking about contraception: how can we encourage more discussions between partners? *Health Education Research*, 14(6), 741-750.
- de Visser, R. (2005). One size fits all? Promoting condom use for sexually transmitted infection prevention among heterosexual young adults. *Health Education Research*, 20(5), 557-566.

- DiClemente, R. J., Wingood, G. M., Crosby, R., Cobb, B. K., Harrington, K., & Davies, S. L. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *Journal of Pediatrics*, 139(3), 407-412.
- DiClemente, R.J., Wingood, G.M., Rose, E.S., Sales, J.M., Lang, D.L., Caliendo, A.M., ... Crosby, R.A. (2009). Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African American adolescent females seeking sexual health services. *Archives of Pediatric & Adolescent Medicine*, 163(12), 1112–1121.
- Duggleby, W. (2005). What about focus group interaction data? *Qualitative Health Research*, 15, 832–840.
- Dutra, R., Miller, K., & Forehand, R. (1999). The process and content of sexual communication with adolescents in two-parent families: Associations with sexual risk-taking behavior. *AIDS and Behavior*, 3, 59 –66.
- Gilmore, S., DeLamater, J., & Wagstaff, D. (1996). Sexual decision making by inner city Black adolescent males: A focus group study. *The Journal of Sex Research*, 33(4), 363-371.
- Glaser, B.G., & Strauss, A. (1967). *The discovery of grounded theory: strategies for qualitative research*. New York, NY: Aldine de Gruyter.
- Guba, E. G., & Lincoln, Y.S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Halpern, E. S. (1983). Auditing naturalistic inquiries: The development and application of a model. (Unpublished doctoral dissertation). Indiana University, Bloomington, IN.
- Hamilton, B.E., Martin, J.A., & Ventura, S.J. (2011). Births: Preliminary data for 2010. *National Vital Statistics Reports*, 60(2).
- Hoffman, S.D. (2008). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.
- Hutchinson, M. K. (2002). The influence of sexual risk communication between parents and daughters on sexual risk behaviors. *Family Relations*, 51, 238-247.
- Hutchinson, M. K., Jemmott, J. B., III, Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health*, 33(2), 98-107.

- Jaccard, J., Dittus, P.J., & Gordon, V.V. (1998). Parent-adolescent congruency in reports of adolescent sexual behavior and in communications about sexual behavior. *Child Development*, 69(1), 247-261.
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
- Krueger, R.A., & Casey, M.A. (2000). *Focus groups: A practical guide for applied researchers* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Mathews, T., Sutton, P., Hamilton, B., & Ventura, S. (2010). State disparities in teenage birth rates in the United States (National Center for Health Statistics data brief, no. 46.) Hyattsville, MD: United States Department of Health and Human Services.
- Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, 62, 279-299.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Miller, B.C., & Fox, G.L. (1987). Theories of adolescent heterosexual behavior. *Journal of Sex Research*, 2, 269-282.
- Miller, B., Benson, B., & Galbraith, K. (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Research*, 21, 1-38.
- Morgan, D. L. (1988). *Focus groups as qualitative research*. Newbury Park, CA: Sage.
- Morgan, D. L. (1998). *The focus group guidebook*. Thousand Oaks, CA: Sage.
- Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage.
- National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP). (2011). *Counting It Up: The Public Costs of Teen Childbearing*. Retrieved from <http://www.thenationalcampaign.org/costs/default.aspx>.
- National Institutes of Health. (1999). *Qualitative methods in health research: opportunities and considerations in application and review*. Washington, DC: National Institutes of Health Office of Behavioral and Social Sciences Research.
- Onwuegbuzie, A.J., & Leech, N.L. (2007). Validity and qualitative research: An oxymoron? *Quality and Quantity*, 41, 233-249.

- Onwuegbuzie, A.J., Dickinson, W.B., Leech, N.L., & Zoran, A.G. (2009). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods*, 8(3), 1-21.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. (3rd ed.). Thousand Oaks, CA: Sage.
- Pazol, K., Warner, L., Gavin, L., Callaghan, W.M., Spitz, A.M., Anderson, J.E.,... Kann, L. (2011). Vital Signs: Teen pregnancy in the United States, 1991-2009. *Morbidity and Mortality Weekly Report*, 60(13), 414-420.
- Perper, K., Peterson, K., & Manlove, J. (2010). *Diploma attainment among teen mothers*. (Fact Sheet Publication #2010-01). Washington, DC: Child Trends.
- Peters, D. A. (1993). Improving quality requires consumer input: Using focus groups. *Journal of Nursing Care Quality*, 7, 34-41.
- Philliber, S.G. (1980). A conceptual framework for population socialization. *Population and Environment*, 3, 3-9.
- QSR NVivo [computer program]. (2012). Version 10. Melbourne, AU: Qualitative Solutions and Research Pty Ltd.
- Seidman I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, NY: Teachers College Press.
- Sherif, M., Sherif, K., & Nebergall, R. (1965). *Attitude and attitude change: The social judgment involvement approach*. Philadelphia, PA: Saunders.
- Singh, S., & Darroch, J.E. (2000). Adolescent pregnancy and childbearing: levels and trends in developed countries. *Family Planning Perspectives*, 32(1), 14-23.
- Somers C.L., & Paulson, S.E. (2000). Student perceptions of parent adolescent closeness and communication about sexuality: relations with sexual knowledge, attitudes, and behaviors. *Journal of Adolescence*, 23(5), 629-44.
- Somers, C.L., & Ali, W.F. (2011). The role of parents in early adolescent sexual risk-taking behavior. *The Open Psychology Journal*, 4, 88-95.
- Stewart, D.W., & Shamdasni, P.N. (1994). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

- Suellentrop, K. (2010). *The odyssey years: Preventing teen pregnancy among older teens*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.
- United States Department of Health and Human Services. (2010) *Healthy People 2020*. Retrieved from <http://www.healthypeople.gov/2020/default.aspx>.
- University of South Carolina Institute for Public Service and Policy Research. (2011). *Public perceptions of pregnancy prevention in Horry and Spartanburg counties*. Columbia, SC: South Carolina Campaign to Prevent Teen Pregnancy.
- Van Manen, M. (1990). *Researching lived experience: human science for an action sensitive pedagogy*. London: Althouse Press.
- Vaughn, S., Schumm, J. S., & Sinagub, J. (1996). *Focus group interviews in education and psychology*. Thousand Oaks, CA: Sage.
- Wilkinson, S. (2004). Focus group research. In D. Silverman (Ed.), *Qualitative research: Theory, method, and practice* (pp. 177–199). Thousand Oaks, CA: Sage.

**Manuscript 2: Exploring the Communication Experiences that Adolescent Males
have with their Partners about Sex and Contraception²**

² Galloway, C.T., Corwin, S.J., Richter, D.L., Prince, M.S., Simmons, D.S. To be submitted to *Journal of Sex Research*.

ABSTRACT

Increasing partner communication about sex and contraception was identified as a protective factor that is amenable to change directly by a teen pregnancy prevention program. Partner support for condom and contraceptive use was also identified as a protective factor, although more difficult to change without having specialized services as part of an intervention or program. The purpose of this study was to explore African American and White 18-19 year old males' experiences of sexual risk communication with their partners, how these experiences were affected by parental sexual risk communication during early adolescence, and how to promote sexual risk communication among partners. From June through July 2012, a total of six focus groups (N=30) were conducted. Qualitative coding and analysis revealed themes related to attitudes about teen pregnancy, males' role in the use of contraception, experiences communicating with their partners about sex and contraception, and strategies to promote partner communication about sex and contraception. Supporting qualitative data are presented in connection with each theme. This study gained insight about the characteristics and quality of partner sexual risk communication from the male's perspective. Implications for interventions promoting improved partner sexual risk communication are discussed.

Key Words: Partner communication, Teen Pregnancy, Sex, Contraception, Males

INTRODUCTION

Teen pregnancy prevention is one of the Centers for Disease Control and Prevention's top six priorities, a "winnable battle" in public health, and of vital importance to the health and quality of life for youth in the United States (CDC, 2012). This adolescent health issue is a prevention priority because of its substantial impact on the teen parent, their children, families and society as a whole. Pregnancy and birth are

significant contributors to high school drop out rates among girls (Perper et al., 2010). The children of teenage mothers are more likely to have lower school achievement, to have lower high school graduation rates, to have more health problems, to have increased likelihood of being incarcerated at some time during adolescence, to become a teen parent, and to face unemployment as a young adult (Hoffman, 2008). Teen pregnancy accounts for nearly \$11 billion per year in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers (NCPTUP, 2011).

Despite recent declines, the U.S. teen pregnancy, birth, sexually transmitted disease, and abortion rates are substantially higher than those of other western industrialized nations (Singh & Darroch, 2000). Furthermore, significant racial and ethnic disparities also exist within the U.S (Matthew et al., 2010). In 2009, birth rates for African American teens (59.0 per 1,000 females) and Hispanic teens (70.1 per 1,000 females) were more than twice that of white teens (25.6 per 1,000 females) (Pazol et al., 2011).

Research indicates when parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased (Kirby, 2007). Increasing parent-child communication about sex and contraception is identified as a protective factor that is most amenable to change directly by a pregnancy prevention program (Kirby, 2007). Partner support for condom and contraceptive use was also identified as a protective factor, although more difficult to change without having

specialized services as part of an intervention or program (Kirby, 2007). Discussing sexual risks and pregnancy prevention with partner were also identified as highly-changeable protective factors (Kirby, 2007). Several studies (Whitaker et al., 1999; DiClemente et al., 2001) have linked teenagers' communication with their partners about sex and contraception with discussions that teenagers have had with their parents about sex.

REVIEW OF LITERATURE

Males Beliefs and Attitudes about Sex and Contraception

While more than fifteen years old, a focus group study was conducted with 27 inner city African American young men ages 15 to 19 years to assess the attitudes and beliefs associated with decisions to have sexual intercourse and use condoms (Gilmore et al., 1996). Four sets of beliefs emerged as key themes: what it means to be a man, the good (physical pleasure) and bad (disease and unwanted pregnancies) things about sexual intimacy, condom use and AIDS as a serious threat (Gilmore et al., 1996). Although the young men generally endorsed condom use, there were numerous contradictory comments; such as condoms diminish sexual pleasure and women requesting condom use indicates the potential presence of sexually transmitted diseases (Gilmore et al., 1996). Ultimately, decisions about the use of condoms appeared to be correlated with the young men's perception of the woman being "clean" or "dirty" and how long he has known her (Gilmore et al., 1996). Another key finding suggests that there is a belief or fear that one's partner is lying, which may hinder partner communication about birth control and condom use (Gilmore et al., 1996). The researchers acknowledged their "high risk" sample may not be representative, but encouraged future studies that focus on

relationships between African American men and their female partners (Gilmore et al., 1996).

Male Attitudes about Pregnancy and Role in Use of Contraceptives

Johnson and Williams (2005) conducted in-depth interviews with 20 men (ages 21-48 and 95% White) who have fathered at least one unintended pregnancy to explore their communication with partners, contraceptive beliefs, and contraceptive behaviors. The interviews were analyzed using a thematic framework; two themes clearly emerged: “deference” and “denial” (Johnson & Williams, 2005). In terms of discussion, planning, decision-making, contraception, the majority of participants deferred to their partner (Johnson & Williams, 2005). The denial theme related to the fact that participants were aware of the risks of unintended pregnancy and yet chose behaviors that increased the likelihood of conception (Johnson & Williams, 2005). The participants typically relied on their partners to use contraception and most said that they had only a “supporting role” (Johnson & Williams, 2005). One of the surprising findings from this study was that men, including their well-educated sample, did not have accurate information about contraceptive methods (Johnson & Williams, 2005). The study team concluded that men need increased knowledge about contraception, and additional research should focus on male’s role and responsibility in contraceptive use and partner communication (Johnson & Williams, 2005). Because this study’s sample was predominantly White and educated, future research should involve males from varied racial and ethnic groups and socioeconomic backgrounds; (Johnson & Williams, 2005).

Experiences of Partner Communication

Coleman and Ingham (1999) used in-depth interviews with fifty-six 16-19 year olds (77% female; study did not define race of participants) to investigate the obstacles that prevent some young people from discussing contraception, particularly prior to their first intercourse with a new partner. The most prominent reason that participants gave for not talking to their partner was fear of a negative reaction (Coleman & Ingham, 1999). The researchers found that this concern was largely unjustified, and suggested that this finding should be widely publicized to encourage partner communication. Several men said that their hesitancy to have a discussion stemmed from the idea that talking about contraception is admitting an intention for intercourse (Coleman & Ingham, 1999). There were some other indications of gender differences in responses; and because the sample was predominantly female, future investigations should look at males or other social classes (Coleman & Ingham, 1999).

Researchers conducted a study to examine the relationship between general sexual communication and contraceptive use, and predictors of open communication from characteristics of adolescent couples and individual adolescents (Widman et al., 2006). In the study, seventy-three adolescent dating couples aged 14-21 years old (91% White and 8% African American) completed measures to assess general sexual communication, contraceptive communication, contraceptive use, relationship satisfaction, commitment, and self-silencing (Widman et al., 2006). The results indicated both male and female adolescents who were more satisfied in their relationship were more open to communicating about sexual topics, and that this association led to increased contraceptive use (Widman et al., 2006). Findings suggest that it is important to convey

to young people that open partner communication about sexual issues is essential for avoiding risky sexual behaviors (Widman et al., 2006).

