CONVERSACIONES ENTRE PADRES E HIJOS: LATINO PARENTS' MESSAGING STRATEGIES ABOUT SEXUAL HEALTH AND PREGNANCY PREVENTION

by

LOURDES MICHELE MARTINEZ

(Under the Direction of Pamela Orpinas)

ABSTRACT

This purpose of this study was to understand how Latino parents and adolescents communicate about adolescent sexual health, dating, and prevention of pregnancy and sexually transmitted illnesses. The goals were to identify the characteristics of Latino parent-adolescent communication—expertise, trustworthiness, and accessibility—that may influence communication about romantic relationships and sexual risk reduction strategies (i.e., abstinence, contraception), identify parental messages about health risks, social consequences, and moral consequences that may influence communication about these topics, and to describe the influence of acculturative factors on parental messages about adolescent romantic relationships and sexual health.

A mixed-method approach was used. A total of 21 parent-adolescent dyads (N=42) completed a brief demographics survey and a set of scales to obtain quantitative measures related to message domains and parental characteristics that may influence the

adolescent's perception of parental advice. An individual, semi-structured interview was then conducted with each parent, followed by the adolescent.

Findings demonstrate that parents talk to their children, but overall conversations are not specific or comprehensive enough to support adolescents' informed decision-making about sexual health or building positive romantic relationships. Community organizations such as churches, schools, and medical settings can support families by providing brief seminars that not only provide technical information about sexual health, but also allow parents to practice how to initiate communication about sex and how to gauge their child's receptivity to discuss the topic further. Recommendations include encouraging parents to actively engage their adolescent in shared communication over time, respond to questions openly and accurately, and demonstrate concern in the teen's life happenings. When parents talk to their children about sex, it builds trust and closeness and reinforces protective behaviors for sexual health.

INDEX WORDS: Latino/Hispanic, parent-adolescent communication, sexual health, pregnancy prevention

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DEDICATION

I dedicate this study to the parents who trusted me to listen to their stories and interview their children, to the adolescents who bravely shared their hopes for the future despite the challenges they have experienced so early in life, and to the clinic staff that helped me recruit families for the study and allowed me to use office space to conduct interviews. I could not have completed this work without you. ¡Gracias por su apoyo!

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CHAPTER 1

INTRODUCTION

"Adolescence is a time of active deconstruction, construction, reconstruction—a period in which past, present, and future are rewoven and strung together on the threads of fantasies and wishes that do not necessarily follow the laws of linear chronology," said psychologist Louise Kaplan in her writings about adolescents (Kaplan, 1984). Adolescence is a time of great change; however, defining the years of adolescence may vary by culture and generation. The World Health Organization (WHO) defines adolescence as the period between ages 10-19 years (World Health Organization, 2009). During this time children begin to explore a sense of self and independence within the family and peer-network. Along with this exploration, adolescents are also trying to make sense of the family values and those that surround them outside of the family nucleus. For Latino children living in the United States—as a first or second generation—there exists a push and pull effect between the culture of origin and the culture they are surrounded by in the United States. Negotiating independence between a traditional Latino culture and a more liberal American culture is bound to have an impact on the choices and resultant behaviors of the adolescent. Understanding how adolescents negotiate their independence becomes particularly important as their choices relate to dating relationships and exploration of sexuality. Given that the median age of the second generation Latinos (born in the United States to immigrant parents) is 14 years and the overall Latino population is growing (Pew Hispanic Center, 2009a), it is necessary for public health researchers to better understand the health needs of Latino

adolescents within the context of bicultural influences. The goal of the present study was to understand how communication about sexual health between Latino parents and adolescents occurs and what the perceived impact is by both parents and adolescents. The remainder of this section situates the problem of adolescent sexual risk behavior and concludes with the specific aims for this study.

Contextualizing adolescent sexual knowledge, behaviors and outcomes

Sylvia, a 17-year-old adolescent, describes having a conversation with her father about sex as awkward because, "He didn't know what to tell me and I tried to end the conversation as soon as possible" (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2012). The previous statement is indicative of how parents and adolescents may feel when they first approach the topic of sexual health. Sylvia's account is one of various stories suggesting the importance of early and frequent parent and adolescent communication about sexual health and disease prevention. According to the 2011 Youth Risk Behavior Survey, 47% of high school students reported ever having sexual intercourse and 6% reported sexual intercourse before age 13 years; of those who reported being sexually active, 40% did not use condoms during last sexual intercourse and 77% did not use birth control (Centers for Disease Control and Prevention, 2012a). Hispanic students were less likely (18%) to report using a method to prevent pregnancy than their non-Hispanic Black (13%) or non-Hispanic White (10%) counterparts (Centers for Disease Control and Prevention, 2012b). A national survey examined the occurrence of sex education and parent communication reported by high school students. Less than a third of respondents (20% girls, 31% boys) who had ever had sex said they had not spoken with their parents about saying no to sex or using methods of birth control

(Centers for Disease Control and Prevention, 2011b). These findings are of concern, particularly in an age when adolescents are constantly accessing media messages from television, print, music and the Internet, which may not align with their parent's cultural values.

Beyond the interpersonal disconnect that may result from a lack of communication about sexual health, societal consequences are magnified. In 2008, teen childbearing cost U.S. taxpayers $10.9 billion (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011a). Cost per state varied according to teen pregnancy rate and population size, but remained high, ranging between a low of $16 million in North Dakota, to a high of $1.2 billion in Texas. In Georgia, teenage childbearing cost taxpayers nearly $465 million in 2008 (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011b). This cost includes $75 million for Medicaid and Children's Health Insurance Program (CHIP), $89 million for child welfare, and $133 million in lost earnings and spending. While teenage pregnancy rates in Georgia declined by 32% between 1991 and 2008, it remains a costly burden on teenage mothers and society, but particularly for communities of color.

The top half of Table 1.1 presents information on Latino health disparities related to teenage pregnancy.

Table 1.1: ***Related Health Disparities among Latinos Compared to Other Racial Groups***

	Latino/Hispanic	Non-Hispanic White	Non-Hispanic Black
Teenage pregnancy			
Teen pregnancy rate (per 1,000), girls 15-19 years	100.5	42.8	114.5
"Don't think I can get pregnant at this time"	42%	26%	32%
"Don't mind if I get pregnant"	24%	22%	20%
Sexually Transmitted Infections (per 100,000) among 15-19 year olds			

Chlamydia	1,191.0	830.1	4,977.7
Gonorrhea	Females: 184.6 Males: 97.6	Females: 134.5 Males: 38.7	Females: 2032.2 Males: 1,012.3
HIV	325.2	149.7	1008.6
Contraception			
No contraception at last sexual encounter	Females: 22%	Females: 12%	Females: 25%

Among adolescent Latinas in Georgia, the rate of teenage pregnancy is disproportionately higher than for other racial/ethnic groups (Curtin, Abma, Ventura, & Henshaw, 2013). Compared to non-Hispanic White and Black same-aged peers, Latinas aged 15-19 years were more likely to report they did not think they could get pregnant and that they did not mind if they got pregnant (Harrison, Gavin, & Hastings, 2012). These findings suggest lack of knowledge on how to prevent pregnancy and of the long-term consequences of teen pregnancy.

Life outcomes are also worsened for adolescent girls who become teenage mothers. These young women are more likely to drop out of school, earn lower lifetime income, and live in poverty compared to same-aged peers who do not have a child in adolescence (Perper, Peterson, & Manlove, 2010). However despite the findings discussed to this point, when asked about teenage pregnancy, 75% of Latino youth report it is detrimental to society (Pew Hispanic Center, 2009a). The evident disconnect between thoughts on teenage pregnancy and unprotected intercourse among Latino adolescents deserves further investigation, particularly when examining related outcomes such as the incidence of sexually transmitted infections.

Disparities also exist within the Latino community, particularly related to the length of time lived in the United States. Teen birthrates are much higher among first generation Latinas (26%) than second generation Latinas (16%). A possible explanation

of this large difference in teen pregnancy is that first generation parents are less likely to talk with their children about sex (38% of first generation, 63% of second generation) and birth control (28% of first generation, 41% of second generation). These findings suggest that understanding differences between first and second generation Latinos is critical to developing effective prevention messages.

In addition to pregnancy, unprotected sexual intercourse carries the risk of sexually transmitted infections (STIs).

Sexually transmitted infections also exact a great toll on young adults. As shown in Table 1.1, in 2012 the rate of Chlamydia among 15-19 year olds was higher among Latinos than non-Hispanic Whites. Similarly, compared to non-Hispanic Whites, Latinos aged 15-19 years had higher rates of gonorrhea (Centers for Disease Control and Prevention, 2011a). Prevalence of HIV infection among Latinos is also of particular concern: It is more than double the rate compared to non-Hispanic Whites (Centers for Disease Control and Prevention, 2013). While comprising 16% of the U.S. population, Latinos accounted for 21% of new HIV infections in 2010. However, the rates of sexually transmitted illness are not surprising when examining the percentage of Latino adolescents aged 15-19 years who report not using any method of contraception at last sexual encounter, compared to non-Hispanic White and Black peers (Pazol et al., 2011). To effectively address the social and disease burden discussed thus far, studies on Latino populations should account for the influence of acculturation and the immediate environment on adolescent sexual behaviors.

Present Study

The **purpose** of this study was to understand how Latino parents and adolescents communicate about adolescent sexual health, dating, and prevention of pregnancy and of STIs.

The **specific aims** were to:

1) Identify the characteristics of Latino parent-adolescent communication—expertise, trustworthiness and accessibility—that may influence communication about romantic relationships and sexual risk reduction strategies (i.e., abstinence, contraception).
2) Identify the parent messages about health risks, social consequences, and moral consequences that may influence communication about romantic relationships and sexual risk reduction strategies.
3) Describe the influence of acculturative factors on parental messages about adolescent romantic relationships and sexual health.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter provides a more granular discussion about parent and adolescent communication within the Latino population. The chapter is organized in three sections. The first section, significance of the problem, examines demographic and cultural characteristics of the U.S. Latino population, as well as risk and protective factors related to teenage pregnancy and sexually transmitted infections. The second section highlights the innovation of the present study. The third section describes the theoretical model guiding this work.

Significance

The U.S. Latino population has experienced exponential growth over the last decade. According to the U.S. Census Bureau, greater than half of the national population increase between 2000 and 2010 was due to growth in the Latino population (Ennis, Rios-Vargas, & Albert, 2011). Compared to other segments of the population, Latinos accounted for four times the growth in other groups and are already the largest minority group (United States Census Bureau, 2004). By the year 2050, Latinos are expected to comprise nearly 25% of the U.S. population. While these projections are impressive, the public health infrastructure is not prepared to handle this rapid growth when one considers how existing health disparities among Latinos would more than double in the coming decades. Additionally a dearth in the literature regarding how to address Latino health needs further aggravates the problem.

The Latino population in Georgia has also demonstrated significant growth. As of 2010 Latinos comprised 8.8% of the population in Georgia, an increase of 96% since the year 2000, and represent a young demographic with an average age of 25 years (United States Census Bureau, 2010a). Compared to native born Latinos living in Georgia, foreign born Latinos were nearly three times more likely to have children, were more likely to be married, and were four times more likely to speak a language other than English in the home (Pew Hispanic Center, 2009b). In Atlanta, Georgia, one of the top metropolitan areas in the nation, people of Mexican origin comprised nearly 60% of the Latino population, followed by Puerto Ricans (8%) and Salvadorans (6%); slightly more than half of Latinos in this area were foreign born (Lopez & Dockterman, 2011). The median income of Latinos in Georgia was $18,000. Of those aged 18-64 years, 27% were living in poverty and less than 50% reported having health insurance (Pew Hispanic Center, 2009b). The increasing population size, the relative youth of Latinos, and the low rate of health insurance are major reasons to focus the attention of public health workers on this population.

The following section describes the influence of acculturation on health beliefs and suggests specific cultural elements that have been noted to influence parent and adolescent communication about sexual health and risk reduction.

Cultural factors

Ethnic culture influences knowledge, attitudes, and practices that are filtered by personal beliefs and values (Wilkinson-Lee, Russell, & Lee, 2006). However, an individual's life experiences greatly influence beliefs and values and should not be disregarded when studying Latino populations (Stein, 2010).

Research on Latinos has often emphasized the effect of acculturation on life trajectories. While there are various definitions of acculturation, the term is defined here as, "the process by which groups or individuals integrate the social and cultural values, ideas, beliefs and behavioral patterns of their culture of origin with those of a different culture" (p.19) (Zambrana & Carter-Pokras, 2010). The construct is often measured by inquiring about the primary language used for daily communications and within the home. However, less frequently researchers discuss the impact of acculturation on beliefs and values. For example, a first generation parent who emigrated from Mexico may speak and understand English and speak it with their second generation children, but still have strong values linked to the country of origin. If the primary measure of acculturation is language, this parent would be considered acculturated. However, if a study examines parents' beliefs about how to communicate with their children regarding sexual health, the parents may reply that children should not discuss or know about topics of that nature. Therefore, the beliefs and related practices demonstrate a lower level of acculturation for this particular topic. I am suggesting that acculturation needs to be examined as a dynamic concept that varies depending on the behavior in question. For this reason, it is necessary to expand the measure of acculturation from simply language spoken, to one that examines how the integration of beliefs and values leads to specific behaviors.

Fortunately, existing concepts can be used to build an index of acculturation for the purpose of this study: traditionalism, *respeto* (respect), and *familismo* (value of family). Traditionalism is the broadest of these concepts and refers to conservative beliefs and values and religiosity. The concept also encompasses gender roles, folk

beliefs and health remedies, collective orientation, and respect for elders and for authority. These aspects of traditionalism are relevant to parent-adolescent communication regarding sexual health and disease prevention and have been examined in the literature. A study of 40 young Latinas of Mexican origin (both U.S. and foreign born) examined how relationships with their mothers, fathers, and male partners influenced their sexual behaviors (Gilliam, 2007). The author found that women are viewed as dignified and that virginity is highly regarded. Therefore, a young woman who engages in premarital sex brings shame to the family. Interestingly, young women who were sexually active but simultaneously held the belief that virginity was important, had fewer lifetime sexual partners and used condoms less consistently than women who did not hold the same belief (Deardorff, Tschann, Flores, & Ozer, 2010). Gender roles are also particularly salient for men. The culture often values a young man who is employed and demonstrates a "hard-working" persona to support his family rather than one who pursues an academic career. Others have also examined the influence of traditional gender roles to describe potential gaps in negotiating condom use, adequate parental communication about sex, and the role of women with respect to birth control (Benavides, Bonazzo, & Torres, 2006; Raffaelli & Lenna, 2001; Zayas & Solari, 1994).

Benavides (2001) recognized the expression of *respeto* as a potential barrier in parent-child communication about HIV prevention. While respect for parental authority is important, respect that prevents the child from asking about sexual health and disease prevention limits communication. Another important concept relevant to Latino beliefs and values is *familismo*, the valuing of family as the primary source of social support and one's identity. To examine the influence of *respeto* and *familismo*, researchers conducted

22 in-depth interviews with Latinas aged 20-45 years, inquiring about family communication regarding dating and sexual issues and the women's self-reported sexual experiences (Raffaelli & Lenna, 2001). For some of the study participants, the extent of communication about sex was their parents telling them "don't get pregnant" without explaining how to avoid pregnancy. For others, socialization about familial values occurred through overhearing adult conversations, primarily among women (mothers, aunts) discussing the shame another member of the family had brought upon them due to a teenage pregnancy. Some of the study participants said they did not have parental monitoring, which is often considered a protective factor against teenage pregnancy (Gilliam, 2007). In these cases, women reported that their fathers told them to only bring home the man they planned to marry (Raffaelli & Lenna, 2001). The rationalization was that bringing home young men they were dating would suggest to neighbors that the young woman was promiscuous. These findings suggest that influential elements both within the family and in the surrounding culture must be examined within the context of an acculturation continuum. In addition to cultural factors, specific risk and protective factors are relevant here.

Risk factors

For most adolescents, risk factors associated with teenage pregnancy are engaging in sexual activity at a young age, having low academic achievement, using drug and alcohol, and, specifically for females, experiencing menarche before 12 years of age (Adolph, Ramos, Linton, & Grimes, 1995; East, 1998). Socioeconomic risk factors may also play a salient role in teenage pregnancy such as living in a low-income household and pertaining to a social network where teenage pregnancy is common. However, specific risk factors for teenage pregnancy and sexually transmitted infections have been

associated with Latino adolescents. Latino adolescents are less likely to use contraception than their non-Hispanic White counterparts, and condom negotiation skills among Latino women are low (Gilliam, 2007; Romo, Lefkowitz, Sigman, & Au, 2001). In some instances, the males report a dislike for condom use or state that birth control is a woman's responsibility, the latter characterized by a centrality of the male perspective (*machismo*) (Benavides, et al., 2006; Gilliam, 2007; Romo, et al., 2001). In consequence, although Latino adolescents may engage in sexual intercourse as often as adolescents of other racial/ethnic backgrounds, they are more often burdened with teenage pregnancy and STIs. However, the Latino adolescents' behavior does not occur in a vacuum; parental communication is critical. Some studies have shown that Latino adolescents and young adults report little or no knowledge about sex or contraception because communication about these specific topics did not occur in the home, particularly for those who reported having "strict parents" (Adolph, et al., 1995; Erickson, 1999; Gilliam, 2007; Romo, et al., 2001). Conversely, Gilliam (2007) also notes that incorrect information from parents may increase susceptibility to pregnancy; such as a mother telling her daughter about perceived adverse effects as a result of using birth control pills.

Protective factors

Despite the discussion thus far, various factors can protect Latino adolescents from teenage pregnancy and STIs. Open communication specifically about sexual behavior is a protective factor; however, good communication about general topics (e.g., school, friends) unrelated to sexual health does not protect against teenage pregnancy or delaying sexual debut (Adolph, et al., 1995; Gilliam, 2007; Kotchick, Dorsey, Miller, & Forehand, 1999; Miller, Forehand, & Kotchick, 1999; Trejos-Castillo & Vazsonyi, 2009). In addition to openness, content of the message is also important: specifically, to openly

talk about family values (Fox & Inazu, 1980; Gilliam, 2007; Weinstein & Thornton, 1989). Romo and colleagues examined video-taped encounters of mothers talking with their adolescent about dating and sexuality. Common themes from the encounters were beliefs and values about sexuality, advice about how to handle various dating and sexuality situations, cautionary recommendations, comments about the adolescent's dating and sexuality situations, and maternal self-disclosure regarding her own experiences (Romo, Lefkowitz, Sigman, & Au, 2003). The adolescent participants were between the ages of 12 and 15 years at the time of the video-taping; they were then surveyed one year later. The authors found that the daughters of mothers who discussed their family values regarding sexuality reported less sexual activity a year later. Similarly, mothers who shared their own experience on dating and sexuality influenced adolescent conservative views on pre-marital sex. The present study distinguishes itself from the Romo and colleagues study by examining a continuum of acculturation to understand how parents frame messages about sexual health. However, the study findings discussed thus far suggest that to fully understand the protective effect of parental messaging, research must examine how much and how often communication occurs and what type of communication is taking place.

Innovation

As previously discussed, acculturation has typically been measured by language use. Cultural factors such as traditionalism, *respeto*, and *familismo* have not been readily formulated in examining changes in values and behaviors regarding communication about sexual health. Given that many Latinos in Georgia are first generation parents raising second generation children, this study has the potential to make a contribution to

the literature by suggesting strategies for tailored health messaging. Effective and targeted communication is of particular importance given the expected growth in the Latino population in Georgia and the higher than average rates of teenage pregnancy and sexually transmitted infections among Latinos.

Theoretical Model

The following section presents the guiding model for this study. I created the framework to be consistent with the purpose and specific aims for this study. The framework organizes relationships between constructs of acculturation and elements of parent and adolescent communication that influence adolescent sexual behavior.

The **conceptual framework** for this study is depicted in Figure 2.1.

