PARENT-CHILD COMMUNICATIONS AMONG A SAMPLE OF SELF-IDENTIFIED OUT GAY MALES: A QUALITATIVE INQUIRY

by

JUNIOR LLOYD ALLEN

(Under the Direction of Michael John Holosko)

ABSTRACT

Purpose. Parent-child communications on sex, sexuality, and/or HIV/AIDS are anxiety causing events for both parents and children. Studies show that these communications can effectively decrease early pregnancies, delay sexual debut, and increase safer sex practices and behaviors among heterosexual teenagers. However, there are no studies that have explicitly explored parent-child communications with self-identified out gay males. ***Method.*** A singular one-on-one participant telephone or face-to-face interview, ranging between 45-90 minutes, was conducted with N = 14 unique self-identified out gay males ages (R_a) 18-30, which asked them to retrospectively recall their parent-child communications on sex, sexuality, and/or HIV. Interviews were recorded and transcribed verbatim. Data analyses were conducted using the iterative inductive and deductive procedures associated with thematic analysis. Identified themes and codes were then discussed with N = 3 participants taken from the larger pool of participants. ***Findings.*** Results showed that the average age of coming out was 16 years of age, which was in par with the national average. Participants: a) had higher education levels, b) identified mainly as Atheist/Agnostics, and c) came from diverse educational and religious backgrounds. White cohort participants had conversations later than Black/African Americans and Hispanics,

however, Hispanics spoke more about sex and/or sexuality than Black/African and White cohorts despite being the hardest subgroup to recruit. After coming out, some conversations: a) got worse, b) stayed the same, or c) improved. Conversations ranged in content from poor (e.g., abrupt, one time) to excellent (e.g., continuous, inclusive of the sexuality spectrum, age appropriate). Six major themes throughout the conversations included: a) reasons for the conversations, b) coming out, c) sexual orientation, d) sexual behavior, e) HIV knowledge, and f) prevention. These themes provided the context used to answer the three overarching research questions guiding this study. ***Conclusion.*** Parent child communications were indeed effective in priming improved sexual behavior and practices, improved mental health, self-esteem, and developed sexual identity. However, parents of gay men often ignored conversations regarding HIV, as it often made HIV a reality that they – the parents – did not want to address. This study offered some recommendations to make the parent-child communications less awkward. Additional studies are needed with this population.

INDEX WORDS: Parent-Child Communications, Gay Males, Communication, Prevention Education, Social Cognitive Theory, HIV, Sexual Orientation, Sexual Behavior, Qualitative Study

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DEDICATION

This dissertation is dedicated to my family –my step father, Larry D. Scroggins, Sr; my mother, Lenna R. Scroggins; and my sister, Schanetta M. Scroggins. Your unwavering and continued encouragement, love, and support have helped me to move past my fears and walk into my purpose. Thank you for always being a listening ear, a voice of reason, and the supportive foundation that kept pushing me beyond my fears. For this I am truly blessed, and indeed, indebted.

Larry Donnell Scroggins, Sr.
October 07th, 1950 – May 27th, 2016
My Step-Father
I will always love you, and I have missed you since. Thank you for your unwavering support and love throughout the process.

Lenna Rose Scroggins
My Mommy Dearest
I am hugely indebted to you for pushing me to conquer my fears and go for my dreams. You have been a solid rock for me through all these years, you have been a motivator, a prayer warrior, a confidant, and my biggest cheerleader.

Schanetta Marie Scroggins
My Sister
Thank you for keeping a smile on my face, and for always willing to hold me accountable and help me to better understand and depersonalize tense and troubling situations.

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In starting the process of writing this acknowledgement section, I am immediately reminded of the African proverb, "it takes a village." Attempting a PhD is no easy feat as there are emotional, mental, financial, and at times, physical stress that comes with reading and reducing sometimes dense, confusing, and complicated information into simplified, coherent and easy-to-understand statements. However, with the unwavering support of family, friends, associates, classmates, dissertation committee members, other faculty and staff, and various others, it became a feasible and do-able process. Overall, I am forever indebted to the host of individuals who have supported, encouraged, and pushed me along and throughout this excursion, especially when I felt the most defeated, thrown my hands up, and attempted to walk away from this experience. These aforesaid individuals, coupled with my dissertation committee members, have provided an increased, solid, and unconditional level of emotional, mental, and physical support that have kept me motivated, driven, and excited throughout, and about, this journey.

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CHAPTER 1

INTRODUCTION

Accurately recording the number of gay, lesbian, bisexual, and transgender (GLBT) individuals residing in the United States is difficult to establish, as such individuals do not always publicly disclose their sexual orientation because of their frequent exposure to numerous social, mental, societal, physical, and familial ostracizing (Ettinghoff, 2013; Johnson, 2016; Savin-Williams, 1994). However, current data reveals that approximately 4% of the U.S. population identified as GLBT (Gates, 2011; Newport, 2015). National sexual orientation population data gathered – on U.S. adults, aged 18 and over, living in the 50 states and the District of Columbia and collected by the Centers for Disease Control (CDC) – in 2013 indicated that 1.6% identified as "gay or lesbian", 0.7% identified as "bisexual", 1.1% identified as "something else", 0.2% stated that "they did not know", and 0.4% "refused to answer the question" (Volokh, 2014). Furthermore, the actual number of known GLBT individuals is difficult to ascertain because of: a) the lack of concrete definitions on sexual orientation, b) the changing and emergent sexual orientation terms and, c) an individual's lack of understanding, openness, and willingness to discuss their own sexual orientation (Coleman & Remafedi, 1989; Meidlinger & Hope, 2014; Shilo & Savaya, 2012), with family and/or friends.

Take for example, in the 1995 film *To Wong Foo, Thanks for Everything! Julie Newmar,* three drag queens Noxema Jackson (portrayed by Wesley Snipes), Vida Boheme (portrayed by Patrick Swayze), and Chi-Chi Rodriguez (portrayed by John Leguizamo) experienced a series of galvanizing familial, social, cultural, and political public events that caused them to identify, and

deal with, the root causes of various inter-and-intra personal behaviors, relationships, and personalities. One character in particular–Vida Boheme–grew up in an affluent family that held traditionalist and heteronormative views on gender and sexuality. Upon disclosing his sexual identity, Vida's character was asked to leave his house, resulting in family abandonment and loss of financial, emotional, and physical support. From then on, Vida associated, communicated, and interacted primarily with other drag queens, some of whom had similarly lived family, social exclusion, and societal experiences. Throughout the film, these friends had several arduous conversations regarding sexual orientation and societal perceptions on gender, gender roles, sexuality, and sexual behaviors. These ongoing conversations, although difficult, quelled their feelings of inadequacy, while helping to increase their personal concerns on self-esteem, solidifying their personal sexual identity, and building community among themselves.

Today in the United States, many GLBT individuals experience similar situations within their families, and throughout society. From a familial perspective, extensive research has addressed the relationship between family ties and the mental, physical, emotional, and sexual well-being of GLBT individuals, especially among adolescents. Results from studies have indicated that family support and communication served as a protective agent against adverse health risk behaviors, poor mental health outcomes, and improved self-esteem concerns and perceptions (Meyer, 1995, 2003; Resnick et al., 1997; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). From a societal perspective and within the last three decades in the U.S., GLBT individuals have advocated for, and won, various battles dealing with fair and equitable treatment. The 1993 signing of *Pub.L. 103.-106, H.R. 2965 - Don't Ask, Don't Tell* prohibited military personnel from discriminating against gay, lesbian, and bisexual individuals on the basis of sexual orientation. In 2015, *H.R. 2976 - The Marriage Equality Act-* supported and provided

equal marriage rights to GLBT individuals. More recently, the U.S. military lifted a ban that prohibited transgender individuals from serving in the U.S. armed forces. Presently, transgender individuals are advocating for access to bathrooms that meet their current gender representation and expression. These issues, although different, have one unique feature—they carry a power/control communicative undertone between dominant and sub-ordinate individuals and groups within our society.

The context in which numerous GLBT sexual health and sexual identity development conversations occurred were frequently influenced by various social audiences (i.e., researchers, policy analysts, activists, government officials, educators, religious leaders, educators, laypersons, etc.) (Cerulo, 1998), who often held harsher opinions when outward and noted behaviors appeared more ambiguous, different, and occurred primarily among marginalized groups (Cerulo, 1998; Maxwell, Robinson & Post, 2003; Tittle, Villemex & Smith, 1978). For instance, within our society, communications that have historically vilified individuals (based on race, sexual orientation, gender, religious beliefs, etc.) were structured in a manner that concentrated on how the act or behavior cast the individual as both a perpetrator and a victim of circumstance. Using Cerulo's (1998) well-cited framework, communication with, and about, GLBT individuals typically differentiated individuals based on their sexual orientation. As suggested, information transfers between victimized individuals took the perspectives of: *contextual sequences* or *doublecasting sequences*. The former prioritizes the act's setting or circumstance, while the latter frames the central subject as both the perpetrator and the victim of circumstances (Cerulo, 1998). Additionally, ambiguous behaviors were defined as actions that contained both deplorable and moralistic elements and while such acts may appear distasteful and unpleasant, they were nevertheless viewed as justifiable (Cerulo, 1998).

As a former direct care mental health social worker and program coordinator in both Florida and Georgia, I interacted daily with GLBT individuals, and one of the numerous issues frequently addressed in departmental meetings and/or conferences were the high rates of human immunodeficiency virus (HIV) within this sub-population. In these work meetings and/or conferences, conversations focused heavily on the impact of new HIV treatment and prevention protocols, some of which included treatment as prevention (TasP), pre-exposure prophylaxis (PrEP), post exposure prophylaxis (PEP), and increased HIV testing and counseling. Similarly, when addressing clients one-on-one, I frequently heard first-hand accounts and recollections of parent-child communications regarding sex and sexuality. According to some of my former clients, some parents: a) had negative views of homosexuality, but were open to conversations, b) accepted their children, but were unwilling to communicate about sexuality and/or sex, c) did not accept or communicate about homosexuality, and sexual behaviors, and/or d) disowned their children because of his/her sexual orientation. Although some clients may have presented with various issues when seeking services, the ones who were most open about sexual behaviors, and/or practices, conveyed that they had previous conversations on sexuality, sexual health, and sexual practices that were both accepting and supportive.

As a service provider, the departmental meetings, and/or conferences, further encouraged me to question the efficacy of the various government identified and tested interventions as well as aroused [in me], a lingering curiosity about what could be done differently to help curb the U.S. HIV epidemic. Now, as a novice social work researcher, this knowledge gap ignited a deepening curiosity to empirically examine additional methods to more adequately examine HIV incidence rates, especially among Black/African American gay, bisexual and transgender (GBT) individuals – the sub-group with the highest HIV infection rates. Taken together, my

experiences as a social work service provider and a potential social work researcher, sparked a research interest that awoke an awareness surrounding the effect of parental opinions on sexual behaviors and one's sexual development, especially as it influenced their sexual behavior and decision-making within, and amongst, GLBT adolescent groups.

Ultimately, an internal review of my personal experiences and biases dovetailed with my educational background caused me to become more aware of the social and personal complexities that most, if not all, GLBT individuals regularly navigated. These early and ongoing communications with clients exposed me to some perceived faulty social public policies, and family principles and standards that most GLBT individuals endured – as these issues affected their self-acceptance, family relationships, and societal acceptance; some of which were associated with gender conformity and non-conformity as well as the various sexual identities and politics. A review of the extant literature helped to illuminate the impact of parent-child communications on sexual behavior and sexual decision making among adolescents. A more widespread search of research articles, found no studies that focused specifically on the effect of parent-child communications with GLBT individuals pertaining to HIV. However, while lesbians, bisexuals, and transgender individuals are important and unique sub-groups within this larger population, this study will focus singularly on the lived experiences of U.S. gay men, as they have the greatest and highest recorded rates of HIV infection.

Study Purpose

The purpose of this qualitative study was to explore the role and impact of parent-child communications about sex and HIV risk in the lives of self-identified out gay men, ages 18-30. There were three aims for this study, and they were:

1. To explore the extent and nature of parent-child communications about sex and sexual behavior among a sample of self-identified out gay men.
2. To provide an opportunity for self-identified out gay men to contribute to the prevention knowledge by presenting their lived experiences of their own parent-child communications.
3. To help build, and/or co-create improved promising practices to help decrease HIV infections within this population.

Research Questions

The three exploratory research questions which guided this study were:

1. How do parent-child communications affect gay men's sexual behavior?
2. How do parent-child communications impact HIV risk?
3. How do parent-child communications shape self-efficacy?

Rationales for the Study

There are several rationales for this study. First, there is a surprisingly large gap in the research literature regarding the impact of parent-child communications on sexual orientation, sexual behaviors, and HIV knowledge and information. Despite the litany of research about the effectiveness of parent-child communications with delaying sexual debut (Berenson, Wu, Breitkopf, & Newman, 2006; Perrino, González-Soldevilla, Pantin, & Szapocnik, 2000; Treboux & Busch-Rossnagel, 1990; Wight, Williams, & Henderson, 2006), there has been no research that explicitly explored the nature and influence of parent-child communications and its influence on sexual identity, sexual orientation, and sexual behaviors among gay males. This study attempts to fill that gap by providing insights that could influence communication efficacy, sex education, knowledge effectiveness, and sexual behaviors within this population.

Second, this study will provide the recruited sample with opportunities to help inform a scholarly contribution regarding the impact of parent-child communications. Previous research has addressed the effects of parent-child communications with various goals, such as examining the effects of parent-child communications on sexual behaviors and sexual debut among primarily heterosexual adolescents (Afifi, Joseph, & Aldeis, 2008; Astone & McLanahan, 1994; Inazu & Fox, 1980; Jessor & Jessor, 1975; Newcomer & Udry, 1987; Small & Luster, 1994; Somers & Paulson, 2000; Udell & Donenberg, 2011). It is anticipated that study participants will provide rich and detailed context regarding how their parent-child communications influenced their attitudes and perception toward sex, sexuality, and/or HIV/AIDS. To add to this knowledge resource, this study will examine and describe the lived experiences of out gay males who experienced these parent-child communications.

Currently, the behavioral research on gay males, specifically those who identify as Black/African American or Hispanic, has primarily focused on HIV/AIDS, and has a decidedly '*reactive*,' rather than '*pro-active*' emphasis. As such, it is often within the confines of reactivity that researchers and service providers – psychologists, public health professionals, social workers, and public policy – design and implement prevention and intervention programs to combat the virus (Meyer, 2003). Unfortunately, much of the current HIV literature and research focus on helping individuals become virally suppressed, in order to decrease the spread of the virus, rather than addressing social and economic needs before a HIV-positive diagnosis (Palmer, 2004; Vanassche, Sodermans, Matthijs & Swicegood, 2014). Similarly, prevention research provides limited sex or sexual health information that may be useful for proactive family-based research, especially in parent-child communications with gay males. As indicated by Raymond et al. (2011), family connectedness impacted and created higher self-esteem and health, while

family rejection resulted in higher instances of HIV risk taking among [gay] males. Conversely, for many [gay males] being connected to the gay community could serve the same role as peers and family, as comfort with one's sexuality can also be associated with health outcomes. Overall, it appears that prevention research addresses *behaviors,* rather than treating *individuals*.

Given the paucity of research literature in this area, these rationales could provide gay males a platform to qualitatively describe their lived experiences with their own parent-child communications, and its effects on their behaviors. If gay males were indeed at increased risk for HIV infection, increased mental health concerns, and/or substance use disorders due to societal expectations based on racial demographics, gender, and/or sexual debut, it was important to understand these risks, by identifying the effectiveness of parent-child communications in helping to decrease these health outcomes.

Study Design

This qualitative study investigated and described how parent-child communications affected sexual behaviors, sexual health, and the perception(s) of risk for HIV infection among a sample of gay males. It incorporated a retrospective design because parent-child communications will have already occurred (El-Masri, 2014; Gordis, 2009), and participants were screened to ensure that they had at least, and at a minimum, one 20-minute conversation, with their parent(s), about this subject. This design allowed for assessing, exploring, and reviewing the type, intensity, and breadth of the communications between individuals and parents as it pertained to sex, sexuality, and HIV/AIDS (Danes, 2012).

Similarly, a cohort design was used to help identify similarities between people who shared a common experience (Gordis, 2009). In this case, the selected study participants were individuals who all: a) shared similar sexual orientation demographics (gay), and b) had at least

one 20-minutes conversation with their parent(s) regarding sex, sexuality, and/or HIV. Before study implementation, the UGA Office of the Vice President of Research granted IRB approval. Data collection was conducted using one-on-one face-to-face and phone interviews lasting between 60 and 90 minutes with approximately $N = 14$ unique individuals. Data validation utilized inter-rater reliability and one focus group containing $N = 3$ randomly selected individuals from the one-on-one interviews and represented each racial group, lasting 60 minutes. This process, known as member checking, asked the participants their opinions on data findings.

Study Justifications

Communication styles play a significant role in one's knowledge acquisition and behavior. Research on communication has indicated that parents are historically, the main sources of information regarding the transfer of knowledge surrounding sex, sexual behaviors, and sexuality for many youth (Aspy et al., 2007; West & Zimmerman, 1987; White & DeBlassie, 1992; Wight et al., 2006). Communication research also noted that the frequency of communication, topic of communication (i.e., having direct discussions about condom use), and one's general affect during communication (i.e., warmth, openness to discussions about sex) were related to one's sexual risk-taking behaviors (Hadley et al., 2009; Udell & Donenberg, 2011). However, much of the previous work on parent-child communications have focused on mother-daughter communications, and heterosexual sexual behaviors (Aspy et al., 2007; DiIorio, Kelley Hockenberry-Eaton, 1999; Eisenberg et al., 2006; Karofsky et al., 2000).

While there is an inventory of promising practices in the existing literature being used by mental health professionals, public health entities, community based organizations (CBOs), AIDS service organizations (ASOs), and social service providers to curtail the spread of HIV,

much of the current research and promising practices operated from a deficit perspective (Isacco, Yallum, & Chromik, 2012; Palmer, 2004; Vanassche, Sodermans, Matthijs & Swicegood, 2014). By "ignoring the person," and focusing on their problems, research on gay males further continue to reinforce negative ideations about sexual orientation that some, if not many, people hold, especially when comparing similarities and differences among dominant and minority groups (Goodwin & Scimecca, 2006; Hughes & Kroehler, 2009; Kivisto; 2003). Ultimately the data, within the amalgamation of literature exploring differences based on race, sexual orientation, gender, etc., is sparse (Abraham, 1993, Annavarapu, 2013; Collins, 1998, 2005; Jaworski & Coupland, 2013; Mong & Roscigno, 2010);

The highest rates of HIV infection in the U.S. are found primarily among Black/African American and Hispanic gay males (Dodge, Jeffries, & Sandfort, 2008; Millett, Flores, Peterson, & Bakeman, 2007). However, data indicates that Black/African American gay males had the highest rates of HIV infections as they accounted for approximately 36% of overall new infections, and young (13-24) Black/African American gay males had approximately 48% of new infections (CDC, 2015a; Millett et al., 2007). While there are various explanatory behavioral factors such as: a greater prevalence of sexually transmitted diseases and unrecognized HIV infection among Black/African American gay males; disparities in HIV testing, care, and treatment access; and various social determinants of health, including but not limited to income, joblessness, limited access to competent healthcare services, homelessness, incarceration and discrimination, that may help explain the discrepancies in HIV infection rates (Abraham, 1993; Isacco, Yallum, & Chromik, 2012; Millett, et al. 2012; Millett, Flores et al., 2007; Millett, Peterson, et al., 2006), there appears to be other issues happening among gay males, specifically Black/African American and Hispanic individuals. One identified issue is the

communication style between gay males, and their parents about sex, sexual behavior, sexual identity development, and potential risk for HIV infection.

Taken together, the main implications of this study reside in the fact that there are no existing studies that have explicitly explored parent-child communications with gay men. Likewise, there appears to be limited knowledge and understanding of the factors, and/or barriers related to facilitating these conversations with gay men. As such, this study attempts to fill that void by providing some additional insights, techniques, and tips regarding how to help parents and child further improve their conversations on sex, sexuality, and/or HIV, and remove any anxieties about having such conversations

Definitions of Selected Terms Used in this Study

While some of the terms used throughout this study may be familiar to most, to increase clarity, it is important to simply define the terms and concepts that are central to the purpose of this research. These terms were found in the literature and they are used to guide the underlying and prevailing concepts associated with this study. These terms, defined below, include:

1. *Participants* for this study were males who were asked to discuss their parent-child communication experiences retrospectively when they were *minors* – under the age of 18. This phase of life is defined as a child, adolescent, or teenager under the age of 18, which is considered by federal law as under the age of legal responsibility. The age of 18 years, which provides a chronological demarcation between "adult" and "child," was not set arbitrarily as it was used as a benchmark when the *26th Amendment to the Constitution*, ratified and signed into law in 1972, declared that persons 18 years of age were able to vote in elections.

2. *Coming Out*, depicts the precise moment in time that a person, male or female, decides to publicly disclose their sexual orientation (i.e., gay, lesbian, bisexual, or transgender [GLBT]) to their parent(s) and/or caretaker(s), friends, medical or mental health service provider, and so on (Cass 1979, 1983/1984, 1984; Dank, 1971; Griffith & Hebl, 2002; McKenna & Bargh, 1998; Savin-Williams, 1990, 1995, 1998; Troiden, 1979). For the purposes of this dissertation, *coming out* was examined specifically within the context of disclosing sexual orientation to parent(s).
3. *Gay* is used as a term in lieu of 'men who have sex with men', 'same gender loving', 'queer', 'GLBT', 'homosexual', and so on. As indicated on the blog, *English Language & Usage* (n.d.), the terms gay and homosexual although used interchangeably, have different connotations. Homosexual is a clinical term, making it appear that individuals who identified as homosexual had: a) certain health or mental health issues, or b) were uncomfortable with their sexual orientation and actively wanted to change. Contrastingly, the term *gay* has been perceived as a more positive term that de-stigmatized one's sexual orientation (*English Language & Usage*, n.d.), and often refered to people, practices, and cultures associated with homosexuality (*Rainbow Café*, n.d.). *Gay* for the purposes of this study was defined as males who have had, or currently have, sexual relationships with other males.
4. *Sexual Orientation* in this study referred to males who self-identified as gay. Individuals who collectively identify as GLBT have emotional, romantic, and/or sexual relationships with males, females or both (Bailey & Zucker, 1995; Savin-Williams, 1990).

5. *Sexual Behavior* implies the ways that gay males experienced and expressed their own sexuality with the increased chances of having an orgasm (Brooks-Gunn & Furstenberg, 1989; Collins et al., 2004).
6. *Sexual Debut* for this study was defined as the age of one's first sexual intercourse encounter, regardless of sexual orientation. In previous studies, *sexual debut* was examined under the classification of *early sexual debut* which was defined as an individual having their first sexual intercourse experience before, or at, the age of 14 (Cavanagh, 2004; Cavazos-Rehg et al., 2009; Harrison, Cleland, Gouws, & Frohlich, 2005). In this instance, *sexual debut* was used instead of 'age of first sexual experience'.
7. *Sexual Knowledge* used here, referred to the acquired possession, and understanding, of information regarding how to: a) protect oneself from sexually transmitted infections (STIs) and sexually transmitted diseases (STDs), b) decrease instances of child birth, c) understand gender roles and expectations during sex, d) properly and effectively use condoms, and f) negotiate sexual behaviors with sexual partners (Curtin, Ward, Merriwether & Caruthers, 2011; Robinson & Davies, 2008).
8. *Sexual Risk Taking* was defined as the behaviors that placed an individual at an increased risk for STDs, STIs, HIV, and/or pregnancy (Hoyle, Fejfar, & Miller, 2000; Huebner & Howell, 2003). Examples of sexual risk-taking noted in the literature included, but were not limited to the following: a) having multiple unprotected sexual partners, b) having sexual intercourse while under the influence of controlled substances (i.e., alcohol, marijuana, or other drugs, etc.), and/or c) incorrect or inconsistent condom use.

9. To fully understand the context of *parent-child communication*, the following definitions are required. First, a *parent* was defined as one of the progenitors of a child (The American Heritage Dictionary, 2000). Similarly, a *paren*t may also be a man or woman who takes on legal parental responsibilities for a *child* (i.e., adoptive father/mother, step-mother/father, grand-parent, court appointed guardian, etc.) (Camasso & Jagannathan, 2013; Gary, 2008; Wu & Thomson, 2001). Accordingly, a *child* was defined as an individual under the age of 18. This is in accordance with the *26th Amendment to the U.S. Constitution,* which constitutes a *child* or someone under the age of legal responsibility. Communication was defined as the exchange of cultural meanings between individuals through a common system of words, phrases, and/or symbols (Gary, 2008). Taken together, the phrase *parent-child communications* was an umbrella phrase used to define the various ways that parent(s) and their child(ren) communicated with each other. For instance, who initiated these conversation(s)?; how were they done (one-on-one or in groups, with a singular parent or with both)?; how frequently were they conducted (once or occasionally and over time)?; parent levels of (dis)comfort with the conversations; child(ren) levels of (dis)comfort with the conversations; the importance of the conversations on sexual debut, identity, and development.
10. *Human Immunodeficiency Virus* (HIV) is the virus that attacks an individual's immune system (AVERT, 2016; CDC, 2016a). *HIV* is diagnosed using the medical procedures associated with Western Blot; once diagnosed, a person can be treated but *not* cured for *HIV* (*National Institute on Drug Abuse [NIDA],* 2016).

11. HIV Transmission is the conscious, or unconscious, process of exchanging specific body fluids (semen, vagina secretions, rectal fluids, breast milk, and/or blood) between HIV-positive and HIV-negative individuals (CDC, 2016b).

12. *Highly Active Anti-Retroviral Treatment (HAART)* is the use of various prescribed drug combinations to treat individuals infected with HIV, to decrease the spread of the virus between individuals regardless of HIV diagnosis (*National Institute on Drug Abuse [NIDA],* 2016; *World Health Organization [WHO]*, 2016).

CHAPTER 2

LITERATURE REVIEW

Introduction

The research literature has indicated that parent-child communications have resulted in later sexual debut and increased condom use among heterosexual teenagers and adolescents. However, there appears to be no research that examines the various ways that the contexts and contents of parent-child communications influenced sexual behavior and identity development specifically among out gay males. To better understand this, the ensuing literature review is organized into the following sub-categories: a) general communication, b) parent-child communications, c) coming out, d) sexual orientation, e) sexual behavior, f) race and HIV, and g) prevention. The overarching theories used to frame this research project were social learning and social cognitive theory, as they appeared to be the most appropriate frameworks to holistically capture the underlying concepts related to understanding how people learn about behaviors in general, and transferred information between two or more individuals, and how individuals developed their perceptions of self-efficacy.

General Communication

It is well known that the emergence and study of communications is a rather complex phenomenon (Huebner & Howell, 2003; Orbe, 1995; Shaw, 2006; Stanley, Markman, & Whitton, 2002), as the nuanced socialized styles of communication are comprised of various factors including, but not limited to: race, gender, sexual orientation, religious beliefs, culture, age, and language, just to name a few (Asante & Al-Deen, 1984; Davis, 2015; Martin, Hammer,

& Bradford, 1994; Orbe, 1995). Normally defined as a simple two-way exchange process, communication minimally occurs in five modes: two people (a listener and a speaker), two processes (sending and receiving) and, a message (van Keulen, Weddington & DeBose, 1998). Similarly, it frequently occurs in one of three contextual phases: a) sending of the message, b) the environment in which the message is sent and, c) receiving the message (van Keulen et al., 1998). These multiple combined phases make communication consistency challenging and problematic, especially when addressing emotional, and/or sensitive issues (Asante & Al-Deen, 1984; Fisher & Broome, 2011). Indeed, different communication styles have also historically neglected and negated the specific and unique aspects associated with racial/ethnic, gender, religious, and social identities (Davis, 2015; Martin et al., 1994).

Traditionally within the extant literature, race appears to be an important factor impacting communication effectiveness (Davis, 2015; Martin et al., 1994; Orbe, 1995). As such, communications within and across racial groups were frequently examined as functions of one's perceived identity alignment (Deetz & Kersten, 1983; Orbe, 1995). For instance, when engaged in heated communication debates, Whites appeared to be relatively low-keyed (i.e., dispassionate, impersonal, and non-challenging), while Black/African Americans appeared rather higher-keyed (i.e., animated, interpersonal, and confrontational) (van Keulen, Weddington & DeBose, 1998). Also, when empirically controlling for mixed setting environments, White individuals communicated more frequently with other White individuals, than they did with Black/African American individuals (Asante & Al-deen, 1984). However, Black/African Americans in similar situations, actively sought out communications with Whites, while they communicated at equal rates with their Black/African American peers (Asante & Al-deen, 1984). Overall, the literature on Black/African American and White communication styles also

suggested that Black/African Americans often changed their actual language styles, in efforts to appear non-threatening to their White counterparts when attempting to engage in cross-racial conversations (Harper, 2006; Majors, 1998; Mincey, Alfonso, Hackney, Loque, 2013; Morgan, 2002).

Both Black/African American and White individuals often embraced differing perspectives on their own communication styles, especially when displaying varying modes of individual behavior. *The Kerner Commission Report* (1968), a seminal and well cited report explicitly exploring the unique vernacular of Black/African American communication styles coupled with their various identified speech patterns, has helped social researchers to document how Black/African Americans and Whites defined and used common words, phrases, and syntaxes (Orbe, 1995). For instance, van Keulen, Weddington & DeBose (1998), indicated that Black/African Americans defined the words "*argumen*t" and "*discussion*" differently, when compared to Whites. More specifically, these authors noted that for Black/African Americans:

> …arguments used for debates are considered modes of persuasion in relation to the debater's material. The presence of persuasion indicates that Black/African Americans are sincere and serious about what they are saying. In arguments for persuasion, Blacks assume a challenging stance with respect to their opponents; not in an antagonistic manner, but in a manner that cooperatively engaged in conversations that will validate their opposing ideas. (p. 68)

On the contrary,

> …Whites fail to make distinctions between these words, as an argument functions only to ventilate anger and hostility … it does not function as a process of persuasion as Whites were taught to use discussion that is without affect and dynamic opposition. (p. 68)

These multiple and nuanced race-specific speech patterns, intents, word choices, and insights suggested that when examining racial differences, communication is, and has been recognized as a cultural marker through which individuals referenced their lived experiences (Scott, 2000).

Like race, gender-based communications also have correspondingly distinctive unique purposes. Findings on gendered communication styles indicated that gender significantly affected how males and females communicated (Collins, 2005; Gray, Adams, Jacobs, & Jacobs family, 1993; Haferkamp, Eimler, Papadakis, & Kruck, 2012; Parcheta, Kaifi, & Khanfar, 2013; Wiranto, 2013). One often cited argument is the longstanding nature versus nurture debate, regarding the various and assumed gendered communication styles (Jeanes, 2007; Wiranto, 2013), used primarily to help maintain social order (Annavarapu, 2013; Jaworski & Coupland, 2005). For instance, males were taught/socialized to communicate in more assertive, dominant, and self-oriented manners, while females were taught/socialized to communicate using more passive, warm, nurturing, emotional, and friendly styles (Annavarapu, 2013; Parcheta, Kaifi, & Khanfar, 2013). Leaper, Tenenbaum, and Shaffer (1999), also suggested that females communicated and worked collaboratively in comparison to males who communicated and worked more authoritatively. Similarly, Miller, Danaher, and Forbes (1986), suggested that males communicated more heavy-handedly (i.e., louder, directly) in comparison to females, who communicated using a softer intonation, which appeared to be more indirect, and/or compromising.

While research on race and gender communication styles provide insights about the various ways that individuals interact and understand each another, it was the discovery of the internet that helped influence and enhance the range of unique communication opportunities and technological styles used to further help individuals define themselves based on how, and with

whom, they communicated – and what issues they addressed. The internet provides individuals who share similar traits and qualities occasions for instantaneous social networking with others, thus creating instant social connections based primarily on similarities (Wang, Segev, & Liu, 2015). Likewise, the internet has provided individuals with unique opportunities to create social networks through connections made without leaving the comfort of their own personal, and/or private surroundings (Li & Tsai, 2015; Qiu, Lin, & Leung, 2013). Also, the technological advancements of the internet offer GLBT individuals the ability to associate themselves with content that satisfies and meets their personalized social, emotional, physical, and psychological needs (Cantril, 1942; Ruggiero, 2000), some of which are based on race, class, gender, sexual orientation, sexual behavior, and contextual needs (Wang et al., 2015).

Unfortunately, the cited research on communications is rather limited, dated, and, in essence, still under development particularly as it pertains to race and gender expectations (Davis, 2015). Researchers examining various communication styles and patterns more broadly, reinforced the importance of specificity and simplicity, especially when communicating difficult information to diverse groups (Davis, 2015; Franklin, 1984; Orbe, 1995). However, the internet explosion provides individuals with a range of opportunities to identify their needs, which in turn, impacts their online, and other, social identity development (Li & Tsai, 2015; Wang et al., 2015). Despite these results, the numerous and various communication styles, patterns, words, images, blogs, messaging patterns etc., used to relate to each other are still being developed and understood. As such, more systematic studies are needed to further understand effective communications between groups, and sub-groups within – and throughout – society.

Parent-Child Communications

The socialization process, specifically for adolescents, regarding gender norms and roles, sexual behaviors, and sexual identity has changed considerably since the 1960s (Astone & McLanahan, 1994; Eisenberg, et al. 2006; West & Zimmerman, 1987; Wu & Thomson, 2001; Zimmerman & West, 1975). The idealized nuclear two-parent family structure has shifted for a number of reasons including, but not limited to: a) the consequences of war, disease, famine, and natural disasters (*Bernard Van Leer Foundation*, 1993), b) economic and political turmoil (Astone & McLanahan, 1994; *Bernard Van Leer Foundation*, 1993; Thomson & McLanahan, 2012), c) a natural population increase (Cernada, Sun, Chang, Tsai, 2007; *Population Reference Bureau*, 2006), and/or d) divorce (White & Booth, 1985; Wu & Thomson, 2001). These demographic realities have broadened today's family and parental definitions to include single parents, step parents, multi-generational families, and mixed or blended families (Astone & McLanahan, 1994), which now may include grandparents as primary caretakers (Price & Yuen, 2005; Whitley, Kelley, & Sipe, 2001), and/or government agencies (Camasso & Jagannathan, 2013). With these, structural societal changes within the family unit and provider roles have evolved to include: mothers as 'breadwinners', fathers as homemakers, grandparents as primary caretakers, or state protective agencies as *ad-hoc* decision-makers, regarding the immediate and long-term needs of children (Astone & McLanahan, 1994; Bumpass & Raley, 1995; Camasso & Jagannathan, 2013; Price, 2005; Whitley, Kelley, & Sipe, 2001).

