

VISUALIZING OPPORTUNITIES AND INSPIRING CHOICES
THAT EMBODY SUCCESS (V.O.I.C.E.S.)

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ABSTRACT

African-American girls experience disparate rates of pregnancy and acquisition of sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV), when compared to their non-Hispanic, white counterparts. Among African-American girls, current pregnancy rates are equal to the national crisis levels of teen pregnancy reported in 1990 (Guttmacher Institute, 2013; National Teen Pregnancy Prevention Campaign, 2015). This qualitative elicitation study was conducted to gain insight into the ways in which African-American mothers and their daughters between the ages of 9 and 14 communicate about sexual health. Early sexual health communication between mothers and daughters is known to enhance the sexual health outcomes of girls. A series of four focus groups and three in-depth interviews were conducted between July and September of 2014. The Theory of Planned Behavior (TPB) was the organizing framework. Theoretical constructs that guided this study were: attitudes, perceived behavioral control, and subjective norms. Results showed that what African-American mothers share with their daughters about sexual health stems from the mother's personal faith, values, and experiences. The information and way that mothers convey the importance of talking about these topics forms a daughter's future subjective norms towards how they will view these topics in the future. Findings from this study can inform interventions to provide support for this understudied population.

Moreover, there are implications for health care providers, particularly school nurses, who are in an ideal position to help mothers learn how to be confident so they can engage in sexual health conversations with their young daughters.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Graduate Studies, have examined a dissertation titled “Visualizing Opportunities and Inspiring Choices that Embody Success (V.O.I.C.E.S.),” presented by Sheila R. Grigsby, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

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LIST OF ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

CDC: Centers for Disease Control

HIV: Human Immunodeficiency Virus

HPV: Human Papilloma Virus

HSV Type II: Herpes Simplex Virus, Type II

STI: Sexually Transmitted Infections

STD: Sexually Transmitted Disease

V.O.I.C.E.S.: Visualizing Opportunities and Inspiring Choices which Embodies Success

GLOSSARY

Adolescence: The transitional period of life when a child begins the physical and psychological transition into an adult. These teenage years are marked by the physical onset of puberty and consequential psychological development.

African American Mother-Daughter Sexual Health Communication: Successful African-American mother-daughter sexual health communication occurs when mothers possess the knowledge, skills, and self-efficacy to effectively communicate with their daughters about sexual health topics.

Serial Monogamy: The frequent initiation of new sexual partners under one calendar year.

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As I have endeavored to complete this terminal degree, I have been extremely blessed to have a very supportive group of family and extended family (friends) who have been with me through various stages of this journey. The names are too many to name, but I would be remiss if I did not name a few. . . Ola Grigsby (Mommy), Richard D. Grigsby (Daddy), Karla Grigsby (Sis), Elizabeth Boykin (Bestie), Anthony Witherspoon (Big Brother), Jewel Stafford (Cheerleader), Glenda and Isaac McCullough, Paul and Shirley Foster, Dietra Wise-Baker, Claudine Murphy, Frances Penn Cleveland (Prayer Warriors), you have been most critical on this journey. Each of you have been with me since the beginning. As I reflect over this journey, I see how God has strategically placed each of you in my life to help me through this phase of my life. Your prayers, laughter, and insight, as well as words of encouragement have guided and supported me more than you will ever know. It has been through your support and belief in the path that God has chosen for me that I have been able to stay the course to this moment of launching this next phase of my career.

Through the relationships, both personal and professional, that I have developed through Faith Communities United and UMSL College of Nursing, I have been able to develop the vision which is V.O.I.C.E.S. It will be through these relationships and future collaborations that I will be able to actualize this vision for the future.

I look forward to this continued journey together.

DEDICATION

This dissertation study is dedicated to the memory of my mother, Ola Mae Reynolds Grigsby (May 7, 1936-November 24, 2011).

While you have not been here to physically walk with me on this journey, your loving spirit has guided me throughout this process with your wisdom and many life lessons that have guided this work. Throughout this journey, I have learned how much you loved me. Dedicating myself to this project (and sometimes losing myself in it), I have developed a deeper understanding of what it means to be a mother and what it means to have a great desire to equip your daughter to be victorious, living out her dreams to the greatest of her abilities.

Thank you, Mommy, for being my first and most influential teacher!

CHAPTER 1

INTRODUCTION

Since 2014 the United States has experienced a gradual decline in the prevalence of sexual activity and adolescent pregnancy (Centers for Disease Control and Prevention [CDC], 2016). While no clear method or strategy has been identified that explains this consistent decline, optimism remains high that adolescent pregnancy and sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV) disease, can be avoided when access to culturally relevant prevention interventions and messages are provided to adolescents during vulnerable times of maturation (Alhassan, Greever, Nwaokelemeh, Mendoza, & Barr-Anderson, 2014; Shamble-Ebron, Dole, & Karikari, 2016). Despite these encouraging overall declines, a disparity exists among these downward trends for adolescents of color. African-American girls maintained rates two times higher than the rate of pregnancy of White adolescent girls in the United States (CDC, 2016). In 2015, adolescents between the ages of 15 and 24 years represented only one-fourth of the nation's population, yet they accounted for half of the 20 million newly reported sexually transmitted infections in the United States (CDC, 2016). At the end of 2014, 22% of 13- to 24-year-olds were living with HIV in the United States (CDC, 2016). African-American women in the United States are disproportionately infected with HIV in comparison to other races (CDC, 2016).

Speculation exists about why the upward trends in teen pregnancy, STI, and HIV acquisition persist among populations of color (CDC, 2016). Contributing factors such as poverty, broken families, and lower levels of education have been cited (CDC, 2016).

However, there appears to still be “something missing” when addressing adolescent sexual health in communities of color.

This dissertation research sought to explore and better understand how African-American mothers can reduce the risk for adolescent pregnancy, STI, and HIV exposure among their daughters. This dissertation is a first step in a program of research entitled Visualizing Opportunities and Inspiring Choices that Embody Success (V.O.I.C.E.S..) that seeks to develop effective interventions that can help reduce adolescent pregnancy and STIs, including HIV, among young African-American women. This qualitative formative study provided an in-depth account of how mother-daughter sexual health communication can delay sexual debut among adolescents when applied early and frequently throughout early development. The study also identified the salient elements needed within African-American communities for sexual health interventions to be most successful.

Sexual Activity in Adolescence

Sexual expression is an important component of adult development (Dancy, Crittenden, & Freels, 2006; Fasula & Miller, 2006). However, early and unprotected sexual activity threatens the well-being of African-American adolescents’ overall health (Hawes, Wellings, & Stephenson, 2010; Markham, Fleschler-Peskin, Addy, Baumler, & Tortelero, 2009). Sexually active adolescents typically lack the skills to protect themselves emotionally and physically from the consequences of sexual contact (Hawes et al., 2010). The CDC estimates that approximately 32% of adolescents will have their first sexual experience by their freshman year in high school, and 47% will become sexually active while in high school (CDC, 2016; Griffith, 2017; “HIV Overview,” 2017). Forty-one percent of sexually active high school students will not use condoms or contraception when having sex

(Griffith, 2017; “HIV Overview,” 2017). Sexually active adolescents are more likely to engage in short, serial monogamous relationships, leading to a greater number of lifetime sex partners (Griffith, 2017; Hawes et al., 2010; Markham et al., 2009). Such relationships greatly increase the likelihood of an adolescent’s exposure to sexually transmitted infections such as Herpes Simplex Virus II (HSV II), Human Papilloma Virus (HPV) and Human Immunodeficiency Virus (HIV), all of which have no cure (McRee, Reiter, Gottlieb, & Brewer, 2011; Newman & Berman, 2008; Woodhead, Chung, & Joffe, 2009). While medical advances continue to be made in detection and treatment, these chronic sexually transmitted infections will negatively impact a person for a lifetime (McRee et al., 2011; Newman & Berman, 2008; Woodhead et al., 2009).

Sexual Communication between Mothers and their Adolescents

Mothers are a child’s first teacher and the most consistent communicator (Biederman, Nichols, & Durham, 2010; Deptula, Henry, & Schoeny, 2010). Through life application, mothers model their personal values and belief systems regarding sexual health topics through their own behaviors to their daughters (Askelson, Campo, & Smith, 2012; Biederman et al., 2010; Cox, Scharer, Baliko, & Clark, 2010; Deptula et al., 2010). The ways in which a mother does or does not discuss sexual health topics greatly impacts a daughter’s knowledge, beliefs, and behaviors (Aronowitz & Agbeshi, 2012; Askelson et al., 2012; Dilorio, McCarty, Denzmore, & Landis, 2007; Hutchinson & Montgomery, 2007; Iliyasu, Aliyu, Abubakar, & Galadanci, 2012; Lefkowitz, Sigman, & Au, 2000). When mothers are not embarrassed, uncomfortable, or apprehensive to engage in open sexual health communication with their daughter, it empowers the daughter to be comfortable with

the young woman she is becoming (Biederman et al., 2010; Gound et al., 2007; Harris, Sutherland, & Hutchinson, 2013; McNeely et al., 2002).

Mother-daughter sexual health communication is most effective when initiated before sexual debut (Aronowitz & Agbeshi, 2012; Askelson et al., 2012; Cederbaum, Hutchinson, Duan, & Jemmott, 2013; Cornelius, LeGrand, & Jemmott, 2008; Fasula & Miller, 2006; Hydee et al., 2013). Such communication serves as a protective factor to reduce sexual risk among adolescents by: (a) delaying sexual debut, (b) increasing condom use, and (c) increasing the use of contraception when adolescents make the decision to become sexually active (Abar, Carter, & Winsler, 2009; Biederman et al., 2010; Crichton, Ibisomi, & Gyimah, 2012; Deptula et al., 2010; Dilorio et al., 2007; Hydee et al., 2013). However, mothers have verbalized that a delay in these critical conversations occurs because mothers are often fearful to discuss these topics or feel anxious about the limited information available to confidently engage in these conversations about sexual health topics (Cox et al., 2010; Harris et al., 2013; McKee & Karasou, 2006).

Study Purpose

This dissertation study is the first step in a program of research entitled V.O.I.C.E.S. (Visualizing Opportunities Inspiring Choices that Embody Success). The constructs from the Theory of Planned Behavior were used to explore African-American mothers' attitudes, subjective norms, perceived behavioral control (self-efficacy), intention, behaviors, and personal beliefs about communicating with their daughters, age 9 to 14 years, about sexual health topics (Askelson et al., 2010; Hutchinson & Wood, 2007; Morrison-Beedy, Cary, Cote-Arsenault, Seibold-Simpson, & Robinson, 2008; Schouten, VanDen Putte, Pasmans, & Meeuwesen, 2007; Sieving, Bearinger, Resnick, Pettingell, & Skay, 2007). The specific

aims of this qualitative study were to identify factors that influence the decision of African-American mothers to communicate with their daughters, ages 9 to 14 years about sexual health topics. Four focus groups and three individual interviews were conducted with African-American mothers and mother-figures. Findings from this dissertation study can be used to inform community-based health intervention programs to enhance sexual health communication between African-American mothers and their adolescent daughters.

Research Question

The research question that guided this study was: “How are the constructs of the Theory of Planned Behavior (TPB) (attitude, perceived behavioral control, and subjective norms) and the personal characteristics of African-American mothers related to their intentions to communicate sexual health topics with their adolescent daughters?”

The following TPB variables were explored in this study:

- Mothers’ attitudes about communicating with daughters about sexual health topics (i.e., facts, emotions, and consequences);
- Subjective norms to comply with the expectations of others;
- Perceived behavioral control (comfort and confidence) to communicate with daughters about sexual health topics;
- Mothers’ intention to communicate with daughters about sexual health topics; and
- Communication behavior between mothers and daughters about sexual health topics.

Assumptions

The following assumptions were made in this study:

- Many African-American mothers lack the knowledge, skills and self-efficacy to communicate openly with their adolescent daughters (9-14 years) about sexual health.
- Mothers who are knowledgeable about sexual health topics will be more comfortable talking to their adolescent daughters about sexual health.
- Mothers with high levels of religiosity/spirituality will value open communication with their daughters.

Hypothesis Statement

African-American mothers' comments on attitudes, subjective norms (control beliefs), perceived behavioral control (self-efficacy), intention to communicate, and actual communication about sexual health topics will be influenced greatly by their strong religiosity and spirituality and desire to share these faith and values with their pre-adolescent daughters. A mother's level of knowledge, self-efficacy, and comfort will influence her ability to communicate this information with ease.

Theoretical Significance

The Theory of Planned Behavior (TPB) guided this study (Ajzen, 1985, 1991; Ajzen & Fishbein, 2004). The theory suggests that a person's attitude, subjective norms, and perceived behavioral control drive intention to perform a behavior, which in turn influences engagement in a behavior (Ajzen, 1985). Past research focusing on parent-child communication about sexual health topics supports the selection of the TPB as an appropriate theoretical framework for exploring the factors that influence a mother's

decision to talk about sex with her daughter (Aronowitz, Todd, Agbeshie, & Rennells, 2007; Askelson et al., 2010; Eisenberg, Ackard, Resnick, & Neumark-Sztainer, 2009; Hutchinson & Wood, 2007; Morrison-Beedy et al., 2008; Moshki et al., 2016; Schouten et al., 2007; Sieving et al., 2007).

Mothers' Beliefs about Discussing Sex (Normative Beliefs)

Normative beliefs refers to the perceived expectations of important peer groups (e.g., family, friends, and church members) and their internal motivation to comply with these expectations (Ajzen & Fishbein, 2004). Two additional factors important in the consideration of a mother's normative beliefs about sexual health communication include a childhood where no sexual health communication occurred with their parents, and life-changing personal experiences. Both factors contribute to the internal motivation of mothers to engage in sexual health communication with their own children (Miller et al., 2009). Life-changing personal experiences in this context are defined as sexual abuse, pregnancy as an adolescent, and/or the acquisition of sexually transmitted infections, including HIV. These experiences serve as powerful incentives for mothers to have these conversations, even if normative influences do not support this behavior (Biederman et al., 2010; Campione-Barr & Smetana, 2004).

Perceived Behavioral Control (Self-Efficacy)

Perceived Behavioral Control is the amount of control a person believes to have over performing a behavior (Askelson et al., 2010). Despite many mothers' belief that they should play a central role in educating their daughters about human sexuality, many shy away from such discussions due to their belief that they are ill-equipped to provide adequate information. Self-efficacy is a critical mediator for successful mother-daughter

communication; this relationship has not been greatly explored with African-American mothers in the literature (Abar et al., 2009; Deptula et al., 2010; Huebner & Howell, 2003). When mothers possess self-efficacy to communicate with their daughter about sexual health topics, it decreases their susceptibility to early sexual debut (Biederman et al., 2010; Gound et al., 2007; Harris et al., 2013; McNeely et al., 2002). Mothers who possess communication self-efficacy are more equipped to master communication skills and maximize opportunities to communicate with their daughters as they are presented within the relationship (Deptula et al., 2010).