Landry and Camelo (1994) used focus groups to explore how 76 unmarried young men (16-29 years) and women (20-29 years) define men's role in contraception and why they do or do not use a method. Twelve focus groups were divided by gender and race/ethnicity: 3 groups with Hispanic males (n=19), 1 group with Hispanic females (n=8), 3 groups with African American males (n=16), 1 group with African American females (n=7), 3 groups with White males (n=18), 1 group with White females (n=8) (Landry & Camelo, 1994). Researchers found that the main motivation to use contraceptives was to prevent both pregnancy and sexually transmitted diseases, particularly HIV/AIDS (Landry & Camelo, 1994). The participants said that the method of contraception used was dependent on the type of relationship involved; condoms were used more frequently in casual sexual relationships (Landry & Camelo, 1994). Males said they rarely discussed contraceptive use with a casual partner and that women initiated most conversations about contraception (Landry & Camelo, 1994). The study also demonstrated despite awareness of the risks of STDs and pregnancy, both men and women reported that they occasionally use no method at all or relied on a method other than condoms with casual partners (Landry & Camelo, 1994). Most participants relied upon "instinctive" criteria, rather than sexually transmitted disease testing, in making the decision to switch from condoms to another form of birth control in longer term relationships (Landry & Camelo, 1994). The researchers suggested that future studies and interventions should focus on methods to increase partner communication and contraceptive method use (Landry & Camelo, 1994).

Influence of Parental Sexual Risk Communication on Partner Communication

Whitaker et al. (1999) interviewed 372 African American and Hispanic adolescent-mother pairs, where the adolescent (14-16 years old) reported having engaged in penile-vaginal intercourse at least once. The interview measures included sexuality discussions, sexual risk discussions, parental responsiveness, partner communication, and condom use (Whitaker et al., 1999). Sexuality and sexual risk discussions with parents were positively related to partner communication (Whitaker et al., 1999). In addition, adolescents' communication with their partners about sexual risk was associated with increased condom use (Whitaker et al., 1999). However, both of these findings only held true when parents communicated with their teens in a skilled, open, and comfortable manner (Whitaker et al., 1999). The researchers recommended examining both the content and the process of parent-teenager communication about sex to increase the field's understanding of how that communication affects adolescents' sexual behavior (Whitaker et al., 1999).

DiClemente et al. (2001) administered a Social Cognitive Theory (Bandura, 1986)-guided survey to 522 sexually active African American females (ages 14-18 years old) to explore associations between parent-child sexual risk communication and partner communication. Supporting the findings from an earlier study, the research team found a positive association between parent-adolescent sexual risk communication and adolescent communication with sex partners (DiClemente et al., 2001; Jaccard et al., 1996). Female adolescents who reported less frequent communication with parents were more than three times less likely to report frequent communication with their male partners about sex, including how to prevent pregnancy and sexually transmitted infections (DiClemente et

al., 2001). The study further suggested that parents “may be key agents in the promotion of open and honest communication about sex between maturing adolescents and the sex partners they select” (DiClemente et al., 2001).

PURPOSE AND RESEARCH QUESTIONS

The purpose of this qualitative study was to explore African American and White 18-19 year old males’ experiences of sexual risk communication with their partners, how these experiences were affected by parental sexual risk communication during early adolescence, and how to promote sexual risk communication among partners. The study was guided by four research questions. First, “What do African American and White 18-19 year old males think about pregnancy at this point in their life?” Second, “What do African American and White 18-19 year old males think is their role in the use of contraception?” Third, “What are the experiences that African American and White 18-19 year old males have had with communicating with their partners about sex and contraception, and what is the potential connection to childhood parental communication?” Finally, “What do African American and White 18-19 year old males think should be the nature of strategies promoting partner communication about sex and contraception?”

CONCEPTUAL FRAMEWORK

The conceptual framework for this study is composed of constructs from three theories: Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991), Social Judgment Theory (Sherif et al., 1965) and Socialization Theory (Philliber, 1980). [N.B. nomenclature in the literature uses “parent-child,” but the researchers recognize that many children/youth are not raised in traditional households. In this study, therefore,

parent or parental was used to represent an adult guardian or significant adult in the child's life.]

The Theory of Planned Behavior (TPB) assumes that *behavioral intention* is the most important determinant of a given behavior (Ajzen, 1985; Ajzen, 1991). According to TPB, a person's attitude towards a behavior (*attitude toward behavior*) and whether individuals who are important to the person approve or disapprove of the behavior (*subjective norm*) are the primary determinants of behavioral intentions (Ajzen, 1985; Ajzen, 1991). In this study, African American and White 18-19 year old males attitudes and beliefs towards sexual risk-taking behaviors were explored in the context of their experiences of communicating with their partners about sexual risks and using contraception. The focus groups assessed African American and White 18-19 year old males' intention to use condoms and contraception by inquiring about their thoughts and attitudes towards pregnancy at this point in their lives.

Ajzen's TPB (Ajzen, 1985; Ajzen, 1991) evolved from Fishbein's Theory of Reasoned Action (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980); both concentrate on the relationship between behavior and beliefs, attitudes and intentions. The TPB differs from the Theory of Reasoned Action in the addition of *perceived behavioral control* as a construct (Ajzen, 1985; Ajzen, 1991). Perceived behavior control is a person's perception of the controllability of a behavior, when it is influenced by factors beyond their control (Ajzen, 1985; Ajzen, 1991). The TPB has been used by studies in the literature related to adolescents' sexual risk-taking behaviors, including Hutchinson's work (2003) where the research team used the theory to explore the role of mother-daughter communication in reducing teens' sexual risk behaviors. In the case of this

study, African American and White 18-19 year old males were asked about their role in the use of contraception with sexual partners, which may clarify their perceived control related to engaging in sexual risk behaviors.

The second component of the study's conceptual framework is from Social Judgment Theory (Sherif et al., 1965), which is an interpersonal communication theory. Social Judgment Theory (Sherif et al., 1965) explains how individuals judge the messages they receive. According to the theory, a listener judges how much a message agrees or disagrees with his or her own attitude or belief system (Sherif et al., 1965). Social Judgment Theory (Sherif et al., 1965) was applied to the study in two ways. First, the individual sexual-risk communication experiences of African American and White 18-19 year old males and their partners were explored. The focus group participants were asked about the specific details of the conversations about sex and contraception with their partners and how receptive their partners were to the conversations. Second, the theory supported the final focus group question designed to elicit ideas from the participants for intervention strategies to increase partner communication about sex and contraception.

The final component of the study's conceptual framework is Socialization Theory, which is based on the idea that children and adolescents learn attitudes and behaviors early in life from adult role models, such as parents (Philliber, 1980). Typically, parents are the first and most important influence on their children. The attitudes and behaviors modeled by parents are learned by their children and manifested in adolescence and adulthood (Philliber, 1980). Parents' behaviors, such as having open and honest discussions with their children about risky sexual activities or contraception,

will result in certain adolescent behaviors, such as delaying initiation of sexual intercourse or talking to their partners about sex (Miller & Fox, 1987; Whitaker et al., 1999). Based on this theory, an adolescent's sexual behavior can be partially predicted by how he or she was socialized by their parents. This current study explored African American and White 18-19 year old males' attitudes and behaviors in the context of their experiences of sexual risk communication with their partners and how these experiences were affected by parental sexual risk communication during early adolescence.

METHOD

The qualitative study design was a combination of phenomenology (i.e., attempting to understand the lived experience of adolescent males) and modified grounded theory using a constant comparative method to determine if observations are holding true to the theory constructs of interest (Van Manen, 1990; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Qualitative data was collected through focus groups. Widely used, focus group research involves collecting qualitative data from a small group of people in an informal discussion 'focused' around a particular topic of interest (Morgan, 1998; Wilkinson, 2004; Krueger & Casey, 2000; Onwuegbuzie et al., 2009). Focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from "information-rich cases" for the development of future programs and interventions (Patton, 2002).

From June through July 2012, a total of six focus groups – three with African American males and three with White males – were conducted. This study stratified the sample by race with focus groups held separately with African American males and White males. This stratification was based on the finding from the literature review that

different races may have unique family dynamics and parenting styles, and distinct attitudes and sexual behaviors (CDC, 2010). Both African American and White males were included in the focus groups to present the opportunity to examine racial differences.

PARTICIPANTS

For this study, purposive sampling was used to identify participants. This sampling strategy is useful because it allows the researcher to purposefully select participants who can provide the desired information for the study (Patton, 1990). Additional recruitment of study participants occurred via word-of-mouth, or the commonly used “snowball sampling” technique (Biernacki & Waldorf, 1981). Recruitment sites (i.e. community-based organizations, recreation facilities, local employers, apartment complexes, churches, local college campuses and organizations) in the Columbia community were identified by the researcher. Flyers with a description of the study, inclusion criteria, and contact information for participating in the study were shared with each of the sites. To enroll in the study, interested participants were asked to either email or call the researcher. All potential participants were screened to ensure they met the study’s inclusion criteria.

To be included in the study, participants were: 1) African American or White; 2) male; 3) age 18-19 years old; 4) sexually-active heterosexual; 5) childless; 6) not living in a household where they are the parental figure to a child/children; 7) able to read and speak English fluently; 8) without cognitive challenges that would prevent them from participating or responding to written and oral questions; and 9) willing to engage in a group discussion with other males about sexual risk communication.

The sample included 30 males (14 African American and 16 White). Table 4.2 presents demographic characteristics of the participants. The majority (83.3%) of participants indicated that they currently live with their family, which may be attributed to the fact that the groups took place in June when students are typically not living on campus. It should be noted that compared with African American males (28.6%), a greater percentage of White males (75.0%) lived with both biological/step-parents when they were young. There was a significant difference in the average age of first sexual intercourse among African American males ($M = 14.75$ years, $SD = 2.06$) as compared to White males ($M = 16.14$ years, $SD = 0.69$) in the sample; $t(28) = 2.54, p < 0.05$. None of the participants reported having biological children; however, over a fifth (21.4%) of African American males reported getting a female pregnant. No White males reported getting a female pregnant.

PROCEDURE

The focus groups were conducted by two African American males aged 30-40 years old, trained by the researcher and who had previous experience facilitating focus groups with young people. The moderators used a detailed 9-item focus group implementation guide. Before each group began, informed consent was obtained from each participant. Participants completed a 13-item, paper-pencil, sociodemographic questionnaire developed to provide descriptive information (e.g., gender, age, race, education, family background, sexual history.) The focus group implementation guide and sociodemographic questionnaire were pilot tested by the researcher with a convenience sample ($n=7$) of African American males in their early to mid-twenties. No

revisions were made to the implementation guide, sociodemographic questionnaire, or data collection procedures based on the pilot test.

Focus group questions were asked in the order of the script in the focus group implementation guide. When a question was asked, participants were given time to express their opinion and describe their experiences. The focus group questions were carefully written to provide answers to the research questions. Moderators used comprehensive probes (Stewart & Shamdasni, 1994) to obtain and clarify responses from participants. For example, the moderator may ask “Would you give me an example of what you mean?” or “I’m not sure I understand, could you explain further?”

The focus groups, ranging in length from 90-120 minutes, were digitally audio and manually recorded. The researcher served as the observer/note-taker during the focus groups and kept detailed notes of the participants' responses and characteristics of group dynamics. Participants were given a \$25 gift card in recognition of their contribution to the study. Contraception and STI/STD prevention health education materials (e.g., brochures, pamphlets, and community resource information) were also offered to participants. The study was approved by the Institutional Review Board (IRB) at the University of South Carolina.

CODING AND DATA ANALYSIS

The digital audio files from the focus groups were transcribed verbatim into Microsoft Word by an (on-line) professional transcription service with experience in social and behavioral research. Verbatim transcripts of the audiotapes, observer notes, and the sociodemographic participant questionnaires were the primary data for analysis. Content analysis was used in analysis and interpretation of the data. The Microsoft Word

text files (verbatim transcripts) were entered into QSR NVivo v.10.0 (2012), a qualitative data management program, for coding, text retrieval, intensive data organization, and content analysis. When necessary, observer notes were referred to for clarification. Data collected from the sociodemographic questionnaires was entered and analyzed using SPSS 19.0. Univariate analysis was run to provide descriptive statistics (e.g., frequencies, percents, means, etc.) for all variables.

In order to develop a codebook, one transcript each from the focus group types (African American and White) were selected at random and independently read by two of the researchers (CG & SJC). Each reader used the discussion guide as an initial framework and, when encountering an idea or meaning, manually marked the text segments and assigned a semantic code. The readers compared their ideas and codes to determine if they arrived at similar interpretations of the data. During this “open coding” process consensus was reached about the definition of each code and a list of codes was agreed upon and finalized (Strauss & Corbin, 1998). A master code book was drafted by integrating and conceptually organizing the lists of codes. Each transcript was then re-coded using this master codebook, and when necessary, new codes were added to the codebook.

To obtain inter-coder agreement, transcript excerpts from each focus group type were manually coded independently by the two researchers. Afterwards, the researchers met face-to-face and counted the number of times they agreed on codes and disagreed on codes. The number of matched codes was divided by the number of mismatched codes plus the total number of matched codes. This fraction indicated the percent of coder agreement; inter-coder agreement of .80 was achieved for the transcripts.

QSR NVivo allows for on-screen coding and analysis of large amounts of text across multiple themes, participant responses, and group types. By using QSR NVivo's output function, all of the coded data were printed out by code type, reviewed for accuracy, and examined for links to other codes. This "axial coding" process was used to connect code categories and to identify relationships between codes which are suggestive of themes (Strauss & Corbin, 1998). Additionally, comparing and contrasting focus group themes within and across groups ("constant comparison method") detected similarities and differences in the data (Strauss & Corbin, 1998). Verbatim quotes from the focus group participants were used to validate the researcher's coding, interpretation, and conclusions.

Although there are no perfect methods for evaluating the validity of the data or trustworthiness of conclusions, there are accepted techniques for increasing the credibility of qualitative research findings (Onwuegbuzie & Leech, 2007). Leaving an audit trail and member checking are two of these recognized strategies. The researcher may leave an audit trail in the form of field notes and memos that have been kept throughout the study design, implementation and analysis phases (Halpern, 1983). Research memos written during the study and notable findings will be summarized with the results.

Member checking is another technique for assessing the "truth value" of the qualitative research (Onwuegbuzie & Leech, 2007). Member checking, also known as informant feedback, requires the researcher to systematically obtain feedback from the study participants about data interpretations and conclusions (Gupa & Lincoln, 1989). In this study, the member checking strategy was employed through two approaches. First,

the researcher obtained necessary clarification of comments from the study participants at the end of each focus group. Secondly, at the conclusion of each focus group, the researcher requested volunteers who would agree to participate in a follow-up conversation. After the transcripts were coded and analyzed, the researcher contacted a subset of the study volunteers (n=3) and reviewed the initial interpretation of findings emergent themes. Volunteers were asked if the themes accurately represented the essence of their focus group conversations. Relevant information from the interviews is summarized in the results section.