Historically, U.S. research on parent-child communications have revealed that when parents facilitated sexual behavior conversations with their children, there was: a) later sexual debut (Lewis, 1973; Wight et al., 2006), b) fewer sexual partners (Berenson et al., 2006; Treboux & Busch-Rossnagel, 1990; Wight et al., 2006), and c) increased contraceptive use (Maulsby et

al., 2013a; Rosenthal, Feldman, & Edwards, 1998; Sorenson, 1973). Findings have also indicated that adolescents who were strongly attached to their parents were more likely to have similar internalized parental standards for engaging in appropriate sexual conducts, and/or behaviors (Aspy et al., 2007; Astone & McLanahan, 1994; Zolten & Long, 1997). For example, when parents disapproved of inappropriate early sexual behaviors, adolescents also held similar beliefs and positions on the subject (Perrino et al., 2000). Ultimately, such findings have indicated that a key aspect of today's family socialization includes more open knowledge, information, popularization, and discussion about sexual knowledge, and appropriate sexual behaviors within society.

The research on the closeness of parent-child relationships also revealed some unique findings pertinent to this study. Adolescents with stronger attachments to their parents were more likely to internalize their parents' standards and expectations regarding appropriate behavioral conduct, when addressing and dealing with sexually charged situations (Aspy et al., 2007; Astone & McLanahan, 1994; Fisher, 1986, 1987, 1988; Hadley et al., 2009; Inazu & Fox, 1980; Jessor & Jessor, 1975; Newcomer & Udry, 1987; Small & Luster, 1994; Somers & Paulson, 2000; Udell & Donenberg, 2011); which were often consequences of their religious belief systems, grounded in strong value-laden perspectives about sex or sexuality (Afifi et al., 2008). As such, when parents held more conservative religious views regarding sex, their children also held similar beliefs, and they (both parents and children) frequently used those belief systems as guides for evaluating their external friendships, relationships, and overall communication styles (Afifi et al., 2008; Karofsky et al., 2000).

Research findings also indicated that mothers primarily socialized their children about sexual knowledge and behavior, as they were more likely to initiate and facilitate conversations

around sex and sexuality, in comparison to fathers (Aspy et al., 2007; DiIorio et al., 1999; Eisenberg et al., 2006; Guzman et al., 2003; Karofsky et al., 2000; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998). Correspondingly, mother-daughter conversations on sex and sexuality occurred more frequently than did mother-son conversations (Afifi et al., 2008; Fox, 1981; Martin & Luke, 2010; Miller & Fox, 1987; Somers & Paulson, 2000), resulting in an increase in condom use, and a decrease in the number of sexual partners among females (Karofsky et al., 2000; Meneses, Orrell-Valente, Guendelman, Oman, & Irwin, 2006). In fact, while 75% of sex and sexuality topics were not discussed with sons, only 33% of topics were deemed 'off-limits' among researched mother-daughter dyads (Rosenthal & Feldman, 1999).

Additionally, while mothers discussed menstruation issues with 93% of their sons and 95% of their daughters, a closer examination of parent-child communication data revealed that fathers discussed menstruation with 49% of sons and 39% of daughters (DiIorio, Phuhar, & Belcher, 2003). Such discrepancies were explained as being related to feelings of inadequacy, based on assumed and prescribed gender norms, that mothers noted when providing sexual health information to their sons (Martin & Luke, 2010; Ogle, Glasier, & Riley, 2008). Other explanations regarding communication discrepancies were based on the notion that sex and sexuality were deemed as uncomfortable topics, and such topics impacted vulnerability, judgment, embarrassment, and disclosure of previous (or lack thereof) sexual behaviors and practices (Afifi et al., 2008; DiIorio, Phuhar, & Belcher, 2003; Ogle, Glasier, & Riley, 2008). Overall, these results also indicated that parents frequently underestimated the rates of sexual activity among their own adolescent children, based on the parental assumptions of their children's sexual activities (Benavides, Bonazzo, & Torres, 2006; Jaccard, Dittus, & Gordon, 1998; Miller & Whitaker, 2001).

Selected empirical findings have suggested that parental attachment and adolescent sexual activity may be interrelated. Using data from some small non-probability based convenience samples, findings indicated that sexual activity occurred later for those who held closer or more supportive relationships with their mothers (Hadley et al., 2009; Inazu & Fox, 1980; Jessor & Jessor, 1975; Newcomer & Udry, 1985; Small & Luster, 1994; Udell & Donenberg, 2011). Other findings indicated that the actual timing of such conversations impacted an individual's sexual behavior and their decision-making choices (Sheeran, Abraham, & Orbell, 1999). For instance, Jaccard et al. (1998), found that when parents attempted to assess their teen's sexual activities based on their behaviors, they frequently missed ideal opportunities to have these important and critical conversations. When parents assumed that their teen child(ren) were dating, they were more inclined to have the in-depth and detailed conversations when compared to when they assumed that their children were not in romantic relationships, nor sexually active (Eisenberg et al., 2006; Ogle et al., 2008).

Interestingly, research findings also indicated that parents were often misinformed about the sexual debut or sexual behaviors of their own adolescent children, which often affected the timing, frequency, context, and content of such conversations (Perrino et al., 2000). This lack of clarity resulted in conversations that appeared to be futile when attempting to change their sexual behavioral patterns and practices (Jaccard et al., 1998). When such conversations started during the first year of their sexual behavior, adolescents had difficulties negotiating condom use with their sexual partners, in comparison to when conversations occurred before their actual sexual debut (Jaccard et al., 1998; Miller & Whitaker, 2001).

Despite the empirical research on parent-child communications regarding sex, sexuality, and perception of risk, the HIV findings on this subject are still mixed. While researchers have

highlighted the impact of parent-child communications on sexual debut, safer sex practices, and sexual behaviors (Hadley et al., 2009; Inazu & Fox, 1980; Jessor & Jessor, 1975; Newcomer & Udry, 1985; Small & Luster, 1994; Udell & Donenberg, 2011), others have underscored the role and influence of peer socialization and adolescent behaviors, especially when thinking about the decision to participate in high risk sexual behaviors (Holtzman & Rubinson, 1995). Studies have reported that adolescent males from single-parent households were more likely to participate in high risk sexual behaviors, and initiate sexual contact, when compared to males living in two-natural parent households (Carlson & Corcoran, 2001; Newcomer & Udry, 1987; Santelli, Lowry, Brener & Robin, 2000; Vanassche et al., 2014; Wu & Thomson, 2001).

With the paucity of research data on parent-child communications and relationships, various interventions were designed to assist parents in having improved conversations about sex, sexuality, and sexual behaviors (Carlson et al., 2000; Ladapo et al., 2013; Lindsay, Band, Cullen & Cullen, 2008; Velleman, Templeton, & Copello, 2005; Wight & Fullerton, 2013). These interventions included practical information on decreasing HIV/AIDS rates, yet many focused heavily on three key factors: a) being Black/African American, b) reducing teenage pregnancies (Lee, Cintron, & Kocher, 2014; Sutton, Lasswell, Lanier, & Miller, 2014), and c) whether sex and sexuality were ever discussed between parents and adolescents (Somers & Paulson, 2000; Zani, 1991). Sutton et al. (2014) conducted a meta-analysis and found that seven of the tested parent-child communication interventions targeted Black/African American youth, one targeted Hispanics/Latinos, and seven had at least 50% African American youth participants. These authors found that the 15 reviewed studies focused heavily on increased condom use to decrease pregnancy rates, and only one included techniques about how to have conversations with teens on HIV. Five of these interventions focused primarily on increasing parents’

knowledge about, and comfort with, discussing sex, five combined parent-child communications, and three focused on communications with youths (Sutton et al., 2014). Overall, these showed promise with decreasing teenage pregnancies and increasing condom use however, information and conversations regarding HIV were still limited (Sutton et al., 2014).

Sexual Orientation

Up until its removal from the *Diagnostic and Statistics Manual III* (DSM-III) in 1973, homosexuality was considered a pathological developmental process that occurred because of *normal* [italics added] individuals failing to conform to their social norms associated with heterosexuality (Conger, 1975; *Focus on Family*, 2004; Jayaratne et al., 2006; Kinnish, Strassberg, & Turner, 2003; Meyer, 2003; Ridge, Plummer, & Peasley, 2006; Stein, 1999; Thomas, Mience, Masson, & Bernoussi, 2014). Since then, some researchers and social scientists have struggled to define and better understand the concept of homosexuality (*American Medical Association House of Delegates*, 1996; *American Psychological Association*, 1997; Bailey, 1999; Davison, 2001; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Herek & Garnets, 2007; Herek, Kimmel, Amaro, & Melton, 1991; Savin-Williams & Ream, 2007; Yarhouse, 1998). Historically, researchers have proposed that homosexuality was a person's conscious choice, and/or an attention-grabbing behavior, thus adding to the need to further provide a clearer, more succinct, stronger, and socially accepted definition (*Focus on Family*, 2004; Herek & Garnets, 2007; Stein, 1999; Szasz, 1960).

Traditionally, U.S. researchers examining the topic of adolescent homosexual identity disclosure to family, friends, and/or co-workers have included the examination of internalized homophobic feelings (Dube & Savin-Williams, 1999; Paradis, 1997; Rosario, Schrimshaw & Hunter, 2004; Savin-Williams, 1990; 1998; Williamson, 2000), as their self-identified disclosure

often brought anticipated feelings of alienation coupled with fears of abandonment (Darby-Mullins & Murdock, 2007; Ragins, 2008; Ragins, Singh, & Cornwell, 2007). These feelings accumulated over the years resulted in: a) a greater risk for adolescents associating with peers who shared similar lived experiences, b) substance use disorder diagnoses, c) heightened rates for major depression and conduct disorders, d) higher instances of sexual risk-taking to suppress feelings of abandonment feelings as they may not feel accepted within, and by, the larger society (especially their peers), and/or e) expressed suicidal ideations or feelings, based on sexual orientation, and HIV/AIDS infection (Cochran, Ackerman, Mays, & Ross, 2004; Eisenberg, & Resnick, 2006; Elizur & Ziv, 2001; Meyer, 2003; Radkowsky & Siegel, 1997; Russell, Truong, & Driscoll, 2002).

When examining various mental health issues among gay males, researchers have highlighted contextual community issues that impacted their outness levels, regardless of gender, race, and societal acceptance. Many gay males often feared being ostracized or ridiculed based on, stigmatization and prejudice within their own social networks, and from the larger society (D'Augelli & Grossman, 2001; Meyer, 1995, 2003). For instance, data on the social acceptance of gay males revealed findings about the continuously problematic and violent behaviors they encountered in the U. S. The *U.S. Department of Justice Uniform Crime Report* [*USDOJ*], (*UCR* 2014), indicated that there were 6,727 victims of hate crimes, in 2013, which included 1,248 or (18.7%) of violence based on sexual orientation. Of these, 56.3% were motivated by anti-gay male bias, and 24.4% were based on anti-lesbian, bisexual, and transgender bias (*USDOJ*, 2014). Most recently, the world was reminded of such violence toward GLBT individuals with the killing of 49 unique individuals in Orlando based primarily on their perceived sexual orientation. This incident could be viewed as a stark reminder of the confirmed violence and non-accepting

attitudes of some individuals in society toward this sub-group. Similarly, research findings have indicated that some out gay males also encountered violence from their own family members (Ettinghoff, 2013; Hunter, 1990), and some teens have faced increased instances of verbal harassment in middle and high school settings (Ettinghoff, 2013). These historically deep-seated negative experiences appear to be the main rationale that many gay males recall when assessing the public and private risks of coming out.

Another long-held differentiation between gay males and their heterosexual counterparts is their own socialization process toward with sex and sexuality. U.S. census data has indicated that approximately 4% of adults aged 18 and older identified as GLBT (*Gallop*, 2016; Gates, 2011). Gay males, unlike their heterosexual peers, often navigated sexual maturation and realization processes without positive and healthy role models, or healthy sexual development discussions as those provided to their heterosexual counterparts (Peterson & Rischar, 2000; Robertson, 2014; Schneider, 1989; Tolan, 1997; Williams, Connolly, Pepler, & Craig, 2005). Accordingly, gay males held higher internalized homophobic feelings and negative self-image, resulting in increased: a) use of substances (Marshal et al., 2008; McCabe, West, Hughes, & Boyd, 2013; Purcell, Parsons, Halkitis, Mizuno, & Woods, 2001; Stall et al., 2001), b) suicidal ideations (Eisenberg & Resnick, 2006; Haas et al., 2011), and c) higher rates of high risk sexual behaviors (Brooks, Landovitz, Kaplan, Lee, & Barkley, 2011; Klitzman, Pope, & Hudson, 2000).

Coming Out

Despite the horrifically egregious and targeted mass shooting at a GLBT club in Orlando, FL in June 2016, U.S. social attitudes toward GLBT rights and acceptance appear to be changing in a more positive direction (Ettinghoff, 2014; Gates, 2015). However, the actual ‘coming out’ process itself, still remains a worrisome and anxiety-provoking activity for many (Waldner &

Magrader, 1999; Zhao et al., 2016). Researchers examining the various issues and concerns that GLBT individuals navigated when deciding to disclose their sexual orientation, have identified varying levels of 'outness' that include: a) not out (closeted), b) partially out (only out to close friends, but not family or work), c) out in safe spaces (friends, some co-workers, some family, GLBT agencies/organizations) or, d) completely out (everyone knows their sexual preference) (Bradford, Ryan, & Rothblum, 1994; Coleman & Remafedi, 1989; Martin, 1993; Meidlinger & Hope, 2014; Moradi et al., 2010; Morris, Waldo, & Rothblum, 2001).

Rationales for these assorted outness levels appear to have some political, personal, and professional justifications (Ettinghoff, 2014; Gates, 2015; Zhao et al., 2016). For instance, proposed rationalizations supporting these aforementioned levels of GLBT outness include: a) attitudes and perceptions of family members (Padilla, Crisp, & Rew, 2010; Savin-Williams, 1994; Waldner & Magrader, 1999), b) societal perceptions (Moradi et al., 2010; Morris et al., 2001), c) religious beliefs and attitudes (Newman & Muzzonigro, 1993; Norwood, 2013; Shilo & Savaya, 2012), and/or d) structural reactions (Ettinghoff, 2014; Newman & Muzzonigro, 1993). These findings also revealed significant relationships between individual levels of outness and issues correlated to: a) increased substance use (Padilla, Crisp, & Rew, 2010), b) mental health (Shilo & Savaya, 2012) and/or, c) suicidal ideations (Blosnich, Nasuti, Mays, & Cochran, 2016; King et al., 2008; McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012).

To further examine these outness levels, researchers identified and used different theoretical frameworks to describe the various circumnavigated GLBT identity juxtapositions against familial, community ties, and social acceptance. For instance, Cass's (1979, 1983/1984, 1984) extensive examination of GLBT identity development and navigation included: a) *identity confusion* – the initial perception of thoughts and feelings that were different from friends and

peers; b) *identity comparison* – the perception of themselves when compared to others; c) *identity tolerance* – acceptance of identity and seeking others with a similar sexual orientation; d) *identity acceptance* – the positive and healthy ideals on being part of the GLBT community; e) *identity pride* – the focus primarily on issues that affect the GLBT community; and f) *identity synthesis* – identity not solely based on sexual orientation, but on other facets of one's life. Comparably, Savin-Williams (1990, 1995, 1998) described the various stages of one's homosexual identity development, which generally included: awareness of same-sex attractions; occurrence of first gay sexual experience; occurrence of first heterosexual sexual experience; labeling oneself as gay or bisexual; disclosing one's sexuality to others (but not family members); experience of first gay romantic relationship; disclosing one's sexuality to family members; and fostering a positive identity. However, although the experiences of lesbians, bisexuals, and transgender individuals are important and unique, this sub-section of the literature review will focus primarily on coming out among U.S. gay men.

Not surprisingly, the most significant relationship that gay males nurtured were with their parents (Dittus, Miller, Kotchick, & Forehand, 2004; Hutchinson, Jermmot, Jemmot, Braverman, & Fong, 2003; Jaccard, Dittus, & Gordon, 1998; Watson, 2014). When disclosing their own sexual orientation, gay males weighed the perceived risks and benefits between coming out, and perceived parental responses (D'Amico & Julien, 2012; D'Augelli & Grossman, 2001; Figueroa & Tasker, 2014; Meyer, 1995). For instance, after disclosing their sexual orientation, their previously reported close relationships before coming out, either changed for the better, deteriorated, or stayed the same (Beals & Peplau, 2006; Ben-Ari, 1995; Cramer & Roach, 1988). Explanations for these differences were based on parents': a) previous exposure to gay males and awareness of their issues and concerns, b) assumptions of non-heterosexual behaviors in their

children, c) levels of education, and/or d) child's age (Bregman, 2013; Bregman et al., 2013; Padilla, Crisp, & Rew, 2010).

The body of research addressing identity development, barriers, and stressors, have also addressed to whom gay males were more likely to self-identify as gay (Švab & Kuhar, 2014; Zhao et al., 2016). Historically, gay males primarily 'came-out' to their mothers, both directly and indirectly (Baiocco et al., 2015; Bregman, 2013; Miller et al., 1998). Specifically, gay males were more likely to come out to their mothers (65.2%) compared to their fathers, as some mothers (9.8%) directly inquired about their children's sexual orientation (Baiocco et al., 2015). Explanations were based on attachment styles, that fostered more perceived honest and open dialogue exchanges between mothers and sons about sexuality and sexual behaviors (Denes & Afifi, 2014). These identified differences were based on the notion that adolescent males formed healthier relationships with their mothers which in turn, facilitated an easier transitional coming out process for both parties (Biaocco et al., 2015). These conversations although difficult, provided sons with opportunities to continue along a path of self-discovery and self-awareness, regarding how they self-identified pertaining to their own understanding of their admitted sexual orientation and sexual behaviors (Dunlap, 2016).

Contrarily, research findings have indicated that more fathers rejected their gay sons at the initial time of disclosure (D'Amico & Julien, 2009, 2012; D'Augelli, Hershberger, & Pilkington, 1998; Floyd et al., 1999; Svab & Kubar, 2014). Such rejection was often motivated by homophobic ideations regarding masculinity (Baiocco et al., 2015; LaSala, 2010; Robinson, Walters, & Skeen, 1989), and the perceived violation of anticipated traditional family values (Figueroa & Tasker, 2014; Newman & Muzzonigro, 1993; Waldner & Magrader, 1999; Webb & Chonody, 2014). However, with continued, detailed, and honest conversations fathers in some

studies became more supportive of their sons as they developed a more holistic and positive understanding of their son's sexual orientation (Denes & Afifi, 2014).

Some research findings have also indicated that "coming out" has some positive health benefits and outcomes. While some gay males felt alienated, and abandoned because of their affirmed sexual orientation, it appeared that with continued family supports and more open and honest conversations, parental perceptions, acceptance, and support changed over time (Boss & Thorne, 1989; Denes & Afifi, 2014; Hobfoll & Spielberg, 1992). Typically, some gay men who disclosed their sexual orientation to their parents had improved mental health outcomes, reduced substance use disorder diagnoses, decreased suicidal ideations and attempts, and fewer risky sexual practices, and/or behaviors (Bregman, 2013; Bregman et al., 2013; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Additionally, these encouraging research findings also suggested that immediate family acceptance had more positive mental health outcomes (i.e., social support, increased self-esteem), and provided protective factors for negative health outcomes (i.e., depression, substance use, and suicidal ideations/attempts, multiple sex partners) (Ryan, Huebner, et al., 2009; Ryan, Russell, Huebner, et al., 2010).

Sexual Behavior

Research on sexual behaviors have generally identified various external stimuli as influencing the timing of one's sexual debut, and sexual behavioral practices of adolescents (Boone & Lefkowitz, 2004), two of which include: a) peers (Latkin, Forman, Knowlton, & Sherman, 2003), and b) the internet (Ross, 2005). Berenson et al. (2006) found that when adolescents believed that their friends did not use condoms, had multiple sex partners, or had sex at a younger age, there was equal or greater likelihoods of them also participating in similar

behaviors. Similarly, when compared to Whites, African Americans and Hispanics had higher rates of: a) sexual activity, b) sex before age 13, c) sex with multiple partners, d) pregnancy, and e) sexually transmitted diseases (STDs) (Kahn et al., 2014; Kotchick, Shaffer, & Forehand, 2001; Meneses et al., 2006). These higher rates often occurred because of an adolescent's exposure to similar behaviors by their peers, as well as their parent's discomfort with having conversations with their children regarding sex and sexual behaviors (Afifi et al., 2008; Meneses et al., 2006).

The internet has now provided individuals with many opportunities to communicate more rapidly, openly, and freely with others, regardless of distance (Ross, 2005). The internet has been used by many adolescents to learn about sexuality, and to communicate with others with similar sexual identities and sexual preferences (DiIorio et al., 1999; Wang et al., 2015). As indicated, many adolescents have used the internet to learn about themselves, find others who have similar sexual orientations, behaviors, and concerns regarding their sexuality and sexual orientation (Bond, Hefner, & Drogos, 2009). Research indicated that adolescents spoke more openly, frequently, and freely with their peers than with parents, and it was within the confines of these peer relationships that they honestly defined, disclosed, and addressed issues regarding sexual behaviors, and practices (DiIorio et al., 1999; Stanton-Salazar, & Spina, 2005). Such conversations, and social support networks, provided some adolescents with the 'safety net' needed to more fully examine their own sexuality and orientation without fear, ridicule, or reprisal from their heterosexual counterparts (Stanton-Salazar & Spina, 2005).

Race and HIV

Since its 1982 outbreak in the U.S., HIV rates have grown exponentially. Currently, there are approximately 1.2 million people affected, with an additional approximately 13% who are unaware of their HIV diagnosis (CDC, 2015b; *Kaiser Family Foundation*, 2014).

Complications related to a compromised immune system, significant weight loss, and other co-morbid and opportunistic infections related to the disease, have resulted in the deaths of approximately 650,000 U.S. individuals (CDC, 2015b; Kaiser Family Foundation, 2014; Klein, 2012; Shahapur, & Bidri, 2014). Of the approximately current 1.2 million HIV infections in the U.S., Black/African American and Hispanic individuals were the two minority groups with the highest annual infection rates, when compared to all other racial groups (Gebo, et al., 2005; *Kaiser Family Foundation*, 2014; Millett et al. 2012; Millett, Flores, Peterson, & Bakeman, 2007; Millett, Peterson, Wolitski, & Stall, 2006; Miller et al. 1998;).

Currently, Black/African American individuals constitute 13% of the U.S. population, and they accounted for approximately 48% of new HIV infections (CDC, 2015b; *Kaiser Family Foundation*, 2014; Millett, et al. 2012; Millett, Flores, Peterson, & Bakeman, 2007; Millett, Peterson, Wolitski, & Stall, 2006). Comparably, Hispanics currently comprise 17.4% (54,000,000) of the U.S. population (Census, 2010, 2014; Gray, Valverde, Tang, Siddiqi, & Hall, 2015), and account for 23% of new HIV infections (CDC, 2016b). The rate of new HIV infections per 100,000 for Black/African Americans (68.9) was around 8 times that of Whites (8.7), and Latinos (27.5) had a rate around 3 times that of Whites (CDC, 2014; *Kaiser Family Foundation*, 2014). It is important to highlight that, and as noted earlier, gay males comprised roughly 2% of the U.S. population however, they accounted for approximately 63% of new infections (*Kaiser Family Foundation*, 2014; Millet et al., 2006). While these data underscored that Whites accounted for the largest number of new infections (11,200), followed by Black/African Americans (10,600), the most significant increase of any age/demographic group were young (13–24), Black/African American gay males who had an approximate 48% spike in new HIV infections between 2006 and 2009 (CDC, 2014; *Kaiser Family Foundation*, 2014:

Millet et al., 2007). In fact, recently released 2016 epidemiological data indicated that Black/African American gay males had a projected lifetime infection rate of approximately 50%, and Hispanics had a 25% lifetime projected rate of HIV infection; in other words, 1-in-2 Black/African American and 1-in-4 Hispanic gay males will likely be infected with HIV within their lifetime (CDC, 2016a).

While research findings have identified racial differences in conjunction with aspects associated with racial socialization as key factors influencing the perception of HIV transmission and risks, the examined co-relationships between religion, family, friends, and education among racial and ethnic minorities, highlighted significant relationships between the perception of risk and sexual behaviors (Díaz, Ayala, Bein, Henne, & Marín, 2001; Frye, et al., 2015; Han, 2007; Herbst et al., 2007). These findings initially identified religion and family supports as key factors characteristically associated with how gay males understood and discussed issues related to sexual orientation and perception of risk (Carballo-Diéguez, 1989; Marín, 1989; Rhodes et al., 2011). Race and ethnicity coupled with sexual orientation also played a key role in one's identity development, as Black/African Americans and Hispanics often navigated gay communities, as well as their own racial ethnic communities with both caution and trepidation (Crenshaw, 1991; Frye et al., 2015; Grov, Bimbi, Nanín, & Parsons, 2006; Han, 2007; Marín, 2003; Teunis, 2007). For example, Black/African Americans and Hispanics did not find much acceptance in their own racial/ethnic groups because of their own sexual orientation, nor did they find acceptance within the larger gay community, because of their race (Brooks, Etzel, Hinojos, Henry, & Perez, 2005; Crawford, Allison, Zamboni, & Soto, 2002; Han, 2007; Lewis, 2003; Loiacano, 1989; B. Marín, 2003; G. Marín, 1989), often resulting in their own sexual orientation becoming consciously hidden.

Other findings regarding the perception of risk, suggested that gender was critical to how Black/African American and Hispanic gay males viewed their own perceptions of HIV risk, and personal relationships within their respective communities (Brooks et al., 2005; Crawford et al., 2002; Icard, 1989; Lewis, 2003; Loiacano, 1989; Marín, 2003; Meyer, 1995; Rhodes et al., 2011). For instance, Black/African American and Hispanic males were often tasked with filling specific gender role responsibilities, coupled with gendered expectations that negated homosexual identity, which was a weakness and an embarrassment within their respective social networks and communities (Brooks et al., 2005; Diaz, 1998; Díaz et al., 2001). To combat these cultural views of sexual orientation, Black/African American and Hispanic gay males often used religious ideologies and gender norms as reference points to suppress their same-sex desires, and meet their family, social, and community standards of "maleness" and "masculinity" (Carballo-Diéguez, 1989; B. Marín, 2003; G. Marín, 1989; Meyer, 1995, 2003; Rhodes et al., 2011).

Black/African Americans

The construction of Black/African American gay male sexual identity revealed both psychological and societal implications specifically regarding sexuality, and identifying with other racial and ethnic groups; particularly, having a solid versus fluid identity. Much research has focused on how positively, or negatively, ethnic identity would impact various socialization processes (Bennett, 2006; Heim, Hunter & Jones, 2011; Sellers & Shelton, 2003). Other research has linked racial and ethnic identity to: a) self-esteem (Heim, Hunter, & Jones, 2011; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Sellers & Shelton, 2003), b) job satisfaction (Collins, 1998; Combs, Milosevic, Jeung, & Griffith, 2012), c) school performance (Eglash, Gilbert, Taylor & Geier, 2013; Royster, 2013), d) personal and social conduct (Anderson, 1994), e) perceived social and emotional support (Brown et al., 2000; Eglash, Gilbert, Taylor & Geier,

2013), f) health (Abraham, 1993), g) identifying and maintaining various levels of mental and emotional support (Quintana, 2007; Sellers & Shelton, 2003), and h) the social norms prescribed to racial and ethnic minorities by Whites (Collins, 1998, 2000).

However, a closer examination of Black/African Americans revealed that racial identity development has undergone a series of definitional and transitional changes in the past century. From nigrescence and social desirability, to racial salience and racial acculturation, changes surrounding African American identity formation have emerged over time significantly in U.S. history (Arbona, Jackson, McCoy, & Blakely, 1999; Bennett, 2006; Cross, 1995; Jones & McEwen, 2000; Pegg & Plybon, 2005; Roberts, et al., 1999; Smith, 1991). While there is a body of research that explored racial identity saliency and achievement (Combs, Milosevic, Jeung, & Griffith, 2012; Heim, Hunter, & Jones, 2011), the relationship between racial identity and self-esteem (Arbona et al., 1999; Sellers, Copeland-Linder, Martin, Lewis, 2006), the relationship between high racial identity development and the ability to navigate developmental models of racial identity with positive self-esteem (Combs, Milosevic, Jeung, & Griffith, 2012), and racial identity and mental health; there is no clear consensus regarding a solid and crystalized meaning of Black/African American racial identity, specifically in terms of community and social acceptance (Brown et al., 2000; Davis, 2016; Sellers, Copeland-Linder, Martin, & Lewis, 2006).

The compilation of research exploring Black/African American racial identity formation and its impact on the individual self has not yet provided a clear or concise definition, or meaning, regarding the formation and maintenance of Black/African American racial ethnic identity (Hurtado, Ruiz, & Guillermo-Wann, 2011; Phinney, 1990). Findings have suggested that Black/African Americans created identities in efforts to safely navigate their surroundings and their interactions with Whites (Davis, 2016). For instance, Black/African American males

often “race switch” – toned down their racial identity and eccentricities – in order to appear non-threatening to their White counterparts (Harper, 2006; Mincey, Alfonso, Hackney, Loque, 2013). Similarly, Majors (1998) proposed the “cool pose” identity persona that rendered specific traits associated with Black/African American identity more invisible and non-threatening. Research findings have also catalogued the various racial and ethnic identity formation phases (negro, colored, Black, African American, minority, racial minority, ethnic minority, and person of color) that many Black/African Americans frequently navigated in order to obtain salience and acceptance from White peers, (Arbona, Jackson, McCoy, & Blakely, 1999; Bennett, 2006; Brown et al., 2000; Davis, 2016; Phinney, 1990; Roberts, et al., 1999; Sellers & Shelton, 2003; Shelton & Sellers, 2000), which is used to further compare their lived experiences with those of their White, and sometimes other racial minority and ethnic, counterparts.

While research has examined the mental and physical well-being and development of Black/African Americans, one area of minimal interest has been the perception of Black/African American heterosexual attitudes toward homosexuality. A pivotal and long-standing research study suggested that Black/African Americans held stronger negative attitudes toward homosexuality, with Black/African American men having a more negative outlook of gay men (Herek & Capitanio, 1995). More specifically, Black/African American gay males, when in the company of Black/African American heterosexual males, had difficulties in navigating racial and sexual orientation issues. Loiacano (1989) found that Black/African American gay males often felt unaccepted by others in the Black/African American community because of their sexual orientation, as well as harbored feelings of denial from the White gay male community because of their race. Similarly, other research findings indicated that Black/African American gay males may refrain from disclosing their sexual orientation based on fears of getting ostracized

by, and disappointing their community, family, and/or friends because they did not fulfil prescribed and traditional gender roles (Armstrong, 2002; Eglash et al., 2013; Herek & Capitanio, 1995; Denizet-Lewis, 2003; Johnson & Ashburn-Nardo, 2013; Lipkin, 1999; Ragins, 2008; Raymond et al., 2011; Savin-Williams, 1995, 1998).

Hispanics

Limited U.S. data exists which examined the relationship between Hispanics and HIV infection. However, current data findings have underscored the notion that Hispanics, like Blacks/African Americans, have experienced similar issues and trends regarding their sexuality and HIV infection. Hispanics are the second largest minority group with high rates of HIV infections, as they account for 21% of overall infections, and 23% of individuals recently diagnosed with HIV (CDC, 2016b). When examining sexual orientation alongside Hispanic heritage, data has suggested that Hispanic gay men accounted for 81% (7,527) of all Hispanics infected with HIV, a number that has increased approximately 16% since 2008 (CDC, 2016b). Explanations for these high HIV numbers were based on findings indicating that Hispanic males (9.2%) were more likely than White males (4.4%), but less likely than Black/African American males (24.0%) to have had sexual intercourse before the age of 13 (Kahn, 2014). Additional explanations about U.S. Hispanic sexual behavior revealed that Hispanics (34.7%) were more likely than Whites (32.8%), and less likely than Black/African Americans (42.1%) to be sexually active overall, and before 13 years of age (Kahn, 2014).

Although the existing data on sexual behaviors were interesting, it was the examination of sexual behavior patterns within the Hispanic community that provided additional cultural perspectives regarding the awareness of, and perception of risk for, HIV infection within U.S. Hispanic populations. Like Blacks/African Americans, Hispanics often felt compelled to hide

their sexual orientation from close family members and friends based on fears of alienation and social exclusion (Díaz, et al., 2001; Lewis, 2003; Marín, 2003; Rhodes et al., 2011). To do so, some Hispanic males moved away from their families and close friends, dated women while still having sexual relationships with men, or used illicit drugs or alcohol to quell their homosexual feelings and ideations (Lopez-Quintero, Shtarkshall, & Neumark, 2005; Marín, 2003; Rhodes et al., 2011). Consequently, many Hispanics frequently had misinformation on, and false perceptions regarding, HIV transmission risks (Miguez et al., 2015; Peterson & Marín, 1988). This was based on language barriers and undertrained service providers working with Hispanic populations (Brooks et al., 2005; Carballo-Diéguez, 1989; Marín, 2003; Rhodes et al., 2011; Sandhu et al., 2013).

Perceptions of HIV knowledge also differed among Hispanics, depending on their birth location (Espinoza, Hall, Selik, & Hu, 2008; Sheehan, Trepka, Fennie, & Maddox, 2015). While it was found that Hispanics, regardless of origin, held rather traditional and conservative beliefs, those who emigrated to the U.S. still assumed that individuals contracted HIV from drinking liquids after someone diagnosed with HIV (Chen, Gallant, & Page, 2012). Equally important to note here was that Hispanics who emigrated to the U.S. were more likely to participate in high risk sexual behaviors (Farrelly, Cordova, Huang, Estrada & Prado, 2013; Sheehan et al., 2015), more so than U.S. born Hispanics. Lopez-Quintero et al., (2005) found that interventions designed to address the specific needs of Hispanic individuals often assumed that *all* [italics added] Hispanics had a similar understanding of sexual risk, which frequently resulted in service providers delivering different approaches to testing and linkage to care. In their study, these authors noted that previous findings suggested 66% of all Hispanics reported never being tested for HIV (Lopez-Quintero et al., 2005). When broken down by region, the rate of those not tested

were higher among Hispanics of Mexican origin (67-71%), and Cuban Americans (71%), when compared to Puerto Ricans (56%) (Lopez-Quintero et al., 2005). These occurrences, according to Sheehan et al., (2015), were based on the notion that foreign-born Hispanic individuals may continue to live their lives based on information imparted to them within their respective countries of origin.

Prevention

U.S. HIV prevention research has helped with decreasing the spread of the virus among individuals who are at an increased risk by producing various interventions that have effectively decreased transmission rates (*Effective Interventions,* 2016). Current HIV prevention intervention research has helped service providers to better explain: a) the relationship between Highly Active Anti-Retroviral Therapy (HAART) and HIV reduction rates (Aziz & Smith, 2011; Eaton, Flisher, & Aarø, 2003; Eaton & Kalichman, 2009; Emlet, Fredriksen-Goldsen, & Kim, 2013; Gebo et al., 2005; Jenkins, 2012; Millet et al., 2006; *National Institutes of Health*, 2011), b) the relationships between family supports, and mental and physical health (Serovich & McDowell, 2007), and c) factors influencing gay male identity development (Dube & Savin-Williams, 1999; Roberston, 2014; Rosario, Schrimshaw, & Hunter, 2011; Savin-Williams, 1998, 2011).