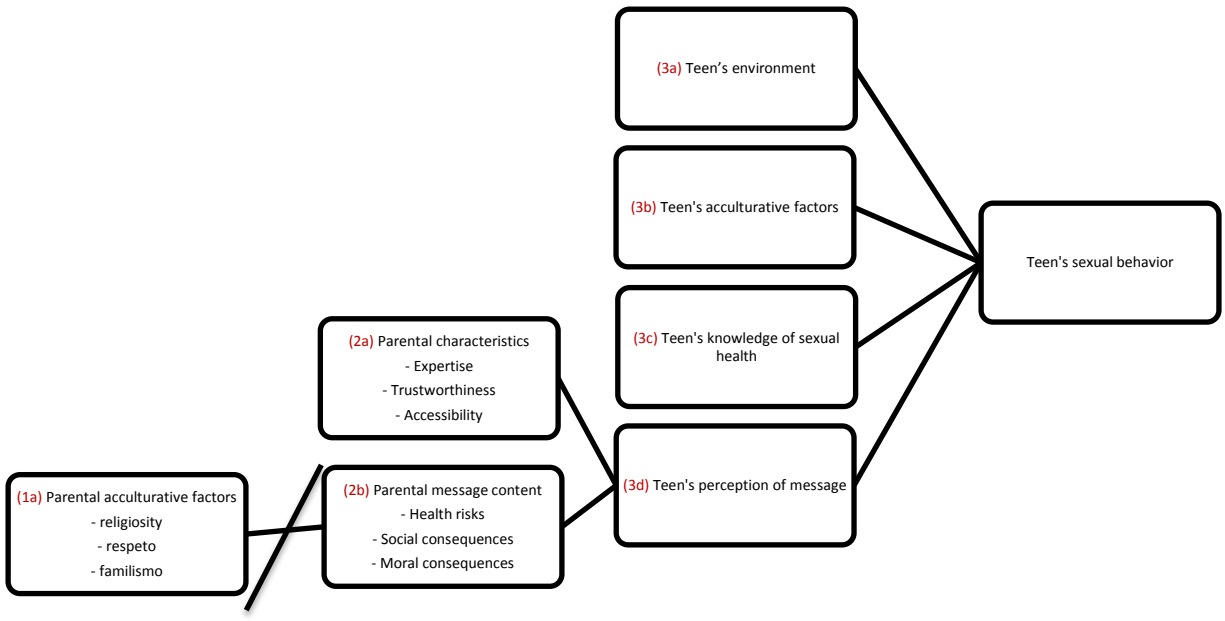

Figure 2.1: Conceptual framework

Moving from left to right on the model, Parental acculturative factors (box 1a) such as a parent's conservative beliefs, religiosity, *respeto* (respect), and *familismo* influence parental characteristics and the message content. A message can be as simple and vague

as "don't get pregnant" or provide explicit strategies on delaying sexual intercourse or using contraception. An adolescent's perception of the parent's message may also be influenced by specific parental characteristics (box 2a): expertise, trustworthiness, and accessibility. Expertise refers to the adolescent's perception that a parent is credible and gives sound advice. As discussed previously, parental self-disclosure about dating and sexuality—if received positively by the adolescent as expertise—may influence conservative beliefs about pre-marital sex (Guilamo-Ramos, Jaccard, Dittus, & Bouris, 2006; Romo, et al., 2003). Trustworthiness refers to the adolescent's perception that a parent is honest and wants the best for their child. Accessibility refers to the adolescents' perception that their parent is available to spend time with them and have conversations as needed. Parental message content (box 2b) is organized into three domains: health risks associated with sexual behavior, social consequences of engaging in sexual intercourse, and moral consequences of engaging in sexual intercourse. Messages related to health risks are factual and inform about outcomes of unprotected sex (e.g., pregnancy, STI). Social consequences relate to feeling embarrassment or gaining a bad reputation as a result of early sexual debut and related outcomes. Messages about moral consequences focus on possible feelings of regret and guilt related to early sexual debut and related consequences. An adolescent's environment (box 3a) refers to the prevalence and acceptance of sexual activity and teenage pregnancy within the peer network and within the nuclear family. Adolescent sexual behavior may be further influenced by the adolescent's perception of the parent's message (box 3d), whether indirect (overhearing familial conversations on the topic) or direct (received from the parent) and by the adolescent's own acculturative factors (box 3b), similar to those discussed for the parent

related to value ascribed to traditionalism and *familismo*. While the adolescent's knowledge of sexual health (box 3c) may be influenced by parental and peer messages, it may also be influenced by elements not included in this framework such as media and school health courses. As a result, adolescent's knowledge of sexual health is located as a separate box in the framework. The proposed conceptual framework is used later to organize results obtained from the scales and interviews, and to situate the discussion section. The following chapter describes the methods used to conduct this study.

CHAPTER 3

METHODS

This chapter describes the methodology of the study in six sections: research design and aims, setting and sample, procedures, survey measures, semi-structured interview, and data management and analysis.

Research Design and Aims

I used a mixed-method approach to better understand parent-adolescent communication about sexual health and romantic relationships. Parents and their children first completed a short survey, followed by a semi-structured interview. Answers on the survey were then used to focus the interview questions and further develop an understanding of parent and adolescent communication from each participant's perspective. The study used a substantive theory stance, which suggests that a conceptual framework or theory guides the study rather than a specific philosophical paradigm (Greene, 2007). As the mixed-method purpose was to develop a better understanding about parent-child communication from participant perspectives, the qualitative method is more pronounced in this study.

As previously described in chapter one, I restate the study purpose and specific aims here for ease of reference.

The **purpose** of this study was to understand how Latino parents and adolescents communicate about adolescent sexual health, dating, and prevention of pregnancy and of STIs. The **specific aims** were to:

1) Identify the characteristics of Latino parent-adolescent communication—expertise, trustworthiness and accessibility—that may influence communication about romantic relationships and sexual risk reduction strategies (i.e., abstinence, contraception).
2) Identify the parent messages about health risks, social consequences, and moral consequences that may influence communication about romantic relationships and sexual risk reduction strategies.
3) Describe the influence of acculturative factors on parental messages about adolescent romantic relationships and sexual health.

Setting and Sample

The community clinic where I recruited participants is located in Gwinnett County, Georgia which has the highest Latino population in the state (162,035) (United States Census Bureau, 2010b). Given that the clinic is one of the few in the state that provides mental health services accessible to Spanish speaking Latinos, participants for the study included residents of other counties. In addition to treatment and intervention programs, the clinic also sponsors prevention programs aimed at Latino families working to maintain their children on a positive and productive life path. The study initially aimed to compare participants between the prevention and treatment arms of the clinic. However, recruitment was higher from the treatment center, and some participants in the prevention center had previously been served by the treatment center. Therefore, it was not feasible to compare participants. Additionally, given the dearth of knowledge in the literature concerning the health perspectives of Latino fathers, recruitment of fathers was equally encouraged but few chose to participate.

Participants were screened to determine appropriateness for the study. Eligibility criteria were these: Latino parents of adolescents aged 12-17 years and their respective son or daughter attending either the prevention or treatment program at the community clinic. Exclusion criteria were adolescents who were currently under psychiatric treatment for a severe mental illness, such as schizophrenia, and adolescents who were monitored by the juvenile detention system regardless of current living arrangements (e.g., parolee). However, since these criteria were self-reported by the parent during the initial screening process, I could not verify accuracy of statements. It was only during the actual interviews that I learned from some parents that their child was being treated for depression or other serious mental health condition (e.g., bipolar disorder, multiple personalities). Another parent admitted her son was currently under house arrest. I elected to retain the interviews with these families in the final sample for the study. The sample of this study consists of 21 parent-adolescent dyads.

Procedures

The following section describes procedures related to recruitment, informed consent and data collection.

Recruitment. Two strategies were used to recruit participants: 1) I presented the project to clinic staff and gave them recruitment flyers; clinic staff informed eligible clients about the study and asked whether I could call them; and 2) I attended clinic sponsored groups and informational meetings to recruit additional participants face to face. Following initial contact through one of the recruitment strategies above, I contacted parents by phone. I attempted three times to contact participants; if no contact was made after the third attempt, I discontinued efforts with the respective dyad. I discontinued

attempts with four potential dyads that had initially expressed interest in participating. Potential study participants also used the study flyer to contact me directly and inquire for further details. I obtained a dedicated phone line for the study with secure voicemail to ensure confidentiality of potential participants.

Informed consent. Once clients agreed to participate in the study, I scheduled a one-time face-to-face meeting. Meetings occurred in the clinic setting (i.e., conference room, other private space) at a time that was convenient for the participant dyad. The clinic hours allowed for much flexibility given their hours of operation are Monday – Thursday 9 AM-9 PM, Friday 9 AM-7 PM, and Saturday open for select parent training and adolescent camp activities. During the face-to-face meeting, parents signed the informed consent and parental permission, and adolescents signed the assent form. I reviewed the forms and answered any questions as necessary in the participants' preferred language to ensure understanding. In addition, clients were informed that participation in the study was voluntary and that refusal to participate would not impact their care at the clinic. However, there were no dropouts. I also asked staff to reinforce this message and direct any questions clients or others had about the study to me. Dyadic interviewing, where two participants interact during the interview, was not employed in this study (Morgan, Ataie, Carder, & Hoffman, 2013). Instead, each participant completed the survey, and I conducted a semi-structured interview with each individual lasting between 20-90 minutes. Individual interviews were preferred due to the sensitivity of the topic and to encourage openness from the adolescent participants. The University of Georgia's Institutional Review Board approved all procedures.

Data collection. My approach to interviewing is ethnographic (Prasad, 2005). Although I did not engage in a lengthy period of field observation my goal was to understand the cultural context of participants both as Latinos and as clients of the community clinic where recruitment took place. Additionally I sought to understand the meaning participants placed on communication about sexual health. Interviews were digitally recorded and transcribed using pseudonyms. I used Express Scribe software to transcribe audio recordings into Word documents. Numeric codes were used to identify parent-child dyads on the transcripts. Interview recordings were kept during the study period to verify meaning during analysis; audio recordings were deleted upon conclusion of analysis. Upon completion of data collection with each dyad, I extended a financial incentive of $50 and related health education material in the parent's language of choice.

During the face to face meeting, parents first completed the survey followed by the interview. Even though questions for the survey were set, my approach during this phase and in preparation for the interview was a romantic conception, which focuses the interviewer on building rapport and an empathic connection with an interviewee thus allowing for in-depth revelations (Roulston, 2010). The adolescent was surveyed and interviewed last. Adolescents were interviewed last to increase their trust in me and assure confidentiality of their data. Even though the adolescent age range was 12-17 years I noticed that adolescents aged 12 and 13 years struggled to answer questions compared with older participants, 14-17 years. Many appeared embarrassed or unwilling to discuss their knowledge of sexual health or conversations they may have had with their parent. As most Latino parents preferred interviewing in Spanish, as a fluent Spanish speaker I conducted interviews in the participant's language of choice (i.e., English or

Spanish). The proposed instruments were available in English and Spanish. Low literacy among the parents' group was a concern, therefore I read the instrument out loud to facilitate completion. Parents who reported they had discussed the topic of sexual health with their adolescent were asked to approximate the time (e.g., age of adolescent, life event that occurred). This information was used to estimate whether communication was initiated due to the adolescent's early sexual debut or in a preventive manner so as to avoid the aforementioned.

Survey Measures

Participants completed a brief demographics survey and a set of scales to obtain quantitative measures related to message domains and parental characteristics that may influence the adolescent's perception of parental advice. I created the demographics survey based on my criteria of interest for this study. The scales used in this study were developed by Guilamo-Ramos, Jaccard and colleagues (2006), who tested them with Latino and African-American parents and same-aged adolescents (Guilamo-Ramos, Jaccard, et al., 2006). The full instrument is in Appendix A.

Demographic variables included in the survey were: age, country of birth, years lived in the United States, level of education, religious affiliation/practice, marital status, and employment status.

Adolescent Sexual Experience was measured using a 0-5 scale, where each question answered "*yes*" yields one point. The brief scale was used with Latino adolescents aged 12-15 years in a similar study examining parental discussions about sexuality and influence on adolescent behaviors (Romo, et al., 2003). Information from

this short survey helped me examine the effect of parents' reported communication about sexual health on adolescents' reported sexual activity.

Parental Expertise, Trustworthiness, and Accessibility (PETA) measures the parent's and adolescent's perspective on the three parental characteristics each measured using three items. Expertise is measured by the following: 1) my child thinks I give good advice, 2) my child finds my advice helpful when talking about important topics, and 3) when my child needs advice on something important they come to me for help. Trustworthiness includes: 1) my child trusts me when we talk, 2) my child knows that I will keep my promises, and 3) my child knows that I am honest with them. Accessibility is measured by the following: 1) It is difficult for my child and me to find time to talk, 2) I find I am too busy when my child wants to talk, and 3) I have trouble finding time to talk with my child (Guilamo-Ramos, Jaccard, et al., 2006). Responses range between a five-point Likert scale 0-*strongly agree* and 4-*strongly disagree*. A Cronbach's alpha of the scale was obtained for the parent sample (α=.82) and the adolescent sample (α=.82) demonstrating adequate reliability.

Parent-Adolescent Communication (PAC) measures parent and adolescent perspectives in three dimensions using three items each. Health risks are measured as follows: 1) my child and I have talked about what might happen if they were to get/get someone pregnant, 2) my child and I have talked about how having sexual intercourse at this time they may get an STI, and 3) my child and I have talked about how if they had sexual intercourse at this time they might get HIV/AIDS. The second dimension of social consequences is measured as follows: 1) my child and I have talked about how they may get a bad reputation if they had sex at this time of their life, 2) my child and I

have talked about how embarrassing it would be if they got pregnant/got someone pregnant now, and 3) my child and I have talked about how their boyfriend/girlfriend may lose respect for them if they had sexual intercourse at this time of their life. Moral consequence is the third dimension and is measured by the following: 1) my child and I have talked about how having sex at this time of life is morally wrong, 2) my child and I have talked about how they may regret not waiting until marriage to have sex, and 3) my child and I have talked about how they would feel guilty if they had sexual intercourse at this time. A four point response scale was used where 0-*not at all* and 3- *a great deal*. Reliability of this scale was adequate for the parent (α=.94) and adolescent (α=.80) samples.

Semi-structured Interview

The purpose of the semi-structured interviews (see Appendix B for the protocol) was to explore how Latino parents and adolescents communicate about romantic relationships, dating, and pregnancy prevention. Open-ended probes were used to seek detail on participant responses (Roulston, 2010). I created one version of the interview questions in English. During Spanish language interviews with parents I translated questions as I progressed through the interview protocol. Parent interviews were composed of four sections: 1) communication patterns they experienced in their own childhood, 2) their adult life experiences regarding marriage, children, and romantic relationships, 3) specific messages and communication they shared with their adolescent regarding the study topic areas, and 4) awareness of human papillomavirus (HPV) and related vaccine. The adolescent interviews also had four sections: 1) an icebreaker to put them at ease regarding favorite subject in school, extracurricular activity involvement, 2)

communication they experienced with their parents regarding the topics for this study, 3) experiences or observations of their peer network as they related to dating and overall body health, and 4) awareness of HPV and the vaccine. All interviews began with the first section for the respective interview type, parent or child. However the order of questions for subsequent sections varied depending on how participants responded. For example, if adolescents introduced the topic of peer networks during our discussion of parent communication I probed further about peer networks to retain the flow of conversation. Once they expressed their thoughts I returned to the topic of parent communication to obtain further detail as needed. Research questions associated with this portion of the study were

1. Which message domain(s) (i.e., health risk, social consequence, moral consequence) of parent and adolescent communication most influence adolescent sexual behavior?
2. Which parental characteristics (i.e., expertise, trustworthiness, accessibility) most influence an adolescent's perception of the message?
3. What cultural aspects (i.e., traditionalism, familismo) influence the discussion of romantic relationships, dating, and pregnancy prevention between parents and adolescents?
4. How do conversations between parents and adolescents vary by gender-role (e.g., mother-daughter, mother-son, and father-son)?

Data Management and Analysis

There were no missing data. Survey and qualitative interview data (i.e., audio recordings and transcripts) were maintained in a secure computer.

Quantitative data analysis. Surveys were collected on paper and identified with a numeric code specific to each participant. SPSS 18 was used for analysis of demographic and scaled instrument data. Descriptive statistics and means tests were used to compare parent and child responses and explore each dyad's answers to findings from the interviews. Therefore, the quantitative component of this study was used as a secondary method supporting the qualitative data.

Qualitative data analysis. The constant comparative method was used to analyze interview data and identify patterns within dyads. Constant comparison allows the researcher to build an understanding of a social process through a theory grounded in data (Boeije, 2002; Charmaz, 2006; Kozma, 1985). The outcome is to help answer questions arising from analysis. Interviews were transcribed in the language conducted. Memo-writing, a process whereby the researcher begins to explore connections in the data (Charmaz, 2006), was incorporated throughout transcript analysis. This technique also helped me remain conscious of personal subjectivities (see Appendix D for the subjectivity statement) that may have influenced how I perceived information during data collection and analysis.

Interview transcripts were first individually read and manually coded line by line to obtain a surface level content analysis of the data and avoid making broad assumptions. Codes were one word or short phrases (Saldaña, 2009). The coding process yielded various themes beyond the immediate scope of this study (Table 3.1). Given that they were not associated with the conceptual framework for this study they are not discussed herein. However the theme related to HPV and related vaccine is briefly described in the next chapter as it was a topic discussed during interviews.

Table 3.1: Developing themes external to study criteria

Themes
Role of religion in adolescent's life choices
Varying level of self-esteem between self-identified virgins and non-virgins
Domestic violence as a norm
Power differential between parents and adolescents based on language skills
Role of the older sibling in socializing younger sibling to familial/parental values and beliefs
Knowledge and perception of HPV and related vaccine

My next step was to create an Excel file where columns were labeled with the elements of the conceptual framework. Interview transcripts were then re-read and original codes were organized based on the framework. For example, an original code that may have read 'discusses STI's' was recoded under 'health risk' and discussions about 'feelings of embarrassment' were recoded under moral consequences.

CHAPTER 4

RESULTS

This chapter is organized in three sections: 1) an overview of the sample for this study, 2) results from the quantitative analyses, and 3) results from the qualitative findings. The qualitative data section is further divided into three sections: 1) parent and adolescent characteristics, 2) messaging about sexual health and pregnancy prevention, and 3) acculturation and respect. Each of these broad areas is represented in the conceptual framework.

Sample overview

A total of 21 dyads (N=42 people) composed of parent and child participated in the study. Table 4.1 details the demographic characteristics of the parent sample. The majority of participants were mothers; only two fathers chose to participate. The large majority reported being married or living with a partner. The sample of parents was fairly young (<40 years) and all but one were born outside the United States, primarily in Mexico. However, most foreign-born parents had lived in the United States between 11 and 19 years. Parents' level of education was evenly distributed between those with a high school diploma or less and those with some college or higher. Most parents reported working outside the home and an annual household income at or below $35,000. A majority (14) of parents reported not having health insurance for themselves. All but one of the parents reported ascribing to a religious faith they practiced weekly or monthly. The majority of parents (15) reported Spanish as the primary language spoken in the home.

The adolescent sample was composed of 12 girls and 9 boys ranging in age from 12-13 years (n=8) to 14-17 years (n=13). Slightly more than half of the children (11) were born in the United States while the rest were foreign-born: Mexico (6), Puerto Rico (2), and Central or South America (2).

Table 4.1 Demographic Characteristics of the Parent Sample

Demographic Characteristic	Parent (n=21)
Sex	
Female	19
Male	2
Age	
31-35	7
36-40	7
43-59	7
Country of birth	
US	1
Puerto Rico	1
México	14
South America	2
Central America	3
Number of years lived in the US	
≤ 10 years	6
11-19 years	13
≥ 20 years	2
Marital Status	
Married/Living with a partner	13
Single	8
Annual household income	
Under $35,000	13
$36,000-$50,000	4
$51,000-$70,000	2
Above $71,000	2
Educational status	
Did not finish high school	9
High school diploma or equivalent	2
Some college	5
College graduate	5

Quantitative analyses

Table 4.2 depicts mean scores in the PETA scale for each parent-child dyad. To protect participant confidentiality, data are grouped by adolescent age range and the parent gender was not identified. Scale scores were calculated as the mean of the items. Thus, scale scores range from low (0) to high (4), where higher scores reflect a stronger support of the construct. Table 4.2 also displays the sexual experience reported by adolescents. The sexual experience scale used a dichotomous answer format and a higher count of "*yes*" answers suggested more experience. However, to aid in discussion and comparison with the other table results, adolescent sexual experience was grouped in the following levels: 1) none, 2) kissed, 2) touched on top of or under clothing, 3) oral sex either given or received, and 4) sexual intercourse with vaginal penetration. None of the adolescent participants reported having had anal sex

Table 4.2: Means in the PETA subscales within Dyads and Child Sexual Experience by Age Group of Child

Dyad #	Parent / child gender	Expertise Parent / child	Trustworthiness Parent / child	Accessibility Parent / child	Sexual experience child
	Younger teens (12-13)				
11	Parent & son	3.33 / **3.67**	3.00 / **3.67**	0.67 / **4.00**	None
12	Parent & daughter	3.67 / 3.67	3.00 / **3.67**	**4.00** / 2.33	None
21	Parent & daughter	**3.00** / 2.67	**3.67** / 2.00	**4.00** / 1.67	None
7	Parent & daughter	3.67 / **4.00**	**3.33** / 2.67	1.00 / **2.67**	Kissed
8	Parent & son	**3.33** / 2.00	3.67 / 3.67	0.33 / **2.00**	Kissed
13	Parent & daughter	**4.00** / 2.00	**3.00** / 2.33	1.67 / **2.67**	Kissed
18	Parent & son	**4.00** / 3.33	**4.00** / 2.67	**3.67** / 2.33	Kissed
20	Parent & son	**2.67** / 1.00	**3.00** / 0.67	2.67 / **3.00**	Touched
	Older teens (14-17)				
5	Parent & daughter	3.33 / **4.00**	3.67 / **4.00**	4.00 / 4.00	None
16	Parent & daughter	1.33 / **3.33**	**2.67** / 2.33	**1.00** / 0.00	None
19	Parent & son	**3.67** / 3.33	**4.00** / 3.00	3.33 / **4.00**	None
1	Parent & daughter	**3.00** / 2.67	2.67 / **3.00**	2.00 / **3.67**	Kissed
3	Parent & daughter	3.00 / 3.00	**3.33 /** 2.67	1.00 **/ 2.33**	Kissed
17	Parent & daughter	**4.00** / 3.67	**4.00** / 3.67	**4.00** / 2.00	Kissed
15	Parent & son	3.33 / **3.67**	3.33 / **4.00**	2.67 / **4.00**	Touched
9	Parent & son	**3.00** / 1.67	**2.33** / 2.00	1.00 / **1.67**	Touched
10	Parent & daughter	**3.33** / 3.00	**3.00** / 2.33	1.67 / **3.33**	Touched
6	Parent & son	3.33 / 3.33	3.67 / 3.67	**3.33** / 2.67	Oral sex
2	Parent & daughter	**4.00** / 3.33	**4.00 /** 3.33	1.67 **/ 2.00**	Sexual intercourse
4	Parent & son	3.33 / **3.67**	**4.00 /** 3.33	2.33 **/ 2.67**	Sexual intercourse
14	Parent & daughter	1.33 / **2.00**	2.00 / **2.33**	1.00 / **2.00**	Sexual intercourse, birth
	TOTAL	**3.22** / 3.00	**3.30** / 2.90	2.23 / **2.62**	

Note: PETA = Parental Expertise, Trustworthiness and Accessibility Scale. Bold indicates higher score. Scores range from 0 to 4; high scores indicate more parental expertise, trustworthiness, and accessibility.

The PETA scale focuses on parental characteristics that influence adolescent sexual behavior. These elements were more salient during the interviews than those describing message content, measured by the PAC scale. Mean values in bold represent the higher mean of the pair.

Overall, parents reported slightly higher perceptions of expertise (3.22 / 3.00) and trustworthiness (3.30 / 2.90) compared to their adolescents. Interestingly during interviews most parents reported they did not have sufficient expertise to speak to their children about sexual health topics and in some cases felt intimidated by their children's knowledge. Compared to parents, adolescents overall perceived higher levels of parental accessibility (2.23 / 2.62). However, means are difficult to interpret given the wide variability across participants.