Attitude toward Sexual Communication with their Daughter

Mothers are typically the main source of sexual health information and attitude formation for their daughters (Dittus, Miller, Kochick, & Forehand, 2004). Pre-adolescents prefer to receive sexual health information from their mothers rather than from other sources; in contrast, this preference changes as the child becomes an older adolescent (Aronowitz & Agbeshi, 2012; Deptula et al., 2010; Dilorio et al., 2007; Fasula & Miller, 2006; Miller et al., 2009). Since a mother's influence is strongest when the adolescent is young, it is important to intervene at this point (Gound et al., 2007). This work begins by talking to adolescents early about sexuality in the hope of decreasing the number of unhealthy relationships, unintended pregnancies, and acquisition of sexually transmitted infections (Aronowitz & Agbeshi, 2012; Biederman et al., 2010; Dilorio et al., 2007; Fasula & Miller, 2006; Gound et al., 2007; McNeely et al., 2002; McRee et al., 2011; Miller et al., 2009; Price & Hyde, 2011; Tesso, Fantahun, & Enquelassie, 2012). To increase the success of mother-daughter interventions focused on sexual health communication, it is important to

understand a mother's attitude towards sexual health communication (Aronowitz et al., 2007).

Subjective Norms

Subjective norms are derived from the individual's perception of their peer group's (e.g., friends, family members, and church members) approval or disapproval towards a certain behavior and their motivation to comply with the referents' opinions. This social pressure greatly influences a mother's self-efficacy (comfort and confidence) and intentions to engage in sexual health communication with her daughter, dependent upon the value given to others in their peer group (Askelson et al., 2010; Grossman, Charmaraman, & Erkut, 2013).

Intention to Communicate about Sex with their Daughter

Earlier studies have been inconclusive on the role that mothers' intention to communicate about sexual topics with their daughters plays in increasing the likelihood that daughters will pursue higher education and make plans for the future (Abar et al., 2009; Deptula et al., 2010; Dilorio et al., 2007; Alhassan et al., 2014; Aronowitz & Eche, 2013). More recent work from Guilamo-Ramos, Jaccard, Dittus, and Collins (2008) describes the utilization of a theoretical framework of behavior change developed to help predict parents' intentions to talk with their children about sexual health as well as understand what motivates parents to talk with their teens about sexuality. This work has promise in that it can lead to the identification of influential factors that can help mothers feel more confident and comfortable to engage in sexual health communication with their daughters.

In using the TPB model for survey and intervention development/assessment, researchers are encouraged to conduct formative studies to elicit information on attitudes,

norms, and perceived control issues related to the desired outcome behavior (e.g., communication with their daughter about sexual health topics) with the target population through qualitative methods, such as focus groups and interviews (Berkley-Patton et al., 2010; Cox et al., 2010; Cornelius et al., 2008; Nwoga, 2000). Focus groups and interviews are utilized to identify and quantify the range of beliefs held by the target population. For example, African American mothers are likely to embrace many control beliefs about engaging in sexual health communication with their daughters. Some may have concerns that discussing sexual health topics with their daughters will lead to their daughter wanting to engage in sexual activity; some may believe that talking about sexual health topics is not their responsibility as a parent; and others may believe that their daughters are not interested in hearing from them regarding sexual health topics (see Figure 1.1). This engagement process was conducted to learn more about the salient beliefs (attitudes, norms, and behavioral control) present in this population.

Significance

Innovative programs are needed to address mothers' lack of self-efficacy to address issues related to sexual health topics with her daughters (Agbemenu, Devido, Terry, Hannan, Kitutu, & Doswell, 2016; Chandler-Coley, Ross, Ozoya, Lescano, & Flannigan, 2017; Cornelius, 2009; Coughlin, 2016; Cox, Scharer, & Clark, 2009; Coyne-Beasley & Schroenbach, 2000; Wingood et al., 2013). African-American mothers are uniquely positioned to reduce the risk for early sexual debut, teen pregnancy, STIs and HIV among their daughters. It is critical that relevant research be conducted in African-American communities to address the needs of this specific population. This doctoral candidate's

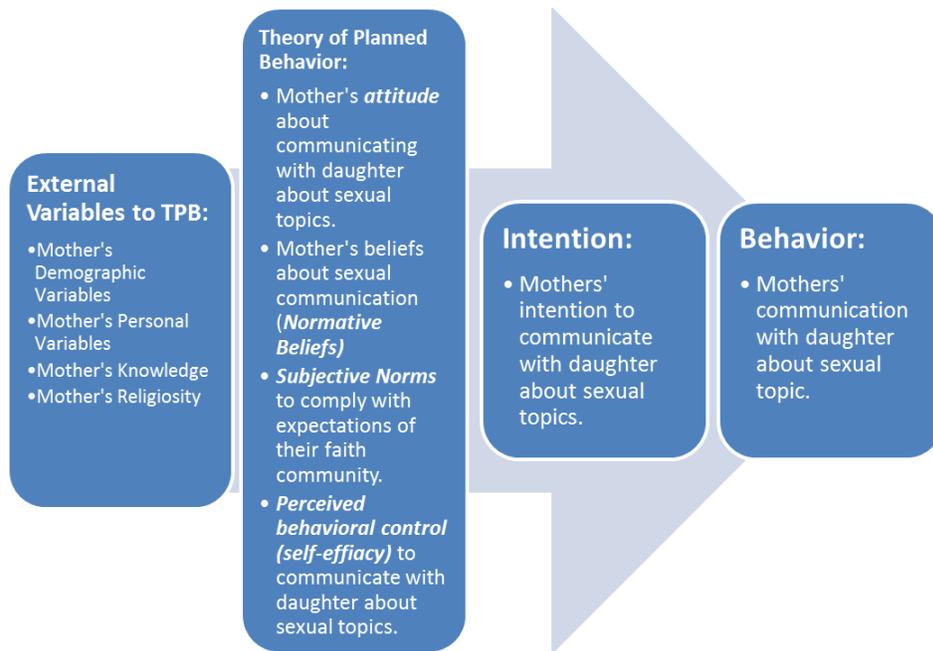


Figure 1.1. Model for dissertation study adapted from Theory of Planned Behavior

program of research will contribute to the growing dialogue of innovative primary prevention approaches being developed to promote African-American mothers' self-efficacy (comfort and confidence) to communicate with their young daughters about sexual health. Through engaging participants as experts on communicating with their own daughters, the investigator will contribute to a community of self-help in which these consultants will be empowered to support one another after identifying their many commonalities and challenges (Stanhope & Lancaster, 2011).

CHAPTER 2

LITERATURE REVIEW

Many African-American youth need to overcome multiple social and environmental obstacles to be successful including but not limited to: pervasive, intense, and chronic poverty at the neighborhood and familial level; crime and violence; inadequate schools; few recreational, cultural, or growth-enhancing community institutions; and peers who are young mothers or are in gangs (Biederman et al., 2010; McHale et al., 2006). Urban African-American youth continue to experience disproportionate rates of teen pregnancy and single parenthood, which often results in dependence on public assistance as they move into adulthood (Barber, Yarger, & Gatny, 2015; Grady, Dehlendorf, Cohen, Schwarz, & Borrero, 2015; Harris, 2013; Satterwhite & Ramaswamy, 2015). This literature review explores the relevant topics that impact a mother's ability to openly communicate with her daughter regarding factors that protect sexual health.

Sexual Activity among Girls

Girls who engage in sexual activity before the age of 18 have a greater likelihood of experiencing the following challenges: substance use/abuse, sexual abuse, teen pregnancy, and sexually transmitted infections including HIV disease (CDC, 2016). The National Teen Pregnancy Prevention Campaign (2015) reports that 46% of adolescents in the nation will experience their sexual debut while in high school. In the state of Missouri, a similar ranking was found at 43.1% (National Teen Pregnancy Prevention Campaign, 2015).

In the United States, one-third of the nation's high school population reports being sexually active (National Teen Pregnancy Prevention Campaign, 2015). Adolescents frequently participate in what is known as serial monogamy, defined as the frequent

initiation of new sexual partners under one calendar year (Dancy et al., 2006; Hawes et al., 2010; Markham et al., 2009; Scott et al., 2011). Serial monogamy leads to an accrual of new sexual partners over a short period, thus increasing exposure to sexually transmitted infections, including HIV.

Pregnancy and Sexually Transmitted Infections in Girls

Most teen pregnancies in the United States occur among girls aged 15 to 19 (National Teen Pregnancy Prevention Campaign, 2015). Although there has been a continual decline in adolescent pregnancy since 1990, the rates of teen pregnancy among African-American girls remain high (Guttmacher Institute, 2013; National Teen Pregnancy Prevention Campaign, 2015). Overall, despite historic low rates, the current rate of teen pregnancy among African-American girls is equal to the highest national crisis rates in 1990 (Guttmacher Institute, 2013; National Teen Pregnancy Prevention Campaign, 2015). In the state of Missouri, adolescent pregnancy rates among 15-19 year olds are disparate regarding rate: 99 per 1,000 for non-Hispanic Blacks, compared to 44 per 1,000 for non-Hispanic Whites (National Teen Pregnancy Prevention Campaign, 2015).

CDC estimates suggest that girls between 15 and 24 years will acquire nearly half of all newly reported sexually transmitted infections (STIs) in the United States (CDC, 2016). The two most frequently reported STIs in adolescent girls are gonorrhea and chlamydia (CDC, 2016). Nationally in 2014-2015, rates of chlamydia infection increased more than seven times the rate in adolescent girls between the ages of 10 and 14 years, while in ages ranging from 15 to 19 years, there was a 232% increase.

One in four new cases of HIV occurs in adolescents between the ages of 13 and 24 years in the United States (CDC, 2016). In females, these cases are attributed to heterosexual

activity (86%) and intravenous drug use (13%) (CDC, 2016). African-American girls are at increased risk of acquiring STIs, including HIV due to predominately having older sex partners (Senn & Carey, 2011). In addition, approximately 60 % of adolescents have not sought STI or HIV testing, which also increases poor sexual health outcomes, as diseases can remain untreated for long periods of time (CDC, 2016).

Mother-Daughter Sexual Health Communication

Mothers have the earliest and most significant influence on their daughters' sexual development and socialization (Biederman et al., 2010). The protective factor in the lives of African-American girls rests in the quality of their primary caregivers' parenting (Deptula et al., 2010). There is a copious amount of literature supporting open and close mother-daughter relationships as a protective factor for a girl to delay sexual debut (Aronowitz & Eche, 2013; Childs, Moneyham, & Felton, 2008; Dilorio et al., 2007; Gilmore, Chen, Haas, Kopak, & Robillard, 2011; Woodhead et al., 2009; Wyckoff et al., 2008). This body of literature also supports that having close maternal relationships increases a daughter's critical thinking skills to make responsible sexual decisions, leading to delayed sexual debut, fewer lifetime sexual partners, and the utilization of condoms and contraception to avoid unintended pregnancies (Teitelman, Ratcliffe, & Cederbaum, 2008; Wyckoff et al., 2008). These findings provide substantiation that having a strong mother-daughter communication foundation in place is critical to the success of improving health outcomes for African-American families (CDC, 2016).

Due to the disproportionate representation of pregnancy and STIs in African-American girls, more research is needed to explore how African-American mothers speak and communicate with their daughters about sexual health. African-American faith and

values may influence a mother’s attitude, intention, and behavior to have successful sexual health communication with their daughter regarding responsible sexual behavior (Abar et al., 2009; Cornelius et al., 2008; Dilorio et al., 2007; Miller et al., 2009).

Additional Factors Influencing Successful African-American Mother-Daughter Sexual Health Communication

Through a thorough review of existing mother-daughter sexual health communication literature, the following factors were identified which contribute to successful and sustainable African-American mother-daughter sexual health communication: mother’s religiosity (personal faith and values), mother’s individual knowledge of sexual health topics, mother’s age at sexual debut and first pregnancy, and a consistent open communication style with the daughter about sexual health topics (Aronowitz & Ageshi, 2012; Cox et al., 2010; Hutchinson & Montgomery, 2007; Miller et al., 2009). When these factors work in tandem, they have been known to produce quality mother-daughter sexual health communication, yielding positive results (see Figure 2.1).

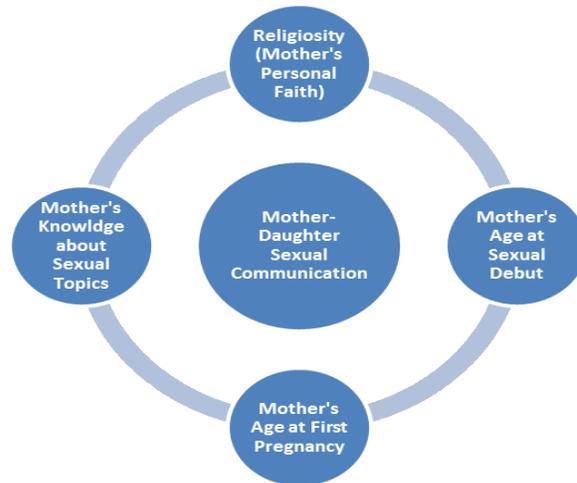


Figure 2.1. Antecedents of Successful Mother-Daughter Sexual Health Communication

Religiosity (Mothers' Personal Values and Faith)

Religiosity is defined as both the importance attributed to and the frequency of engagement with religious beliefs, private and public religious practices, and the application of religious beliefs to everyday life (e.g. , prayer, ministry, bible study, choir) (Leonard & Scott-Jones, 2010). A family's belief system influences the values as well as the comfort in the mother's ability to communicate about general and specific sexual health topics (Cornelius, 2009; Nwoga, 2000). Mothers who profess that their religious beliefs are very important will talk more about sex-based health topics with their adolescents (Cornelius, 2009). Evidence supports the notion that mothers who are secure in their religious beliefs will be secure in sharing their views with their daughters when equipped with accurate information (Dilorio et al., 2000). Research has also confirmed that African-American mothers are greatly influenced by culture, faith traditions, and social norms that are important to them (Biederman et al., 2010; Cornelius et al., 2008; Dilorio et al., 2007; Schouten et al., 2007; Shamble-Ebron et al., 2016). These influences are critical as adolescent girls develop their own individual belief systems which will be closely related to their personal self-worth and self-efficacy.

Mothers' Own Experiences

Mothers will often delay critical conversations about sexual topics based on their own personal fear, anxiety, or lack of information (Aronowitz & Agbeshi, 2012; Biederman et al., 2010; Fasula & Miller, 2006). A mother who had an early sexual debut will be more likely to communicate with her daughter about sexual health topics. Mothers reported that if relationships with their own mother had been open and welcoming of questions and conversations, they would have been more likely to delay their own sexual initiation

(Biederman et al., 2010; Brown & Tabi, 2013; Bynum, 2007; Cox et al., 2010; Shamble-Ebron et al., 2016). Because their mothers received poor or no education from their own mothers, they had very little sexual health information/education to share with them as adolescents. Hence, the lack of communication about sexual health was perpetuated from generation to generation. Due to these negative experiences as an adolescent, mothers felt the need to change this communication style and learn how to talk to their daughters about sexual health topics (Brown & Tabi, 2013; Cornelius et al., 2008; Harris, 2013; Shamble-Ebron et al., 2016). Personal experiences with STIs by mothers significantly influenced their belief systems about their child's potential level of risk and the importance of discussing such topics with their daughters before they became sexually active (Askelson et al., 2010; O'Donnell et al., 2005).