RESULTS

A summary of themes by race appears in Table 4.2. These themes, including racial similarities and differences are described in the sections that follow. The researcher believes saturation was reached after conducting at least two focus groups with each race.

Attitudes about Pregnancy

Focus group participant were asked “At this point in your life, describe how you would feel if a partner got pregnant.” This question was used to examine participants’ attitudes about pregnancy at this point in their lives. The themes that emerged were a desire to avoid pregnancy and the male’s role in preventing pregnancy.

Desire to Avoid Pregnancy

Most participants wanted to avoid getting a partner pregnant at that point in their lives. Participants talked about how if they learned that their partner was pregnant, they would feel “scared” and “like a failure.” One African American teen said, “I’m telling

you, it breaks your heart if they get pregnant. You'd be like, oh man, what have I done? I should have just stayed home that day." When asked "Why do you feel this way?"

some participants focused on the consequences of having a baby as a teen. One African American male shared his thoughts about avoiding pregnancy:

When you bring a baby in the world, you've got to make sacrifices. Like right now, I can't afford no sacrifices. A baby in the world, first I'm going to have to drop out of school, probably get a job, some low paying job, you know what I'm saying, then I've got to take care of my kid, you know what I'm saying, diapers and all that junk. And I'll feel like a failure, because right now education is pretty much going to get you where you need to go in the world. So I ain't trying to be no failure.

Other participants said that they simply "wouldn't be ready" for the responsibilities of fatherhood as a teen.

Male's Role in Preventing Pregnancy: Wear a Condom

Many focus group participants acknowledged their role and said that they could do their part in preventing a pregnancy by using condoms. An African American male shared, "I've pretty much told all of my partners either it was gonna be with a condom or it wasn't gonna be at all." One White teen said "always make it clear with your partner you're gonna wear a condom."

While acknowledging the importance of using condoms, some participants described how consistent condom use can be a challenge. A White male said, "I mean I think you know what you should do, but it's a matter of actually doing it, which throws teenagers off, because they're more in the moment." Both African American and White teens said that condom availability can affect the likelihood of use. One African American teen recalled a time that he did not use a condom: "like me and [my partner]

we use protection. But I guess like at the moment I didn't 'cause I probably didn't have one." Another African American male said,

Say you're in the bed, 'Oh, let's [have sex], ' Oh, I gotta run to the car to get a condom. Forget that, I'm going in. Some stuff, you've got to compromise. I don't feel like going to the car, I'm just going to get it in, pull it out.

Several focus group participants said that it was important to "make sure you have your rubbers" prior to going out to increase the likelihood that you will use protection.

Males' Role in the Use of Contraception

Focus group participant were asked to "Describe your role in the use of birth control." This prompt was used to examine participants' beliefs, attitudes, perceived control and intention to use contraception. The themes that emerged were: contraception is a shared responsibility, mistrust of partners to use contraception, and the belief that contraception does not always work.

Shared Responsibility

Regardless of race, most participants felt that using contraception was a "shared" responsibility between male and female partners. The idea of a shared responsibility for contraception was explored in one of the groups with White teens:

Participant 4: [The responsibility for contraception is] shared.

Participant 3: Yeah.

Participant 2: It's shared.

Participant 3: Shared all the way.

Participant 4: There's no 'it's your fault I got pregnant.' No, it's both our faults. We both had sex. We both knew what we were getting into. We both knew there was a risk, and we both took that risk anyways, and it happened to us. So it's completely shared, 100 percent.

In another group, a White teen said, “She’s responsible for her part. You’re responsible for your part.” Overall, participants felt that it was the guy’s responsibility to “wear a condom” and the female’s responsibility to take a hormonal method (i.e., “the pill,” “the shot”) of contraception. A White male shared his thoughts about dual protection: “I think if you do [hormonal] birth control and a condom, you’re being very smart, but if you’re using just birth control, you’re only kinda smart.” Despite the expressed ideal of dual protection, participants shared conflicting behavioral accounts where one or both partners failed to use contraception. As an example, in a follow-up (member checking) interview, an African American teen said, “Fact is guys don’t use condoms like they should.”

Mistrust of Partners to Use Contraception

In every African American group but only one White group, participants shared comments that demonstrated a lack of trust in their partner to correctly and to consistently use contraception. “Just ‘cause the girl say she’s on [birth control] doesn’t mean she’s on [birth control],” said an African American participant. A White male shared his experience, “I’ve actually had a girl lie [about using birth control], but I did use a condom anyway.” One African American teen said,

I trust her but it’s always a side of me that want to make sure. Like if she’s taking the pill, I’ll be like let me see the little prescription to make sure you know just in case...let me see you on the right day. It’s Thursday. Okay.

Some African American participants believe that there are females that may attempt to sabotage male efforts to use contraception. An African American male said, “have your own condoms with you, ‘cause the girls that got their own condoms they

probably done sat in that bathroom...[the girl] held that junk up to the light with that needle and poke a hole.”

When African American participants were probed about why females may intentionally not use or damage contraception, teens said that it was an effort “to trap” them. This entrapment terminology was used to depict the female’s deceptive behavior (i.e., intentionally not using or damaging contraception) in an attempt to become the male’s long-term girlfriend/partner or to gain financial support through a pregnancy and child. An African American male said, “Some girls lie about being on birth control just so you won’t wear a condom...they like to trap you.” An African American teen further explained this idea, “[Girls] know we smart and they see we’re going on to a right path...they might try to trap you.” In a follow-up (member checking) interview, an African American teen shared “you can’t trust girls [to use birth control] because some are trying to get pregnant...like if [the guy] is a success.” The terms “success” or “on to the right path” were used in the context to describe males who attended college or excelled in sports (with the potential to go professional), and who were viewed as likely to make a lot of money.

Surprisingly, in the African American groups, some participants said that their parents were the ones who warned them that females may intentionally not use or damage contraception. An African American teen shared, “My daddy told me don’t do nothing stupid and watch out for the crazy [girls].” In another group, an African American male said,

Momma used to always tell me that when girl got her own condom don’t use it, use your own. I’d be like why, it’s a condom. Momma said, it’s a condom all right but that little needle, that little hole [*popping sound*].

Contraception Does Not Always Work

In every focus group, there were some participants that expressed concern about the effectiveness of contraception. Frequently stated comments included “don’t trust [birth control]” and “[birth control] doesn’t always work.” A White teen said, “I mean [birth control] got defects. I always see people messing themselves up on birth control kind of easily. It doesn't make me a fan.” An African American adolescent shared his thoughts,

I have had sex with a girl that was on birth control...even though she was on it, I still had that mindset of don’t trust it...’cause my momma said it don’t work ...it won’t work 100 percent of the time ... it might be that one time when it don’t work.

Participants also voiced concern about the durability and effectiveness of condoms. An African American male said, “Some types of condoms don’t work...’cause they can pop.” A White teen shared his father’s advice to him,

My dad said even if you have a condom, that the condom is there so that you can kind of go inside and then pull out...if it busts while you are inside, that's where the problem comes in. My dad always told me even with the condom on, still pull out because it's kind of like that extra step to prevent it.

During follow-up (member checking) interviews, participants were asked whether they felt that contraception worked. One White male and one African American male said that birth control failure had more to do with “user error” and “inconsistent use.”

However, when probed with the same question in a different follow-up interview with an African American participant, he said “birth control just doesn’t always work.”

Partner Communication about Sex and Contraception

Focus group participants were asked to “Describe the conversations that you have had with current or former partners about sex and contraception.” The themes that emerged were related to the type of relationship between the partners.

Type of Relationship

Regardless of race, participants said that the conversations with their partners varied depending on the type of relationship. Relationships were defined by the participants as either casual (i.e., “hook-up,” “side piece”) or serious (i.e., girlfriend, “main girl”).

Casual Partner

Participants acknowledged that their conversations with casual partners were limited and in some cases, nonexistent. As an example, an African American teen said, “With the side girls, two or three texts, [the conversation] ain’t going to be that long.” A White male shared that a conversation with “a hook-up” might be as simple as “you’re good, right?” An African American male admitted “It wasn’t even a conversation...I guess it was just an understanding of how we were gonna do it.” In a follow-up (member checking) interview, an African American male said that sex with a casual partner “just happens...there’s no conversation because it was not planned... [guys] don’t care about anything but the sex.” A White teen described a typical interaction with a casual partner,

I really don't think there's the conversation of birth control and stuff like that with a casual hook-up 'cause I don't think it's, like, comfortable for either one at the time. So I think they more rush into it...the guy just wears a condom regardless of what the girl does to prevent it.

Serious Partner

In contrast, when talking about conversations with serious partners, participants described more detailed, on-going interactions. An African American teen said, “You gotta go through the whole nine yards, you know what I’m saying? From birth control to if I do get you pregnant what’s our plans...all that stuff.” When probed about the difference in conversations with serious versus casual partners, one White male said, “You just trust each other more, so you’re gonna have more of an in-depth conversation.”

Participants said conversations about sex and contraception came up when they had “been established in the relationship for a while” or something (i.e., “a song,” “TV show or a movie”) prompted the topic. A White teen remembered the moment when he initiated a conversation with his girlfriend about sex and contraception, “We were watching *16 and Pregnant*...that’ll mess you up. I was thinking we’re not much different than them. What’s going on?”

Regardless of race, participants said that their conversations with serious partners focused on pregnancy prevention and using birth control, and that they rarely spoke of sexually transmitted diseases. An African American male said, “Like my girl and I talk all the time...we both agree that we don’t need no babies...I’m gonna wear a condom.” Similar to other participants’ experiences, a White teen recalled that his girlfriend was receptive to talking about sex and contraception:

Participant 5: I kinda went about [talking with my girlfriend] like [another participant]. Like I asked [girlfriend] if she was on it and –

Moderator: On?

Participant 5: Birth control...I asked her if she was on [the pill]. She said ‘no,’ so I try to do my part with the condom.

Moderator: Okay. And how did she respond like when you brought it up?

Participant 5: She wasn't opposed to it. She was like open-minded to the whole birth control because she felt like she should be on it as well...so we talked about [birth control] over the course of days as well.

A White teen disclosed a conversation with his girlfriend, “she told me that she was taking birth control and that made me feel more comfortable.” In another group, a White male expressed relief in knowing that his girlfriend was on a hormonal contraceptive: “Anytime I talked with [my girlfriend], [the conversation] was about birth control...’cause like I usually wear a condom, but I mean sometimes I don't wear one, but I feel safe because I know that [my girlfriend’s] on birth control.”

Strategies to Promote Partner Communication about Sex and Contraception

Focus group participant were asked “What do you think would be the most effective ways to motivate young men to talk to their partners about sex and using birth control?” and “How can we communicate messages to young men?” The themes that emerged were focusing on the consequences of unprotected sex and delivering the message.

Focusing on the Consequences of Unprotected Sex

Regardless of race, participants said that having straight-forward messages which focused on the consequences of unprotected sex could motivate young men to talk to their partners about sex and contraception. A White teen said that messages should ask simple questions that cause males to think: “Can you take care of yourself? Do you really think you can take care of a kid? Do you feel like you're financially prepared? Do you want a child?” A White adolescent felt that “focusing on the sacrifices required to be a teen parent...all the fun things...college...your career” could motivate males to talk to

their partner. An African American teen said that “you have to make guys think of the future... know the risks of what could happen if they’re not using birth control.” Several participants mentioned creating “fear factor” type commercials, such as the graphic anti-smoking ads, in which the consequences (i.e., financial cost, loss of freedom, loss of educational and career opportunities) of unprotected sex could be highlighted.

Delivering the Message

When asked how to communicate the messages, both African American and White participants felt that schools, television, and social media were the most promising outlets. Several males said “have a required assembly” at schools with a program that will “catch teens’ attention.” Other participants said that cell phones or *Twitter* could be used to send messages (texts or *Tweets*), such as contraception reminders “Make sure you use a condom today!” or teen pregnancy statistics. Focus group participants said that recruiting respected spokespersons (i.e., celebrities, professional athletes, coaches) to share messages could motivate males to talk.

DISCUSSION

This study extends the existing literature by examining male perspectives of partner sexual risk communication and by exploring the specific content of these discussions. Focus groups were used to elicit information about participants’ behavioral intentions, attitudes, and beliefs towards pregnancy, sex, and contraception learned in the context of exploring sexual risk communication with their partners. Information was also gathered about how to promote improved partner sexual risk communication. Structured

within the aforementioned conceptual framework and literature, this discussion attempts to address each of the study's research questions.

Attitudes about Pregnancy

Previous research (Gilmore et al., 1996) investigated the beliefs associated with decisions to have sexual intercourse and to use condoms. Gilmore and colleagues (1996) identified that one of the “bad things about sexual intimacy” was an unintended pregnancy. This study further supports these findings and suggests that young males want to avoid an unintended pregnancy and fatherhood at this point in their lives. Both African American and White teens talked about how if they learned that their partner was pregnant, they would feel “scared” and “like a failure.” Most participants were primarily focused on the consequences (i.e., “sacrifices” of time, energy, money, personal/professional goals) of dealing with both a pregnancy and a child as a teen. Many focus group participants acknowledged their role and said that they do their part in preventing a pregnancy by using condoms.

While acknowledging the importance of using condoms (“[sex] was gonna be with a condom”), some participants described how consistent condom use can be a challenge. A White male's comments encapsulated this idea: “I mean I think you know what you should do, but it's a matter of actually doing it, which throws teenagers off, because they're more in the moment.” Participants shared honest accounts (i.e., “forget that, I'm going in”) of unprotected sex. Regardless of race, teens said that planning ahead for condom availability could affect the likelihood of use. These findings corroborated Johnson and Williams' (2005) research in which “denial” was identified as a theme related to the fact that participants were aware of the risks of unintended

pregnancy and yet chose behaviors that increased the likelihood of conception.