Younger adolescents (12-13 years) reported little to no sexual experience, primarily kissing, compared to older adolescents (14-17 years) who ranged from having no sexual experience through sexual intercourse with vaginal penetration. One of the adolescents who reported having sexual intercourse had had a full-term birth.

In a few instances, concurrence was noted in expertise (dyads 3, 6, 12), trustworthiness (dyads 6 and 8), and accessibility (dyad 5). Only one dyad (6) demonstrated concurrence on at least two dimensions: expertise and trustworthiness. During interviews, this dyad reported sharing comprehensive sexual education and both parent and child were satisfied with their level of communication. The parent in this dyad was also the only one who chose to conduct the interview in English.

Regarding expertise, most of the dyad means were not too divergent suggesting fairly even perceptions between parents and teens. Five dyads (8, 9, 13, 16, and 20) had a

wider gap in their perception of expertise. Parents in these dyads reported higher perceived expertise; however, in dyad 16 the adolescent reported a higher perception of parental expertise. Adolescents in these five dyads were almost evenly divided between the two age groups: younger (dyads 8, 13, 20) and older (dyads 9 and 16), negating an age-related influence on perception. Sexual experience reported by adolescents in these five dyads ranged from no experience to touching.

On the dimension of trustworthiness, slightly more dyads had wider gaps in parent-child means (3, 7, 16, 18, 19, 20, and 21). Two of these dyads (16 and 20) also reported wide gaps in expertise. The interviews I had with the parent and child in dyad 16 are consistent with the previous results where both mother and daughter confirmed little communication was shared about sexual health. However the mother in dyad 20 reported very specific conversations she had with her son about contraception and respecting partners although he did not recall those during his interview. Additionally this dyad's divergent scores may reflect communication by the parent did not resonate with him resulting in low perceived expertise and trustworthiness. Similar to expertise, the adolescent age groups represented by these dyads were almost evenly divided (younger- 4 and older- 3), and sexual experience reported by these teens ranged from no experience to touching.

Adolescents more often than parents reported higher perceived accessibility. Twelve dyads (1, 3, 6, 7, 8, 10, 11, 12, 15, 17, 18, and 21) evenly divided between older and younger adolescents demonstrated wide gaps in the mean scores of accessibility. Four of these dyads (3, 7, 18, and 21) also had large gaps in trustworthiness. While it is possible that an association exists between perceived accessibility and trustworthiness,

there is insufficient support based on mean scores. When comparing the level of sexual experience reported by teens in these 12 dyads to perceived parental accessibility, sexual experience ranged from no experience to touching; and one teen reported having oral sex. Interestingly, of the three teens (2, 4, and 14) who reported sexual intercourse, gaps between parent and child means on any of the three dimensions were not large. However their mean scores for accessibility were low. In the case of dyad 14, which represented the teen that had a full-term birth, all three dimensions were at or below the average for the groups.

Table 4.3 depicts mean scores in the PAC scale for each parent-child dyad. To protect participant confidentiality, data are grouped by adolescent age range and the parent gender was not identified. Similar to data from the PETA scale, PAC scores were calculated as the mean of the items. Thus, scale scores range from low (0) to high (3), where higher scores reflect a stronger support of the construct. Table 4.3 also displays the level of education reported by parents. Educational level was identified as: 1) less than a high school degree when the parent reported not finishing high school, 2) high school or GED when a diploma was obtained, 3) some college indicated at least one semester of college attendance, and 4) college graduate included at least a bachelors level diploma.

Table 4.3: Means in the PAC subscales within Dyads and Parent Level of Education by Age Group of Child

Dyad #	Parent / child gender	Health risk Parent / child	Social consequence Parent / child	Moral consequence Parent / child	Parent level of education
	Younger teens (12-13)				
21	Parent & daughter	2.67 / 2.67	**2.33** / 2.00	2.33 / 2.33	< High school
7	Parent & daughter	1.67 / **3.00**	0.00 / **2.00**	0.33 / **1.00**	< High school
13	Parent & daughter	**3.00** / 2.33	**3.00** / 2.00	3.00 / 3.00	< High school
20	Parent & son	**2.67** / 0.67	**2.33** / 0.00	**2.00** / 1.00	< High school
11	Parent & son	0.33 / **1.00**	0.00 / **0.67**	0.00 / **1.67**	High school / GED
12	Parent & daughter	**3.00** / 2.33	1.33 / **1.67**	1.00 / **2.67**	High school / GED
8	Parent & son	0.00 / 0.00	0.00 / **2.33**	0.00 / **2.67**	Some college
18	Parent & son	**0.67** / 0.00	0.00 / **0.33**	0.00 / **0.67**	College graduate
	Older teens (14-17)				
3	Parent & daughter	**3.00** / 2.00	**2.00** / 1.00	1.33 / 1.33	< High school
15	Parent & son	**3.00** / 1.33	2.33 / 2.33	3.00 / 3.00	< High school
9	Parent & son	1.67 / **3.00**	1.33 / **2.00**	2.00 / **3.00**	< High school
2	Parent & daughter	**3.00** / 0.67	**2.33** / 0.33	**2.33** / 1.33	< High school
4	Parent & son	**2.67** / 1.33	**2.33** / 1.33	0.33 / 0.33	< High school
14	Parent & daughter	**3.00** / 2.33	**3.00** / 1.67	**3.00** / 1.00	Some college
19	Parent & son	0.67 / **2.00**	0.00 / **1.33**	0.33 / **2.33**	Some college
5	Parent & daughter	**3.00** / 2.67	**3.00** / 0.67	**3.00** / 1.00	Some college
6	Parent & son	**3.00** / 2.67	1.67 / **2.33**	1.33 / **2.67**	Some college
16	Parent & daughter	**2.67** / 0.00	**2.00** / 1.33	**3.00** / 1.00	College graduate
1	Parent & daughter	1.00 / **2.00**	0.67 / **1.67**	2.00 / 2.00	College graduate
17	Parent & daughter	1.67 / **2.33**	**1.67** / 1.00	**2.00** / 1.67	College graduate
10	Parent & daughter	**1.00** / 0.00	2.00 / **2.33**	2.00 / **3.00**	College graduate
	TOTAL	**2.06** / 1.63	**1.59** / 1.44	1.63 / **1.84**	

Note: PAC = Parent Adolescent Communication Scale. Bold indicates higher score. Scores range from 0 to 3; high scores indicate more parental messages of health risk, social consequence, and moral consequence.

The PAC scale focuses on the type of parental messages about sexual health used in communication with adolescents. Message types are contrasted with parent's level of education. Mean values in bold represent the higher mean of the pair.

A comparison between parent and adolescent total means for each message type demonstrates parents primarily focused on messages about health risks (getting a disease or becoming pregnant) followed by moral consequences (experiencing feelings of guilt or regret) (2.06 / 1.63), while the opposite was reported by adolescents (1.84 / 1.63). These mean scores also suggest that participants felt these topics were discussed between some of the time to a moderate amount of the time. However more importantly, parents and children disagreed on the primary and secondary message type. Both parents and teens reported social consequences (getting a bad reputation or feeling embarrassed) the least discussed message type of the three (1.59 / 1.44).

Parents of younger adolescents who reported their education as less than a high school degree appeared to discuss each message type more often than parents with a high school degree and above. Among parents of older teens, a similar pattern was observed where parents with less education reported sharing messages more often than parents with a college degree. However, among parents of older teens who reported a college graduate level of education, messages about moral consequences were discussed more often than health risks and social consequences.

In a few instances, concurrence was noted in health risks (dyads 8 and 21), social consequences (dyad 15), and moral consequences (dyads 1, 3, 4, 13, 15). Only one dyad (15) demonstrated concurrence on at least two dimensions: social and moral consequences. This dyad's mean scores suggest they perceive a lot of communication

occurs related to social and moral consequences. Both parent and child reported being active participants in their church. The parent in this dyad spoke extensively about the messages they convey and how they elicit conversation with their children by asking questions about their opinions on any given topic. Interestingly the parent described specific messages about pregnancy prevention and diseases however the parent child mean score on health risks for this dyad was very different (3.00 / 1.33). This difference may suggest the child has not retained the health risk message as completely as those for social and moral consequences.

Regarding the message category of health risks nine dyads demonstrated wide gaps in parent and child means (2, 4, 9, 15, 16, 17, 19, 20, and 21) although there were no major differences between who reported the higher score. A more obvious difference is noted by age group, however. Seven of the nine dyads were among the older teen group. This suggests a possible age-related influence on perception of parental messaging related to health risks.

On the dimension of social consequence, seven dyads had wide gaps in parent-child means (2, 5, 7, 8, 14, 19, and 20). However, neither child age nor parental level of education appeared to influence gaps in this message type. Regarding messaging about moral consequences, six dyads (5, 8, 12, 14, 16, and 19) presented wide gaps between parent and child mean scores. Four of these dyads were from the older teen group and represented parents who reported an educational level of some college or being a college graduate.

While there were seven dyads that demonstrated wide gaps in mean scores among any two message types, one dyad (19) had wide gaps across all three message types. In

all three elements the teen reported the higher mean score of the dyad, while the parent reported these message types were infrequently shared. During my interview with the parent of this dyad, the parent told me that communication with the teen is scarce because the teen's behavior is good and he '*does not cause trouble*.' The parent's perception is that communication occurs if the teen demonstrates poor behavior. However, during my interview with the teen he expressed feeling lonely and not having anyone who understood him, stating his parents were busy with work.

Qualitative findings

Following the conceptual framework (Figure 2.1), this section is organized in four main parts that discuss parent and adolescent results related to the study aims. First, I describe parent and adolescent characteristics related to expertise, trustworthiness, and accessibility. Second, I analyze parental messaging about sexual health and pregnancy prevention, particularly health risks, social consequences, and moral consequences. Third, I discuss cultural factors that influence parental characteristics and messages. I conclude the qualitative findings by providing a few case examples demonstrating the variation observed on characteristics and messaging.

Specific Aim 1: Parent and adolescent characteristics

Three parent characteristics were used in this study to understand how each influences adolescent sexual debut and overall knowledge of sexual health. The characteristics studied were parental expertise, trustworthiness, and accessibility. A quantitative measurement of these was obtained via a scale administered separately to parents and children in this study. Quantitative findings were discussed earlier in this chapter. The following subsections describe how each characteristic presented itself during the interviews first with parents and then with the children.

Expertise

Parents approached the topic of expertise from two distinct points: 1) perceived knowledge gaps and challenges associated with the topic, and 2) feeling empowered to initiate and maintain a conversation with their child.

Parents said they did not have an equal level of knowledge as their children and felt unprepared to talk. In the statement that follows, the parent is responding to a lesson her son gave her on puberty in boys and related hormonal changes.

> *Barbara: Ya ahorita ya hasta uno tiene que hablar con la verdad de todo. Ya no es como antes que los pajaritos, los niños más bien nos explican a nosotros. Porque ni en la escuela me lo enseñaron. Yo no sabía ni que era la pubertad. [Translation] Barbara: Now one has to speak with the truth about everything. In other words it is not like before about the little birds, kids now are explaining things to us. Because not even in school did they teach me this. I didn't even know what puberty was.*

I asked one of the mothers if she had started talking to her daughter about having a romantic relationship and Estefania stated, "*Pues le hablo a veces que son la consecuencias. Más no sé explicarle como otras cosas. Porque en la escuela ya más o menos les explican a ellos, ya están más despiertos en estos tiempos.*" [*Translation: Well sometimes I talk to them about the consequences. I don't really know how to explain about other things. Because in school more or less they explain things to them and they are more alert nowadays.*] Similarly, another mother discussed the topics she has delayed discussing with her son.

Migdalia: Bueno drogas un poco le he hablado de eso, pero nada de sexo he hablado con él. Nada. Ni de embarazo. Ni siquiera le he dicho a los cuantos años le sale el esperma. Ni yo sé. No tengo ni idea.

[Translation] Migdalia: Well I have talked to him a little about drugs but nothing about sex. Nothing. Not even about pregnancy. I haven't even told him at what age he will ejaculate. I don't even know. I don't even have an idea.

In all three cases mothers felt at a loss on what to tell their children given their own admitted lack of information and their child's increased awareness from exposure in school. Parents who believe the school provides sufficient instruction may choose to avoid talking with their children on the topic. A possible impact of this decision is the child believing their parents do not have enough expertise on the subject and therefore choosing to avoid talking to them if they have a question.

There were other parents who described conversations they had with their children where they admitted not having enough expertise or learning something new from their child. Relaying an experience when she spoke to her son about avoiding promiscuity and practicing safe sex, Alicia told him, "*A mi escúchame si quieres y créeme la mitad de lo que yo te digo porque yo no tengo la preparación que los maestros pero escucha tu maestro. Busca la información.*" [*Translation: Listen to me if you feel like it and believe half of what I tell you because I don't have the preparation your teachers have, but listen to your teacher. Look for the information.*] In this case, the mother admits to her child that while she may not have all the information he needs, he should still seek out the information provided by his teachers and other sources to ensure he keeps himself safe. Her involvement may be indirect, but it demonstrates awareness

of resources and communicates to the adolescent that this is an area he should learn more about. However, some parents were surprised when they learned how much their child actually knew.

> *Olga: Pero como ella me habló tanto y me lo dijo de una manera tan jocosa y como tan natural que para ella 'mami yo no he visto pene nada mas de esa manera.' Yo lo he visto si le da un sífilis, lo he visto si le da una gonorrea. Digo yo que?! Yo todavía a la edad que tengo no he visto ni siquiera figura de poderle decir si tiene sífilis se ve así. Pero ella en la escuela si lo sabía. O sea demasiado lo sabía.*
>
> *[Translation] Olga: But since she talked to me so much in such a natural manner that for her it was like, "Mom I haven't just seen a penis in that form. I've seen one with syphilis; I've seen one with gonorrhea." I said what?! At my age I still couldn't even imagine how a penis with syphilis looks like. But she knew from school. In other words she knew too much.*

When this mother realized what her then 13-year-old daughter was revealing to her, she admitted to feeling less expert than her daughter, and this led Olga to think, "*Entonces digo para que sigo hablando, saben más que yo. Mejor me callo porque saben más que yo." [Translation: Then I thought well why should I continue talking, they know more than me. It's better if I stay quiet because they know more than me.]* At this moment Olga questioned her role as a parent guiding her children when she realized they had learned something she had not experienced in her lifetime. A realization such as this can make a parent feel less confident and prevent them from initiating future conversations to avoid losing credibility or feeling inadequate in front of their children. Reinforcing this

claim is an example relayed by another mother who explained how her daughter was fact checking her knowledge.

> *Ana: Creo que le hizo la misma pregunta a la tía que yo le había dicho para ver si le estaba hablando con la verdad sobre la menstruación, sobre la persona que te toque, cosas así. Así le estaba yo diciendo algo que era o algo que era no más para asustarla o como para decirle que estaba malo.*
>
> *[Translation] Ana: I think she asked her aunt the same question that she asked me to see if I was speaking the truth about her menstruation, about people touching her, and things like that. To see if what I was telling her was true or simply to scare her or to say it was bad.*

Ana was not concerned that her daughter had asked her aunt (Ana's sister) because she trusted her and felt her sister could give her daughter proper guidance. The example illustrates that children who may not fully trust their parents' expertise will seek out another source that can corroborate what their parent has told them. This highlights a critical point for parents not only to become informed but also to speak factually and build trust with their adolescents.

During the interviews parents discussed events that cued them to initiate conversation with their adolescents. It was during these initial conversations that some parents discovered how much their children actually knew about certain topics. For example Rosario stated, "*Ya después cuando empezó a andar un poquito de rebelde yo me di cuenta que ella sabía muchísimo más de lo que yo pensaba. Porque en mi ignorancia yo pensaba que conforme ella fuera creciendo yo iba hablarle." [Translation: Later when she became a little bit rebellious I realized that she knew so much more than*

what I thought. Because in my own ignorance I thought as she grew older I would begin talking to her.] Some parents similarly expected to observe cues such as a child saying they liked someone in their class or asking them a question about puberty in order to initiate conversations. These parents neglected the role of the child's environmental influences as additional sources of information, where the adolescent may not have relied on the parent to provide them information.

Certain topics also created difficult situations when parents simply did not know where to begin the conversation. As I discussed what made one mother decide to initiate a conversation with her son, she told me she lacked the male perspective but was trying to remain open.

> *Migdalia: Entonces con el mayor yo le digo, 'Papi yo no soy hombre y yo no sé qué tanto sea a tu edad de hombre porque no sé, no lo he vivido. Le digo, pero si piensas que yo te lo puedo contestar, te lo contesto, le digo yo no tengo pena pero no sé si tú te vas a sentir bien conmigo.*
>
> *[Translation] Migdalia: Then with the older one I say, "Papi I'm not a man and I don't know what it's like to be a boy of your age because I don't know, I haven't lived it." I tell him, "But if you think that I can answer, I will answer." I tell him, "I'm not embarrassed but I don't know if you will feel comfortable telling me."]*

While this mother admits her knowledge is limited, she communicates her willingness to answer his questions and concurrently recognizes that he may feel somewhat embarrassed about sharing or asking his mother questions. A majority of the single mothers in this sample experienced similar concerns not knowing how to speak to their sons about sexual health and development. Recognizing this potential challenge, I asked

one mother if she would feel embarrassed if her son initiated the topic with her instead of her initiating the topic with him.

> *Rosario: Tampoco me daría pena, no. Pero si yo voy y les pregunto si no me atrevo. No me atrevo. No sé cómo manejar eso. Como que yo me necesitaría educarme mucho de eso. No quiero sonar grotesca, grosera. Que ellos vean que el sexo vaya ser algo sucio.*
>
> *[Translation] Rosario: I wouldn't be embarrassed if they approached me. But I don't dare approach them and ask questions. I wouldn't know how to handle that. I would need to educate myself about that. I don't want to sound dirty; that they view sex as being something dirty.*

Rosario's statement reflects her own childhood experience where her own mother made her feel sex was dirty and it was not to be discussed despite experiencing sexual abuse by a family member. Her struggle now as a mother was to inform her children, but the challenge was two-fold. First, she felt ill-prepared with factual information and while visibly open to answering questions her children had, she was not confident about initiating or carrying a conversation with them. Second, she was aware that her experience of sexual abuse could negatively influence their understanding of sexuality. Sadly, Rosario was not the only parent who relayed experiencing some form of abuse in childhood. However, I noticed that others who had either been abused or molested were more likely to want to engage their children particularly on the topic of appropriate versus inappropriate touching. While Rosario may have felt she did not have the expertise to discuss her son's physical development and other aspects of sexual health, she certainly had the knowledge and confidence to describe what was appropriate

touching. It is my assessment that some parents neglected the knowledge they had, believing it was insufficient even though it could be used as a foundation for them to build upon together with their children.

Conversely, not all parents in the sample believed they had low expertise. Some described actively educating their children on an aspect of the topic.

> *Beatriz: Yo siempre trate de hablarle y explicarle, "Bueno ven trae una hoja y un lápiz. Esto es la mujer así es el útero con la formita así, esto es la vagina, esta es la vulva inferior, entonces el clítoris que es así que es asá." Yo lo que le pude explicar le expliqué.*
>
> *[Translation] Beatriz: I always tried to talk to her and explain, "Well come and bring a paper and a pencil. This is the woman, this is the uterus with the shape like this, this is the vagina, this is the inferior vulva, and this is the clitoris like this and like that." What I was able to explain I explained.*

Beatriz was certainly familiar with her own anatomy and confident enough to explain it to her daughter. She was not hindered by what she did not know, instead choosing to share the knowledge she had and believed would benefit her daughter. Another mother, the only parent who preferred to conduct the interview in English, provided her son with more information than what the school provided, feeling it was her responsibility.

> *Flor: I appreciate what the school has to say but I'd rather give him my version of things. I think that's important and I always qualify it to them: "I'm telling you this but you are not to tell your friends because their parents have the right to teach them whatever way they want to. This is between you and me. This is our deal."*

Flor provided explicit examples of the conversations she had with her children about sexual health and pregnancy prevention. She and her son were the only dyad that described different types of sex and contraception during conversations (i.e., vaginal, oral). She attributed her knowledge and approach to experiencing her own teenage pregnancy and her current career as a counselor for adolescent youth. Her goal was to speak with her children in a manner that provided them accurate information and discouraged them from early sexual debut or pregnancy. These examples demonstrate that some parents had developed not only sufficient expertise to talk with their children but also felt confident and even responsible in doing so.

The discussion on expertise in the adolescent interviews focused primarily on their acquisition of information through school, and then through other sources such as parents or siblings. I chose to approach the adolescent interviews by asking what topics they learned about in health class. As all of the participants were at least in middle school, it was safe to assume they had at least one formal health course and could respond to the question even if only superficially. Most of the adolescents relayed that school taught them about sexually transmitted infections, menstruation, contraception (i.e., condoms), abstinence, the reproductive system, and other general topics such as nutrition, fitness, substance abuse, and mental health (e.g., "dealing with sadness"). Some of the children stated their parent had discussed a given topic before they heard about it in school, while others responded having no conversation with their parent or lacking information. I asked Maricela (16 years) if her mother had talked to her about diseases.

Somewhat she would mention them but not with details. This is what will happen if your partner has a disease or something or when you catch it or…not with details cause I think I couldn't have a conversation like that with my mom. I guess the school would be in charge of that because they would actually tell with details.

Maricela highlights two important aspects to parent-child communication about sexual health in her response: 1) potential for feelings of embarrassment, and 2) amount of detail provided in the conversation. Embarrassment was also noted as a challenge for parents. If it were acknowledged directly when parents and children discussed this topic it could place both of them at ease and help them recognize that while there may be some discomfort the topic is worth discussing. The fact that Maricela believes school should provide more detail than her mother suggests she believes her mother's expertise may not be at the level necessary for her to obtain certain information. Her belief may stem from indirect messaging from her mother in not providing details about diseases or perhaps examples that could contextualize information for Maricela. Sara (17 years) describes how her mother had previously talked to her about menstruation before she heard about it in school.