Mothers Who Have an Open Parenting Style

Mothers who are open and transparent in their communication with their daughters are more likely to have communication self-efficacy to discuss a wide variety of topics. Self-efficacy for communication opens the door to have more successful sexual health communication as their daughters reach adolescence (Grossman et al., 2013; Hutchinson, Jemmott, Sweet-Jemmott, Braverman, & Fong, 2003). This self-efficacy leads to more transparent and open communication in the mother-daughter relationship (Aronowitz & Agbeshi, 2012; Askelson et al., 2012; Biederman et al., 2010; Cox et al., 2010; Miller et al., 2009). In early research, adolescent participants reported longing for their mothers to openly share how to manage sexual feelings (Bynum, 2007; Campione-Barr & Smetana, 2004; Cornelius et al., 2008; Marhefka, Mellijns, Brackis-Cott, Dolezal, & Ehrhardt, 2009). Female adolescents and college students who reported open communication with their

mothers were more likely to delay sexual activity until they felt prepared; these same females also reported being more likely to use contraception and condoms at sexual debut, which led to lower incidence of pregnancy and STI transmission (Bynum, 2007; Harris, 2013; Williams, Pichon, Davey-Rothwell, & Latkin, 2016). Parents who grew up in homes where the sexual health communication was limited reported a desire to have more open communication with their mothers. This desire translated into an open parenting style with their children, because it was not provided to them during their adolescence (Grossman et al., 2013). Communication repetition in this relationship about sexual health topics is critical due to the power of reinforcement of medically accurate information with adolescents and adults (Askelson, Campo, Smith, Lowe, Dennis, & Andsager, 2011; Bersamin, Bourdeau, Fisher, & Grube, 2008). Mothers who actively engaged their daughters by using teachable moments increased their daughters' feelings of closeness, increased comfort, and added to a greater transparency within the relationship (Eisenberg, Sieving, Bearinger, Swain, & Resnic, 2006).

Mothers' Knowledge about Sexual Topics

Despite the importance of mothers' beliefs playing a central role in educating their daughters about human sexuality, a second reason that many shy away from such discussions is their belief that they are ill-equipped to provide adequate and/or accurate information (Afifi, Joseph, & Aldeis, 2008). A mother's preconceived beliefs about appropriate sexual health conversations with their daughters will often paralyze a mother from having age-appropriate conversations with their daughters. Oftentimes, mothers who do engage in these conversations feel that these conversations should be focused exclusively

on the negative consequences of sexual activity (Askelson et al., 2012; Biederman et al., 2010; Cox et al., 2010; Miller et al., 2009).

Mother-Daughter Sexual Health Communication Literature

A significant amount of literature has been written about the topic of mother-daughter sexual health communication. The five communication dimensions from *The Attitude Change and Persuasion Framework* (Jaccard & Dittus, 1993) was used to organize existing literature into major categories and themes concerning early mother-daughter sexual health communication (Jaccard & Dittus, 1993; Jaccard & Dittus, 1993; Lederman, Chan, & Roberts-Gray, 2004) (see Table 2.1). The following five communication dimensions will be discussed: extent, parenting style, content, timing and general family environment.

Table 2.1

Five Dimensions of Mother-Daughter Sexual Health Communication

Dimensions	Description
General Communication Environment (in family)	How did the mother and daughter communicate prior to adolescence?
Parenting Style	Is communication open or closed? Are mothers supportive? Are mothers transparent in sharing past? Possess mutuality?
Extent	How frequent do mothers and daughters communicate about sexual topics?
Content	Which sexual topics are discussed?
Timing	When does sexual conversation occur? Before or after sexual debut?

Source: Jaccard & Dittus, 1993; Lederman et al., 2004

Dimension One: General Communication Environment

A strong foundation of general communication must be firmly established within the family unit before introducing any other type of communication. Close dyad relationships will have frequent transparent conversations about a variety of topics and concerns, eventually leading to open discussions about sexual health topics (Abar et al., 2009; Aronowitz & Agbeshi, 2012; Deptula et al., 2010; Dilorio et al., 2007). Mothers who have non-punitive disciplinary practices (authoritative parenting) will offer explanations and encourage reflection regarding negative behavior. Open communication styles have an overall protective effect for adolescent girls during this crucial time of development (Aronowitz & Eche, 2013; Childs et al., 2008; Dilorio et al., 2007; Gilmore et al., 2011; Pittman & Chase-Lansdale, 2001; Woodhead et al., 2009; Wyckoff et al., 2008). Mothers communicate with their daughters through sharing knowledge and normative beliefs about sexual health topics (Aronowitz et al., 2007; Cox et al., 2010; Deptula et al., 2010; Hutchinson & Wood, 2007; Schouten et al., 2007). Mothers model and teach their daughter social skills related to gender-specific messages about society's perception of female conduct, roles in male-female relationships, levels of physical attraction and affection, as well as age-appropriate physical contact with persons of the opposite sex through explicit and implicit messages and actions received (Dilorio, Pluhar, & Belcher, 2003; Pluhar & Kuriloff, 2004).

Barriers to sexual health communication are created when mothers have control beliefs that inhibit or limit communication. These beliefs include: embarrassment, discomfort, and lack of knowledge about the topic (Biederman et al., 2010; Miller et al., 2009; Sidze & Defo, 2013). Holding onto these beliefs leads to behaviors such as: avoiding

the discussion of sexual health topics; discussing an abstinence-only message from the home; sexual health discussions should be provided at schools or by health care providers; personally believe that discussing sexual health topics will encourage sexual activity as well as the belief that their daughters are too young or not interested in having these conversations (Biederman et al., 2010; Miller et al., 2009; Sidze et al., 2013).

Dimension Two: Parenting Style

A mother's parenting style is the most significant predictor of the success of mother-daughter sexual health communication (Cox et al., 2010; Deptula et al., 2010). Huebner and Howell (2003) and Pittman and Chase-Lansdale (2001) defined three types of parenting styles:

- Authoritarian parent: makes all decisions in the mother-daughter relationship;
- Authoritative parent: allows collaborative decisions to occur between mother and adolescent; and
- Permissive parent: allows the adolescent to make all decisions without parent influence.

The mother-daughter relationship must first have a solid foundation based on open communication before sexual health communication can have a lasting effect as the daughter gets older. In the mother-daughter relationship, mothers who embraced authoritative parenting were found to be the most successful. Pittman and Chase-Lansdale (2001) assigned the following attributes to authoritative parents: warm and accepting, inductive discipline which offers explanation and reflection, non-punitive disciplinary practices, and consistent childrearing practices. Mothers who embraced this parenting style were more likely to have children with higher levels of academic achievement, self-reliance,

social development, self-esteem, and fewer behavior problems than those raised in permissive or authoritarian homes (Deptula et al., 2010; Piko & Balazs, 2012; Saunders, Hume, Timperio, & Salmon, 2012; Shakib et al., 2003).

Homes with authoritarian parenting styles were found to be more punitive in their discipline and more likely to have adolescents with severe behavior problems and limited age-appropriate autonomy (Abar et al., 2009; Gallitto, 2015; Ginsburg, Durbin, Garcia-Espana, Kalicka, & Winston, 2009). African-American parents are more likely to be authoritarian or restrictive in their parenting, while fewer will utilize permissive or authoritarian styles (Abar et al., 2009; Ginsburg et al., 2009; Shakib et al., 2003). These stricter parenting styles across social class lines is viewed as necessary to aid the development of effective coping abilities in the face of the harsh realities of racism and discrimination often experienced by African-American children (Abar et al., 2009; Aronowitz & Eche, 2013; Shakib et al., 2003; Smalls, 2009).

Mothers who are authoritative communicators are more likely to have daughters with high comfort and confidence to engage in difficult conversations with their mothers about topics which include their personal fears, concerns about body changes, peer relationships, and direct sexual health topics (Askelson et al., 2012; Gallitto, 2015; Pikos & Balazs, 2012; Robinson, Mandleco, Olsen, & Hart, 1995). These mothers utilize parental warmth and acceptance and provide inductive discipline and non-punitive disciplinary practices while providing consistency in childrearing, leading to positive developmental outcomes in children (Pittman & Chase-Lansdale, 2001).

Mothers who are authoritarian communicators are more likely to dominate conversations with their daughters, and daughters are less likely to have frequent sexual

health conversations with their mothers due to the fear of being badgered or punished for their questions and interest in topics related to sexual health topics (Biederman et al., 2010; Cox et al., 2010; Hutchinson & Montgomery, 2007; Miller et al., 2009; Nwoga, 2000).

Dimension Three: Extent

Extent is defined as how frequently sexual health communication occurs within the mother-daughter relationship. A strong foundation where communication is consistent and strong for mothers and daughters is critical before sexual health communication can begin (Aronowitz & Eche, 2013; Biederman et al., 2010; Cox et al., 2010). Mothers who engage in early sexual health conversations with their daughters provide socialization and understanding of their familial culture through modeling values, beliefs, and critical thinking skills (Aronowitz, Rennells, & Todd, 2006; Cox et al., 2010; Shamble-Ebron et al., 2016). Adolescent girls who had regular conversations about sexual health topics with their mothers were found to be more informed than their peer counterparts whose mothers did not routinely communicate with them (Aronowitz & Agbeshi, 2012; Askelson et al., 2012; Biederman et al., 2010; Dancy et al., 2006; Hawes et al., 2010; Miller et al., 2009; Woodhead et al., 2009). When daughters believe that they are safe to discuss a variety of social topics, sexual health communication is more likely to occur. Adolescent girls who are equipped with accurate information are more likely to utilize critical thinking skills to make decisions to avoid early pregnancy and exposure to STIs, including HIV/AIDS (Bleakley, Hennessy, Fishbein, & Jordan, 2009; Childs et al., 2008; Dancy et al., 2006; Hawes et al., 2010). In contrast, when mothers reported low general communication within the relationship, daughters were more likely to engage in risk-taking behaviors (e.g., sex without condoms, substance use, drug trafficking, school truancy, and violence) (Abar et al., 2009).

Dimension Four: Content

The different types of sexual health topics discussed in mother-daughter sexual health communication has been well described in the literature (El-Shaieb & Wuretle, 2009; Hawthorne, 2002; Kukulu, 2006; Satterwhite & Ramaswamy, 2015). Sexual health communication is typically initiated between mothers and daughters between the ages of 10 and 13 years (Aronowitz & Agbeshi, 2012; Crichton et al., 2012; Dilorio et al., 2007; Hutchinson & Montgomery, 2007; Miller et al., 2009). Topics most frequently listed as being initially discussed include: body changes, puberty (menstruation), definitions of sex, and human reproduction (Hawthorne, 2002; Kukulu, 2006; Satterwhite & Ramaswamy, 2015). As daughters get older, content will evolve to include more advanced topics such as: dating, negotiation skills, sexual debut, condoms, birth control, and STDs including HIV/AIDS.

The literature describes four different categories of sexual health content mothers use to discuss sexual health topics: (a) sexual safety; (b) development and societal concerns; (c) experiencing sex; and (d) solitary sexual activity (Angera, Brookins-Fisher, & Inungu, 2008; Hydee et al, 2013; Shamble-Ebron et al, 2016). Sexual safety is defined as activities that lead to the protection of their daughter's physical safety (Angera, 2008). These activities include but are not limited to initiation of sexual activity, abstinence, birth control and condom use, healthy relationships, and dating safety.

Developmental and societal concerns include topics that are culturally and age appropriate to daughters' intellectual development (Aronowitz & Eche, 2013; Biederman et al., 2010). The primary example in this category includes the developmental changes that occur in a girl between the age of 9 and 12 years. These developmental changes are

primarily physical and include menstruation, voice changes, hair growth, the development of breasts, and sudden spikes in height and body proportions. In girls ages 13 and older, the concern shifts to environmental (outside) influences: wearing make-up, peer pressure from peer group and the opposite sex, curfews, and dating in groups versus one-to-one encounters. Conversations concerning societal issues will depend greatly on the mother-daughter dyad, cultural/ethnic composition, and the faith/values of the mother or influential figure having the conversation. Mothers who engage in conversations about their family's faith and values help to frame their daughters' worldview about their personal experiences as well as to shape their stance on societal issues that may or may not impact their families, friends, or themselves personally (Abar et al., 2009; Adamczyk & Pitt, 2009; Williams, Pichon, & Campbell, 2014).

As far as experiencing sexual activity, when a girl makes the decision to become sexually active, it is usually due to peer pressure from a sexual partner. When conversations are initiated early, daughters will not make these decisions in solitude but will include their mother or a mother-figure (Angera et al., 2008; Aronowitz & Eche, 2013; Cederbaum et al., 2013; Robert & Sonenstein, 2010; Schouten et al., 2007). These influences will guide girls to make the best decision for them at this point in their development. Solitary sexual activity (masturbation) is frequently a taboo topic within many families and is difficult for many mothers to discuss with their daughters (Grossman et al., 2013; Shulman, Horne, Pichon, & Campbell, 2003). Due to these conservative beliefs, many mothers will never be comfortable or confident to engage in these types of conversations with their daughters. It is important to provide mothers with resources or outside agencies who can assist in the initiation of these conversations with their daughters, because many would not initiate these contacts on their

own (Akpabio, Asuzo, Fajemilehin, & Ofi, 2009; Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chircop 2006; Wakley, 2011).

Mothers whose conversations were broader to include sharing information about their family's values and belief system, attitudes, and sharing their own personal experiences with their daughters developed multi-dimensional relationships where there was transparency within the relationship to openly discuss a wide variety of topics (Aronowiz & Eche, 2013; Cederbaum, 2012; Cornelius, 2009; Cox et al., 2009). Mothers are most likely the parent who delivers sexual health information with their children (Aronowitz & Agbeshi, 2012; Miller et al., 2009). When engaging in these discussions, women focus primarily on safety, culture and moral aspects of sexuality. To help girls to develop critical thinking skills, mothers share current facts and resources to help their daughters to develop the life skills needed to maintain a life free from unplanned pregnancy and disease. Mothers who are less comfortable with sexual health communication are more likely to not possess comfort or confidence to have open conversations with their daughter (Costos, Ackerman, & Paradis, 2002; Pluhar & Kuriloff, 2004).

As early adolescence begins, there is a delicate balance between obedience, independence, and individuality present within the mother-daughter relationship. Subjects which cause frequent disruption to this delicate balance include the discussion of topics such as clothes and appearance, friends, activities, TV programs, music, telephone usage, how to treat others, the completion of homework, and bedtime/curfew (Bersamin et al., 2008; Bleakley et al., 2009).

A girl's first period is her official physical rite of passage into womanhood (Hawthorne, 2002). This developmental milestone helps mothers to initiate sexual health

discussions with their daughters (Aronowitz & Eche, 2013; Biederman et al., 2010; Cox et al., 2010; Kukulu, 2006). Having conversations about this topic allows mothers to share their personal experiences as well as acquired expertise with their daughters. How this subject is introduced and managed by the mother or mother-figure lays the foundation for a girl's sexual health knowledge as well as her attitudes and beliefs about the mechanics of her reproductive health system. The messages heard and internalized are critical during this developmental period, because they are carried with them into their adulthood (Bennett & Harder, 2014; Brock & Jennings, 1993; Bynum, 2007). A favorable experience lays a strong foundation for the girl's self-esteem and self-worth; whereas girls receiving misinformation are more likely to have low self-esteem and self-worth going into adulthood.