Also, current U.S. HIV data have provided more knowledge and explanations of the relationships between gay males and family supports (Díaz et al., 2001; Wilson et al., 2014), substance use, sexual orientation and HIV status (Wilson et al., 2014), and HIV risk-taking behaviors (Millett et al, 2012). Taken together, the results from these aforementioned studies have spawned various promising practices that have helped to effectively decrease not only U.S. HIV infection rates, but also worldwide (Lorimer et al., 2013; Verboom, Melendez-Torres &

Bonell, 2014); while also increasing and extending quality of life outcomes for HIV-infected individuals (Årestedt, Saveman, Johansson, & Blomqvist, 2014; Barile, Edwards, Dhingra, & Thompson, 2014; Li et al., 2016; *National Institutes of Health*, 2011; Wamoyi, Fenwick, Urassa, Zaba, & Stones, 2010).

Although findings on HIV risk/contraction are compelling, additional research results regarding the specific factors associated with HIV transmission rates are still contradictory. A review of epidemiologic literature pointed to the historic fact that gay males, specifically Black/African American and Hispanics have had continuously, and alarmingly higher rates of infection when compared to other racial and ethnic gay males (CDC, 2016b; Drabkin et al., 2013; Fields et al., 2012; Flores, Blake, & Sowell, 2011; Forney et al., 2012; Millett, Flores et al., 2007; Millett, Peterson, Flores et al., 2012; Millett, Peterson, Wolitski et al., 2006). However, U.S. Epidemiological data from 2010 and 2014 reflected a change in HIV infection status among gay males. More specifically, while U.S. White gay males remained at 11,201 new infections, U.S. Black/African American gay male infection rates decreased from 10,600 to 9,008 new infections, and Hispanic/Latino gay male infection rates increased from 6,700 to 7,552 new annual infections (CDC, 2016b). Finally here, the estimated number of new infections for young U.S. Black/African American gay males have decreased to approximately 57%, down from almost 87%, in new infections among all Black/African Americans gay males (CDC, 2015b).

With higher rates of HIV impacting Black/African American gay males, researchers have identified, and recognized various associative factors including, but not limited to, age, race, family support, access to treatment, multiple sex partners, mental health, substance use, and condom fatigue as possible explanations (Drabkin et al., 2013; Fields et al., 2012; Flores, Blake,

& Sowell, 2011; Forney et al., 2012; Herek & Capitanio, 1995; Herek & Garnets, 2007). However, Maulsby et al. (2013b) and Millett et al. (2006) conducted systematic literature reviews and found: a) fewer HIV risk behaviors, b) lower cases of unprotected anal intercourse (UAI) with their main male partners, c) fewer male sex partners, and d) higher rates of condom use during anal sex among Black/African American gay males, when compared to White gay males. They also found that Black/African American gay males had: a) significantly lower substance use, and b) were less likely to use any drugs or alcohol during sex, apart from sex workers who reported higher risk sexual behaviors (Fields et al., 2012; Maulsby et al., 2013a; 2013b; Millet et al., 2006; Stall et al., 2001). Currently, there are no studies that have addressed similar issues among Hispanic gay males.

Social Learning Theory (SLT) and Social Cognitive Theory (SCT)

Bandura's initial ideas regarding learning and cognition were explained as a three-way dynamic, reciprocal theory, used to examine the numerous ways that environmental influences, personal factors, and behavior, were all synergistically intermingled. SLT described how learning was a continual, lifelong, and interactive process that occurred as a behavioral consequence related to imitation, observation, and modeling (Bandura, 1969, 1977a, 1977b). Therefore, the primary process associated with such ongoing learning suggested that:

> Virtually all learning phenomena resulting from direct experiences can occur on a vicarious basis through observation of other people's behavior and its consequences for them. Man's capacity to learn by observation enables him to acquire large, integrated units of behavior by example without having to build up the patterns gradually by tedious trial and error. Similarly, emotional responses can be developed observationally by witnessing the affective reactions of others undergoing painful or pleasurable experiences. Fearful and

> defensive behaviors can be extinguished vicariously by observing others engaged in the feared activities without any adverse consequences. And behavioral inhibitions can be induced by seeing others punished for their actions. (Bandura, 1977b, p. 2)

Individuals initially, and primarily, learned how to adjust their behaviors based on the perceived, and presented rewards, and/or punishments (Martin, 2004; Rescorla & Solomon, 1967). Behaviors that offered the greatest rewards were reinforced and reproduced, while the behaviors that resulted in harsher punishments were ignored and dismissed (Rescorla & Solomon, 1967). Hence, the definitive premise underlying SLT was the belief that learning occurred because of events happening, observed rewards and consequences, and individuals developed the motivation to either reject or reproduce the observed event (Jehu, 1975; Vygotsy, 1978).

To understand the foundations of SLT, Bandura (1969, 1977a, 1977b, 2002) highlighted the conscious components associated with learning, which included: a) attention, b) retention, c) reproduction, and d) motivation. Attention was defined as the act of observing people or behaviors as they occurred within their current surroundings (Bandura, 1977a, 1977b). Some examples (both acceptable and unacceptable behaviors) include: students studying together in the library, siblings protecting each other, teachers providing class lecture, friends laughing and talking, gang members helping the elderly with their bags, students skipping class on senior skip day, police officers monitoring a football game, and the list continues. Retention was defined as the act of storing observed positive or negative behaviors (Bandura, 1977a, 1977b). This process used verbal coding to help associate a name with an image such as Paris with the Eiffel Tower, The University of Georgia with its Bulldog (UGA), a red octagon to suggest stop and so on. Reproduction was defined as the duplication of behaviors observed within, and throughout the environment (Bandura, 1977a, 1977b). An example of this was taking a swimming class and

then moving one's body from one side of the pool to the other. Finally, motivation was defined as having a good reason to either replicate or ignore the observed behavior(s) (Bandura, 1977a, 1977b). Taken together, these terms provided the foundation that explained self-efficacy – or belief that individuals could successfully achieve similar outcomes by reproducing the observed components associated with their expected outcomes (Bandura & Adams, 1977; Rosenstock, Strecher, & Becker, 1988).

It appeared that the underlying and possibly prevailing assumption of SLT was that learning was a continual life-long process. This was based primarily on the nature of human developmental interactions and the desire to improve oneself through social acceptance (Ormrod, 2004). Since individuals were always learning and navigating various routes to achieve a desired outcome, they were not always fully engaged in the process of imitating others based on the observed self-motivation tactic inspired by the setting of goals to reach a desired outcome (Bandura, 1991). Additionally, SLT proposed that individuals were more likely to adapt behaviors from those whom they admired, or those who they revered within particular fields in order to either meet, or surpass, the level of these well-regarded individuals (Bandura, 1976, 1991). For example, junior level faculty writing their research agendas and timelines that outlined their 5-year plans, 7-year plans, and their tenure and promotion plans. In this instance, the *student* displayed behaviors that were not only deemed acceptable to the *teacher*, but also exuded confidence in him/herself, and commanded the respect that he/she may have sought from others (Bandura, 1991).

This view of learning is not new to social sciences however, one major underlying proposition associated with such learning hinged on information exchange relationships and the interactions between individuals, or the interactions between an individual and their environment

(Salomon & Perkins, 1998). With these grounded aspects of SLT in place, other related concepts/factors must also be acknowledged and addressed. These concepts/factors, as identified in several reviews of SLT, included: a) reciprocal determinism, b) behavioral capability, c) expectations, d) self-efficacy, e) observational learning (modeling), and f) reinforcements (Bandura, 1969, 1977a, 1991; Cheng & Chu, 2014; Cowan, Langer, Heavenrich, & Nathanson, 1969; Salomon & Perkins, 1998). These key concepts/factors, their definitions, and an example of how they are used in the extant literature are presented in Table 1.

Table 1

Key Concepts, Definitions, and Examples of Social Learning Theory

Concepts	Definitions	Examples
Reciprocal determinism	The dynamic interaction of the person, behavior, and the environment in which the behavior is performed	The influence that interactions between behavior, personal factors, and environment have on behavior changes
Behavioral capability	Knowledge and skill to perform a given behavior	In order to perform a task or behavior, a person must know what to do and how to do it
Expectations	Anticipated outcomes of a behavior	The anticipated results an individual wants from taking a particular action
Self-efficacy	Confidence in one's ability to take action and overcome barriers	The personal factor that is influential in changing particular behaviors
Observational learning (modeling)	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior	Learning through the experiences of others rather than through one's own experiences
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of reoccurrence	The positive or negative responses to a particular behavior that affect whether or not an individual will repeat it

When applying these concepts within the context of the SLT spectrum, it is important to realize that a person's self-efficacy is based on their belief that they are in control of their own "motivations, emotional states, thought processes, and patterns of behavior" (Bandura, 1994, p. 26). For example, when addressing HIV rates, assuming that teenage males had informative conversations with a parent, he would be able to effectively negotiate condom use, have lowered sexual partners, or have sex while sober, thus reducing his risk for HIV infection. However, for others who were not in the ideal conversational situation, the concepts associated with SLT would provide an arsenal of information regarding safer sex practices which may help decrease HIV infection rates, and aid with predictive behaviors that decreased the chances of infection, as he would be able to quickly and effectively anticipate how to deal with behaviors that were not within the context of safer sex practices (condom negotiation) with his sex partner(s), or how to protect himself should the condom break or slip off during intercourse.

The appeal of SLT, for this dissertation is not only its relevance, but its extensive and deep-rooted ties to previous research that provided more in-depth explanations of an individual's behavior and learning (Bussey & Bandura, 1999; Cowan et al. 1969; Levine & Resnick, 1993; Rescorla & Solomon, 1967; Salomon & Perkins, 1998; Solomon & Turner, 1962). Thus here, SLT provided an appropriate lens through which to explore communication leading to behavioral change, particularly as it pertained to self-efficacy and outcome expectations. For instance, when examining the relationship between race and career development, Hackett & Byars (1996) pointed out that differential standards used to judge the lifestyle choices of Black/African American women often weaken their self-efficacy, and their ability to predict how their environments responded to their behaviors. Other researchers have noted that self-efficacy, as defined by SLT, might cause Black/African American women to consider themselves as inferior

to their White counterparts. Collins (1998), and Hackett and Byars (1996) pointed out that being a Black/African American female frequently resulted in a noticeable secondary status with respect to jobs, wages, or promotions, even when controlling for their own educational level. As these examples highlighted, depending on a woman's level of self-awareness relating to her experiences with racism and gender identity, coupled with her pre-existing level of self-efficacy, she may attribute external behaviors to structural inequalities, rather than internalizing themselves as weak or inadequate (Hackett & Byars, 1996).

While SLT has been used extensively to explain how individuals develop and reproduce peculiar habits, it is not clear how particular or specific behaviors became unlearned. When addressing issues pertaining to SLT, it could be assumed that self-determination was also the underlying and required incentive needed to elicit acceptable change (Bandura, 1989; Martin, 2004; Perry, Perry, & Rasmussen, 1986). Given this assumption, minimal consideration is provided to the influence of the multiple external or internal influences that are contributing to the behaviors exhibited by one person. Although individuals learned from those with similar traits, the question of whether they had the will power to distinguish between *"good"* and *"bad"* was not clearly answered, particularly for those with mental health issues. For instance, SLT does not consider what factors may be associated with a kleptomaniac's desire to steal, although s/he may not have a need to steal, or a drug addict's relapse after 7 years of sobriety, although s/he has followed the steps necessary to main her/his sobriety. Indeed, both instances carry negative consequences, which may include jail time, probation, fines, or family disruption. If, according to SLT, individuals have a strong motivation to stop a behavior, but when disruptions occur, it appears that SLT does not provide explanations for such disruptions or their causes.

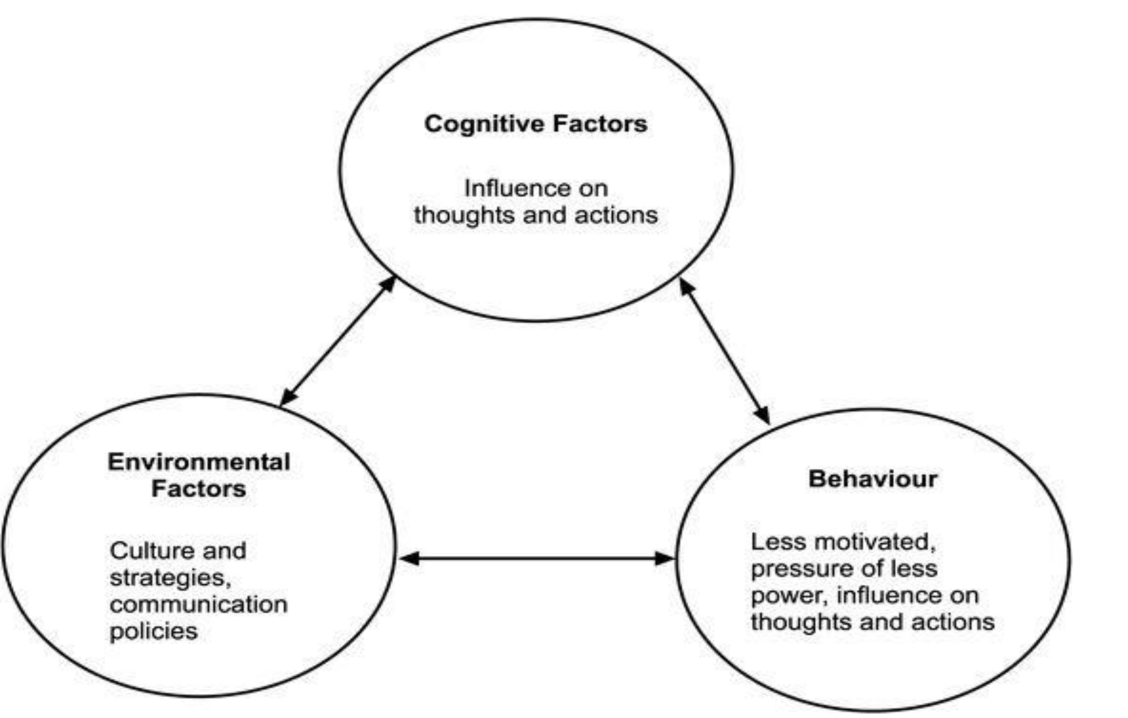

Figure 1: Schematization of triadic reciprocal causation in the causal model of social cognitive theory.

To address the aforesaid theoretical weaknesses, Bandura (1986, 1989, 1998, 2001a, 2001b) expanded SLT by examining the decision-making processes associated with one's learning. Instead of explaining how individuals may unlearn information and behaviors, Bandura examined how individuals perceived of their own self-efficacy and defined outcome expectancies, and thus social cognitive theory (SCT) evolved from his previously proposed ideas influencing and defining the main concepts he associated with SLT (Bandura, 1986, 2001a, 2001b). Accordingly, Bandura (2001b), asserted that "people are self-organizing, proactive, self-reflecting, and self-regulating, not just reactive organisms shaped and shepherded by environmental events or inner forces" (p. 266). In this instance, the ongoing transactions occurring between environment, personal, and behavioral determinants, as showcased in Figure 1, have an influential role regarding how one's cognition is formed.

Using these connections as a guide, self-efficacy is, and continues to be, the key factor affecting and influencing both perceived self-efficacy and anticipated outcomes (Bandura, 1986, 1998, 2001b, 2004; Luszczynska & Schwarzer, 2005). As such, "individuals are neither driven by inner forces nor automatically shaped and controlled by external stimuli" (Bandura, 1986, p. 18). Fittingly, individual motivations and actions are intimately linked to, and regulated by forethought of outcomes (Bandura, 1986, 1989, 1998), and precaution regarding expectations (Luszczynska & Schwarzer, 2005). In its entirety, the revised definition of self-efficacy – within the context of SCT – suggests that an individual's belief in their capabilities to perform a required specific action to obtain a specific outcome, determines whether that individual will attempt to execute that expected action (Bandura, 1986, 1989, 2001b). Therefore, individuals were no longer concerned with positive or negative rewards, as they developed some abilities to choose what activities to attempt, and which ones to either ignore or attempt later when they felt they could successfully obtain the desired outcome (Bandura, 1986, 1989, 2001a, 2001b, 2004; Luszczynska & Schwarzer, 2005).

Regarding the ability to self-select which observed behaviors they wanted to perform, Bandura (2001b) distinguished between *acquisition* and *performance* as individuals did not always perform everything they had learned. In terms of acquisition, Bandura (1986, 1998, 2004) clarified and extended the concepts associated with the reproducing process described in SLT. In SCT, such reproducing involves three sequential steps: a) extracting the generic features from the social exemplars, b) integrating the extracted information into composite rules, and c) using the rules to produce new instances and models of behavior (Bandura, 2001b, p. 275). Ultimately, when individuals integrated these three steps, they developed improved strategies and perspectives that successfully resolves the presented problem(s) (Bandura, 1998, 2001b).

For instance, an individual without knowledge regarding how his/her lifestyle habits affected their health has no reason to change the 'bad habits' they already enjoyed. However, after learning effective changes, they adopt the new information while integrating their own specific needs to help create plans that meets their unique needs.

Similarly, individual performances were more inclined to be behaviors that presented them with the best and most valued outcomes, regardless of whether those outcomes provided unrewarding or punishing outcomes (Bandura 1989, 1998, 2004). Using this theoretical framework, individuals became motivated to perform acts and/or observed behaviors that often resulted in beneficial returns and outcomes (Bandura 1998, 2004). In instances where there is doubt or non-commitment to the behavior as a consequence of perceived external influences, individuals may tailor their behaviors and adopt a more pragmatic approach toward the situations (Bandura 1998, 2004). For instance, individuals who desired to make new friends/associates may participate in social groups, activities, and events (i.e., going to music festivals, participating in online chat rooms/groups, participating in social groups on a college campus) that aligned with their own personal interests. The responses they received from these events, will either enhance, or diminish, their current or sequential group participation. Individuals with successful outcomes will continue the behavior while individuals with poor outcomes will either change the behaviors, or discard the idea of socializing, altogether.

Finally, this theoretical framework took into consideration the multiple ways that individuals learned and processed information, and their anticipated outcomes. SCTs evolution capitalizes, expounds, and suggests that individually perceived self-efficacy will influence an individual's willingness and ability to accomplish a specific behavior. Individuals who have crystallized expectations based on information that they have personally heard, seen, and/or

experienced will more likely select events and/or issues that they feel they can successfully accomplish. Ultimately, it considers the effects that these experiences have on an individual's overall decision-making potential, ability to achieve an outcome, and willingness to execute a specific behavior.

Conclusion

The previously reviewed literature offered insightful and timely information about a variety of concerns that can be configured in terms of main study question areas. While previous research findings have indicated that parent-child conversations resulted in a later sexual debut, increased condom use, or decreased number of sexual partners (Hadley et al., 2009; Inazu & Fox, 1980; Jessor & Jessor, 1975; Udell & Donenberg, 2011), there is limited information available concerning how parent-child communications impacts and influences the lived experiences of out adolescent gay males. This is one of the unique features of this study for this population. The gaps in the literature pertain to context and content of the parent-child communications and how these communications influenced sexual behavior and identity development. The paucity of literature examining parent-child conversations, specifically with gay males served as the catalyst for this study. In this sense, parent-child communications can be perceived as the main qualitative content question areas, used as a heuristic lens, that will be explored in the ensuing method.

CHAPTER 3

METHOD

Introduction

The previously reviewed research literature made it explicitly clear that when parent-child communications occurred frequently, they: a) were indeed significant, b) impacted how children learned about sexual orientation and sexual behaviors, and c) affected the perceived potential risks for HIV infection. However, despite these findings, there are few known studies that have examined *how* parent-child conversations impacted sexual behaviors, sexual identity, and perception of HIV risk among self-identified out gay men. In reviewing the parent-child communication literature, it was revealed that researchers, service providers, and interventionists, when addressing sex and sexuality, habitually used the phrase *sexual behavior* interchangeably with *sexual orientation,* and routinely focused these parent-child communications primarily on heterosexual needs, sexual behaviors, and identity development (Afifi et al., 2008; Guzman et al., 2003; Klein et al., 2005; Martin & Luke, 2010; Morgan, Thorne, & Zurbriggen, 2010). Also, as noted in the previously reviewed extant literature, there were few empirical findings on parent-child communications with fathers and their children (specifically with their sons), mothers and sons, and how such communications may be offered, personalized, supported, and structured (Afifi et al., 2008; Swain, Ackerman, & Ackerman, 2006).

This chapter provides a detailed description of the qualitative technique used in this study. Accordingly, it is organized into various sub-sections that include: a) study purpose, b)

research questions, c) reflexivity statement, d) research strategy, e) qualitative method, f) participant inclusion criteria, g) participant recruitment, h) dependability check (pre-testing), i) data collection, j) data analysis, k) credibility checks, l) ethical considerations, and m) conclusion.

Study Purpose

The purpose of this qualitative study was to explore the role and impact of parent-child communications about sex and HIV risk in the lives of self-identified out gay men, ages 18-30. There were three aims for this study, and they were:

1. To explore the extent and nature of parent-child communications about sex and sexual behavior among a sample of self-identified out gay men.
2. To provide an opportunity for self-identified out gay men to contribute to the prevention knowledge by presenting their lived experiences of their own parent-child communications.
3. To help build and/or co-create improved promising practices to help decrease HIV infections within this population.

Research Questions

The three exploratory research questions which guided this study were:

1. How do parent-child communications affect gay men's sexual behavior?
2. How do parent-child communications impact HIV risk?
3. How do parent-child communications shape self-efficacy?

Reflexivity Statement

As a student-qualitative researcher, my role was both complex and confusing as I brought various biases, assumptions, presumptions, and expectations to this research process. My initial

research approaches were grounded in my previous work and research experiences, and interestingly, my own cultural and racial background. However, this study, the study's purpose, and the research questions were influenced primarily by my work experiences and interactions with gay males whom I encountered as a direct-care case manager and service provider in homeless shelters, substance abuse treatment programs, AIDS service organizations, and other community based organizations that provided services for HIV-diagnosed (and undiagnosed) individuals. Working and volunteering in these different organizations, I was regularly inundated with local, national, and international data on HIV infection rates among gay men, treatment outcomes from various biomedical and behavioral interventions, and field tested research interventions aimed toward reducing new HIV infections, and providing treatment for those already infected. However, despite some impressive findings, I was frequently left with three discrete, yet unique and unanswered, questions:

1. How can the historical datasets and treatment outcomes influence the creation of improved cutting edge interventions for individuals who are HIV-negative?
2. Are researchers asking the right research questions? and
3. With the mountain of extant research and data, why are gay men, specifically Black gay men, still at such an increased risk and disadvantage for HIV infection?

These questions, coupled with my work and lived experiences laid the foundation for my assumptions and biases, which affected and influenced this research topic, the proposed research questions, data collection, and eventual data analysis (Leavy, 2014; Padgett 1998).

Noting such biases and assumptions based on my previous work experiences as a direct mental health therapist, program director, and nascent educator to individuals on topics such as sex, sexuality, and HIV/AIDS perceptions and risks influenced the processes used to do data

collection and analysis. Highlighting the awareness of these multiple and conflicting internal perspectives, provided additional insights about how the research was to be conducted, interpreted, and findings presented (Etherington, 2007; Patton, 2002). It also informed how and why the qualitative approach best suited this study (Etherington, 2007; Patton, 2002). Lastly, the trainings I received regarding how to facilitate these conversations have positively increased my own comfort level with discussing this topic and having conversations with individuals, regarding how to best decrease HIV risk.

Growing up Afro-Caribbean, I learned at an early age that certain questions, issues, and topics were often left unaddressed in both the Black/African American community and within the Black/African American family; one such topic was homosexuality. As a child, I grew up in a community that held conservative views regarding gender roles, norms, and expectations, specifically when addressing male and female roles in intimate, and/or platonic relationships. I was socially taught that women were expected to be subservient to their husbands, and husbands should protect and provide for their wives and children. Similarly, boys were socialized to participate in active and aggressive sports, while girls were expected to participate in non-contact sports, as well as ensured that their future children and husband would not have to worry about the more domesticated aspects of housework. Also, I was taught that it was "Adam and Eve, *not* Adam and Steve." Consequently, I grew up with the understanding that homosexuality was a deviant behavior that needed to be suppressed, and hidden as it violated various social, cultural, and religious norms. Subsequently, I shunned and disassociated myself from anyone who identified as gay. Along those same lines, anyone—specifically males—who identified as gay were also shunned and shamed by both the community and their immediate family. Infrequently, there were healthy instances and portrayal of gay men receiving support from family and friends.

Fortunately, as I became older, I started to question my own biases, as well as the relationships that I held with others, including gay males.

As an adult, I was fortunate enough to align myself with individuals who challenged my position and antiquated perspectives on sexuality. Throughout the years, I volunteered and worked with various organizations and individuals who helped me to contextualize the lived experiences of gay men. During these instances, I learned that some gay men chose not to disclose their sexual orientation because of the shame and stigma associated with homosexuality; some chose not to disclose their sexuality as they often felt that "it was no one's business whom they slept with," some chose not to disclose because they did not want to disappoint their fathers, and others disclosed to people outside of their family who they felt were trustworthy. The ones that were out regarding their sexual orientation, either had supportive families or felt that their sexual orientation was something that they had finally clarified, understood, and clearly defined for themselves. As such, they could clearly articulate their sexual orientation to their friends, family, or bystanders who questioned the legitimacy of their sexual orientation.

With these interactions, I developed a rather structured approach and understanding of communication and rapport building with self-identified out gay men. Due to the levels of interaction that I have had with gay men in both work and social environments, I believe that I developed the comfort level needed to comfortably address these sensitive topics and to get critical insight and feedback from the research participants. Over the years, my guiding work philosophy with this population has been to listen first, then respond. By this, I often spent numerous hours engaging in conversations, listening to their stories about their various relationships (or lack thereof) with their biological families, their friends and their multiple (or few) intimate relationships, all of which have influenced how, and with whom, they approached

and interacted with. The underlying and often obvious outcome to me was to frequently note the lack of parent-child communications, and/ or miscommunications about the topics of sex, sexuality, and HIV.

Although my work and social experiences have provided me with unique insights into the lives and worlds of gay males, I have personally never engaged in extended parent-child communications around sex or sexuality. In fact, growing up, I was often told, “don’t get a girl pregnant, until you can take care of both the girl and the child,” or “do not have sex until you can handle all that it brings”. Unfortunately, having conversations about the nuances of sex never occurred. As such, I personally struggled with having conversations regarding likes and dislikes during sex, condom negotiations, and the option to stop during intercourse if I felt uncomfortable. It was not until the later years (early 20’s) while sitting with a nurse during a physical that I asked, and was awkwardly educated about sex, sexuality, and sexual health. Regrettably, much of the information I received seemed rehearsed, robotic, and disingenuous as it appeared to address the needs of White males, rather than a Black male in need of concrete sexual health advice.

This dissertation aimed to explore the role and impact of parent-child communications about sex, sexuality, and HIV risk in the lives of gay men. The assumptions herein were that parents: a) were comfortable talking to their children about sex, b) felt concerned regarding the well-being of their children as it pertained to HIV infections, and/or c) felt that it was important to talk to their children in hopes that they would learn how to make healthy, and safe sexual choices while decreasing any health risks associated with those decisions. Based on anecdotal information from friends, when a person identified as gay, parent-child communications were typically based on the usual scare tactic (i.e., please don’t get AIDS and die, and to always use

condoms), rather than an informational or educational approach (i.e., how to use condoms, how to negotiate condom use, safer sex practices, etc). This perspective suggested that parents were partially using antiquated information on sex, sexuality, risk for HIV infection, discussing sex from a traditional heterosexual perspective, and were basing conversations on sexuality from the conversations of their own experiences with their parents as teenagers. Also, I assumed that the conversations were different, based on race and the gender of the parent.

The assumptions that I brought to this study were closely related to what I anticipated to encounter in the findings. First, I assumed that Black and Hispanic gay men had different conversations about sex and sexuality, when compared to White gay men. Second, it was my belief that gay men who had parent child communications were more likely to have an improved sense of self, a more protective approach to sex, and were more likely to better effectively negotiate condom use with sexual partners, regardless of race. Finally, I assumed that individuals who had conversations about sex and sexuality were likely to hold similar attitudes toward sex as their parents. I arrived at these assumptions based on my readings in the literature as well as my interactions with friends and clients who sought advice regarding their own sexual identity and communications with their parents. Within each of these interactions, I learned not to frown when their opinions did not align with mine, and made the necessary efforts needed to ensure that individuals were heard. Lastly, within the various work and volunteer organizations, I was afforded opportunities to conduct face-to-face interviews and focus groups specifically on sex, sexuality and HIV. Because of the nature of these responsibilities, I learned how to actively engage and listen to clients, and then develop an informed understanding of their needs. During these exchanges, primarily the focus groups, I learned some unique techniques for engaging a

client and being supportive, while not becoming overly clinical. These experiences have shaped how I anticipated the focus group conversation to unfold.

Research Strategy

The research strategy was three-fold. First, it was used to examine what influence, if any, did parent-child communications have on the changes in self-identified out gay men's attitude toward sex, sexuality, and/or HIV. Second, it helped to explore how parent-child communications impacted the perception of HIV. Third, it illuminated how parent-child communications affected gay men's self-efficacy to negotiate, and/or use condoms with sexual partners.

Based on a pre-test of *N=3* gay males who were interviewed after IRB approval, supplementary data was collected using one-on-one interviews which lasted between 45 and 96-minutes. A data analysis was conducted on transcripts from the one-on-one interviews using the inductive and deductive procedures associated with thematic analysis (Alhojailan, 2012; Attride-Stirling, 2001; Braun & Clarke, 2006; Elo & Kyngäs, 2008; Gooden & Winefield, 2007; Tuckett; 2005). Finally, a singular follow-up focus group lasting 90-minutes was used to clarify the identified themes. These steps helped to highlight, clarify, and provide a deeper, more succinct, understanding of how parent-child communications affected sexual identity and sexual behaviors (Creswell, 2013; Merriam 2009; Palinkas, 2014; Yoshikawa, Weisner, Kalil, & Way, 2013).

Qualitative Method

The utilization of a qualitative and research design method is often applied when attempting to provide in-depth understanding of a social phenomenon that does not require nor lend itself to precise enumeration (Palinkas, 2014; Patton, 2002), but instead offers opportunities for *thick, detailed,* and *comprehensive* [italics added] descriptions of the lived experiences being

investigated (Merriam, 2009; Palinkas, 2014; Patton, 2002). The overall aim of qualitative research is "to understand and represent the experiences and actions of people as they encounter, engage, and live through situations" (Elliot, Fischer, Rennie, 1999, p. 216). The compulsory invocation and foundation for applying a qualitative methodology is often supported by the ability to discover "the meanings seen by those who are being researched, and with understanding their view of the world rather than that of the researcher" (Jones, 1995, p. 2). Hence, qualitative methods are habitually employed when,

> …the research context is poorly understood, when the boundaries of the domain are ill-defined, when the phenomenon is not quantifiable, when the nature of the problem is murky or when the investigator suspects that the status quo is poorly conceived and the topic needs to be re-examined. (Morse, 2003, p. 883)

Ultimately, various approaches used in such research provides opportunities to holistically extract and interpret participant's lived experiences (Creswell, 2013; Denzin & Lincoln, 2000; Stake, 2010).

When applying qualitative inquiry, researchers seek to "make explicit the implicit structure and meaning of human experiences" (Sanders, 1982, p. 354). To obtain such detailed and comprehensive descriptions and understandings, qualitative methods often require researchers to immerse themselves in the daily routines, perceptions, nuances, and operations of the individuals being studied (Denzin & Lincoln, 2000; Merriam, 2009; Tracy, 2010). These engagements were often conducted using various participatory data collection procedures, which minimally included: a) naturalistic observations, b) case notes, c) document analysis when available, d) rapport building, and/or e) structured, semi-structured, or unstructured interviews

(Goering & Streiner, 1996; Malterud, 2001; Merriam, 2009; Minkler, 2000; Patton, 2002; Sandelowski, 2000a; Tracy, 2010).

When designing this study, the various qualitative research methods (e.g., case study, phenomenology, grounded theory, ethnography, and narrative inquiry) were reviewed, and their specific methodologies (Creswell, 2013; Denzin & Lincoln, 2000; Merriam, 2009; Patton, 2002). These methods and their methodologies appeared to be interactive, interpretive, naturalistic, humanistic, and emergent (Creswell, 2013; Denzin & Lincoln, 2000; Merriam, 2009; Patton, 2002). Although these methods provided some level of flexibility, a basic and descriptive qualitative research design was chosen because there appeared to be no other studies examining this issue, and using a simplistic qualitative design would provide an opportunity to explore in-depth understandings of an inadequately understood phenomena (Lambert & Lambert, 2012). Similarly, using this methodology does not require a highly abstract rendering of the data that is often not as theoretically embedded in a specific form of interpretation (Sandelowski, 2000b). For instance, a general qualitative study allows the researcher an opportunity to present the *facts* [italics added] of the phenomena being studied rather than re-presenting the events through a pre-constructed lens as those associated with phenomenology, ethnography, case study, narrative, and/or grounded theory (Sandelowski, 2000b).

Participant Inclusion Criteria

Eligible participants met the following criteria. First, they self-identified as out gay males between the ages of 18 and 30. Second, they fell into one of the following racial categories: Black/African American, Hispanic, or White. These key demographics were primarily based on data from the *National Centers for Disease Control* (CDC) which emphasized that youth within the identified demographics (13–24) accounted for 26% of new

2010 HIV infections (CDC, 2016b). However, because of the obviously sensitive nature of the investigated topic, there were foreseeable IRB issues related to obtaining consent, and assent, to have such conversations with minors (Flewitt, 2005; Hill, Knox, Thompson, Williams, Hess & Ladany, 2005; Morrow & Richards, 1996; Punch, 2002). This sensitivity helped to support the rationalization for soliciting adult males older than 18 years of age, as they could provide meaningful data for this project, without much restriction, in comparison to participants under the age of 18. Similarly, the racial, gender, and sexual orientation demographics with the highest HIV rates were Black/African American, Hispanic, and White gay males (CDC, 2016b).

In addition to race, age, sexual orientation, and gender demographics, participants recruited for this study had to answer "*Yes*" to the following questions:

1. Between ages 18 and 30,
2. Had at least one parent-child communication lasting between 20-30 minutes on sex, sexuality and/or HIV/AIDS, and
3. Acknowledged that their parents were aware of their self-identified sexual orientation.