When I would tell my ovaries hurt when my head hurt she was like ok this is because girls go through this and she would tell me little by little not just parts. She doesn't wait for specific moments she just tells you if you ask and she doesn't try to hide it which is the good thing about it.

In her description, Sara addresses four critical points she values about her mother's approach. First, her mother "little by little" provided her information so it was not given

to her all at once rather as elements she developed in her adolescence. Second, she states her mother was not planning for a specific or right time, rather she provided the information as it was relevant to Sara. Third, "she tells you if you ask" demonstrates that Sara is confident her mother is open to answering questions and is likely a trusted source of information. Finally, Sara appreciates her mother's honesty, stating "she doesn't try to hide it." It appears that children's perceptions of their parents' expertise are closely linked to the degree with which they trust their parent. The element of trustworthiness is described later in this section.

I was particularly interested in what adolescents remembered about contraception and sexually transmitted infections, given the more conservative curriculum promoted in Georgia. Miguel (14 years) one of the more talkative boys told me, "*They said that either you wait until you're married or try to use a condom. I mean, we all pretty much know we can get it* [the condom] *at the gas station*." While I was satisfied to hear that he recalled abstinence and condoms are methods to avoid contracting a sexually transmitted infection, I was surprised by his confidence and knowledge regarding where to obtain condoms. The use of "we" suggests his peer group and perhaps specific to teen boys; it piqued my interest given three other boys in the sample independently offered the same point of information during their interviews. However, I did not ask them about it and thus it remained unclear how they came to that realization: whether it was information they heard second hand through a friend or if a family member informed them of where they could get condoms. In Miguel's case, his father expressly stated he wanted him to ask him for condoms so it is not likely Miguel would have used a gas station to obtain them.

During interviews with the younger teens I generally led into the conversation by asking what their parents had told them about keeping their body healthy. Marcos (12 years) stated, "*Like they usually say half of everything they say in school*." While most of my interviews with the 12 year olds were challenging simply because they may have felt embarrassed to talk about the topic of sexual health and pregnancy prevention, Marcos was one of the most difficult interviews because he used one word answers for most of my questions. For this reason when he replied to my question above with a full sentence I paid attention. In his quote he offers a glimpse into the degree he believed his mother discloses information in comparison to his school. I found this telling, given his mother admitted it was difficult to talk with Marcos because he was a very private person and preferred not to share himself openly with her or his siblings. She further noted that when he began to open up and recognized it, he would immediately shift back into himself. The onus on parents with children like Marcos may be greater as conversations should probably occur early and provide factual information; possibly in time as trust builds the child may be more likely to disclose information or ask questions. Older adolescents on the other hand were more talkative about what they learned in class.

> *Lissette (17 years): STDs. Well obviously the first thing they teach us is abstinence, which I really don't agree with but I mean it's what they teach. And then they go on to tell you about STDs and stuff like that. I think that the approach they take is to try and scare you away from it rather than to actually teach you, which I just feel it doesn't work because you literally see the people laughing in class. It's ridiculous. Nobody listens.*

Consistent with what Miguel said about abstinence, Lissette describes what she recalled from the class. However, she adds the perception that students have about the curriculum, almost that it is a joke when she says "people laughing in class." While some people, including, adolescents may resort to laughter when they feel embarrassed, this begs the question as to whether the curriculum could be presented in a way that actively engages them as Lissette suggests rather than sensationalize the reasons such as diseases for not having sex. However, the surrounding environment influences curriculum. Lissette extrapolated the influence of her community's belief on the curriculum she received:

> *They talk about STDs and stuff but they don't talk about pregnancy and condoms. They definitely don't talk about the pill…religion is very concentrated…I feel there would be a huge scandal if they started teaching contraception as opposed to abstinence.*

In this case where the curriculum is limited to discussing one form of contraception (i.e., abstinence), parents would need to supplement what children are learning in school to enable them to make wise decisions about their sexual health as they develop into adults rather than assuming if a topic is not discussed the teen will not be the wiser. The converse of this argument, as I learned from parent interviews, is that some believed if they talked about it, teens "would want to go do it." The dichotomy to educate versus parents' views of the knowledge as encouraging early sexual debut is obvious and challenging for public health messaging.

In some cases, adolescents noted various sources of information about sexual health including their parents, siblings, the internet, and other adults. I asked Marta (12

years) if her mother had ever talked to her about how to protect herself if she had sex and she said, "*Yeah. She said to use a condom. And that is all she would tell me."* When prodded further Marta said her mother had shown her the condom package but not the condom itself or how to use it. Marta's mother introduced a visual of the contraceptive she was describing, which certainly helps to reinforce what a condom looks like. It was the only incident described in this study when a mother reportedly showed her daughter a condom following discussion of its use as a contraceptive. However, condom negotiation skills were noticeably absent from this incident and the class discussions teens described. I do not expect that in a conservative educational climate that promotes abstinence, condom negotiation skills will be practiced. However, this is an aspect that parents could and should discuss particularly with young Latinas who have reported low skills in this area (Jemmott, Jemmott, & Villaruel, 2002).

Trustworthiness

As noted in the previous section, trust played a role in perceived expertise of the source. Teens described trust as affected by the amount of comfort they had with a parent or others in their life. In contrast, parents often described strategies they used to gain their child's trust. These included listening, being a friend, answering questions, normalizing the topic of sexual health, remaining calm when approached by the teen to discuss the topic, and using family time to address questions. Parents shared the conversations they used to obtain trust. Often these conversations began with topics their child talked a lot about such as music or hair. One mother explained how she integrated herself into a conversation with her daughters.

Olga: Yo le sigo la corriente hasta donde yo puedo y como yo quiero. Pero ¿cómo es que ustedes saben eso? ¿Y por qué me hacen esa pregunta y qué tanto tú sabes? Y ahí me meto como hacemos la conversación totalmente informal pero ellas se sienten cómodas continuando hablando de lo que estaban hablando. [Translation] Olga: I go with the flow as far as I can and want to. How is it that you girls know that? And why do you ask me that question, how much do you know? And like that I get myself in the conversation and it is informal but they feel comfortable continuing to talk about what they were talking about.

Olga describes her strategy of integrating herself to learn more about what her daughters are discussing. That they continue to discuss the same topic even after she has joined them makes her feel they trust her. She also describes active participation asking them about their level of knowledge on a given topic rather than just listening to their opinions. Some of the mothers also discussed this approach as coming alongside their teen as a friend and stated it was a helpful method to encourage conversation. I was curious whether success was specific to the parent and child's gender being the same and whether this differed for mothers and sons. In one mother-son dyad, I asked the mother what her son's response is when she provides him with information. Flor stated, *"It's positive. He's oh really mom? Yeah. It's actually positive. When it comes to sex I don't think he's ever distrusted anything that I have said. Or it doesn't seem like it."* As discussed in the previous section, Flor's background as a youth counselor and her approach to remain open with her children about all topics is likely the reason she believes there is trust in their relationship. Therefore, the gender of each dyad member was less an issue when trust and other characteristics such as expertise were present.

The role of the person initiating conversation should not be understated because the initial question is typically what guides the rest of the conversation, as I learned from the interviews. I asked parents if they or their children initiated conversations.

> *Estefania: Le digo, "¿Cómo te fue en la escuela?" Como ahorita dice que tiene novio. Y le digo, "¿Que dice el novio?" Y trato "de ser tu mejor amiga." Porque le digo, "Todo lo que a mí me cuentes" le digo "no se lo voy a contar a nadie." Entonces le digo, "Yo no me espanto porque es cosa del mundo y tarde que temprano un día lo van a experimentar."*
>
> *[Translation] Estefania: I tell her, "How was school?" Because now she says she has a boyfriend. And I tell her, "What does the boyfriend say?" And I try "to be your best friend." Because I tell her, "Everything you tell me" I tell her "I'm not going to tell anyone." So then I tell her, "I am not going to be scared because that is part of life, sooner or later you will experience it."*

This mother highlights the example of normalizing that her daughter likes a boy and has stated they are dating. Her strategy is not only to normalize the relationship but also to reinforce that as a mother she is also her friend and will hold her daughter's secrets. Olga also recognized the value of being a friend to her daughters stating, "*Quiero tratar y trato de que ellas me vean como una amiga más que como una mamá. Porque la mamá es como no te toco no te menciono este tema pero la amiga me arriesgo y hablo.*" [*Translation: I want to try and I try that they see me as a friend more than as their mother. Because the mother it's like you can't mention those topics with but the friend you risk it and talk about it*.] She makes the point that, despite what she thinks and feels, she works to control her feelings so that they do not become a barrier to trust and open

discussion with her children. Alternatively, when I spoke to teens about the aspect of friendship with their parents, I noticed that when adolescents were younger (12 or 13 years) they were more likely to take their parents' words at face value, whereas the older adolescents often referred to personal observations as proof of the parents' intent. Therefore, parents stating they wanted to be a friend to the child was not enough for some teens as they judged a parent's friendship on observed behavior and experience. As explained by one mother, to understand her children, she believed it was important for her to remember what it was like to be their age. Isabel stated, "*Para corregirlas yo doy vuelta atrás y digo ¿cómo reaccionaba yo cuando yo tenía esa edad? Porque si yo no me pongo a quererlas entender a como yo pienso ahora pelearíamos a diario.*" [*Translation: In order to correct their behavior I turn back and think how did I react when I was their age? Because if I try to understand them how I am today we would be fighting daily*.] Her approach goes beyond stating her willingness to be a friend, but actively positions her in trying to understand her daughter's perspectives.

Actions were characteristic of how parents worked to obtain their child's trust. None was clearer than mothers who described how they actively encouraged their husbands to talk with their children. A mother discussed how she coached her husband to speak with her three sons about sexual health, although in his opinion that is not a discussion appropriate for parents to have with their children. Barbara told me, "*Le digo a mi esposo: si ellos miran que tú estás preguntando y hablando con ellos va llegar el momento en que te tengan confianza; se van arrimar a preguntarte.*" *[Translation: I tell my husband that if they see you are asking them questions and talking there will come a time when they will trust you; they will want to come by you and ask you questions.]*

Barbara's goal is that her husband engages her three sons in a conversation that she believes the boys would benefit from. She states the benefits for her sons "*they will ask you questions*" but also includes benefits the father will experience '*they will trust you.*' While Barbara conveyed that she continues to encourage her husband with little success, other mothers were also helping their male partners along. The partners' greatest challenges were embarrassment and not being sure about what to say to their children. Therefore, if fathers were able to share consistently meaningful moments with their children, they could build upon a foundation of trust when adolescence came around and facilitate sensitive discussions. However, the challenge most fathers may experience is recognizing these conversations are part of their parental role and not just for the mother to handle.

Beyond using a strategy to actively gain trust, some parents simply told their children they wanted to gain their trust. I asked Susana if she thought her daughter would tell her she wanted to have sex.

> *…le digo tenme confianza… que ella me diga, "mira mamá paso esto y el otro." O, "mira mami quiero tener relaciones" pero que me diga. Pero no creo que me lo diga. Con hablarle que se tiene que proteger yo creo que es suficiente. [Translation] …I tell her trust in me…that she can tell me, "look mom this and this happened." Or, "look mom I want to have sex" but I want her to tell me. I don't think she will tell me but by speaking to her that she needs to protect herself I think that is sufficient.*

Susana asks her daughter to trust in her enough to tell her she wants to have sex, but she figures her daughter will not tell her. While she does not allude to why, Susana is

hopeful that their discussion about protection (i.e., condoms) will serve the daughter well and encourage her use of contraceptives. Later when I interviewed her daughter Maricela, she revealed to me that she had in fact had sex but chosen not to tell her mother because she was fearful of her mother's response. Parental response was often a concern voiced by the adolescents. Maricela reported using condoms during intercourse. However it is unclear whether her decision was based on her mother's advice, her knowledge from school, her partner's request or a combination of factors. At the time of the interview, Maricela was no longer dating that boyfriend; she had chosen to practice abstinence and was looking forward to sex after marriage.

Parents' levels of comfort were influenced when discussing sensitive topics, particularly when parents are of the opposite sex as their child. I asked one of the fathers in the sample what he talks to his youngest daughter about.

> *Noel: Sabe yo no soy de esas personas que 'no pues tu eres niña ve y platica con tu madre.' No, yo soy directo con ellas. Yo les digo las cosas como son. Y si mi niña pregunta algo pues le voy a contestar, no voy a salirme por la tangente. Pero no sé si sea bien hablarles muy abiertamente de sexo a esa edad o no. [Translation] Noel: You know I'm not one of those people that say "no you are a girl go speak to your mother." No I am direct with them. I tell them how it is. And if my daughter asks me something well I'm going to answer and not give her a tangential response. But also I'm not sure if talking too openly about sex at her age is good or not.*

At this point, he was asking me what I thought was most appropriate. While he may not have realized it, the question was challenging to me. On one hand I wanted to say you

should discuss these topics with your children and on the other I wondered could I do the same if I were a parent. Having no children myself, I did not want to be disingenuous; therefore, I admitted I understood this was difficult for him as a parent and as a man, but that I believed he should answer his children honestly when they asked a question as this would build trust between them. I also worked in an answer from a previous interview where the mother told me that you should answer based on the child's developmental level. He appeared satisfied with the answer and said he would continue to speak openly with his daughters. Similarly Flor shared how she talks to her son about various topics.

> *We try to keep an open relationship. I know there was one time that he* [the son] *had an experience that he didn't go all the way but he got pretty close. So he told his dad but he wouldn't tell me. And he asked his dad not to tell me so he doesn't know I know…but at least he has that with his dad and that makes me feel comfortable.*

This is an example where the child identifies different sources with whom to speak, where he may address general health and diseases with the mother, but reserves the sexual experience conversation with his father with whom he may feel more comfortable. Flor felt peace of mind that her son has a trusted male role model with whom he can confide and that she knows will provide him with sound advice. Alternatively others like Alicia described that she knows her 15-year-old son does not discuss certain topics with her.

> *Mi hijo dice, 'a mí no me gusta que se metan en mi vida. Si yo quiero yo voy a contar mis cosas pero que me obliguen hacer o decir algo que yo no quiero eso*

no me gusta.' Tú estás bien. Pero me deja en dudas porque él me dice que no ha tenido relaciones sexuales pero no lo sé realmente.

[Translation] My son tells me, "I don't like people getting in my life. I will share if I want to but don't obligate me to say or do something that I don't want to do." You are doing right. But he leaves me in doubt because he tells me that he hasn't had sexual relations but I don't really know.

During her son's interview, José reported to me that he had not had sex up to that point. However, he felt that such information should be private from his mother. I asked whom he would share such information with and he replied an uncle, his mother's brother. In this case since José did not have a relationship with his birth father or a stepfather, he sought the closest and most trusted male role model.

While some parents thought they should speak with their children about sexual health and pregnancy prevention, others like Migdalia discussed being cautious in what she says to her sons.

Si hablo demasiado con ellos, pues van a querer hacer lo que quieran. Entonces ahora ya no. No sé. Porque me gustaría que hubiera una forma de decirles pero que al mismo tiempo tuvieran miedo de hacerlo. Porque a veces digo, decirles es como dar la receta y no querer que lo cocine.

[Translation] If I speak too much with them, then they will want to do whatever they want. So now I don't do it. I don't know. Because I would like there to be a way of telling them but at the same time they would be afraid of doing it. Because sometimes I think, telling them is like giving them the recipe and not wanting them to cook it.

Migdalia voiced the struggle that a few of the other parents also mentioned. These parents were concerned that having a conversation with their children could be interpreted by them as permissiveness. This is similar to Barbara's recollection earlier that her husband did not feel this kind of talk is appropriate for parents to have with children. Parents may have felt that their role is to guide and discipline their children not have conversations about sexual health that could be left to their school or even as a discussion among friends, given most parents reported this is how they learned about the topic in their own youth. The challenge in today's society is that children receive messages about sex and relationships from multiple channels, and these messages are often unfiltered, lacking necessary information or parental values. Therefore parental messaging requires a fine balance between educating the adolescent on sexual health but also communicating the parent's behavioral expectation.

During interviews with the adolescents, responses to the characteristic of parental trustworthiness could be divided into elements that facilitate trust and barriers to trust. Barbara's son felt particularly comfortable and open about talking with his parents.

> *Antonio (14 years old): I feel comfortable with my mom and my dad. I tell them anything and they just give me advice if I need some and they're open too, I guess. They won't freak out if I tell them I had sex. They would just be oh well did you like it or ask me like questions like that. We just talk about it.*

In this case, Antonio believes he can trust his parents and speak to them openly about him having sex without fear of repercussion. However, from his mother Barbara's interview, it was clear that her husband did not discuss these topics with her sons, therefore Antonio

may have been verbalizing his ideal scenario despite not having told his mother he already had engaged in a sexual experience at this early age.

Adolescents also discussed trusted sources both within and outside the family unit. Examples included siblings, aunts, uncles, friends, and school counselors. Common traits the trusted sources possessed included being easy to talk to, listening, and sharing some commonality with the adolescent. Lissette (17 years old) describes two people outside her family unit.

> *One of them is my school counselor. I've known her since I got here and our families met outside of school too. And then there is Mary the founder of my school club. She is a psychology major and it's really easy to talk to her and she seems to understand.*

While Lissette also included her parents as trusted sources she specified the parents were mainly whom she went to for academic advice. However when she wanted to discuss more personal concerns whether related to relationships or feelings she was having she identified the sources described in her quote.

Parental response was often cited as a critical element when adolescents considered the type of information they would share. For example, I asked Maricela (16 years old) what her mother had said when the mother asked Maricela if she was sexually active.

> *She would tell me when you start having sex tell me just don't do it behind my back or something like that. And I would think, how am I going to tell my mom I'm being sexually active? I can't do that, I just couldn't. The first thing that would come to mind if I tell my mom I had sex, she's going to hit me or she is*

going to scream and punch me. So I'm not going to tell her because I had feared she was going to do something.

Despite her mother's genuine interest in knowing and Maricela's awareness that her mom wanted to know, she felt unsafe in disclosing she had had a sexual relationship with her boyfriend at age 15. Therefore it is clear that what may not have been said in the interviews is the difference between what parents say to their children verbally and the non-verbal or other conflicting messages that may lead the adolescent to select what they will disclose, when, and to whom. Some adolescents clearly wanted to avoid being questioned or lectured. José (15 years old) admitted, "*She could just talk about it but she starts asking me a lot of questions … I just don't feel comfortable asking her but I feel comfortable when she talks about it.*" Similarly, when asked if she shares with her mother issues that worry her, Rosa (13 years old), said "*If I tell her then* [the mother will say] *don't do it or she gives me a long talk for hours and hours so I don't say anything.*" These comments highlight the adolescents' need to establish boundaries about what they share with parents. I also gathered that the approach some parents use (e.g., excitable response, questioning) creates a barrier for the adolescent to continue sharing. However, a few adolescents like Marta (12 years old) withheld their worries from parents for other reasons. She expressed, "*I can trust them a little bit but I don't want to bother to tell them because it's not important.*" Marta observed her parents were burdened with the care of her two other siblings, and her 16-year-old sister's child. Therefore, Marta perhaps felt withholding information was best to avoid adding more stress on her parents. Interestingly, during their separate interviews Marta's parents each told me that after their

oldest daughter became pregnant, they had begun engaging Marta and her younger sister in active conversations about relationships, so they would avoid following the same path.

Accessibility

Parent responses to the characteristic of accessibility focused on not having enough time to talk with their child or on the strategy they used to communicate willingness to talk. The most common reason for lack of communication given by parents, usually from the single mothers, related to time limited by work inside and outside the home. They recognized the need to have more conversations, but were unsure how to carve out that space. I asked Margarita what topics she wished to discuss further with her daughters and she said, "*Yo hablo menos de lo que debería. Yo quisiera de verdad tener más conversación con ella pero no tengo tanto tiempo y casi siempre cuando ella quiere hablar yo estoy ocupada.*" *[Translation: I speak less than what I should. I really wish I could have more conversations with her but I don't have a lot of time and almost always when she wants to talk I'm busy.]* The positive elements here are that Margarita is willing to talk and so is her daughter. However, the areas that need attention are Margarita's perception that she needs "*a lot of time*" to talk and the difficulty finding a time that works for both her and her daughter. It is possible that with tailored and directed messaging Margarita could learn to deliver clear messages in brief exchanges with her daughter. To address the varying schedules, both Margarita and her daughter mentioned they spend time together in the car or sometimes doing household chores like folding laundry. These instances could be ideal moments for them to have these brief conversations.

I asked parents how they communicated their willingness to talk with their children and to describe the strategies they used. Susana plainly said, "Y*o soy la que le ando tirando atrás. Hasta se enfada. Yo le digo, 'sorry mi hija lo siento mucho pero tienes que escucharme lo que yo te estoy diciendo.'* " *[Translation: I'm the one that is running after her. She gets mad. I tell her, "sorry daughter but you have to listen to what I am trying to tell you."]* In her comment Susana is not only expressing her perceived availability to have conversations with her daughter but also the priority she gives those conversations when she states "*you have to listen*." The encouraging element here is that Susana wants to inform her daughter about a topic she feels is important to discuss. However as I have suggested earlier, the adolescent's perception of what the message is and how it is delivered influences how well the message is received. In this case, Susana confirms her daughter's reaction is to "*get mad,* " which likely results in low uptake of the message. Rosario also described what she tells her daughter to communicate her accessibility to talk.

> *Yo siempre le he dicho a mi hija, 'a mi háblame de todo lo que tú quieras. Yo no me voy a espantar. Yo soy tú mamá y siempre voy a estar ahí para todo. Nunca te voy a dejar sola.'*
>
> *[Translation] I've always told my daughter, "talk to me about whatever you like. I'm not going to be frightened. I am your mother and will always be here for everything. I will never leave you alone."*

However despite voicing her openness and accessibility, Rosario told me that she did not go into much detail with her daughter and would feel a certain level of discomfort with certain topics.