Furthermore, Landry and Camelo (1994) found that both men and women reported “occasional” sex with no contraceptive method or used a method other than condoms with casual partners.

Males’ Role in the Use of Contraception

Johnson and Williams (2005) concluded that men need increased knowledge about contraception, and additional research should focus on male’s role and responsibility in contraceptive use and partner communication. In that study (Johnson & Williams, 2005), males typically relied on their partners to use contraception and most said that they had only a “supporting role.” However, in this study, participants felt that using contraception was a “shared” responsibility between the male and the female partners. Overall, participants felt that it was the male’s responsibility to “wear a condom” and the female’s responsibility to take a hormonal method (i.e., “the pill,” “the shot”) of contraception.

Nevertheless, in every African American focus group and one White group, participants shared comments that demonstrated a lack of trust in their partner to correctly and to consistently use contraception. “Just ‘cause the girl say she’s on [birth control] doesn’t mean she’s on [birth control],” said an African American participant. These beliefs support earlier findings (Gilmore et al., 1996) where young (15-19 years old) African American men believed that their partners were dishonest about contraception use.

When African American participants were probed about why females may intentionally not use or damage contraception, teens said that it was an effort “to trap” them. An African American teen further explained this idea, “[Girls] know we smart and they see we’re going on to a right path...they might try to trap you.” Surprisingly, in the African American groups, some participants said that their parents were the ones who warned them that females may intentionally not use or damage contraception. As an example, an African American teen said that his mother alleged that females may intentionally damage condoms (“Momma said, it’s a condom all right but that little needle, that little hole”). This phenomenon can be supported by Socialization Theory, where the attitudes and behaviors modeled by parents are learned by their children and manifested in adolescence and adulthood (Philliber, 1980).

Parental influence and communication was also evident in participants’ belief that contraception does not always work. “My momma said [birth control] don’t work,” said an African American teen. Regardless of race, participants frequently stated “don’t trust [birth control]” and “[birth control] doesn’t always work.” However, during follow-up (member checking) interviews, one White male and one African American male said that birth control failure had more to do with “user error” and “inconsistent use.” “User error” could potentially be a result of lack of correct knowledge about contraception. This assumption is supported by Johnson and Williams’ (2005) finding that even well-educated men did not have accurate knowledge about contraceptive methods.

Males' Experiences Communicating with Partners

In a previous study, the most prominent reason that participants gave for not talking to their partner about sex and contraception was fear of a negative reaction, which the researchers later found to be largely unjustified (Coleman & Ingham, 1999). This study supports Coleman and Ingham's later conclusion in regards to "serious" relationships. Teens' stories demonstrated that their partners' (i.e., girlfriends) were receptive to on-going conversations about sex and contraception. However, in more "casual" relationships, participants said that conversations were either limited (i.e., "two or three texts") or nonexistent because of the timing (i.e., "just happens"), focus on physical pleasure (i.e., "don't care about anything but the sex"), or the uncomfortable nature (i.e., "I don't think it's comfortable for either one at the time") of the interaction. Landry and Camelo (1994) also concluded that racially diverse males rarely discussed contraceptive use with casual partners.

Gilmore and colleagues (1996) suggested that some young men have a belief or fear that their partner is lying, which may hinder partner communication about birth control and condom use. One of this study's emerging themes was mistrust of partners to correctly and consistently use contraception. Because of this mistrust, especially among "casual" partners, there may be less partner communication about sex and contraception.

Furthermore, in a similar study, adolescents who were more satisfied in their relationship were more open to communicating about sexual topics (Widman et al., 2006). When probed about the difference in conversations with serious versus casual partners, one White male said, "You just trust each other more, so you're gonna have

more of an in-depth conversation.” Additionally, constructs of the Social Judgment Theory (Sherif et al., 1965) can be used to strengthen the participants’ accounts of meaningful communication experiences with their serious partners.

Strategies Promoting Partner Communication about Sex and Contraception

According to previous studies (Johnson & Williams, 2005; Landry & Camelo, 1994), there is a need for studies and interventions focused on exploring methods to increase partner communication about sex and contraception. In this study, participants were asked to suggest ways to motivate young men to talk to their partners about sex and contraception. Regardless of race, participants said that having straight-forward messages, like the anti-smoking campaigns, that focused on the consequences of unprotected sex would provide motivation. Participants suggested using the school system, social media or technology to spread messages encouraging partner communication about sex and contraception.

LIMITATIONS OF THE STUDY

Although this study provides insight into a population that has received little attention in this area, it is not without limitations. The males that self-selected for participation may be more comfortable talking about sexuality than those that chose not to participate. Therefore, these results may not accurately represent all 18-19 year old African American and White males. However, focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from “information-rich cases” for the development of future programs and interventions (Patton, 2002).

The researcher's presence during data gathering, which is often unavoidable in qualitative research, could have affected the subjects' responses (Anderson, 2010). To reduce the impact of these “interviewer effects,” the focus groups were conducted by gender-concordant moderators (Choi & Comstock, 1975). Additionally, focus group participants may have presented socially desirable depictions of their sexual and family relationships. To help reduce this bias, participants were assured that there are no right or wrong responses and that the data was de-identified.

Because the participants were asked to remember their experiences from five to ten years ago, there was the potential for recall bias. Participants may not have accurate memories of their conversations with their parents. However, the decision to use retrospective recall was related to IRB minor consent requirements. If the participants were under 18 years old, parental consent would be required which could have been potentially uncomfortable for both the parent and child, and could have compromised recruitment and sample size. The focus group moderators attempted to address this retrospective limitation by orienting the participants in a way to limit bias. Another related limitation is the lack of data from the partner's perspective.

The researcher acknowledged that there was potential for researcher bias due to the significant reliance on the researcher's experience and judgment when using qualitative methods. However, member checking and field notes were used to mitigate bias. Another potential limitation was changes to the research instrument, when moderators became more proficient and more probing in later focus groups thus producing more rich responses. To address this concern, the moderators used a detailed focus group implementation guide. Furthermore, to ensure familiarity and consistency,

all moderators participated in a training session, where the focus group implementation guide was reviewed (Choi & Comstock, 1975).

This study was also subject to the limitations inherent in the conceptual framework, which served as a guide for developing the research questions. However, “open coding” and subsequently “axial coding” of the data allowed the researcher to account for themes that may emerge outside of the original framework (Strauss & Corbin, 1998).

IMPLICATIONS

Although limited, the studies that have explored adolescent partner communication from the males’ perspective were conducted more than ten years ago. Often, these studies (Landry & Camelo, 1994; Gilmore et al., 1996) reflect the mid-1990s emphasis on HIV/AIDS prevention. Given the time lapse and the evolving perspective of HIV/AIDS from a death sentence to a chronic disease (Mandell, 2010), there was reason to explore males beliefs, attitudes and behavioral intentions related to contraception and partner communication. Furthermore, there are few qualitative studies that have deeply examined this topic for purposes of informing the development of an adolescent male sexual risk reduction intervention. This study adds to the existing literature by examining the content and quality of conversations between males and their partners. The findings have several implications for research and practice.

Additional research should be focused on understanding the concepts of partner mistrust and entrapment, predominantly observed among young African American teens. It would be interesting to explore the role that parents, especially mothers, may play in fostering these beliefs and related implications. Furthermore, examining the topic from

the female partner perspective may also provide additional insights. Another area for exploration is the belief that contraception does not work. Specifically, investigating the origins of this phenomenon and how mistrust of contraception influences contraceptive practices.

In this study, males recognized that they have a role in preventing an unintended pregnancy. Overall, study participants felt that using contraception was a “shared” responsibility between the male and the female partners. These findings have immediate implications for practice. Teen pregnancy prevention professionals should support programs tailored for males that encourage them “to own their share” of the responsibility for contraception. Programs and health communication campaigns should build upon current beliefs (i.e., the importance of using condoms) and expand to address the barriers to consistent condom use.

Table 4.3. Demographic and Behavioral Characteristics of Focus Group Participants (N=30)

| Variable | Sample (N=30)^a | |
|---|----------------------------------|-------------|
| | <i>f</i> | (%) |
| Age | | |
| 18 years old | 24 | 80.0 |
| 19 years old | 6 | 20.0 |
| Race | | |
| African American | 14 | 46.7 |
| White | 16 | 53.3 |
| Current Living Situation | | |
| Living with roommates/friends | 3 | 10.0 |
| Living with family | 25 | 83.3 |
| Other | 2 | 6.7 |
| Living Situation When Young | | |
| Lived with both biological or step-parents | 16 | 53.3 |
| Lived with biological or step-mother | 7 | 23.3 |
| Lived with biological or step-father | 2 | 6.7 |
| Rotated living between biological or step-mother or father | 4 | 13.3 |
| Other | 1 | 3.3 |
| Current Employment Status | | |
| Not employed | 14 | 46.7 |
| Employed <30 hrs./wk. (Part time) | 13 | 43.3 |
| Employed >30 hrs./wk (Full time) | 3 | 10.0 |
| First Member of Family to Attend College, n=29 ^a | | |
| Yes | 3 | 10.3 |
| No | 23 | 79.3 |
| Do not know | 3 | 10.3 |
| Ever Diagnosed by a Doctor as Having an STD | | |
| No | 30 | 100.0 |
| Ever Gotten a Female Pregnant | | |
| Yes | 3 | 10.0 |
| No | 25 | 83.3 |
| Do not know | 2 | 6.7 |
| Current Relationship Status | | |
| Single | 14 | 46.7 |
| Casual Relationship (i.e., hook-ups, dating) | 9 | 30.0 |
| Serious Relationship (i.e., girlfriend) | 7 | 23.3 |
| Variable | <i>M</i> | (SD) |
| Age at First Sexual Intercourse, n=29 ^a | 15.6 | 1.4 |

^aTotal Sample is 30, unless otherwise noted

Table 4.4. Summary of Commonly Expressed Themes and Sub-Themes by Race

| Major Themes and Sub-themes | Groups* | Theory/Construct |
|--|---------|--|
| <i>Attitudes about Pregnancy</i> | | |
| Desire to Avoid Pregnancy | AAM, WM | Theory of Planned Behavior/ |
| Male's Role in Preventing Pregnancy: Wear a Condom | AAM, WM | Attitude and Behavioral Intention |
| <i>Males' Role in the Use of Contraception</i> | | |
| Shared Responsibility | AAM, WM | Theory of Planned Behavior/ |
| Mistrust of Partners to Use Contraception | AAM | Perceived Behavioral Control |
| Contraception Does Not Always Work | AAM, WM | Socialization Theory/ Learned attitudes and behaviors |
| <i>Partner Communication about Sex and Contraception</i> | | |
| The Type of Relationship | | |
| Casual Partner | AAM, WM | Social Judgment Theory |
| Serious Partner | AAM, WM | |
| <i>Strategies to Promote Partner Communication</i> | | |
| Focusing on the Consequences of Unprotected Sex | AAM, WM | Social Judgment Theory |
| Spreading the Message | AAM, WM | Theory of Planned Behavior/ Attitudes and Beliefs |

*AAM=African American Males; WM=White Males

REFERENCES

- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckmann (Eds.), *Action-control: From Cognition to Behavior* (pp. 11-39). Heidelberg: Springer.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179 –211.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Biernacki, P., & Waldorf, D. (1981). Snowball sampling: problems and techniques of chain referral sampling. *Sociological Methods and Research*, 10(2), 141-163.
- Centers for Disease Control and Prevention (CDC). (2010). Youth Risk Behavior Surveillance – United States, 2009. *Morbidity and Mortality Weekly Report*, 59(SS-5), 1–142.
- Choi, I.C., & Comstock, G.W. (1975). Interview effect on responses to a questionnaire relating to mood. *American Journal of Epidemiology*, 101(1), 84-92.
- Coleman, L.M., & Ingham, R. (1999). Exploring young people's difficulties in talking about contraception: how can we encourage more discussions between partners? *Health Education Research*, 14(6), 741-750.
- DiClemente, R. J., Wingood, G. M., Crosby, R., Cobb, B. K., Harrington, K., & Davies, S. L. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *Journal of Pediatrics*, 139(3), 407-412.
- DiClemente, R.J., Wingood, G.M., Rose, E.S., Sales, J.M., Lang, D.L., Caliendo, A.M., ... Crosby, R.A. (2009). Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African American adolescent females seeking sexual health services. *Archives of Pediatric & Adolescent Medicine*, 163(12), 1112–1121.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention and behavior*. Reading, MA: Addison-Wesley.

- Gilmore, S., DeLamater, J., & Wagstaff, D. (1996). Sexual decision making by inner city Black adolescent males: A focus group study. *The Journal of Sex Research*, 33(4), 363-371.
- Glaser, B.G., & Strauss, A. (1967). *The discovery of grounded theory: strategies for qualitative research*. New York, NY: Aldine de Gruyter.
- Guba, E. G., & Lincoln, Y.S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Halpern, E. S. (1983). Auditing naturalistic inquiries: The development and application of a model. (Unpublished doctoral dissertation). Indiana University, Bloomington, IN.
- Hoffman, S.D. (2008). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.
- Hutchinson, M. K., Jemmott, J. B., III, Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health*, 33(2), 98-107.
- Jaccard, J., Dittus, P.J., & Gordon, V.V. (1996). Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives*, 28, 159-65.
- Johnson, S.D., & Williams, L.B. (2005). Deference, denial, and exclusion: Men talk about contraception and unintended pregnancy. *International Journal of Men's Health*, 4(3), 223-242.
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
- Krueger, R.A., & Casey, M.A. (2000). *Focus groups: A practical guide for applied researchers* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Landry, D. J., & Camelo, T. M. (1994). Young unmarried men and women discuss men's role in contraceptive practice. *Family Planning Perspectives*, 26, 222-27.
- Mandell, Brian. (2010). HIV: Just another chronic disease. *Cleveland Clinic Journal of Medicine*, 77, 8.
- Mathews, T., Sutton, P., Hamilton, B., & Ventura, S. (2010). State disparities in teenage birth rates in the United States (National Center for Health Statistics data brief, no. 46.) Hyattsville, MD: United States Department of Health and Human Services.