Additionally, participants all answered "Yes" to *one or more* of the following questions:

a) Had unprotected sex with someone of the same gender within the past 6-months?
b) Had one or more sexual partner of the same sex in the past 6-months?
c) Had been tested for HIV within the past 6-months?

Participant Recruitment

Before the study began, IRB approval was sought, and UGA approved it for one-year (October 2016 – October 2017) [See Appendix A, p. 225]. Information that was addressed in the IRB included, but were not limited to: a) the title and type of research that was conducted, b)

information about the principal investigator, c) the type of review that was requested, d) the demographics of the participants who were to be recruited for this study, and e) the proposed data collection methods. The study proposed to collect data from individuals over the age of 18; therefore, an expedited review process was requested. This study's purpose was about having communications about sex, as such, it was assumed that the research participants were comfortable discussing issues regarding coming out, and talking with parents about sex, sexuality, and/or HIV. If participants needed further support outside the scope of this research, they were provided with a referral sheet for counseling sessions at the Counseling and Psychiatric Services (CAPS) department at the University of Georgia, or to local community based organizations that addressed sexual identity concerns [See Appendix B, p. 226]

Pre-test (*N=3*) and individual (*N=14*) participants were recruited using purposive and convenience sampling through field outreach at the local state health department, AIDS service organization (ASO), and through UGA's GLBT resource center. For this study, purposive sampling was defined as the selection of unique and targeted research participants to provide specific insights (Teddlie & Yu, 2007; Tongco, 2007). In this instance, participants were self-identified gay males between the ages of 18 and 30 who had at least one parent-child communications around sex, sexuality, and HIV. Similarly, convenience sampling was choosing individuals that were easily available based primarily on race, gender, availability, and sexual orientation (Holosko & Thyer, 2011). Here, rather than examine the experiences of the GLBT spectrum, participants who self-identified as Black/African American, Hispanic, or White out gay males, and who had at least one 20-minute parent-child communication about sex and sexuality were asked to share their experiences.

Flyers describing the study were posted in common public access areas, as well as an e-mail which described the study was sent to the identified contact person at the approved ASO, health department, and/or UGA's LGBT resource center for dissemination to their respective listserv (Hamilton, & Bowers, 2006). Similarly, online recruitment (Facebook, Twitter, Instagram, and Snapchat) was also used as a supplementary method to reach a larger and potentially more diverse research pool of geographically proximal and interested participants based on the identical contact information (Amon, Campbell, Hawke, & Steinbeck, 2014; Dillman, Smyth, & Christian, 2009; Hamilton & Bowers, 2006). Each flyer [See Appendix C1, C2, D1 and D2, pp.227-230], had a brief description of the study, the primary contact for the study, the primary contact's telephone number and an email address, the primary investigator's name, email address, and affiliation with UGA and this study, and the study number (Pearson, Follette, & Hayes, 2012).

Relatedly, pre-test and individual participants were recruited using the techniques associated with linear snowball sampling. In definition, snowball sampling is the process of accessing research participants through contact information that was provided to, and by, other research participants (Holosko & Thyer, 2011; Noy, 2007). Using linear snowball sampling techniques, each research participant was asked to disseminate and share the study flyer, information on the study, and the purpose of the study within their social networks, and then to refer potential participants to the researcher, who then contacted each referred individual regarding their interest and availability to participate in the study, after their one-on-one interview (Atkinson & Flint, 2001; Noy, 2007; Yoshikawa, Weisner, Kalil, & Way, 2013). The justification for using a snowball sampling technique was based on the notion that gay men could be classified as difficult to reach populations based on their sexual orientation. Finally here,

individuals were all pre-screened for participation eligibility by telephone using the IRB approved telephone script [See Appendix E, p. 231].

Each participant was also ethically informed that their involvement in this study was voluntary. They were also informed that the study would be a one-time approximately 45-60-minutes interview regarding their experiences with having a conversation about sex and sexuality with their parents, and there would not be any monetary compensation for their time. Participants were informed about the purpose and rationale for the study however, they were not provided any of the research questions (Bailey, 2007). They were also informed of the option to protect their personal identity by using a pseudonym [of their choice], or obtain an assigned pseudonym [by the researcher] (Kaiser, 2009). Finally here, all participants were informed that they could stop the interview or leave the focus group, without any risks, consequences, or prejudice, if they felt uncomfortable at any point during the study (Orb, Eisenhauer, & Wynaden, 2001).

All participants were informed that the interviews would be digitally recorded, and transcribed verbatim, to ensure the integrity and quality of the conversations (Crist & Tanner, 2003). Participants were also informed that after the interviews were transcribed, and if they so chose, they would be provided an opportunity to review the transcripts to make any necessary clarifications, ask questions, and/or amendments to their own interview (Krefting, 1991; Lincoln & Guba, 1985; Orb, Eisenhauer, & Wynaden, 2001). While all participants were reassured about the anonymity of the study, they were also informed about the precautionary steps that would be taken to fully protect their confidentiality, which minimally included: who accessed the data, data storage, length of time data would be kept before being destroyed, whether the data would

be used in the future, and whether consent would be sought for additional data use in future projects (Arksey & Knight, 1999; Kvale, 1996; Street, 1998).

Lastly, before initiating any individual interviews and focus group, all pre-test and individual participants who met the inclusion criteria and agreed to participate were sent an email acknowledging their willingness to participate in the study, the pre-selected date, time, and method (phone or in person for one-on-one interviews) for the interview [See Appendix F, p. 233] and sent an electronic copy of the IRB approved informed consent form [See Appendix A, p. 225]. The elements in the consent form minimally included: the IRB study number, the purpose of the study, who was conducting the study, the rationale for selecting the participant for the study, time commitment, benefits to be expected from their participation, potential risks with the study and how they will be managed, contact information for the supervising faculty, principal investigator, and for the school of social work, their voluntary commitment, or refusal, to participate in the study, and lastly, the IRB contact information for UGA (Bailey, 2007). After interviews were completed and transcribed, a follow-up thank you email which included the transcribed interview was sent to each individual participant for his review [See Appendix G, p. 234].

Dependability Check (Pre-Testing)

Dependability checks in qualitative studies refer to the small-scale trial-run of a study that is often done to pre-test the clarity of a questionnaire designed for a larger study (van Teijlingen & Hundley, 2001). Before fully implementing the data collection process, a preliminary test (or trial run) was conducted to ensure that the interview protocol, research procedure, and study integrity issues were properly adhered to prior to the full execution of the study (Bowden, Fox-Rushby, Nyandieka, & Wanjau, 2002; van Teijlingen & Hundley, 2001).

This process helped to ensure that questions: a) were clear, b) were culturally relevant to the research participants and the phenomenon being investigated, c) used language that was understandable to the participant, e) provided marginal insight regarding the time commitment for each participant in the study, f) established that participant replies were interpreted in terms of the information that was required, g) were asked using terms and contexts that were both logical and simplified, and h) assessed whether each question provided an adequate range of response (Bowden et al., 2002; Chenail, 2011; van Teijlingen & Hundley, 2001). Before the implementation of the pre-test, participants were recruited using the abovementioned inclusion criteria. Therefore, convenience and purposive sampling techniques were used to enlist participants in this phase of the study; however, they were not informed that this was a trial run, in order to get more realistic answers that would help to clarify the interview protocol.

Pre-Testing

The pre-test interviews were conducted in Athens, GA, with *N=3* individuals [or *N=1* individual from each racial group], and lasted between 30 and 45 minutes. During the pre-testing interview process, participants were asked the anticipatory interview questions, which were later transcribed, and then initially reviewed for clarity, consistency, and order sequencing (Bowden et al., 2002; van Teijlingen & Hundley, 2001), with my major professor. When interview questions appeared unclear in the transcribed text because of having multiple parts, or ambiguous word choices, the questions were simplified by re-formatting the questions using more simplistic and clear word choices (Bowden et al., 2002; Chenail, 2011). An example of a question with ambiguous word choices was "*how open were your parents when discussing sensitive topics*?", and this sentence was changed to "*could you describe your parent(s) openness when discussing issues related to male sexual health, condom usage, HIV/STD screening, sex,*

and/or sexuality during your parent-child conversation(s)?". Lastly, each interview question and its potential answer was aligned with 1 of the 3 overall dissertation research questions (P. Reeves, Personal Communication, August, 2016).

The identified rationales for conducting a qualitative pre-test included identifying how: a) to ethically gain access to the population being studied, b) to recognize unique cultural differences among research participants, and c) to estimate time length of interviews to help decrease respondent fatigue (Hurst et al., 2015; van Teijlingen & Hundley, 2001; van Wijk & Harrison, 2013). The first objective of this pre-test was to assess the proposed outlined recruitment techniques of locating and accessing self-identified out gay males, who had at least one parent-child communication about sex, sexuality, and HIV. Using the recruitment techniques outlined by Davis, Taylor, and Bench (1995) who used gatekeepers to access a vulnerable population, I also reached out to individuals who worked directly with this population, informed them about the study and its purpose, and then asked them to recommend potential research participants. However, one noted concern with this recruitment method was the challenge of finding local Hispanic gay males who were willing to talk about their experiences. The inclusion criteria for the study called-for Black/African American, Hispanic, and White gay males however, after talking with some Hispanic gay males, they reported that their overall culturally strong Catholic and ethnic beliefs may impact how many self-identified out gay Hispanic males would be willing to publicly address any parent-child communications on sex, and/or sexuality.

The second pre-test objective was to explore any cultural, and/or ethnic similarities, and/or differences between the three sub-groups (van Wijk & Harrison, 2013). As I probed these participants, I thought about their willingness to be vulnerable and share their personal stories

about the "*awkwardness*" that they encountered, when having parent-child communications about sex, sexuality, and HIV. As they recalled their encounters with such communications with their parents, they all had shared and similar experiences regarding their levels and feelings of awkwardness when talking to their parents about sex. As I self-reflected on the participants' recollection of their conversations, I thought about the nuanced differences between Black/African American, Hispanic, and White cultural understandings of masculinity. For Whites, it was the participants who internalized their own masculine identity, while for Black and Hispanics, it was the parental internalizations of social masculinity that underscored the crux of the conversations between parents and children. Taking this observation into account, it was incumbent upon me to now integrate, weave, and navigate the role of masculinity between the groups and how that concept influenced the content of these conversations.

The third pre-test objective was to estimate the length of time needed for a full interview as well as to ensure participants did not get fatigued with the process (Hurst et al., 2015). As noted in the existing qualitative methodology literature, participants may become fatigued if an interview was too long, or the questions were repetitive (Rubin & Rubin, 2011). To circumvent this, participants were initially informed that the interview would last between 45 and 60 minutes, and that they could stop the interview at any point if they felt tired, or did not want to participate further. Special attention was also given toward sequencing of data gathering, but the approach routinely remained: participant informed consent, demographics, main questionnaire, and then next steps for this research process (Alexander, 2004). Overall, this initial pre-test helped me to think holistically about the interview questions as well as gave me a raised consciousness about the participant's similarities and differences.

Data Collection

As previously noted, qualitative data collection can be managed through a variety of data collection techniques (e.g. direct observations, participation in the setting, in-depth interviews, and/or document analysis), or simply using just one of the previously mentioned four techniques (Merriam, 2009; Patton, 2002). For the purposes of this dissertation, I used one-on-one face-to-face or telephone in-depth retrospective interviews as the primary method for data collection, then I followed up with a face-to-face focus group to further answer any follow-up questions or clarify the themes that arose throughout the analysis process. Similarly, as suggested by some well-regarded qualitative researchers (Creswell, 2013; Merriam, 2009), qualitative data collection and analysis were best conducted simultaneously to best provide researcher flexibility and modification. Interviews were transcribed and data analysis began after each interview was completed.

Recruited participants who met the previously mentioned inclusion criteria were asked to participate in an individual face-to-face or telephone interview, lasting between 45-60 minutes. The purpose of the one-on-one interview was to gather information about the phenomenon under investigation and to reduce potential assumptions of the phenomenon into more specific and concrete terms (Berg, 2009; DiCicco-Bloom & Crabtree, 2006; Padgett, 1998). These $N=14$ interviews were used to help discover and understand parent-child communication experiences (DiCicco-Bloom & Crabtree, 2006; Sandelowski, 2000b). Finally, to help with establishing a rapport with research participants, I re-introduced myself, orally reviewed the study purpose, and reviewed the participant consent form to verify willingness to participate (Alexander, 2004). Participants were then asked if they had any questions before the interview started, and whether

they were willing to voluntarily participate in the study. All *N=14* participants stated that they understood the study purpose, and voluntarily agreed to participate in the study.

Next, one-on-one retrospective interviews lasting up to 95-minutes were conducted either by telephone (*N=8)* or face-to-face (*N=6)* in a secure and approved location. Participants who were not available to do a face-to-face interview because of location, mobility, and/or availability to meet in person were offered the chance to participate by telephone. All retrospective interviews were conducted in a secure office (Room 239, Room 242, Room 300), behind closed doors, and with three recording devices (laptop and two voice recorders). All participants were informed that their interview was being recorded, would be later transcribed, and then sent to them to proof read and edit, if they so choose. All *N=14* interviews were held on UGA's campus, in the School of Social Work building, and in a room with closed doors, protective blinds, with adequate space and lighting, and necessary equipment (tape recorder, batteries, notepad, and pencil) to properly provide confidentiality.

First, detailed participant demographics were gathered [See Appendix H, p. 235]. To gain a more detailed depiction of the purpose of the study, research participants were asked to retrospectively recall the instances of their parent-child communication(s) about sex, sexuality, and/or HIV. A semi-structured approved interview guide with questions arranged from general to specific was used to explore participant experiences. Some of these questions [See Appendix I, p. 236] included: a) *who initiated the conversations?,* b) *what were the topics of the conversations?,* c) *how frequently did the conversations occur?*, d) *which parent did they communicate more frequently with and why?* and e) *outside of parent-child communications how else did the participant learn about sex, sexuality, and HIV?* This method, coupled with the 3-main research and interview questions, helped me to gather a richer description of the

conversations from the participant's subjective and personal experiences (Mayoh & Onwuegbuzi, 2013), and to make textual meaning of the effect of their parent-child communication experiences (Bogdan & Biklen, 2003).

Finally, personal memos to myself regarding questions that arose, perceptions of the interview process as well as the interview process itself, and personal issues that arose during and after, were written after individual interviews and focus group were conducted. Stocker and Close (2013), suggested that the process of writing a memo after each interview was an additional research tool used to help organize thoughts, perceptions, and reactions to participant disclosures. Charmaz (2006) also stated that such memos provided a "space and place for exploration and discovery" (p. 81). I deemed the memos, in this instance, as a collection tool used to process, and address, any preconceived notions about the interviews, expectations with and from the interviews or participants, and to help with the development of future steps.

Data Analysis

The qualitative data analysis process used was two-fold, as it incorporated the inductive and deductive techniques associated with thematic qualitative analysis (Braun & Clarke, 2006; Elo & Kyngäs, 2008; Tuckett, 2005). Thematic analysis processes were used as an opportunity to aid with listening to the recordings, and reading the transcripts in efforts to better understand the participants' perspectives, which in turn, were then used to help answer each research question (Alexander, 2004; Aronson, 1995). To adequately understand the participants lived experiences, data analysis for this study occurred sequentially with the on-going data collection, i.e., one-on-one interviews were executed, audio recordings transcribed, and then analyzed. The process used for analyzing the data followed the iterative and recommended outline provided by Creswell (2013) which nominally included: a) organizing the data, b) reading and memoing, c)

describing, classifying, and interpreting data into codes and themes, d) analyzing the data, and e) representing and visualizing the data. This process also included a well-cited hermeneutical interpretation method outlined by Ricoeur (1971), which minimally included: a) naïve reading, b) structural analysis, and c) comprehensive understanding or interpreted whole.

The iterative procedures associated with inductive data analysis process included reading, and re-reading each transcript several times, to obtain a cogent, in-depth, comprehensive, and holistic understanding of the phenomena being studied, as it was experienced and expressed by each of the *N=14* research participants (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). Reading and re-reading these transcripts provided opportunities to become familiar with the data, become familiar with each participant's experience, and to begin loosely identifying and uncovering the units of analysis that provided the context, which underscored the participant experiences in relation to the phenomenon being investigated (Crist & Tanner, 2003; Flood, 2010; Graneheim & Lundman, 2004; LaRossa, 2005).

After the initial readings of each transcript to gain additional insights on how each participant understood and described their experiences with parent-child communications, subsequent readings provided opportunities to pay closer attention to the transcripts, and to begin identifying potential concept words, that were later used to create code words which, then led to the eventual creation of themes (LaRossa, 2005). Accordingly, codes were defined as "the features of the data that appears interesting to the researcher, and refers to the most basic segment, or element of the raw data that can be assessed in a meaningful way regarding the phenomenon" being studied (Braun & Clarke, 2006). All emergent codes were documented in the margins of, and throughout the transcript texts (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). The emergent codes were either then recorded based on my understanding of

each participant's experiences or using the participant's exact words, or via in-vivo coding (LaRossa, 2005; Strauss, 1987).

Next was the structural analysis and de-construction of data. This process was defined as the interrogation of the central and natural themes that emerged during the initial reading phase of each transcript (Graneheim & Lundman, 2004; LaRossa, 2005). During this phase, LaRossa's (2005) concept-indicator model process, which is based primarily on the constant comparison of words, phrases, or sentences (indicators), that were used to describe a label or name (concept). According to LaRossa (2005):

> The *basic,* defining rule of constant comparison is that, while coding an indicator for a concept, one compares that indicator with previous indicators that have been coded in the same way. An *indicator* refers to a word, phrase, or sentence, or a series of words, phrases, or sentences, in the materials being analyzed. A *concept* is a label or name associated with an indicator or indicators; stated another way, a concept is a symbol or conventional sign attached to a referent, (p. 841).

This reframed interrogation of the data helped facilitate the solidification of 6 concrete themes based on the similarities between the identified codes. During this stage of analysis, the data were coded "for relevance based on the phenomena within a given category" (LaRossa, 2005, pp. 846 - 847). This level of coding provided opportunities to identify and define the relationships if any, that existed within a theme or between themes (Braun & Clarke, 2006; Strauss, 1987). Table 2 and Table 3 provides an example of this process in further detail.

As shown in Table 2, when reading Jason's recollection of the conversations about sexual health, he described how his father used scare tactics to terrify him into believing that being gay was wrong, and he would automatically become infected with HIV. He stated:

> My father would give me talks about how it's illegal to be gay, and how it's violent, that sex between men is violent and terrible and you'll suffer horrifying anal bleeding for days and just terrible… My father and his attempts to terrify me of a gay sexual life would tell me that, if I ever did anything with a man, I would automatically contract HIV.

Table 2

Example of Extracted Data and Coding Process

Example of Extracted Data	Coded As
My father would give me talks about how it's *illegal to be gay*[1], and how it's violent, that sex between men is *violent and terrible*[2] and you'll suffer *horrifying anal bleeding for days and just terrible*[3]… My father and his attempts to *terrify me*[4] of a gay sexual life would tell me that, if I ever did anything with a man, I would *automatically contract HIV*[5].	1. Illegality 2. Violent 3. Horrifying 4. Terrifying 5. Automatic HIV

In this excerpt, Jason used the indicator phrases "*it's illegal to be gay*," "*it's violent*," "*sex between men is violent and terrible,*" "*you'll suffer horrifying anal bleeding*," and "*if I ever did anything with a man, I would automatically contract HIV*" to describe how conversations between him and his father were structured using terrifying language, designed to force him to suppress any homosexual feelings and/or ideations. In this instance and context, it was unclear about whether Jason was scared being gay or contracting HIV however, based on his use of the word "terrify' it was made evident that he felt alarmed about both being gay and contracting HIV. At face value, this phrase helped to create the concept of 'scare tactic' to identify as gay and risking potential HIV risk. However, while this phrase only helped clarify a concept or a moment in time when one conversation occurred, the phrase did not clarify the long-term effects on cognition for Jason. Similarly, this snapshot did not tell us whether the conversations were in

comparison to others that he had had previously, or with someone else. As such, reading the next sentence, helped to contextualize Jason's relationship with his father.

In Table 3, Jason spoke about how his mother used comforting language to help him understand sexual health.

Table 3

Example of Extracted Data and Coding Process

Example of Extracted Data	Coded As
My mother was just, *she became more concerned*[1] and she'd ask me every now and then, are you being safe? *Are you making good decisions?*[2] You're not just sleeping around with anybody you can, right? And I would always, I would *have to comfort her and be like no mother, I'm not*[3]. I am not sleeping with everybody I can find and I am being safe. … My mother tried to be *a bit more open-minded*[4] and would occasionally be like so these are, *you need to understand what sexually transmitted diseases are*[5].	1. Mother's Concern 2. Decision Making 3. Reassurance 4. Mother's Openness 5. Safety

In other conversations with his mother, Jason recalled how she attempted to educate him about sexual health diseases without scaring him. In this instance, he described his interactions with her as such:

> My mother was just, she became more concerned and she'd ask me every now and then, are you being safe? Are you making good decisions? You're not just sleeping around with anybody you can, right? And I would always, I would have to comfort her and be like no mother, I'm not. I am not sleeping with everybody I can find and I am being safe. … My mother tried to be a bit more open-minded and would occasionally be like so these are, you need to understand what sexually transmitted diseases are.

Here, the exact indicator phrases were *"she became more concerned," "she'd ask me every now and then," "are you making good decisions,"* and *"my mother tried to be a bit more open-minded."* These phrases suggested that his mother tried to be more supportive and encouraging of his sexual orientation, while promoting positive sexual health practices. These concept phrases were used to create the indicator phrase "maternal concern." In both interactions, Jason presented dueling dialogue with his parents. On one hand, he had a father who embodied heteronormative ideologies of maleness while he had a mother who was supportive and wanted him to be as informed as possible about how to better protect himself from contracting a STI/STD, and/or HIV.

While conducting data reduction coding, it was also important to note that the contextualization of these two conversation styles highlighted not only the implied structural gender norm expectations of Jason, but how he perceived and further developed his own self-esteem, as well as how he navigated relationships. His use of the phrase "*my father and his attempts to terrify me of a gay sexual life,"* indicated that his father held various gender expectations that he wanted his son to emulate. These expectations could have also been culturally and generationally transferred by his grandfather to his father, based on the socialized expected ideas of manhood and gender.

Next, the data reduction process of participant (*N=14*) interviews included the utilization of concrete in-vivo examples (participant's actual verbatim words/phrases) taken from the transcribed interviews, and were used to create the preliminary themes used to describe the participants' experiences with having the parent-child communications, and how those conversations influenced decision making practices (Braun & Clarke, 2006; Crist & Tanner, 2003; Yukhymenko, Brown, Lawless, Brodowinska, & Mullin, 2014). The identified in-vivo

examples were then condensed based on the perceived similarities of patterns and trends which helped to move from generalized explanations to specific experiences (Attride-Stirling, 2001; Tuckett, 2005), as depicted in Figure 2. This coding style allowed for the identification of similarities and/or relationships if any, that existed within a potential theme or between two or more themes (Strauss, 1987).

During this phase, I gained a broader understanding of how parent-child communication varied in the types of information discussed. Likewise, this process was used to holistically explore additional events and/or behaviors that resulted from the parent-child communication experiences. Ultimately, the themes emerged based on the connections that were made by the participant using the various concepts and personal descriptions. The 6 identified themes were then centralized and coded to illicit the observed and identified shared meanings that specifically addressed the phenomena being investigated (Crist & Tanner, 2003; Flood, 2010). Finally, after identifying similarities with the in-vivo codes, six major and minor deductive themes were identified. These initial six themes included: a) extent and nature of conversations, b) communication content, c) sexual behavior, d) sexual orientation content, e) prevention education, and f) HIV knowledge. The major themes emerged based on connections made by the participants using the various concepts and descriptions.

In instances where there were difficulties pertaining to coding clarity, inconsistent codes, or other coding difficulties, there were discussions with my major professor to help elucidate and guide the nuanced process. In addition to this analytical method, additional memos and journal notes were written to further document the process and aide the researcher to better understand, connect, and trace the analytical process (Snyder, 2012). The purpose of this analytic step was to: a) connect the data to the literature, b) connect ideas highlighting the convergence and

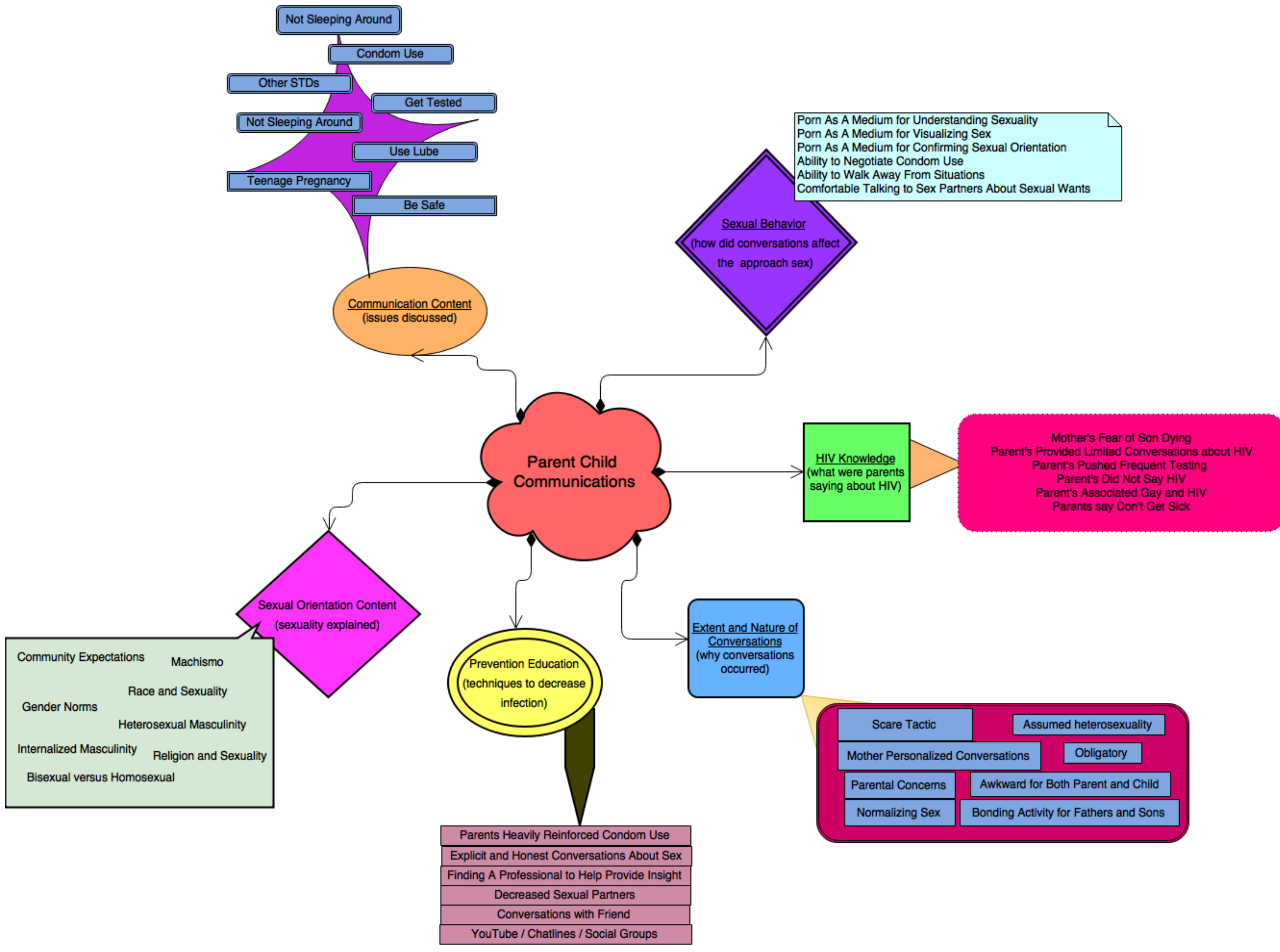

Figure 2: Visual representation of the codes and their main theme representations from one-on-one interviews.

divergence of participant experience(s), and c) provide a holistically comprehensive understanding of the findings (Snyder, 2012).

Overall, the data analysis steps prompted the researcher to also explore the relationships between themes, as well as assess the use of language in the parent-child communications. This process encouraged me to think about other ways of understanding these data. For instance, Braun and Clarke (2006) underscored the use of thematic analysis by suggesting that it "identifies, analyzes, and reports patterns (themes) within data. It minimally organizes and describes the data set in (rich) detail" (p. 6). The idea of exploring the relationships between identified themes lends itself to the possibility of having a comprehensive understanding of the complexity of parent-child communications and the barriers that both parents and children faced when attempting to have a healthy dialogue about sex, sexuality, and potential health risks. Thinking specifically to the notion that thematic analysis can work with, or without, a theory provided an added support when exploring similarities and ideas between identifiable themes and concepts (Braun and Clarke, 2006). Ultimately, the utilization of thematic analysis provided an additional and supplementary manner through which to explore the various ways that individuals experience parent-child communications.

Credibility Checks

Different credibility checks are critical throughout various stages and phases of qualitative research (Md Ali & Yusof, 2011). Two unique components for securing and checking the credibility of a qualitative research project include triangulation, and/or the corroboration and correspondence of study results from different sources (Bryman, 2006; Creswell, 2013; Goering & Streiner; 1996; Merriam, 2006; Moran-Ellis et al., 2006; Yoshikawa et al., 2013). Accordingly, Merriam (2009) proposed four processes to address these concerns:

a) the use of multiple methods, b) the use of multiple sources of data, c) the use of multiple investigators, and/or d) the use of multiple theories to confirm emerging findings, through which validity and reliability can be achieved.

For this study, triangulation was done in two ways: investigator triangulation and member checking. Investigator triangulation is defined as the process of using two or more [in this case: the primary investigator, and my major professor] reviewers to review and define the codes and themes from the first three coded interviews (Merriam, 2009). During this process, we reviewed the coded transcripts and defined the major and minor themes (Malebranche, Fields, Bryant, & Harper, 2009; Miles & Huberman 1994). Upon completion of the original coding task, and an agreement reached pertaining to codes and themes to examine, the other transcribed data were coded using the created codebook (Malebranche et al., 2009). In instances where new codes were identified, they were discussed with the major professor, and then added to the code book (Malebranche et al., 2009; Merriam, 2006).

Additionally, and with the participant's permission, member checking was also used to examine the credibility and dependability of these data. Accordingly, feedback was requested from randomly selected research participants to seek content clarity, and rule out any form of misinterpretation on behalf of the researcher (Carlson, 2010; Doyle, 2007; Merriam, 1998). This was done to help eliminate any misinterpretations of the participant experiences through critical participant feedback (Merriam, 2009).

N=3 participants were randomly selected from the face-to-face interviews. Participants were asked about their willingness to participate in a follow-up focus group lasting 45 minutes, after their initial face-to-face interviews. The rationale for the focus group was to obtain a more detailed and richer understanding of the identified themes and their meanings based on the

parent-child communications identified themes found in the face-to-face interviews. According to Flood (2010), this process helped the researcher and those researched, to co-create a clearer, more detailed, and holistic understanding of the lived experiences of the research participants. Similarly, Morgan (1996), suggested that the use of focus groups after one-on-one interviews, provided additional perspectives on the phenomenon being studied from a broader population, as well as provided the researcher with an opportunity to validate conclusions drawn from the face-to-face data output. During the focus group, one theme [nature and context of the conversations] was clarified and redefined to [coming out] as it more accurately addressed and represented the lived experiences of each participant.

Ethical Considerations

As previously indicated, the rather sensitive nature of this topic calls for repeated and sincere reassuring of participant confidentiality. To protect participants and their information, they were provided with an IRB approved copy of the consent form, then they were asked to provide verbal consent to participate in the study. All transcribed data files were kept on a desktop computer (and jump drive) that was not connected to an Internet source. Files will be kept for a reasonable amount of time — approximately seven years — before being destroyed. Lastly, participants were informed about the dissemination process for this research project, and/or used for future use(s), and/or training(s) when working with parents, and/or children to provide improved educational strategies regarding communication on the topic of sex, sexuality, and risk for HIV infection.

Conclusion

This chapter presented a qualitative methodology research agenda to explore the role and impact of parent-child communications about sex and HIV risk in the lives of self-identified out

gay men, ages 18-30. A detailed research plan that included descriptions of the employed qualitative method, inclusion criteria, the recruitment, the data collection and analysis plans, and method limitations, that helped to produce a comprehensive investigation into the lived experiences of these participants.

CHAPTER 4

RESULTS AND DISCUSSIONS

Introduction

This chapter presents the results and discussions from the *N* = 14 semi-structured interviews as they related to the study questions. It consists of three sub-sections: a) socio-demographics, b) parent-child communications styles, and c) the six major themes, and their sub-themes, extracted from the qualitative interviews.

The Socio-Demographics

All study participants were offered an opportunity to either choose, or to be provided with, a pseudonym. Figures 3.1, 3.2, and 3.3 collectively, highlight the demographics for the *N* = 14 study participants, broken down by race. There were *N* = 5 (36%) Black/African Americans [Figure 3.1], *N* = 4 (28%) Hispanics [Figure 3.2], and *N* = 5 (36%) Whites [Figure 3.3]. Their overall ages ranged (R_a) between 18 - 30 years, *M* = 26.3, *SD* = 2.8, [Black/African Americans *M* = 25.8, *SD* = 3.9; Hispanics *M* = 27.5, *SD* = 2.5; Whites *M* = 25.8, *SD* = 1.6]. Regarding both sexual orientation and HIV status, there were *N* = 13 (93%) self-identified gay male participants, and *N* = 1 (7%) queer participant. Likewise, there were *N* = 11 (79%) self-reported HIV-negative, and *N* = 3 (21%) self-reported HIV-positive participants.

All reported being employed (either full or part-time). Likewise, participants stated that they: were Agnostic, *N* = 6 (43%), Atheist, *N* = 1 (7%), or had the following religious belief systems, *N* = 7 (50%) [*N* = 1 (7%) Christians, *N* = 1 (7%) Buddhist, *N* = 1 (7%) Jehovah's Witness, *N* = 2 (14%) Catholics, *N* = 1 (7%) Lutheran, *N* = 1 (7%) Spiritual]. They reported

their education as: high school N = 4 (28%), baccalaureate education N = 4 (28%), and master's N = 6 (43 %) degrees. Similarly, N = 12 (86%) participants reported at least one sexual encounter in the past 6-months, while N = 2 (14%) reported no sexual encounters. Finally here, within the last 6-months, N = 8 (57%) reported having a HIV-negative test, N = 3 (21%) did not have a HIV-test, and N = 3 (21%) reported no HIV testing because of their already known HIV-positive diagnosis.