> Y*o nada más generalizo pero no toco ese punto ¿me entiende? Si sabes que ya tuviste relaciones, ¿cómo te fue? ¿qué paso?, …no, no, no. No se me mete en la cabeza que ella pueda tener eso. Yo no sé. Ella dice que no, pero no sé.*
>
> *[Translation] I only generalize but I don't discuss that point you understand? If I know you already had sex, how did it go? what happened?… no, no, no. It doesn't fit in my head that she can have that. I don't know. She says no but I don't know.*

In this exchange with Rosario, I again observed how parents wanted to believe their children who said they were not having sexual relationships, but more importantly that parents felt ill-equipped to handle detailed conversations and truthful responses from their adolescents. Therefore if parents are non-verbally communicating they cannot handle certain information or would prefer not to know, it is likely the adolescent is receiving this message and withholding information despite the parent's verbal message of openness and accessibility.

Similar to the parent interviews, adolescents described accessibility related to time. For example Sara (17 years old) often did not engage her father as often as she did her mother.

> *I don't usually because he works late and when he gets to the house he just wants to eat and relax and watch TV. I would give him that space because he's been working and I don't want to bother him that much.*

Similar to Marta who described not sharing information with her parents to avoid worrying them, Sara observes her father's need to decompress and so she withholds questions during the time he arrives home from work. However, in her interview and her mother's interview both described how as a family they were accustomed having

conversations about any topic in which the father and her older brother participated equally. Therefore in their case there were opportunities to ask questions and obtain answers during these family meetings. Alternatively, others like Maite (15 years old) described stressors that limited accessibility.

> *We had a lot of problems but at the same time she used to work so when I was finishing my eighth grade year she would be working a lot. So I would just be at home with my little brothers.*

Interestingly, feeling that she wanted more from her relationship with her mother, Maite pursued counseling and eventually convinced her mother to participate. In their separate interviews each of them told me that through weekly activities encouraged by their therapist (e.g., walking or dining out together) they began to mend their relationship and felt more comfortable talking with each other. The scenario reinforces that willingness and dedicated time even if brief can facilitate quality discussions between parents and children. An example of this is presented by Laura (16 years old) when I asked how she had developed such a grounded sense of herself to remain abstinent until marriage. Laura replied, "*Common little conversations in the car or at home. Not 'ok let's sit down and have the sex talk.' No; little bits here and there throughout my life.*" In this statement she addresses the frequency and informal nature of the conversations, despite her mother's verbalized concern in her own interview of not talking to her daughters enough or even about topics like dating. Overall, adolescents described having conversations with their parents when they had a question about what they had learned at school or somehow been exposed to in their environment (e.g., billboard, friends). Using these external cues could

aid parents in beginning conversations with their children and eliciting their thoughts and perspectives on the issue.

Specific Aim 2: Messaging about sexual health and pregnancy prevention

This study examined parental messaging on specific topics (i.e., sexual risk reduction, sexual health, and romantic relationships) and categories (i.e., health risk, social consequence, and moral consequence). Each is presented in separate sections and include both parent and child interview findings.

Topic: Sexual risk reduction

During interviews two options were discussed as mechanisms of decreasing sexual risk: 1) abstinence and 2) contraception. At times they were discussed in tandem and other times were viewed as mutually exclusive. First, parents addressed abstinence to decrease sexual risk. When asked what she teaches her children Margarita responded, "*En casa se practica lo único que se ha predicado y se predicara siempre es la abstinencia total. No hay opción para nada más.*" [*Translation: At home we practice the only thing that has ever been and will be preached always which is total abstinence. There is no option for anything else*.] Others shared similar messages about abstinence until marriage, but the tone was conveyed in a less authoritative manner, suggesting a desire rather than a rule.

> *Graciela: Le dije que a mí me gustaría que tú te abstuvieras hasta que ya tú fueras una persona mayor de edad. Claro que vas a tener un hombre al fin pero hasta que te llegue ese momento yo quisiera que te casaras y formaras tu familia. [Translation] Graciela: I told her that I would like her to abstain until she was older. Of course she is going to be with a man but until that time I would like her to get married and form a family.*

Isabel: Mira realmente de cómo prevenir el embarazo no te puedo decir que yo he hablado con ella. La única manera de la que yo he hablado de prevenir un embarazo es no teniendo sexo. Hasta ahorita es hasta donde he llegado. He estado pensando que ahorita que va cumplir sus 13 años va ser momento de yo explicarle.

[Translation] Isabel: Look in reality I can't tell you that I have talked to her about how to avoid getting pregnant. The only way I have spoken about preventing pregnancy is not having sex. Until now that's all I've said. I've been thinking that now that she is going to turn 13 it will be the time to explain it further.

Conservative beliefs were evident when the topic of contraception arose. For example Margarita, who claimed abstinence was the only form of contraception she discussed with her daughter, was aware that her daughter learned about contraceptive methods in school. However she added, "*No es un tema que hablamos en la casa porque es que ese tema sería ya algo que tiene que ver cuando se case y como todavía no tiene ni el novio."* [*Translation: It is not a topic we discuss at home because that topic would be something to discuss when she gets married and she doesn't even have a boyfriend.*] In her opinion, condoms were a form of birth control to be used within a marriage and the only scenario that would trigger her concern would be if her daughter had a boyfriend. Other parents were divided on the approach to encourage sexual risk reduction. Barbara shared, "*Como por ejemplo al de 17 años, yo lo he llevado a comprar condones. Y mi esposo me dice, '¿estás llegando a ese extremo?' Le digo que ya no es un extremo es una necesidad.*"

[*Translation: For example I have taken the 17-year-old to buy condoms. My husband says, "you've gone to that extreme?" I tell him it is no longer an extreme it is a necessity.*] While I did not get a sense from Barbara that her husband was against his son using condoms, he was obviously in disagreement with her active involvement purchasing them for her son.

Parents who encouraged condom use typically stated they wanted the adolescent to use condoms if they chose to have sex and in some cases offered to get the condoms for adolescents. However few parents were as explicit as Flor, the mother of a 14-year-old boy.

> *What I tell him is that condoms are not foolproof. The last time we talked he said, "Well what if you put two of them on?" So I was very blunt and I said, "Well then that defeats the purpose of having sex." But I don't think I have shared any other methods with him because I think the other ones depend on the girl, probably, maybe I'm wrong.*

Despite Flor's honest answer when talking to her son, she admits the discussion on contraceptives has been limited to condoms. Even among parents with daughters the singular form of contraception discussed was condoms. Alternate forms of contraception (i.e., shots and female condoms) were only discussed by two parents. However the most common form of contraception discussed in this study sample were condoms. Yet in some cases parents used words that indicated condom use but the word was not used. Olga said she used the word "*cuídate*" (take care of yourself) when her oldest son departed for an evening out. I asked her to contextualize what that meant when she used it in reference to her oldest son to which Olga replied, "*El sabe lo que yo le estoy*

diciendo – cuídate. Protégete, [tu cuerpo físico].*Con las hembras no he tocado esos temas así.*" *[Translation: He knows what I'm tell*ing him*- take care of yourself. Protect your body. With the girls I have not touched on those topics that way.]* Olga's belief was that her daughters would abstain until marriage and despite engaging in conversations with them about sexually transmitted diseases she had not bridged the conversation to discuss contraception with them. On the other hand, some mothers of daughters preferred to speak plainly.

> *Roxana: Le digo mejor llévate los condones y no tengas pena. Es normal. Yo sé que tú lo vas hacer. Si yo te digo que no lo vas hacer tú lo vas hacer. Entonces más vale que estés prevenida. Llévate los condones y así. Y me dice ella que no, que yo nunca voy hacer eso.*
>
> *[Translation] I tell her look its better if you take the condoms, don't be embarrassed. It's normal. I know that you are going to do it. If I tell you no you are going to do it. So then it's better that you are prepared. Take the condoms. Then she tells me no, I'm never going to do that.*

While Roxana certainly was clear with her daughter about using condoms, the message she sent of "knowing she would do it" potentially allows her daughter to live up to her mother's expectation that as long as she uses a condom there will not be a negative consequence. If Roxana's goal was to delay the onset of an early sexual debut, it may have been more effective to communicate her expectation of her daughter abstaining or delaying sexual relations while concurrently discussing the methods used in preventing pregnancy and disease. One of the two fathers who participated in the study was very clear about who talks to his daughter about sexual risk reduction.

Esteban: Pero del sexo yo no hablo con ella. Honestamente yo no hablo con ella. Mi esposa le pinta las cosas como puede ser. Inclusive yo creo que mi esposa le dice como aquí [in the United States] *ya es normal tener sexo pues que use preservativos. Y entonces como le digo yo no hablo con ella respecto al sexo, es mi esposa.*

[Translation] Esteban: But about sex I don't talk to her. Honestly I don't talk to her. My wife explains things how they could be. Additionally I think my wife tells her, because here [in the United States] *it's normal to have sex, to use contraceptives. So I don't talk to her about sex, it's my wife.*

It was clear Esteban felt unprepared and perhaps outside of his comfort zone having such a conversation with his teenage daughter. Despite this feeling, he recognized that the culture he lived in the United States was more permissive than that of his country of origin, which he uses as his reference point for more conservative values. While it certainly helped that Esteban's wife was also a youth counselor, this scenario supports the belief stated earlier by some of the mothers in the study that the responsibility of talking to children about these topics often falls to them. However, there also seems to be a contradictory message when mothers, such as Barbara described earlier, purchase contraceptives for their children and are then criticized by their husbands for being permissive.

From the adolescents' perspective, they were exposed to messages directly from their families and indirectly from friends. Commenting on what she observes with her friends' parents, Laura describes three sources of information: her mother, school, and her older brother.

Laura (16 years old): I was never taught that sex isn't an option; it's for when you get married. And then at school I learned about condoms but at first they told me straight out no, that is not an option. I mean of course my mom talked about condoms but not as much as you have to be abstinent. Abstinence, abstinence, abstinence. I learned more about birth control and condoms from my brother.

Some of the adolescents admitted they felt awkward when a parent talked to them about sex or sexually transmitted diseases. One teen shared how her mother urges her to think about the intentions of the person she is with. I asked her how she could distinguish a boy's intentions.

Maite (15 years old): Well I guess by the way that he acts. Because sometimes at school you see guys that are the player type that have a different girlfriend every two weeks and there's actually some guys that have been with a girl for years.

In her response, Maite had deduced the "*player type*" as those more likely to reflect a partner with poor intentions—to have a partner only to have sex—such as what her mother warned her about.

While the majority of the adolescent sample reported they had not had much sexual experience, one male adolescent reported vaginal sex with his previous girlfriend. I asked Antonio (14 years old) what kind of contraception he used when he had sex, and he mentioned using condoms. I followed up by asking what his parents had told him about having sex.

A long time ago they used to tell me it's better to wait until you get married and not to do it at a young age. But if I'm in love and we get to do it, well to not treat her bad or nothing like that, just treat her good.

Antonio was aware that his parents' wish was for him to delay early sexual debut yet the opportunity presented itself when the female partner's mother left for work. Antonio described how they used condoms "*most of the time*" and sex occurred at the girlfriend's house while there was no immediate adult supervision. Interestingly he also shares another element of his parents' message, which was to "*not treat her bad*" suggesting he should be cognizant of his partner and demonstrate respect towards her. I noticed that it was mostly parents of boys that included the element of showing respect toward a partner whereas parents of girls focused more on girls' respecting themselves. More on this topic is discussed later in the section on acculturation and respect.

Most of the adolescents acquired specific information about sexual risk reduction from school. However Miguel (14 years old) credited his knowledge to conversations with his mother.

> *She told me that there are not just condoms for males, that there is also a condom for women. So I didn't know that. She said those are more effective.* [Me: Did you know that there is also protection for oral sex?] *Yeah there's a finger condom. It's weird. My mom told me about the oral sex one that there is like a little square that you put in front of her and I was like oh.*

Miguel's comfort at discussing this topic with his mother is certainly unique when compared to most of the other adolescents in this sample. However the fact that his mother had this knowledge to share and that she did so openly and in a manner that Miguel was receptive to likely accounts for the ease with which he learned and later shared the information.

Topic: Sexual health

To increase knowledge about sexual health, parents described the types of information they shared with their children. For example, I asked Esperanza if she speaks to her children about sexually transmitted diseases in specific or general terms.

> *A veces en general. Pero siempre les hago saber que hay muchas enfermedades hoy en día. Las enfermedades se transmiten, pues ahí le digo, y me dicen si, ya nos han dicho en la escuela.*
>
> *[Translation] Sometimes in general. But I always let them know that there are many diseases nowadays. Diseases can be transmitted, so I tell them, and they tell me they have learned about it in school.*

In this case Esperanza was certainly broaching the topic of diseases; however, she did not provide specific information or engage her kids, therefore it was more likely that they would be dismissive of her attempt to hold a conversation. I noticed various parents who admitted to lacking enough information on the topic of sexual health and disease prevention relay the same reaction from their children who often answered "*yes we learned about it in school*." This was where the conversation ended for most of them. Few explained their struggle with not having enough information to engage their children as clearly as Rosario who told me, "*No sé qué hacer. Yo sé que me tengo que educar pero ¿dónde, cómo? ¿qué hago? Porque yo quiero que el crezca lo más sano posible.*" *[Translation: I don't know what to do. I know I have to educate myself but where, how? How do I do it? Because I want him to grow up as healthy as possible.]* I could feel Rosario's frustration at not having the tools and skills she needed to inform her son. Some parents reported they received books from family in their country of origin and a

few used the Internet as a resource. However it was clear that knowledge building was an area to develop further among the parent sample.

Others like Flor who had enough knowledge to provide explicit instruction struggled with empowerment versus permissiveness when thinking about the conversation she will eventually have with her younger daughter compared to her son.

> *I haven't decided if I'll buy both of them a condom at some point because I do want her to have the power. I don't want her to leave it up to some guy to carry her condom. But at the same time I want her to be a normal girl. I worry about the permission thing. Will the moment that I buy it, is it telling her, "Go" and I worry about that. No I don't know I haven't decided yet.*

Interestingly this was not the same concern she voiced with her son when she talked to him about using condoms. Flor's experience is consistent with what other parents who had both a boy and a girl described. They were more focused on adequately preparing the son to protect himself and avoid an early sexual debut. But parents assumed a more conservative stance with the daughter or they voiced a greater struggle about having the same conversation they had with the son.

Adolescents said their primary source of information came from school. Yet often the younger participants aged 12 and 13 years reported "forgetting" what they had learned in school. Their response suggests either a sense of embarrassment talking to me or perhaps a genuine lack of memory regarding what they learned given most reported little (i.e., kissing) to no sexual experience.

Topic: Romantic relationships

Overall these parents did not talk with their children about positive relationships or romantic relationships. However, mothers of daughters more often described messages aimed at preparing them to withstand pressure to have sex from a male partner or peer network, respect themselves, focus on academics, and avoid physical violence.

> *Margarita: Yo soy muy clara. Yo le digo, 'un muchacho va a querer solamente aprovecharse de ustedes si lo que quiere es tener sexo con ustedes. Un buen muchacho jamás va a querer tener sexo con ustedes sin estar casados. Simplemente son malas intenciones.*
>
> *[Translation] Margarita: I am very clear. I tell them, "a young man will only want to take advantage of you if all he wants is to have sex with you. A good man will never want to have sex with you without being married. They are simply bad intentions."*

Beyond suggesting that a "*good man waits"* Margarita also used her message to reinforce her belief in and teaching of abstinence until marriage. Speaking with her daughter, Susana similarly characterized men as only interested in one thing.

> *"Ellos los muchachos son tremendos. Pues si la mujer va, ellos encantados de la vida. Los hombres lo que quieren es eso, mi hija, nada más. Que tú le des chance o le des entradita y ellos son felices. Pero si tú te das a respetar todo marcha bien," le digo.*
>
> *[Translation] "They, young men are terrible. Because if a woman gives in, they are delighted. Men, all they want is that, my daughter, nothing more. That you give them a chance, give them just enough leeway and they are happy. But if you respect yourself everything goes well," I tell her.*

Susana's advice reminded me of a message I heard throughout my own adolescence, "*El hombre propone y la mujer dispone*." [*Translation: The man propositions and the woman decides.*] Both messages suggest that by not succumbing to a male partner's advances the woman demonstrates respect for self and avoids being used for sex. While it is certainly helpful for mothers to prepare their daughters to navigate unwanted sexual advances and to recognize they have a choice to have sex or not, these messages carry a reactive tone. A counterbalance is missing to communicate how in a good relationship between consenting adults there will be mutual respect and agreement about if and when to engage in a sexual relationship. To fully empower their daughters, mothers can augment their message by not only warning against bad behavior, but also encouraging positive characteristics of good relationships. Ana provides an example of a message that begins to address positive relationship traits such as love and affection.

> *Entonces le digo a ella, "tienes que estar segura de lo que vas hacer. Tu primera vez es algo que nunca se te olvida. Entonces que sea un día especial con una persona que tú quieras. No nada más porque quieras perder tu virginidad porque tus amigas dicen."*
>
> *[Translation] So I tell her, "you have to be sure about what you are going to do. Your first time is something you will never forget. So let that day be special with someone that you love. Don't just do it because you want to lose your virginity or because your friends tell you to."*

Similarly, Estefania talked to her daughter frankly about having sex and grounding her priorities.

Tarde o temprano lo vas a vivir, lo vas a experimentar. Y es bonito como te dije pero con la persona que tú quieras y a su tiempo. No antes. Tu meta - enfócate en estudiar en hacer tu futuro, salir adelante, y ya después viene todo lo demás. [Translation] Sooner or later you are going to live it, you will experiment. It is nice like I told you but with the person that you love and in time. Not before. Your goal- focus on studying and making a future, moving forward, and later everything else comes on its own.

Estefania wove two messages in one. In this case she expresses her wish for her daughter to delay early sexual debut until she finds someone she loves and that her present concern should be on her academic preparation. Most parents who asked their children to delay having sex for later in life coupled their message with a focus on academics.

Some mothers also shared histories of abuse at the hands of their partners and it was evident that their personal experience influenced their messages regarding relationships.

Rosario: Yo le digo, "prepárate hija, el día que tú te cases si un hombre te pega una vez, déjalo. Porque el que te pega una vez te pega siempre. Y si te engaña una vez, déjalo, porque el que te engaña una vez te engaña siempre." [Translation] Rosario: I tell her, "prepare yourself daughter, the day that you get married if a man hits you once, leave him. Because the one that hits you once will hit you always. And if he lies once, leave him, because he will lie forever."

Rosario's intent, based on her own experience, was to help her daughter avoid the violent experience she endured with her partner. It is likely that she is unable to draw from a positive relationship experience to counterbalance the empowering message she

attempted to deliver – do not accept violence at the hands of a partner. However, it may be possible to support parents like Rosario to frame the message in a way that promotes positive behaviors while still communicating that violence is never acceptable.

Mothers of boys however did not use messages warning them about women making untoward advances. Instead their messages focused on teaching their sons to respect women. Alicia's message to her son is an example of what I often heard from these mothers, "*Para tener una relación tienen que estar casados, tienen que respetarse, y ser fieles. No maltratar a la mujer ni la mujer al hombre porque eso es algo mutuo.*" [*Translation: To have a relationship* [sex] *you have to be married, you have to respect each other, and be faithful. Don't mistreat the woman nor should she mistreat the man because that is a mutual thing.*] It can be argued that in this message there are more examples of positive relationship characteristics than in those shared by mothers of daughters. However, I learned from the interviews that mothers of daughters believed there was more at stake if daughters had sex early (i.e., pregnancy) compared to boys. As a result this basic premise may have been the primary reason relationship and contraceptive messaging differed between boys and girls.

When asked about romantic relationships, most of the adolescents stated they had not had conversations with their parents about this topic, but were told to wait on dating. Laura (16 years old) used humor to convey the expectation her mother shared with her.

> *She* [mother] *gave me until I'm 18. I can date when I'm 18. Sometimes I play around. When I'm 18 I'm going to introduce you to the boyfriend that I've been keeping from you and she looks at me and I say, "you know I'm kidding."*

These messages about waiting until a particular age or phase of life such as college were most often heard from adolescents whose parents advocated abstinence as the primary and often only means of sexual risk reduction.

A few of the teens stated they believed their parents modeled a good relationship based on closeness or longevity of the union.

> *Lissette (17 years old): They've been married for 25 years now. I think if that's not a good marriage I don't know what is. They are very happy. I mean of course they have fights and what not but they'd do anything for each other at the end of the day.*

Lissette captures the reality of a relationship that has its ups and downs but also highlights the feeling her parents have expressed over time "*they are very happy*." However, most interesting were the traits the adolescent participants used to describe what a good relationship meant to them such as trust, respect, loyalty, shared beliefs, and not fighting over petty things. Despite their age range the adolescents in this study demonstrated a deeper understanding of relationships than what I had expected.

> *Maricela (16 years old): So now it's just like getting to know the guy and his likes and dislikes and that he respects what I do and my decisions and what I want to do when I get older.*

Maricela compares her shift in thinking after she became more involved in the church and was no longer seeing the boyfriend with whom she had sex at 15 years of age. Miguel (14 years old) transcended the stereotypical response expected from a boy his age when he spoke to me about a good relationship saying, "*Everything is not serious and always making out and cuddling and all…we can just chill, watch TV, play X-box and nothing*

sexual has to come up." Even Marta (12 years old) who struggled to give me a full sentence throughout her entire interview shyly said, "*It's like when you're not rushed to have any type of like…* [Me: sex or physical relationship?]*...Umhmm.*" While it is not possible from this study to absolutely discern how or where adolescents developed these concepts, the larger and more important lesson is these teens have begun to establish their beliefs about positive relationships. Parents have the unique opportunity to expand upon positive behaviors because it is an area that is not discussed in the school curriculum. By nurturing these conversations, parents can build trust with their children and elicit their thoughts and feelings on the topic to enable discussion about more sensitive topics such as sexual health and pregnancy prevention.

In addition to the three message topics discussed thus far, I examined three messaging categories derived from the second scale administered to parents and adolescents: 1) health risk, 2) social consequence, and 3) moral consequence. Findings are discussed in the following section organized by category.