- Miller, B.C., & Fox, G.L. (1987). Theories of adolescent heterosexual behavior. *Journal of Sex Research*, 2, 269-282.
- Morgan, D. L. (1998). *The focus group guidebook*. Thousand Oaks, CA: Sage.
- National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP). (2011). *Counting It Up: The Public Costs of Teen Childbearing*. Retrieved from <http://www.thenationalcampaign.org/costs/default.aspx>.
- Onwuegbuzie, A.J., & Leech, N.L. (2007). Validity and qualitative research: An oxymoron? *Quality and Quantity*, 41, 233-249.
- Onwuegbuzie, A.J., Dickinson, W.B., Leech, N.L., & Zoran, A.G. (2009). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods*, 8(3), 1-21.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. (3rd ed.). Thousand Oaks, CA: Sage.
- Pazol, K., Warner, L., Gavin, L., Callaghan, W.M., Spitz, A.M., Anderson, J.E.,... Kann, L. (2011). Vital Signs: Teen pregnancy in the United States, 1991-2009. *Morbidity and Mortality Weekly Report*, 60(13), 414-420.
- Perper, K., Peterson, K., & Manlove, J. (2010). *Diploma attainment among teen mothers*. (Fact Sheet Publication #2010-01). Washington, DC: Child Trends.
- Philliber, S.G. (1980). A conceptual framework for population socialization. *Population and Environment*, 3, 3-9.
- QSR NVivo [computer program]. (2012). Version 10. Melbourne, AU: Qualitative Solutions and Research Pty Ltd.
- Sherif, M., Sherif, K., & Nebergall, R. (1965). *Attitude and attitude change: The social judgment involvement approach*. Philadelphia, PA: Saunders.
- Singh, S., & Darroch, J.E. (2000). Adolescent pregnancy and childbearing: levels and trends in developed countries. *Family Planning Perspectives*, 32(1), 14-23.
- Stewart, D.W., & Shamdasni, P.N. (1994). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

- Van Manen, M. (1990). *Researching lived experience: human science for an action sensitive pedagogy*. London: Althouse Press.
- Whitaker, D.J., Miller, K.S., May, D.C., & Levin, M.L. (1999). Teenage partners' communication about sexual risk and condom use: The importance of parent-teenager discussions. *Family Planning Perspectives*, 31(3), 117-121.
- Widman, L., Welsh, D.P., McNulty, J.K., & Little, K.C. (2006). Sexual communication and contraceptive use in adolescent dating couples. *Journal of Adolescent Health*, 39(6), 893-899.
- Wilkinson, S. (2004). Focus group research. In D. Silverman (Ed.), *Qualitative research: Theory, method, and practice* (pp. 177–199). Thousand Oaks, CA: Sage.

CHAPTER 5

DISCUSSION

This chapter discusses the study results. The study aims and research questions will be used as a framework for discussing the results of the study. This chapter also includes a discussion of the application of the theoretical framework. Finally, this chapter concludes with an acknowledgement of the study limitations, implications for practice and future research, and final conclusions.

Specific Aim 1: To explore African American and White 18-19 year old males' experiences of sexual risk communication with their parents during early adolescence and how these experiences affected their attitudes and beliefs about sex, pregnancy, and contraception.

This study extends the existing literature by examining male perspectives of parent-child sexual risk communication and by exploring the specific content of these discussions. Focus groups were used to elicit information about participants' attitudes and behaviors towards sex and contraception learned in the context of sexual risk communication with their parents during early adolescence and how it affects their attitudes, beliefs and behaviors in late adolescence. Information was also gathered about how to promote improved parent-child sexual risk communication. This component of the study was guided by three research questions. First, "What experiences did African

American and White 18-19 year old males have with their parents communicating with them about sex and contraception when they were young?” Second, “What are African American and White 18-19 year old males’ beliefs and attitudes about sex and contraception?” Finally, “What do African American and White 18-19 year old males think should be the nature of the communication between parents and their children?” Structured within the conceptual framework and literature, this discussion attempts to address each of these research questions.

Parenting Styles

Previous research (Miller et al., 2001) suggested that the impact of parent-child communication depends on overall parenting style (Baumrind, 1991), including the degree of parent-child closeness. This study further supports these findings and suggests that parenting style influences the nature of the communication between parents and their children.

Both African American and White teens said “it’s all in your parenting.” Participants said that it was important to have a history of an “open” and honest relationship with their sons in order to facilitate more difficult conversations, such as those about sex and contraception. In this study, participants’ interpretation of an open and honest parent-child relationship included parents being a constant presence (“be with your son when he’s young”) and participating in daily activities. The ideals described by the participants align with high levels of parental responsiveness, a hallmark of “authoritative” parenting (Baumrind, 1991).

However, among the African American participants, several mentioned a preference for fathers acting “as a parent and as a friend.” Overall, the conversations that

African American males had with their fathers were more explicit (i.e., “go get what [you] can get”) than those of their White counterparts. These types of conversations may reflect a changing nature of the role of the father into more of a peer or friend. It is also worth noting that only 6 out of the 14 (42.9%) African American participants reported living in a household with their biological or step-father when they were young.

In the current study, one of the reasons that participants thought that parents did not talk to their sons about sex and birth control was life’s competing priorities. Such competing priorities, including work and household obligations, and other related social factors could influence parental responsiveness and overall parenting style.

Parent-Child Sexual Risk Communication

In previous studies (Jaccard et al., 1998), adolescents typically only reported parent-child sexual risk communication that they considered “noteworthy.” In this study, participants had to recall experiences from five to ten years earlier. Given this time interval, participants may not have accurate memories of their conversations with their parents. Like such earlier studies, participants may have had a tendency to recall only significant encounters.

However, Jaccard and colleagues (1998) also found that adolescent perceptions and reports were more predictive of sexual behavior than maternal reports. The messages that focus group participants said that their parents most often shared were to use condoms, practice abstinence, and avoid getting a female pregnant. In alignment with Socialization Theory (Philliber 1980), the importance of condom use and abstinence were also messages that participants said that they would encourage with their own [future]

children. Although this message is seemingly conflicting, participants (and their parents) believed that abstinence should be promoted first, but condoms should be encouraged if a teen chooses to become sexually active.

Although most participants said that they preferred to talk with their fathers about sex, their mothers often initiated the topic with their sons. Furthermore, the perspective of an African American teen was that “guys want to hear from [the parent] that they are closest to.” African American participants most often discussed their mothers’ dominant role in talking with them about sex and birth control, which is consistent with previous research (Jaccard et al., 1998). One of the possible reasons for these experiences was that many of the African American participants (50.0%) lived with only their biological or step-mother when they were young.

Clawson and Reese-Weber (2003) concluded that emphasis should be placed on encouraging parents to discuss sexuality with their child prior to initiation of sexual activity. Their study (Clawson and Reese-Weber, 2003) suggested additional research with African American adolescents. In this study, the majority of White teens said that their parents talked to them prior to their first sexual experience. While in the focus groups with African American teens, the majority of participants said that their parents talked to them after their first sexual experience. The conversations took place around the end of middle school or beginning of high school for both African American (12-15 years) and White (12-14 years) participants. According to participant responses to the sociodemographic questionnaire, there was a significant difference in the average age of first sexual intercourse among African American males ($M = 14.75$ years, $SD = 2.06$) as compared to White males ($M = 16.14$ years, $SD = 0.69$) in the sample; $t(28) = 2.54, p <$

0.05. This finding further supports the research (Somers & Ali, 2011) that suggested that parents should talk to their children earlier about sexual risk behaviors.

According to de Visser (2005), there is a need for exploring ways to develop parents' skills and motivations for talking to their children about sexual health. In the current study, participants were asked to suggest ways to motivate parents to talk to their sons about sex and contraception. Both African American and White teens said "it's all in your parenting." Many participants felt that parent-child sexual risk communication would be easier when parents had a history of open communication and a good relationship with their son. Participants' felt that an open and honest relationship could be established easier when parents were a constant presence and participated in daily activities. During these normal interactions, such as "shooting hoops," parents should "ease into" tough subjects, like sex and contraception.

Males Beliefs and Attitudes about Sex and Contraception

In this study, the research question about beliefs and attitudes was examined by asking the participants what they would want their future sons and daughters to know about sex and contraception. Most participants' indicated that their responses would be different based on the gender of their child. Similar to the findings from Gilmore and colleagues (1996), participants would emphasize the importance of condom use with their male children. In keeping with Socialization Theory (Philliber, 1980) and the construct of subjective norm of the Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991), participants said that they would encourage their sons to "use protection" in a manner "like my dad told me."

However, with female children, participants' messages quickly changed to stress abstinence. During the focus groups, the concept of "liability" emerged related to participants' desire for their daughters to not bear the physical burden of a teen pregnancy or be viewed as promiscuous (i.e., "a ho"). From the majority of participants' perspectives, this "liability" could be avoided by females maintaining their virginity as opposed to using correct and consistent forms of contraception.

Specific Aim 2: To explore African American and White 18-19 year old males' experiences of sexual risk communication with their partners, how these experiences were affected by parental sexual risk communication during early adolescence, and how to promote sexual risk communication among partners.

This study extends the existing literature by examining male perspectives of partner sexual risk communication and by exploring the specific content of these discussions. Focus groups were used to elicit information about participants' behavioral intentions, attitudes, and beliefs towards pregnancy, sex, and contraception learned in the context of exploring sexual risk communication with their partners. Information was also gathered about how to promote improved partner sexual risk communication. This component of the study was guided by four research questions. First, "What do African American and White 18-19 year old males think about pregnancy at this point in their life?" Second, "What do African American and White 18-19 year old males think is their role in the use of contraception?" Third, "What are the experiences that African American and White 18-19 year old males have had with communicating with their partners about sex and contraception, and what is the potential connection to childhood parental communication?" Finally, "What do African American and White 18-19 year

old males think should be the nature of strategies promoting partner communication about sex and contraception?”

Attitudes about Pregnancy

Previous research (Gilmore et al., 1996) investigated the beliefs associated with decisions to have sexual intercourse and to use condoms. Gilmore and colleagues (1996) identified that one of the “bad things about sexual intimacy” was an unintended pregnancy. This research further supports these findings and suggests that young males want to avoid an unintended pregnancy and fatherhood at their age (18-19 years old). Both African American and White teens talked about how if they learned that their partner was pregnant, they would feel “scared” and “like a failure.” Most participants were primarily focused on the consequences (i.e., “sacrifices” of time, energy, money, personal/professional goals) of dealing with a pregnancy and a child as a teen. Many focus group participants acknowledged their role and said that they could do their part in preventing a pregnancy by using condoms. These findings align with the study’s conceptual framework, or specifically constructs from the TPB (Ajzen, 1985; Ajzen, 1991), where a person’s attitude towards a behavior is one of the primary determinants of behavioral intentions.

While acknowledging the importance of using condoms (“[sex] was gonna be with a condom”), some participants described how consistent condom use can be a challenge. A White male’s comments encapsulated this idea: “I mean I think you know what you should do, but it's a matter of actually doing it, which throws teenagers off, because they're more in the moment.” Participants shared honest accounts (i.e., “forget

that, I'm going in") of unprotected sex. Regardless of race, teens said that planning ahead for condom availability could affect the likelihood of use. These findings corroborated Johnson and Williams' (2005) research in which "denial that a pregnancy could occur" was identified as a theme related to the fact that participants were aware of the risks of unintended pregnancy and yet chose behaviors that increased the likelihood of conception.

Males' Role in the Use of Contraception

Johnson and Williams (2005) concluded that men need increased knowledge about contraception, and additional research should focus on male's role and responsibility in contraceptive use and partner communication. In that study (Johnson & Williams, 2005), males typically relied on their partners to use contraception and most said that they had only a "supporting role." However, in this study, participants felt that using contraception was a "shared" responsibility between the male and the female partners. Overall, participants felt that it was the guy's responsibility to "wear a condom" and the female's responsibility to use a hormonal method (i.e., "the pill," "the shot") of contraception.

Nevertheless, in every African American focus group and one White group, participants shared comments that demonstrated a lack of trust in their partner to correctly and to consistently use contraception. "Just 'cause the girl say she's on [birth control] doesn't mean she's on [birth control]," said an African American participant. These beliefs support earlier findings (Gilmore et al., 1996) where young (15-19 years

old) African American men believed that their partners were dishonest about contraception use.

When African American participants were probed about why females may intentionally not use or damage contraception, teens said that it was an effort “to trap” them. An African American teen further explained this idea, “[Girls] know we smart and they see we’re going on to a right path...they might try to trap you.” Surprisingly, in the African American groups, some participants said that their parents were the ones who warned them that females may intentionally not use or damage contraception. As an example, an African American teen said that his mother alleged that females may intentionally damage condoms (“Momma said, it’s a condom all right but that little needle, that little hole”). This phenomenon can be supported by Socialization Theory, where the attitudes modeled by parents are learned by their children and manifested in adolescence and adulthood (Philliber, 1980).

Parental influence and communication was also evident in participants’ belief that contraception does not always work. “My momma said [birth control] don’t work,” said an African American teen. Regardless of race, participants frequently stated “don’t trust [birth control]” and “[birth control] doesn’t always work.” However, during follow-up (member checking) interviews, one White male and one African American male said that birth control failure had more to do with “user error” and “inconsistent use.” “User error” could potentially be a result of lack of correct knowledge about contraception. This assumption is supported by Johnson and Williams’ (2005) finding that even well-educated men did not have accurate knowledge about contraceptive methods.

Males' Experiences Communicating with Partners

In a previous study, the most prominent reason that participants gave for not talking to their partner about sex and contraception was fear of a negative reaction, which the researchers later found to be largely unjustified (Coleman & Ingham, 1999). This study supports Coleman and Ingham's later conclusion in regards to "serious" relationships. Teens' stories demonstrated that their partners' (i.e., girlfriends) were receptive to on-going conversations about sex and contraception. However, in more "casual" relationships, participants said that conversations were either limited (i.e., "two or three texts") or nonexistent because of the timing (i.e., "just happens"), focus on physical pleasure (i.e., "don't care about anything but the sex"), or the uncomfortable nature (i.e., "I don't think it's comfortable for either one at the time") of the interaction. Landry and Camelo (1994) also concluded that males rarely discussed contraceptive use with casual partners.