Dimension Five: Timing

Sexual health communication in the dyad relationship works best when it is initiated before sexual debut (Boone & Lefkowitz, 2007). A mother has the most influence over her daughter developmentally between the ages of 9 and 14 years (Aronowitz & Agbeshi, 2012). Mothers should initiate relevant, age-appropriate conversations with their daughter through gauging their current level of physical and emotional development (Aronowitz & Agbeshi, 2012; Askelson et al., 2012; Dilorio et al., 2007; Hydee et al., 2013). When a mother underestimates her daughter's level of maturity and interest in sexual health topics, the effectiveness of sexual health communication greatly diminishes (Aronowitz et al., 2007). When mothers delay initiating sexual health conversations, the likelihood of their daughters listening and valuing the messages drastically declines due to the change in influence from parent to peer to partner (Byers, Sears & Weaver, 2008). However, when daughters hear information from their peers that is contradictory to what has been heard from their mother

or other adult figures, daughters will believe the messages shared previously by their mother (Dilorio, Dudley, Soet, & McCarty, 2004; Eisenberg et al., 2006; Grossman et al., 2013).

There are three types of sexual health conversations between mothers and daughters. These conversations include: (a) the big talk, which discusses the facts about sexual health topics; (b) tea talks provide opportunities for mothers to teach critical thinking skills while sharing family morals and values; and (c) social issues, which address difficult politically charged social issues such as abortion, unwed parenthood, same-sex relationships, gender roles, and sex with multiple sex partners (Adamczyk & Pittt, 2009) All three types of conversations, when staged throughout the relationship, lead to age-appropriate mother-daughter discussions about sex and sexuality throughout the period of early adolescence.

The first type of conversation, known as “the big talk,” focuses on fact-based dialogue and stresses sharing biological facts on specific body changes occurring during puberty (Cornelius et al., 2008; McNeely et al., 2002). This exchange of information is most comfortable for the mother because of the didactic delivery of information (Eisenberg et al., 2006; El-Shaieb & Wurtele, 2009; Grossman et al., 2013). These conversations are straightforward and involve topics such as body changes, menstruation, and personal hygiene (Akers, Bimla, Schwartz, & Corbie-Smith, 2010; Bennett & Harder, 2014; Costos et al., 2002; DiClemente et al., 2012; Gillen, Lefkowitz, & Shearer, 2006; Martin & Luke, 2010; Short, Black, & Flynn, 2010). However, when mothers are not equipped with accurate information, these conversations can create more confusion in young girls because of inaccurate or incomplete information being conveyed, which can lead to a variety of problems as girls begin to explore their sexuality.

The second type of conversation is known as “tea talks” (Cornelius et al., 2008; McNeely et al., 2002). These discussions include topics such as contraception, sexually transmitted infections, and pregnancy prevention (Akers et al., 2010; Boone & Lefkowitz, 2007; Eisenberg et al., 2006; Santa-Maria et al., 2014). Mother-daughter discussions involving these topics increase as an adolescent’s awareness of sexual risk increases. Topics include negotiation skills, managing dangerous situation, and disease transmission (Akers et al., 2010; Boone & Lefkowitz, 2007). Girls who have open conversations with their mothers about dating partners and resisting sexual pressure are more likely to report sexual abstinence or consistent condom use when engaging in sexual behaviors (Santa-Maria et al., 2014). This evidence quantifies the need to provide mothers with communication skills to be self-efficacious to assist their daughters develop critical thinking skills to make age-appropriate choices about their sexual health.

The third conversation type is known as “social issues” (Cornelius et al., 2008; McNeely et al., 2002). These conversations are greatly influenced by personal religious and value systems (Cornelius, 2009; Landor, Gordman, Simon, Brody, & Gibbons, 2011). These conversations give mothers an opportunity to share their faith and value systems (social norms) by prompting discussions that promote greater personal sharing (bonding) within the relationship. Social media, radio, and television provide opportunities to discuss sexual health topics. Examples of topics discussed in the media include gender roles, sexual relationships outside of marriage, abortion, teen pregnancy, and same-sex relationships. Mothers and mother-figures should utilize these opportunities to interject value-laden messages into daily conversations and interactions. This deliberate exchange of ideas and

values between mothers and daughters helps to develop relationships with communication transparency (Aspy et al., 2007; Grossman et al., 2013).

African-American Mothers' Sexual Health Communication Style

Race and ethnicity have been found to have a significant influence on a mother's attitude and intention to communicate about sexual health topics with their daughters (Abar et al., 2009; Alhassan et al., 2014; Aronowitz & Agbeshie, 2012; Coard, Wallace, Stevenson, & Brotman, 2004). Research suggests that a mother's ethnicity acts as a mediator (predictor) for maternal discomfort and infrequent communication within the dyad (Aronowitz & Abgeshi, 2012; Bynum, 2007). Pittman and Chase-Lansdale's (2001) sample of 302 African-American mothers illustrated a direct correlation between mothers' parenting style, daughters' sexual debut, and likelihood of becoming pregnant as a teen (Aronowitz & Eche, 2013; Barber et al., 2015). Mothers who had permissive parenting styles were more likely to have daughters who sexually debuted at earlier ages than daughters whose mothers' parenting style was more authoritarian (restrictive).

Ogbu's (1993) Cultural-Ecological Theory of School Performance asserts that culture affects parenting behavior because parents socialize their children to develop skills necessary for adult competence in their defined population and cultural group. Campione-Barr and Smetana's research (2004) presents how culture affects parenting behavior. They postulated that despite great diversity within the African-American community, all African-Americans must make psychological sense out of and cope with the dominant culture's openly disparaging views of prejudice and discrimination (Campione-Barr & Smetana, 2004). These strategies, described as "racial socialization," are practices that parents employ to protect and teach their children how to navigate their environments. Defined, racial

socialization refers to “the promotion of psychological and physical health through child-rearing in a society where dark skin and/or African features may lead to discrimination and racism, which in turn can lead to detrimental outcomes for African-Americans” (Peters, 1985, cited in Rodriguez, McKay, & Bannon, 2008, p. 1). Some examples include high rates and chronicity of behavioral problems, depression, and anxiety (Rodriguez et al., 2008). Racial socialization messages focus on cultural heritage and pride which helps to build a synergistic, verbal, deliberate, and proactive message (Smalls, 2009). The more parents are engaged in specific racial socialization practices, the more their children show better behavioral competence (Abar et al., 2009; Alhassan et al., 2014) and heightened self-esteem (Constantine, Jerman, & Huang, 2007).

Earlier research reported African-American parents, regardless of their respective social class line, were more likely to be authoritarian (restrictive) in their parenting style (Abar et al., 2009; Aronowitz & Eche, 2013; Cox, 2006; Gound et al., 2007; Meneses, Orrell-Valente, Guendeman, Oman, & Irwin, 2006; Robinson et al., 1995). African-American mothers in these studies reported being unaware of their daughters’ level of sexual activity; therefore, causing them to underestimate their daughters’ readiness to initiate (timing) or to have ongoing sexual health communication with their daughters (Cox, 2006; Robinson et al., 1995). This limited and infrequent sexual health communication implies that the protective effect reported in previous literature does not apply to the African-American mother-daughter relationship (Cox, 2006). More current research in this population has helped to better reveal how these cultural differences are necessary to build strong competent adults in this society (Aronowitz & Eche, 2013; Shamble-Ebron et al., 2016; Smalls, 2009).

In a different study of primarily African-American mothers, participants were found to have more of an authoritarian parenting style where they were more comfortable to share biological facts, warnings, and rules concerning sexual health topics (e.g., sexual reproduction, personal hygiene, and health issues) (Cornelius et al., 2008; Grossman et al., 2013; Meneses et al., 2006; Pinderhughes & Hurley, 2008). Mothers stated that these conversations required minimal personal disclosure of past experiences that were more difficult conversations to have with their daughters (Cox et al., 2010; Crichton et al., 2012).

There has been a dearth of work that addresses the inclusion of cultural messages in health risk reduction programs (Alhassan et al., 2014; Aronowitz et al., 2006; Coard et al., 2004). This research has found that cultural relevance makes a difference in the retention of information and knowledge (Alhassan et al., 2014). Banks-Wallace and Parks (2001) explored the impact of racism on maternal thinking and practice as it relates to the protection of their daughters (Aronowitz & Eche, 2013; Barber et al., 2015; Nikolajski et al., 2015). These culturally relevant practices have been suggested as necessary to be integrated at every stage including program conceptualization, study design, implementation, analysis, interpretation, and dissemination (Alhassan et al., 2014; Aronowitz et al., 2006; Coard et al., 2004).

These inconsistent findings across studies reinforce the need for more research to be conducted exclusively with African-American mothers to learn more about the influence of knowledge, self-efficacy, intentions, and personal factors which impact the readiness of African-American mothers to communicate with their daughters about sexual health topics. As these previously described research studies depict, the evidence reported has provided limited exclusive descriptions of the African-American mother-daughter dyad conversations

about sexual health topics. It cannot be assumed that African-American women are a monolithic group that parent only one way (Aronowitz & Eche, 2013; Coard et al., 2004; Cox, 2006). Other outside influences include the decayed communities, increased crime, and substandard social services many African-Americans are surrounded by.

The literature has consistently reported that mothers who are the most successful in having sexual health communication with their daughters are those whose communication style is open and whose authoritative parenting style promotes comfort and confidence within the dyad to have difficult conversations about abstract topics. There is limited representation of this group in the literature. More research is needed to describe the impact of belief systems, attitudes, faith/values, and/or personal behaviors that enhance the ability of African-American mothers to have confident and comfortable communication with their daughters about sexual health topics.

Personal Factors in African-American Women that Influence Communication about Sexual Health Topics

Additional external factors to note that influence African-American mothers' ability to communicate with their daughters are due to a mother's personal experiences during her own maturation process. These external factors contribute to a woman's personal experiences and include the following: a woman's own personal health communication experience as a young girl, additional personal factors (i.e., age at personal sexual debut, first pregnancy, first live birth), as well as personal experiences with STIs, including HIV.

African-American Women's Faith and Values

African-American women by nature rely heavily on their faith and values to provide direction and comfort throughout the course of their lives (Holt et al., 2009; Marks,

Nesteruk, Swanson, Garrison, & Davis, 2005; Mattis, 2000; Mattis, Fontenot, Hatcher-Kay, Grayman, & Beale, 2004; Maturi & An, 2010). A Black woman's faith is something that cannot be encapsulated into a well-defined ideology but can best be described as a unique and personal lived experience. Through this acknowledgment, the importance of faith and how it is manifested in the individual lived experience is something that continues to evolve in our society as we continue to explore the positive effects of faith on one's health.

Traditionally in the literature, faith has been described as a person's religiosity or congregation that a person and/or family is connected to (Ball, Armistead, & Austin, 2003; Braxton, Lang, Sales, Wingood, & DiClemente, 2007; Landor et al., 2011; Marks et al., 2005; Mattis et al., 2004; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998). Engaging women of faith has significantly changed as we look at three distinct generations of women (Millennials, Generation X, and Baby Boomers) raising young women in today's society (Fingerman, Pillemer, Silverstein, & Sutor, 2012; Huver, Otten, DeVries, & Engels, 2010; Shakib et al., 2003). Baby Boomers, the oldest of these generations and born between 1946 and 1964, represent older mothers and grandmothers who rely more on traditional values and have a greater appreciation for the importance of the faith and its connection to church and weekly participation.

Women of Generation X, the middle generation, were born between 1966 and 1976. These women represent mothers, aunts, and mentors who are working with younger girls. These women are the first generation of women to have obtained higher education, are more skeptical towards society and employers, and have a more pragmatic approach to maintaining family. This generation embraces the memories and traditions from their past while having the ability to pick and choose from those traditions to embrace new

technology. These women are unique in their position because they see both the advantages and disadvantages to both the old and the new.

Lastly, Generation Y or Millennials were born between 1987 and 1994. This group of mothers are the generation who has been most exposed to diversity and technology. This group is less loyal than previous generations. If interactions, activities, or participation are not linked to technology, then the likelihood of interest, participation, or follow through is usually low. Their connection to faith and religious tradition is much more fluid than the first two generations described. They recognize their faith guides them through their daily walk, but their connection to a congregation is usually through their parents or grandparents, thereby making their connection and commitment to these institutions not as important because the commitment is not theirs personally (Cornelius et al., 2008).

Spirituality and Religiosity Defined

Miller et al. (1998) defined religiosity as the extent to which one is engaged in religious belief and practice. Religiosity has been conceptualized as an individual-level protective factor against a host of risk behaviors (Abar et al., 2009; Berkley-Patton et al., 2010; Gillium & Griffith, 2010). Mattis (2000) described religiosity as one's adherence to prescribed ritual and beliefs about God (or a set of gods); whereas religiousness may involve participation in prescribed rituals. Spirituality is defined as an intimate relationship with God that is actualized through a series of activities requiring internalization (journey of self-reflection, self-criticism, and self-awareness), and the genuine and consistent commitment to beliefs and values (e.g., quest for goodness). For African-American women, Mattis (2000) included an additional dimension that culminates in a greater understanding of the

relationship between self, God, and the larger community which includes both the community and family.

Further, spiritual and religious beliefs have been shown to influence African-American people's understandings of forgiveness, liberation, hope, justice, salvation, the meaning and purpose of life, and their responses to oppression (Gillium & Griffith, 2010; Williams et al., 2016). Spirituality and religion have played central roles in structuring African-American people's interpersonal relationships, including their ideas about social obligations, choice of romantic partners, and their definitions of community-shaped notions of civic responsibility. They have also influenced their political beliefs and patterns of political participation (Coyne-Beasley & Schoebach, 2000; Gillium & Griffith, 2010; Iles, Boekeloo, Seate, & Quinton, 2016).

The Role of the Black Church in the African-American Community

The Black Church in the African-American community has been the nurturer of culture, the champion of freedom, and the hallmark of African-American civilization (Berkley-Patton et al., 2010; Coyne-Beasley & Schoenbach, 2000). Historically, the church has been the hosting space for educational forums and the home for social service centers; whereas the pulpit has been the launching pad for political advocacy, activism, and collectivism. The Black Church represents the traditional place where black leadership has been developed and revered. The culture of the church challenged the everyday occurrence of an existence where Blacks were seen in subservient roles in the 1950s, 1960s and 1970s (Ball et al., 2003; Cornelius, 2009; Coyne-Beasley & Schoenbach, 2000). Today, the Black Church continues to represent a place of power, reverence, and respect. This respect for the institution and the inherent power that it carries within the black community leads to the

importance of its inclusion when addressing social justice issues of importance (Coyne-Beasley & Schoenbach, 2000).

To have relevance in the African-American community, a faith perspective component must be integrated into any intervention created that will work exclusively with this population. One of the distinguishing characteristics of the African-American community lies in how it is enmeshed with a combination of family, community, and faith. This cultural blend makes it difficult for persons outside of the culture to truly understand faith, family, and community as being independent from one another (Gillium & Griffith, 2010; Marks et al., 2005). This faith-family-community connection helps its members to actualize the linkage between health and religiosity in the African-American population, which is generally stronger than the linkage found in Caucasian populations (Berkley-Patton et al., 2010; Cornelius, 2009; Holt et al., 2009; van Olphen et al., 2003; Wingood et al., 2013).

One way that this faith-family-community connection can be measured is by the reported frequency of church attendance between Blacks (53.3%) to that of their White counterpart (43.2%). Research also suggests that African-Americans who report being religious not only live longer but experience greater levels of life satisfaction (e.g., lower mortality rates, higher self-esteem) while experiencing lower levels of suicide, substance abuse, and depression (Ball et al., 2003; Gillium & Griffith, 2010; Iles et al., 2016; van Olphen et al., 2003). Some religious factors that support improved health include increased social support over time and the promotion of healthy lifestyle behaviors (van Olphen et al., 2003). This promotion of healthy lifestyles helps with the avoidance of risky behaviors (e.g.,

less smoking, drinking, substance abuse, improved diet, and safer sex practices) and the pressure to conform to religio-ethical norms (Marks et al., 2005).