Category: Health risk

Health risks presented in the scale (pregnancy, sexually transmitted disease, and HIV/AIDS) were associated with unprotected sex at an early age. During interviews I asked whether any of these three outcomes were mentioned or if parents described additional health risks. Parents mostly told their children that having sex could lead to becoming pregnant or getting a disease. However, most discussions remained broad and non-descript. For example, Susana told her daughter, "*Empecé a decirle, 'hija no tienes que hacer eso porque es malo, puedes agarrar enfermedad'.*" [*Translation: I started to tell her, "daughter you don't have to do that because it's bad, you can catch a disease."*]

The mention of a sexually transmitted disease was reduced to "disease" and the word "sex" or similar reference was not used explicitly, instead sex was referred to as "that." Few parents reported providing specific details on associated health risks, but the few who did were explicit about contraception or disease transmission.

> *Berta: A él le enseñaron* [sobre] *los preservativos. Entonces yo agarre y me puse a platicar con él y le dije mi hijo esto es algo natural. Lo de los condones no es nada malo. Esto se usa cuando tú ya vas a tener una relación íntima con una persona cuando ya sea tu momento. No es porque la persona este enferma. Para prevenir cualquier enfermedad y para evitar un embarazo.*
>
> *[Translation] Berta: They taught him* [about] *the contraceptives. So I started talking with him and I told him it was natural. There is nothing bad about condoms. It is used when you are going to have an intimate relationship with a person and it is your time. It's not because that person is sick. It is to prevent any kind of disease and a pregnancy.*

Berta surprised me because despite preaching abstinence until marriage to her children and reporting her devout faith she believed it was necessary to answer their questions directly and comprehensively. She was one of the few parents who also described how she elicited her children's opinions by asking them what they thought about what they observed or learned from their environment. Berta said she was committed to educating her children so they would not grow up lacking information, as she had experienced in her own youth. While most parents in this study said they had talked to their children far more than they had experienced from their own parents in their childhood, parents lacked the knowledge of, and felt ill-prepared to discuss specific details about sexual health and

associated risks. Another mother stated she mentioned disease names (e.g., AIDS and gonorrhea) when talking to her daughter, but preferred to use analogies about the disease transmission process.

> *Roxana: Es como cuando cocinamos cuatro comidas de diferentes sabores tienes que tener una cuchara para esta y otra cuchara para esa. Porque tú metes una a las cuatro vas echar a perderlas todas. Entonces le digo agarra una limpia. Así pasa con las personas. Si tú te metes con varios muchachos o el muchacho se mete con varias chicas y tú te toca te fregaste: te contagia de una enfermedad. [Translation] Roxana: It's like when we cook four meals with different flavors you have to use a spoon for this one and another spoon for that one. Because if you stick one into all four meals you are going to mess them all up. So then I tell them grab a clean one. The same happens with people. If you get involved with various guys or a guy gets involved with various girls and you get it then you got messed up. You will have gotten a disease.*

Although simple and non-specific the analogy easily conveys how diseases are spread without protection. However, beyond stories such as the one Roxana relayed here or the details Berta shared with her son, most parents concluded their discussion of health risks by mentioning outcomes (i.e., pregnancy, sexually transmitted disease) but not the processes behind these or the effects of these outcomes on their developing bodies.

All of the adolescent participants were able to recall a class on sexually transmitted diseases in school, with AIDS being mentioned most. The curriculum in the state of Georgia promotes abstinence as the main method of preventing disease and pregnancy, although classes may also discuss contraceptives. Teens who discussed

religion as a prominent aspect of their home and extracurricular life unanimously said abstinence was the only foolproof approach to preventing disease and pregnancy. For others when they recalled parental messaging regarding pregnancy or diseases, various approaches were noted.

> *Luis (13 years old): We* [with mother] *were talking about a show called Two and a Half Men. So then we were talking about when he gets laid, mostly every day but I think he never gets them pregnant. So we were talking about stuff like that. She likes the show but she doesn't want me to do that if I'm older. I don't want to have sex every day with other people that I don't know.*

Luis' mother used a television character's risky behaviors to express what she wanted her son to avoid. While it is reinforcing to know that she used this environmental cue to engage her son, it may have also been practical to elicit his thoughts about how the character is exposing himself and his many partners to disease and a potential unplanned pregnancy and whether he used contraception to avoid these risks. Therefore with some guidance the conversation could have provided fertile ground to develop the topic further between Luis and his mother. Later in the interview he discussed awareness of condoms, their use, and where to purchase them.

Adolescents like Maribel (16 years old) said her mother had been explicit with her, as she described it to me, "*She* [mother] *would tell me whenever I want to have sex to tell her; or she would tell me what condoms were for and how to keep myself safe from getting pregnant early.*" However, Maribel was dating a boy three years older than her and he pressured her to have sex, which ultimately resulted in one sexual encounter and a pregnancy. During her interview Maribel noted that pressure from her older boyfriend,

fear of losing him, and her inability to negotiate or even mention condom use were all contributing factors to why she did not use a condom. This example highlights the need for consistent and open conversations about health risks so that adolescents can better understand that one unprotected sexual experience can alter their life course. Additionally Maribel's story highlights the need to teach condom negotiation skills and promote positive relationships.

Category: Social consequence

Social consequence encompasses messages that communicate feelings of embarrassment from outcomes related to early sexual debut (e.g., pregnancy, STI) or obtaining a bad reputation. Various parents used relatives or their children's friends as examples of the challenges associated with early sexual debut. When Beatriz's daughter came to her to relate that one of her classmates was pregnant, Beatriz told her, "*No lo hagas como lo hiso ella pero si admírala porque ella hizo a un costado la vergüenza o lo que dirán y siguió adelante estudiando. Pero no la tomes como ejemplo.*" [*Translation: Don't do it the way she did it but you can admire that she put aside the embarrassment or what people would say and kept studying. But don't use her as an example*.] In her message Beatriz highlighted social consequences that her daughter's friend experienced. She was also clear with her daughter that she did not want her to follow the same path. Unlike messaging she gave her older son focused on health risks, contraception, and respecting a female partner, Flor's message to her daughter had social consequences associated with it.

As she gets a boyfriend I will tell her what's appropriate… you have to have some respect for your house, for yourself, for how others see you. So reputation will still be not as important but still important.

Reputation was never mentioned when she talked about messages she delivered to her son. The only times it was mentioned during her interview were when she discussed her own childhood and becoming a teenage mother and then again when referring to how she would approach her daughter. Based on these instances, reputation is important to a girl's early sexual debut, but not to a boy's. This gender role discrepancy was further reinforced by most of the mothers who related social consequences such as embarrassment and a bad reputation as common outcomes observed in their youth. However mothers in this study reported trying to focus less on social consequences and more on the loss of carefree adolescent years to care for a child, having to work to support the child, or dropping out of school. The following example demonstrates how Roxana discussed setting aside social consequences when talking to her 16-year-old daughter who had a baby.

Pero todavía no es todo tarde porque va seguir su vida, que espero que este tropiezo que tuvo le sirva...que piense si va hacer sus cosas pero que sea responsable de sus actos. Y la gente siempre va hablar que esta niña con ese se metió aunque no sea cierto.

[Translation] But it's still not too late because your life will continue, and I hope that this misstep she had will help her… to think if she is going to do her things but to be responsible for her actions. People are always going to talk that this girl got involved with this guy even if it is not true.

Roxana aimed to prepare her daughter for what others may say, but reinforced that her daughter's concern should be on taking care of herself and her young child. Her message demonstrates a shift in her perspective from what she knew in her youth to how she has chosen to educate her daughters.

Adolescents presented similar perceived social consequences found among the parent sample. Laura (16 years old) noted that students in her school could obtain condoms from the nurse's office and I asked if she knew people who did, to which she responded, "*No not from the nurse's office because that gives you a bad rep. It's like wow they're desperate to get laid… they'll go to the nurse's office!*" Beliefs such as the one Laura shared could potentially be a barrier to adolescents reluctant to obtain condoms in school for fear of being labeled as promiscuous. Boys who were asked what they thought would happen if they got a girl pregnant at this age often responded similarly to Antonio (14 years old).

> *My dad would tell me to get a job and probably drop out of school and just start working my whole life and try to get as much money as I can so that when my baby grows up he won't have to be poor and just take care of the girl I'm with*.

While it was certainly Antonio's perception of what his father would say to him, I noticed a sense of assuming a provider role more common in boys. Alternatively girls often described a social consequence. I asked Leticia (12 years old) what her mother has told her about potential consequences of sexual activity to which she replied, "*She said if I have sex this early I could get any kind of disease and if I got pregnant she said that it would be embarrassing. I mean I would be embarrassed about that.*" Similarly, Marta (12 years old) whose 16-year-old sister had already had a baby told me that if she got

pregnant early, "…*everybody would be disappointed in me; it's not right to get pregnant at my age.*" Leticia and Marta's descriptions were in line with social consequences associated with embarrassment and damaged reputations, whereas Antonio's response did not reflect those components. These findings reinforce that when social consequences are discussed, they are more likely directed toward girls than boys.

Category: Moral consequence

The message of moral consequence refers to regret or guilt over an early pregnancy or acquired sexually transmitted disease. Overall parents reported these messages were more common in their own youth compared to those they shared with their children. When a message containing a moral consequence was discussed, it was often filtered through the lens of religion to reinforce and guide behavior.

> *Margarita: Si en la conversación que estamos teniendo surge algo que no está de acuerdo con lo que yo le estoy enseñando, yo en ese momento corrijo. Yo doy el consejo y no sólo un consejo de mi parte sino de presentarle lo que la Biblia dice con relación a eso.*
>
> *[Translation]Margarita: If in the conversation we are having something arises that is not in agreement with what I'm teaching, I correct it at that moment. I give advice and not just on my behalf but also what the Bible says related to it.*

The Bible is often used as a guide to distinguish between right and wrong. While Margarita did not specify that she talks about guilt or regret, she mentions using the Bible to help guide her child's behavior and thereby correct what she perceives and what the Bible says is wrong. Conversely some of the mothers held strong moral beliefs, but they

described placing them aside when imparting a message. Flor described her son's apprehension to messages containing a moral tone.

> *I don't talk about the moral part of sex because I've tried a couple of times and I see his rejection to it. And I rather have his trust in me than fear that he is going to get in trouble when he does decide to have sex.*

Flor's strategy to withhold discussing regret or guilt associated with early sexual debut is based on observing what message type works best to engage her son in conversation. Flor was the only parent who seemed to tailor her message based on her child's reaction. Most of the parents described how, when they delivered such a message, their child might complain or simply stop talking. Therefore her ability to observe and refocus messaging was an enabling factor in maximizing her son's openness and receipt of the information.

Some parents described moral consequences as right versus wrong when they addressed having multiple sexual partners. For example Rosario told me, "*Si quieren tener sexo, mi punto de vista es que no está bien que tengan sexo con uno y con otro y con otro. Pero en fin si es lo que quisieran hacer, deben protegerse.*" [*Translation: If they want to have sex, from my point of view it is not right to have sex with one and then another and another. But in the end if that is what they want to do, they must protect themselves.*] In this example it is evident that Rosario placed her own beliefs aside in the second half of the statement when she promotes use of condoms if multiple sexual partners are planned. However, I did not discuss whether she thought not using contraception within a monogamous relationship was acceptable. Distinguishing between advice to use a condom with only one partner versus multiple partners may be an area for further exploration in studies on parent and child communication on the topic.

Overall, adolescent participants did not describe parental messages that carried moral consequences of guilt or regret. Younger adolescents (12-13 years) compared to their older counterparts (14-17 years) more often discussed abstinence until marriage and also used comments very similar to what their parents expressed. However, a few exceptions were those older adolescents who practiced abstinence. For example, Laura (16 years old) described a casual incident riding in the car with her mother and passing a billboard about AIDS, "*See they are perfectly normal people but they are suffering on the inside and that's probably like how people who have sex are feeling and now they're feeling really dirty and that's why you shouldn't do it.*" Laura's mother was reinforcing her message of abstinence by stating that early sexual debut would make her feel dirty (i.e., guilty, regretful) particularly if it resulted in a sexually transmitted disease. Maricela (16 years old) who had previously been sexually active had joined a church and decided she would practice abstinence. I asked her what lessons she was obtaining on the topic of sex from her church teachings. She replied in a mix of Spanish and English.

> *Eso es un pecado* [That is a sin] *having sex before marriage. Eso yo lo se entonces* [I know that so] *that's why one of the main reasons I don't do it is because when I was sexual I wasn't thinking that. That was my past and I know that God left my past behind.*

Maricela describes sex before marriage as a sin, something you would feel guilt or regret about following its occurrence. Now that she has become aware of her behavior through her affiliation with the church she has chosen another path. Interestingly her mother did not deliver these messages nor was she involved in the church.

This example demonstrates that messaging can be delivered by other sources with successful results as evidenced by Maricela's story.

Specific Aim 3: Cultural Factors

Cultural factors in this study were expressed using two components: traditionalism and familism. Traditionalism was previously defined as comprised of various concepts. Of those described conservative beliefs and values, religiosity, gender roles and respect for elders in authority were observed in participant interviews. The concept of respect was particularly salient. The section concludes with the second component of acculturation, familism, the valuing of family as the primary source of support and one's identify.

Conservative beliefs and values

Conversations with parents yielded a continuum of conservative beliefs and values. Consistent with the literature on primarily immigrant Latino populations, parents in this study held a conservative stance regarding their adolescent's sexual activity. Parents discussed that having sex at a young age is not appropriate and some also mentioned their plan to chaperone or have another family member chaperone their daughter on an outing such as Estefania did when her daughter asked to go unaccompanied on a group outing to the mall with friends. She stated, "*Si quieren yo los llevo con mucho gusto. Mientras yo vaya y sepa con quien va pues está bien.*" [*Translation: If you want I will happily take you. As long as I go and know who is going then it's OK.*] In contrast, chaperoning was not presented by parents of sons. Some of the parents expressed that they wanted their children to wait until marriage to have sex; a feeling that was mostly prevalent among those who had daughters and attended church regularly. A few of the mothers who were married to the father of their children believed

they modeled marital and familial values in their home. For example Olga refers to her children's awareness of how she and her husband modeled family life stating, "*Y como veían que uno reforzaba tanto los valores, el de casarnos, el de no salir embarazada. Nos ve como somos, nos ve como nos comportamos, como estamos de involucrados en la iglesia.*" [*Translation: And since they saw that we reinforced values so much, that of getting married, not getting pregnant. They see how we are, they see how we behave, how we are involved in church.*] However, parents also discussed concepts that were inconsistent with their conservative beliefs and how they had to adjust to these incongruences.

> *Barbara: Cosas de las que uno miraba con respeto, ya aprende uno a mirarlas, como decir, bueno ya pasó. ¿Qué más nos queda? Y para mí anteriormente…no era que me persignara, pero si era de las que yo decía que mis hijos no van a ser así. No mis hijos van a estar bien educados. Y ahora miro y digo ¿para que hablaba? Los hijos no son como uno quiere.*
>
> *[Translation] Barbara: Things that one looked upon with respect, you learn to look at them like well it happened. What else are we left with? And for me previously…it wasn't that I would make the sign of the cross but I was one of those who said my children are not going to be like that. My children are going to be well-behaved. And now I look and wonder, why did I speak? Kids are not how one wants them to be.*

Part of what Barbara was referring to was that her oldest daughter had gotten married early and had a child and that her sons were in her words "*more rebellious*" and would sometimes go out without permission. Her quote expresses her struggle to assimilate the

rules she grew up with and those she and her husband used to manage their family in the United States. Barbara believed that the lifestyle in the United States where both parents had to work outside the home was not conducive to monitoring children's unsupervised time after school. Other parents described a different set of challenges, however. During her interview, Olga admitted that two of her children were gay, and she struggled with this truth.

> C*uando ella me ha hablado de las inclinaciones sexuales para mí es un total escándalo. El varón lamentablemente podríamos decir es homosexual. Y cuando descubrimos eso para nosotros fue como un balde de agua caernos encima. Por nuestra creencia cristiana, por nuestra formación, por nuestros valores, por los ejemplos que le hemos dado… con la Biblia en la mano le digo "mira esto es lo que Dios piensa." Esto es lo que nosotros pensamos. Y esto es lo que tú estás haciendo. Tú vas a tener un amor incondicional de papá y mamá. Pero tú sabes que no fue lo que te enseñamos… que no es lo que a Dios le agrada.*
>
> *[Translation] When she talked to me about her sexual preferences, to me it is scandalous. The boy sadly we could say is homosexual. When we found out, it was like a bucket of cold water falling on us. Because of our Christian beliefs, our upbringing, our values and the examples we've given… with the Bible in hand I tell him "look this is what God thinks." This is what we think. And this is what you are doing. You will have unconditional love from mom and dad. But you know this was not what we taught you… it is not what pleases God.*

The message in this quotation clearly reflects the clash between parental conservative beliefs and values and the reality of their children's lives. This clash contributed to a gap

in communication for some as parents referenced scripture and children struggled to balance their upbringing with being true to themselves.

Most parents admitted that unlike their own childhood where little information was received directly from their parents, they wanted to talk openly with their own children. Roxana advises her daughter to observe a boundary at liking boys. She gave her daughter the following example telling her, "*Pues me gusta ese muchacho pero hasta ahí. Pero hay que diga me gusta ese muchacho, con el me voy acostar; o me gusta otro, también lo voy hacer. No, eso no.*" [*Translation: Well I like that boy, but stop there. But some may say oh I like that boy I'm going to have sex with him; or I like another I'm also going to have sex with him. No, not that.*] Roxana was communicating to her daughter that while it was fine to like boys it was not necessary to have sex with them and certainly not acceptable to have multiple sexual partners. Other parents used a different approach wanting to be honest with their children and telling them that sex is not bad and feels good, but they should not rush into it.

> *Isabel: Yo le he hablado por ejemplo que yo sé que a la edad que ella tiene sensaciones, uno tiene necesidades, uno tiene ganas, hablándole sexualmente. Todo a tu tiempo, no corras. Vas a disfrutar, vas a tenerlo. Esperen.*
>
> *[Translation] Isabel: I have talked about for example that I know at her age she has sensations and needs, wants, speaking sexually. Everything in time, don't rush. You will enjoy, you will have it. Wait.*

Similarly, Flor and her husband spoke honestly about sex, but paired the message with the outcomes of sexual activity.

One of the things that my husband and I always have talked about is telling him that it does feel good to have sex. We've never told him sex is horrible. It's going to feel good but these are the consequences.

Flor and Isabel represented a less conservative stance than others in the sample. Both had immigrated to the United States while still teenagers, a factor that may have influenced message content given their upbringing in two cultural settings. Despite their openness both were also consistent with their message of not rushing to an early sexual debut.

Adolescents also shared their reactions toward their parents' conservative values. Maite (15 years old) described an example regarding her mother's request to meet her boyfriend telling me, "*I guess she always wanted that to happen. She actually wanted me to tell her and have the guy come over. Yeah, but it's awkward…formal*." Whereas Maite's mother likely wanted the opportunity to assess whom her daughter was interested in, Maite viewed the "meeting" as overly formal perhaps for the status the boyfriend occupied in her life. Becoming aware of the adolescent's social network may be one way for parents to monitor their child's friend and romantic relationships more closely. Overall, conversations with adolescents about their conservative beliefs and values were less prevalent than in the parent interviews, much as I had expected given the different cultural settings and generations.

Religiosity

Religiosity has often been an element connected with Latino culture, particularly among immigrants who retain devoted religious practice and beliefs from their home country. Religion in this study emerged as a moral compass and as a supportive parental resource. Parents who were actively practicing their religious faith with their children

believed that a Christian upbringing is important and the Bible may be used to teach about relationships and guide people as stated by Margarita.

> *La Biblia no es religión; la Biblia es la palabra de Dios. Y la palabra de Dios es muy clara y habla específicamente de las relaciones personales entre el prójimo, entre esposo y esposa, entre los hijos entre los padres. Da consejos para los padres y da consejos para los hijos.*
>
> *[Translation] The Bible is not religion; the Bible is the word of God. The word of God is very clear and speaks specifically about personal relationships between neighbors, husband and wife, children and parents. It gives advice to parents and guidance to children.*

Other parents while not engaged in an organized religion recognized that their child who was actively involved in the church had positively benefitted from the experience, dressing more modestly and changing their previously combative behavior. Susana told me, "*Y es lo que me dijeron en la escuela, cambió mucho tu hija. Y ojalá así siga dicen. Pues está muy metida en la iglesia. Pues si sigue así, pues está bien perfecto*." [*Translation: And it's what they told me, your daughter has changed a lot. Hopefully it will remain that way. She is very involved in the church. If she stays that way, then it's fine, perfect*.] This mother viewed her daughter's church involvement as a positive turning point in her life and encouraged her continued involvement despite not being part of an organized church community herself.

For some teens, religiosity was represented as a spiritual connection or a social custom, while for others it offered a support network. Those who regarded religion as

spiritual included Maricela (16 years old) who described her experience in English and Spanish.

> *I do consider myself having a relationship with God and a communication with him... I didn't go to church at all, I used to dress like a guy. It was crazy; it was como una etapa que ya pasóo* [like a phase that has passed]. *Now it's like going the right way and I know that I am. God changed me.*

On the other hand, attending church groups was seen as a way of socializing for some teens such as José (15 years old).

> *And they have activities like today they have firesides and they just talk a lot. Sometimes they go to the malls and do activities and people dress up in costumes and you have to walk around and look for them.*

Religiosity therefore presented itself as tangible outcomes in the teens' lives as opposed to abstract guidance noted by some of the parents.

Gender roles

Parents discussed traditional gender roles as they pertain to which parent should educate children on the topic of sexual health and pregnancy prevention, variation of message content as it relates to a child's gender, and countering negative messages based on machismo beliefs. While this study contained more mothers than fathers, my respondents noted that women are most often placed in the role of educating the children about the topics of puberty and sexual health. However there were variations depending on the familial makeup (e.g., married and single parent households) and even between married couples. Roxana remarked that her husband initiates conversations with their daughters independent of speaking with her about it stating, "*El sabe cuando le toca*

hablar, no le voy a decir, el no me pregunta, ¿le digo esto? El sabe, a él le salen las palabras y se lo dice a ella." [*Translation: He knows when it's his turn to speak, I'm not going to tell him, he doesn't ask me, should I say this? He knows, the words come to him and he talks to her*.] Conversely, there may be times when parents who are separated may present dual and opposing messages, such as what Estefania described.