All recalled having at least one 20-minute conversation with their parent(s) about sex, sexuality, and/or HIV. The ages of their first communication on sex, sexuality, and/or HIV ranged (R_a) between 6 - 20 years, M = 12.1, SD = 3.7, [Black/African Americans, M = 11.8, SD = 1.8; Hispanics, M = 11.0, SD = 6.4; Whites, M = 13.4, SD = 2.6]. Ultimately here, N = 11 (79%) participants had parent-child communications before coming out, and N = 3 (21%) had communications after coming out. All participants disclosed their sexual orientation to their parent(s) at some point during their formative years, M = 16.6, SD = 2.7 [Black/African Americans, M = 15.8, SD = 2.3; Hispanics, M = 17.3, SD = 2.6; Whites, M = 16.8, SD = 3.3].

Overall, there were an estimated N = 754 conversational instances (M = 54.6, SD = 131.7) of parent-child communications about sex, sexuality, and/or HIV [Black/African American M = 6.2, SD = 5.3; Hispanic M = 145.3, SD = 238.9; White M = 30.4, SD = 40.4]. However, two of these conversations were deemed as outliers as participants reported greater than 75 conversational instances. In turn, these numbers skewed the findings, and were eliminated from the summary average calculations of communication instances. A re-calculation resulted in N = 164 conversational instances (M =13.7; SD = 21) of parent-child communications [Black/African American M = 6.2, SD = 5.3; Hispanic M =20.3, SD =36.6; White M = 10.4, SD = 12.4]. Further, there was a noted age range (R_a = 0 – 15) between the first conversation and

Socio-Demographic Data of Black/African American Self-Identified Out Gay Men (N=5)					
Name	Kennedy	Ronn	Josiah	Ricardo	Bill
Age (in years)	28	26	19	28	28
Gender	Male	Male	Male	Male	Male
Race	Black/African American	Black/African American	Black/African American	Black/African American	Black/African American
Sexual Orientation	Gay	Gay	Gay	Gay	Gay
HIV status	Positive	Positive	Negative	Negative	Negative
Highest Education Completed	Masters	HSD	Some College	Masters	Masters
Employment Status	Employed	Employed	Employed	Employed	Employed
First Conversation	12	9	12	12	14
Age at Coming Out	16	18	12	17	16
Religious/Spiritual Backgrounds	Spiritual	Christian	Agnostic	Lutheran - Baptist	Agnostic
Number of Conversations	15	7	4	2	3
Conversation Before or After Dating	Before	Before	Before	Before	Before
Parents Education Levels	Trade(d)(m)	College(d)(m)	Associates(m)	High School(d)(m)	Bachelors(m) / Masters(d)
Parents Religious Backgrounds	Baptist	Christian(d)(m)	Christian	Baptist	Christian(d)(m)
# in Household at Age of Coming Out	4	6	4	10	3
Sex Last 6 months	Yes	Yes	Yes	No	Yes
HIV Test Last 6 Months	No	No	No	Yes	Yes
Notes: d-dad; m-mom					

Figure 3.1. Socio-demographic data of Black/African American self-identified out gay men (n=5).

Socio-Demographic Data of Hispanic Self-Identified Out Gay Men (N=4)				
Names	MJ	Norge	Daniel	Malcolm
Age (in years)	30	28	28	24
Gender	Male	Male	Male	Male
Race	Hispanic	Hispanic	Hispanic	Hispanic
Sexual Orientation	Gay	Gay	Gay	Gay
HIV Status	Negative	Negative	Negative	Positive
Highest Education Completed	Bachelors	Bachelors	Masters	High School
Employment Status	Employed	Employed	Employed	Employed
First Conversation	20	6	11	7
Age at Coming Out	17	21	15	16
Religious/Spiritual Backgrounds	Catholic	Jehovah's Witness	Atheist	Buddhist
Number of Conversations	1	75	5	500
Conversation Before or After Dating	Before	Before	After	Before
Parents Education Levels	High School(m)	College(d) / High School(m)	Bachelors(d) / Masters(m)	High School(m)
Parents Religious Background	Christian(d) / Baptist(m)	Jehovah's Witness(d)(m)	Jewish(d) / Christian(m)	Christian
# in Household at Age of Coming Out	3	3	3	4
Sex Last 6 Months	Yes	Yes	No	Yes
HIV Test Last 6 Months	Yes	Yes	Yes	No
Notes: d-dad; m-mom				

Figure 3.2. Socio-demographic data of Hispanic self-identified out gay men (n=4).

Socio-Demographic Data of White Self-Identified Out Gay Men (N=5)					
Names	Jason	Josh	Nick	Adam	Charles
Age (in years)	25	28	25	24	27
Gender	Male	Male	Male	Male	Male
Race	White	White	White	White	White
Sexual Orientation	Gay	Gay	Queer	Gay	Gay
HIV Status	Negative	Negative	Negative	Negative	Negative
Highest Education Completed	Technical School	Master's	GED	Bachelors	Masters
Employment Status	Employed	Employed	Employed	Employed	Employed
First Conversation	15	15	13	9	15
Age at Coming Out	17	15	13	17	22
Religious/Spiritual Backgrounds	Agnostic	Agnostic	Agnostic	Agnostic	Catholic
Number of Conversations	5	15	100	30	2
Conversation Before or After Dating	Before	After	After	Before	Before
Parents Education Levels	GED(d) Graduate(m)	Bachelors(d) / High School(m)	Bachelors(m)	Bachelors(d) / High School(m)	Some College
Parents Religious Backgrounds	Muslim(d) / Episcopalian(m)	Atheist(d) / Christian(m)	Christian	Christian	Baptist(d) / Catholic(m)
# in Household at Age of Coming Out	2	3	7	2	4
Sex Last 6 Months	Yes	Yes	Yes	Yes	Yes
HIV Test Last 6 Months	Yes	No	Yes	Yes	No
Notes: d-dad; m-mom					

Figure 3.3. Socio-demographic data of White self-identified out gay men (n=5).

sexual orientation disclosure, $M = 4.9$, $SD = 4.3$ [Black/African American $M = 4.0$, $SD = 3.4$; Hispanic $M = 7.8$, $SD = 5.5$; White $M = 3.4$, $SD = 3.8$]; where “0” represented $N = 3$ participants who had disclosed their sexual orientation to their parents, during their initial parent-child conversations.

Finally among the sample, participants were asked about their parent’s educational attainments and religious backgrounds. Parental educational attainments included: $N = 1$ (4%) general education diploma, $N = 7$ (30%) high school diplomas, $N = 2$ (9%) trade school certificates, $N = 2$ (9%) some college, $N = 8$ (35%) bachelor’s degrees, and $N = 3$ (13%) master’s degrees. These data also revealed that parents’ religious affiliations included: $N = 11$ (50%) Christians, $N = 4$ (18%) Baptists, $N = 2$ (9%) Jehovah’s Witnesses, $N = 1$ (4%) Jew, $N = 1$ (4%) Muslim, $N = 1$ (4%) Episcopalian, $N = 1$ (4%) Atheist, and $N = 1$ (4%) Catholic. Finally, in this sample, $N = 9$ (64%) participants had parents with mixed religious beliefs (i.e., mom identified as a Christian, and dad identified as a Jew), while $N = 5$ (36%) had parents with a singular religious belief system (i.e., both parents identified as Christians).

Discussion of Socio-Demographics

Figures 3.1, 3.2, and 3.3 described some expected and unique features of participant demographics in this study. Expectantly, the “coming out” age among participants were congruent with previous U. S. data, which revealed that gay individuals disclosed their sexual orientation to their parents at, or around, 16 years of age (D’Augelli, Hershberger, & Pilkington, 1998). Also, participant HIV-positive rates were congruent with the existing literature, which frequently highlighted HIV infection rates among Black and Hispanic gay males, between the ages of 18 and 29, as higher when compared to White gay males and most other age groups (CDC, 2014, 2015b, 2016b; *Kaiser Family Foundation*, 2014; Millet et al., 2006). This study

did not ask participants to address how they became HIV infected therefore, a supplementary study is needed to further examine individual issues that resulted in the increased HIV infection rates among this sub-population. Interestingly, *N* = 1 participant stated that he identified himself as “queer”. This participant revealed that he was attracted to gay men and masculine presenting transmen (i.e., female to male individuals, and/or masculine presenting females). Finally here, *N* = 1 participant turned 30 after being recruited and scheduled for the interview.

Conversely, there were several unique features within this sample. The educational attainments among participants in this sample were higher than expected as a large portion (79%), had post-high school education (e.g., technical college, some college, bachelor’s, or master’s). Although somewhat surprising, the extant literature suggested that gay males who delayed ‘coming out’, had higher educational outcomes in comparison to gay males who ‘come out’ at an earlier age (Barrett, Pollack, & Tilden, 2002; Black, Gates, Sanders, & Taylor, 2000; Carpenter, 2005; Pearson & Wilkinson, 2017). Some explanations for such differences, according to Barrett et al., (2002), were that some gay males pursued their education goals for longer periods of time so that they could: a) avoid ‘blue-collar’ jobs, b) participate in the diverse and accepting climates found on college campuses, and/or c) counterbalance the negative effects of the homophobic atmospheres that they observed in high schools, their respective communities, and/or from family and friends. Likewise, it appeared that these educational goals also affected employment stability, as all participants were employed at the time of data collection.

When examining communication frequency, Tables 4a, 4b, and 4c collectively highlighted an estimated *N* = 754 instances of parent-child conversations. However, calculating the reported data revealed two potential overestimations of these rather in-depth, and often emotional, conversations. Therefore, reported frequencies greater than 75 communication

instances were removed, and then the communication data re-calculated. The re-configured frequency estimates suggested that there were approximately, on average, 164 communication instances of total parent-child conversations on sex, and/or sexuality. Likewise, the estimated average waiting time, between the first conversation and coming out, was 4.85 years. Essentially, it appeared that participants waited to disclose their sexual orientation to their parents based on their parental conversational tones, parental attitudes toward homosexuality, or the participants' limited understanding about their own sexual orientation. As indicated in the extant literature, GLBT individuals frequently delayed disclosing their sexual orientation to their immediate families because of the frequently perceived, and experienced, negative reactions (D'Augelli, Grossman, & Starks, 2005; D'Augelli et al., 1998; Ragins, Singh, & Cornwell, 2007). For example, D'Augelli et al., (2005), found that youth whose parents were aware of their sexual orientation reported significantly more instances of verbal, and/or physical abuse. Conclusively here, results showed that Hispanics, in this sample, waited longer to disclose their sexual orientation to their parents, in comparison to Blacks ($M = 15.8$, $SD = 2.3$) and Whites ($M = 16.8$, $SD = 3.3$).

A closer examination of these conversations revealed that Hispanic parent-child communications were longer in duration than those among Black/African Americans and Whites. In fact, Hispanics ($M = 20.3$, $SD = 36.6$) reported twice as many hours of conversations as their White peers ($M = 10.4$, $SD = 12.4$), and three times as many hours of conversations as their Black/African American peers ($M = 6.2$, $SD = 5.3$). This finding was surprising [to the researcher] because when recruiting participants, this Hispanic sub-group was the most difficult to access. Actually, several recruited Hispanic participants frequently stated that, "Hispanics do not like to talk about sex, so it is going to be difficult finding Hispanic gay men to talk". Despite

this, it appeared that one explanation for the increased length of such communications may have been related to Hispanic cultural values which emphasized the core family structure known as *familismo*, or "a multi-dimensional construct that includes the dimension of maintaining a strong attachment to family through feelings of reciprocity, loyalty, closeness and the dimension of feeling a duty to family and conforming to traditions and rules established by elders" (Suizzo, Jackson, Pahlke, Marroquin, Blondaeu, & Martinez, 2012, p. 36).

For Hispanics, family values also served as an important protective barrier against public socio-cultural social, religious, and/or sexual orientation issues (Baumann, Kuhlberg, & Zayas, 2010; Delgado, Updegraff, Roosa, & Umana-Taylor, 2011; Smokowski & Bacallao, 2007). Broadly speaking, it was posited that familismo buffered the contextual relationship between individual identities, and family attachment, primarily for the provision of emotional support (Keefe, Padilla, & Carlos, 1979; Sabogal et al., 1987; Snowden, 2007). Ultimately, it appeared as though Hispanic families frequently ignored their own feelings and attitudes toward sexuality in an effort to promote and encourage safer sexual behaviors, better mental health, and improved and informed decision-making choices (Martinez, 2013; Villatoro, Morales, & Mays, 2014).

Another unique finding here was the noted religious differences between parents and their children. Parental religious ideologies varied vastly to include a broader range of primarily Christian beliefs. As noted in Tables 4a, 4b, and 4c, participants reported that their parents held more Christian (50%) and Baptist (18%) ideologies, in comparison to any other religious sub-groups found within this sample. This finding itself was expected, because 71% of the participants were from, or lived in, the south, which has been dubbed the "Bible Belt" because of its rigid Christian ideologies. In turn, this finding provided additional insights regarding communication content, context, and/or frequency, as religious beliefs historically, and

predictively, affected attitudes toward homosexuality (Adamczyk & Pitt, 2009; Miller, 2005). More specifically, U.S. religious beliefs often and frequently, highlight and categorize homosexuality as unnatural, ungodly, and impure (Yip, 2005). It has been argued that because of parental religious involvement, exposure to religious literature, and interactions with religious friends, many of the participants parents dreaded engaging in, participating with, and/or supporting homosexual conversations for fear of religious and societal punishment, which ultimately resulted in parents having minimal conversations about sex, and/or sexuality with their adolescent child(ren) (Olson, Cadge, & Harrison, 2006; Regnerus & Smith, 1998; Scheitle & Adamczyk, 2009; Sherkat & Ellison, 1997; Wilcox, 1996).

Additionally, 42% of the participants stated that they were Agnostic. Although few U.S. studies have examined religious meanings for GLBT individuals (Barton, 2010; Schuck & Liddle, 2001; Halkitis et al., 2009; Jeffries, Dodge, & Sandfort, 2008; Jeffries, et al., 2014; Meanley, Pingel, & Bauermeister, 2016; Seegers, 2007), none of these studies examined the relationship between Agnosticism and sexuality. Within this sub-sample of Agnostics, 67% were White, and 33% were Black/African American. However, this difference in religious belief was an anticipated finding because of the continued historic and proselytized discrimination of society toward GLBT individuals (Barret & Barzan, 1996; Jeffries et al., 2008; Ritter & O'Neill, 1989; Tan, 2005). The differing religious belief between parents and their sons was surprising as the literature revealed that parents and children often shared similar religious beliefs (Aspy et al., 2007; Astone & McLanahan, 1994; Hadley et al., 2009; Somers & Paulson, 2000; Udell & Donenberg, 2011). However, as indicated by Tan (2005), [gay men] are often challenged to "look beyond the tenets of organized religions, and to seek more intensely for answers to the meaning of existence and of faith" (p. 141). They may not summarily subscribe to the same

dogmatic views of religion as their parents but rather, ascribe different meanings to religion based primarily on their personal existences, beliefs, and/or wants. For this sample, it appeared that having a different belief system than their parents, helped them to re-unify sexual identity with their own self-acceptance, religious identity, and self-esteem (Barret & Barzan, 1996; Tan, 2005), and helped them to maintain a healthy family, community relationship, and societal acceptance (Jeffries et al., 2008).

Parent-Child Communications Styles

This sub-section provides conversational characterizations, contextualization, and distinctions of individual communications, and the style of such communications recorded within the $N = 14$ participant interviews. As previously noted in the literature [reviewed for this study], parent-child communications have effectively helped young adults and adolescents to: a) delay sexual debut, b) increase safer sex behaviors and practices, and c) become more comfortable with communicating their sexual desires to their partners, when deciding to either initiate, engage in, and/or change their sexual behavior practices. However, one core limitation found within the extant literature, influencing the rationale, purpose, and research questions associated with this study, was the nature of these parent-child communication styles. Essentially, what attributes made parent-child communications more effective when addressing self-esteem, sexual behaviors, and/or attitudes toward sex, sexuality, and HIV, in a sample of gay men?

All $N = 14$ participants vividly recalled that the parent-child communications on sex, sexuality, and/or HIV were awkward, but rather empowering. Awkward, because of the topic of the conversations with their parents; but empowering, because it prepared them to effectively, freely, and openly express and discuss their emotional, mental, and sexual health needs with their friends, and/or sexual partners. Despite these however, each parent-child communication fell on

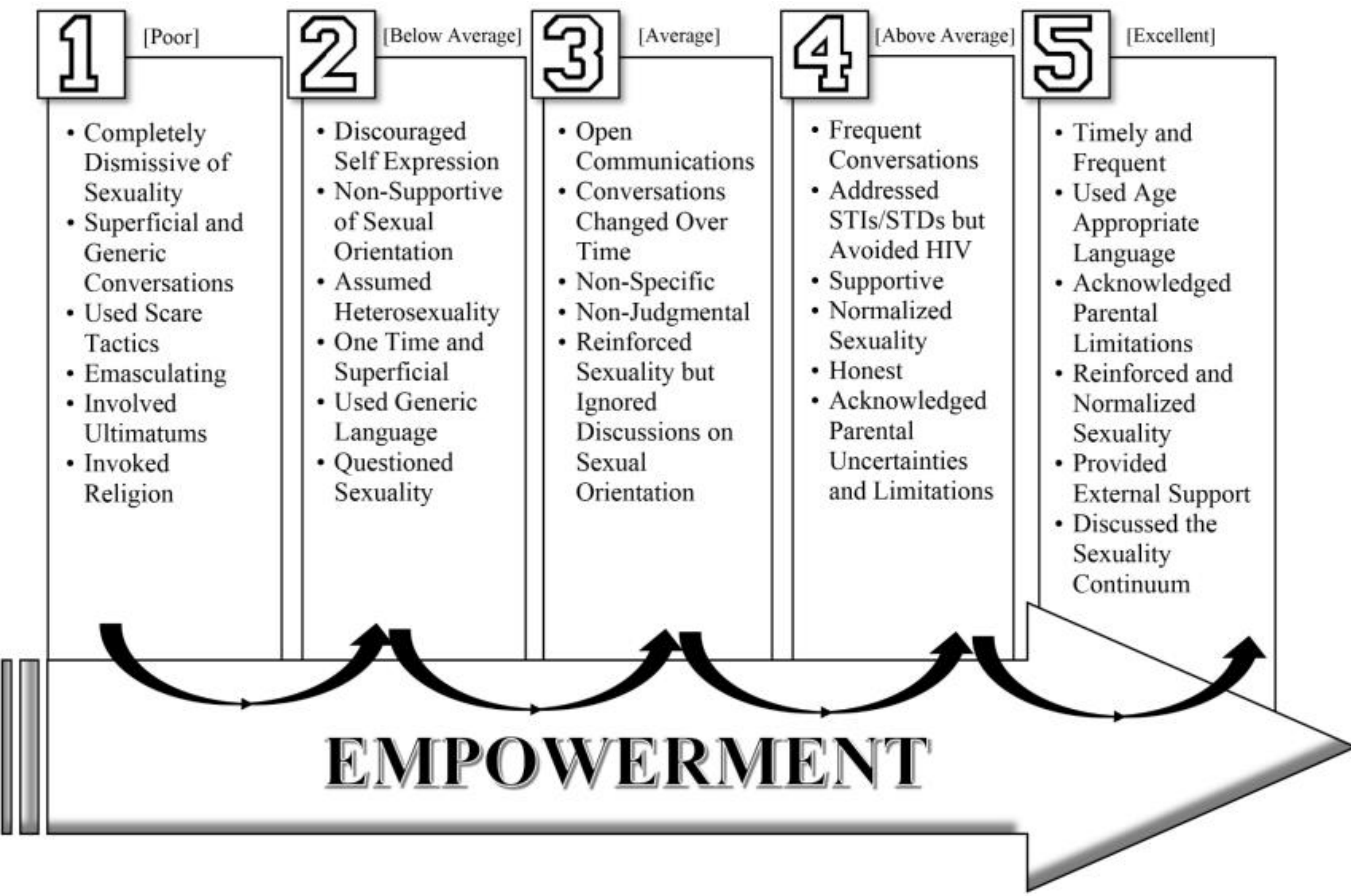

Figure 4. Parent-child communication styles and characteristics.

a continuum, ranging from poor to excellent, based on parental: a) style(s), b) engagement, and c) the character of the provided information as indicated throughout the data.

Figure 4 highlights the range of parent-child communication styles related to sexual behavior change(s), sexual identity development, and understanding of HIV risk. Some parent-child communications began with an overall explanation of the spectrum of sexuality, and were continual based on age, and parental assumption(s) of their son's sexual debut. These conversations often originated under the auspice of informing their child about the sexuality continuum, with a primary focus on heterosexual identity and heterosexual sex, because of the assumption that their child was really 'straight'. However over time, and with the child's comfort level of their coming out being tabled, the parent-child conversations developed into more continued, in-depth discussions of sex, sexuality, and with more detailed information about how to protect oneself from STIs/STDs, and/or HIV. Additionally, these concerns detailed parental concerns for their sons. For example:

> When I was 16, my mother had a conversation with me. Soon, before I came out, my uncle was [diagnosed as] HIV positive, so she talked about, being safe and that whenever, and if I had already done stuff that I shouldn't feel uncomfortable asking her, or I can just call someone else, and like have the conversations. But she always stressed don't be uncomfortable, but always, she says, use protection, in whatever you do.
>
> Bill, 28, African American

For participants who reported having quite successful [and effective] conversations [levels 4 and 5] in Figure 4, their reported collective similarities were that these conversations often: a) occurred repeatedly over time, b) involved transparency, honesty and openness from parent(s), c) used non-judgmental language to address sex and sexuality, d) contextualized

parental reflections and personalization of their own lived experiences, e) used explicit but age appropriate content, f) used age appropriate terms, g) incorporated parental initiation and follow-ups over time, h) reassured sexuality, i) acknowledged parental limitations while involving professional non-biased support, j) incorporated active listening to their child while ensuring that the child felt heard, understood, and respected, and k) were direct, one-on-one, in person types of conversations. Three randomly selected conversations that encapsulated and described above average [Level 4], and excellent [Level 5] parent-child communication attributes are presented below.

First, Daniel is a 28-year-old Hispanic gay male who was adopted when he was a baby. He recalled having a generalized conversation initiated by his parents around the mechanics of sex (e.g., why people had sex, how babies were created, and why some individuals, and/or parents adopted). One day, he recalled having a conversation with his parents about homosexuality after they (his parents) found gay porn websites on the family computer, because he haphazardly cleared the internet history and cache. Although feeling embarrassed, Daniel recalled that this conversation was both supportive and nonjudgmental [Level 5], and ensuing others with his parents, focused on normalizing and re-assuring his sexual orientation, sexual behaviors, and sexual identity, provided him with safety precautions about how to approach and engage in safer sex practices, and used non-judgmental language. He stated:

> I remember, it was kind of, semi-embarrassment, I guess at one point where, you know, like 13 or 14, and I guess I had been watching porn, and somehow, I had left that open on the computer or they have gone through the browsing history, and at that point I didn't know about deleting, but I think I started [after that]. And basically, they found that it was gay porn that I was watching, and then there were conversations around, my

> sexuality, and whether I was gay, or weren't gay, or whether I was just curious about looking at gay porn. And then, kind of a conversation around yes men and men can have sex, and women and women can have sex, and men and women can have sex, and that there are, they're all okay. And then, I think as time passed, and within the context of being aware of regardless of whether I was watching straight or gay porn, you know, there is kind of healthy ways to have sex, and unhealthy ways … and kind of you know, be mindful that just because you see it on the screen, doesn't necessarily mean that that's the best way to have sex, or that this is how everyone performs sex, or this is what the expectation is.

Like Daniel, Norge is a 28-year-old Hispanic male who initiated the conversation with his parents at age 6, when he found a used condom in a bedroom in the family's new house. Upon finding the condom, Norge brought it to his parents, thinking it was a balloon. His mother graphically, and age appropriately explained to him that it was not a balloon, but rather a condom; she told him what a condom was, and how it was used. Consequently, from that point on, Norge recalled feeling comfortable discussing sensitive topics with his parents. They normalized sexual practices when they communicated openly, explicitly, and honestly about the nuances of sex, sexual behaviors, sexuality, and protection with him, continuously over time, while providing opportunities for follow-up questions. Although he communicated with both parents about sex, it was the one-on-one, open and honest conversations with his father that influenced him more, as he perceived that they bonded as males, around a sensitive topic [Level 4]. Accordingly, he described his experiences as follows:

> Um, when we talk about straight sex, it went well. They talked many times … I knew very little about what sex was, and they always told me how to [stay] protected … they

> taught me very good, since I was very little. They told me how to use a condom, how to be protected, and well, my dad, told me how to do it. How to, oh God, I don't know how to say that in a nice way. Um, how to tease a girl, how to have to intercourse with a girl, and my mom was more, she taught me how to talk to a girl… I felt very, very comfortable talking about that with them. They were always very nice and any kind of question that I had, they would respond to me very honestly. And before they knew I was gay, even when I asked them about gay sex, they would tell me very honestly, what it was and how to [stay] protected.

Finally here, Adam, a 24-year-old White gay male, recalled his feelings as his mom attempted to ensure that he was a well-rounded and well-informed young man, especially as it related to his feelings, perceptions, and attitudes toward sex. He remembered that these [Level 4] conversations minimally included: a) how to prevent teenage pregnancies, b) protecting himself from STDs, STIs, and HIV, and c) normalized pre-marital sex as something that others did while still emphasizing protection, if he chose to engage in sex. Although these conversations were detailed and repetitive, Adam noted that the strengths of these frequent and on-going conversations were that he felt supported, heard, and respected by his parents, especially his mother, after disclosing his sexuality. Drawing parallels between himself and his friends, Adam realized that his mother's forthrightness, openness, and candidness around such a sensitive topic made it easy to communicate with her, unlike his gay friends who stated they did not have any parent to communicate with about their sexuality. He described his experiences as:

> Okay, I think one of the first things that she said after I told her was like, well, you know that's who you are, and that's something that you're going to do, then you really do need to be careful about it…she wanted to know what would I have done at that point, which

> did get a little bit interesting just because it's not something that, at that point, I was really comfortable sharing with my mother. [But] I am glad that we were able to do it, because I know, I had friends that were gay that had a really, really, hard time talking to their parents, and weren't getting the information that they wanted or needed. So, it was a good feeling. It made me feel, like I was being listened to.

However, not all conversations in the sample were as pleasant, supportive, and/or empowering, but approximately 79% of these parent-child communications improved over time, minimally from poor [Level 1] to average [Level 3]. In such occurrences, parents and children learned how to communicate outside of their own specific knowledge specialty, as it pertained to sex, and/or sexuality. These occurrences included parental knowledge and understanding of sex from a heterosexual perspective and its correlation to STD/STI, and/or teenage pregnancy protection, coupled with the child's (in)ability to adequately, or accurately address their own understanding(s) of sexuality. Therefore, parents often negated, neglected, or ignored topics about homosexuality, until the child directly inquired about the spectrum of sexuality. As noted by various participants, conversations that started off poorly were a result of their parents deeply held religious beliefs, male gender norms, and/or cultural expectations. However over time, and with patience, and sometimes ultimatums, some conversations improved to include parental concerns and worries about their son's own safety.

Three randomly identified parent-child communications that incorporated poor, below average, and average attributes that were the least effective in the study were those that: a) used scare tactics repeatedly, b) were perceived as being emasculating, c) were superficial, d) were dismissive, e) were non-compromising, and/or f) were non-supportive of a homosexual identity. In these instances, the participants recalled that their parents failed to emotionally engage with

them during their talks about sex, sexuality, and often, only encouraged '*being safe*' [sexually], after they identified as gay.

First, Ricardo, a 28-year-old Black/African American gay male, recalled how his parents used non-compromising, dismissive, and emasculating language when talking to him about sex, and/or sexuality. His [Level 3] conversations were both incongruent with his sexual identity, and non-relatable to his sexual desires. The conversations often immediately silenced any emotional topics about sexuality, and ultimately created an environment where other GLBT family members also suppressed their sexual identity, moved away, and/or participated in riskier sexual behaviors. He recalled one specific attempt to have a conversation with his parents, and his mother's verbal, non-verbal, and dismissive attitudes coupled with the constant conversations about heterosexual sex with his father that created communication blockages between him and his parents. His experience was as follows:

> I think for me, when I had the conversation with my mother, it was more her non-verbal that really stood out to me … her hand gestures like, simply [showed] that she was confused and frustrated with trying to communicate. Her [many] faces communicated like, why are we talking about this … verbally, she really didn't have much to say and non-verbally, I could tell that she was really uncomfortable … And I think with her identifying that she had a son that would end up, you know, being with the same gender, I think that was very uncomfortable for her. For my father, it was always when you going to get a girlfriend. Someday you're going to be having sex with a woman and was very emasculating to me, you know … And so, the conversations were just like, just don't have it, because the world was crazy and you don't want to end up like your brother with no badass kids and you don't want to end up like me …

Josiah, a 19-year-old Black/African American gay male, recalled that the conversations [Level 2], with his mother, were sparse and abrupt. During interactions with her, he realized that she was uncomfortable with talking about sex, specifically homosexuality, which was evidenced in her language and her disapproving non-verbal communication styles. When asked to recall this conversation, he stated:

> Yeah, [she told me] not to just do it with anybody and make sure that I have been using protection, basically. It was like a short, kind of conversation, … except, when I came out, that's when they just wanted me to be safe so they like, you know, she sat me down and was like be safe, and make sure you don't, like, do anything with anybody and you know [the] basic little rules that parents have for their children.

Finally, Jason is a 25-year-old White gay male who spoke with both parents about sex and sexuality. Like many of the other participants, Jason's initial [Level 1] conversations focused only on heterosexual sex; however, after coming out, his father repeatedly used scare tactics to dissuade his *assumed* homosexual choice, and further attempted to emasculate Jason because of his stated sexual orientation. Although Jason spoke openly with both parents, it was often the conversations initiated by his father that were the most difficult to have, because he often felt unheard, neglected, and ignored. Here, he described one conversation he recalled having with his father:

> He would [normally] start the conversations himself in an attempt to keep my scared straight by pulling me into a room and say, son I'd like to talk to you, and that would be about an hour, two hours of him ranting about how it's illegal to be gay, and how it's violent, that sex between men is violent and terrible and you'll suffer horrifying anal

bleeding for days and just terrible… Dad would deny it. He would just throw it off as a phase, and be like, oh when you're with your first woman it will change.

Discussion of Parent-Child Communications Styles

Figure 4 presented some selected attributes, identified throughout the 20.5 hours of audio recorded and analyzed parent-child communications, that helped to rank communications from poor [Level 1] to excellent [Level 5]. Essentially, these data served as a nuanced parental "do's" and "don'ts" checklist, that could be helpful for parents when initiating, and/or engaging in conversations about sex, and/or sexuality with adolescents, specifically gay men. As noted in Figure 4, some parent-child communications began poorly, but over time, parents and children developed the necessary skills and techniques required to address issues related to sex, sexuality, and/or HIV, at least on the average level [3]. Likewise, some parent-child communications started excellent [Level 5], and moved back and forth between average [Level 3] and excellent [Level 5]. Explanations for such vacillations included, but were not limited to: a) parents' knowledge regarding how to have, and live with, a gay son, b) the son's inability to accurately describe, and/or explain his understanding of his own sexuality, c) some parents' religious beliefs, d) parent's conflicted gender and role expectations of their son, e) parents' education levels, and f) parents' exposure to other GLBT individuals.

It appeared that religion/religious beliefs may have affected how some parents structured their conversations on sexuality with their children. In some cases, parents who held deep-seated religious beliefs were less likely to engage in conversations about sex, sexuality, and/or HIV. Some participants felt that parental religious beliefs affected their ability, and/or willingness, to effectively communicate about any other sexuality preference outside of heterosexuality. In such conversations, parents often quoted the Bible as the definitive moral source of their belief about

sexuality, or used religious types of scare tactics to attempt to scare their child to be straight. Conversely, some parents were unsure about how they could effectively divorce their previously held religious beliefs to fully support their sons. Together, these conversations, even after coming out, seemed superficial in their content [Levels 1, 2, and 3] as they only reminded the son to use condoms in all instances of sexual behaviors, and discussed nothing further. Interestingly, and surprisingly, several parents chose closer relationships with their sons over their own religious beliefs, some developed a deeper relationship with religion in efforts to better understand their relationship with their sons, and others used religion as a justification for their continued attitudinal beliefs toward homosexuality.

Comparably, several participants stated that their parents attempted to have conversations with them about sex and sexuality however, after they disclosed their sexual orientation, their conversations around sexuality stopped, abruptly. Some explanations offered included: a) parents stating that they had uncertainties about how to relate to their gay son, b) parental fears about HIV transmissions, c) parental awareness of the ongoing, and often negative, societal attitudes and stigmas toward gay men, and d) parental uncomfortable levels, talking about homosexual sex with their sons. For instance, although several of the participant fathers were accepting of their son's sexual orientation, these same fathers were most uncomfortable when talking about homosexuality, because the concept of man-to-man sex was a foreign notion, that they have never personally considered, or experienced. Similarly, some mothers were uncomfortable discussing issues of homosexuality with their sons, because they felt uncomfortable imagining their sons having sex with another man. These factors taken together, appeared to affect the overall efficacy and frequency of parent-child communications around sex, and/or sexuality with these gay males. However, despite these issues and concerns, almost all

(85%) of these participants felt that their parent-child communications improved with time, as parents became more comfortable with the idea of homosexuality. They no longer feared having the conversations openly, honestly, and freely with their sons; often reminding them to use protection, be safe, and not to be promiscuous.

Other conversations were initially classified as ‘average’, because the parents initially recognized their child’s sexuality, but did not engage with them about sexuality until they were older. In these conversations, parents used rather basic and generic language around sexuality, however, did not address issues pertaining specifically to homosexuality. Like their parents, some of the participants recalled that these conversations were often ‘average’, because they—the child—were unsure, and/or unaware of the appropriate questions to ask about sexuality, and/or were afraid to ask sexually specific questions that would inadvertently reveal their sexual orientation. Despite the starting and ending position in the continuum in Figure 4 [Level 1 – Level 5], the majority of these conversations eventually encased a positive framing that reinforced, and/or primed future healthier sexual health behaviors. In fact, the positive content characterizations helped to make these rather ‘sensitive’ conversations less awkward, more effective, impactful, and frequent, especially as it pertained to having conversations on sexual matters with young gay adults, and/or adolescent gay males.

As suggested by Rothman, Bartels, Wlaschin, & Salovey (2006), effective communications address issues specific and relevant to the discussed behaviors, and should be communicated in ways that impact individual thoughts and behaviors. In all of these cases, participants reported that their parent-child communications positively reinforced their willingness to minimally engage in conversations about sex, safely with their sexual partners. Additionally, some researchers maintained that conversations incorporating positive attributes

should be framed in ways that avoided highlighting negative socio-behavioral risks, and collaboratively achieve optimal behavior change rewards (Gerend & Cullen, 2008; Myers, 2010; Rothman et al., 2006; Rothman & Salovey, 1997; Rothman, Salovey, Antone, Keough, & Martin, 1993). These authors recommend that parent-child communications should normalize sexual orientations, sexual curiosities, and sexual behaviors by providing an amalgamative and summative perspective on various sexually related topics. For these study participants, positive parent-child communications included in-depth, frequent, and personalized parental explanations about the health benefits and outcomes of having decreased sexual partners, increased condom use, and transparent communications with sexual partners on topics related to STIs, STDs, and/or HIV. Finally, repeated conversations, appeared to create a foundation that: a) helped to prime future parent-child communications, b) created a closer bond between parent and child, and c) fostered an atmosphere where children felt more comfortable addressing other sensitive and topical issues with their parents.