As this chapter summarizes, there is a dearth of literature which explores the science of how mother-daughter sexual health communication occurs as well as how this consistent communication influences a daughter's future success. In addition to selected constructs from the Theory of Planned Behavior, additional personal and external constructs were also explored and identified as possible contributing factors which assist mothers to be able to communicate with their daughters.

CHAPTER 3

METHODS

This qualitative, elicitation study was the first step in a program of research that is based in the hypothesis that mother-daughter dyads who participate in sexual health conversations can be empowered to improve their communication, thereby reducing risk for the daughter for early sexual debut, teen pregnancy, and acquisition of STIs, including HIV. This qualitative study aimed to identify factors that influence the intentions and decision of African-American mothers to communicate with their daughters (aged 9-14 years) about sexual health topics (e.g., sex facts, values, emotions, and consequences of early sexual debut). The Theory of Planned Behavior framed this study. Four focus groups and three individual interviews were guided by the key constructs of the theory: (a) mothers' personal attitudes about communicating with their daughter about sexual health topics; (b) subjective norms to comply with the expectations of others; (c) perceived behavioral control (self-efficacy) to communicate with their daughter about sexual health topics; (d) intention to communicate about these topics as well as (e) actual communication (behavior) about sexual health topics. Other variables of interest were mothers' demographic and personal and sexual health variables.

Theoretical Framework for this Study

Ajzen and Fishbein's (2004) Theory of Planned Behavior (TPB) guided this dissertation study. The Theory of Planned Behavior has been empirically tested and found to be among the best theoretical models for examining health behavior outcomes (Ajzen & Fishbein, 2004; Francis et al., 2004). TPB has been used extensively for the development and assessment of health interventions with the aim of increasing intention to engage in the

target behavior, such as health communication (Aronowitz et al., 2007; Askelson et al., 2010; Hutchinson & Wood, 2007; Schouten et al., 2007). A model of the theoretical framework displays the directional relationship of constructs which leads to intended behavior or behavioral control (see Figure 3.1). The framework hypothesizes that human behavior is guided by three considerations: behavioral, normative, and control beliefs.

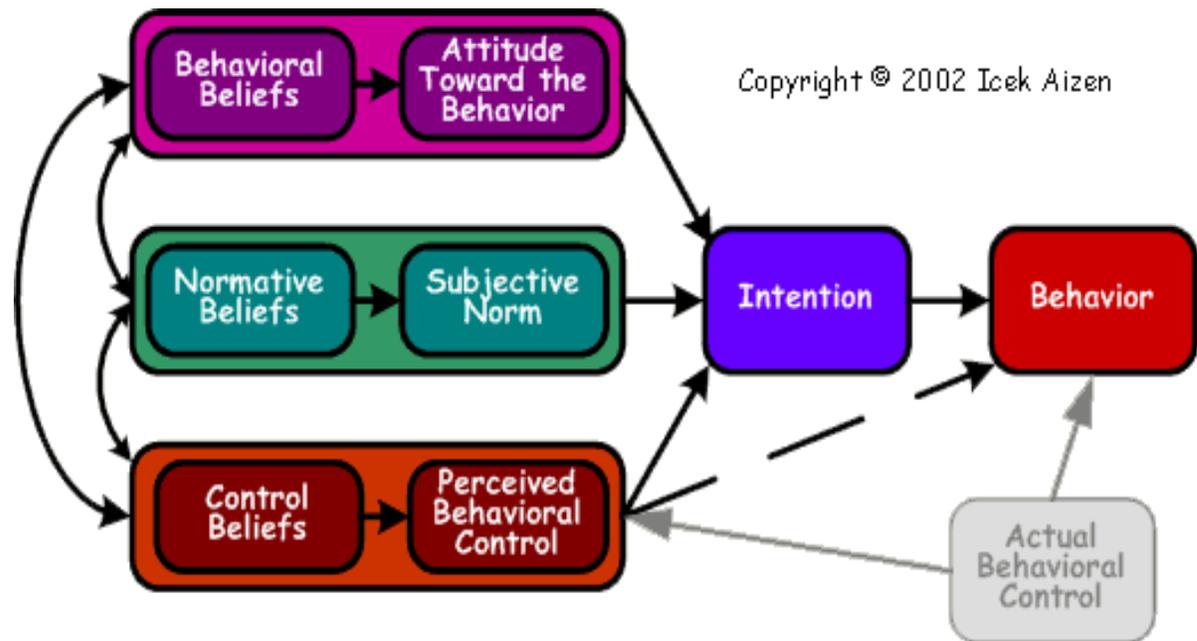


Figure 3.1. Ajzen & Fishbein's Theory of Planned Behavior (TPB)

The TPB proposes that behavioral intentions reliably predict whether a person will engage in a behavior. As intentions, or motivation, to complete the behavior increases, so does the likelihood that the behavior will be achieved. Three independent determinants influence a person's intention to engage in a specific behavior: attitudinal beliefs, subjective norms, and perceived behavioral control. Attitudinal beliefs are driven by a person's appraisal of whether a particular behavior will lead to a particular behavioral outcome, and

whether the behavioral outcome is valued by the individual. Subjective norms are derived from the individual's perception of their peer groups' (e.g., friends, family members, church members) approval or disapproval for the behavior and their motivation to comply with the referents' opinions. Perceived behavioral control—self-efficacy (the strength of an individual's perceptions of the degree to which opportunities/resources and barriers/impediments are likely to facilitate or hinder behavior change) is a function of control beliefs (the factors that may facilitate or impede performance of the behavior) and the perceived power of this factor to make the behavior difficult or easy. Specifically, does a person believe that they have the skills, resources, and opportunity needed to overcome barriers (real or perceived) to perform said behavior? Perceived behavioral control is often the most predictive determinant of behavioral intentions and actual performance of the target behavior.

This dissertation study utilizes the Theory of Planned Behavior to explore African-American mothers' personal attitudes about communicating with their daughter about sexual health topics; subjective norms to comply with expectations of others; perceived behavioral control (self-efficacy) to communicate with daughter about sexual health topics, and mothers' demographic, personal and sexual health variables. The theory posits that people's expectations and values about engaging in a behavior form their behavioral, normative, and control beliefs. These belief systems influence people's attitude, subjective norms, and perceived behavioral control toward their intention and ultimately their behavior (Downs & Hausenblas, 2005). These variables are hypothesized to impact on the mothers' intention to communicate about sexual health topics; and the actual behavior of interest (sexual health communication) between mother and daughter.

The TPB model was selected for its ability to assist in future survey and intervention development/assessment. Researchers utilizing this study are encouraged to conduct formative studies to elicit information on attitudes, norms, and perceived control issues related to the desired outcome behavior (e.g., successful sexual communication with daughters) with the target population via qualitative methods, such as focus groups and interviews (Francis et al., 2004).

Both focus groups and interviews were conducted to identify the wide range of beliefs held by the population. For example, African American mothers are likely to embrace certain behavioral beliefs concerning the potential outcomes of having sexual health conversations with their daughters. Some examples of these beliefs may be: (a) the belief that having conversations about sexual health topics will encourage sexual activity in their daughters; (b) their daughters are not interested in having conversations with them about sexual health topics; or (c) talking to their daughters about sexual health topics encourages earlier sexual debut. This process helped to identify and prioritize the factors important to this community of study compared to what has been reported in the literature. Ajzen and Fishbein (2004) suggested that in conducting the elicitation process, TPB assessment tools can be tailored to appropriately measure potentially modifiable determinants (attitudes, norms, and behavioral control) with the target population, and subsequently, determine to what degree TPB factors are related to the desired outcome (Francis et al., 2004). The Elicitation Phase is the recommended first step in conducting research utilizing the Theory of Planned Behavior (Francis et al., 2004). Ajzen and Fishbein (2004) stated that an adequate sample of 5-25 participants is needed to understand and appropriately measure potentially modifiable determinants (attitudes, norms, behavioral

control) with this target population, and subsequently, to determine to what degree TPB factors would be related to the desired outcome (i.e., mothers who communication with their daughters about sexual topics) (Ajzen & Fishbein, 2004; Berkley-Patton et al., 2010; Hutchinson & Wood, 2007; Schouten et al., 2007).

Setting/Sample

A convenience sample of African-American mothers was recruited from a variety of locations, such as local congregations, schools, and community centers throughout the Metropolitan St. Louis, Missouri area. Recruitment was achieved for this study primarily through word of mouth. The primary recruitment focus was with faith communities where the primary investigator had strong relationships and connections with key community leaders who had regular and frequent contact with participants meeting the study criteria. From these connections, personal invitations were made for participation in the focus group sessions.

Interview Guide

The focus group guide was developed utilizing the constructs of interest from the Theory of Planned Behavior. The same guide was used for the three individual interviews. The following constructs from the theory were of interest:

1. Mother's attitude about communicating with daughter about sexual health topics;
2. Subjective norms to comply with the expectations of their faith community;
3. Perceived behavioral control (self-efficacy) to communicate with daughter about sexual health topics;
4. Mother's intention to communicate with daughter about sexual health topics

5. Current communication behavior between mother and daughter about sexual health topics.

Additional variables external to the Theory of Planned Behavior that were also measured include:

1. Mother's demographic variables (age, zip code, relationship status, number of children in household, education level, and employment status);
2. Mother's personal and sexual health variables (religiosity, mother's age at sexual debut, and age at first pregnancy).

Participants were also administered a demographic survey to collect the following data: mothers' age; zip code; relationship status; number of children in household; education level; employment status; church affiliation; mother's age at sexual debut and mother's age at first pregnancy.

Procedures

Approval of this study was obtained from the principal investigator's dissertation committee in February 2014. The University of Missouri-St. Louis IRB approved this study in June 2014. The University of Missouri-Kansas City provided an IRB waiver.

Focus group sessions and three individual interviews were conducted between July 2014 and September 2014. There were originally three focus groups scheduled. Due to low numbers in participation, an additional four focus group sessions were planned. One focus group session was converted into an individual interview because only one participant showed up. Two additional focus group participants had scheduling conflicts; those two were conducted as individual interviews as well.

Participants were sent postcards that contained directions to the University of Missouri-St. Louis, College of Nursing. In addition, an electronic version of a confirmation letter was forwarded through email reminding participants of their upcoming participation in the focus group session. On the day before and the day of the session, text messages were sent to participants reminding them of their participation in the upcoming focus group session.

Participants were screened by telephone prior to the focus group. During the telephone screening, each participant was provided a unique identifier to ensure confidentiality after agreeing to participate in the study. Upon arrival for the focus group, participants were greeted and asked to check in. Each participant was offered refreshments at the focus group sessions. After signing in, participants' unique identifiers were confirmed. Participants were given placards with only their first name to maintain confidentiality of participants in attendance at sessions. Participants were also provided with the University of Missouri-St. Louis IRB Consent Forms (see Appendix A) for further review and signature. In addition to consent forms, participants were given a Demographic Questionnaire (see Appendix B) for completion. The consent process was covered in detail by a non-partial observer, a research assistant at the University, to ensure that participants were not coerced into participation. Each focus group session lasted approximately two hours. At the completion of the focus group sessions, each participant received a \$15.00 gift card.

Study Procedures for Data Collection

Recruitment

This research study utilized a convenience sample and a snowball recruitment technique in the Metropolitan St. Louis area. There were 65 women who were contacted as

potential participants through email and word of mouth. The following strategies were instituted for recruitment: personal referrals and endorsements from church leadership (e.g., pastor, deacons, and ministry leaders), word of mouth, announcements utilizing social media (e.g., Facebook, Constant Contact, etc.) to women meeting the inclusion and exclusion criteria for this study (Polit & Beck, 2008). Participants were screened by telephone for entrance into the study based on the following exclusion/exclusion criteria: (a) Are you an African-American mother or mother-figure with a daughter between the ages of 9 and 14 years? (b) Do you live in the St. Louis Metropolitan area? and (c) Can you read and complete the survey instrument with little to no assistance from the researcher?

Telephone Screening Process

Once participants indicated an interest in the study, each person was called by the principal investigator, who explained the reason for the study and ensured that participants met the inclusion/exclusion requirements for participation. Once interest was established, participants were asked the above inclusion/exclusion criteria. Women were asked a series of questions from the Parent-Child Sexual Risk Communication (PCSRC) scale to determine their self-reported level of sexual health communication with their daughters. The Parent-Child Sexual Risk Communication (PCSRC) sub-scale (Cronbach Alpha=0.86), originally developed by Hutchinson et al. (2003) was adapted with her permission to allow two additional topics that would be relevant for mothers with daughters who had pre-adolescent daughters (9-11 years) (see Appendices C and D). Mothers were pre-screened to assure that they had indeed started having these types of conversations with their daughters before being invited to participate in focus group activities.

Data Collection Procedures

During data collection, 11 open-ended questions were tailored from earlier TPB studies to create the focus group guide for this survey (Ajzen, n.d.; Francis et al., 2004). The same guiding questions were used for focus groups and individual interview participants. In addition, participants were asked to provide their individual opinion for each of the topics that were proposed. After each question was introduced, women were asked to share their views, experiences, and observations as related to the discussion of the group. Notes were taken by a research assistant from UMSL College of Nursing to capture any observational information shared during this phase of data collection.

Data Analysis

Focus groups and individual interviews were recorded electronically. Electronic recordings were transcribed verbatim, and the transcripts were checked against the recordings for accuracy. The seven transcripts from the focus groups and interview sessions yielded a total of 605 single-spaced pages of data for analysis. One investigator (the Ph.D. candidate) analyzed the data. A post-positivist approach, content analysis was used (Sandelowski & Barroso, 2003). Codes were initially generated from the written transcripts of these conversations. Using content analysis techniques, data were organized into themes derived from the Theory of Planned Behavior (TPB) constructs (Sandelowski & Barroso, 2003). Themes were identified and rank ordered through a systematic content analysis; exemplars were selected to support findings (Clarke & Braun, 2013; Fritz et al., 2016; Morgan, Thorne, & Zurbriggen, 2010). Aligning with Azjen's recommendations for conducting elicitation studies, these ten recurrent themes represented the most common salient beliefs expressed by mothers when discussing sexual health topics with their pre-

adolescent daughters (Ajzen, 1991; Francis et al., 2004). The emerging themes and mind-maps were created to organize and follow the data that emerged from the transcripts being reviewed.

These themes were further developed and refined through collaboration with a nursing professor who is an expert in qualitative methodology. Major themes were supported through sub-themes and rich text exemplars (Fritz, Corbett, Vandermause, & Cook, 2016) from the participants in the focus group and interview sessions. Comparisons were made across transcripts, looking for shared themes. A lengthy summary of the emerging themes was written and shared to corroborate triangulation of themes found in the review of the transcripts (Neergaard, Olesen, Anderson, & Sondergaard, 2009). Lastly, the major themes and sub-themes were grouped together, subsuming minor related themes into the groupings discussed in the next section (Ajzen, n.d.; Fritz et al., 2016).