> *Él me dijo que su papá le había dicho que no le importaran las mujeres cuando estuviera más grande. Qué pues eso lo hacen los hombres. Entonces le digo que tú el día de mañana no vas a crecer con esa conciencia, que vas por aquí o por allá y se queda un niño como decimos nosotros rodando por ahí. Pues eso no se me hace justo. Él dice OK mami, yo no voy hacer así.*
>
> *[Translation] He told me that his father had told him that women should not matter to him when he grew up. That is what men do. So I told him that he would not grow up with that thinking that he can go around here and there leaving a child like we say rolling around. I don't think that is fair. He says OK mom, I won't be like that.*

While it certainly helps that Estefania counteracts the message and reinforces positive behavior, there is a risk her son will align himself with his father to gain his favor. Estefania's situation highlights one of the many challenges that single mothers in this study described in having conversations with their sons. Olga represents another variation on parental approaches.

> *Cuando mi esposo y yo hablamos, él es como más penoso para tocar ese tema a los muchachos. Entonces dice, "tú se lo tocas, tú le dices." Pero él y yo si dialogamos que pensamos. Que hacer, como hacerlo, dile tú, dile tal y tal cosa.*

[Translation] When my husband and I talk, he is shy about discussing those topics with the kids. So he tells me, "you bring it up, you tell them." But he and I discuss what we think. What to do, how to do it, you tell them this, say this other thing.

Olga demonstrates how she and her husband jointly discuss what they want to communicate to their children although she does the actual message delivery. These examples show the diversity of messages and styles used by parents in this study.

The role of fathers in the sexual education of Latino children could not be fully explored given that only two men chose to participate. However some female participants elaborated on the father's role. Barbara, the mother of one of the male adolescents, suggested that mothers are often the only parent initiating conversation on these topics.

Casi la mayoría de los hispanos le dan la responsabilidad a la esposa… Tenemos amistades mi esposo y yo, y casi todas las señoras comentan y todas coincidimos casi lo mismo: que los papas siempre le avientan a uno toda la responsabilidad. [Translation] The majority of Hispanics leave the responsibility to the wife… We have a group of friends my husband and I, and almost all the women comment and we all agree that fathers always throw all the responsibility to us the mothers.

While Barbara did not discuss the reasoning for this, she went on to describe how she encourages her husband to build trust with their sons by talking about contraception and other related topics. Another parent shared that her own father had made it clear that discussion about sex was "*woman's talk, not for men*." Therefore, it is possible that, culturally, Barbara's observation may be an unwritten rule where women are assumed to have the responsibility for educating the children on sexual health and disease prevention.

Some mothers also discussed that their male partner's role was not to be involved. In some cases, the mother preferred it this way because the children were not the partner's biological children. However, for some men, gender role was not the barrier, rather it was a feeling of embarrassment. Some women reported their husbands were "*embarrassed to talk*." Of the two fathers in this study, one took an active role in conversation with his daughters while the other believed it was clearly his wife's domain given her career as a counselor. The role of fathers in parent-child communication and the experiences they have is an area that continues to need further exploration.

Adolescents also described different parent roles regarding messaging and dichotomous teachings, particularly if there were boys and girls in the family. For example Lissette (17 years old) recalled the following scenario.

> *They always told my sister and I to date somebody you have to bring them home first. You can't do all this stuff before. You get married. But with my brother they encourage him to do it. It's kind of weird actually. My dad especially would always ask if he got a girl.*

When I asked Lissette if her father said something similar to her and her sister she replied, "*Oh no. Absolutely not. My dad would kill any guy who would try to touch us. So it is completely different.*" Similarly Isabel remarked that her husband had different rules for his teenage son compared to his three young daughters, stating he did not want them to start dating at age 16 despite that being the age his son began dating. These examples underscore how both adolescents and parents, primarily mothers, recognize there are gender differences in message type and that fathers may not be as involved in the

delivery of sexual health and prevention messages due to embarrassment or not viewing this as part of their parental role.

Respect

The element of respect, described as a component of traditionalism, has often been associated with reverence for elders. In this study variations of respect also arose in messages about decreasing sexual risk and having romantic relationships as described earlier. These variations included respect between parent and child, and respect for self and for a partner.

Respect between parent and child suggests that parental authority is observed by the child. While most of the parents in this study claimed that the topics of sex and pregnancy were not discussed in their own childhoods out of "respect" for the parent-child relationship, there appeared to be carryover of this feeling into how some of the parents handled their children. In one instance described earlier, Barbara remarked that she and her husband disagreed about her choice to speak openly with her three sons about sex and contraception. He believed she was encouraging disrespect from her sons, and it appeared her actions were in conflict with his expectation of how parents and children should interact.

"Respect for self" was often intended as a way for the daughter to receive respect from others. Beyond sharing the direct message that teens should behave in a way that demonstrated self-respect, parents also conveyed the social consequence of having sex at an early age would result in others losing respect for the woman (girl). Closely tied to the discussion of self-respect, respect for partner was discussed by some participants. Flor

described her struggle talking with her 14-year-old son given the environmental influences that contradicted her message about respect.

> *I have talked to him a lot about respecting girls. It's very hard to convince boys to respect girls because they hear on the radio all the time how girls are not worth anything. So even for me that I'm very aware of it it's very hard to convince him that you don't call a girl names…*

During interview conversations about preventing sexually transmitted diseases, some of the younger boys said their parents' message was to wait until marriage and not treat the girl "*bad"* but with respect. Miguel (14 years old) told me he doesn't ask if a girl is taking birth control "*out of respect*." This same teen suggested that when a girl demonstrates resistance to having sex, he felt respect for her.

Girls, more than boys, received the message of respecting themselves and in some instances the added warning that lack of respect for self would lead boys to disrespect them. Conversely, boys who received messages about respect were more likely to hear it in the context of it being their responsibility to treat women with respect. The danger in hearing a young man say he does not ask for proof of contraception "*out of respect"*" is that a partner may be withholding the truth and place both partners at risk. Girls may decide not to ask a partner to wear a condom "*out of respect*." The critical aspect of respect between partners is to define sexual responsibility where both partners are responsible for contraception and birth control to prevent an early pregnancy and sexually transmitted diseases. Additionally both should respect each other's wishes to consent to sexual activity. Based on findings here, parents could augment the information children

receive in school by discussing respect in terms of how to talk about contraception with a partner and the importance of consent to engage in sexual activity.

Familism

The component of familism was expressed more subtly and in a variety of contexts from spending time as a nuclear unit to imposing rules of appropriate behavior. Participants described family closeness as verbal affection, eating together, and equal distribution of chores in the home. A few of the participants described holding family meetings to discuss matters such as grades, behavior problems, outings, and even finances; but no one described the family meeting as an opportunity to discuss sexual health and disease prevention. Most of the parents recognized that if they did not talk to their children others would, and this created some concern as they would not be able to control the message. In many circumstances older siblings often communicated similar messages to those held by parents about respect, romantic relationships, and even academics. Therefore, it is possible that older children, who often were identified as the first line confidants for younger siblings, could be effectively engaged in delivering parental messages on the topic of sexual health and disease prevention.

Case examples

The thematic analyses presented in the previous sections highlight common areas but also large variations across dyads of parents and children. In this section, I use case examples (Tables 4.4 to 4.6) to demonstrate the variation observed in parental characteristics. Comparisons are based on mean scores from the PETA scale. A dyad was classified as "high" when parent and child mean scores were between 3.0 and 4.0 and as "low" when mean scores were at 2.0 or below for both parent and child. "Parent higher than child" refers to a noticeable gap in mean scores where the parent perceived

demonstrating more of that characteristic than the child did. A quote by each parent and child is used to support the comparison score. In some cases the quote may not directly reflect the characteristic as some interviews diverted from the intended questionnaire depending on what the participant wanted to discuss.

Table 4.4: Case examples of parental expertise perceived high or low by both parent and child and perceived higher by parent than child

Comparison	Quote
High	Margarita: *Tratamos de que todos los días a la hora de la cena comamos juntas y ahí es donde salen las conversaciones y si surge algo que no está de acuerdo con lo que yo estoy enseñando y en ese momento corrijo*. [Translation: We try every day at dinner time to eat together and that is where conversations occur and if something arises that is not in line with what I'm teaching I correct it at that moment.] Laura (16 years): *She especially talks to me about herpes and AIDS and getting pregnant. My whole family is really open with everything so we are just like oh hey what's this STD?*
Low	Noel: *No sé si estuve haciendo bien o no porque le digo no resulto, mi propósito fue guiarla por un buen camino*. [Translation: I don't know if I was doing right or not because it didn't work out, my purpose was to guide her down the right path.] Maribel (16 years): *He was disappointed because he felt that he didn't do enough* [referring to her pregnancy.]
Parent higher than child	Susana: *Yo le he dicho todo. Está bien que con condón sería mucho mejor que inyección porque puede agarrar una infección.* [Translation: I've told her everything. It's good to use condoms better than with the shot because she could get a disease.] Maricela (16 years): *She did mention what would happen if you have sex with someone that has something or passed it on but not with details*.

Note. Parental expertise refers to providing good advice and talking about important topics.

Table 4.5: Case examples of parental trustworthiness perceived high or low by both parent and child and perceived higher by parent than child

High	Flor: *We've never told him sex is horrible. It's going to feel good but these are the consequences. I don't think he's ever distrusted anything I've said.* Miguel (14 years): *We've always had a very close and open relationship. We talk about anything*.
Low	Alicia: *Me deja en dudas porque él me dice que no ha tenido relaciones sexuales pero no lo sé realmente. Y pues si me daría mucho temor.* [Translation: He leaves me doubting because he says he has not had sexual relations but I don't really know. So yes I would be very fearful.] José (15 years): *I don't really like talking about that with my mom. I talk about that with my uncle probably.*
Parent higher than child	Esperanza: *Yo siento que si tienen la confianza de venir y decirme. ¿Quién sabe?* [Translation: I feel that they do have trust to come and talk to me. Who knows?] Luis (13 years): *Well it depends on what it is* [although admitted willingness to talk to her when he should have sex.]

Note. Parental trustworthiness refers to trust and honesty in the parent-child relationship.

Table 4.6: Case examples of parental accessibility perceived high or low by both parent and child and perceived higher by parent than child

High	Beatriz: *Siempre tratamos de que haya un momento en lo de la casa para hablar para conversar. Y cuando hay una reunión siempre salta un tema.* [Translation: We always try to have time at home to talk. When there is a get together a topic always arises.] Sara (17 years): *She doesn't wait for specific moments she just tells you if you ask and doesn't try to hide it which is the good thing about it.*
Low	Ana: *Ella por así era muy rara la vez que ella me hacia una pregunta a mí. Ella es bien reservada.* [Translation: It's rare that she comes to me and asks a question. She is very reserved.] [however mother shared all the topics she explicitly talks to daughter about despite daughter not asking her]. Maite (15 years): *We had a lot of problems. She would get home and she wouldn't really see us. And then like I guess we didn't really talk at all*. [Later in interview described activities therapist recommended for mother and daughter to spend more time together.]
More by parent	Paola: *A mí no me tuvieron en la conversación nunca. Trato de responder solamente lo que ella me pregunta. No le doy más información de lo que me pregunta.* [Translation: I was never included in the conversation (in youth). I try to respond to only what she asks. I don't give her any more information.] Jessica (14 years): *My mom tells me why I shouldn't have sex until marriage. I have a sister and I feel like she's my daughter cause my mom works 24-7 so I feel like she's mine and it's really hard.*

Note. Parental accessibility refers to finding time to talk.

As these tables demonstrate, a combination of survey and interview data can be used to highlight variations in participant responses and provide useful context for scale scores described earlier in this chapter.

Among the developing themes presented earlier in Table 3.1, I chose to briefly expand upon awareness of HPV and the related vaccine as this was a component of the semi-structured interview protocol, although not an element of the conceptual framework.

During interviews I asked parents about their knowledge and perceptions of HPV and the vaccine, and attempted to gauge their intent to vaccinate their son or daughter. However, as I collected data I recognized that while most parents had heard of the vaccine, general knowledge was low. Parents had questions about the novelty of the vaccine and its effectiveness, and most were not aware it was also available for boys. They also discussed concerns about cost, side effects, and the belief that vaccination would encourage teens to have sex. Awareness was obtained from television commercials for most, followed by a physician (gynecologist or pediatrician). A few parents had chosen to vaccinate their child and thus demonstrated the most relative awareness and support for the vaccine. Consistent with the literature, parents who received a positive recommendation from a physician to vaccinate the child followed through or verbalized intent once the child was older, between 13-15 years. In one case however, a parent described incorrect information presented by a physician which caused them to delay vaccinating their child. These findings suggest education about HPV and the vaccine is still necessary for parents and medical professionals. The following section presents a discussion of the study findings.

CHAPTER 5

DISCUSSION

This mixed-method study examined how 21 dyads of Latino parents and adolescents communicate about sexual health, romantic relationships, and prevention of pregnancy and sexually transmitted infections. Using scales and interviews, I examined how parental characteristics, message content, and cultural factors affected the adolescent's knowledge of sexual health, perception of the message, and ultimately their sexual behavior. Findings demonstrate that parents talk to their children, but overall conversations are not specific or comprehensive enough to support adolescents' informed decision-making about sexual health or building positive romantic relationships.

The conceptual framework (Figure 2.1) I designed for this study proposed that parental characteristics and message content directly influenced the teen's perception of the message which was a factor that impacted the teen's sexual behavior. I discuss salient elements of the framework in the following sections.

Characteristics

Parental characteristics examined in this study were expertise, trustworthiness, and accessibility. Interview data suggest that two of these, expertise and trustworthiness, particularly influenced communication between parents and adolescents. Interestingly scale data suggest that a low perception of accessibility, on behalf of the parent and the adolescent, may be a factor in older adolescent's decision-making about sexual intercourse.

Expertise

Despite most parents reporting high perceived levels of expertise on the PETA scale, parents who reported lower levels of education during interviews were likely to feel they lacked the necessary knowledge to communicate with their adolescent about sex. The inconsistency may be related to perception of expertise, however. The items measuring expertise relate to giving advice, whereas the discussion of expertise during interviews focused on knowledge to answer questions about sexual health and disease prevention. Therefore this subtle difference in perceived meaning of expertise prevents comparison between methods but suggests an expanded construct that can be explored further.

Many parents in this study believed their child received what was needed from school and did not require their further input. However, it has been shown that adolescents prefer receiving information about contraceptives from parents, followed by a health education class (Hacker, Amare, Strunk, & Horst, 2000). Therefore parents need to equip themselves to support and elaborate upon what their teen learns in school. Latino immigrant parents with low economic resources are favorably inclined to access resources that can improve familial interpersonal relationships, particularly those that involve face-to-face interaction with peers and culturally tailored information (Allen et al., 2013; Hurwich-Reiss, Rindlaub, Wadsworth, & Markman, 2014; Villalba, Gonzalez, Hines, & Borders, 2014). Community organizations such as churches, schools, and medical settings can support families by providing brief seminars that not only provide basic technical information about sexual health but also allow parents to practice a skill such as how to initiate communication about sex and how to gauge their child's

receptivity to discuss the topic further. Applied workshops are particularly helpful for Latino parents who may not speak English or may have low educational attainment from their country of origin.

Trustworthiness

Messages to parents about the importance of communication should emphasize that consistent and open discussions with adolescents can improve trust and closeness. Families that demonstrate high functioning relationships report more parent and child communication about sex (Malcolm et al., 2013). Specifically, good parent-child relationships are important in reducing unprotected intercourse particularly among younger adolescents, delaying intercourse initiation, and increasing diagnosis of a sexually transmitted infections (Deptula, Henry, & Schoeny, 2010). Parents who actively engage their adolescent in shared communication over time, respond to questions openly and accurately, and demonstrate concern in the teen's life happenings increase the probability of being seen by the adolescent as an expert and trusted source. However, a belief that hindered some parents from engaging their teen in conversation was that, if they provided information, particularly about contraception, it could encourage sexual behavior. Yet research has shown that adolescents who receive comprehensive sex education compared to those who receive an abstinence-only education are at 50% lower risk of teen pregnancy (Kohler, Manhart, & Lafferty, 2008). Additionally, sex education that includes abstinence and birth control information positively influences contraception behaviors, partner selection, and reproductive health outcomes (Lindberg & Maddow-Zimet, 2012). When parents talk to their children about sex, it builds trust and, closeness, and reinforces protective behaviors related to sexual health.

Accessibility

While interviews did not reveal accessibility as a factor in parent-child communication about sexual health, quantitative data from the PETA scale demonstrated that among the three older teens who reported having sexual intercourse, both parents and teens in those dyads scored low means for accessibility. It should be noted that there were other dyads among the older teen group that had similarly low means, except the sexual experience of those teens had not progressed beyond touching. A relationship between perceived accessibility and teen sexual intercourse cannot be properly determined based on data collected in this study. However this finding suggests an aspect that can be examined in a larger study.

Messaging

Parental messages related to sexual risk reduction were mixed and non-specific and often included varying messages depending on the adolescent's gender. This affected the teen's perception of the message as suggested in the conceptual framework. Specifically, during adolescent interviews older teens described their preferences related to parental messaging on the topic of sexual risk reduction.

Sexual risk reduction

Regardless of the risk reduction strategy parents communicated—abstinence or contraception—information was incomplete. Parents missed opportunities to expand and situate the teen's understanding of learned material and answer questions. More importantly, adolescents reported they had not learned how to communicate about their wishes to abstain from sex or how to engage in condom negotiation with a partner. These skills may not be covered in a school curriculum and are critical to promoting responsible and positive relationships as teens grow into adulthood.

Mean scores from the PAC scale suggest parents perceived they mainly delivered messages about health risk (getting pregnant or getting a disease) followed by messages about moral consequences (experiencing regret or guilt). Adolescents perceived the reverse however. Scale items asked parents if they discussed pregnancy and sexually transmitted diseases, which allowed parents to answer affirmatively. However as mentioned earlier related to expertise, parents often did not provide details and thus reduced specific communication about HIV or other STIs to diseases and thus minimized the effectiveness of the message received by the adolescent. Conversely, if parents responded to the scales items about health risk messaging while contemplating the limited information they received in their own youth it is possible they had a more favorable perception of their own messaging. Parents should be reminded of the influence their messages have on teen behavior and more importantly how critical messaging becomes when addressing topics of sexual health. Based on scale scores parents and teens disagreed on the primary and secondary messages exchanged. Parents can effectively communicate with their teens by listening to teen's concern, observing their reaction to the message, and refocusing it as needed. However I am not suggesting that if a teen reacts negatively to a parent's message of abstinence the parent should change their message and encourage sexual debut. Rather I am suggesting in a situation such as this, parents listen to the teen's question and answer openly and directly. Parents should then observe the teen's reaction to their response. If the teen reacts negatively parents can refocus the message with fact-based information. Conversely if the teen reacts positively the parent can extend communication about values, beliefs, and expectations for the adolescent's future. These conversations are not meant to occur for

long or planned periods of time. As suggested by dyads who demonstrated consistent communication, parents can engage children early and consistently during routine activities such as car rides to school. Brief and targeted messages that balance facts and parental values demonstrated the highest retention among older adolescents in this study.

Gender differences

Girls and boys received different messages, concerning relationships, reputation, and respect, which is consistent with findings from other similar studies (Griffiths, French, Patel-Kanwal, & Rait, 2008; Murphy-Erby, Stauss, Boyas, & Bivens, 2011). Girls more often than boys were told to be on alert and to protect themselves from partners (men) who would try to use them only for sex, likely because parents believed their daughters had more to lose than sons such as becoming pregnant and derailing their academic careers. When parents talked about obtaining a bad or damaged reputation, it was tied to a girl having sex early, but it was never discussed for boys. Others have found that while parents may feel challenged discussing relationships with their teens, the message content should not reinforce gender stereotypes and instead discuss aspects of unhealthy relationships and how to avoid these (Akers, Yonas, Burke, & Chang, 2011). Girls in this study were also more likely than boys to describe how they would feel embarrassed or experience parental disappointment as a result of an early pregnancy, supporting the pattern that these girls have received the differential messages. When parents talked about respect, girls were told to respect themselves and their bodies whereas boys were told to respect girls by treating them right and not behaving aggressively or inappropriately. Results from the PAC scale also demonstrate girls more than boys received messages regarding social consequences (bad reputation or

embarrassment) propagating a sexual double standard. Initiating discussion of positive romantic relationships may be one way that parents can introduce communication about sexual health and pregnancy prevention for their adolescents and share a message that is equally applied to girls and boys. Additionally parents may be able to discuss familial values and expectations and elicit their adolescents' thoughts on the topic.

Teen preferences

Adolescents were clear when describing what they expected or preferred from parent communication. Teens, particularly those 14-17 years old, specified wanting details and facts rather than opinions. Communication by parents is particularly important as Latino teens are not likely to use contraception consistently (Hacker, et al., 2000). Teens also preferred conversations that were naturally occurring rather than structured and planned. Those who had conversations consistently over time also appeared more secure in their knowledge compared to those teens that did not feel they could obtain information from parents. Other researchers similarly have found that adolescents believe effective teenage pregnancy prevention strategies include more information about pregnancy and birth control, education about relationships, and communication with parents (Hacker, et al., 2000). As this study showed, the teen's perspective is equally if not more important because it is the teen who decides how much of the message to receive. Therefore, parents are required to build trust and speak openly with their teen to understand their perspective. Messages need to be specific and tailored based on the teen's behavior (Deptula, et al., 2010). Those who are abstinent need messages and resources to support their decision, whereas those who are sexually active need information about and access to contraception (Hacker, et al., 2000). However, in

this study, not all parents knew whether or not their children had had sexual intercourse. In a study to promote reduction of sexual risk behaviors adolescents aged 10-14 years selected gain-framed messaging related to academic achievement, while loss-framed messages were selected to communicate about pregnancy and sexually transmitted infections (Camenga et al., 2014). Teens in that study suggested that both loss and gain-framed messaging was important; however, loss-framed messages led to more discussion within the teen focus groups. Thus, parents can begin talking to their children early and frequently, communicating their wish for them to focus on academics while also discussing the outcomes of early sexual debut and unprotected sex (Guilamo-Ramos et al., 2006).