Although these parent-child communications had an overall general and effective influence, some participants recalled conversations that lacked adequate, relevant, and/or time-sensitive information. In these conversations, participants recalled receiving subjective information fraught with parental concerns that were irrelevant to their immediate, and/or long term needs, thus creating a 'decision problem' (Myers, 2010). As defined, a decision problem,

> refers to one's conception of the acts, outcomes, and contingencies related to a specific choice and propose several factors that influence which frame a decision-maker will adopt, including one's cultural norms, habits, and personal characteristics and the formulation of the problem. (Myers, 2010, p. 502).

In these instances, conversations focused primarily on parental needs, used language that reinforced traditional heterosexual gender norms and expectations, and/or were non-supportive of the sexual orientation of the child. These occurrences in turn, often resulted in health and mental health issues, substance use and abuse, lowered self-esteem, and internalized self-hate, and an inability to express themselves to their parent(s), as often highlighted elsewhere in the extant literature (D'Augelli & Patterson, 2001; Denizet-Lewis, 2003; Dube & Savin-Williams, 1999; Ettinghoff, 2013; Jemmott, Jemmott, & Fong, 1992; Ragins et al., 2007).

Taken together, the contextualizing of these conversational contents positively influenced how these study participants developed ongoing communication patterns with their parents. For instance, when parents normalized sexuality perspectives using language that was accepting, rather than ostracizing, they were more likely to have increased conversations, that were inviting and honest with their sons. Conversely, parents who adhered to the rather rigid gender and sexual orientation norms, communicated less openly, and used more judgmental and ultimatum types of words and/or phrases, ultimately left their gay sons unheard and feeling dismissed. These data revealed that having conversations framed in more acceptance, humanized positivity, and re-occurring ways, were more effective in inciting safer sexual practices and more communicative tactics in comparisons to conversations that were framed from a negative perspective.

Major Themes

The six major identified themes derived from the analysis included: a) reasons for conversations, b) coming out, c) sexual orientation, d) sexual behavior, e) HIV knowledge, and e) prevention education. These themes are presented in Figure 5 and will be explored more thoroughly as they influenced the content of the parent-child communications of the $N = 14$

research participants. While these major themes helped to contextualize the content of the parent-child communications, Figure 5 should not be deemed as all-inclusive or encompassing for all the possible themes and sub-themes but more so, be used to illustrate the major content areas, encapsulated by relative similarities within, and across, each major theme.

The major themes were initially analyzed using a set of three underpinning questions, which minimally asked: a) why were these conversations happening?, b) when were these conversations occurring?, and c) how did participant communicate with their parents regarding the topic of sex, sexuality, and HIV? Finally, the identified and selected themes were based on the person, rather than frequency within the conversations. For instance, rather than counting the amount of times a theme occurred throughout the parent-child communications, each theme was counted once based on the participant regardless of how many times it occurred throughout the parent-child interactions. This technique assisted in identifying the subsequent sub-themes that 'hung together' beneath the major theme umbrella and served as a validity check to assessing the relative congruence between the subsequent themes and the sub-themes.

Theme 1: Reasons for Conversations

All conversations in this study usually started out as rather uncomfortable and awkward experiences for both parents and their sons. However, they were frequently viewed as necessary opportunities for parents to educate their sons on issues related to safety, teenage pregnancies, and/or sexual behaviors. As such, the sub-themes that emerged beneath the first major theme, were: parental obligations, external triggers, parental discovery and responses, and normalizing and de-stigmatizing sex and sexuality.

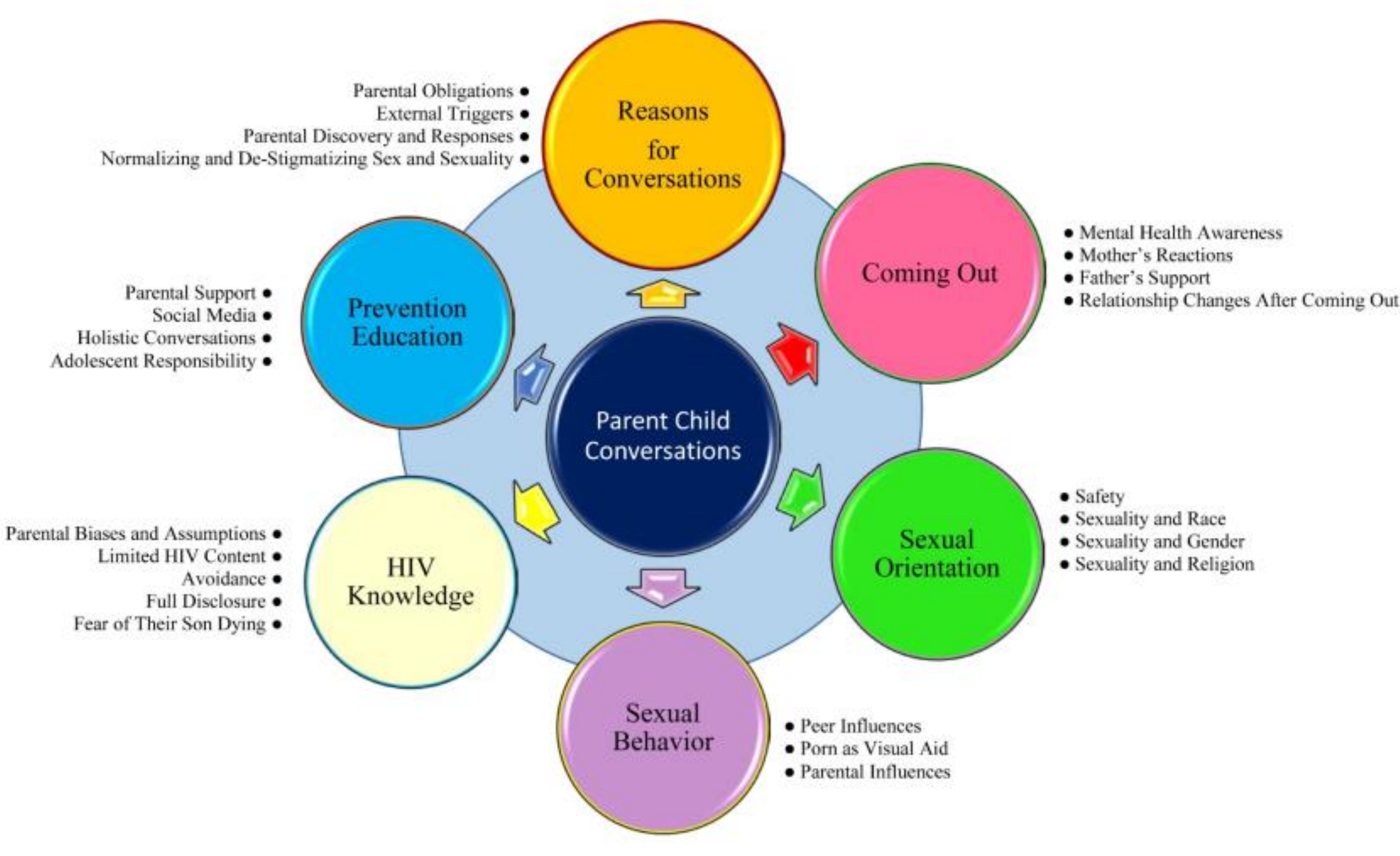

Figure 5. Major and minor themes of the parent-child conversations (n = 14).

Parental obligations. While 64% of these participants recalled that the initial conversations about sex and sexuality focused primarily on heterosexual sex, 57% of the participants stated that their initial conversations appeared as the obligatory parental 'thing to do'. This obligatory notion was weaved into these conversations because parents felt the need [as stated by the sample participants] to: a) provide at a minimum, a basic information introduction, and/or overview of sex, b) offer information on how to protect oneself from STIs, STDs, early teenage pregnancy, and/or HIV infection, c) normalize adolescent sexual desires as a natural part of one's identity development, and d) sometimes reinforce their own heteronormative ideas on sex:

> I remember we were outside doing yardwork, like we were cleaning out the garage, doing yard work, washing the car, I think in like early spring, because we were getting things ready from winter to spring. And he, I remember he awkwardly approached me, and he was like, you know, I know you're a good student and you're really on top of your stuff, cause I was really a well behaved kid, you know. Super involved. Nerdy Kid. And he's like, but, we should have the talk and it really, honestly didn't last that long. If it lasted 15-20 minutes, that was about it. And I remember, it was, like the basics, your mom and I aren't stupid. Like you know, kids these days. We're not going to tell you not to have sex, but if you do decide to have sex, do so safely, use condoms, don't get a girl pregnant, and you can always come to your mom and I, you can always talk to us. We're here for you, don't be shy and, I believe we also talked about masturbation, saying that everybody does it. I remember him saying, I do it myself, it's just a natural part of being an adolescent, growing up, teenager. And, I remember that, we talked a little bit about porn magazines. And, it kind of ended with him saying, you know, do you have any questions,

> and I don't think I was uncomfortable but I was like, no, I think I'm good. You don't have to talk about this anymore. And then we kind of just continued working outside, I guess.
>
> Charles, 27, White

External triggers. Relatedly, 43% of participants recalled that the reasons for their conversations were a result of various external triggers. These external triggers were related to: a) interactions with medical personnel who had concerns about their sexual health and behaviors and in turn, told the parent, b) a teacher reporting a case of domestic abuse between the participant and his boyfriend, c) a teenage cousin became pregnant and the father warned his son to protect himself, d) a TV show about a gay man trying to find his "*Prince Charming*", e) an internet history browser that showed gay porn, or f) a therapist intervening between a parent and a child, all prompting these needed conversations. For these participants, these identified external sources triggered these conversations:

> When I came out the closet, after me and my first boyfriend fought, I remember sitting in the principal's office and the principal told her that I got into a domestic dispute and he said that he wasn't pressing charges or anything like that and that I wouldn't have to go to court, I was just going to get suspended. And my mom, he handed me the phone and my mom was super upset, before I could even get a word out of my mouth, my mom is cursing me out because she thinks that I hit my ex-girlfriend because I was dating a girl at the same time that I was dating a boy. … He was okay with it though for like 7 months, but when I told her that I got into a fight with my boyfriend, she was like, your what? I was like, my boyfriend David, and she said, she just gave like a really deep sigh, and I remember she [stated], I'll be there to come get you, in like 15 minutes, and that's pretty

> much all that she said. … I get home, and we sit down, it's me, her, which makes it even more uncomfortable that she had my little brother and my older brother there at the same time because prior to [that], maybe a few months earlier than that, there [were] rumors going around that I was messing around with a boy and so my older brother got suspended for fighting somebody, like my older brother, his friends, they jumped somebody because, there [were] rumors going around school that I was messing with a boy, and I denied it at the time. And so, we all sat down that day and my mom was like, okay, start from the beginning. She was like, I don't know what you want to tell me, but you have to tell me something. And she was like, you getting suspended from school is definitely not okay. And so, I told her, and then everybody was just sitting there super-duper quiet, and the next thing that came out of my mom's mouth was, she started to kind of get a little emotional and she was like, I don't care that you're gay, I am mad that you got suspended from school, for being gay. This is something that we could have handled outside of school. … Yeah, she was just pissed as hell that I got suspended from school. She was really upset … She wasn't upset about me being gay, she was upset [with me for] fighting, for getting in trouble at school.
>
> Malcolm, 24, Hispanic

Parental discovery and responses. All participants reported that the frequency and content of their conversations changed after coming out, and/or their parents discovered that they were having gay sex. In this sub-theme, there were various mixed (positive and negative) reactions. While 85% of participant parents wanted to show their acceptance of their son's sexuality, new and clearer boundaries were set within the household regarding acceptable versus unacceptable behaviors, new rules for male friends who visited the house, more monitoring of

sexual activities, and screening their son's whereabouts more vigilantly outside of the home. Two well noted explanations for these behaviors were anxiety and surprise. Taken together, these parents generally wanted to use these conversations to create a more open culture of sexual awareness, openness and acceptance, and they also wanted to ensure the overall safety of their son. One example of this positively framed conversation was:

> He knew that I was having sex with guys. He wanted to make sure that I was safe. In doing that he asked me if there was anything that I wanted to ask him; not that he had had sex with guys or anything like that, but just in general. And I really didn't have any questions for him, but then we had a conversation from there about, how to treat like male visitors coming into the house. Like, before this, I had just had guys spend the night, just friends and whatever, and you know like you do growing up or whatever, and after coming out, I'd had girls spending the night, it wasn't a big deal. But then, he had never thought that there should be a need to have an open-door policy, so that started happening—that conversation should there be open doors when you're having guys over, and things like that.
>
> Josh, 28, White

Conversely, 35% of participants recalled that their parents were initially not as accepting of their sexuality. For these participants, their parents invoked one or a combination of various techniques, such as: a) frighten them into being straight, b) questioned the legitimacy of their sexual orientation, c) used the Bible as justification for their beliefs that homosexuality was wrong, and/or d) castigated them into believing that their sexuality was a very wrong moral choice, ultimately resulting in their conversations being limited or tense. One participant highlighted his conversation as follows:

> Dad would deny it. He would just throw it off as a phase, and be like, oh when you're with your first woman it will change. He wanted me to one day say, I've suddenly become straight, and he feels like I am making, that I am choosing to make a huge mistake. He doesn't see it as, that's part of who I am.
>
> Jason, 25, White

Normalizing and de-stigmatizing sex and sexuality. Finally here, 64% of parents used these conversations to attempt to 'normalize sexuality' as an innate part of one's human sexual development. For instance, parents often described a sexuality continuum, re-assured their sons' that their feelings were normal, and made themselves available to answer any follow-up questions that their sons asked. When describing aspects of these conversations, one participant recalled how his mother invoked a very supportive approach to help demystify any previously held negative assumptions about sexuality. He stated that within the conversations, she,

> "…talked about the stigmatization of gay men and that they would all get HIV, and that this was untrue. But there is a perception that, if you are gay, then you are going to have HIV, and kind of letting me know that that was a stereotype about gay men that existed and continues to exist, but, that HIV is not a death sentence. There are medications now, and many people go on to live with HIV. There's no need to be scared of people who have HIV. But you know, to take preventative measures such as using condoms, or not using, not doing, you know shooting drugs. [She wanted] me to you know [how not to] contract HIV, but, kind of letting me know that there are still complications of it."
>
> *Daniel, 28, Hispanic*

As indicated in Theme 1 and its four sub-themes overall, the reasons spurring the differing initiations of communications about sex and sexuality varied. However, some parents

appeared to initiate the conversations primarily to raise their own concerns about sexual safety, and to impress upon their child, their parental concerns and worries related to their son's overall well-being, coupled with information about how to decrease STIs/STDs, and teenage pregnancies. Regardless of knowing whether their child was gay, it appeared that these parents wanted to primarily stress the importance of safe sex. Upon learning that their child was gay, some parents tried to normalize sexuality as an innate aspect of one's development and identity, therefore, they started to include content in their conversations about the various aspects of the sexuality continuum, coupled with what it meant perceptually, to be gay in todays' society. Others focused their conversation contents on sexual protection in order to help decrease the chances of their son becoming HIV infected.

Theme 2: Coming Out

Interestingly, 21% came out before, 29% came out during, and 50% came out after, the initial parent-child conversations on sex and all recalled that coming out was a very critical and emotionally anxious concern for them. The lack of conversation content about coming out issues caused participants to grapple, query, question, and re-negotiate their relationships with themselves, and how they viewed their friends and families. Almost all participants recalled in these conversations about frequently feeling abandoned, alienated, isolated, and unwanted. However, after these conversations, they often participated in healthier, less risky, and safer sexual behaviors – as they were now, more aware of the residual effects of non-disclosure. This sub-section five sub-themes were: mental health awareness, mother's reactions, father's support, and relationship changes after coming out.

Mental health awareness. For all participants, coming out was anxiety-provoking and rather momentously personal, as they attempted to connect both their declared sexuality and self-

identity. Eighty-five percent of the sample stated that coming out directly [*mom, dad I am gay*], or indirectly [*son, let's have a talk about the gay porn I found on the computer*], felt like a re-birth of self and a re-building of their self-esteem in unimaginable ways that helped them to think very differently about their life, provided them with a better sense of purpose, helped them to 'walk in their own truth', unmasked them, and gave them permission to accept and love more aspects of themselves. As such, during these conversations, all issues seemed to trickle down to each youth's own mental health and self-awareness – and in all cases, their eventual betterment. This is not to imply that tabling this main issue for these participants was an easy thing to do – and this finding is indeed consistent with the existing literature for GLBT individuals (Boss & Thorne, 1989; Bregman, 2013; Bregman et al., 2013; Denes & Afifi, 2014; Hobfoll & Spielberg, 1992; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Here is a riveting and emotional recollection of a participant coming out to his mother:

> God, [coming out] was like a 360, I was a whole new person, and I was so happy. I started to participate in school functions, I joined the drama club, I became a cheerleader, and I [became] very popular in high school from then on because I was a lot more confident and able to exude that confidence and put myself out there and get to know people because I wasn't afraid of them blurting out such and such about me. And, that was a big fear with making friends too, before coming out, was I was afraid that they were going to find out, or figure out that I was gay, and they weren't going to be friends with me. So, it really just made me, gave me the confidence that I needed to just you know talk to people, and initiate a conversation to start with. [Originally] I was afraid that if I opened my mouth too far, that rainbows and unicorns were going to fucking spill out of it. And so, it was just, it was a big change for me. It really changed who I was, and

especially living in a small country town and being so well received and being able to be who I was, just did wonders for my self-esteem.

Nick, 25, White

Mother's reactions. Among these participants, 64% came out to their mothers first. Their mothers, as recalled by the participants, provided a broader range of both positive and negative emotional and verbal responses to their coming out. Participants who recalled these maternal, positive emotional and verbal responses, described their mothers as being more understanding, and more willing to talk with them about their overall sexual identity, sexual wants, and sexual desires (Baiocco et al., 2005; Dittus et al., 2004; Hutchinson et al., 2003; Jaccard et al., 1998; Miller at al., 1998). The added perception here, was that mom attempted to make these conversations about sex easier to understand, and she spoke more clearly and openly regarding the nuances of sex and sexuality, at times personalizing their experiences with sex to make it more relatable to the their sons:

I think with that aspect [that she had us so young] my mom made us feel comfortable having those conversations because growing up, she didn't feel like she was able to talk to our grandma about those things or even our papa. And so, it made her, it made her feel better about herself as she was able to have those conversations with us. And it was actually, it actually worked out because you know me and my older brother are actually, like really closer to age, and so with her doing that, me and him were able to have that same dialogue without her, and so it was, like we kind of like had each other to kind of like talk those things about, and then we passed it along to my little brother who's now, uh, 19, and growing up, like, as, as a teenager he would ask me questions all the time. I mean, he didn't really start asking me questions until after I came out the closet. But at

> that time, he was then like 12, cause then he was like really asking me like, a lot of questions. But, I think my mom just made it comfortable enough. And I know a lot of people that weren't that comfortable having those conversations with their parents, which is why they would always come to my mom about those things. Because my mom just didn't tell us, about those things, she actually told, you know, she was actually like teaching our friends as well.
>
> Malcolm, 24, Hispanic

Conversely, 28% of mothers initially displayed some relatively negative emotional and verbal responses to their son's coming out. Some recalled that various explanations included the notion that mothers did not want to imagine their sons performing sexual acts on men, mothers' religious belief in the scripture that addresses sexuality, racial, ethnic, and cultural norms and expectations of their sons, and/or one son influencing others. When describing an instance of this, one participant recalled:

> I had a few [gay] DVDs in my room, that I hid underneath my bed and my sister, my twin sister, actually found them, and she put them in my nephews' bed for him to find and bring to my mom. And I came home and she confronted me about it, and I'm like, oh, well, I got these from such and such place, and she was like, you know what, just pack your shit, put it all in a bag. I'm going to take you down to the men's shelter. So, I was like okay, this is it. I'm getting put out now, so, I go to my room, packing my stuff and she stops me,' cause I guess, her and my father had a conversation, because I wasn't working at that time, I think, yeah. I just became unemployed again, yeah, unemployed, so I didn't have any [money] to survive or do anything, so [she and] my dad, they had a conversation or whatever, [he] calmed her down, and she stopped me in the middle of the

stairs, and had a conversation, and she's like, if you're [going to] live in this house, you better be this certain type of way; if not, you're out.

Ronn, 26, Black/African American

Father's support. Father and son parental-dynamics varied, as fathers displayed a narrower range of emotions, and provided more tangible, and less emotional, support for their sons, when coming out was discussed (Denes & Afifi, 2014). While 71% of participants recalled that their fathers were supportive of their sexual orientation, 40% remembered that their fathers became overly protective after they came out. When recalling and describing their interactions with their fathers, they stated that although they were less talkative than their wives about this subject, they were more outwardly attentive, inquired more about their whereabouts, offered more tangible types of support, two fathers reinforced the notion that "*if anyone tries to mess with you, let me know*", and provided personal one-on-one bonding time to help ensure that he was well prepared for the real world:

> My dad focused on, he was like, I don't want you to get sick like your uncle. And I'm like, why does me being gay have to equally equate to me being HIV positive, but, and so he was, it came, I wouldn't even say it was like disappointing, but it almost became like, he became instantly like poppa bear and was like, I'm trying to protect you from everything. And everything, all the time was, like I don't want you to get sick, don't mess with certain kinds of people. And I was like, what does that mean? It was a very strange reaction, when I look back it.

Bill, 28, Black/African American

Relationship changes. All participants recalled that their relationship with their parents changed more openly after coming out; some were positive, and others improved overtime. For

64% of participants, they recalled that their relationships with their mother became re-casted. For instance, it appeared that many mothers saw the relationship now as ‘best friends,’ rather than simply ‘mother and son’. One common explanation provided for this was related to the perception of re-found trust and honesty, because their son disclosed his sexual orientation. Subsequently, mothers often made more inquiries about their son’s sex life, had extended conversations about who they were sleeping with and at times openly, and comparatively, discussed their personal sexual experiences. When asked how they made sense of these newly developed relationships, they recalled discussing how being open with their mothers gave them new opportunities to develop a better relationship with her, as she feels she now has more trust:

> Once I finally came out as gay to her, she just sort of snarkily commented that she wished that I had told her first, and she made a big deal out of letting me know that she didn’t care, and all of that. So, from then on, she was way more comfortable having those conversations with me than I was comfortable having with her, and so she would just openly ask, so when was the first time you had sex, like, whatever. [She would] casually bring it up in like care rides and stuff like that. The longest conversation that we had about it was probably after I had brought a boyfriend over to her house. She had boldly just asked me the next morning, so how was the sex? And after getting over my initial shock, of her asking me that question, I just talked to her about it, and like I had mentioned that we had had sex and she never even asked like if we were being safe or anything like that.

Josh, 28, White

Overall, these anxiety-provoking coming out conversations helped both parents and sons address their own anxieties and internalized fears and apprehensions. Coming out triggered

various conversations about mental, physical, and sexual health concerns, as participants no longer felt the need to hide their sexuality. Mothers and fathers reacted generally supportive, but somewhat differently, to this tabled event. For the parents, some had appropriate and periodical ‘check-ins’ regarding sexual behaviors, as well as encouraged, though at times limited, healthy and safer sexual behavior practices to their sons. For the participants, this communication helped them to self-select what they needed from their parents, as well as helped better reinforce their total personal identity.

Theme 3: Sexual Orientation

Sexual orientation as a major theme was meant to encompass various issues related to self-disclosure and acceptance of sexual orientation, from both parent and participant perspectives. When deciding to accept, define, declare, and/or deny their sexual orientation, all participants navigated their parents’ attitudes toward accepting their own sexuality, foremost. This content was rather varied, based on multiple and differing assumptions, and/or presumptions that parents held about sex, and/or sexuality. Some of these were grounded in the parent’s own exposure, or lack thereof, to GLBT individuals. This sub-section presents information about how parents addressed sexual orientation, and provides insight about how the participants understood and explained their own sexuality. The sub-themes here were: safety, sexuality and race, sexuality and gender, and sexuality and religion.

Safety. All conversations between parents and their children minimally addressed, or alluded to, personal safety, at some point. For all parents, the underlying message to their sons was consistent about continued condom use. After finding out about their son’s sexual orientation or sexual activity, either directly being told about it, or finding out about it indirectly, parents increased their communication content about safety to include more health-related

conversations about chlamydia, gonorrhea, and other STIs/STDs. Some even demonstrated [with a cucumber] how to use a condom as well as other forms of protective barriers. Others preferred that their son had sex within their own house – as an additional safety measure, and some made themselves more available to address any additional questions that their sons might have about safe sex:

> And then it came out that I was having sex with men, and that I was gay. And my family was fine with it, but, they've always been super big on you need to use condoms, oh you're sexually active, here is a box of condoms, are you using condoms. They explained verbally how to use them, but I mean, I'm a pretty smart kid… also, my grandma would go through my room as a teenager, and was like, why aren't there any more condoms in your drawer.
>
> Nick, 25, White

Sexuality and race. In some conversations, issues of race and sexuality were frequently blurred during discussions. Conversations about sexual orientation differed based on the race of the participants. For the N = 5 Black/African American participants, conversations about sexuality addressed a wide array of societal held perceptions about Black/African American males, HIV/AIDS rates, and community and gender expectations. For these study participants, the conversations around sexuality not only addressed external perceptions of Black men, but also how Black gay men intersected with the Black community, HIV rates among Black gay men, negative societal perceptions of Black men, and community expectations of Black men:

> Race plays a role because we are all aware of a lot of the traumatic experiences and their long history of oppression that African American have experienced being in the United States. And I think that, people, many people from my parents' generation had not

> worked through that. And so, it's like you have all of that, that you're really working through and then you add on the sexuality part, it becomes a lot for them to balance. You know. It becomes a lot for them to kind of work through. And [how can] you connect to something that you cannot relate to? How do you begin to address that with your child and I think, in my experience growing up, my parents were big on family image. Big on, not making your family look bad. So, we had a family friend, his name was Rob Clarity (Lord, may he rest in peace), he did ballet. He went to Berkeley University, and everyone knew he was gay, and now that I'm older I knew he was a flaming queen, as we would say. Um, but it was okay for Mr. Clarity to be who he was as long as he didn't talk about his life, you know. Our family members loved him, they embraced him, but I remember growing up, I never saw his partner, I never heard him talk about anything sexual, until I got older. And by that time, he had retired from school, from being an administrator, and he had died, and now that I'm older, lo-and-behold, [I now know] what he died from.
>
> Ricardo, 26, Black

Like Black/African Americans, the $N = 4$ Hispanic gay males had similar parent-child conversations that blended sexuality and race. In these, the prevailing concept of machismo, especially among gay males addressed issues of masculinity, social norms, public presentation, and sexuality:

> Machismo, in a culture so machista, like Cuba, you're supposed to walk a certain way, sit a certain way, talk a certain way. You can never pronounce the letter "s" at the end of a word, or in between a word. It's just for women. Even though when you talk, the word doesn't make any sense because you don't pronounce it correctly, [and because of that] I just felt, I actually don't know why, I just used to be a very shy person, and don't talk

about myself to people … It's awful because like I was saying, if you are, if you are a top, you are not gay. You are just curious or whatever they want to call it, but if you are a bottom, you are, they put you very low in society, like the lowest thing you can do. You can kill someone and that would be kind of okay, but if you are a bottom, that would be super bad … So, to have this kind of conversation with them, they get upset because, for Cubans, it's okay to be a top, but it's never okay to be a bottom … So, what I decide to do was to tell them, the next time they asked me, and my mom never asked me again, but my dad did ask me one more time, like 3-months later, and I told him no, I'm a top, completely a top.

Norge, 28, Hispanic

For the N = 5 White gay males, race was not really an issue of discussion/conversation. In fact, for this sub-sample, it was often their own personal expectations of masculinity that were affected when they came out. In this White cohort, they felt that their race made it easier to talk more openly about sexuality and acceptance, felt less judged by society for their sexuality, provided easier access to health and wellness information, and allowed them open access to various conversations on sexuality and social inclusion:

So, I do have that privilege that I do get to talk about my sexuality. I can be very open about it. While, and then I find that people, like you've mentioned, who are Black and Hispanic and they don't get that. For example, I have a privilege, I'm privileged with that because then everyone is like, Oh my gosh, you're gay. That's so brave, and wonderful. And then, all the basic White girls would come to me and like, you're my new gay husband. And, then I get to hear their stories of how they wish, that how, all the cute men are either single or gay. And it's just, Lord you're a walking stereotype. So, I am more

> privileged in the fact that I can actually talk about my sexuality. I'm not going to be shamed by other White people for it. Unless I walk into a Baptist Church.
>
> Jason, 25, White

Sexuality and gender. For many of these participants, there were various opinions about gender weaved into the content of their conversations. Sixty-four percent reported internalized dual identity conflicts about the social meanings of manhood. These conflicts dealt with having children and extending the family name, community involvement, and questioning the meaning of being both male and gay for themselves, and in relation to their families, friends, and social norms:

> Oh, me as a Black person, my dynamic with my parents, I don't think was as bad as some of my other friends. But I could pick up on all these, I call them "White girl aggressions" for masculinity. It's things my uncles would say, I would hear at the barbershop, I would hear them say about other more feminine men, where I'm like okay, there's no way I would ever have these conversations or even talk to my uncles and some of my other cousins about what homosexuality is. Cause they essentially put up 3 or 4 walls before you even, could even address being gay, so, it was always one of those things where, I think, as Black gay men, we sometimes have to put on a façade just to exist in the world and even in certain Black communities. Just to survive. So, that you, can just get through your life without, I guess being, I don't want to say picked on, but like, just targeted for just dumb stuff.
>
> Bill, 28, Black/African American

Sexuality and religion. Various issues related to religion were also mentioned in these conversations. About 71% of participants recalled that they feared coming out or talking about

their own sexuality because of their family's rigid religious belief systems, and as such, many participants (43%) reported that their family members' religious beliefs negated their own sexual orientation. Here, their family members and church directly intervened to influence and impact the conversations. When describing these experiences, participants recalled that their parents referenced popular Bible verses that negated sexuality, and two recalled how the church intervened on their parent's behalf to "cure them" of homosexuality:

> When I told the church, the pastor decided, you know, [decided to] sit down and talk to me. He's like, well, because I was on the praise and worship team, he's like, with your lifestyle, unfortunately, if you don't change, you can no longer be a part of the praise and worship team. We can't have someone such as yourself on, you know, up on top and leading praise and worship events to our church. And, I was like okay, that's perfectly fine, but, how are you going to explain to them, the reason why you're taking me down? You know, so, that kind of threw them back, and they said, well, you know, what conversations are going to happen now. My parents always like have that real, picture perfect family, like everything was okay but things really weren't really okay at home. So, I said, one thing I told them, well, if you take me down, what excuse and reason are you going to give the church? You know, I'm perfectly fine and healthy sitting down in the pew, why am I not up there playing guitar and singing? So, that kind of took them back, and they didn't take me off. The only reason why they didn't take me off was because I said that I would go to therapy. I would go to therapy in, Edinburgh and see a therapist, a counselor, through the church and I did. And, I didn't like it all because they pretty much tried to, they were manipulating everything I was telling them about what I was going through. They would make it seem like well, just because the devil's in your

life, and in your school. Like, where am I going to get the devil at school. You know, I'm not doing anything extra outside of school, that would make me, you know, I would get off the path that you always say that I should be on. So, I did that for a whole month. Then they did shock therapy to tell you the truth, it was terrible. IT WAS TERRIBLE! Uh, I, regretted the moment that I told them I was gay from that point on. And even though growing up, they caught me with boys, about 4 or 5, about 4 times before. So, I mean, it wasn't something that they should have been in shock about because, well, like I said, they have caught me before.

MJ, 30, Hispanic

In this major theme, and throughout their conversations, participants recalled instances of their parents relaying, to them, both community perceptions and gender role expectations, race and ethnic norms, and the invocation of religious ideologies. However, for all of these participants in retrospect, coming out was the most beneficial thing they could have done for themselves emotionally, mentally, and physically, as it meant that they now lived a life that they wanted, rather than what society, and/or their family wanted and expected from them. Despite some of the difficulties expressed above, the conversations were generally re-framed as being positive for many participants and their parents.

Theme 4: Sexual Behavior

Throughout the interviews, it appeared that parent-child communications shaped how participants approached sex with partners. Interestingly however, much communication about sexual behavior and sexual practices were shaped by their peers and pornography, with some parental input, as peer influences for many of these participants was indeed a powerful

supplement to their ongoing parental conversations. The sub-themes here included: peer influences, porn as visual aid, and parental influences.

Peer influences. All participants recalled that developmentally and gender-wise, their conversations about sexuality with their peers were often more candid, because of their ability to relate easier and more openly, to each other (Latkin et al., 2003). In these often continued honest, and blunt conversations, participants discussed their sexual behaviors, attitudes and opinions about condoms, and/or being safe, sharing many personal stories with friends. However, 78% of the participants also relayed how they encouraged their friends, or were encouraged by their friends to also use condoms more often with all sexual partners. Some of these conversations also addressed worries about sexual behaviors, sexual adaptations, and sexual satisfaction. Other conversations were more personalized to help individuals understand the fluidity of sex (male-male, male-female, female-female, male-transgender, female-transgender), and/or relationship boundaries:

> I guess today, it's more along the lines of who are you having sex with, [and] there's been a theme running very recently. We know that one of our friends have a rather large penis, so we're all very concerned about how he is having sex with people. There's another friend who recently came out, after being married to a woman for a long time, so he is basically exploding unto the gay scene. A lot of conversations around that, and how he is managing that, and coping with that, but he's apparently having a lot of very pleasing sex to him, so that's very good. And he hasn't asked us for a lot [of] advice or anything, as his gay friends, we would have expected more. So we were concerned at first, but like I said, he seems to be managing just fine. [Also] I don't know, we do sort of initiate conversations with like, make sure to use condoms, use PrEP, he already knew

to do these things and stuff like that, we just run the gamete of things we talk about … [As for me] I'm in an open relationship with my boyfriend, so, I always tell them like so, you know I just like really don't understand the grindr thing and they would be like you should totally get on it, and I'm just like, yeah it's not my thing, so then they talk about like, how I could go have sex with people, not using grindr, and stuff like that … I talk to them about me personally, I have like a pretty low sex drive in general but when I do have sex outside of the relationship, it's with friends. So, I have, asked my friends if they want to have sex before, that's like not unusual for me, but like, it's shocked a few of them, I'll say, just by me asking them that. I do think that that comes from coming out so early, and, that being so normal, sex in general. I've had a few friends ask me, and then that just became normal. I don't know if I'm getting at what you wanted … for me and my boyfriend, it was sort of the negotiation of us being in a relationship in general. We had already lived together and had been messing around for, about a year before I asked him if he wanted to be boyfriends. He had been having sex with other people and said basically that, unless it's okay that we had sex with other people, he is pretty sure that he would hurt me, in the end, like, cheat on me. So, an open relationship to us, is basically just, a way of saying like that's not going to be the reason we break up. Like, you can have sex with somebody else, I can have sex with somebody else, we'll tell each other about it, sometimes we won't, but, if ever that comes up in conversation, you're of course, like allowed to be like jealous, about it, but that can't be the reason that we break up.