Gilmore and colleagues (1996) suggested that some young men have a belief or fear that their partner is lying, which may hinder partner communication about birth control and condom use. One of this study's emerging themes was mistrust of partners to correctly and consistently use contraception. Because of this mistrust, especially among "casual" partners, there may be less partner communication about sex and contraception.

Furthermore, in a similar study, adolescents who were more satisfied in their relationship were more open to communicating about sexual topics (Widman et al., 2006). When probed about the difference in conversations with serious versus casual partners, one White male said, "You just trust each other more, so you're gonna have

more of an in-depth conversation.” Additionally, constructs of the Social Judgment Theory (Sherif et al., 1965) can be used to strengthen the participants’ accounts of meaningful communication experiences with their serious partners. As an example, an individual is more likely “to accept” a serious partner’s message (i.e., shared responsibility for contraception) when the message closely aligns with his or her own attitudes or beliefs about the subject (i.e., using contraception).

When considering the potential connection to childhood parental sexual risk communication, there are some parallels with partner communication. In this study, many participants felt that parent-child sexual risk communication would be easier when parents had a history of open communication and a good relationship with their son. Similarly, participants admitted that it is easier to talk with a serious partner (with whom they have an actual relationship) than a casual partner. According to study participants, this willingness to engage in partner communication is due to trust and openness – the same required needs for parental communication.

Strategies Promoting Partner Communication about Sex and Contraception

According to previous studies (Johnson & Williams, 2005; Landry & Camelo, 1994), there is a need for studies and interventions focused on exploring methods to increase partner communication about sex and contraception. In this study, participants were asked to suggest ways to motivate young men to talk to their partners about sex and contraception. Regardless of race, participants said that having straight-forward messages, like the anti-smoking campaigns, that focused on the consequences of unprotected sex would provide motivation. Participants suggested using the school

system, social media or technology to deliver messages encouraging partner communication about sex and contraception.

Use of Theory

The conceptual framework for this study was composed of constructs from three theories: Socialization Theory (Philliber, 1980), Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991) and Social Judgment Theory (Sherif et al., 1965). The study aims and research questions were based on these theories. The use of theory also facilitated the development of the focus group questions. As illustrated in Figure 5.1, the conceptual framework was useful for analyzing the data and providing a framework for discussion.

Socialization Theory is based on the idea that children and adolescents learn attitudes and behaviors early in life from adult role models, such as parents (Philliber, 1980). Socialization Theory (Philliber, 1980) has provided the basis for several related studies, including Clawson and Reese-Weber's (2003) examination of parent-adolescent sexual communication in relation to adolescent sexual behavior. This study explored African American and White 18-19 year old males' attitudes and behaviors in the context of their experiences of sexual risk communication with their parents during early adolescence. The basic tenets of Socialization Theory (Philliber, 1980) were supported by the study findings. Specifically, parental messages, such as the importance of condom use and abstinence, were the same messages that participants said that they would encourage with their own [future] children.

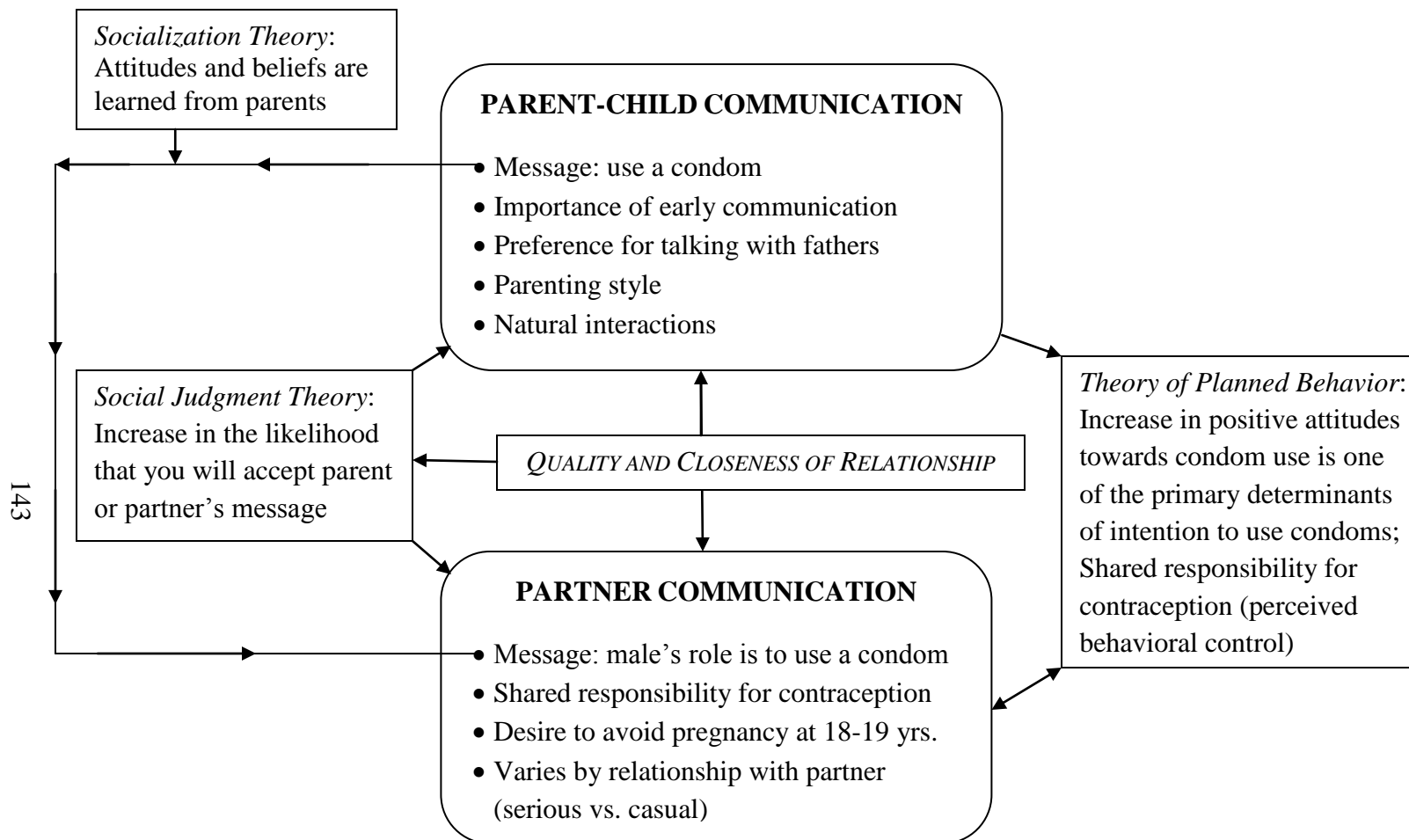


Figure 5.1 Integration of the Study Results and Conceptual Framework

NOTE: The conceptual framework for this study is composed of constructs from three theories: Socialization Theory (Philliber, 1980), Theory of Planned Behavior (Ajzen, 1985; Ajzen, 1991) and Social Judgment Theory (Sherif et al., 1965).

The Theory of Planned Behavior (TPB) assumes that *behavioral intention* is the most important determinant of a given behavior (Ajzen, 1985; Ajzen, 1991). According to TPB, a person's attitude towards a behavior (*attitude toward behavior*) and whether individuals who are important to the person approve or disapprove of the behavior (*subjective norm*) are the primary determinants of behavioral intentions (Ajzen, 1985; Ajzen, 1991). In this study, the focus groups assessed African American and White 18-19 year old males' intention to use condoms and contraception by inquiring about their thoughts and attitudes towards pregnancy at this point in their lives. Many focus group participants acknowledged their role and said that they could do their part in preventing a pregnancy by using condoms. These findings aligned with constructs from the TPB (Ajzen, 1985; Ajzen, 1991). *Perceived behavioral control* was also significant in the study (Ajzen, 1985; Ajzen, 1991). Specifically, African American and White 18-19 year old males were asked about their role in the use of contraception with sexual partners, which helped to clarify their perceived control related to engaging in sexual risk behaviors.

The final component of the study's conceptual framework was the Social Judgment Theory (Sherif et al., 1965), which explains how individuals judge the messages they receive. According to the theory, a listener judges how much a message agrees or disagrees with his or her own attitude or belief system (Sherif et al., 1965). Social Judgment Theory (Sherif et al., 1965) was applied to the study in three ways. First, the theory supported the focus group question designed to elicit ideas from the participants about ways to increase parent-child communication about sex and contraception. Second, the focus group participants were asked about the specific details

of partner conversation about sex and contraception and how receptive their partners were to the conversations. Lastly, the theory supported the final focus group question designed to elicit ideas from the participants for intervention strategies to increase partner communication about sex and contraception. Social Judgment Theory (Sherif et al., 1965) was used to strengthen the participants' accounts of meaningful communication experiences with their parents and "serious" partners.

Limitations of the Study

Although this study provides insight into a population that has received limited attention in this topical area, it is not without limitations. The males that self-selected for participation may be more comfortable talking about sexuality than those that chose not to participate. Therefore, these results may not accurately represent all 18-19 year old African American and White males across the United States. However, focus group results are not intended to be generalized to a larger population, but can be used as valuable insights from "information-rich cases" for the development of future programs and interventions (Patton, 2002).

The researcher's presence during data gathering, which is often unavoidable in qualitative research, could have affected the subjects' responses (Anderson, 2010). To reduce the impact of these "interviewer effects," the focus groups were conducted by gender-concordant moderators (Choi & Comstock, 1975). Additionally, focus group participants may have presented socially desirable depictions of their family relationships. To help reduce this bias, participants were assured that there are no right or wrong responses and that the data was de-identified.

Because the participants were asked to remember their experiences from five to ten years ago, there was the potential for recall bias. Participants may not have accurate memories of their conversations with their parents. However, the decision to use retrospective recall was related to IRB minor consent requirements. If the participants were under 18 years old, parental consent would be required which could have been potentially uncomfortable for both the parent and child, and could have compromised recruitment and sample size. The focus group moderators attempted to address this retrospective limitation by orienting the participants in a way to limit bias. Another related limitation is the lack of data from the parents' perspective.

The researcher acknowledged that there was potential for researcher bias due to the significant reliance on the researcher's experience and judgment when using qualitative methods. However, member checking and field notes were used to mitigate bias. Another potential limitation was changes to the research instrument, when moderators became more proficient and more probing in later focus groups thus producing more rich responses. To address this concern, the moderators used a detailed focus group implementation guide. Furthermore, to ensure familiarity and consistency, all moderators participated in a training session, where the focus group implementation guide was reviewed (Choi & Comstock, 1975).

This study was also subject to the limitations inherent in the conceptual framework, which served as a guide for developing the research questions. However, "open coding" and subsequently "axial coding" of the data allowed the researcher to account for themes that may emerge outside of the original framework (Strauss & Corbin, 1998).

Implications for Future Research and Practice

While considerable research has been conducted to identify the effects of parent-child sexual risk communication on the sexual risk behaviors of adolescents, the majority of the literature has focused on the impact on females' sexual risk behaviors (Coleman & Ingham, 1999; DiClemente et al., 2001; Hutchinson et al., 2003). This research has been used to develop promising interventions, such as HORIZONS (DiClemente et al., 2009), that target adolescent females to reduce sexual risk behaviors. There are few qualitative studies that have deeply examined this topic for purposes of informing the development of an adolescent male sexual risk reduction intervention, which is the long-term goal of this research. In addition, this study adds to the existing literature by examining the quality of conversations between males and their parents. The findings have several implications for research and practice.

Additional research should be focused on the influence of varying parenting styles on parent-child sexual risk communication. Parenting styles are influenced by social and contextual influences. It may be interesting to explore how some of these influences, such as single-parent families, female-headed families and lower socio-economic status, affect parenting style and sexual risk communication. Furthermore, examining parental perspectives on these topics may also provide additional insights. Another area for exploration is the father-son relationship and its influence on sexual risk communication and behaviors. Specifically, investigating how the changing role of the father into the peer/friend influences the son's sexual risk behaviors.

The findings related to the timing of parent-child sexual risk communication have immediate implications for practice. Teen pregnancy prevention professionals should

support programs that encourage parents to incorporate developmentally appropriate messages into natural interactions with their children during childhood and throughout adolescence. Parents should talk to their children about sex and contraception at an early age prior to sexual initiation. Furthermore, programs should build on the current messages (i.e., “wear protection”) that males are receiving and expand to include current a more comprehensive view of sexual health (i.e., information beyond just the importance of wearing a condom).

Although limited, the studies that have explored adolescent partner communication from the males’ perspective were conducted more than ten years ago. Often, these studies (Landry & Camelo, 1994; Gilmore et al., 1996) reflect the mid-1990s emphasis on HIV/AIDS prevention. Given the time lapse and the evolving perspective of HIV/AIDS from a death sentence to a chronic disease (Mandell, 2010), there was reason to explore males beliefs, attitudes and behavioral intentions related to contraception and partner communication. Furthermore, there are few qualitative studies that have deeply examined this topic for purposes of informing the development of an adolescent male sexual risk reduction intervention. This study adds to the existing literature by examining the content and quality of conversations between males and their partners. The findings have several implications for research and practice.

Additional research should be focused on understanding the concepts of partner mistrust and entrapment, predominantly observed among young African American teens. It would be interesting to explore the role that parents, especially mothers, may play in fostering these beliefs and related implications. Furthermore, examining the topic from the female partner perspective may also provide additional insights. Another area for

exploration is the belief that contraception does not work. Specifically, investigating the origins of this phenomenon and how mistrust of contraception influences contraceptive practices.

In this study, males recognized that they have a role in preventing an unintended pregnancy. Overall, study participants felt that using contraception was a “shared” responsibility between the male and the female partners. These findings have immediate implications for practice. Teen pregnancy prevention professionals should support programs tailored for males that encourage them “to own their share” of the responsibility for contraception. Programs and health communication campaigns should build upon current beliefs (i.e., the importance of using condoms) and expand to address the barriers to consistent condom use, especially with casual partners.