CHAPTER 4

RESULTS

African-American mothers/mother-figures (n=19) participated in this study. Mothers/step-mothers comprised 78.9%; grandmothers 15.7%; and mentor/family friend 1.0%. The majority (68.4%) of participants were 36-50 years of age; 15.7% were 35 and younger and 15.7% were over the age of 50. Most participants were married (63.1%) and had at least a Bachelor's degree or higher (57.5%).

Ten themes aligned with the major constructs of the Theory of Planned Behavior and are summarized in Table 4.1.

TPB Construct: Attitudes

A person's attitude toward a behavior takes into consideration both a person's belief about the consequences of such behavior combined with the corresponding negative and/or positive judgments that are linked to participating in the behavior (Francis et al., 2004). The mothers who participated in this study were asked to consider both the internal and external factors which most impact their willingness to have ongoing sexual health conversations with their daughters.

Theme 1: Faith/Values/Religiosity

Mothers' attitudes toward having sexual health conversations with their daughters were greatly influenced by their individual personal faith/values/religiosity. Participants felt strongly about teaching their daughters how to live an honorable life through teaching life skills and values as they develop into adulthood. Examples were candidly shared describing how mothers' faith, religious practices/teachings personal faith greatly influenced these conversations.

Table 4.1

Mother’s Sexual Health Communication: Theory of Planned Behavior Constructs, Study Prompts and Themes, and Supporting Exemplary Quotes

Theory Construct	Prompts and Themes from Qualitative Study	Exemplary Quotes Supporting Themes
Attitude	<p><u>Theme 1:</u> Faith/Values/Religiosity: “What do you believe are the advantages of routinely talking to your daughter about sexual topics?”</p>	<p><u>Theme 1:</u> “I think the base of all of those conversations are intertwined with our faith and with our values. That is a part of every conversation whether its sex, personal hygiene. I mean I don’t care what we are speaking of and in my home and the relationship that I have with my daughter, values and our faith plays a big part in everything that we talk about.”</p>
	<p><u>Theme 2:</u> Barriers to Sexual Health Communication: “What are some ways that mothers can disarm their daughters to discuss sexual health topics?”</p>	<p><u>Theme 2a:</u> “Sometimes, it just catches me off guard the way she talks.”</p> <p><u>Theme 2b:</u> “I’ve tried to use her language, you know, even if this is a song or what I do know with acronyms with texting, you know, with names in words and acronym and then they’re like ‘what? You know that?’ You know, because I guess getting back to go try it on to see how it looks—because I found that I have been wrong about some things and admitting it. You know what? That does look okay. I was not afraid to say it. I was wrong.”</p>
Perceived Behavioral Control	<p><u>Theme 3:</u> Mother’s comfort to discuss sexual health topics: “What factors or circumstances would enable you to routinely talk to your daughter about sexual topics?”</p>	<p><u>Theme 3:</u> “I always just try to find that moment like there’s a moment in life if I’m with one daughter alone I’m with the other daughter alone. . .”</p>

50

(table continues)

Subjective Norms	<p><u>Theme 4: Own Mother's Influence</u> "How has your relationship with your mother influenced how you talk to your daughter about sexual topics?"</p>	<p><u>Theme 4a:</u> "I think that I just followed suit. My Mom had always talked to me. We always had a very good open relationship. So, I think I just kinda follow suit. I think, you know, just for me and things that I hear, I think you should always be able to talk to your Mom even now at 46."</p>
	<p><u>Theme 5: Other Important People:</u> "Are there individuals or groups who would disapprove of you routinely talking to your daughter about sexual topics?"</p>	<p><u>Theme 4b:</u> "Me and Mom had a close relationship, but she's never [been] open with talking about sex or those sorts of things and so that always made me very open with my children."</p>
	<p><u>Theme 6: Teaching Faith/Values:</u> "How does your faith/values influence how you talk to your daughter about sexual health topics?"</p>	<p><u>Theme 5:</u> "My father's side of the family was very different, but also at such a conservative level that they have, you know, blinders on to what was really going on."</p>
Intentions (to Communicate)	<p><u>Theme 7: Daughter's readiness to talk—speaking daughter's language :</u> "What factors would contribute to helping you to feel comfortable to talk to your daughter about sexual topics?"</p>	<p><u>Theme 6:</u> "I think faith is important because faith is what a common trait in most African American families. You rarely find African-American families that don't have faith. I mean that's what helped us to survive, so many negative consequences."</p>
		<p><u>Theme 7:</u> "I've tried to use her language, you know, even if this is a song or what I do know with acronyms with texting, you know, with names in words and acronym and then they're like 'what? You know that?'"</p>

(table continues)

Behavior
(communication)

Theme 8: Daughter's development – Changes to behavior:
“What factors make it difficult or impossible for you to talk to your daughter about sexual topics?”

Theme 9: Sexual health topics discussed:
“Do you routinely talk to your daughter about sexual topics?”

Theme 10: Life Skills through personal life experience:
“What are the life lessons I want to share with my daughter as she is growing up?”

Theme 8: “Yes. Her Mom and I noticed that when she would talk on the phone, it was now private. She would go to a different room. . . So, we knew it had to be a guy that she was wanting to get close to and she started keeping secrets.”

Theme 9: “I didn't wait for a cue. We have check-in conversations with her . . . and I think it just always kept her on track so that, you know, she felt like she got her curiosity, you know, answered and moved on.”

Theme 10a: “To be honest with you, I don't want anybody else's voice to speak louder than mine.”

Theme 10b: “The best thing we can do is surround our children with people that are teaching the same messages that. . .”

Mothers shared how messages from their faith community must be translated so that their family's best intentions were prioritized. Participants talked about how important it was to translate Bible teachings heard in church versus what was happening in real world. Making these translations led mothers to have conversations with their daughters to discuss how these teachings were relevant to their family's faith and values, as exemplified by the following quote:

So, it's just more about the application piece—more so that—again why was it written and who wrote it? You can know the 66 books [of the Bible] all day long but again, how do you use that? . . . versus . . . What's your risk? . . . I try not to be ritualistic.

The following quote by one mother described her experience of growing up in a religious household and how she vowed to raise her children differently where there were more conversations on real life issues and not just emphasizing religion as a solution to life's problems.

growing up in a religious household and everything was—Jesus, Jesus, Jesus, we had no life outside of school and church. That was all we did. And, so that was the one thing that I vowed when I had a family, I'm not dealing with this. They would know Jesus. I want them to have a personal relationship with him. However, we don't have to be at church 24/7 for them to have a relationship with Christ.

Another participant described how her church family was her “village of social support.”

This extension of family allowed mothers to have social support when needed.

I rely on my church to be a part of my village. . . Members can be friends, sometimes co-workers.

Theme 2: Discomfort with Sexual Health Communication

Within the mother-daughter dyad, discomfort with communication was experienced most frequently when daughters expressed disagreement with the mother's expressed family's faith/values or when mothers were asked to discuss content believed to not be age-

appropriate. As it relates to this research, this often translated into discomfort to answer questions related to sexual intercourse. Despite this comfort barrier, mothers were motivated to engage in these conversations to help their daughters avoid the consequences of poor choices. The strongest motivator for mothers to have these uncomfortable conversations was the belief that their role as mother was to serve as their daughter's primary sexual health educator.

So, I don't want to encourage her, but at the same time I don't wanna scare her away from [talking] – I wanna be the one that tells her the truth.

Some mothers were uncomfortable having these conversations because they never had sexual health conversations when they were their daughter's age. Participants desired their daughters to have better life experiences than their childhood experiences had been.

So, it's a boundary that I have put up because my mother and I never had conversations about anything. We never had the birds and the bees talk. We never had the talk about boys. We never had the talk about menstrual cycles. We never had a talk about feelings. That was all learned in my adulthood. We never had those talks and that's something that I said that I did not want my girls to experience.

Recognizing and responding to the cues that their daughters gave was critical for mothers to identify so that they could initiate sexual health conversations. Mothers described how having awkward conversations about topics like "oral sex" was necessary, despite the mother's own personal discomfort. So, while awkward, acknowledging the importance of having these conversations was critical to ensure having future conversations.

But oral sex, I'm not comfortable with. I'm not comfortable when I hear answers that I'm not ready to hear, you know. . . but I don't wanna scare her away.

Discourse about same-sex relationships was the most difficult to engage in due to mothers' personal beliefs about this lifestyle. Many mothers had not been exposed to same-sex relationships outside of social media and television. This limited exposure made

conversations more one-sided and difficult to have because of judgments about what was appropriate and inappropriate behavior as exemplified by the following quote.

When it comes to this I'm old school. . . I believe a man should be with a woman and a woman should be with a man. I myself feel it is a barrier for me 'cause I don't know how to speak on it because I would just tend to want to shy away from it.

TPB Construct: Perceived Behavioral Control (PBC)

Perceived Behavioral Control or self-efficacy refers to how confident a person is in performing a said task or activity. Throughout the course of the focus groups and interviews, mothers were asked to differentiate between their use of the words comfort and confidence to communicate with their daughters about sexual health topics. Mothers expressed having the most confidence to communicate with their daughters about daily activities and a wide range of topics not related to sexual health. Women expressed the most comfort when sharing stories with their daughters about their family's faith and values.

Theme 3: Confidence Discussing Sexual Health Topics

Throughout the focus groups and interviews, women used both comfort and confidence interchangeably throughout data collections to discuss their conversations with their daughters. Mothers overwhelmingly expressed the most confidence when describing how they prepared their daughters for their first menstrual cycle.

OK for me. It was easy for me to talk to them about their menstrual. I never was talked to about mine, but for some reason, it was easier for me to talk to my daughter.

TPB Construct: Subjective Norms

Fueled by a person's normative beliefs, subjective norms are influenced by the people, circles, or communities closest to them. These influences help shape a person's culture by defining what and who has the greatest influence over their personal decisions

and lifestyle choices. Participants with this influence were included in what was described as “their village of influence” (Ugarriza, Simpson-Robinson, Braxton, & Raiford, 2006, p. 25; van Olphen et al. 2003; Cox et al., 2009). This group provided social support and stood in as accepted information brokers when mothers were perceived as not being “the experts” to have these conversations with their daughters. These members had established trust between members which proved to be invaluable when mothers were not allowed to engage in sexual health conversations with their daughters.

Theme 4: Own Mother’s Influence

Mothers participating in these focus groups and interviews had a great desire to be the gatekeepers to control how sexual health information was conveyed to their daughters. Many participants shared that the single factor having the most influence as well as intention to communicate was their previous level of sexual health communication with their own mother (daughter’s grandmother). The mother-daughter relationship’s lasting impact was heard throughout the stories told where daughters recalled vividly the significant role that their mothers (now grandmothers) had on them growing up. This strong bond is described below.

I just believe there’s a bond that you just cannot explain between a mother and her child that no matter how good other people are to you, you just need your mother and that was the one thing that stuck with me.

Participants recalled past conversations with their mothers at their daughter’s current age greatly impacted their self-efficacy to successfully have these conversations with their daughters today. One participant expressed that because her mother was not someone she felt that she could have these intimate discussions with when growing up. this empowered

her to make a different experience with her daughter during this critical stage of development.

I'm trying to build a relationship with her to say, "Well, I can go to my Mom. You know, I can say this to my Mom. You know. . . and I have already verbally expressed to her that I wanna be here for you 'cause I didn't have my mother there for me.

Women who had limited sexual health conversations with their own mother expressed having low self-esteem, which led to poor choices, which sometimes compromised their personal safety and integrity. This poor preparation led to women feeling inadequately prepared to have these conversations with their daughters because they were ill-equipped in their own sexual health education. This self-awareness discussed during the data collection sessions led to participants acknowledging how little they were prepared as young women and having a desire for a better experience for their daughters growing up.

If my mother had been present, the things that I was into or situations I was faced with as a child and as a young person, I don't think I would have had to do that. I [later] learned my mother didn't get it from hers. So, [I] couldn't fault my mother for not doing something she didn't even know how to do.

Theme 5: Other Important People

Participants noted that their daughter's father was most significant in their daughter's development of her self-esteem and self-worth with the opposite sex. Women noted that their daughter's father played critical roles in validating their value as a young woman. Mothers conveyed stories of how they facilitated opportunities for their daughter's father to model ideal treatment she should expect from boys. These experiences were instrumental in the development of their daughter's confidence.

So, that's what made me pull my husband into a lot of stuff with how like you know, you are her father. You know, you need to express to her, validate her.

As described earlier, mothers discussed “villages of support.” These supportive extended family members reinforced family values to their daughters that were not accepted when coming from the mothers.

The best thing we can do is surround our children with people that are teaching the same messages that . . .we’re teaching . . . So, if I can put her around T.S. in her village, around you, around S.F. and you’re all saying the same thing I’m saying, but you’re not mom. It reinforces my message. To her, it’s different because its Ms. T. that’s saying it. It ain’t mom trying to ruin my life.

Theme 6: Teaching Faith/values through Personal Life Experiences

Women’s personal faith and values were the foundation taught to their daughters about personal life and relationship experiences. Sharing their family’s faith with their daughters encouraged conversations which supported topics that were in alignment with their faith and values. This mother describes how children will often stray from their foundation teachings but will return to those lessons that have been instilled in them.

[Growing up] we went to church--. We went to church Monday through Sunday and I still veered off. Kids are gonna do that. But once you instill that in them they know the way. They’ll come back to it. You gotta let them live their life just like you lived yours. You just gotta be the bigger voice in their heads and say, “Okay, now you know. I raise you like this, you know you’re not supposed to do this, you know this is the way that you were brought up.” And they’ll come back to it.

TPB Construct: Intention (to Communicate)

When considering the TPB, the “intention” construct is the closest proximal measure of a person’s future behavior. This relationship between intention and behavior is critical to understand and manipulate when developing interventions in communities (Francis et al., 2004). Therefore, it was critical to learn directly from this population during this study the factors that personally influenced African-American mothers to engage in sexual health communication with their daughters.

Theme 7: Daughter's Readiness to Talk

Women shared that when their relationships with their daughters were open, dialogue was more frequent, which made having conversations about sexual health topics easier to achieve. Mothers described how being familiar with the current slang was a difficult but important task to maintain their daughter's safety and well-being. It became particularly important to understand the current nuances used in music lyrics and social media. One mother describes how going out to eat with her daughter was an opportunity to have conversations about a variety of topics.

We go out eating. It's just the two of us. I bring up conversations. I will even start a topic to get her talking and I'll do it in multiple different ways, but I want her to know I'm there.

Mothers used these conversations as an opportunity to gauge where their daughters were developmentally. One participant described how uncomfortable her daughter was to use the "correct words" to describe certain sexual activities when talking to her.

And she said, "Mom, I can't say it." And I said, "Well, if you don't say it, how will I know what you're talking about." She didn't wanna say the word "anal."

Theme 8: Daughter's Development

Mothers discussed a variety of ways that their daughters' physical development, verbal cues, and developing interest in boys had prompted changes in their daughters' behaviors. Women described being direct as well as humorous in starting these conversations with their daughters. Many participants noted that cues to begin these conversations included their new curves, a new interest in dresses, as well as dramatic changes to their hair. Other cues included a new interest in personal hygiene as well as an open interest in boys.

she was a total tomboy until she got to middle school. So, for me, I noticed it instantly, if her outfit wasn't right, she wouldn't leave for school yet, she was one of the kids that hated skirts. Now, I can't keep her out of them. . . fitted clothing that she tries to wear to show her little shape. The lip gloss. I was always, "Put something on your lips." Now, I don't have to do that. Her hairstyles. Just her appearance changed as how I knew it.