Josh, 28, White

Porn as visual aid. Interesting, 78% of participants reported that they viewed pornography on their own, and often without any parental knowledge or consent, in efforts to learn about their own sexuality. For these men, they watched gay porn to visualize gay sex between men, and to learn, if anything, about these acts of sex, what they looked like, and/or techniques that they could use to make it more pleasurable:

> When you're a teenager, like I've said, I was about damn near the only gay person in town, so, a lot of my information early on, that like my family couldn't answer, or like, you know, little sexual things that I didn't, maybe even fetishes, that I didn't feel like talking to my family about. It doesn't matter how open you are with your family, if you like pissing in somebody's mouth you don't want to tell your grandma about it, over thanksgiving dinner, you know what I mean. Um, so, little things like that, are things [that] I would like Google or look up. There was also, when I was younger, and this doesn't really [have] much to do with being gay, as much as it's a man thing, there was a website called "jackinworld", kind of embarrassing but mostly dedicated to just masturbation, different forms of masturbation, and things you could do. This was also useful for me in terms of gay sex because it taught me things that I could do to other men where as it really is supposed to be teaching you about self-love and masturbation. But it taught me things that I didn't really know that I could use with other boys at the time.
>
> Nick, 25, White

Interestingly, 42% also viewed straight porn, primarily, as a litmus test for better assessing whether they were gay, bisexual, or straight. For these participants, porn was a discreet vehicle for looking at male bodies without getting caught or condemned by peers, and/or friends. Some actually refrained from viewing gay porn, because they did not want to get caught

or labeled as being gay, especially because they were unsure about their own sexual orientation, at the time. Whether it was a pornographic website, a naked picture, a magazine, or a video, straight porn helped some participants to solidify their own sexual orientation:

> I guess at the time I was kind of facing a lot of, you know, Christianity crisis, kind of. I was definitely not supposed to be gay. God really doesn't like that. So, a lot of googling about morality and things like that. And just kind of, is this okay, and what is it like. I mean, I'd seen straight porn before and I was, I guess looking back, I was kind of fixated on the man. I didn't want to watch gay porn because I was hiding, from being gay, and that would really fling the door wide open in my head. And so, I don't know, I guess once I really watched it for the first time, it was kind of like a signal in my own head.
>
> Adam, 24, White

Finally here, a total of 11 men recalled using porn to visualize, and/or confirm their own sexuality, with 36% questioning the absence or existence of condoms, and what that meant for them as a gay male. For these men, the utilization or lack thereof, of condoms made them also question the sexual behaviors of their sexual partners:

> I guess porn kind of shaped, had gave me that like, unrealistic expectations of how sex works. Like my friends were able to kind of give me that realistic expectations. [For instance], you start kissing, you give some head, you eat a little ass and then you start fucking. It doesn't really work like that all the time. I'm like, and then, like there was never, you saw the condom on, you didn't talk, we didn't, they really didn't show how that happened, or if that broke up, if that ruined the mood, a lot of it didn't really show

like any lube being used or anything like that, so it gave that unrealistic expectations, like how bodies looked, like how big dicks were and all that.

Bill, 28, Black/African American

Parental Influences. In 85% of the parent-child communications about sex, and after coming out, participants became more aware and conscious of their sexual partners and behaviors. For these youths, conversations with their mothers actually helped them to better communicate with their partners about sexual wants and desires, and empowered them to make better informed decisions about sex, with whom they decided to have sex with, or the situations in which they chose to engage. These conversations also helped them to know when, or if, they should walk away from situations that appeared threatening to their physical health, especially when sex-partners appeared to be lying about sexual health, sexual behavior, and/or are uncompromising about condom use.

I think I don't necessarily have a certain feeling about [sex]. I mean, I guess in a way, I guess what she told me was like be safe, and be careful, with who you deal with. I guess that kind of liked rubbed off on me in a way, cause I'm very like, I don't have sex with many people. Like I have sex with one person and that's it, for a very long time and that's just how it is. And, I mean, he gets tested every, I believe three months. He's like really conscious about it, so he does it every three months. And, I don't do it with anyone else, like literally, no one else. So, I mean, like I guess, unless I am being reflective; he's shown me the results and everything like that. So, I mean, it's not like, I'm just like listening to what he is saying. So, I guess I kind of, am, take his word for it, and a long with what I am seeing. So, I guess I am being, protected in that sense.

Josiah, 19, Black/African American

While it was assumed [based on the earlier literature review] that peers and parents influenced the participants' sexual behavior, it was an interesting finding about the educative influence of porn on sexual identity development, and/or confirmation. For these participants, it appeared that having exposure to porn provided opportunities to privately explore sexual likes, and/or wants. Additionally, porn helped them formulate questions and inquiries about condom use, especially as it applied to the larger society, and with sexual behaviors. This is not to say that having the conversations with peers and family members were not effective or influential in priming behavior, but having the conversations in conjunction with the video representations can be developmentally, psychologically, educationally, and emotionally helpful. However, as noted in previous studies, one noted concern here would be the safety and negative sexual implications that visual porn may have on sexual behavior, STIs/STDs, and HIV infection (Eaton, Cain, Pope, Garcia, & Cherry, 2012; Mustanski, Lyons, & Garcia, 2009)

Theme 5: HIV Knowledge

As stated in the study introduction, HIV infection rates have historically burdened U.S. gay males. Therefore, it was important to understand how parents addressed their understanding of, and concerns about, HIV with their gay sons. In this sub-section, the identified sub-themes were: parental biases and assumptions, limited HIV content, avoidance, full disclosure, and fear of their son dying.

Parental biases and assumptions. HIV conversational content appeared to happen in conjunction frequently with parental biases and assumptions about HIV within the overall gay community. For 71% of these participants, conversations about HIV clearly became more prevalent and detailed after they came out to their parents. For them, their parent's own fears about HIV, and parent's pre-exposure to friends and family members who suffered and died

because of complications from the virus, created a surprisingly heightened awareness of the direct and indirect effects of HIV on individuals. For some, it was the stigma associated with HIV that fueled their parent's fears about the information that was addressed:

> I guess I got the details of what sex is, why people do it, and then how I should go about it, as far as not being you know promiscuous or anything like that, [but after coming out] I guess it was even more open than it was before, because I think, I don't want to generalize, but I think for her knowing that I was gay made her think about me getting HIV, or something like that. And so it kind of made sexual health discussions come to the forefront, again … one of the first things that she said after I told her, was, she didn't really immediately [go] into the HIV conversation. She was like, well, you know, that's who you are, and that's something that you're going to do, then you really do need to be careful about it.
>
> Adam, 24, White

Limited HIV content. Forty-two percent of the participants recalled that their parents were hesitant to talk about HIV directly with them. It was not until they became older that they actually reflected, and learned about the many and various reasons that crippled their previous parental communications, and/or the recognition of HIV. As surprisingly indicated by these participants, 35% of their mothers had intimate, and/or close experiences with family members, and/or friends living with, and/or dying from HIV. Seeing these extended family members living with HIV, struggling with obtaining adequate medical care, medication acquisition and adherence, and then later dying, engrained in the minds of some parents, that this was a serious potential issue that their son may have to deal with in their future. Therefore, having conversations about HIV, for these parents, cemented the hard reality about HIV, and its

potential effects in society. They recalled how their parents refrained from actually saying "HIV," but instead reminded them to be very careful and be safe:

> I know now, I did not before. Growing up my mom used to do beauty pageants, and my god-dad is, inadvertently now, he is like my god mom, if that makes any sense, like my Aunt Tweedy Bird used to be my Uncle Dwayne. But he wasn't like really like my real uncle, he was just like one of my mom's like really close friends and she really didn't talk about that whole aspect of things because he actually was living with it for a really long time. He actually passed away in 2005, but yeah before then she never really talked about it a whole lot, and then she said that it scared her because in the era that I grew up in, I was born in 92, and so in that era that I grew up in obviously it was a really big deal for people that had HIV and AIDS, and I guess for someone, for it to be so close to home for my mom, it was one of those subjects that she was kind of scared to talk about. One, because it wasn't personally happening to her, but it was happening to people around her and she just didn't know how to, kind of, cope with it, and express it to others.
>
> Malcolm, 24, Hispanic

Avoidance. Interestingly, like in the instances mentioned above, parents would also often provide in-depth conversations about STIs and STDs however, avoided any detailed or in-depth discussions on, or about, HIV. For some, they recalled that their parents actually avoided saying the word 'HIV' but were willing to talk about other chronic illnesses:

> They never, and I remember this because they still do it, they never say HIV. It's always, well you don't want to get sick, or they would be your uncle went through all this; you don't want to get sick … My uncle didn't get extremely sick early in the 90s, well 94/95-ish, but he did get sick one time, and they just thought it was the end of everything but

> then I think my mom lost friends in the church that nobody ever talked about. There was a distant cousin that we went to the funeral and I remember and I think it wasn't me—cause I wasn't going to ask anybody—but somebody else asked like how she died and they gave like this vague ass 'oh she was sick answer' and we're like, what, we had just talked about my aunt's husband passing away from like, he had rheumatoid arthritis, he had prostate cancer, he had stage four lung disease. So, I'm like we gave all these specifics for this guy but like when we talked about her 'oh, she was sick'. So, then I put it together in my head, and I'm like okay, so this just doesn't affect gay men. This is something that is kind of across the board. That's all they said, they never really talked, they never said HIV. But everyone knew what it, everyone knew like what we were talking about when they said that.
>
> Bill, 28, African American

Full disclosure. Conversely, there were few parents (21%) who addressed the topic of HIV in its totality, and reality. In these instances, parents openly addressed the notion that there were various ways, outside of sexual intercourse, that an individual may contract the virus:

> So, I remember my mom pretty much saying at the beginning what, you know, HIV was because she was a social worker back in the 80s when the HIV scare came out. And, when she was working as a social worker, there was a huge scare of HIV and everyone was worried that if you even touched someone with HIV, or drink the same water, you could die. So, she talked about that scare, you know in the professional setting. And working with people who have HIV, and primarily with gay men, and with intravenous drug users. And then also, I'm not sure if she used the word but talking about the stigmatization of gay men, that they would all get HIV, and that this was untrue. But

there is a perception that, if you are gay, then you are going to have HIV, and kind of letting me know that that was a stereotype about gay men that existed and continues to exist. But, that HIV is not a death sentence, there are medications now, and many people go on to live with HIV, there's no need to be scared of people who have HIV, but you know, to take preventative measures such as using condoms, not using, not doing, you know shooting drugs, that, you know, not, you know, wanting me to you know contract HIV obviously, but, kind of letting me know that there are still complications of it, and also, you know, not to, be afraid of people who might have HIV.

Daniel, 28, Hispanic

Fear of their son dying. Finally here, in 57% of conversations, participants recalled that their parents did not want to address the topic of HIV/AIDS, because it reminded them of family, and/or friends who died from complications with HIV. For these parents, as revealed in subsequently more detailed conversations with their sons, talking about HIV with their sons made the subject and topic a reality that they were openly fearful to face with their own child:

It wasn't until later on in life that I think we had acknowledged the fact of Black gay men and HIV, and that's because unknowingly to me, there was a close member to the family that had passed away from AIDS. But I didn't know that when I was a child. I didn't find it out until later. I think that the fact that in my mom's mind all she saw was a Black gay man with HIV, and she saw what the most extreme negative outcome of what that could be, which is death and I think that she did not want that for me, and I think that that was a lot of [stuff to deal with], I think that that played a lot of reasons as to why she thought the way that she thought, with her, not really being open and accepting to my [sexuality].

And she also, later on, confirmed that it did play a role in some of the thought processes.

Kennedy, 28, Black/African American

Findings about the avoidance of difficult topics have been explored in the extant literature with results indicating that parents attempt to protect the child by filtering information in an attempt to minimize adjustment difficulties (Barnes, Kroll, Lee, Jones, & Stein, 2000; Huizinga et al., 2010), and decrease any unnecessary stress (Thastum et al., 2008). Participants recalled that most parent-child communications about HIV were limited in scope and depth primarily because parents feared losing their sons to the virus. As such, conversations were usually generic and common sense reminders to be safe, use protection, and were based primarily on the assumptions that if their sons were gay, they would become HIV infected. Additionally, the finding here provides some parallel insights regarding the emotional reactions to coming out from parents, as noted previously, in Theme 2 above. As previously indicated, approximately 40% of mothers personally knew someone who was living with the virus, and witnessed both the direct and indirect effects of the virus on that person's quality of life, causing parent's to be both scared and worried for their sons. Ultimately, these observations and interactions influenced not only how parents addressed HIV, but also, when and what information they provided to their sons.

Theme 6: Prevention Education

The final theme, prevention education content encapsulated how participants learned about sexual health and protection techniques. This theme was different from HIV knowledge content, because it provided participants with concrete and direct practice tips/behaviors, necessary to help decrease their chances of acquiring STIs, STDs, and/or HIV infection. Here, prevention was examined from the participant's perspective regarding their own unique needs

from their parents' perspectives, through either direct or indirect educational instructions given pragmatically to their sons. It also provided information for both parents and their sons to do in order to make subsequent conversations easier, and less awkward. The sub-themes included: parental support, social media, holistic conversations, and adolescent responsibility.

Parental support. Sixty-four percent of participants recalled getting direct and explicit instructions regarding how to protect themselves from various STIs/STDs and other health issues. Within these concrete instructions, participants recalled that their parents addressed sexual behaviors with partners, encouraged decreasing sexual partners, and again, demonstrated explicitly how to use a condom:

> Yes okay, at the time we really didn't like, I was not really like prepared for that whole thing, but she thought it was necessary because my older brother, the way that that happened actually was my older brothers fault because him and his dumb ass friends they decided to draw in their notebooks, you know, you remember like, oh God, I'm about to show my age real quick. You [remember] when they had the overhead projectors, and when you were in school, they would show, you know, this is the male private part, this is the female private part. And so my brother and his friends thought that it was cute to fill in the blanks. Because when he would take his sticky tab off of like the male private part there wasn't really actually like a private part there, we were in elementary school. But, yeah, so my older brother and his friends thought that it would be cute to be drawing boobs and vaginas and penises, you know in place of where those were. And so my mom was like, oh hell no. So she was like, so now we definitely have to sit down and have the talk. So, I remember just watching SpongeBob and she was like okay, so I am going to show you how to put on a condom, and I was like what, like no, I am not ready for this.

> And she was like, I know, I'm not ready for this either but she was like, I feel like we need to have these conversations, so ever since that moment where she was showing us how to put on a condom, there have been little conversations [about] just, general things, like, she wouldn't go so heavy into it. After she found out that we were having sex, then that's whenever the conversations got a little bit more in-depth. But, before then, it was just you know, putting on the condom, show us how to put it on, which surprisingly, I have done pretty well, considering the fact that like, condoms are like really, I have a love-hate relationship with them now, but I was really good at putting them on whenever I was younger. She showed us how to put on condoms, then she showed us, Lord Jesus, what is that thing—dental dams.
>
> Malcolm, 24, Hispanic

Social media. Although participants used their conversations with their parents to learn about sex, and/or sexuality, many also utilized their friends, and/or the internet as an additional educational learning tool. In fact, several participants reported that they learned about prevention from internet YouTube videos, scouring the internet until they ended up on a website such as *The Trevor Project*, a coming out YouTube video showcasing both positive and negative reactions to coming out, a health education course, or a communication course that helped to orate how they felt and what they wanted from a sexual partner:

> When I was in college it was even weirder because here I am a communications major [communicate common gender] and I'm learning about sex my first day. You know what it means to have an orgasm or what it means to be in tune with your body. I remember the professor saying like, if you can't be in tuned with your body, then you don't need to have sex, cause then someone else is going to be teaching you about how to use your

> body to learn your body and what you enjoy and what you like doing. And I just thought that was so weird because that didn't align with how I was raised. I identified that because I wasn't willing to take the risk of trial and error, and contracting HIV, or um, I think when I first became a teenager HPV was really big at that time and so a lot of teenagers were like catching like Herpes and stuff, I'm like I can't be that girl.
>
> Ricardo, 28, Black/African American

Holistic conversations. The generalized recommendation from all study participants to their parents was about engaging in more open, respectful, continual, and holistic conversations about sex and sexuality with their child. For these participants, having conversations that addressed the full sexuality spectrum: a) opens conversations about what it means to be GLBT, b) provides opportunities for inquiry and follow-up questions, and c) suggests that it is safe to talk to parents about 'different' sexualities until the child is comfortable disclosing his sexual orientation. Also, having these conversations allows for more honesty and trust from both parties regarding what is known, comfortable, and/or unsure. When describing the importance of more desirable holistic conversations, participants stated that these conversations created a 'safe space' to ask questions, created a culture of trust, openness, and honesty between parent and child, and introduced different ways to think about sexuality:

> I think in general, when you have conversations about it, that there is a wide spectrum with sexuality. It's not fixed, it's not defined, and it's fluid, and to kind of let your kid, ask any and all questions. Be aware of awkward conversations, but that all questions are allowed and all questions are valid. And if you do not know the answer, tell them you do not know the answer and you will try to find out, or find someone who can, do not give wrong information. And be very open about it, and also the diversity of it – it could be

women-women, men and men, women and men, different races and ethnicities, you know, that sexuality and how people identify or even demonstrate their sexuality, and how they wear their clothes, or show off their bodies can be different. As long as no one is hurting anyone and it's consensual then it's okay. And about not judging one as better than the other.

Daniel, 28, Hispanic

Adolescent responsibility. In this final sub-theme in Figure 5, participants overall indicated that prevention was a bi-directional, but an on-going process. Accordingly, gay men should be more tolerant of their parents, as parents are not fully equipped to talk about sex and sexuality outside of the heterosexual spectrum. The adage, "*kids do not come with an instructional manual*" was ironically stated by several participants, in retrospect. The sample concurred that it is important for gay men to give their parents' time to process such important information. When asked to describe their experiences, they generally stated that gay men needed to remember that parents are also challenging their own heterosexual and heteronormative upbringing, their social norms and expectations, and they needed time to process this new information as well as have uncomfortable conversations about sexuality:

…people always tell me that I am my mother's hope because I believe that, now that I work in HIV and AIDS, it's allowed me to educate my mother. I mean, my mother is 67 and she was born in 1949, and her first-time voting was yesterday. … But I think it takes a special person to be able to not make what they think about them and be able to challenge them. I'm not uncomfortable having uncomfortable conversations with my mother. I'm comfortable with having uncomfortable conversations with her.

Ricardo, 28, Black/African American

Finally here, prevention content should include more than just conversations about condoms and other safe sex practices. For these study participants, having honest, transparent, and holistic conversations with their parents, appeared to effectively affect sexual behaviors, sexual identity, and communication with both friends and sexual partners. Although it should be noted that participants spoke frequently with their peers because of the relative age similarities, as well as used social media to gather a wide array of information about prevention techniques, having open and honest dialogue with parents empowered these participants to explore and fact-check alternative information and external information. Likewise, having the conversations with parents helped to create a more holistic self-identity as participants felt comfortable talking about some of the information that they heard from peers and friends, or found on the internet with their parents.

This exploratory qualitative study found many unique and varied insights regarding why, what, and how, parents communicated with their gay sons about sex and sexuality. The identified six major themes and their many sub-themes focused on the importance of conversations and their contents, as well as selected barriers that may indirectly or directly affect these conversations. Overall, these retrospective data showed that despite some negativity, emotionality, anxieties, threats, and fears of being potentially alienated from their families, the conversations proved for the most part, to be both positive and informative for parents as well as their children. In turn, this generally resulted in better mental-health awareness, improved self-esteem, increased safer sex practices and behaviors, and a new found conversational safe space between these children and their parents, which benefitted both groups.

Discussion of the Research Questions

This study was guided by three exploratory questions that helped anchor the underpinning of the ensuing method, findings, and data analyses. In order to successfully determine whether these questions were answered, selected data was taken from two or more of the six previously presented themes and their subthemes, as no one question had a clear-cut or direct answer regarding what parents required to have effective communications. Figure 6 provides an illustration of the corralled findings of the thematic content beneath each question.

The first question asked, *how do parent-child communications affect gay men's sexual behavior?* Of the stated sexual behaviors listed in question one [see Figure 6], condom use appeared approximately five times more frequently, than any other behavioral method noted in these conversations. In the overall conversations, only five fathers, and nine mothers exhaustively emphasized condom use. In fact, as indicated in the previous sub-section, condom use was both referenced and educationally demonstrated, by several participant mothers.

The second issue, having decreased partners, was described as a safety concern by both mothers and fathers who periodically and informally reminded their sons to have fewer, if not only one, sexual partner. Also, mothers primarily addressed issues about sex partner frequency before coming out, even though they may have suspected that their son may be gay. After their son came out, mothers continued to recommend that they be careful with who, and how many people, they chose to have sex with. Finally here, for Black/Among African American and Hispanic participants, race was not tabled in the discussion of decreased partners. For instance, Black/African American participants recalled parents describing rather negative perceptions of being a Black/African American gay male in society. Likewise, Hispanics addressed issues

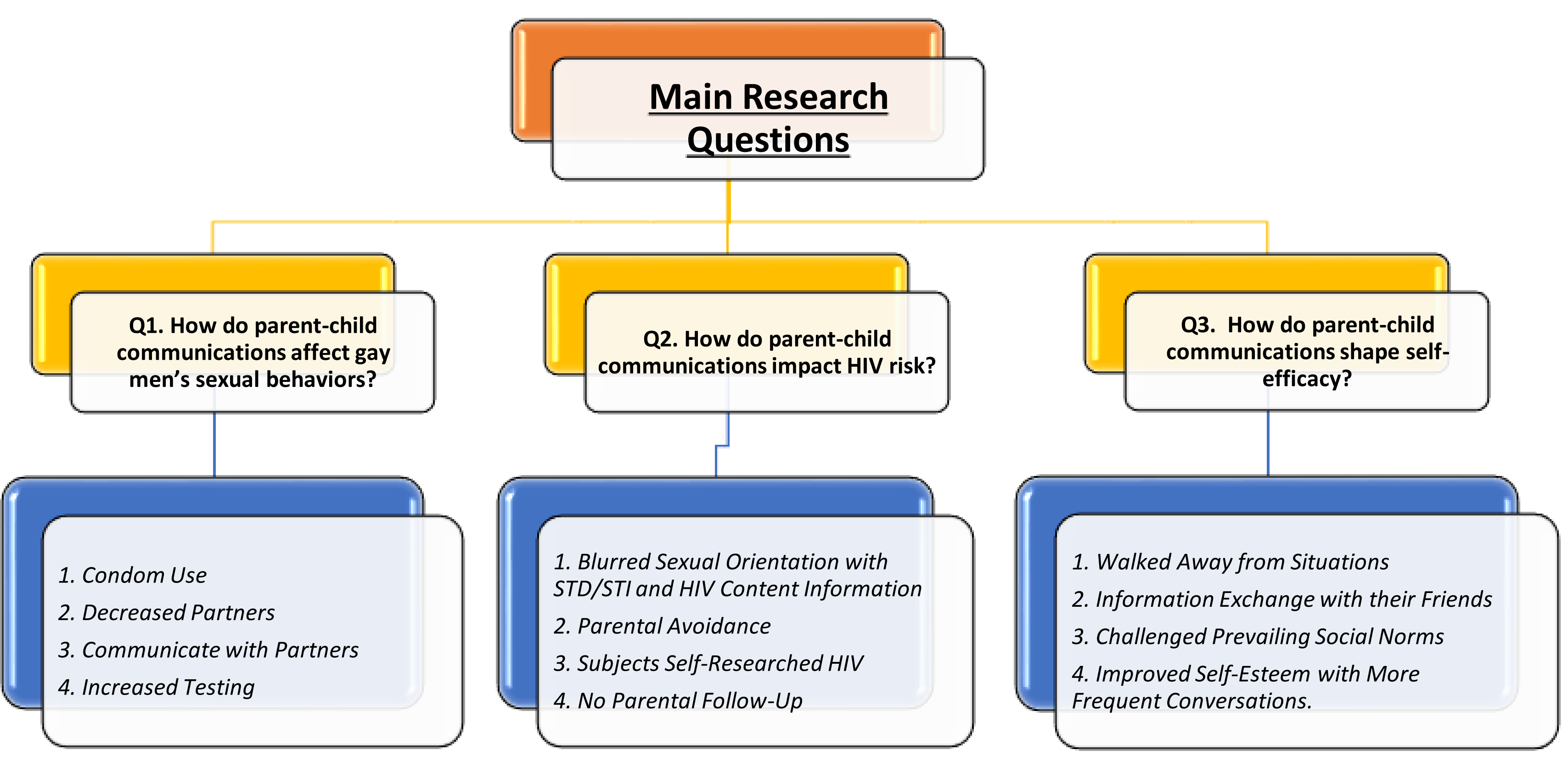

Figure 6. Research questions of the study about parent-child communications (n = 14).

related to the Hispanic cultural stigma of sexuality. Interestingly however, it was three of the five White mothers who recommended that their son's only date other White partners.

Similarly, the third issue addressed was communication with partners. This again was exclusively facilitated by mothers, not fathers. Here, mothers offered many educational, and relationship tips to their sons such as: a) don't sleep with the wrong person, b) use condoms, c) get tested, and d) question your partners about their STIs/STDs, HIV status, and sexual behaviors. This line of inquiry, as mentioned by the sons, occurred after they came out, and then their parents began to perceive them as adults rather than sons, thus changing the relationship from mother-and-son, to best friends, confidantes, and/or someone who they could talk to at any time about sex or sexuality concerns.

The fourth issue discussed when addressing sexual behavior was increased testing. Here again, this issue was primarily discussed in mother-son conversations, and less in father-son conversations. When increased testing was discussed, it tended to be mentioned from a *'why'* perspective, rather than, a *'how'*, or *'where'* perspective. In these instances, mothers tended to mention it in passing, along with a list of other recommended safe sex practices, and they really did not provide additional information about testing (i.e., where to go, how often to get tested, who to talk to, etc.). Taken together, participants stated that these conversations continually reinforced and primed healthy sexual behavior practices that they were comfortable doing. As such, it is safe to suggest that parent-child communications affected sexual behaviors of the majority of these sons, as they developed the acumen to effectively replicate these behaviors with their sexual partners, and their mothers were the parental unit that ensured that this issue was addressed.

The second question, *how do parent-child communications impact HIV risk?* appeared to be the most difficult content in these conversations. As previously indicated in the themes and sub-themes, the issue of HIV tended to be consciously avoided in most of these conversations, particularly before the coming out event. Rationales for this were based on external triggers, sexual orientation assumptions, pre-exposure to both inaccurate and biased HIV information, and parent's recalling close family and friends struggling with, and losing their battle with HIV. These aforementioned situations helped to blur sexual orientation content with STI/STD and HIV, especially as it related to being gay. Consequently, this caused another issue addressed as many of these parents completely avoided discussing issues related to HIV. Several participants recalled however, that as they got older, their parents revealed that they were fearful about the topic because they assumed the worse.

Along these same lines, the third issue under this second question was that participants self-researched HIV content. The adverse consequences of parents avoiding conversations about HIV was that these participants were left to rely on peers, social media and other sources to get correct, and hopefully helpful information about how to most effectively protect themselves from STIs/STDs, and/or HIV infections. As such, when parents who blurred sexuality with HIV, reacted negatively to their son's sexual orientation, or invoked religion to justify their own biases, participants were more likely to participate in sneaky and riskier sexual practices.

Finally here, some parents did not provide any follow-up conversations about health and wellness with their sons. In fact, these types of conversations were limited in frequency, and any attempt to address issues related to sexuality, and/or HIV were neglected. Several participants recalled that when talking about HIV, parents often used the generic phrases 'be safe", or "don't get sick". These issues, taken together, suggested that parents did not adequately nor effectively

addressed issues related to HIV, which ultimately left these participants searching for information on their own, and at an increased risk of HIV infection as they were unaware of how to properly protect themselves.

The third and final question was *how do parent-child communications shape self-efficacy?* Interestingly, although communications about HIV were the most difficult for parents to have, when parents were supportive of their child's sexual orientation, the participants recalled feeling more empowered to make safer sex decisions, some of which included: a) using safer sex techniques and practices such as condoms, b) having more open communications with their sexual partners, c) developing an intimate and clearer understanding of their own sexual wants and needs and, d) being able to walk away from situations that they deemed as unhealthy or unsafe, regardless of how their sexual partners felt.

The second issue, information exchange with their friends, was perceived as a way to address age-related and age-appropriate issues as they pertained to sexual identity development, curiosities and building relationships, and/or friendships. Although many participants recalled having a renewed purpose and sense of identity, the conversations they had with their friends helped them to think differently about sex, sexuality, and sexual behaviors. For instance, several participants recalled that their peers challenged them to utilize condoms, to explore safer sex practices, and to identify and examine their own sexual wants. These conversations were 'real, raw, and non-judgmental' and were helpful in the continuous re-crafting, re-branding, and re-building of their personalized self-esteem.

Additionally, such communications helped participants challenge prevailing and existing social norms. Accordingly, it appeared that with continuous friendships, they felt less inclined to stress about racial, gender, and religious norms, but instead chose to showcase that their

sexuality was just *a part* of their identity, not its *defining* feature. For instance, when participants revealed their sexuality to their parents, their worries, concerns, or apprehensions about being socially accepted by others, were often put to rest. Instead, participants decided to re-engage in social and community activities that bonded them to their respective communities.

Finally, participants recalled that they had improved self-esteem when conversations about sexuality occurred more frequently. Their improved self-esteem occurred when their parent-child conversations helped to normalize and de-stigmatize sexuality. For example, when parents addressed sexuality, and engaged in conversations about tough topics such as sex, sexual partners, sexual behaviors, participants felt like an equal, a friend, and a confidant who could share intimate details of their lives with their parents. Essentially, these conversations helped participants to be more open with themselves and their parents. Ultimately, and based on these abovementioned issues, parent-child communications effectively addressed and helped to boost self-esteem.

CHAPTER 5

LIMITATIONS, CONCLUSION, AND IMPLICATIONS AND RECOMMENDATIONS

Limitations

There are several limitations that must be addressed and tabled. This study, like many qualitative studies (Graneheum & Lundman, 2004; Jeffries, Dodge et al., 2008; Jeffries Okeke et al., 2014; Ogedegbe, Mancuso, & Allegrante, 2004) did not endeavor toward generalizability (Holosko, 2006), as it qualitatively explored and examined retrospectively, the unique lived experiences of self-identified out gay males, ages 18-30, who had at least one 20-minute conversation with their parent(s) about sex, sexuality, and/or HIV, during their adolescent years. Therefore, issues related to participant recall, biases, and researcher bias all collectively impacted the type and quality of information recorded, analyzed, and presented in this study. Although there were some quantitative data available, no statistical analyses were conducted using these data. As such, having a complementary quantitative methodology accompanying this qualitative study may help to further strengthen, and/or broaden its scope and reach.

This study used purposive and convenience sampling techniques to explore the experiences of self-identified out gay males between 18 and 30 years of age. The experiences of those younger than 18 or older than 30 were not examined, and they may have different perspectives and opinions about the effectiveness of their parent-child communications, in retrospect. Assumptively, the information garnered from these specific sub-groups would yield different information on the effectiveness of parent-child communications, if recruitment and sampling techniques were done differently. Similarly, the experiences of those who were not

out, those who were lesbian, transgender, bisexual, or those who did not have these conversations were neither examined nor addressed. It is important however, to consider future and additional research that examines the disclosure and communication processes associated within these various sub-groups (Mattis, 2002).

For this study, there were three forms of unintended biases: measurement bias, participant-response bias, and researcher bias. As indicated by Richie et al. (1997), measurement bias is based on how qualitative questions are presented to elicit specific types of response information, which may be a result of question wording, sequencing, and/or structuring. Consequently, participants may self-select how they subjectively chose to answer questions; sometimes choosing to ignore negative information, while primarily highlighting and focusing on only the positive portrayals of their family, and/or self (Davis, Thanke, Vilhena, 2010; Randall & Fernandes, 1991). Finally here, there were several researcher biases regarding research questions, data collection and analyses, and interpretation (Chenail, 2011). Ideologically, the best way to potentially combat these biases was to corroborate information with a senior faculty member, as well as conduct a pre-test on the questionnaire (i.e., using $N = 3$ research participants who met inclusion criteria). Likewise, a post-test (e.g. focus-group) using $N = 3$ members from the one-on-one interviews was also used to help clarify terms. This steps were used to cross-reference theme clarity, research question formulation, and to further critically examine and explore the response data. This is noteworthy, as the numerous friendly interactions with the participants, intimate interactions with the data and themes, and with experts in the field of qualitative study may inadvertently and indirectly have affected how these data were analyzed, how information was interpreted, and what was omitted in the final result

presentation. Therefore, the final results may not be applicable to all, and are vulnerable to modification, as soon as new information becomes available (Fereday & Muir-Cochrane, 2006).

Finally, these participants were asked to retrospectively recall their intimate and often rather emotional, and/or awkward parent-child communications, and other personal conversations. As years passed, it could be assumed that many conversational events became re-framed either through comparative conversations with friends, siblings, and/or parents, which in turn, affected the accuracy of information recall (Elder et al., 2007). Quite surely perhaps, other information was forgotten, dismissed, and/or omitted. Since there are no known methods to truly validate the accuracy of participant statements, the information provided could be perceived as questionable. However, given the limited research in this area, and the extensive details shared in these rather intense interviews, future studies are needed to examine communication and non-communication practices between parents and their GLBT children. Finally, this pioneering qualitative study collected much rich text data with a sub-group, which has never been empirically studied in this topic area.

Conclusions

The following concluding remarks reflect the main conclusions highlighted throughout the previously reviewed literature, some method limitations, and study findings.

Highlights from the Literature

1. It was noted that communication overall, is a fairly complex phenomenon, regardless of race, gender, class, power and authority, socio-economic status, style, parent-child relationships, religious beliefs, and/or educational levels. As such, communication itself becomes further complicated when sensitive topics, and/or issues, such as sexual orientation or sexual behaviors, are at the forefront of these discussions.