Acculturation

Acculturation is often measured by primary language spoken (Thomson & Hoffman-Goetz, 2009). It has been more challenging to assess the concept more broadly. However, the degree of acculturation is fluid and dependent on the issue under study. Even though most parents in this study preferred to speak Spanish and reported it was the language they and their children spoke in the home, there was an evident shift in messaging from the content of moral and social consequences they received in childhood compared to those they presented to their children. Mean scores on the PAC for both parents and children suggest messages about social consequences (bad reputation, embarrassment) were the least discussed. It is possible that as most parents in this study have lived in the United States longer than ten years the societal pressures associated with early sexual debut are not comparable to those they experienced in their youth in countries of origin. As for teens, many discussed observing school-aged peers who had become pregnant thereby routinizing outcomes of early sexual debut. These shifts in

societal norms may be the reason parent and child mean scores about messaging related to social consequences was lower than scores for health risk and moral consequences. Therefore measuring attitudinal shifts may be one lens to examine the process of acculturation. A similarly stratified study also found that Latino immigrant parents who have resided in the United States longer than ten years reevaluate the openness of their communication with their children, opting to provide more details than what they received in their home country (Murphy-Erby, et al., 2011). Concurrently, increased rates of sexually transmitted illnesses in Latin America are also prompting more open discussions than in previous generations. In a randomized controlled trial in Mexico researchers examined the impact of a training curriculum on parent-adolescent communication about general and sexual risks (Villarruel, Cherry, Cabriales, Ronis, & Zhou, 2008). Findings include parents recognizing that talking to their children can help prevent disease, and overall increased frequency of parent-child communication and parents' comfort talking to adolescents. Therefore it appears that by appealing to the aspect of collectivism and familismo, Latino parents can be supported and encouraged to have open discussions with their children and lead teens to make informed decisions and develop healthy relationships.

Limitations

This study has some limitations. One limitation was the small sample size. While saturation, the point when no new information emerges from coding (Saldaña, 2009), was achieved and it is an adequate tool in qualitative studies to determine when to cease recruitment, findings based on the scales were limited as a result of the sample size. A larger and more diverse sample that includes more fathers would have enhanced findings and possibly suggested new relevant themes or clarified existing ones.

Another limitation was that recruitment occurred in one mental health and substance abuse clinic representing an at-risk population, predominantly from a lower socioeconomic level. Study participants reported experiences with domestic violence, childhood abuse, mental health conditions, and a variety of other relational challenges that may have affected how they responded. Therefore findings from this study are not applicable to a broad Latino population and thus limit generalization.

I was the only researcher coding transcripts and as such this is considered a limitation. Quality in a mixed methods study includes two elements: 1) quality of method - using those standards set for that specific method (e.g., reliability and validity of a survey, descriptive detail in participant observation) and 2) inference quality - which is concerned with the degree of consistency displayed between inferences and the literature available on the phenomenon (Greene, 2007). While memo-writing was used to elucidate my personal subjectivities and provide a map of how themes were developed, the coding process was not attempted by a second researcher. To mitigate this limitation I included the parents' original text in Spanish and elaborated my inferences about the data in the results section thereby supporting the reader's analysis of the findings.

Recommendations for practice

Based on findings from this study, recommendations for parents include three specific actions. First, parents are encouraged to have open and accurate communication to build trust and reinforce protective behavior. In this study, parents who answered their teens' questions as they arose reported more open communication compared to parents who planned to talk when they observed their child demonstrate romantic interest in another teen. Using external cues, such as questions asked, parents have the opportunity to answer honestly and factually. If parents do not have the answer to a question, they

can refer to factual resources to explore answers with their child and thereby reinforcing trust. The second action parents can take to enhance communication about sexual health with their teen is to discuss characteristics of good relationships and skills to demonstrate respect for a partner. Initiating conversation early in a child's life about showing respect for family and friends, and later transitioning the conversation from friends to a romantic partner can reinforce trust in the parent-child relationship and facilitate communication about more sensitive topics as they child matures, such as sexual health, pregnancy, and disease prevention. A third recommendation for parents is to weave conversations about values and beliefs and personal expectations for the adolescent's future into routine communication with teens. Most adolescents in this study had observed their parents struggle to make ends meet and were clear that parents wanted them to go to college and build a better life for themselves. However, adolescents who demonstrated the clearest sense of parental expectations also described how their parents shared personal life experiences. Most often these were older adolescents and those who had chosen abstinence. Therefore, parents who share their values and beliefs in the context of a fact-based message can help promote protective behaviors such as delayed sexual debut.

The teen's environment is also a critical factor in determining sexual behavior. Churches, schools, and clinics can be leveraged to support parent-child communication. These community organizations can provide brief skills-based training on effective communication to build parent's expertise and confidence in delivering messages about sexual health. While applied training is most effective with populations with lower levels of education, written materials that provide talking tips and that are organized using scenarios can also be used as long as the literacy is adequate for the target population. I

provided parents and teens with reading materials designed specifically for Latinos related to the study topic areas. Parents reacted positively to the materials but were more apparently grateful for answering their specific questions about communication strategies, reinforcing that face to face interaction was important. Clinics and schools in particular can help teens abstain from sex by developing skills to communicate their decision clearly and assertively. Similarly, teens should learn about condom negotiation skills in the context of sexual health education particularly in light of increasing rates of certain STIs among youth aged 15-19 years. Communicated as a risk-reducing behavior and a form of respect for self and partner, condom negotiation should be part of a comprehensive sex education curriculum. Community organizations can also encourage adolescent academic pursuits and same-age peer socialization. Opportunities that actively support the adolescent's pursuits are necessary. One of the adolescents in this study described his passion and talent for fixing cars and discussed his dream of becoming a mechanic. He shared how family and his school had allowed him to learn more about car engines through applied experience. The same adolescent shared how he enjoyed participating in church functions that offered youth socialization. These are examples of how the teen's environment can support healthy pursuits. Finally, clinics can provide adolescents who are having sex with easy access to medical care and effective contraception. Among the three teens in this study who reported having sexual intercourse, access to condoms and medical care was not identified as the reason they chose to have sex. Furthermore, all three reported inconsistent use of condoms. Therefore, clinics can help teens who are choosing to be sexually active to keep their bodies healthy and reduce the incidence of early teen birth.

A final recommendation is made related to messaging. Based on findings from this study and others described earlier, teens are clear about effective messaging. Instead of an abstinence only message, provide comprehensive sex education that reinforces abstinence for teens but more importantly provides accurate information about pregnancy and STIs. Older teens in particular are practicing their decision-making abilities as part of their development, and messaging that assumes a comprehensive approach to sex education better equips adolescents to make informed decisions. Similarly message framing is important. When discussing abstinence, parents and others can focus on the gains or positive outcomes of a care-free youth, on developing academic or other professional pursuits to enhance their future, and particularly for older teens practicing courtship that develops respect for self and partner and allows them to affirm a strong sense of self rather than becoming consumed by another person. Parents who wish to discuss risk-reduction behaviors for teens that are sexually active or further reinforce abstinence can frame messages that focus on the loss associated with unprotected sex such as early pregnancy, truncated youth due to increased responsibility, risk for disease and related effects such as unappealing physical symptoms, sterility, and death. However as stated earlier, delivering messages does not occur in a vacuum. Parents can increase the effectiveness of their communication with teens if they listen, speak openly and accurately, observe the teen's reaction, and most important refocus the message to maximize receipt.

Implications for research

As this study demonstrated, cultural factors influence parental messages about sexual health which coupled with parental characteristics influence the teen's perception of the message. However future studies can examine how parent level of education and

shifting attitudes about sexual health specifically change a message. Observing direct interaction between parents and teens as they exchange messages and react to these would be of particular value to increase the effectiveness of public health communications.

The mixed-method approach used in this study highlights the utility of mixing methods to develop a broader or deeper understanding of specific topics. This study suggests areas that can be explored further through a mixed-method approach such as the role of perceived parental accessibility on adolescent sexual behavior, gauging parental readiness to talk about sexual health particularly among fathers, and variation of message receptivity among older teens depending on their stance for or against abstinence. Beginning with a qualitative method can help inform the creation of more appropriate and sensitive instruments to measure effects in larger samples.

Appendix A - Scales

Parental Expertise, Trustworthiness, and Accessibility Scale

Parent

1. My daughter thinks I give good advice to her.
2. My daughter finds my advice helpful when we talk about important topics.
3. When my daughter needs good advice about something important, she comes to me for help.
4. My daughter trusts me when we talk.
5. My daughter knows that I will keep my promises to her.
6. My daughter knows that I am honest with her.
7. It is difficult for my daughter and me to find a time to talk.
8. I find I am too busy when my daughter wants to talk with me about things.
9. I have trouble finding time to talk with my daughter.

Parent (Spanish)

1. Mi hija piensa que yo le doy buenos consejos.
2. Mi hija piensa que mis consejos son beneficiosos cuando hablamos de temas importantes.
3. Cuando mi hija necesita algún consejo sobre algo importante, ella busca mi ayuda.
4. Mi hija confía en mi cuando hablamos.
5. Mi hija sabe que cumplo con las promesas que le hago.
6. Mi hija sabe que soy honesta con ella.
7. Es difícil para mi hija y yo encontrar tiempo para hablar.
8. Encuentro que estoy muy ocupada cuando mi hija me quiere hablar.
9. Se me hace difícil encontrar tiempo para hablar con mi hija.

Adolescent

1. My mother gives me good advice.
2. The advice my mother gives me is helpful when we talk about important topics.
3. When I need good advice about something important, I go to my mother for help.
4. I can trust my mother when we talk.
5. My mother keeps her promises to me.
6. My mother is honest with me.
7. It is difficult for my mother and me to find a time to talk.
8. My mother is too busy when I want to talk to her about things.
9. My mother has trouble finding time to talk with me.

Adolescent (Spanish)

1. Mi madre me da buenos consejos.
2. Cuando hablamos de temas importantes, mi madre me da consejos beneficiosos.
3. Cuando necesito consejos sobre algo importante, busco la ayuda de mi madre.
4. Puedo confiar en mi madre cuando hablamos.
5. Mi madre cumple lo que me promete.
6. Mi madre es honesta conmigo.
7. Es difícil para mi madre y para mí encontrar tiempo para hablar.
8. Mi madre está muy ocupada cuando quiero hablar con ella.
9. A mi madre se le hace difícil encontrar tiempo para hablar conmigo

Parent-Adolescent Communication Scale

Parent

1. My daughter and I have talked about what might happen to her if she were to get pregnant
2. My daughter and I have talked about how if she had sexual intercourse at this time in her life, she might get a sexually transmitted disease (STD).
3. My daughter and I have talked about how if she had sexual intercourse at this time in her life, she might get HIV/AIDS.
4. My daughter and I have talked about how she might get a bad reputation if she had sexual intercourse at this time in her life.
5. My daughter and I have talked about how embarrassing it would be for her if she got pregnant now.
6. My daughter and I have talked about how her boyfriend might lose respect for her if we they had sexual intercourse at this time in her life.
7. My daughter and I have talked about how having sexual intercourse at this time in her life would be morally wrong.
8. My daughter and I have talked about how if she had sexual intercourse at this time in her life she might regret not waiting until she was married.
9. My daughter and I have talked about how she would feel guilty if she had sexual intercourse at this time in her life.

Parent (Spanish)

1. Mi hija y yo hemos hablado de las cosas que le podrían pasar si ella estuviera embarazada ahora.
2. Mi hija y yo hemos hablado de cómo si ella tuviera penetración sexual en este punto de su vida, ella podría contraer una enfermedad de transmisión sexual (ETS).
3. Mi hija y yo hemos hablado de cómo si ella tuviera penetración sexual en este punto de su vida, ella podría contraer el VIH/SIDA.
4. Mi hija y yo hemos hablado de cómo tener penetración sexual en este punto de su vida ella podría conseguir una mala reputación.

5. Mi hija y yo hemos hablado de cómo tener penetración sexual en este punto de su vida le daría vergüenza si ella saliera embarazada.
6. Mi hija y yo hemos hablado de cómo tener penetración sexual en este punto de su vida su novio podría perderle el respeto.
7. Mi hija y yo hemos hablado de cómo tener penetración sexual en este punto de su vida sería moralmente incorrecto.
8. Mi hija y yo hemos hablado de cómo tener penetración sexual en este punto de su vida me arrepentiría por no haber esperado hasta que se casara.
9. Mi hija y yo hemos hablado de cómo tener penetración sexual en este punto de su vida sentiría remordimientos.

Adolescent

1. My mother and I have talked about what might happen to me if I were to get pregnant.
2. My mother and I have talked about how if I had sexual intercourse at this time in my life, I might get a sexually transmitted disease (STD).
3. My mother and I have talked about how if I had sexual intercourse at this time in my life, I might get HIV/AIDS.
4. My mother and I have talked about how I might get a bad reputation if I had sexual intercourse at this time in my life.
5. My mother and I have talked about how embarrassing it would be for me if I got pregnant now.
6. My mother and I have talked about how my boyfriend might lose respect for me if we had had sexual intercourse at this time in my life.
7. My mother and I have talked about how having sexual intercourse at this time in my life would be morally wrong.
8. My mother and I have talked about how if I had sexual intercourse at this time in my life I might regret not waiting until I was married.
9. My mother and I have talked about how I would feel guilty if I had sexual intercourse at this time in my life.

Adolescent (Spanish)

1. Mi madre y yo hemos hablado de las cosas que me podrían pasar si yo estuviera embarazada ahora.
2. Mi madre y yo hemos hablado de cómo si yo tuviera penetración sexual en este punto de mi vida, yo podría contraer una enfermedad de transmisión sexual (ETS).
3. Mi madre y yo hemos hablado de cómo si yo tuviera penetración sexual en este punto de mi vida, yo podría contraer el VIH/SIDA.
4. Mi madre y yo hemos hablado de cómo tener penetración sexual en este punto de mi vida yo podría conseguir una mala reputación.
5. Mi madre y yo hemos hablado de cómo tener penetración sexual en este punto de mi vida me daría vergüenza si yo saliera embarazada.
6. Mi madre y yo hemos hablado de cómo tener penetración sexual en este punto de mi vida mi novio podría perderme el respeto.

7. Mi madre y yo hemos hablado de cómo tener penetración sexual en este punto de mi vida sería moralmente incorrecto.
8. Mi madre y yo hemos hablado de cómo tener penetración sexual en este punto de mi vida me arrepentiría por no haber esperado hasta que me casara
9. Mi madre y yo hemos hablado de cómo tener penetración sexual en este punto de mi vida sentiría remordimientos.

Adolescent Sexual Experience

The following set of questions will be placed within the adolescent survey following the above scaled instruments.

1. Have you ever kissed someone?
2. Have you ever touched someone over the clothes?
3. Have you ever touched someone under the clothes?
4. Have you ever touched someone's genitals?
5. Have you ever had sex?

Appendix B - Interview Protocol

Parents

I'm going to start the interview by asking a few questions about your experience growing up and the communication between you and your parents.

1. Did your parents talk to you about 'life' (i.e., romantic relationships) as you were growing up?
    a. If yes, what did they say?
    b. If no, why do you think they did not?
2. Which parent was more likely to talk to you about 'life' topics?
3. Tell me about what you wish they would have talked with you about?

The next topic we are going to discuss has to do with your thoughts and behaviors about romantic relationships now as an adult.

1. What do you believe a good romantic relationship looks like? A bad one?
2. How old were you when you married?
3. How old were you when your first child was born?
4. Do you currently use contraception? Have you ever used it?

The next questions are about how you talk with your adolescent.

1. What are your expectations for your child's life? [Prompt if needed- finish high school?]
2. How important is it to you to communicate about romantic relationships and pregnancy prevention with your adolescent?
3. What kinds of topics do you talk about? [If no discussion has occurred probe as to why not? What has held you back?]
4. Do you know if your adolescent has a boyfriend or a girlfriend at present?
5. Have you talked to your adolescent about dating?
    a. Prompt: Healthy relationships, showing love and affection appropriately (i.e., non-violent)
    b. Prompt: Sex, contraception, sexually transmitted infections
    c. Prompt: Pregnancy
6. How did you bring it up? What did you say? How old were they when you had the discussion? [If the discussion has not occurred probe as to why not and what has been the barrier(s)]
7. [Ask only if they have a child of both genders] How do your conversations differ between son and daughter?
8. [Ask only if there is a spouse/partner in the home] Does your spouse talk to them too?
9. Is this a one-time conversation or do you want them to ask you? Do you think it is appropriate that they ask you about these topics?

10. What age do you think it is OK for a girl to become pregnant? A boy to become a father?
11. Do you think a woman should be a virgin when she gets married? Should a man be a virgin when he gets married?
12. If your adolescent got pregnant or got someone pregnant now how do you think you would react?
    a. [If pregnancy has occurred], what was your reaction? Your spouse's reaction?
    b. [If they have younger children] Has your communication with them changed as a result? How?
13. If your adolescent was diagnosed with a sexually transmitted infection how do you think you would react?

The last question I have for you is about a prevalent sexually transmitted infection called the Human Papillomavirus (HPV). Research has shown that some people, who are repeatedly infected with HPV, may develop different types of cancers.

14. Have you heard of HPV? The HPV vaccine?
    a. Yes – what have you heard?
    b. Has your child been vaccinated?
        i. Yes – how many times? Why did you choose to vaccinate them?
        ii. No – why not?
    c. No – provide pamphlet and recommend they speak to medical provider

Thank you for your time. We have completed the interview. Please let me know if you have any questions. Now I will escort you to the waiting area and bring your son/daughter into the room for the second part of this meeting with them.

Adolescents

Now that we have finished the survey, I'm going to ask you some questions about yourself.

1. How old are you?
2. What grade are you in?
3. What is your favorite subject in school?
4. What kinds of things do you like to do for fun?
5. Do you have any brothers or sisters living with you?

The next few questions I'm going to ask you are about how you communicate with your parents. I want to remind you that what you say here is confidential. Unless it is an illegal activity as we discussed when you signed the permission paper, I will not share any information with your parent.

1. Do you talk about keeping your body healthy? If yes, what is said? If no, why not?

2. Is it easy for you to talk to your parents about things that worry you (at school, with friends)?
3. What do you think your parents want you to do (accomplish) with your life? How have they let you know this?
4. Do your parents talk to you about dating? If yes, what is said?
5. Do you talk about having a boyfriend/girlfriend? What a good relationship is?
6. Which parent (mom or dad) talks to you about these things? Do you think they speak to you and your sibling differently (boy vs. girl; older vs. younger)?

I would like to ask you a few questions about what you have heard or learned about dating and keeping your body healthy.

7. Do you have friends that are currently dating?
8. Do you currently have a boyfriend/girlfriend?
    a. If yes, do your parents know?
    b. If no, what would happen if they found out?
9. Where have you learned about dating? (Prompt: parents, friends, TV)
10. Have heard about sexually transmitted infections? How do you keep yourself safe from a sexually transmitted infection?
11. How do you prevent pregnancy?
12. Do you have friends that are currently having sex? If yes, do they pressure you about it?
13. Do you have friends who are/have been pregnant? What do you think about their situation?
14. Do you think it is important for a person to be married before having sex?
15. If you got pregnant/got someone pregnant at this age what do you think your parents would say/think?

The last question I have for you has to do with a very common sexually transmitted infection called the Human Papillomavirus (HPV).

16. Have you heard of HPV? The HPV vaccine?
    a. Yes – what have you heard? Have you been vaccinated?
        i. Yes – how many times?
    b. No – provide pamphlet

Thank you for your time. We have completed the interview. Please let me know if you have any questions. Now I will escort you to the waiting area where your mother/father is. [Provide incentive at this point].

Appendix C - Demographic Survey

The following questions are meant to help me obtain a general understanding of the participants in this study. All parents in this research study will complete this survey.

1. Your age:_____
2. Country of birth:_____
3. Country of birth of your child: _____
4. [If born outside of the United States] Number of years lived in the United States:_ _____
5. County where you currently live:_____

For the following questions please make the appropriate selection using the keypad provided to you.

6. Marital status: [mark one]
    a. Married
    b. Living with a partner
    c. Single
7. Annual household income: [mark one]
    a. Under $35,000
    b. $36,000-$50,000
    c. $51,000-$70,000
    d. Above $71,000
8. Educational status: [mark one]
    a. Did not finish high school
    b. High school diploma or equivalent
    c. Some college
    d. College graduate
9. Employment status: [mark one]
    a. Not working at present time
    b. Work in the home
    c. Work outside of the home
10. Health insurance status: [mark one]
    a. No insurance
    b. Public insurance
    c. Private insurance
11. Living arrangement: [mark one]
    a. Self with spouse/partner and children
    b. Self with spouse/partner, children, and extended family (siblings, parents)
    c. Self with children
    d. Self with children and extended family (siblings, parents)
12. Primary language spoken in the home: [mark one]
    a. English
    b. Spanish

13. What is your religious faith?: [mark one]
    a. Catholic
    b. Methodist
    c. Protestant
    d. Pentecostal
    e. Other:_____
    f. I do not practice a religious faith

Thank you. Now that we have completed the survey component we will move to the interview. [Continue to interview protocol].

Appendix D - Subjectivity statement

As a Latina, daughter of Cuban immigrants, I am sensitive to issues related to Latinos and acculturation. My life has been a crossroads between cultures- born and raised in America but expected to align with traditional Cuban values and traditions. I believe it was going to many doctor visits with my family members and translating for them that made me want to go into the health field and help people. As a result I have had varied experiences first as a recreational therapist and later as a health educator. My career in healthcare and most recently in public health has focused my interests on the health communication needs of Latino immigrants, specifically as it relates to acculturation and its effects on preventive health outcomes.

It is because of my experiences as a Latina between two cultures and my interest in health that I felt qualified to embark on this inquiry, specifically as it related to understanding the influence of culture on health messaging. My fluency in Spanish was an added strength in conducting research with a limited English-proficiency population. Conversely, I was aware that my experiences as a Cuban American do not reflect those of the many cultures I expect to learn about in my research, and I am cognizant of this potential bias. Additionally, I do not have personal experience as an immigrant therefore I am sensitive to related issues discussed by participants.

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