TPB Construct: Action (to Communicate)

Giving daughters the tools they need to be successful is the job of a parent, particularly the mother. Women used reflective as well as direct questions to begin conversations. Mothers described that the best strategy was individualized, in that what worked for one daughter frequently did not work for a different child. Mothers desired the opportunity to develop their daughters' critical thinking skills so that they could learn how to successfully think through real-world situations as they were encountered.

Theme 9: Sexual Health Topics Discussed

Mothers stressed the importance of being transparent with their daughters. A large range of sexual health topics were discussed with their daughters. Topics ranged from puberty (e.g., body changes, menstruation) and safe touch to the physical act of sex, pregnancy and STIs including HIV.

Theme 10: Teaching Life Skills

Through much candor, mothers described using real-world examples to discuss how they taught their daughters to be self-aware and confident in their own skin. One mother described her techniques for teaching her daughter how to talk to her so that conversations could be open and honest as well as respectful.

I told her even as a little kid, I said, "If you're angry with me, I want you to say, 'Mom, I'm angry with you.'" Because I wasn't given that opportunity [growing up]. So, I was trying to teach her how to talk to me.

Some mothers described how using humor and the element of surprise to disarm her daughter so conversations could occur about these topics and not be so awkward.

And so, one day out of the blue, I just simply asked her, ‘Who told you your booty is big?’ And she about passed out, like, how did you know somebody said that to me?

Using reflective questions to generate dialogue about boys their daughters were currently interested in was one communication strategy used by women to encourage these discussions with their daughters.

So, I ask her about the person she’s interested in now. What makes you like this person? Is he one of those bad boy types? What is it that really attracts you to this person? Is it popularity?

Some mothers also described using more direct questions to understand their daughters’ motivation to want to become physical with boys.

Are you kissing on this little boy because it makes you feel loved? . . . Not for fear, but for a mirror to put up in their own face.

Discussion

This qualitative, elicitation study was conducted to address the limited research detailing the exclusive experiences of African-American mothers who engaged in sexual health conversations with their pre-adolescent daughters. For culturally relevant best practices to be developed, a better understanding of how African-American mothers approach their daughters to discuss sexual health topics with their adolescents is needed (Aronowitz & Agbeshie, 2012; Brown & Tabi, 2013; Muturi & An, 2010; Wingood et al., 2011). Findings from past studies demonstrate that African-American mothers engage in sexual health communication in a variety of ways. Participants reported drawing from their strong faith/values to engage in ongoing dialogue with their daughters about sexual health. This unique approach sets this population apart from past studies, which excluded the

consideration of faith/values when discussing these topics with their daughters. Mothers in this sample also expressed their discomfort with discussing same-sex relationships due to their personal belief systems.

Mothers in this study expressed a strong desire for their daughters to be well-rounded adults who maintain a healthy balance between traditional church attendance/activities and other social activities. Mothers used their faith foundation as the framework to teach their daughters about life and womanhood. Like many African-American women, participants relied heavily on their faith and religious traditions to manage their health and well-being (Abar et al., 2009; Gillium & Griffith, 2010). Past researchers have shown that adolescents whose homes have a strong faith foundation are more likely to also have supportive family and extended family (i.e., village members) (Cox et al., 2009; van Olphen et al., 2003). These support systems help adolescents remain abstinent longer, have fewer sex partners, and have sex less frequently (Aronowitz, et al., 2013; Deptula, et al., 2010). These protective factors also delayed the potential negative consequences of sexual activity such as teen pregnancies and acquisition of sexually transmitted infections (Deptula et al., 2010; Kirby, 2007; Lagus, Bernat, Bearinger, Resnick, & Eisenberg, 2011).

Participants believed strongly that they, along with their family's faith and values, should be the greatest influences with their daughters (Aronowitz & Agbeshie, 2012). Mothers in this study were most comfortable speaking with their daughters about sexual health topics which were believed to be age appropriate for their daughters. Mothers actively described how they prepared their daughters during their entrance into puberty; more specifically, preparing for their first menstrual cycle, changing bodies, and unstable emotions during this development period. Participants whose own mothers had not had

sexual health conversations with them while growing up were intrinsically motivated to have these conversations with their daughters.

There were sexual topics which were difficult for participants to discuss because they believed they were not age appropriate or did not align with their family's faith/values. Participants described the importance of initiating these conversations early to ensure the safety and well-being of their daughters. Mothers described using real-world examples when encountering topics where there was communication discomfort. Despite this discomfort, mothers intentionally engaged in sexual health conversations to strengthen their relationships with their daughter. By consciously pushing past these feelings of awkwardness, mothers greatly strengthened their personal relationship with their daughters. Past literature has confirmed that daughters who have open relationships with their mothers experience an increased sense of comfort and confidence to engage in sexual health conversations as their daughters mature (Angera et al., 2008; Heller & Johnson, 2010; Pluhar, Jennings, & Dilorio, 2006).

Mothers in this study expressed notable discomfort when their daughters had questions concerning oral sex and same-sex relationships. In the African-American community, there continues to be significant stigma and discrimination against people who are gay, bisexual, or queer (Adamczyk & Pitt, 2009; DeMarco et al., 2011; Derose et al., 2010). This stigma and discrimination comes from traditional Christian teaching that utilizes literal interpretations of Bible teachings for daily living (Abar et al., 2009; Francis & Liverpool, 2009). Despite more media and television exposure supporting the acceptance of same-sex relationships (e.g., marriage laws and civil rights legislation), some from this community have been slow to adjust to these changes across racial and cultural lines

(Anderson & Fetner, 2008). Mothers in this study expressed a desire for training and education about less discussed topics such as oral sex and same-sex relationships so they could be more confident in explaining these issues with their daughters. School nurses are uniquely positioned to provide sexual health education to increase mothers' self-efficacy to engage in sexual health conversations with their daughters (Akpabio et al., 2009; Wakley, 2011).

Limitations

This elicitation study had limitations, which must be considered when interpreting the findings. A limiting factor in this elicitation study was that all data collected were through self-report. The participants in this study were homogenous regarding race, religion, ethnicity, and socio-economic status; therefore making the results from this study less generalizable to other racial/ethnic groups of mothers and daughters. Recruitment of participants representing more diverse socio-economic status is needed to determine if this was an influencing factor when mothers discussed these topics with their daughters. Additional useful information to collect would be the participants' age at first sexual encounter as well as age at first pregnancy.

Implications for School Nurses

This study has implications that are important for nurses, particularly school nurses who have direct access to developing girls and their mothers. Parent-child sexual communication acts as a protective factor for adolescents (Kao & Manczak, 2012). Mothers are the first teacher of their daughters for safety and life skills (Aronowitz & Agbeshie, 2012). School nurses are ideally positioned to influence the understanding of sexual health topics as well as to provide access to resources available to members of their respective

school districts and communities. Mothers in this study expressed a desire to learn how to communicate with their daughters about sexual health topics that were unfamiliar or do not support their religious/faith beliefs (Cornelius, 2009; Gillium & Griffith, 2010; Holt et al., 2009; Wingood et al., 2013; van Olphen, et al., 2003). Due to their position in school settings and the community, school nurses are well-equipped to meet the needs of mothers who desire to enhance their sexual health communication skills.

School nurses are the healthcare champions in school districts. School nurses can help to influence, foster, and instill confidence among parents to deliver sexual health messages. Successful delivery of such messages may result in the dismantling of myths and inaccurate information about sexual health. In turn, dissemination of sexual health information and sound resources to constituents is beneficial to the community (Ratanasiripong, 2014; Robert & Sonenstein, 2010).

Nurses in the school setting are educators who can train both parents and adolescents in medically accurate and culturally accepted language of sexual health facts. This comprehensive message helps to create acceptance between people from diverse backgrounds and traditions (Smalls, 2009). Past studies have shown that parents from different racial/cultural backgrounds communicate differently about sexual health topics with their children; these differences need to be studied to be better understood (Cox, 2006; El-Shaieb & Wurtele, 2009; Gilmore et al., 2011; Smalls, 2009).

Conclusion

The ways in which African American mothers communicate with their daughters about sexual health topics has not been well studied in the literature. Mothers in this study reported drawing from their faith, values, and personal experiences to have sexual health

conversations with their daughters. Utilizing one's faith to approach discussing such topics during adolescence merits further examination to determine how such influences impact the effectiveness of sexual health conversations. Further, more research is needed to investigate whether this unique approach between mother and daughter delays sexual debut. Culturally sensitive interventions are needed to assist African American parents' self-efficacy to engage in sexual health conversations with their children. Such dialogue may serve to enhance sexual health, increase protective factors, and reduce unintended pregnancies and STIs in the African American community.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

The aim of this study was to identify how African-American mothers are personally influenced to engage in sexual health communication with their daughters. This qualitative formative study was conducted as the first step in the development of V.O.I.C.E.S., a faith-based intervention focused on increasing sexual health communication between African-American mothers and daughters. The major findings from this dissertation study demonstrated the expressed personal influences of African-American mothers to communicate with their daughters about sexual health topics. The following Theory of Planned Behavior constructs were tested during the study: attitude, perceived behavioral control, subjective norms, intention to communicate, and actual communication behavior. The primary investigator served as a facilitator of focus groups and interviews to further explore issues related to self-efficacy, attitudes, faith and values, intention to communicate, as well as communication transparency within the mother-daughter dyad.

Discussion

The key findings from this study were linked back to the Theory of Planned Behavior and were classified into ten major themes. Mothers in this study strongly believed that one of their most important roles as a parent was to be the primary sexual health communicator for their daughter. The mother's attitude toward sexual health communication was greatly influenced by the participant's personal faith/values and religiosity. These beliefs defined the framework for conversations that were most appropriate to discuss with their pre-adolescent daughters. While the mothers were open in the information shared with their daughters, there were some areas that they felt were not age-appropriate to discuss with

them. These topics included oral sex and same-sex relationships. However, even though were advanced topics, mothers did share that when they answered questions they related their answers back to their family's faith/values and religiosity as appropriate (Aronowitz & Eche, 2013; Cox et al., 2010; Wingood et al., 2013). Throughout study transcripts, mothers described how their faith foundation greatly influenced and enriched their personal life and development (Abar et al., 2009; Cox et al., 2010). Participants also described their congregations as safe spaces where they would like to receive medically accurate information as well as information that supported the daily application of their faith teaching (Cornelius, 2009).

The mothers in this study expressed great self-efficacy to engage in a wide variety of topics leading to conversations discussing sexual health. Mothers participating in this dissertation study consistently expressed a high level of comfort, confidence, and openness in their mother-daughter relationship. This strong communication foundation was established through a consistent, stable environment for daughters to approach their mothers to share their problems and concerns. Mothers described being most comfortable to navigate these difficult conversations because of their existing communication relationships with their daughter.

Participants described their own mother's influence as being the strongest motivator for the type of sexual health communicator she is with her own daughter. Mothers in this study reported never having these conversations with their own mothers (Bynum, 2007). In not having these conversations as a young person, mothers expressed that they often were not equipped to have these conversations with their own daughter or daughter figure. Throughout focus groups and interviews, participants described instances where

communication was both open or did not exist. With both experiences, the desired outcome was the same: mothers had a great desire to give their daughters what they never received as a young person (Marhefka et al., 2009). Mothers noted that other important people who helped influence their communication with their daughters included their significant others and extended family members (e.g., sisters, cousins, or close family friends).

Mothers introduced their family's faith/values and religion through the initiation of age-appropriate sexual health topics as their daughters entered this new life stage. Having these real-life conversations with their daughters increased the shared communication comfort between mother and daughter. Having these conversations also increased the mother's credibility with their daughter during a time when daughters are beginning to lean more heavily on their peer group for social support.

These mother-daughter conversations worked best when the daughters were engaged and were ready to have these types of conversations with their mothers. The initiation of these conversations was most frequently prompted by the developmental stage of the daughter. The success experienced in current (and possibly future) conversations between a mother and daughter was greatly influenced by the existing communication foundation of the relationship.

Sexual health communication between African-American mothers and their young daughters is an understudied topic in current literature. A major strength of this study has been the methodological connection to the constructs of the Theory of Planned Behavior. This study adds to the existing body of knowledge in the areas of mothers' sexual health communication and intention to communicate, as well as mothers' perceived behavioral control (comfort and confidence) to discuss these critical topics with their daughters

(Aronowitz et al., 2007; Askelson, et al., 2010; Hutchinson & Wood, 2007; Schouten et al., 2007). The results from this study will lead to the development of a culturally-based curricula (V.O.I.C.E.S.) and tailored interventions that can assist African-American mothers to enhance self-efficacy for sexual health conversations with their young daughters (Grigsby, in press).

Mothers participating in this dissertation study consistently expressed a high level of comfort, confidence, and openness in their mother-daughter relationship. This strong communication foundation was established through a consistent, stable environment for daughters to approach their mothers to share their problems and concerns. This self-efficacy also led to a greater comfort for the dyad to engage in a wide variety of conversations. Consistently, the participants expressed direct intentions to discuss sexual health topics that had not previously been defined as such. Verbalizing a desire to explore more topics with their daughters confirms the participants' intention to have these conversations with their daughters in the future.

Participants expressed a great reliance on their family's faith and values to help provide a strong foundation on how to approach discussing sexual health topics with their daughters (Aronowitz & Eche, 2013; Cox et al., 2010; Wingood et al., 2013). This need was confirmed as participants described how their faith foundation greatly influenced and enriched their personal life and personal development (Abar et al., 2009; Cox et al., 2010). Mothers deemed their congregations as safe spaces where they would like to receive medically accurate information as well as information that was going to support their faith teaching (Cornelius, 2009).

Mothers reported never having these conversations with their own mothers (Bynum, 2007). While never having this conversation as young people, women shared a great desire to give their daughters what they never received as a young person (Marhefka et al., 2009). Not having these conversations as young people, mothers were often not equipped to have this conversation with their own daughter or daughter figure.

Health professionals should be reminded that many mothers have never received any formal training in sexual health; without this life-skill training and preparation, many are not equipped to have conversations about sexual health topics (Akpabio et al., 2009; Aston et al., 2006). Public health professionals working in this area should focus their efforts to develop culturally sensitive, evidence-based interventions for African-American mothers to increase their self-efficacy (confidence) and comfort to engage in these conversations with their daughters early and often. Conversations that are driven by purposeful dialogue is critical so that daughters feel that they are being heard as well as understood. These intentional steps also include having access to local and regional resources which are critical to the success of assisting daughters to reach their full potential academically, physically, and spiritually.

Nurses and other public health professionals should consider utilizing more technology to engage participants to begin having these conversations in the safety of their own home or safe spaces (Cox et al., 2009; DeMarco, Kendricks, Dolmo, Looby, & Rinne, 2009; Golterman & Banasiak, 2011; Williams, Ekundayo, Udezulu, & Omishakin, 2003). Through developing social support networks, women are more likely to engage in conversations where they are affirmed by common faith, values, and interests (Harris, 2013; Shamble-Ebron et al., 2016; van Olphen et al., 2003). A viable place to begin developing

these networks is within the faith community. Participants from the same or similar faith community will share many of like characteristics, making conversations about these topics less difficult to begin and maintain. Establishing these community networks within faith community settings helps to quickly provide a framework for investing in the mother-daughter dyad to be successful sexual health communicators. The evidence clearly supports the success of having community-based programming that helps to improve mother-daughter communication patterns (Cornelius, 2009; Fisher et al., 2012; Long et al., 2004a; Long et al., 2004b).