Conclusions

This qualitative study explored African American and White 18-19 year old males’ communication experiences with their parents and partners about sex and contraception, and their attitudes and beliefs about sex, pregnancy, and contraception. Although there is a great deal of literature in this field, there are few qualitative studies that have deeply examined this topic for purposes of informing the development of adolescent male sexual risk reduction interventions.

Health promotion professionals interested in reducing adolescent sexual risk behaviors should carefully consider the findings of this study. The results may be useful for developing pilot interventions to support: 1) the improvement of parent-child sexual risk communication among African American and White males and their parents; and 2)

the improvement of partner communication about sex and contraception among African American and White males and their partners.

REFERENCES

- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckmann (Eds.), *Action-control: From Cognition to Behavior* (pp. 11-39). Heidelberg: Springer.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179 –211.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Anderson, C. (2010). Presenting and evaluating qualitative research: strengths and limitations of qualitative research. *American Journal Pharmaceutical Education*, 74(8), 1-7.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Baumrind, D. (1966). Effects of authoritative parental control on child behavior. *Child Development*, 37, 887-907.
- Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance use. *Journal of Early Adolescence*, 11(1), 56-95.
- Biernacki, P., & Waldorf, D. (1981). Snowball sampling: problems and techniques of chain referral sampling. *Sociological Methods and Research*, 10(2), 141-163.
- Centers for Disease Control and Prevention (CDC). (2010). Youth Risk Behavior Surveillance – United States, 2009. *Morbidity and Mortality Weekly Report*, 59(SS-5), 1–142.
- Centers for Disease Control and Prevention (CDC). (2011). *Sexually Transmitted Disease Surveillance 2010*. Atlanta,GA: U.S. Department of Health and Human Services.
- Centers for Disease Control and Prevention (CDC). (2012). Winnable Battles. Retrieved from <http://www.cdc.gov/winnablebattles/>.
- Choi, I.C., & Comstock, G.W. (1975). Interview effect on responses to a questionnaire relating to mood. *American Journal of Epidemiology*, 101(1), 84-92.

- Clawson, C. L., & Reese-Weber, M. (2003). The amount and timing of parent-adolescent sexual communication as predictors of late adolescent sexual risk-taking behaviors. *The Journal of Sex Research*, 40(3), 256-265.
- Coleman, L.M., & Ingham, R. (1999). Exploring young people's difficulties in talking about contraception: how can we encourage more discussions between partners? *Health Education Research*, 14(6), 741-750.
- de Visser, R. (2005). One size fits all? Promoting condom use for sexually transmitted infection prevention among heterosexual young adults. *Health Education Research*, 20(5), 557-566.
- DiClemente, R. J., Wingood, G. M., Crosby, R., Cobb, B. K., Harrington, K., & Davies, S. L. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *Journal of Pediatrics*, 139(3), 407-412.
- DiClemente, R.J., Wingood, G.M., Rose, E.S., Sales, J.M., Lang, D.L., Caliendo, A.M., ... Crosby, R.A. (2009). Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African American adolescent females seeking sexual health services. *Archives of Pediatric & Adolescent Medicine*, 163(12), 1112-1121.
- Duggleby, W. (2005). What about focus group interaction data? *Qualitative Health Research*, 15, 832-840.
- Dutra, R., Miller, K., & Forehand, R. (1999). The process and content of sexual communication with adolescents in two-parent families: Associations with sexual risk-taking behavior. *AIDS and Behavior*, 3, 59 -66.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention and behavior*. Reading, MA: Addison-Wesley.
- Gilmore, S., DeLamater, J., & Wagstaff, D. (1996). Sexual decision making by inner city Black adolescent males: A focus group study. *The Journal of Sex Research*, 33(4), 363-371.
- Glaser, B.G., & Strauss, A. (1967). *The discovery of grounded theory: strategies for qualitative research*. New York, NY: Aldine de Gruyter.
- Guba, E. G., & Lincoln, Y.S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Halpern, E. S. (1983). Auditing naturalistic inquiries: The development and application of a model. (Unpublished doctoral dissertation). Indiana University, Bloomington, IN.

- Hamilton, B.E., Martin, J.A., & Ventura, S.J. (2011). Births: Preliminary data for 2010. *National Vital Statistics Reports*, 60(2).
- Hoffman, S.D. (2008). *Kids having kids: Economic costs and social consequences of teen pregnancy*. Washington, DC: The Urban Institute Press.
- Hutchinson, M. K. (2002). The influence of sexual risk communication between parents and daughters on sexual risk behaviors. *Family Relations*, 51, 238-247.
- Hutchinson, M. K., Jemmott, J. B., III, Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health*, 33(2), 98-107.
- Jaccard, J., Dittus, P.J., & Gordon, V.V. (1996). Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives*, 28, 159-65.
- Jaccard, J., Dittus, P.J., & Gordon, V.V. (1998). Parent-adolescent congruency in reports of adolescent sexual behavior and in communications about sexual behavior. *Child Development*, 69(1), 247-261.
- Johnson, S.D., & Williams, L.B. (2005). Deference, denial, and exclusion: Men talk about contraception and unintended pregnancy. *International Journal of Men's Health*, 4(3), 223-242.
- Kershner, S. & Flynn, S. (2009). *Population left behind 2009: An assessment of sexual health information and services provided by South Carolina colleges and universities*. Columbia, SC: SC Campaign to Prevent Teen Pregnancy.
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
- Krueger, R.A., & Casey, M.A. (2000). *Focus groups: A practical guide for applied researchers* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Landry, D. J., & Camelo, T. M. (1994). Young unmarried men and women discuss men's role in contraceptive practice. *Family Planning Perspectives*, 26, 222-27.
- Mandell, Brian. (2010). HIV: Just another chronic disease. *Cleveland Clinic Journal of Medicine*, 77, 8.
- Martinez, G., Copen, C.E., & Abma, J.C. (2011). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010. *National Vital Health Statistics Reports*, 23(31).

- Mathews, T., Sutton, P., Hamilton, B., & Ventura, S. (2010). State disparities in teenage birth rates in the United States (National Center for Health Statistics data brief, no. 46.) Hyattsville, MD: United States Department of Health and Human Services.
- Maxwell, J. A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, 62, 279–299.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Miller, B.C., & Fox, G.L. (1987). Theories of adolescent heterosexual behavior. *Journal of Sex Research*, 2, 269-282.
- Miller, B., Benson, B., & Galbraith, K. (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Research*, 21, 1-38.
- Morgan, D. L. (1988). *Focus groups as qualitative research*. Newbury Park, CA: Sage.
- Morgan, D. L. (1998). *The focus group guidebook*. Thousand Oaks, CA: Sage.
- Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals*. Thousand Oaks, CA: Sage.
- National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP). (2011). *Counting It Up: The Public Costs of Teen Childbearing*. Retrieved from <http://www.thenationalcampaign.org/costs/default.aspx>.
- National Institutes of Health. (1999). *Qualitative methods in health research: opportunities and considerations in application and review*. Washington, DC: National Institutes of Health Office of Behavioral and Social Sciences Research.
- Onwuegbuzie, A.J., & Leech, N.L. (2007). Validity and qualitative research: An oxymoron? *Quality and Quantity*, 41, 233-249.
- Onwuegbuzie, A.J., Dickinson, W.B., Leech, N.L., & Zoran, A.G. (2009). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods*, 8(3), 1-21.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*. (3rd ed.). Thousand Oaks, CA: Sage.

- Pazol, K., Warner, L., Gavin, L., Callaghan, W.M., Spitz, A.M., Anderson, J.E.,...
Kann, L. (2011). Vital Signs: Teen pregnancy in the United States, 1991-2009.
Morbidity and Mortality Weekly Report, 60(13), 414-420.
- Perper, K., Peterson, K., & Manlove, J. (2010). *Diploma attainment among teen mothers*.
(Fact Sheet Publication #2010-01). Washington, DC: Child Trends.
- Peters, D. A. (1993). Improving quality requires consumer input: Using focus groups.
Journal of Nursing Care Quality, 7, 34-41.
- Philliber, S.G. (1980). A conceptual framework for population socialization. *Population and Environment*, 3, 3-9.
- QSR NVivo [computer program]. (2012). Version 10. Melbourne, AU: Qualitative Solutions and Research Pty Ltd.
- Seidman I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, NY: Teachers College Press.
- Sherif, M., Sherif, K., & Nebergall, R. (1965). *Attitude and attitude change: The social judgment involvement approach*. Philadelphia, PA: Saunders.
- Singh, S., & Darroch, J.E. (2000). Adolescent pregnancy and childbearing: levels and trends in developed countries. *Family Planning Perspectives*, 32(1), 14-23.
- Somers C.L., & Paulson, S.E. (2000). Student perceptions of parent adolescent closeness and communication about sexuality: relations with sexual knowledge, attitudes, and behaviors. *Journal of Adolescence*, 23(5), 629-44.
- Somers, C.L., & Ali, W.F. (2011). The role of parents in early adolescent sexual risk-taking behavior. *The Open Psychology Journal*, 4, 88-95.
- Stewart, D.W., & Shamdasni, P.N. (1994). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.
- Suellentrop, K. (2010). *The odyssey years: Preventing teen pregnancy among older teens*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.
- United States Department of Health and Human Services. (2010) *Healthy People 2020*. Retrieved from <http://www.healthypeople.gov/2020/default.aspx>.

- University of South Carolina Institute for Public Service and Policy Research. (2011). *Public perceptions of pregnancy prevention in Horry and Spartanburg counties*. Columbia, SC: South Carolina Campaign to Prevent Teen Pregnancy.
- Van Manen, M. (1990). *Researching lived experience: human science for an action sensitive pedagogy*. London: Althouse Press.
- Vaughn, S., Schumm, J. S., & Sinagub, J. (1996). *Focus group interviews in education and psychology*. Thousand Oaks, CA: Sage.
- Weinstock, H., Berman, S., & Cates Jr, W. (2004). Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspectives in Sexual and Reproductive Health*, 36(1), 6-10.
- Whitaker, D.J., Miller, K.S., May, D.C., & Levin, M.L. (1999). Teenage partners' communication about sexual risk and condom use: The importance of parent-teenager discussions. *Family Planning Perspectives*, 31(3), 117-121.
- Widman, L., Welsh, D.P., McNulty, J.K., & Little, K.C. (2006). Sexual communication and contraceptive use in adolescent dating couples. *Journal of Adolescent Health*, 39(6), 893-899.
- Wilkinson, S. (2004). Focus group research. In D. Silverman (Ed.), *Qualitative research: Theory, method, and practice* (pp. 177-199). Thousand Oaks, CA: Sage.

APPENDIX A – CONCEPTUAL MODEL CONSTRUCT DEFINITIONS

| Theory | Construct | Definition |
|----------------------------|---|--|
| Socialization Theory | Learned attitudes about sex and contraception | African American and White 18-19 year old males' attitudes towards sex and contraception learned from their parents during early adolescence. |
| | Learned behaviors about sex and contraception | African American and White 18-19 year old males' acceptable behaviors involving sex and contraception learned from their parents during early adolescence. |
| Theory of Planned Behavior | Attitude towards sex and contraception | African American and White 18-19 year old males attitudes towards sex and contraception |
| | Beliefs about sex and contraception | African American and White 18-19 year old males beliefs about sex and contraception |
| | Subjective Norms | African American and White 18-19 year old males beliefs about whether their parents approve or disapprove of them using contraception (and engaging in risky sexual behaviors) |
| | Behavioral Intention | African American and White 18-19 year old males' intention to use contraception |
| | Perceived Behavioral Control | African American and White 18-19 year old males' perceived control to use contraception |
| Social Judgment Theory | | African American and White 18-19 year old males' experiences communicating with their partners about sex and contraception |
| | | African American and White 18-19 year old males' ideas for intervention strategies to increase partner communication about sex and contraception |

APPENDIX B – FOCUS GROUP ITEMS

| Focus Group Question | Topic Area | Theory/Construct |
|--|---|--|
| Tell me about the conversations that you had with your own parents about sex. | Experiences of parent/child communication | Socialization Theory/Learned attitudes and behaviors |
| Let's just say that you have a young son. What would you want your son to know about sex and birth control? | Beliefs and attitudes about sex and contraception | Theory of Planned Behavior/Attitude and Subjective Norms |
| What do you think would be the most effective ways to motivate parents to talk to their male children about sex and birth control and share the things that you have just mentioned? | Experiences of parent/child communication | Socialization Theory/Learned attitudes and behaviors |
| At this point in your life, describe how you would feel if a partner got pregnant? | Attitudes about pregnancy | Theory of Planned Behavior/Attitude and Behavioral Intention |
| Describe the conversations that you have had with current or former partner(s) about sex. | Experiences of partner communication | Social Judgment Theory |
| Describe your role in the use of birth control? | Role in use of contraceptives | Theory of Planned Behavior/Perceived Behavioral Control |
| What do you think would be the most effective ways to motivate you, or other young men, to talk to their partner(s) about using birth control? | Motivation for encouraging partner communication | Theory of Planned Behavior/Attitudes and Beliefs |
| If we put you in charge of getting the word out to others (your peers) about the importance of talking to your partner about sex and birth control, what would you do to make sure everyone knew about it? | Social marketing and health communication message ideas | Social Judgment Theory |

APPENDIX C – SOCIODEMOGRAPHIC QUESTIONNAIRE

Sociodemographic Questionnaire

Directions: Please answer the following questions by circling your answer or filling-in the blanks. Please do not put your name on the form.