2. Given their historic and continued marginalization, and the prevailing negative societal perceptions and characterizations of GLBT sub-groups in the U.S. today, coming out is often deemed as both a difficult and anxiety provoking situation, for many. Some noted factors affecting this process include, but are not limited to: fear of being ostracized, fear of family neglect and abuse, fear of being bullied, religious disdain, family values, social stigmatizations, perceived violation of social and gender norms and expectations, family abandonment, potential substance abuse, conceivable social isolation, and consequential negative mental and emotional repercussions.
3. Historically gay males, and more recently, Black/African Americans and Hispanics have shouldered the greatest burden of U.S. HIV infection rates, with Black/African American gay males being the minority sub-group with the highest rates of overall infection. The interrelated and cyclical variables of race and sexual identity expectations have played a significant role in the multiple familial, social, and cultural networks. Additionally, these core variables affected: a) how and when they sought HIV/AIDS care, b) how they approached issues related to sex and sexuality and, c) the varying degrees of personal comfort GLBT individuals develop when navigating their social identities, or their various racial, and/or sexual communities.
4. The extant body of literature reviewed for this study, empirically supported the idea that all forms of discussions about sex were important for both children and parents, especially for parents with children who identify as a part of the GLBT community. In short, data in this study confirmed the presence of various poignant difficulties, challenges, and information shared between gay men and their parents, in these often unchartered territories. The norm in all such conversations seemed influenced by

both the styles of the conversation, and the breaking down of parent-child barriers to achieve more positive oriented conversation outcomes.

Highlights from the Method

1. As noted within the study method, accessing this sample had various limitations. Therefore, other researchers could benefit from external networking, trainings, and collaborations with various community stakeholders, providers, and community organizations to assist in participant recruitment of similar groups, as was done for this study. Perhaps the challenges involved with accessing this sample could have been off-set by incentivizing the study, or casting a wider net for larger social networks outside of the immediate community to enhance this sample size.
2. Additional studies with this sub-group may also include a more diverse sample of gay men (e.g., race, socio-economic status, age, location, etc.) to examine parent-child communications, or lack thereof, given the noticeable anxieties and challenges of both parents and children, found in this study. Similarly, solely examining the retrospective experiences of parents of gay men to identify their own recalled anxieties about learning of their son's sexual orientation, and ensuing conversations which provide additional insights regarding how to improve the facilitation of these conversations.
3. An additional range of qualitative methods including strategies such as participatory action research (PAR), photo voice, case studies, phenomenology, narrative inquiry, and using more advanced forms of social technology to both access and analyze study data, could help to further complement qualitative studies.

Highlights from the Findings

1. Regarding this sample, it was homogenous by gender and sexual orientation however, heterogeneous by race and age, which was part of the purposive and convenience sample selection process. Nonetheless, surprisingly these data did not show much racial difference across many of the study findings, as it related to communications. It also appeared that being gay strongly underscored and contextualized most of the study findings presented throughout the major and minor themes.
2. Actual communication styles emerged as an unanticipated critical component impacting these ongoing parent-child communications. Parents involved in such communications as well as their child, would do well to understand the nuanced rules of basic sender-receiver communication engagement, prior to starting these discussions. When it occurred, this basic understanding helped initial conversations become more constructive, insightful, ongoing, honest, knowledgeable, and respectful. Ultimately, the stylistic findings herein, were almost as important as the analyzed content of these sessions, as communication styles greatly shaped the shared experiences expressed by this sample.
3. The various themes and sub-themes of the data presented herein, were subject to the interpretive lens of the researcher. Other researchers may have analyzed these data in different ways, and used different methods. The researcher consciously tried to present these themes as being equally important, however in the analyses across these themes, it appeared that some of this content was more important, e.g., coming out, the stated limited HIV conversations, conversational knowledge, trust, respect, behavior, and parental support.

Implications and Recommendations

Results from the reviewed literature, method, and findings revealed several unique challenges and opportunities related to having more effective parent-child communications between self-identified gay males and their parents. This sub-section is organized with recommendations for parents first, followed by recommendations for gay males. These recommendations were also rooted in the *National Association of Social Workers Code of Ethics,* particularly as they pertained to the values associated with: a) dignity and worth of the person, b) importance of human relationships, and c) integrity (*NASW*, 2017).

These data revealed that for parent-child dyads, communications about sex and sexuality emoted both ongoing uncomfortable and awkward feelings. Despite these feelings, they surprisingly resulted in some positive and rewarding outcomes. Therefore, the following recommendations may benefit present, and/or future communications. It should be noted however, that these are not presented as a *"one-size-fits-all"* remedy, as some recommendations may hold more importance than others and, they are often idiosyncratic to the time sensitive unique needs of each parent-child dyad. While this study could target many formal and informal stakeholder sub-groups, the two-immediate sub-groups that will be discussed in further detail below, are parents and children. Regarding the data about *conversational styles*, it is recommended that parents:

a. seek external supports about how to carry out such conversations,
b. research information about the knowledge offered in such conversations,
c. conduct more frequent, recurring, and timely conversations with their child(ren),
d. try to always use age appropriate language,

e. acknowledge and be honest with themselves and their child regarding their own parental anxieties, uncertainties, and limitations about the conversations on sex, sexuality, and/or HIV,

f. remember to normalize and reinforce sexuality and sexual orientation with their child(ren),

g. include updated information about STIs/STDs, HIV, sexual behavior, sexual identity, and prevention education,

h. openly express the various reasons for the conversations,

i. assess the child's readiness to have such conversations, up front,

j. assess the timeliness of the content presented,

k. ensure that the potential for the child to come out is tabled in the most open and supportive ways possible, and

l. try to be as consistently affirming, non-judgmental, and positive throughout this conversational process, which will undoubtedly have numerous uncertain, and emotional twists and turns.

Next, when examining the ***content***, parents should:

a. initially, and minimally, address the reality that having these conversations about this subject-matter with their child(ren) will be difficult,

b. seek supports outside of the conversation, research multiple and different kinds of age-appropriate resource materials, and acquire timely knowledge and personal confidence in being able to appropriately convey this information,

c. openly recognize and acknowledge the general sexuality continuum, e.g., gay, lesbian, bisexual, transgender, and/or straight,

d. be mindful that coming out is a major potential conversational flashpoint embedded in these dialogues,
e. understand that the child's actual coming out moment may happen before, during, and/or after these conversations,
f. be conscious of blending together content related to e.g., sexual behavior and sexual orientation, HIV/STIs/STDs, relationships with friends and family members; and almost all subject content is underpinned by feelings of ongoing uncertainty, anxiety, and ambivalence, and
g. not be afraid to openly and honestly, say what they don't know.

Overall, the above-noted recommendations highlight some unique techniques that may help parents to more effectively facilitate conversations with their gay children. Additionally, study data also revealed that although some fathers were fairly supportive throughout the process, it was the mothers who were the most supportive and took the lead with facilitating the conversations. Findings that were congruent with the external literature regarding the parent-child relationship between mother and sons (Baiocco et al., 2015; Bregman, 2013; Dittus, Miller, Kotchick, & Forehand, 2004, Hutchinson et al., 2003; Švab & Kuhar, 2014). Again, it should be noted that there is no singularly presented prescribed content package that parents need to memorize when discussion sensitive topics, as children may bring their own personal issues and concerns to these conversations that will greatly shape the information shared.

Like parents, GLBT *conversational styles* should minimally include:

a. being honest and forthright with their parents about their personal understandings of their own sexuality,
b. being patient with their parents and the entire coming out process,

c. opting for more frequent and shorter conversations, rather than longer drawn-out ones,
d. seeking external supports to help them process the ongoing information,
e. promoting external supports groups and organizations, outside of the family, if needed,
f. realizing that mom and dad individually communicate differently, both when they are separate and when they are together,
g. embracing compromising viewpoints, to better understand parent-child shared conversations,
h. being open to discussing the process of self-disclosure,
i. realizing that their parents are frequently anxious, uncertain, and not knowledgeable about homosexuality, in general,
j. honestly answering all parental questions about sexuality and sexual behaviors, and
k. recognizing that it is okay to be gay, but do not assume that your parents have to be okay with it.

Content-wise, it is also important for GLBT individuals to:

a. address their own sexual orientation upfront,
b. learn to be more comfortable with their own sexual orientation,
c. table and address emotional issues and concerns, as they inevitably arise during these conversations,
d. be more open to understanding parental viewpoints, even if the content is already known to you,

e. re-assure their parents that they did not do, or say, anything that affected your sexual orientation,

f. understand that the processes and the struggles of being gay in today's society will underpin various aspects of much of these conversational content, and

g. not be afraid to address their own sexual health in detail, to their parents.

Again here, it is important to recognize that these parent-child communications are bi-directional in nature, and they require continued openness and honesty, to be effective. Parents are often the first initiation and introduction to various societal and gender norm expectations. GLBT individuals should identify, and then patiently inform their parents about their own unique needs. In summary, this sub-section presented unique and specific recommendations that have implications for helping to improve effective parent and child communication styles and content.

Moving to additional recommendations, while researchers continue to work to find a cure, improve current prevention efforts, identify promising practices that will have a lasting impact on the lives of those affected or impacted by HIV/AIDS, and/or identify best practice techniques to improve parent-child communications [as recommended above], especially between parents and GLBT individuals, it is important not to forget other important key stakeholders who may benefit from the findings presented in this study. These include: 1) front-line practitioners (i.e., school social workers, child welfare social workers) who work directly with gay youth, 2) researchers, and 3) policy-makers (i.e., healthcare services).

Outside of parents, the second most influential group who work directly with, and potentially influence the lives of GLBT individuals, are frontline workers (i.e., school social workers, and child welfare social workers). It has been deemed that additional empirical evidence is drastically needed here, as GLBT youth are coming out at various stages of

adolescent development, and/or are more frequently experimenting with their own sexual orientation at earlier ages (Griffith & Hebl, 2002; Savin-Williams, 1990, 1995, 1998). The prevailing literature indicates that age-related peer groups have a significant impact regarding how information about sexuality gets shared, how sexuality and sexual identity is developed, and the various forms of sexual behaviors that adolescents may choose to participate in (Aspy et al., 2007; Harper, 2006). By highlighting the concepts surrounding social desirability (Van de Mortel, 2008), or 'group-think' (Mayo-Wilson, 2013), school-based social workers can use the findings from this study, and others, to identify and implement age-appropriate and age-related interventions that help young GLBT adolescents address and process their feelings, attitudes, and/or perceptions on sex, sexuality, and potential risk of HIV infection [See Appendix J, p. 237, for a complied list of federally approved prevention tools]. Similarly, the way that these young GLBT individuals are informationally socialized, coupled with the hours spent in school and with their peers, make school social workers a prime stakeholder positioned to provide insight and input regarding how better education, awareness, and interventions, specifically those about sex and sexuality, are implemented in school settings. Findings from this study could be used to inform school social workers about the specific desires, and wants of this target population, and how to provide more, and/or improve current, services to this ever-growing population.

Like school social workers, child welfare social workers working with GLBT individuals would also be ideal stakeholders. Child welfare social workers are charged with the central task of providing culturally competent care to children regardless of social demographics, gender, sexual orientation, class, etc. Many times, these social workers are not afforded appropriate, and/or adequate training, specifically surrounding the more nuanced issues related to GLBT identity, and/or living with HIV, which often result in inappropriate, inadequate, and ineffective

treatment and care (Estrada & Marksamer, 2006a, 2006b; Mallon & Woronoff, 2006). For instance, some researchers (Anhalt et al., 2003; Dibble, Eliason, DeJoseph, & Chinn, 2008; Eliason & Hughes, 2004) found that because these service providers received inadequate training and exposure to GLBT individuals, there is a heightened level of insensitive, discriminatory practices, and/or unethical and differential treatment based on their trained heterosexist orientation to treatment. The results from this study may serve to challenge these widely entrenched 'off-the-shelf' educational trainings, by providing these frontline workers with insights about the lived experiences of GLBT individuals, their relationships with their parent(s) and discussing issues related to sex, sexuality, and/or HIV, and the content and context regarding how to facilitate more effective in-home conversations. Similarly, results may further encourage child welfare social workers to have more honest and open dialogue with GLBT individuals, as it pertains to identity crystallization, sexual behaviors, HIV risks, and community navigation.

Similarly, researchers are also considered to be important stakeholders. Thinking of my own HIV research orientation as a service provider and a graduate student, I remember being taught about state and national programs and interventions that catered primarily to HIV-positive individuals, while ignoring the social, emotional, and physical needs of HIV-negative individuals. I received much in-depth training and 'one-size-fits-all' information on promising practices and interventions with this population. The results from this study could be used to provide additional insights on diverse methods, approaches, and/or theories about knowledge about HIV and effective communications. In this area, clinical, qualitative, and quantitative researchers could also have more impact about how additional research gets funded and implemented, and identifying the needs of such vulnerable populations, like those living with HIV, GLBT youth, and/or communications. The results of this study could be used to also

anchor approaches that combine more aspects of sexual behaviors with mental health and substance abuse components. Conducting such research could help to potentially create more holistic interventions addressing short and long term mental health issues related to coming out, parent-child communications, and/or issues associated with HIV.

Finally, policy-makers working with children and families, GLBT individuals, HIV prevention and care, as well as those working with senators, congressmen, and other politicians are also considered possible stakeholders. Currently, the National HIV/AIDS Strategy (NHAS) and Healthy People 20/20 have proposed an AIDS-Free generation through the process of "getting to zero" (*White House Office of National AIDS Policy*, 2010). To help facilitate this initiative, results from this study may be used to help develop practices, or suggest improvements regarding how parent-child conversations impact an individual's understanding of sex, sexuality, and potential risks for HIV/AIDS transmission. For example, the results could be used to identify the types of informational resources parents could obtain to maintain their knowledge base on HIV/AIDS and sexual orientation. Since previous findings have shown positive relationships among parent-child conversations and sexual debut, increased condom use, and decreased peer pressure (Hadley et al., 2009; Inazu & Fox, 1980; Jessor & Jessor, 1975; Newcomer & Udry, 1984; Small & Luster, 1994; Udell & Donenberg, 2011), the findings from this study could help influence policies that add additional knowledge and resources to support parents obtaining and maintaining updated and timely information about sex, sexuality, and HIV/AIDS. Likewise, findings could be used to create a safe space where parent-child conversations around such difficult to have conversations, specifically sex, take place.

Policy changes may also affect primary care physicians working directly with, as well as those participating in, or conducting, research with GLBT individuals. Research exploring the

interactions between doctors and GLBT patients have shown some degrees of inadequacy, based on perceived and biased notions of how to treat such patients, how to have conversations around sexual behavior with such patients, and how to approach uncomfortable conversations surrounding teenage sexual health, in general (Lombardi & van Servellen, 2000; Schilder, Kennedy, Goldstone, Ogden, et al., 2001; Woods, 1979). Because of the confirmed perceived negative stigma that U.S. GLBT individuals continually encounter in many healthcare settings, this research may provide doctors with timely information that may help facilitate conversations with these sub-groups that are more culturally sensitive and appropriate (Dean, Meyer, Robinson, Sell, Sember et al., 2000). The effect of including such a policy change could potentially sharpen their protocols and hands-on practice skills. Essentially, policy for medical service providers could shift the needle from the traditional medical model approach (i.e., treating the problem after it occurs), to a more person-centered one (i.e., address other major issues affecting quality of life), which are more in line with what the profession of social work strives to achieve (Holosko, 2017). As noted in both the literature review and the findings, participants recalled having direct interactions with various professionals both before and after coming out, however, the treatment protocols provided by these professionals, seemingly never change.

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APPENDICES

APPENDIX A

Approved IRB Consent Form

Approved by University of Georgia
Institutional Review Board
Protocol # STUDY00003371
Approved on: 10/20/2016
For use through: 10/19/2017

IRB Administration Approved, Standard Consent Form for Exempt Research

CONSENT TO ACT AS A HUMAN RESEARCH PARTICIPANT

The University of Georgia

Parent-Child Communications about Sex, Sexuality and HIV Risk Among a Sample of Out Gay Men: A Qualitative Study
Research Project Title

Junior Lloyd Allen, Graduate Dissertation, 770.376.5669
Primary Contact's Name, Course, Telephone Number

You have been asked to participate in a research study that is being conducted by a Social Work Graduate student at The University of Georgia, 279 Williams Street, Athens, Ga, 30605. If you agree to participate, we will schedule a time for a 60-90-minute audio recorded interview at 279 Williams Street, Athens, GA, 30605.

The purpose of this qualitative study will be to explore the role and impact of parent-child communications about sex and HIV risk in the lives of out, gay men.

The purpose of the study, terms of your participation, as well as any expected risks and benefits, must be fully explained to you before you give your consent to participate.

You should also know that participation in this research is entirely voluntary. You may refuse to participate or may withdraw from participation at any time without jeopardy to future medical care, mental health, education or other entitlement.

If, during the course of this study, significant new information which has been developed during the study becomes available, which may relate to your willingness to continue to participate, this information will be provided to you by the investigator.

Any information derived from this research project which personally identifies you will *not* be voluntarily released or disclosed to anyone outside of the research team, except as specifically required by law. Confidentiality will be maintained to the degree permitted by the technology used for any information transferred via email. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties. All identifiers and audio recordings will be removed and/or destroyed as soon as data collection and transcription are completed in efforts to decrease any breach of participant confidentiality.

If you would like to volunteer in the member checking process, and/or if you would like a final copy of the contextualized research findings, you may give your contact information to the Primary Contact. This is not required for participating in this study. However, if you choose to volunteer you will be sent a copy of your transcribed interview to edit and clarify any answers as well as make additional comments on your answers to the interview questions and may also choose to receive a final copy of the research findings that situates and contextualizes your response in conjunction with others; at which point, all additional contact information will be destroyed.

If at any time you have questions regarding this research or your participation in it, you should contact the Primary Contact, his supervisor, or UGA Institutional Review Board (IRB) who must answer your questions. If, at any time, you have comments regarding the conduct of this research or if you wish to discuss your rights as a research participant, you may contact the University of Georgia's IRB at 212 Tucker Hall, 310 East Campus Road, The University of Georgia, Athens, GA, 30602, T: 706-542-3199, E: irb@uga.edu.

You will be given a copy of this consent form to keep.

APPENDIX B

External Mental Health References

Family Counseling Service of Athens, Inc; [www.fcsathens.com]
Address: 1435 Oglethorpe Ave, Athens, GA, 30606
Number: 706.549.7755
Services Provided: Individual counseling, group counseling, couples counseling, children and divorce, anger management, intimate partner violence, help for veterans, and child guidance and parenting
Payments Accepted: Credit/Debit Card, Medical Insurance, Payments accepted on a sliding scale

Banyan Tree Counseling Services; [www.banyantreecenter.com]
Address: 1 Huntington Rd, Suite 103, Athens, GA, 30606
Number: 706.850.7041
Services Provided: General counseling, sexual identity and development, sexual trauma, couples and family, alcohol and substance abuse, depression, PTSD,
Payments Accepted: Self-pay, cash, credit/debit card, insurance

Aspire Clinic – The University of Georgia: College of Family and Consumer Sciences
Address: 210 Mc Phaul, Athens, GA, 30602
Number: 706.542.4486
Services Provided: Parent-child conflict communications, child and adolescent issues, substance use, family transitions, family disagreements and conflicts, grief and loss, sexual issues, self-esteem and self-improvement
Payments Accepted: Sliding Scale ($15-$65) depending on annual income

Counseling and Psychiatric Services
Address: 55 Carlton Street, Athens, GA, 30602
Number: 706.542.2273
Services Provided: Short term individual counseling, crisis intervention, group counseling, medication evaluation, and referrals may be provided to other external partners
Payments Accepted: Student insurance, financial assistance available for individuals who demonstrate financial need.

APPENDIX C1

Posted Recruitment Flyer 1

APPENDIX C2

Emailed Recruitment Flyer 1

APPENDIX D1

Posted Recruitment Flyer 2

APPENDIX D2

Emailed Recruitment Flyer 2

APPENDIX E

Telephone Screening Questionnaire

PHONE SCRIPT FOR RECRUITMENT

Principle Investigator (JLA):
Hello [participant name]. This is J. Lloyd Allen, doctoral candidate in the school of social work at The University of Georgia. I am also the Principal Investigator for the research project entitled *Parent-Child Communication on Sex, Sexuality, and HIV with a Sample of Gay Males: A Qualitative Study*.

This study is an excellent opportunity for gay men to contribute to the prevention knowledge building processes by presenting insights regarding how their own lived experiences of parent-child communications influenced their sexual decision making ideologies, their personal identity development, and their interaction with others. It is my hope that other gay men, parents, service providers, community stakeholders, and others will appreciate and benefit from your input and experience. Do you think you might be interested in participating in this study?

If [participant] says yes, PI [JLA]:
Great! Do you have any questions or concerns regarding anything related to the study?

> *If the participant has questions or concerns*, PI will appropriately respond to questions or expressed concerns. If [participant] is satisfied and has no additional questions or concerns.
>
> *If the scholar has no questions or concerns*, PI [JLA]: Would you like to participate in this study?
>
> > *If yes*, JLA: Great! But before enrolling research participants, I need to ask you some questions to determine your eligibility for the main study. And so what I would now like to do, is ask you a series of questions, which should take about 5 - 7 minutes of your time.
> >
> > There is a possibility that some of these questions may make you feel uncomfortable or distressed; if so, please let me know. You do not have to answer those questions if you do not want to.
> >
> > Additionally, all information that I receive from you during this process, including your name and any supplementary information that can possibly identify you, will be strictly confidential, and will be kept in a locked office, on a secure computer *NOT* connected to the internet.
> >
> > Though this is just a preliminary process to determine your eligibility, I want to remind you that your participation is voluntary. If, after answering these questions, and it is determined that you are qualified to participate in this study, you may elect not to participate. Also, if you do not qualify to participate in this study, all information will be immediately destroyed.
> >
> > Do I have your permission to ask these questions?

If yes, PI [JLA]: Ask the following questions

1. Are you 18 years of age or older,
    i. If yes, how old are you?
2. Have you had at least one parent child communication lasting between 20-30 minutes on sex, sexuality and/or HIV/AIDS?
3. Is your parent(s) aware of your sexual orientation?
4. Did you have more than one sexual partner of the same gender in the past 6-months?
5. Did you get tested for HIV within the past 6-months?

If no, PI [JLA]: I understand and appreciate your consideration. Thanks for your time and have a great day.

Close

Thank you for your time and I look forward to interviewing you about your parent child communication experience(s). I will send you an email shortly with various days, times, and potential locations that are open for an interview. I would appreciate your prompt response via the online questionnaire. Once the online questionnaire has been received, you will be contacted via the email address you have provided to confirm your interview preferences (mode, day, and time).

If you don't have any additional questions, I hope you have a wonderful day!
Good bye!

APPENDIX F

Email Confirmation

Insert Date

Hi **Insert Participant Name**,

I hope all is well. Thank you again for agreeing to participate in this study. I would like to confirm the interview time with you. I understand your preferences to be **Insert DAY, Month, Date, Year**, at **Insert TIME and specify EST, CST, MST, PST** and this will be a **Insert Phone or Face-to-Face** interview. The interview should last approximately 45 - 60 minutes and will be recorded. If this time, date, or location does not work with your schedule, please feel free to contact me at jlalle13@uga.edu to identify a new date, time, and/or location.

Also, find attached a copy of the consent to participate form. This form, as well as any additional questions will be discussed before the interview. Please bring all questions that you have. In the event that you have follow-up questions, please do not hesitate to contact me at the email address above.

I look forward to chatting with you about your experiences.

Regards,

J. Lloyd Allen, MSW
PhD Candidate
University of Georgia
School of Social Work
279 Williams Street
Athens, Georgia, 30605
jlalle13@uga.edu

APPENDIX G

Thank You and Follow-Up Email

Insert Date

Hi **Insert Participant Name**,

I hope the holidays were relaxing, and you had some quality time with friends and/or family.

Find attached the transcribed interview that we conducted on **Insert Date of Interview**. Take some time to review it, make any necessary edits, and have it back to me by **Insert Deadline Day, Month, Date, Year, & Time EST/CST/MST/PST**. In the event that you decide to clarify, delete or add information, please use track changes options in word, or if it works best for you, make the edits on the document and then scan the document back to me, I will then make the final edits based on what you've written, added, and/or deleted. Upon finalization of the data analysis process, and the amalgamation of information, I will forward you and the other participants a final copy of the findings.

In the event that I don't hear back from you by **Insert Deadline Day, Month, Date, Year, & Time EST/CST/MST/PST**, I will assume that you are okay with the interview as is, and I will proceed without any changes made to your interview

Thank you again for your participation.

Regards,

J. Lloyd Allen, MSW
PhD Candidate
University of Georgia
School of Social Work
279 Williams Street
Athens, Georgia, 30605
jlalle13@uga.edu

APPENDIX H

Participant Demographics Questionnaire

Age (in years and months):

Gender:

Race:

Sexual Orientation:

HIV Status:

Highest Educational Level Attained:

Employment Status:

Age at first conversation:

Religious / Spiritual Background:

How old were you when you first came out to your parents?

Approximately, how many times before the age of 18 did you and your parent(s) have a conversation about sex, sexuality, and/or HIV?

Did conversations start before dating?
If so, approximately how old were you?

Did conversations start after dating?
If so, approximately how old were you?

Parent(s) highest education level attained?

Parent(s) religious/spiritual background?

Who were the members of your household at time of ‘coming out’?

APPENDIX I

Parent-Child Communication Interview Guide

1. Tell me about your experience(s) with having the conversation(s) about sex with your parents.

2. Tell me about your experience(s) with having the conversation(s) about sexual health with your parents.

3. Tell me about your experience(s) with having the conversation(s) about sexuality and risk for HIV/AIDS, with your parents

4. Think back to the times that you had the conversations about sex, which parent were you more likely to have conversations with about sex and sexuality, and why?

5. Think back to the times that you had the conversations about sex, describe the openness that your parents had regarding sensitive topics associated with sex, sexuality, and HIV/AIDS?

6. How did your parents integrate issues associated with sexual orientation in conversations about sex?

7. Describe your parents reaction when you told them about your sexuality, and did the conversations on sexual behaviors change?

8. How has having the conversation with your parents impacted your approach to sex?

9. How do you think having the conversation with your parents impacted your self-esteem, sense of self, and sexual identity?

10. What do you think parents should know about sexuality and HIV/AIDS?

11. Outside of your parent(s), who else did you talk to about sexuality and sexual behaviors?

12. How do you think race/ethnicity played a role in the type of conversations that were had?

13. How would you improve parent child communication regarding sex and sexuality?

14. Do you think your parents linked sexual orientation with HIV/AIDS?
    a. If so, where do you think they got their information from?
    b. If not, what do you think caused them to not link the two?

15. Is there anything else that we should know, that we did not discuss?

APPENDIX J

Selected Prevention Tools and Their Key References for Education/Prevention

Prevention Tools	Key Reference(s)
1. Adolescent Prevention Marketing Initiative	Kennedy, M. G., Mizuno, Y., Hoffman, R., Baume, C., & Strand, J. (2000). The effect of tailoring a model HIV prevention program for local adolescent target audiences. *AIDS Education and Prevention, 12*(3), 225-238.
2. Be Proud, Be Responsible	Borawski, E. A., Trapl, E. S., Adams-Tufts, K., Kayman, L. L., Goodwin, M. A., & Lovegreen, L. D. (2009). Taking Be Proud! Be Responsible! to the suburbs: A replication study. *Perspectives on Sexual and Reproductive Health, 41,* 12-22. Jemmott, J. B., Jemmott, L. S.,. Fong, G. T., & McCaffree, K. (1999). Reducing HIV risk-associated sexual behavior among African American adolescents: Testing the generality of intervention effects. *American Journal of Community Psychology, 27,* 161-175.
3. Collaborative HIV Adolescent Mental Health Program [CHAMP]	Baptiste, D. R., Bhana, A., Petersen, I., McKay, M., Voisin, D., Bell, C., & Martinez, D. D. (2006). Community collaborative youth-focused HIV/AIDS prevention in South Africa and Trinidad: Preliminary findings. *Journal of Pediatric Psychology*, *31*, 905-916. Bell, C. C., Bhana, A., Petersen, I., McKay, M. M., Gibbons, R., Bannon, W., & Amatya, A. (2008). Building protective factors to offset sexually risky behaviors among black youths: A randomized control trial. *Journal of the National Medical Association*, *100*, 936.
4. Dare to be You	Miller-Heyl, J., MacPhee, D., & Fritz, J. (1998). DARE to be You: A family-support, early prevention program. *Journal of Primary Prevention, 18*, 257-285.
5. Families Matter	Miller, K. S., Lasswell, S. M., Riley D. B., & Poulsen, M. N. (2013). Families Matter! Presexual risk prevention intervention. *American Journal of Public Health, 103,* e16 – e20. doi:10.2105/AJPH.2013. 301417
6. Get Real About AIDS	Main, D. S., Iverson, D. C., McGloin, J., Banspach, S. W., Collins, J. L., Rugg, D. L., & Kolbe, L. J. (1994). Preventing HIV infection among adolescents: Evaluation of a school-based education program. *Preventive Medicine*, *23*(4), 409-417.
7. ImPACT	Li, X., Stanton, B., Galbraith, J., Burns, J., Cottrell, L., & Pack, R. (2002). Parental monitoring intervention: Practice makes

	perfect. *Journal of the National Medical Association, 94,* 364-370. Stanton, B., Li, X., Galbraith, J., Cornick, G., Feigelman, S., Kaljee, L., & Zhou, Y. (2000). Parental underestimates of adolescent risk behavior: A randomized, controlled trial of a parental monitoring intervention. *Journal of Adolescent Health, 26*, 18-26.
8. Keeping It R.E.A.L. (Responsible, Empowered, Aware, Living)	DiIorio, C., Resnicow, K., McCarty, F., De A. K., Dudley W. N., Wang, D. T., & Denzmore, P. (2006). Keepin' it R.E.A.L.!: Results of a mother-adolescent HIV prevention program. *Nursing Research, 55*, 43-51. DiIorio C., Resnicow, K., Thomas, S., Wang D. T., Dudley, W. N., Van Marter, D. F., & Lipana, J. (2002). Keepin' it R.E.A.L.!: Program description and results of baseline assessment. *Health Education and Behavior, 29*, 104-123.
9. Making Proud Choices	Jemmott, J. B., Jemmott, L.S.,. Fong, G. T., & McCaffree, K. (1988). Abstinence and safer sex: HIV risk-reduction interventions for African American Adolescents. *Journal of the American Medical Association, 279*, 1529-1536.
10. Parent Adolescent Relationship Education Program	Lederman, R. P., Chan, W., & Roberts-Gray, C. (2004). Sexual risk attitudes and intentions of youth aged 12-14 years: Survey comparisons of parent-teen prevention and control groups. *Behavioral Medicine*, *29*(4), 155-163. Lederman, R. P., Chan, W., & Roberts-Gray, C. (2007). Predictors of middle school youth educational aspirations: Health risk attitudes, parental interactions, and parental disapproval of risk. In A. M. Columbus & A. M. Columbus (Eds.), *Advances in psychology research* (Vol. 4, pp. 233-241). Hauppauge, NY: Nova Science Publishers. Lederman, R. P., Chan, W., & Roberts-Gray, C. (2008). Parent-Adolescent Relationship Education (PARE): Program delivery to reduce risks for adolescent pregnancy and STDs. *Behavioral Medicine, 33,* 137-143.
11. Project Taking Charge	Jorgensen, S. R. (1991). Project Taking Charge: An evaluation of an adolescent pregnancy prevention program. *Family Relations, 4*, 373.
12. Reaching Adolescents and Parents	Anderson, N. R., Koniak-Griffin, D., Keenan, C. K., Uman, G., Duggal, B. R., & Casey, C. (1999). Evaluating the outcomes of parent-child family life education. *Scholarly Inquiry For Nursing Practice*, *13*, 211-234.

13. Reducing the Risk	Hubbard, B. M., Giese, M. L., & Rainey, J. (1998). A replication study of reducing the risk: A theory-based sexuality curriculum for adolescents. *Journal of School Health, 68*, 243-247. Kirby, D., Barth, R. P., Leland, N., & Fetro, J. V. (1991). Reducing the Risk: Impact of a new curriculum on sexual risk-taking. *Family Planning Perspectives, 23,* 253-263.
14. Seattle Social Development Project	Hawkins, J. D, Kosterman, R., Catalano, R. F., Hill, K. G., & Abbott, R. D. (2005). Promoting positive adult functioning through social development intervention in childhood: Long-term effects from the Seattle Social Development Project. *Archives of Pediatrics & Adolescent Medicine, 159,* 25-31. Lonczak, H. S., Abbott, R. D., Hawkins, J. D., Kosterman, R., & Catalano, R. F. (2002). Effects of the Seattle Social Development Project on sexual behavior, pregnancy, birth, and sexually transmitted disease outcomes by age 21 years. *Archives of Pediatrics & Adolescent Medicine, 156,* 438-447.
15. Seeking Safety	Hamilton, N. (2006). African-American Center for Excellence (AACE) Program; SAMHSA grant number TI14126; final report. Unpublished report, Operation PAR.
16. Straight Talk	Frye, V., Bonner, S., Williams, K., Henny, K., Bond, K., Lucy, D., ... Koblin, B. A. (2012). Straight Talk: HIV prevention for African-American heterosexual men: Theoretical bases and intervention design. *AIDS Education and Prevention*, *24*, 389-407.
17. Strong African American Families	Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., ... Neubaum-Carlan, E. (2004). The Strong African American Families program: Translating research into prevention programming. *Child Development, 3,* 900. Murry, V. M., Berkel, C., Brody, G. H., Gibbons, M., & Gibbons, F. X. (2007). The Strong African American Families program: Longitudinal pathways to sexual risk reduction. *Journal of Adolescent Health*, *41*, 333-342. doi:10.1016/j.jadohealth.2007.04.003 Murry, V. M., Berkel, C., Chen, Y., Brody, G. H., Gibbons, F. X., & Gerrard, M. (2011). Intervention induced changes on parenting practices, youth self-pride and sexual norms to reduce HIV-related behaviors among rural African American youths. *Journal of Youth and Adolescence*, *40*, 1147-1163.
18. Teen Talk	Eisen, M., Zellman, G., & McAlister, A. L. (1990). Evaluating the impact of a theory-based sexuality and contraceptive education program. *Family Planning Perspectives*, *22,* 261-271.

19. The LifeSkills Training	Griffin, K. W., Botvin, G. J., & Nichols, T. R. (2006). Effects of a school-based drug abuse prevention program for adolescents on HIV risk behavior in young adulthood. *Prevention Science, 7,* 103-112. Griffin, K. W., Botvin, G. J., Nichols, T. R., & Doyle M. M. (2003). Effectiveness of a universal drug abuse prevention approach for youth at high risk for substance use initiation. *Preventive Medicine, 36,* 1-7.
20. Youth Focused Media Communication Project	Birhan Research and Development Consultancy (BRDC). (2008). Youth Focused Media Communication strategy for addressing HIV/AIDS and other related social issues in Ethiopia. Retrieved online on August 8th, 2015, from http://54.172.146.51/sites/default/files/g3p_documents/88/youth-focused-media-communication-project-final-rpt-08.pdf