This dissertation study is the beginning of a career-long exploration of the possibilities available to African-American youth to pursue their goals and avoid life-compromising experiences such as early child-bearing and acquisition of STIs including HIV (Abar et al., 2009; Dilorio et al., 2007). The vision for this project will be for mothers and daughters to increase their education about sexual health topics while improving their communication skills through guided practice. Through the engagement of this elicitation process with African-American mothers, a TPB questionnaire will be created (i.e., the SRGRIGS Inventory) to determine the salient normative, behavioral, and control beliefs as well as the social referents underlying the overall belief structure in a mother's intentions to communicate with their adolescent daughter about sexual topics (Francis et al., 2004).

The limitations of this dissertation study must be considered. This was a small sample exploratory study which limited the study's generalizability. Participants were all from the same geographical area. All mothers reported as communicating with their daughters about sexual health topics. A better measure of a mother's frequency of sexual health communication needs to be utilized to accurately score a mother's level of sexual

health communication. This information will better gauge mothers' current communication level.

Implications for the Future

Key findings from this qualitative study need to be explored further. For example, the development of a TPB-based survey instrument for future studies should be created. This tool would be an effective way to examine the salient normative, behavioral, and control beliefs as well as the social referents that underlie the overall belief structure in a mother's intention to communicate with her daughter about sexual health topics (Aronowitz et al., 2007; Askelson et al., 2010; Francis et al., 2004; Hutchinson & Wood, 2007).

Future phases are planned that will provide a comprehensive examination of the factors which contribute to the ability of African-American mothers to communicate with their young daughters about sexual health topics. Mothers need intervention programs that can help them enhance sexual health communication skills (Coughlin, 2016). These life skills have not been addressed in other areas of their educational preparation and/or experience; therefore, many mothers are lacking the skills to engage their daughters comfortably and confidently in conversations about sexual health topics. In many cases, mothers lack these skills because the behavior was never modeled for them. Public health professionals working in this area should focus their efforts to provide mothers with accurate information and develop evidence-based interventions for mothers which will increase self-efficacy (confidence) and comfort to engage in these conversations with their daughters early and often (Agbemenu et al., 2016; Cornelius, 2009; Cox et al., 2009; DeMarco et al., 2009; Golterman & Banasiak, 2011; van Olphen et al., 2003). Conversations coupled with

ongoing access to local and regional resources are critical to the success of assisting daughters to reach their full potential academically, socially, and spiritually.

Additionally, novel theoretically-based interventions are needed in the African-American community that can enhance open communication about sexual health between mothers and daughters. Researchers should consider engaging key community leaders of influence (e.g., clergy/faith leaders, schools, sports, and recreation facilities, and medical professionals) in an effort to develop relevant primary prevention approaches grounded in behavioral science. Such approaches should be theoretically guided and aim to assist parents in gaining the knowledge, support, and communication skills needed to discuss sexual health topics. Also, theoretically-guided community approaches should be culturally tailored to promote and motivate sexual health conversations among mothers and daughters in ways that align with their family's personal faith and values. Mothers could greatly benefit from programs that provide education about sexual health and that enhance their communication skills. Providing parents with the skills to have these conversations with their daughters and sons before sexual debut occurs will help young people to better navigate through the highly emotional time that is critical to their sexual health development.

APPENDIX A

IRB CONSENT FORM



Division of Nursing

One University Blvd.
St. Louis, Missouri 63121-4499
Telephone: 314-516-6691
Fax: 314-516-XXXX
E-mail: grigsbys@umsl.edu

Informed Consent for Participation in Research Activities

(V.O.I.C.E.S.) Visualizing Opportunities to Inspire Choice which Embody Success
Phase I: Focus Group

Participant _____ HSC Approval Number _____

Principal Investigator _____ PI's Phone Number _____

Introduction:

You are being asked to volunteer for a research study. This study is being conducted at the University of Missouri St. Louis—College of Nursing. The researcher in charge of this study is Ms. Sheila R. Grigsby, PhD (c) under the supervision of Dr. Pat Kelly, Faculty Sponsor, University of Missouri Kansas City-- School of Nursing.

Ms. Grigsby is asking you to take part in this research study because you are an African-American woman who has a daughter or you are a mother-figure to a girl between the ages of 9-14 years. Research studies only include people who choose to take part. Please read this consent form. Ms. Grigsby will review this consent form with you. Ask her to explain anything that you do not understand. This consent form explains what to expect: the risks and benefits, if any, if you consent to participate in the study.

Background:

Mothers are a child's first teacher and the most consistent communicators with their children. Through life application, mothers model their personal values and belief systems regarding sexual health topics through their own behaviors to their daughters [43]. Innovative programs are needed which focus on African-American mothers to be effective in communicating with their daughters about sexual health topics during adolescence. Your participation in this research will assist in the identification of how self-efficacy, intentions, and current behaviors influences a mothers' ability to communicate with her daughters about sexual health topics.

Purpose:

V.O.I.C.E. S., is a research study being conducted to help understand sexual health communication between African-American mothers and their adolescent daughters, ages 9-14 years. This research will explore African-American mothers' attitudes, beliefs and current behaviors when talking with their adolescent daughters about sexual health topics.

Short Title of Research Page _ of _

You will be one of approximately 25 subjects participating in a focus group discussing these topics at the University of Missouri St. Louis—College of Nursing.

Study Procedures and Treatments:

If you agree to take part in this study, you will be asked to participate in *one* focus group session which will last approximately two hours on an agreed upon date and time. Your participation will involve the sharing of your personal opinions with 5-7 other African American mothers' about your attitudes, beliefs and current behaviors when talking to your adolescent daughters about sexual health topics.

The following study visits and procedures will occur during Phase I of this Research:

Study participants will be asked to participate in *one* focus group session that will last approximately two hours. For the sake of capturing all of the information shared during the focus group sessions, sessions will be audio recorded so that information can be transcribed and analyzed.

At the completion of the focus group session the participants' involvement in this study will be complete. Study participants interested in participating in Phase II of this research will need to complete separate informed consent procedures.

At any time during the study you *may* change your mind or decide *not* to participate in this focus group/study. You are free to stop participating at *any* time and for *any* reason.

At the completion of this research, you may request to review the results from this study from the researcher responsible for this study, Ms. Sheila R. Grigsby, PhD (C).

Possible Risks or Side Effects of Taking Part in this Study

Minimal Risk: The minimal risk in participating in this study will be a breach in confidentiality.

Possible Benefits for Taking Part in this Study

Direct Benefits: There are no direct benefits to you for taking part in this study.

Indirect Benefits: The information learned will help in the creation of a future intervention working with African-American mothers to effectively communicate with their adolescent daughters', ages 9-14 years about sexual health topics.

Costs for Taking Part in this Study:

There are no monetary costs to you for participating in this research study.

Payment for Taking Part in this Study:

To compensate you for your time in participating in this study (focus group) you will be given a \$10.00 gift card at the completion of the focus group.

Alternatives to Study Participation:

The alternative to participating in this research is to not participate in this focus group.

Confidentiality and Access to your Records:

The results from the V.O.I.C.E.S. research may be published or presented for scientific purposes. Your name or contact information will ***not*** be named in any reports of the results. Your study participation will be confidential and will ***only*** be shared with the (IRB) Institutional Review Board (a committee that reviews and approves research studies). This University Committee is in place to approve study procedures and to make sure that study requirements have been met to participate in University approved studies. The study team will keep all information about you confidential as provided by law, but complete anonymity cannot be guaranteed. If you leave the study or are removed from the study, the data collected before you left may still be used along with other data collected as part of the study. For purposes of follow-up studies and if any unexpected events occur, subject identification will be filed at the University of Missouri—Kansas City, School of Nursing under appropriate security (password-protected) and access limited to the researcher responsible for this study, Ms. Sheila R. Grigsby, PhD (C) and Faculty Sponsor, Dr. Pat Kelly.

If you agree with these statements and sign this consent form, you are allowing the Investigator, Ms. Grigsby, to collect information about you for the purposes of this research.

Contacts for Questions about the Study:

You should contact the IRB Administrator of UMKC's Adult Health Sciences Institutional Review Board at 816-235-5927 if you have any questions, concerns or complaints about your rights as a research subject. You may call the researcher, Ms. Sheila Grigsby at (314) 516-6691 if you have any questions about this study. You may also call Dr. Pat Kelly at (816) 235-2617 if any problems come up.

Voluntary Participation:

Taking part in this research study is voluntary. If you choose to be in the study, you are free to stop participating at any time and for any reason. If you choose not to be in the study or decide to stop participating, your decision will not affect any care or benefits you are entitled to. The researchers may choose to stop the study or take you out of the study at any time

- if they decide that it is in your best interest to do so,
- if you no longer meet the study criteria, or
- if you do not comply with the study plan.

They may also remove you from the study for other administrative reasons. You will be told of any important findings developed during the course of this research.

**FOCUS GROUP CONSENT FORM
SIGNATURE PAGE**

You have read this Consent Form or it has been read to you. You have been told why this research is being done and what will happen if you take part in the V.O.I.C.E.S. study, including the risks and benefits. You have had the chance to ask questions, and you may ask questions at any time in the future by calling Ms. Sheila Grigsby, PhD(C) at 314-516-6691.

By signing this consent form, you volunteer and consent to take part in this research study. Study staff will give you a copy of this consent form.

I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I consent to my participation in the research described above.

Participant's Signature

Date

Participant's Printed Name

Signature of Investigator or Designee

Date

Investigator/Designee Printed Name

Short Title of Research Page _ of _

APPENDIX B

DEMOGRAPHIC SURVEY

DEMOGRAPHIC QUESTIONNAIRE

(PHASE I: Focus Group)

I would like to learn some basic information about the people completing this survey.

1. What is your date of birth? _____ (month/day/year)

2. What is your marital status?

- a) Married b) Living with a partner c) Separated d) Divorced e) Widowed
f) Single, Never been married

3. How many years of school did you finish?

- a) Completed 8th grade or less
b) Completed 9th, 10th, or 11th grade
c) Completed 12th grade
d) Completed some college (but did not receive a degree)
e) Received an associate's degree
f) Received a Bachelor's degree
g) Received a Master's degree
h) Doctoral or Professional degree

4. What is your current work status?

- a) Employed Full Time
b) Employed Part Time
c) Temporarily Laid Off
d) Illness or sick leave
e) Unemployed
f) Full time taking care of children
g) Student
h) Permanently Disabled
i) Retired
j) Other _____

****if unemployed skip to question 6**

APPENDIX C

PERMISSION TO USE PARENT-CHILD SEXUAL RISK COMMUNICATION SUBSCALE

-----Original Message-----

From: Mary Katherine Hutchinson <kathy.hutchinson@nyu.edu>

To: Grigsby, Sheila <grigsbys@umsl.edu>

Cc: RedirectSTL_grigsbys <sgrigsby91@aol.com>

Sent: Wed, Mar 28, 2012 4:22 pm

Subject: Re: Use of Instrument for Dissertation Research

dear sheila

you are most welcome to use the scale.

a copy of the english version of the scale is attached.

colleen d'Iorio at Emory has a yes/no scale to measure mother-child sexual communication and other measures of family processes. so please check out D'Iorio's work, Guilamo-Ramos Jaccard and Dittus, Kim Miller, Velma Murry and others.

you already have the psychometrics article for the PTSRC-III so i will attach some other papers that may interest you.

we just completed the jamaican mother-daughter HIV risk-reduction intervention. the main results paper will be coming out shortly. in short, the 2 day intervention increased mothers' knowledge and monitoring / supervision. the intervention also increased girls' knowledge, condom use self-efficacy and condom use intentions.

best of luck and let me know if i can assist in any way,

kathy hutchinson

On 3/28/12, Grigsby, Sheila <grigsbys@umsl.edu> wrote:

Greetings Dr. Hutchinson:

I hope that this email finds you doing well.

My name is Sheila Grigsby. I am currently Assistant Professor at the University of Missouri--St. Louis in the College of Nursing. I am currently completing my coursework for my PhD work and hope to begin work on my Dissertation in Fall 2012. My interest throughout my career has been in women's health, STI/HIV/AIDS prevention and awareness, and community based participatory research involving the African American faith community.

I am currently well into my last course at the University of Missouri--Kansas City. The course project requires me to identify funding for my research as well as complete the application process to successfully be funded. As a direct result, I am currently preparing my first

application to the America Nursing Foundation due on May 1, 2012.

My dissertation research involves the development of a mother-daughter communication intervention that focuses on sexual communication. With my dissertation, I plan to pilot a communication intervention with 25 African American mother-daughter dyads, adolescents ages 9-14 years. I would like to use your PTSCR-III Scale which you published the psychometric results in Nursing Research 56(1),pp. 1-8 (2007), as one of the tools for my pre-post test survey for my participants. In using your scale, I am hoping to measure an increase in the amount of sexual communication occurring within the dyad as a direct result of involvement in the dyad.

Please let me know what additional information I can provide to help you in making your decision.

I greatly admire your work and how you have been able to gradually build on your trajectory since working with Dr. Jermott. I hope to continue building on your work through my future research.

Thank you for your consideration of my request.

Sincerely,

Sheila R. Grigsby

APPENDIX D

ADAPTED SCREENING QUESTIONS OF PARTICIPANTS INTO V.O.I.C.E.S.

(Hutchinson et al., 2003)

Screening Question Stem: “Have you and your daughter ever talked about. . .”	Possible Response
Body Changes	0 for “no”; 1 for “yes”
Menstrual Cycle	0 for “no”; 1 for “yes”
Sexual Intercourse	0 for “no”; 1 for “yes”
Birth Control	0 for “no”; 1 for “yes”
HIV/AIDS	0 for “no”; 1 for “yes”
Sexually Transmitted Infections	0 for “no”; 1 for “yes”
Birth Control	0 for “no”; 1 for “yes”

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VITA

Sheila R. Grigsby was born September 1, 1971, in Cape Girardeau, Missouri. She was educated in the Meridian Public School System in Mounds, Illinois. During her last semester of high school, she was one of 50 statewide recipients of an Illinois Governmental Internship Program within the State of Illinois Department of Health. After completing this internship, she then pursued undergraduate studies and was awarded a B.S. degree in Nursing and a certificate in Health Information Management from Saint Louis University in 1995. She later returned to academics to earn a dual Masters in Public Health and Community Health Nursing at Saint Louis University in 2005.

In addition to the academic journey, Ms. Grigsby has spent over 20 years as a nurse educator, researcher, patient advocate, and community activist. She has acted as a catalyst to mobilize faith communities compassionately concerning the issue of STI/HIV/AIDS and other related health disparities since 1995. Ms. Grigsby has worked as Assistant Professor at the University of Missouri-St. Louis College of Nursing since 2007, where she teaches primarily Community Health Nursing in the undergraduate nursing program. In addition, Ms. Grigsby is the Founder and Board Chair of Faith Communities United (2002), an organization whose mission is to mobilize the faith community to respond to HIV/AIDS and related issues.

Ms. Grigsby entered the University of Missouri-Kansas City School of Nursing Ph.D. program with a passion to make a difference by studying intervention development for African-American women and girls most at risk for STI/HIV/AIDS. Ms. Grigsby is well-poised to develop programs and interventions designed for this population. Upon completion of the Doctor of Philosophy degree, Ms. Grigsby will continue to teach, research, and

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