1. What is your age? (Enter years): _____ years
2. What is your race/ethnicity?
 - a. Black/African American
 - b. White
 - c. Other (please specify): _____
3. What campus do you currently attend? (Check one)
 - a. Midlands Technical College
 - b. University of South Carolina
 - c. Benedict College
 - d. I am currently not in school.
 - e. Other (please specify): _____
4. Which of the following best describes your current living situation? (Circle One)
 - a. Living alone
 - b. Living with spouse/partner
 - c. Living with friends/roommates
 - d. Living with family
 - e. Other (please specify): _____
5. Which of the following describes your living situation most of the time when you were young? (Circle One)
 - a. Lived with both of your biological or step parents
 - b. Lived with just your biological or step mom
 - c. Lived with just your biological or step dad
 - d. Rotated living between your biological or step mom and dad
 - e. Lived with other family member (please specify): _____
 - f. Lived with non-family member (please specify): _____
 - g. Other _____
6. What was your zip code when you were young? _____

7. Do you have a paying job?

- a. No
- b. Yes

If 'Yes' – do you work full (31+ hours/week) or part (<30 hours/week) time?

- a. Full time
- b. Part time

8. Are you the first member of your family to go to college?

- a. No
- b. Yes
- c. I don't know

9. Have you ever been diagnosed by a doctor as having a sexually transmitted disease (STD), such as Chlamydia or Gonorrhea?

- a. No
- b. Yes
- c. I don't know.

10. What is your current relationship status? (Circle One)

- a. Single
- b. In a casual relationship (i.e., hook-ups, dating)
- c. In a serious relationship (i.e., girlfriend)
- d. Married
- e. Separated
- f. Divorced
- g. Widowed
- h. Other (please specify):_____

11. Have you ever gotten a female pregnant?

- a. No
- b. Yes
- c. I don't know.

12. At what age did you first have sexual intercourse? (please specify)_____

13. Why did you want to participate in this focus group? (please specify)

Thank you for your time.

APPENDIX D – INFORMATIONAL LETTER

Exploring African American and White 18-19 year old males' communication experiences with their parents and partners about sex and contraception

An Exploratory Qualitative Study

Conducted by
Charlotte Galloway, MSPH, PhD(c)
School of Public Health
University of South Carolina

We are recruiting African American and White 18-19 year old males to take part in a focus group study. The information we obtain from participants will assist us in developing interventions that address parent-child and partner communication about sex and contraception.

If you decide to take part in the study, you will be asked to attend one of several focus groups where you will be asked to discuss your experiences and share your opinions about communication related to sex and contraception. There will be approximately 6-8 males in your group. Separate groups will be conducted with African American males and White males.

Before you take part in the study, you will be read a consent form that describes all the procedures for the focus group, including how your rights as a participant will be protected. You will be given the opportunity to ask and have your questions answered. Your participation will be completely voluntary and you may stop participating at any time.

During the group, you will be asked to introduce yourself using whatever name you prefer. You will be asked to use only a first name. During the discussions, no one will pressure you to share any information you do not want to share.

The group discussions will be tape recorded so we can be sure we remember exactly what was said. Only members of the research team will be allowed to listen to the tapes. When not in use, the tapes will be kept in a locked file cabinet, and they will be destroyed when the study is completed. You will receive payment in the amount of \$25 for completing the focus group session. This money is to reimburse you for your time and the contribution you make to the study. The session should last about 90 minutes.

If you are interested in taking part in the focus group study, please let the staff member who gave you this information know that we may contact you. You may also contact us at cgalloway@teenpregnancysc.org or 803-678-4502.

APPENDIX E – FLYER/EMAIL TEXT

Are you 18 or 19 years old?

Are you an African American or White male?

Are you willing to talk about sex?

The University of South Carolina is studying ways to improve males' communication experiences with their parents and partners about sex and birth control. Currently, we are recruiting African American and White 18-19 year old males, who are sexually active heterosexuals, to take part in a focus group study.

The information we obtain from participants will assist us in developing interventions that address parent-child and partner communication about sex and birth control. Participants will be asked to discuss their communication experiences and share their opinions about sex and birth control.

Each focus group should last no more than 90 minutes and will be held on your campus. Participants will receive refreshments and a \$25 gift card for completing the focus group session. This money is to reimburse participants for their time and the contributions to the study.

If you are interested, please contact the study coordinator at cgalloway@teenpregnancysc.org or 803. 678.4502.

APPENDIX F – INFORMED CONSENT FORM

Exploring African American and White 18-19 year old males' communication experiences with their parents and partners about sex and contraception

An Exploratory Qualitative Study

Investigator: Charlotte Galloway, MSPH, PhD(c)

Advisor: Sara J. Corwin, MPH, PhD

Department of Health Promotion, Education and Behavior

The University of South Carolina is studying ways to improve African American and White 18-19 year old males' communication experiences with their parents and partners about sex and contraception. We are asking you to take part in our study. We want to learn about the experiences that you have had with your parents and partners. We also want to learn what you think are ways to improve communication around sex and contraception. About 96 people will take part in the study. We will use what we learn to find ways to develop interventions supporting: 1) the improvement of parent-child communication about sex and contraception among African American and White males and their parents; and 2) the improvement of partner communication about sex and contraception among African American and White males and their partners.

Your comments are important to us. Participation in this study involves minimal risk to you. Improving communication about sex and contraception is important to everyone, so many people may benefit from our research. There is no cost to you to take part in our study. You will also receive payment in the amount of a \$20 gift card for completing the focus group session. This money is to reimburse you for your time and the contribution you make to the study.

We want to talk with you today for about an hour and a half to two hours. We will ask you to share your opinions. We will tape record our talk. Only the study team will be able to hear any tape recording or view any written notes. We may write about what we learn from you for published reports or presentations. You will not be named in our written records or in any other reports or presentations. Others in the group will hear what you say, and it is possible that they could tell someone else. Because we will be talking in a group, we cannot guarantee that what you say will remain private. But, we expect you and all other group members to respect the privacy of everyone in our group.

Whether you take part in our study is up to you. You can leave the group at any time. You can decide not to answer any question. If you have questions at any time, please ask. If you have questions later, please contact Charlotte Galloway at (803)771-7700 or Dr. Sara J. Corwin at (803) 777-3636.

If you would prefer not to contact Ms. Galloway or Dr. Corwin, but would like to talk with someone about this study, you can contact Thomas Coggins, Director, Office of Research Compliance. You can phone Mr. Coggins at 803-777-7095 or visit his office on the 5th Floor, Byrnes Building at 901 Sumter Street, University of South Carolina, Columbia, SC 29208.

APPENDIX G – FOCUS GROUP IMPLEMENTATION GUIDE

Directions

Sections written in *Italic font* are to be read to participants.

Materials and Equipment

- 2 digital audio recorders
- 10 pen or pencils
- 10 sociodemographic questionnaires
- 10 informed consent forms
- Table tent or nametag for each participant

Introduction and Informed Consent (10 minutes)

As participants arrive they will be given a table tent or nametag and a sociodemographic questionnaire to complete. The moderator will offer refreshments to the participants and share the location of the closest restroom. After an initial welcome, the moderator will briefly describe the purpose of the focus group, emphasizing the following points:

You have been invited to participate in a group discussion of the experiences that you have had communicating with your parents and partners about sex and birth control. We invite you to share your personal thoughts and opinions as they will help us better understand how to develop programs to improve communication between males and their parents and partners about sex and birth control.

Next, informed consent will be obtained. Distribute a copy of the consent form to each participant. Ask the participants to follow along as you read the form out loud. After reading the form, emphasize the following points:

We will be audio recording the session. We do not want to miss any of your comments. Only members of the research team will have access to the audio recordings. If anyone is uncomfortable with being audio recorded, please say so, and of course, you are free to leave. The audio recordings will be kept in a locked file cabinet. They will be transcribed without any names or other identifying information. Once the audio files have been transcribed, they will be destroyed. In any reports or presentations of the findings, names will not be used. We also ask that each of you keep confidential the information shared in this group and the names of participants.

At this point, ask participants if they have any questions. In order to facilitate group interaction, the moderator will ask each participant to introduce himself using a first name. Emphasize that they can use any name they choose.

Following the introductions, the moderator will describe what is expected of participants in terms of the group discussions (e.g., the ground rules):

Before we get into our discussion, let set a few ground rules. First, speak up so that everyone can hear you and let's try to have just one person speak at a time. Please say exactly what you think. Don't worry about what I think or your neighbor thinks. There are no right or wrong responses. Everyone's ideas and experiences are important.

Introduction of Focus Group Questions/Topics (80 minutes)

The moderator will introduce each question, and explore it thoroughly before moving on to another question/topic. Approximately 10 minutes is allocated for discussion of each of the following questions/topics. The moderator will elicit opinions from each participant, and use prompts and probes as needed to assist participants to provide detailed descriptions of their experience and to give examples when ever possible. Questions are to be addressed in the following order.

I will introduce each question and then allow time for each participant to respond. For the sake of today's conversation, I will be using the term 'parent' to mean any adult that is in your life in a typical parental or guardian role. Sometimes people use the term 'sex' to cover a lot of behaviors, but for this conversation 'sex' refers to oral, anal or vaginal sex. Let's get started with our first question.

1. *Where do you remember hearing or learning about sex and birth control?*

Prompt: What about from your parents?

Well, I'm glad that you said parents...

Introduction of a recent survey of SC parents about sex and birth control and talking to their children about sex and birth control.

I would like to share some of the results from a recent survey of parents in South Carolina.

- *Nearly 90% of parents strongly agreed that they talk openly with their child about waiting to have sex*
- *7 out of 10 parents strongly agreed that they talk openly with their child about using condoms or birth control methods.*

2. *What do you think about what I just shared?*

Now, tell me about the conversations that you had with your own parents about sex and birth control.

Prompt: Age at first conversation?

Was the first conversation before or after you had sex?

Nature of the conversations (was it really a conversation or one-sided)?

If your parents did not talk to you about sex, why do you think that was the case?

Were there opportunities to ask questions?

Did you trust the information that parents provided?

Did you feel like your parents knew what to say?

Were your parents comfortable?

Did the conversations meet your needs/answers questions? Why or why not?

Conversations include topic of birth control?

Conversations include topic of STIs, HIV?

Did religion/the church have an influence on the conversations?

How do you feel that your experience might have been different from other men?

3. *Let's just say that you have a young son. What would you want your son to know about sex and birth control?*

Prompt: How would you go about doing this?

When would you start the conversation? At what age?

How often would you try to talk to your son about this topic?

How would you encourage your son to feel comfortable asking you questions?

How would the conversation differ if you had a daughter?

4. *Given the things that you have just mentioned, what do you think would be the most effective ways to motivate parents to talk to their male children about sex and birth control?*

Now, let's discuss another related topic...talking to your partner about sex and birth control. To begin...

5. *At this point in your life, describe how you would feel if your partner got pregnant?*

Prompt: Are you concerned about this happening to you?

Do you think that it's possible or likely that you could get someone pregnant?

Why do you feel this way?

How important is it to you to prevent pregnancy?

What can a man do to prevent pregnancy? (Attempting to get at males' perception of their role in preventing pregnancy)

Ok, based on your responses, we can assume that most of you are not ready for parenting.

6. *So, describe the conversations that you have had with current or former partner(s) about birth control and sex.*

Prompt: Was there a real conversation?
Who started the conversation?
How did you or your partner start the conversation?
How did your partner respond to the conversation?
When did it occur (at what stage in the relationship or at what point in the casual encounter/hook-up)?
What was the nature of your sexual interaction ('casual' vs. 'serious')?
How long did the conversation last?
How often did you talk about birth control? Did you only discuss it once?
Was pregnancy prevention a focus?
Was disease/STI prevention a focus?
Did the conversation change as the relationship got more serious?

Let's talk a little more about pregnancy and contraception.

7. *Describe your role in the use of birth control?*

Prompt: Who is responsible for it?
Did you take a supporting role or become involved?
Did you trust your partner to correctly and consistently use birth control?
What do you feel men should know about birth control?

It sounds like you feel like you have some sort of role... (or other appropriate transition)

So, if we wanted to get men to talk to their partners about using birth control...

8. *What do you think would be the most effective ways to motivate you, or other young men, to talk to their partner(s) about using birth control?*
9. *If we put you in charge of getting the word out to others (your peers) about the importance of talking to your partner about sex and birth control, what would you do to make sure everyone knew about it?*

Prompt: How would you reach young men?
Where - school & campus/after school programs/clubs/fraternities?
What would be the message?
Types of strategies/activities/classes/school programs?

One final question before we end, are there things that we didn't discuss that you would like to talk about?

Thank you for helping us out. Please make sure you receive your gift card before you leave.

After wrap-up comments, thank the participants for attending the focus group and providing useful information. Distribute the gift cards and be sure to have them sign the receipt form.

APPENDIX H – RESEARCH MEMOS

African American males:

- Researcher comes from a different place when analyzing these groups (versus White males) because of sympathy of some of males' home life.
- Some comments in the African American groups give the overall impression that it's "just sex" and not a serious decision or part of life.
- Mistrust of females was a strong undertone in these groups and belief that some girls desire to be pregnant. However, mom plays important role in parent-child communication. Is there a connection?
- Overall, lack of correct knowledge about contraception.
- Several males mentioned desire for "friendship" type relationship with their fathers. In several of the groups, teens talked about their father being absent from their life.
- Males freely talked about their "girls on the side." Consideration for analysis: difference in contraceptive behaviors between casual versus serious partners.
- During member-checking interview, male shared that "your parents model the relationship" but many of his friends do not come from two parents homes so they do not have role models for developing relationships.

White males:

- Overall, lack of correct knowledge about contraception.

- Some males talked about directly asking partner if she had STD, but few males said that they or their partner had had STD tests...rather they were relying on rumors about someone's status or visual inspection. In member-checking interview, teen said that lack of STD testing was probably a result of people living in denial of status or fear of results.

Additional notes:

- The researcher's past experiences conducting focus groups with females about similar topics may influence the perceptions/results/interpretations of the male focus groups.
- Note for analysis: themes related to conversations between partners need to be coded separately for serious and casual partners.
- Participants generally appeared to want to learn more about contraception. Teens seemed grateful for the educational pamphlets about birth control and other sexual health topics.
- Religious influences were not as big of a factor as expected, but more common in the African American groups than the White groups.
- Most participants felt that they had a lot to lose if their partner got pregnant (i.e., they saw themselves on the right path, such as going to college) which could influence the findings.